Makerere University

REVIEW OF UCMB OPERATIONAL PLAN 2004 - 2006

April 2006 - May 2006

June 2006

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AVSI	Associazione Volontari per il Servizio Internazionale
COWA	Companionship of Works Association
DHC	Diocesan Health Coordinator
DHMT	District Health Management Team
DHO	Diocesan Health Office
DKA	Dreikoning Aktion – Austrian Foundation
EAS	Executive Assistant Secretary
ES	Executive Secretary
FA/FM	Financial Administration / Financial Management'
FM	Financial Management
FY	Financial Year
GIFMU	Global Initiatives Fund Management Unit
HSD	Health Sub-District
HDP	Health Development Partners
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRM	Human Resource Management
HSSP	Health Sector Strategic Plan
ICT	Information and Communication Technology
IICD	International Institute for Communication and Development
JMS	Joint Medical Stores
LLU	Lower Level Unit
MDGs	Millennium Development Goals
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MP	Meeting Point
NGO	Non Governmental Organisation
OD	Organisation Development
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PME	Planning, Monitoring and Evaluation
PNFP	Private not for Profit
PPPH	Public-Private Partnership for Health
RC	Roman Catholic
RCC	Roman Catholic Church
SMART	Specific, measurable, achievable, realistic, time-bound
SVOFG	Vronstein Foundation - Netherlands
SWAp	Sector Wide Approach
SUO	Standard Unit of Output
TA	Technical Assistance
ToR	Terms of Reference
UCMB	Uganda Catholic Medical Bureau
UEC	Uganda Episcopal (Bishop's) Conference
UJAS	Uganda Joint Assistance Strategy
UMMB	Uganda Muslim Medical Bureau
UPMB	Uganda Protestant Medical Bureau
WB	World Bank

EXECUTIVE SUMMARY

The Uganda Catholic Medical Bureau (UCMB) decided, in consultation with consultants and the key donors of the Operational Plan 2004 – 2006, to conduct a review. This would then be treated as a near-end of term review, and to focus on gathering information that could provide input to the upcoming strategic planning process. In this regard, UCMB commissioned a team made up of Ria van Hoewijk of I/C Consult (Netherlands) and George W. Pariyo of the Makerere University Institute of Public Health (Uganda) to carry out the review.

Objectives of the review

The review was supposed to look at effects and impact of the implementation of the Operational Plan 2004 – 2006, as well as to provide input for the next strategic plan. Specifically the objectives were to: 1) Assess the effectiveness of the implementation of the UCMB Operational Plan 2004-2006 in meeting its operational objectives, advancing the pursuance of the underlying strategy, and recommend issues that can be addressed before the end of the Plan's period to assure maximum achievement of the still pertinent objectives; and 2) To identify issues emerging in the ever-changing external/internal environment that may require substantial modification of the Mission and Policy of the health services and the related fundamental strategic options of the Strategic Plan 2006-2010, and provide pertinent recommendations.

Methods Used

In order to strengthen validity of the findings and avoid any biases that might be introduced by reliance on one method, different methods were used in a process known as triangulation: desk research; focus group discussions, interviews, observations (field visits, Technical Review Meeting), questionnaires and a validation workshop with UCMB staff.

Key Findings on Implementation of the Operational Plan 2004 - 2006

Achievements

The core question for the review was: what difference did UCMB make? The following is a summary of the key achievements in relation to the strategic objectives.

Place in the national health system
The advocacy and lobbying on the national level (mainly by UCMB) resulted in an undisputable recognition by government and development partners of the important contribution of faith-based health sector, often referred to as Private-not-for-Profit (PNFP) sector, to the achievement of the Health Sector Strategic Plan I (and II) targets and the health-related MDG goals. At present the materialisation of this 'recognition' is not according to (UCMB's) expectations, but it was unanimously stated that UCMB can not be blamed for that.

Faithfulness to the mission
The church values as seen in the UCMB mission and policy statement seem to be translated into reality in most of the UCMB affiliated (and broader PNFP) facilities. UCMB has built on these values and reinforced the mission of the church in 'healing'. Faithfulness to the mission could (amongst others) be read from themedian value of fees charged. UCMB uses this as a proxy indicator for equity. Here UCMB faces a problem. Facilities further lowered user fees and/or introduced flat fees during the period under review. However they seem to have reached a ceiling by now.

Credibility and constructive internal and external relations
At the national level, relations between the PNFP (UCMB) sub-sector and the government seem to have become strained. At the decentralised district level the relations are also not yet in line with the concept of 'partnership', although large

differences can be found between districts and sub-districts. There are no data available as to conclude on the difference between RCC (or PNFP) led sub-districts.
Internal relations, both within a facility and within UCMB greatly improved as reported by many. This was mainly attributed to the approach of the UCMB advisors in assisting the facilities to develop constitutions and manuals as well as in helping them to reflect on performance. This reflection (or monitoring and evaluation) was backed by adequate data. Here the ICT project proved to be very valuable and key in the capacity building process.
At the UCMB (umbrella body) level more consensus or internal cohesion is reported, which is also reflected in the level of attendance at UMCB organised events and at the Annual General Meeting.

Transparency and accountability
Upwards and vertical accountability (to government, other UCMB facilities and the Bureau) has improved: the percentage of annual reports from the LLUs increased from 40% in 1998 to 96% in 2005 (however this was already achieved before the start of this Operational Plan). The quality is, according to UCMB, quite good although differences can be found between LLUs and between dioceses. Since 2001, all hospitals provide annual reports (in 2000 it was still 81%). Also here quality differs.
Downwards accountability is still a challenge.
Transparency and accountability requires appropriate financial procedures and systems. Here UCMB contributed a lot (development of modules for financial and materials management), although the quality of management in this area is still rather low. There are strong differences between the hospitals.

Performance of the health facilities
Looking at the four criteria which UCMB developed for performance: access, equity, efficiency and quality, improvements are crystal clear on access and efficiency (see the UCMB Annual Reports). This is a remarkable success given the pressures: dwindling resources and high staff turnover rates.
Overall quality can be read from the findings of the accreditation process (for hospitals) and the Diocesan Health Department assessment exercise. As no historical data are available nothing can be concluded on level of improvements.

Quality of staff, management and boards and their interrelation
In particular here improvements were attributed to the UCMB contributions.
Quality of management as reported by UCMB staff, diocesan health office and facility staff themselves, and others, is substantially improved; more self-confidence, able to read performance data, more transparency and accountability, improved cost-consciousness, increased awareness of the need for result oriented management and accounting, more teamwork, seeing the broader picture, improved external relations.

Other effects of work done or decisions taken by UCMB
UCMB's legitimacy has increased. This is quite certainly because of the relevance and quality of the services for the affiliated facilities as perceived by them. UCMB is appreciated by its constituency as seen in the level of contributions; from 40% in 1998 to 96% of the facilities contributing in 2005.

Planned objectives and targets not fully or not yet met

As stated above, the pace of improvements in financial administration and management is below expectation.
Much new effort went to the further alignment of the PNFP training schools. This new development might have diverted attention from planned targets, but under the circumstances of a changing external environment, was perceived to be justified. However, one of the key PNFP actors (the Church of Uganda) considered that the time was not (yet) ripe for a more formalised harmonisation of training schools on their part.
Some targets on the technical capacity of hospitals in the areas of Social Welfare, Palliative Care and Mental Health have not (yet) been achieved. No one of the persons met referred to this omission, which puts a question mark on the relevance of these targets.
Although UCMB has been able to increase its working capital from Ushs. 225,881,634 in 2004 to 359,833,210 (total budget for 2005 was 2,431,113,280), it is far from being

able to cover the 'skeleton' costs (2 management staff, 1 secretary and 1 driver) from locally generated income. Organisational sustainability and to a lesser extent 'predictability' of income is, however, quite good. More attention should be given to absorption capacity. Under spending is at about 15-20% and solutions in the area of increasing staff capacity seem to have reached a ceiling.

Appropriateness of strategies

In general the capacity building, lobbying and advocacy strategies are appropriate taking into account the mandate of the Bureau and the context. However, an overemphasis on rational strategies (convincing others through facts and figures) is noticed, possibly diminishing the role of the more political and emotional dimensions of change processes.

Critical success factors and risks

a. Both the advocacy and lobbying strategies and the organisational capacity building efforts rely heavily on the *quality of data management* (relevance and accessibility), which has been outstanding. The risk here is that UCMB still relies on the professional skills and knowledge of an ex-pat staff member, seconded by an Italian NGO (AVSI). It is not certain when and if this staff member will be able to bring his Uganda counterparts to the required level by the end of his current assignment in 2007.
b. UCMB's *reflection and learning capacity and willingness* is extraordinary. UCMB shows in its annual reports, in discussions and workshops, a genuine interest in finding avenues to improve on what they did and (not fully) achieved: "Did we do the right things and did we do these things right?" seems to be a natural question that is tabled regularly in different forms and fora. Evidence based PME (planning, monitoring and evaluation) is well developed. However, the effectiveness of a system, although computerised where possible, depends on its users. At present the log frame underlying the 2004 - 2006 Operational Plan can hardly serve as an adequate monitoring (and evaluation) guide as sight on the key objectives and indicators is easily lost in the huge number of objectives (47), targets (71) and indicators (112). The risk is that monitoring and evaluation is only done once a year in preparing the annual report and the next year's work plan, while it should be in-built in the daily management and leadership practice. It also relies heavily on the more than average capacity of the Executive Secretary (who will soon be replaced by somebody else) to deal with complexity.
c. There is a clear *balance between the 'technical' and the 'spiritual' dimension* of UCMB as an organisation: structure, procedures and systems seem to be adequate for the responsibilities the Bureau has agreed to take up, while sight on the vision and mission of the Bureau is kept alive. In the UCMB case - the balance seems in particular to be fostered by the present Executive Secretary.
d. UCMB managed to attract a *good mix of high profile professionals; committed, well skilled support staff and competent management*. They all seem to have the vision and mission of UCMB close to their heart and are very competent in translating this into strategies and approaches which meet international standards without losing touch with the reality on the ground and the priorities set by the 'clients'. As retention of this calibre of staff is not that easy and two ex-pats (the OD and the FM advisor) are preparing for the end of their contracts after handing over to local staff, this critical success factor can easily be lost.
e. *Dedication* for the work is high and sometimes reconciling private and work commitments is not always easy. The tendency of 'going for the best' could easily end up in perfectionism that does not necessarily serve its purpose any longer (see the 112 indicators and the sophisticated financial administration modules).
f. *Funding mechanisms* enable UCMB to set priorities based on a thorough scanning of the internal and external environment, followed by a genuine dialogue with the core donors instead of just going with the donor's agenda. Both volume (although absorption remains a concern) and modalities (flexibility and support for institutional strengthening for instance) are *adequate*.
g. Last but not least, we should mention the *backing from the church leaders* for the process of further improvement of the performance of the RCC health sub-sector. Here UCMB should be alert: it takes possibly extra efforts to ensure continued backing.

Suggested strategic directions

Merging the context analysis (economic hardships - real and perceived; fragile public-private partnership; increasing global initiatives; increasing health care costs; increasing power of government and its apparently lessened interest for partnership with the PNFP sector; high pressure to achieve MDGs and Uganda Health Sector goals leading to verticalisation; increased perception of corruption; loss of confidence in SWAp/Budget Funding mechanisms) with the critical success factors results in the following suggestions for the next strategic plan period:

Dialogue within the PPPH partnership
It is necessary to re-invigorate the partnership through renewed efforts at dialogue at the national level. The existing structures e.g., the Health Policy Advisory Committee (HPAC) and the Health Development Partners (HDP) could be a starting point. Advocacy and lobbying efforts could also be directed to speeding up the cabinet approval process for the PPPH policy.
Efforts should be made towards kick-starting a process at the district/local authority level similar to the HPAC arrangement at national level. The participation by PNFP personnel e.g., Diocesan Health Co-ordinators and hospital managers in the District Health Management Team (DHMT) which is charged with joint planning and co-ordination of health services could be a start.

Strengthen old and build new alliances
It is necessary to revisit and strengthen existing alliances and, where possible, to build new ones at national (Health Development Partners and a number of government officers) and international levels (traditional donors (e.g., CORDAID, Italian Episcopal Conference and others). At the local district/health sub-district levels, PNFP personnel should take advantage of the existence of a number of donor-supported projects aiming to develop good governance and improved service delivery (SNV, Northern Uganda Social Action Fund, USAID and UNDP supported projects, other local civil society organisations). Within the Church itself, there are other departments like Caritas whose efforts could be synergistic with those of PNFPs.

Revival of PPPH Desk
It is of paramount importance to revive the institutional mechanism that is already in place to facilitate the public private partnership, i.e., the PPPH desk in the MOH.

Invest in "soft" skills
While there have been great achievements in more technical skills e.g. generation and use of data, financial administration, this has opened a new area that will become increasingly important. It is clear that PNFP and government staff alike, especially at the local level, will need to acquire and/or develop a new set of skills to strengthen communication in general, advocacy and lobbying and constructive/strategic negotiating. This will enable them to articulate the case for a fair share of the resources available, as well as being able to present their activities and achievements in a way that is perceived to be collaborative and non-threatening by the other (especially government) stakeholders.

Support the strengthening of the system as a whole
It is clear that a one-sided development could result in the burden of providing health care shifting ever more onto the PNFP shoulders. It is thus of interest to the PNFP themselves that the government facilities also improve and offer services of reasonable quality. Many performance assessment tools and indicators as well as feedback techniques have been developed by the PNFP and UCMB in particular which could offer a valuable learning to the public facilities.

Special focus on the North
There are strong indications that the humanitarian situation in Northern Uganda is getting higher and higher on the national and international agenda. Strengthening a presence in the North e.g., through the presence of a regional co-ordinator or advisor could ensure a more relevant and timely support to reinforce the achievements of UCMB.

Strengthen systemic approach

It is clear that the systems approach taken by UCMB should continue and be strengthened. Vertical programmes and projects are currently and will remain a reality for the foreseeable future. The level of funding going through vertical programmes/projects and its consequences on the rest of the system cannot be ignored by UCMB and affiliated facilities. This means there is a need for UCMB to develop capacity to support facilities to be able to selectively engage in some vertically funded programmes/projects, while not losing sight of the overriding imperative to develop, strengthen and maintain functional systems. UCMB will need to continue its role of providing support to develop and strengthen the system as a whole, as well as providing technical advice on how hospitals can participate in projects while maintaining a systems orientation. In order not to lose the momentum with hospitals and diocesan health offices, it will be important for UCMB to maintain a dedicated officer to help in sourcing and following up projects as is currently the case under GIFMU.

Implications

Accepting these suggestions requires that a high profile staffing of the Bureau continues.

The current Executive Secretary is well positioned to transition into a behind the scenes supportive role. This could include high level analysis of policies and their implications for the UCMB and facilities, and offering general strategic guidance and liaison with the Church authorities to ensure adherence to the mission and protection of autonomy, while functioning as an integral part of the national health system.

Short term improvements

a. Stay alert on the quality of the PPPH both at the national and the decentralised level.

b. Strengthen the recently agreed focus for the OD advisors on (the position of) the diocesan offices (vis-à-vis the hospital if existing in that diocese, as well as vis-à-vis the Caritas department of the diocese), and through these offices focus on the LLUs.

c. Continue the systemic (OD) approach on the hospital/Diocesan Office level; attune the assessment exercises with the accreditation procedures so as to avoid confusions on the relation between the two exercises.

d. Continue the interdisciplinary OD/management development approach as team of UCMB advisors; consider the possibility to work as ‘account managers’ which means that each advisor has a prime responsibility for a number of dioceses. This is in order to enhance cost effectiveness as well as to promote and demonstrate the inter-linkages between the core processes of an organisation. Exclude the senior advisor from this as she should give guidance to the overall process and assist, where needed, in more complex situations.

e. Strengthen the contextualised, tailor made OD (including FM) approach.

f. Continue support for contingency planning for those hospitals and Diocesan Offices for which this is more appropriate at this moment in time, instead of embarking on a full fledged Strategic Plan for every facility. Where possible and relevant, support strategic planning (scenario planning) at the facility level from the perspective of the bigger picture (local, national and even international ‘landscape’).

g. Continue the exercise to review and renew agreements (MoUs) between UCMB and its ‘clients’. Replace ‘pushing’ strategies by ‘pulling’ in the sense of rewarding self-initiated, self-supported, pro-active, innovative and future oriented searches for constructive solutions, and terminate the support where a sufficient level of ‘self-renewal’ organisational capacity can be noticed.

h. Gradually replace trainer or advisor-dependent methodologies for professional development of management by more peer based methodologies, such as joint action research, peer reviews (or ‘visitations’) and methodologies based on a one-to-one collegial basis, such as ‘PAL’ (Peer Assisted Learning) or ‘Critical Friend’.

i. Review time allocation of staff to different objectives so as to find out if and how more staff/advisor time can be made available to search for avenues to achieve the objectives that got less attention (assuming these are still relevant), such as enhancing

the capacity to deliver holistic services and therefore increase knowledge and skills on mental health care, palliative care and social welfare.

1 INTRODUCTION

1.1 Background

The Uganda Catholic Medical Bureau (UCMB) is the health office of the Catholic Church in Uganda and the technical arm of the Uganda Episcopal Conference's Health Commission. It currently implements the Operational Plan 2004 - 2006 under the framework of the Strategic Plan 2001 - 2005. The previous Operational Plan 2001 – 2003 was reviewed in November 2002 (report February 2003). Internal and external circumstances forced UCMB to delay the Mid-Term Review of the current Operational Plan and the renewal of the Strategic Plan. It was therefore decided by UCMB in consultation with the consultants and the key donors of the Operational Plan 2004 – 2006 to treat the review more as an (near) end of term review, and to focus on gathering information that could input the upcoming strategic planning process.
More background information on UCMB can be found in chapter 2.

Objectives of the review
As stated above the review was supposed to look at effects and impact of the implementation of the Operational Plan 2004 – 2006, as well as to provide input for the next strategic plan.
In the ToR (see Appendix 1) this was stated as follows:

A. To assess the effectiveness of the implementation of the UCMB Operational Plan 2004-2006, in meeting its operational objectives, advancing the pursuance of the underlying strategy and recommend issues that can be addressed before the end of the Plan's period to assure maximum achievement of the still pertinent objectives.
B. To identify issues emerging in the ever-changing external/internal environment that may require substantial modification of the Mission and Policy of RCC health services and the related Strategic Plan 2006-2010, fundamental strategic options and provide pertinent recommendations.

A list of six key strategic options was derived from discussions with UCMB management and through focus group discussions conducted on 7th March with Diocesan Health Coordination Officers and on 19th April with hospital management staff and board members. The list of participants can be found in Appendix 2. There emerged three inter-linked strategic dilemma's for the Catholic Health Sector:

a. Integration (in the national health system) versus autonomy.
b. Enhancing quality and sustainability versus remaining faithful to the mission.
c. Vertical programmes versus a systemic approach.

Furthermore the list indicates some issues related to the approach of UCMB:

d. How to improve quality of management: clear roles, checks and balances, transparency and accountability, dynamic management etc.
e. How to improve the advocacy role?

Methodology
The methodology used in the review was largely qualitative and placed emphasis on triangulation of findings from a range of approaches that included desk review of key documents, plans and reports (see Appendix 3 for documents reviewed); focus group discussions and individual self administered interviews (see Appendix 2 for list of participants and respondents and Appendix 4 for summary of results); key informant interviews (see Appendix 5 for list of key informants interviewed), observations (field visits to two sites and participation in Technical Review Meeting). A validation/debriefing workshop was conducted on the last day of fieldwork with UCMB staff.

Constraints
Given the limited time available, primary data could not be gathered, so the team had to rely on existing documents and data. The UCMB annual reports as well as other publications, however, provided relevant information and reliability of this information is not questioned since no counter indications were found during the review.

Little time could be spent on field visits. However, it was felt that the choice of the facilities visited, together with the annual reports and the reports of the various UCMB workshops and meetings gave sufficient insights into the impact of UCMB's work.
Furthermore the team was constrained by the limited accessibility of the government health officers. It was, for that reason, not possible to counter check some facts and figures and perceptions on trends and expectations for the future, from the point of view of the MOH stakeholders.

Report Content
In chapter 2 relevant background information on UCMB and the Operational Plan under review is given. Chapter 3 highlights the main achievements in terms of effects and impact, and tries to unpack the factors and actors which contributed to ('critical success factors') or hindered these achievements. This is followed by a brief chapter (chapter 4) describing the main relevant characteristics of the context UCMB is operating in as to allow a matching of UCMB's possibilities and limitations in fulfilling its mission and the opportunities and challenges in the context resulting in possible strategic directions. These directions can be found in chapter 5. Chapter 5 also contains more concrete, operational suggestions for improvements and it presents some suggestions for the organisation of the upcoming strategic planning process.

Although UCMB has been extremely helpful in providing lots of relevant documents and additional information, the sole responsibility of the content of the report lies with the consultants.

2 UCMB

2.1 Brief History[1]

UCMB is the operational office of the Health Commission, one of the 12 Commissions of the Uganda Episcopal Conference (UEC), the umbrella body that brings together all the Roman Catholic bishops and archbishops from the 19 Catholic dioceses and 4 Ecclesiastical Provinces of Uganda.

UCMB was established in 1955 together with the Uganda Protestant Medical Bureau (UPMB). The main purpose from the beginning was liasing with government, streamlining the disbursement of funds to the then voluntary health sector[2] and to develop nurse training. Currently the core functions of the Bureau are: supporting the health facilities of the Roman Catholic Church (RCC) through "data collection and management, dissemination of information, facilitating of fora and sharing of experience" and "advocacy, lobbying and representation".[3]

The need for a coordinating body became even greater after the departure of most of the expatriate missionaries because the services were taken over by the dioceses and – to a lesser extent – congregations, while some new others were set up by parishes or congregations for a variety of reasons, ranging from meeting the health needs of the community to meeting the financial needs of the parishes. In the Mission Statement and Policy document as approved by the bishops' conference in Uganda in 1999 UCMB clearly defined itself as operating within the overall mission of the church, operating on a not for profit basis and having a "preferential option for the poor".

Since the mid-eighties UCMB has facilitated the establishment of a Health Coordination Office in most dioceses so as to respond to the need for greater coordination, resulting from the continuing emergence of many new health units highlighting the limited capacity of government services during these days.
One of the other major past achievements of UCMB was the establishment of Joint Medical Stores (JMS), in cooperation with the Uganda Protestant Medical Bureau. JMS, a drug procurement agency, ensured a regular supply of essential health care goods to the voluntary health sector during the years of unrest when both government organization and trade collapsed, thus permitting a minimum of service to the people. JMS is an independent body although UCMB and UPMB are represented on its Board.
Towards the end of the eighties, in order to face the challenge posed by the HIV/AIDS epidemic and the development of primary health services required by the country, UCMB established two specific desks to assist the Executive Secretary on issues related to HIV/AIDS and primary health care (PHC). The Focal Point for HIV AIDS operates, since 2000, as an independent unit under the Secretary General's office. The Global Initiatives Fund and Management Unit (GIFMU) was established four years later (2004), to handle financing mechanisms of Global Initiatives. It is a unit jointly steered by some departments of UCS, among them UCMB and FP for HIV-AIDS. A separate PHC desk is no longer operational.

Towards the mid nineties it became progressively apparent that the challenges posed by the re-organization of government, by decentralization, and by health sector reforms, required a new change at UCMB. The difficulties posed by the changes in the environment were compounded by the increasing financial constraints faced by the voluntary health sector, perceivable also at UCMB in terms of decreased contributions from the units. In this period UCMB with UPMB negotiated successfully with Government a revival of the forgotten support of government to not-for-profit health

[1] Use is mainly made of the Mission Statement and Policy of the Catholic Health Services in Uganda, UCMB, June 1999, the ToR for the End of Term Review of the UCMB Operational Plan, Daniele Giusti, 12-2-2006 and the report of the November 2002 review (January 2003).
[2] This sector is now referred to as the private not-for-profit (PNFP) sector. It comprises mainly of faith-based, or church affiliated health services (both facility and non facility based).
[3] See: Mission Statement and Policy of the Catholic Health Services in Uganda, UCMB, June 1999, p.3.

sector units[4]. In so doing it also contributed to the establishment of a formal relationship in the form of a 'partnership' between the public and the private sector, known as the "Public Private Partnership for Health" (PPPH). The legal backing of the PPPH is still lacking as political approval of the PPPH Policy has been delayed due to unsolved issues concerning the position of "traditional and complementary health providers".

In 1996 the main funding agency of that time, Bilance[5], commissioned an assessment by a team of public health experts whose results prompted the Health Commission to appoint a committee charged with the task of studying "avenues for reform of UCMB and the sustainability of its role". The conclusions of the study made by the Committee highlighted the need of a higher professional profile of the Bureau and the trimming of its size, accompanied by a shift from an implementing to a facilitating and representation role. The main objective then became to strengthen the system so as to enable the facilities to strategically position themselves and deliver an appropriate package of quality services in line with the mission. The Episcopal Conference accepted the Committee's suggestion and gave mandate to UCMB to enter into the restructuring process. A further consultancy commissioned by Memisa (which in the meanwhile took over from Bilance the support of UCMB), taking into account the ongoing process of restructuring of UCMB, discussed with the former Executive Secretary of UCMB and the Committee the terms of a way forward plan, which resulted in an Operational plan 1998/2000 that started on 1st January 1998 under Memisa funding. The current ES was recruited then as TA to the ES in 1998, and later took over the office.

In March 2000 a workshop involving the major in-country and external stakeholders took place, during which a Strategic Plan 2001-2005 was outlined and agreed upon[6]. Within the frame of the agreed strategy an Operational Plan 2001-2003 was implemented with support of multiple funding partners among whom Cordaid is the most important (see 2.5).
The implementation of this plan was reviewed in November 2002 with a positive assessment. One of the weaknesses was found in the absence of quantified, measurable indicators for progress, which resulted in a 2004-2006 Operational Plan with 112 mostly quantitative indicators. Key recommendations given were:

- Operate the revised Operational Plan as a rolling plan within the 5-year Strategic Plan.
- Strengthen the Human Resource Unit of the Bureau and develop a more comprehensive Human Resource Development plan.
- Maintain and optimise UCMB's involvement in policy development and assure that RCC health service concerns are taken into consideration in national key health policy decisions.
- Develop strategic alliances with all partners as part of the process of ensuring managerial and financial sustainability.
- Give greater prominence to pastoral care in subsequent reviews of the Strategic Plan.
- Clarify the organisational position of the Nurse Training Institutions and ensure optimal use of their training capacity.

2.2 Position in the National Health System

The position of UCMB in the National Health System is seen in:

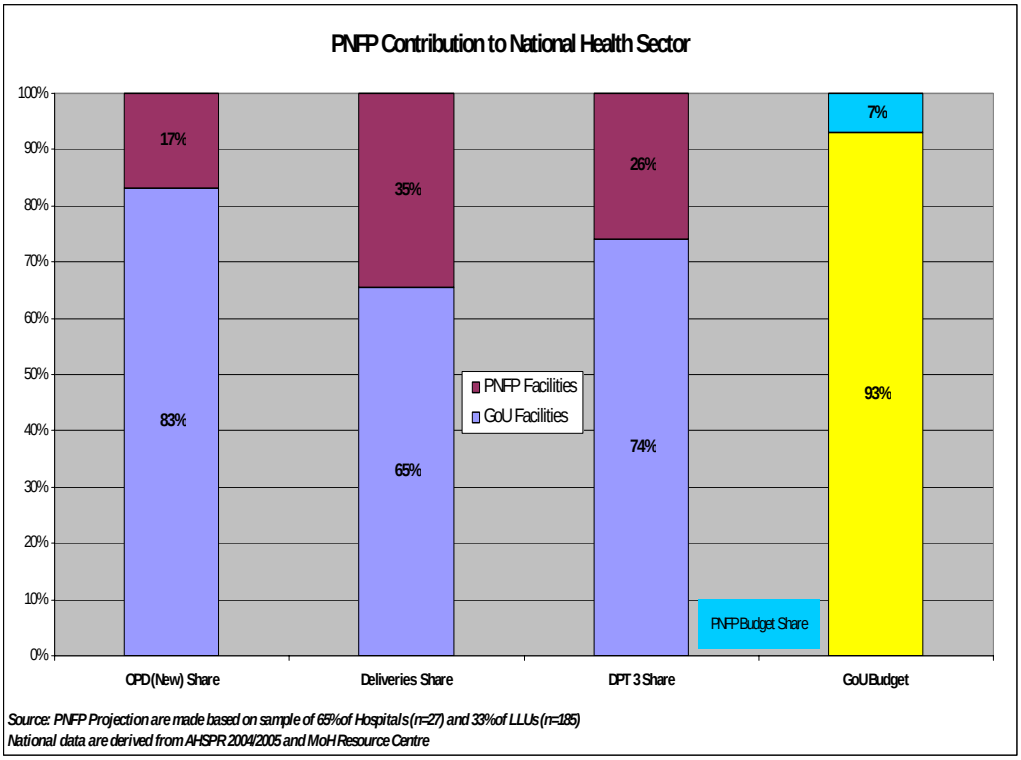
1. The number of facilities owned by the Roman Catholic Church (RCC) in relation to the total number in the country;

[4] Government subsidies were available starting at the fiscal year (FY) 1997/98, see Daniele Giusti, 2004, fig. 3.
[5] Bilance merged in 1999 with other Dutch Catholic Development NGOs, such as Memisa and is now operating under the name Cordaid.
[6] The rationale being that is that a Strategic Planning exercise would take place every 5-6 years and include an assessment of the Mission. Operational Planning would occur every three years and allow a certain degree of time overlap between one plan and the following. The mid-term review of each Operational plan would constitute the basis of adjustments of the plan nearing its end and of the next mid term period planning.

2. The contribution of the RCC sub-sector in terms of percentage of the total number of services delivered;
3. The share of the total available health budget, generated by the RCC facilities;
4. The share of the government health budget allocated for the PNFP sub-sector (grants are for the PNFP sub-sector as a whole).

Currently[7] the RCC owns and manages 27 hospitals which is 25% of the total number of hospitals in Uganda; 19 Diocesan Offices with about 230 Lower Level Units (LLUs), representing about 15% of the overall number of LLUs in the country, and 13 Training Schools, which is 40% of the total number of training schools.
On the parameters mentioned under 2 – 4 only a few specific RCC data could be found. The information below is therefore not disaggregated and shows the picture for the whole PNFP sub-sector. The RCC health sub-sector owns about 2/3 of the hospitals and training schools and about 1/2 of the LLUs, which gives an indication of the position of the RCC sub-sector within the overall PNFP sub-sector.[8]
The percentage of services provided by the PNFP sub-sector can be read from the graph presented by the UCMB Executive Secretary during the April Joint Technical Review Meeting (figure 1).

Figure 1: Contribution of PNFP to the National Health Sector



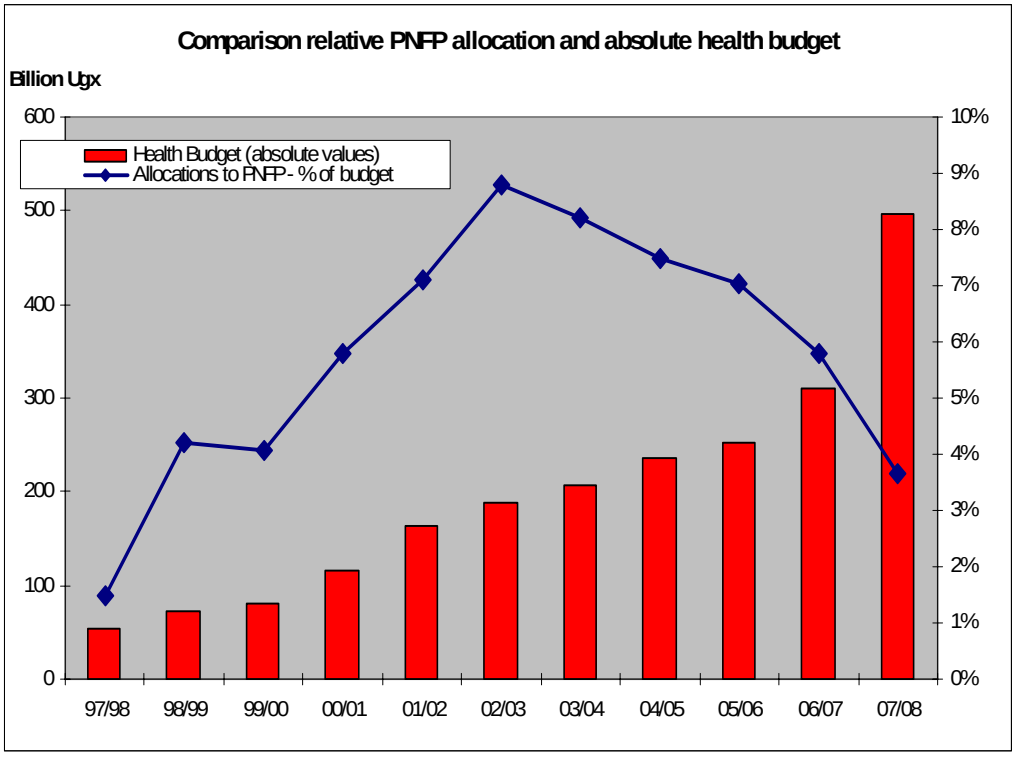
The picture varies from district to district with the PNFP sub-sector dominant in the hard to reach areas.

According to the National Health Accounts 1998/99 – 2000/01 (reported in Health Sector Strategic Plan II -p. 85) the PNFP sector seemed to control a large amount of resources financing health service delivery (32% PNFP, 42% household and 26% public finances). This datum was anyway misleading because the PNFP sector there referred to included non-facility based PNFP – i.e. local and international NGOs. Calculation of contributions of the PNFP other than percentage of services delivered and resources controlled could not be found as no comparable data are available from MoH, but it is evident that the PNFP sub-sector and in particular UCMB also

[7] Data are copied from the power point presentation prepared in 2006 by the UCMB data management advisor.
[8] UPMB owns 14 hospitals, 242 LLUs and 7 training schools. UMMB owns 3 hospitals, 46 LLUs and is planning to open 1 training school at Kibuli Hospital.

contributes substantially in terms of infrastructure and in-service training of staff who then transfer to the public sector (in-country brain drain costs).
From the financial year 1997/98 to 2002/03 the percentage of the health budget allocated for the PNFP sub-sector[9] rose from about 2% to almost 9%, but since then it dropped to 7% in 2004/05. While a dramatic fall relative to the total health budget is foreseen to less than 4% in 2007/08 (see figure 2) the MoFPED official assured the team that in absolute terms the allocation to the PNFP sub-sector will for the coming financial year remain at the level of the previous year, even where the government budget is expected to go down dramatically.

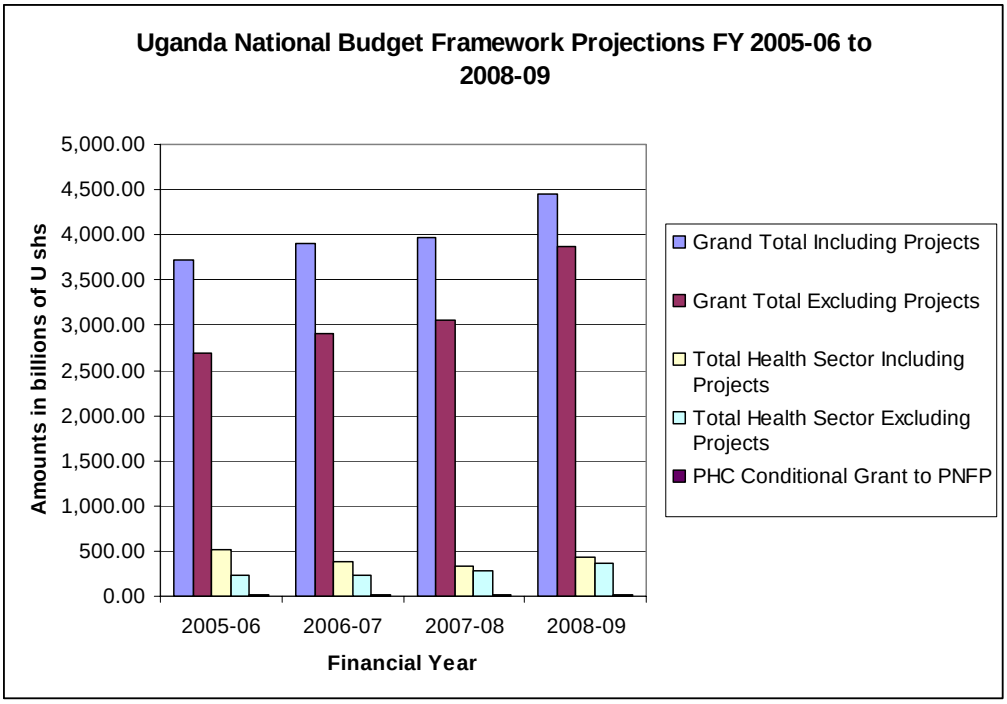
Figure 2: Comparison of PNFP Allocations Relative to Total Health Budget



Overall, we see a projected fall of total health sector allocations relative to the total national budget (figure 3). Contrary to the Abuja Declaration where African Union Heads of State pledged to increase the health sector share of the national budget to 15%, we see a decline from 13.7% in FY 2005-06, to 9.6% in FY 2006-07, to 8.4% in FY 2007-08 before rising again slightly to 9.6% in FY 2008-09.

[9] Includes financial resources as well resources in kind i.e., PHC Conditional Grant, staff salaries and credit lines for drugs/supplies.

Figure 3:Projections for the Ugandan National Budget Framework FY 2005-06 to FY 2008-09



Source: Based on figures contained in the MTEF, March 2006.

For the RCC units contribution more or less stabilised (drugs units and training schools) or decreased, resulting in a total decrease from 12.303 billion in 2003-04 to 11.568 billion in 2005/06 (See UCMB 2005 Annual report, p. 90).

2.3 The 2004 – 2006 Operational Plan

Background

In November 2003 several partners (including funding agencies) attending a "Consensus Conference" received an extensive "near end term" self assessment of the implementation of the Operational Plan 2001 - 2003, along with a proposal for a new plan for the period 2004 - 2006, articulated in two scenarios[10]. All participants agreed that the Bureau should continue scaling up its activities in the light of the increasing demand of service from the affiliated units. The Plan was hence approved and funded to levels close to its ideal scenario. The Operational Plan 2004-6 maintained a strong 'systemic' approach to operations, similar to the previous Operational Plan.

The entire Strategic Plan 2001 - 2005 thus aimed at 'building the system', but in 2003 it was already clear that new, more vertically oriented approaches were emerging, that were not present in the year 2000 when the strategy was outlined. This notwithstanding the choice of the 2003 Consensus Conference was clear: UCMB should maintain its focus on 'building systems' and favour the establishment of other units within the Catholic Secretariat to address vertical programme issues.

Objectives

The objectives of the 2004 - 2006 plan are only slightly different from the previous plan:

1. The RCC Health Services occupy a place in the National Health System that is beneficial to the needs of the populations and their mission (10 objectives);
2. Improved quality and sustainability in faithfulness to the Mission Statement (14 objectives)
3. Increased dynamic and transparent management (8 objectives)

[10] UCMB had prepared two proposals: a conservative scenario implying the scaling down of operations in the course of the Plan, and an ideal scenario entailing a sustained accelerated level of operations for the period.

4. Improved cohesive internal organisation[11] and external organisational arrangements (8 objectives)
5. Improving advocacy (2 objectives)
6. Overarching objectives: disaster preparedness plan developed and funding acquired; Mission and Policy Statement of RC Health Services and the Mission Statement, functions and structures of the Health Commission and UCMB revised in accordance (June 2005); new Strategic Plan developed (end of 2005); current Executive Secretary replaced (April 2006); each year one area for innovation or an emerging innovative approach is identified, researched and developed.

Strategies

The core strategies foreseen are[12]:

a. Liasing and lobbying with the Ministry of Health (MoH) and other national authorities, preparing policy contributions, ensuring that the Health Commission and the UEC can take decisions, based on well informed technical advice;
b. Strengthening Diocesan Health Coordination and hospitals, ranging from providing hands-on technical services support to improve functioning, management and quality of care in hospitals, diocesan health offices and, through them lower level units (LLUs); assisting all levels in reducing user fees, improving community based health care, and implementing the Partnership Policy; developing multi-sectoral cooperation; facilitating improvement of Human Resource Management and development; and improving the use of information for planning and development of services.

Furthermore some facilitating strategies are noticed: research in critical subjects, a scholarship programme, elaborating a disaster preparedness plan for the health facilities and the establishment of a desk for implementing vertical / multi-sectoral programmes.

Finally the development of a new strategic plan was planned to take place before the end of 2005 and the succession of the Executive Secretary in April 2006.

2.4 Resources

Financial resources

The Operational Plan 2004 – 2006 activities are covered through three Cordaid contracts (including technical assistance) and five other contracts (see 2004 Annual report, p. 12 and 2005 Annual Report, p. 15). The grand total income in Euro's for 2004 was 1,191,351, for 2005 it was 1,215,557. A total of Euros 527,000 is expected from already committed sources (table 1).

Table 1: Structure of income 2004, 2005 and 2006 projections in percentages

Source	Cordaid	COWA &AVSI	AVSI M&P	CUAMM	DKA	DKA EcoSan	SVFOG	IICD	Local	Carried forward
2004	64.0	2.0	5.0	4.0	5.0		4.0	4.0	8.0	4.0
2005	24.1	3.9	8.4	2.5	1.2	4.8	4.1	6.9	9.1	35.1
2006	75.9	4.7	-	-	-	-	4.7	14.6		

Total expenditure in Euro's in 2004 was 765,745 and in 2005 it was 958,378.

Table 2: Structure of expenditure 2004 and 2005 in percentages

Cost centre	Accel. Progr.	Train.[13]	Organ. Set up	Skel.[14]	Subc on	Depr	Equip	Allocat.[15] Capital Fund (04)	Research etc.	Global Fund
2004	24.0	26.0	2.0	9.0	4.0		14.0 (ICT)	11.0	5.0	5.0
2005	38.7	35.7		10.2	8.3	4.1	1.7	0.8	0.5	

[11] Quality of governance and management on the facility / Diocesan Health Office level: checks and balances, transparency and accountability etc.
[12] See Investing in Faithfulness to the Mission, Strategic Plan 2001 – 2005, Operational Plan 2004 – 2006, p. 9.
[13] Scholarships, ad hoc training and tailor made courses.
[14] Core personnel (ES, AES, accountant, secretary and driver) and office costs related to core personnel.
[15] Transfers to General Reserve and to emergency Preparedness Fund.

Human resources
The Bureau has opted to build its own (in house) capacity and carrying out its own operations by having recourse to expatriate and local technical assistance (mainly with short term contracts), and by accompanying them with junior professionals employed on longer term contract, in view of providing an institutional embedding to the Technical Assistance's (TA) expertise.

Table 3: Staffing in full time equivalents as per end of the year

Category	Management	Support staff, incl. Accountant	Professional staff	Seconded staff (ex-pat)	Ex-pat consultants
2004	1	4	4	2	< 2[16]
2005	1	4	6	1 (AVSI)	< 2[17]
2006[18] (foreseen)	2				

The ex-pat senior Organisational Development (OD) advisor will gradually hand over to the Ugandan OD adviser in 2006. The ex-pat data management advisor will hand over during 2007, while the (modality of the) continuation of the ex-pat financial management advisor is yet to be discussed.

2.5 Governance and Management Structure

The Bureau operates within the organisational arrangements of the Roman Catholic Church in Uganda which is highly decentralised with individual dioceses being party to and yet entirely independent of the UEC. As UEC has no hierarchical mandate over the bishops (who are directly appointed by the Pope), the Catholic Secretariat and consequently UCMB have no hierarchical power over the affiliated health facilities. The Board of Trustees of the Dioceses, of which in most cases the Bishop is chairperson, are the proprietors of the facilities, while governance and management are delegated to Board of Governors and Management Teams respectively. For the management of some facilities MoUs are developed with congregations outlining responsibilities and powers.
The present mandate of the Bureau stems from a Health Commission resolution in 1997. The 'power' or influence is *de facto* based on the quantity, quality and broadness of information, the professional approach and the charisma of the ES. See further section 3.4.

The Health Commission (one of the commissions of the UEC) operates with an Executive Board and a Planning and Finance Committee that oversees budget planning and expenditures[19]. The UCMB office, which is located on the same compound as the Catholic Secretariat operates as the secretariat of the Health Commission and should also be seen as one of the departments of the Catholic Secretariat. It is therefore bound to systems and procedures set by the Catholic Secretariat while at the same time it needs to implement decisions taken by the Health Commission: dual accountability.

[16] The OD ex-pat advisor worked a total of 24 weeks for UCMB. The ex-pat financial management advisor worked for 10 months full time as UCMB staff in 2004 (January – October).
[17] The OD ex-pat consultant worked a total of 31 weeks, the ex-pat financial advisor a total of 22,5 weeks for UCMB.
[18] Figures for 2006 will become available on 31 August 2006.
[19] Income and expenditures are administered under an UCMB sub account under the account of the Catholic Secretariat and is externally audited. Signatories: two at the Catholic Secretariat and one at UCMB (the ES).

3 PROGRESS

Preamble
It is evident that UCMB has done a commendable job. The quality of the support is outstanding (confirmed by affiliated facilities as well as outsiders). It is reflected in the various useful tools made available for the facilities, the documentation of the support processes (files), the quality in terms of relevance and usefulness of the data collected for advocacy and lobbying as well as for internal reflection and analysis and improvement of the performances of the facilities, and moreover it is seen in the impact at national, Bureau and facility level (see 3.1 and 3.2).
UCMB has a non disputable positive reputation, despite questioning by some (insiders as well as outsiders) of the 'tone' of the recent presentations of the issues of concern. UCMB could and should be applauded for that.

Background
For the monitoring of the plan a set of 47 objectives, grouped under six strategic goals and 112 SMART indicators (28 outcome, 50 output, 34 process related) were developed. Seventy one targets were set for the end of the plan period. During the implementation period (till the end of 2005) 10 indicators were dropped as no longer relevant due to changes in the (mainly) external environment, three are – according to UCMB – achievable only at the end of the plans' period and 16 were postponed. For the list of achievements as reported by UCMB see Appendix 6 and the 2004 and 2005 Annual Reports.

The team did not find any indication to question the reliability of these data.

The focus of the review team was more on the progress in terms of effects and impact of the direct (technical advice, OD facilitation etc.) and indirect (advocacy, lobbying etc.) support for the affiliated facilities: what difference did UCMB make? Answering that question demands an analysis of the underlying 'theory' of UCMB on the linkages between vision and mission, ultimate goals (or strategic objectives), intermediate goals or objectives, strategies and areas of intervention. See Appendix 7 for the flowchart of UCMB's achievements.

Section 3.1 presents the achievements in terms of effects and impact as perceived by different stakeholders and as found in the various reports. Thereafter the team analyses how UCMB made a difference (3.2) and evaluates the appropriateness of the strategies and methodologies (3.3). In 3.4 the team highlights the main critical success factors (and actors) and some risks.

3.1 Effect and Impact of UCMB's Interventions

Place in the national health system
This can partly be read as 'improving / fostering an enabling external environment' (see flow chart on the logic of UCMB's goals and strategies, Appendix 7), since a recognised place in the national system facilitates the possibilities for the UCMB facilities to perform according to agreed targets (in case of service contracts, which is not yet the case) or in terms of expectations.

The advocacy and lobbying at the national level resulted in a non disputed recognition by government and development partners of the important contribution of the PNFP sub-sector to the achievement of the HSSP I (and HSSP II) targets and the health-related Millennium Development Goals (MDGs). This has (before the reviewed Operational Plan period) materialised in the PPPH concept (conditional grants).

Almost all targets set in the Operational Plan 2004 – 2006 on this strategic objective one (attendance of meetings, continuation of PPPH desk and functioning P-PNFP working group and implementation of PPPH) were met. This, however, did not yet result in a more balanced (between PNFP contributions and share of the national budget) or output-based allocation of funds (conditional grants) for the PNFP sub-sector, although the number of services delivered in the RCC hospitals and LLUs

increased (see figure 4, figure 5 and figure 6). Unanimously it was stated by various stakeholders that UCMB is not to blame for that: “They did everything they could do”.

The PPPH desk (under the wings of the MoH, but located outside the MoH premises), which mandate is to foster and monitor the PPPH is - according to most of the people met - not performing according to expectations. This is perceived as beyond the control of UCMB. It was partly attributed to the delay in the approval of the PPPH policy due to the unsolved issue on the position of the traditional and complementary health practitioners (see further chapter 4 ‘Context’).

In terms of allocations the upward trend came to a standstill from 2003/4 on and even slightly decreased, while the contributions by the PNFP sub-sector increased (see figures 4 – 6).

Figure 4: Allocations of Government subsidies to PNFP health sub-sector

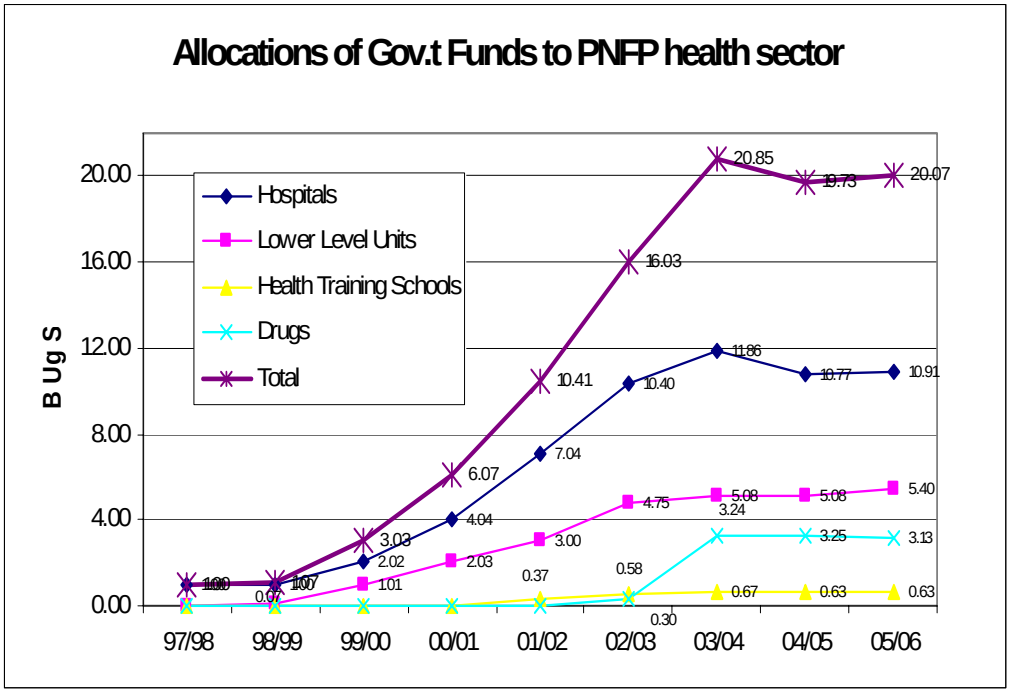


Figure 5: Performance of the RCC heath network – HOSPITALS: Access – SUO OP (Median Values)

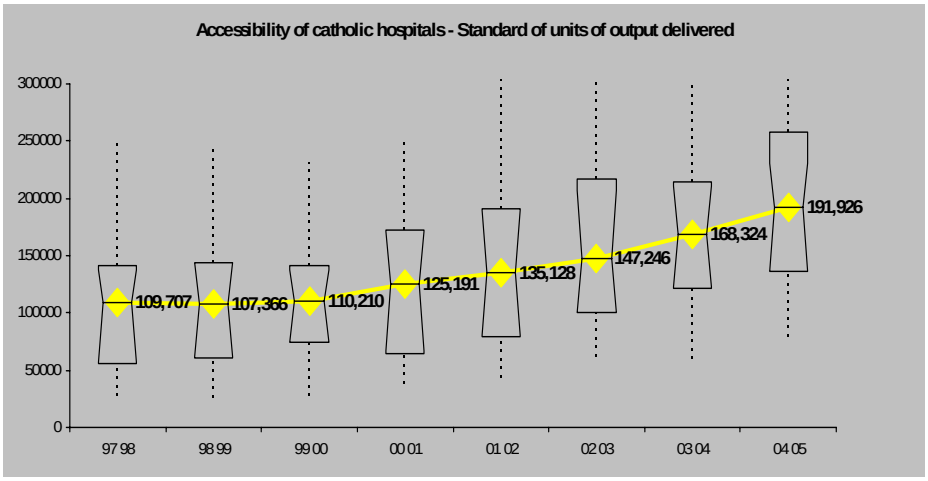
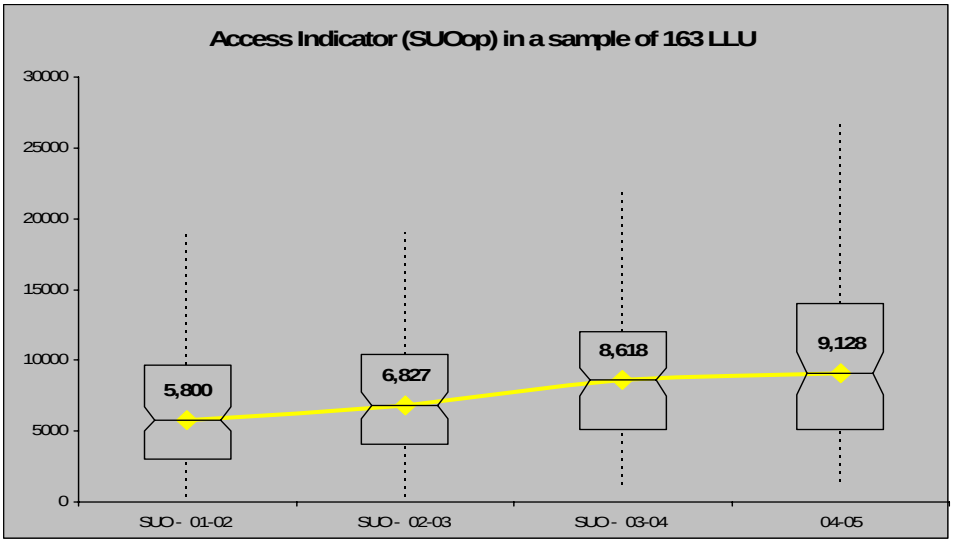


Figure 6: Performance of the RCC heath network – LLUs: Access – SUO OP (Median Values)



Both in the October 2005 National Health Assembly[20] and in the April 2006Technical Review Meeting, Development Partners, reacting to a presentation given by UCMB on behalf of the PNFP sub-sector, recognised the important contribution of the PNFP, and pleaded for "a solution" (an extra allocation to the PNFP) in order to solve the human resources issue as presented clearly by UCMB on behalf of the PNFP sub-sector.

In terms of participation of the LLUs and Diocesan Health Co-ordinators (DHCs) in health planning and management the 2005 Annual Report shows that the targets set for 2005 were (more than) achieved. Progress is, however, difficult to read from the 2004 and 2005 reports as baseline data on participation are lacking.

Faithfulness to the mission

Faithfulness to the mission has different aspects: accessibility / affordability of health services for the poor or equity (as seen in level of median fees); quality of interactions between management and staff, between staff and patients, between facility and other providers and actors, which all should reflect respect for human dignity, integrity and openness, transparency and accountability, subsidiarity etc.[21]

PNFP/UCMB facilities in general perform better than public facilities on these aspects as confirmed by different categories of stakeholders, including government representatives. How come? In the PNFP sub-sector what can be called a 'faith-based anchor' can be noticed, providing a sense of purpose, which is to deliver quality care, accessible for the poor. This translates in a culture of dedication, which is - according to people met within and outside the PNFP sub-sector alike - not or hardly seen in the public sector. The church values as seen in the mission and policy statement seem to be translated in reality in most of the UCMB (and broader PNFP) facilities. UCMB has built on these values and reinforced the mission of the church in 'healing'. It is reflected amongst others in efficiency data: staff at PNFP facilities see on overage more patients per day than staff in public hospitals (and this has increased over the last years), mostly because working hours of staff in PNFP facilities are close to 40 hours a week, which is not the case for staff in public hospitals according to many interviewees in and outside the PNFP sub-sector. This is not to deny the fact that also for some PNFP facilities viability can be questioned looking at the average number of patients seen a day by a staff member, while it is not clear if and how much time is spent on other (preventive) programmes.

The relatively better performance cannot be attributed to a higher percentage of qualified staff in the PNFP sub-sector as compared to the public sector. It is generally

[20] Annex IV of the Aid Memoire 11th JRM: Remarks by the Development Partners representative (Swedish Ambassador) at the opening of the 3rd National Health Assembly.

[21] See Mission Statement and Policy of Catholic Health Services, approved by the UEC in 1999.

known that government facilities have more professional staff and tend to be better equipped. However, despite looking, the team did not come across any data that could provide a comparison between equivalent level PNFP and public facilities.

Faithfulness to the mission should also be read from the median value of fees charged. UCMB uses this as a proxy indicator for equity. Here UCMB faces a problem. Hospitals further lowered user fees and / or introduced flat fees during the period under review: from an average of Ushs. 1,303 for Standard Unit of Output (SUO) in 2003/04 to Ushs. 1,128 in 2004/05, while LLU's did not succeed in even stabilising the fees, which went up from Ushs. 1,148 in 2003/04 to Ushs. 1,210 in 2004/05. These units (and this is also predicted for hospitals) seem to have reached a ceiling here. Further lowering is hindered as government subsidies (conditional grants) can not (any longer) be used for (topping up of) salaries. The salary gap between the PNFP and government sector has increased, and additional donor support is unpredictable and often earmarked for non-salary budget lines. It should be mentioned here that many interlocutors referred to the public sector where de facto services are also not free, as often non-official 'fees' were charged or patients are referred to the private for profit sector, staffed by persons who also appear on the government pay roll.

Credibility and constructive internal and external relations
This is not reported separately in the UCMB reports. However, it seems an important intermediary variable in the achievement of a recognised place in the national health system.

At the national level relations between the PNFP sub-sector (UCMB in particular) and the government seem to have become strained as many interlocutors from inside as well as outside the UCMB sub-sector reported. Reference is made to the tone of the interactions and the 'communication problems': mainly low accessibility of national government officials, but insufficient transparency from the PNFP sub-sector facilities as well. As stated before, the PPPH policy still lacks legal backing and this hinders the functioning of the PPPH desk. The PNFP sub-sector has no counterpart of this government controlled[22] PPPH desk.
At the decentralised level (districts and other local authorities) the relations are also not yet in line with the concept of 'partnership', although large differences can be found between districts and sub-districts. Differences were attributed mainly to (the 'chemistry' between) personalities. The review could not find data as to see if RCC facility led sub-districts score better on this issue.
The team was informed by many interlocutors (also from the local government itself) on the interpretation of government officials and district representatives (in the district council) of their role with regard to achievements on health indicators, which might hinder 'constructive relations'. Government officials and councils alike seem to perceive themselves as 'owners' (and supervisors) of the public facilities. This dominates their responsibility for achievements in terms of health status (HSSP II and MDG health related goals) of the entire population of their (sub-)district. Harmonisation and rationalisation from this perspective is a bridge too far, although it is high time to rationalise the health system looking at the apparently low efficiency in Uganda of the system as a whole.[23] See also chapter 5 'Context'.

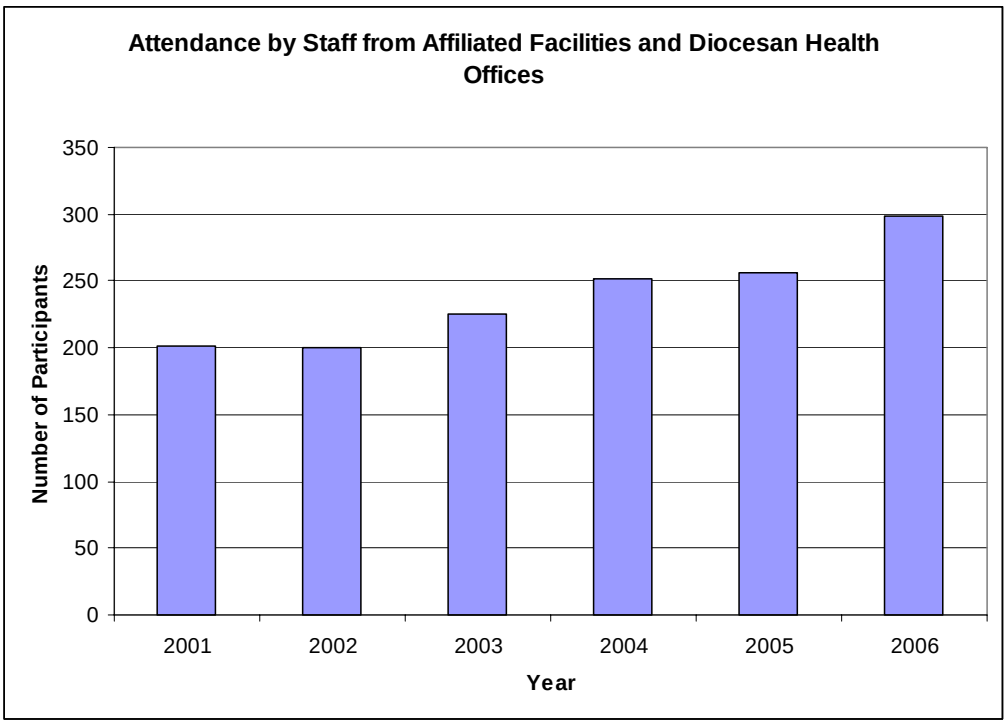
Although formal relations between LLUs, the Diocesan Health Coordinator (where existent), the Diocesan Health Department Board, the hospital management, the Hospital Board, the Board of Trustees and the church leadership might be clear and could be read in the respective constitutions and other documents, *de facto* a more rational and result based approach in planning and monitoring & evaluation, let alone harmonisation and rationalisation is not yet seen everywhere.

Internal relations, both within a facility and within UCMB greatly improved as reported by many, although the improvements differ between facilities ("Some do not pick up".).
At the UCMB level more consensus or internal cohesion is reported, such as on the issue of seconded public servants to the UCMB hospitals. This cohesion is also

[22] Development partners mainly perceive the Italian donor for the PPPH desk as de facto 'controlling' the desk, even discouraging other donors to come in.
[23] Compared to other countries on input and output criteria.

reflected in the level of attendance at UCMB organised meetings and the Annual General Assembly (figure 7).

Figure 7: Attendance of Annual General Meetings by Staff from Affiliated Facilities and Diocesan Health Offices 2001 to 2006



Transparency and accountability

Transparency and accountability can be read from the (timely) availability of accurate information on the performances of a (UCMB) facility (including financial performance, available financial and human resources and all that).

Upwards and vertical accountability to government and UCMB (other facilities) has improved: the percentage of year reports from the LLUs increased from 40% in 1998 to 96% in 2005 (down from 97% in 2004, while it was 95% in 2003). The quality is according to UCMB quite good although differences can be found between LLUs and between dioceses. Since 2001, all hospitals provide annual reports (in 2000 it was still 81%).[24] Also here quality differs.

Downwards accountability is still a challenge. Pressure is lacking here as patients are not (yet) strongly organised or consulted through patient panels, and communities lack awareness of their rights. The paradox is that abolishing of fees in government health facilities seems to decrease claim making power (on availability, affordability and quality of services) of the patients, while this policy is meant to respond to their rights.

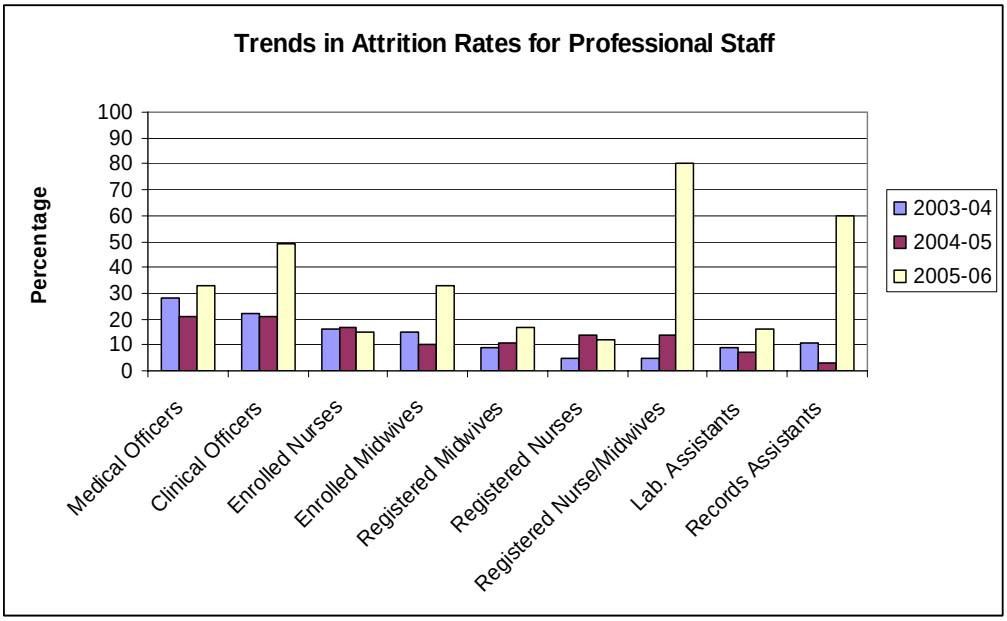
Transparency and accountability requires appropriate financial procedures and systems. So far[25], 6 hospitals have concluded the process of the development of financial manuals. Cost centres are identified by some, here and there some cost centres have a budget. Cost-based and cash-based bookkeeping are still mixed in most cases. Capital development plans and capital budgets are still rare. Planned cost reduction measures are hardly seen. Cost consciousness is rather low, although improved compared to the start of the programme. Still half of the hospitals do not have an external auditor and not all current auditors provide management letters with advice for improvements.[26] The UCMB progress assessment of 2006[27] on this aspect of managerial capacities reveals that in particular involvement, understanding and use of

[24] See data provided by UCMB in 2005 Annual Report, p. 89.
[25] See 'Strategic Plan – UCMB financial management programme, draft text, 06-04-06 (AB)
[26] UCMB once called the external auditors for a meeting.
[27] Computers (level and quantity), accounting (level and understanding), FiPro (programme-specific) and management (involvement, understanding, use of data).

data by management in general is still weak. There are strong differences between the hospitals.

Performance of the health facilities
Looking at the four criteria which UCMB developed for performance: access, equity, efficiency and quality[28], improvements are crystal clear on access[29] and efficiency (see the UCMB Annual Reports). This is a remarkable success given the pressures: dwindling of resources and high staff turnover rates. Further improving equity is probably beyond the control of UCMB if external circumstances remain unfavourable. Figure 8 shows the attrition rates for professional staff working in RCC hospitals.

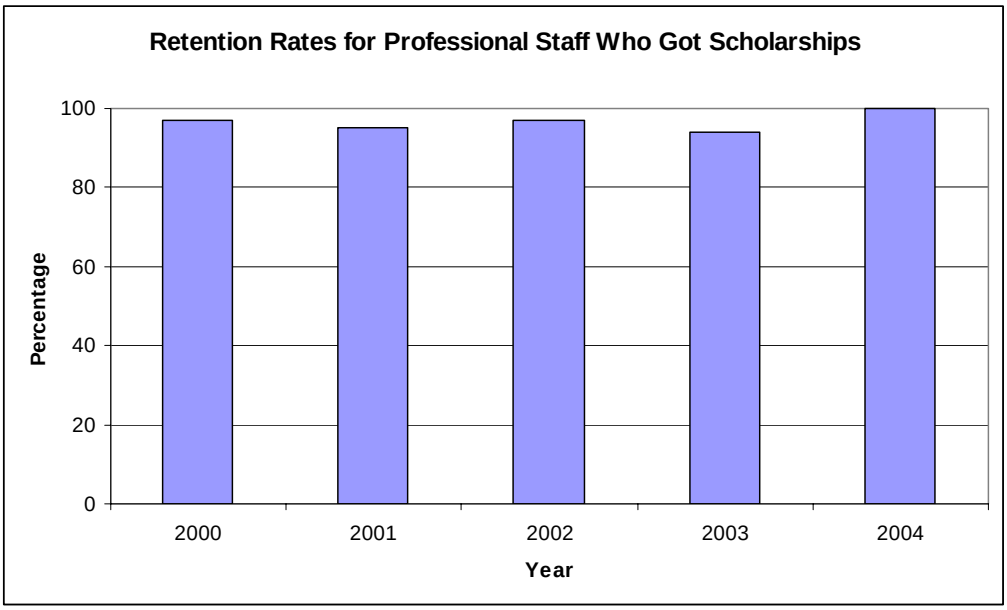
Figure 8: Trends in Attrition Rates for Professional Cadres Working in RCC Hospitals (2003-04 to 2005-06)



An average of 65 scholarships has been awarded every year for various categories of staff. Impact in terms of improved percentage of skilled staff is expected but data are not yet sufficiently accurate on this. Moreover, it is difficult to attribute changes in staffing levels to the scholarship programme because of the confounding effect of attrition due to differences in pay between PNFP and government facilities. However, available data shows a very high retention of staff who had benefited from the scholarship scheme and completed their training (figure 9).

[28] The UCMB HMIS (the four performance criteria and indicators) is in accordance with the government HMIS, although the government HMIS also includes 'sustainability'.
[29] UCMB uses SUO which measures a facility's workload as a proxy measure for access in the absence of a more refined measure. It is questionable to what extent this indicator is a good measure for access.

Figure 9: Trends in Retention Rates for Professional Staff Who Had Benefited from Scholarships and Had Completed Training (2000 – 2004)



It should be noted that opportunities for training for staff at UCMB facilities still outnumber chances of staff on the government pay roll[30], but at the same time massive movement from the PNFP sub-sector to the public sector is noticed with this argument cited (training opportunities) among the main reasons given by people who transferred to a government facility.

Overall quality can be read from the findings from the accreditation process (for hospitals) and the Diocesan Health Department Assessment Exercise.[31] As no historical data are presented nothing can be concluded on level of improvements. For more information on the accreditation and assessment methodologies see 3.3.

Quality of staff, management and Boards and their interrelations
In particular here improvements were attributed to the UCMB contributions.
Quality of management as reported by themselves and others as well is substantially improved: more self-confidence, able to read performance data, more transparency and accountability, improved cost-consciousness, increased awareness of the need for result oriented management and accounting, more teamwork, seeing the broader picture, improved external relations. This is not to deny that large differences between the facilities can be seen where it comes to putting all this in practice. While the learning (and improvements) of some facilities sky-rocketed, others faced too many challenges (mainly leadership) to benefit from the assistance provided. This enormous variance between hospitals and between diocesan offices cannot be attributed to differences in size, local circumstances or other complicated factors. The quality of facility, Church as well as local leadership was widely emphasised as the key critical factor in this (see also 3.4).

Other effects of work done or decisions taken by UCMB
UCMB's legitimacy has - quite certainly because of the relevance and quality of the services for the affiliated facilities as perceived by them - increased: UCMB is appreciated by its constituency as seen in the level of contributions: from 40% in 1998 to 96% (in 2005)[32] of the facilities that do contribute.

[30] From UCMB and MOH reports, 1.4% of UCMB affiliated workforce obtain UCMB scholarships, compared to 0.7% of government paid workforce who obtained MOH scholarships for formal training.
[31] UCMB 2005 Annual Report, p. 86.
[32] 1998: 40%, 1999: 54%, 2000: 65%, 2001: 84%, 2002: 89%, 2003: 95%, 2004: 97% and 2005: 96%.

One of the Operational Plan 2001-2003 Mid Term Review recommendations was to find avenues to align the nurse training schools. UCMB initiated the formation of a formal coordinating body for all PNFP schools. Recently one of the mainstream churches assessed that the time was 'not yet ripe' to pursue this. UCMB accepted to host a desk which will - as an interim solution - serve as a non-formal coordinating body.

UCMB enhanced the development of the other departments of the Catholic Secretariat. It modelled good ("scientific") planning (based on very clear mission), monitoring and evaluation and horizontal and vertical reporting and transparency and (financial) accountability in the larger organisation.

Planned objectives and targets not, not fully or not yet met

One of the recommendations of the 2002/03 Mid-Term Review was to "develop strategic alliances with all partners as part of the process of ensuring managerial and financial sustainability". UCMB has been able to increase its working capital from Ushs. 225,881,634 in 2004 to 359,833,210 in 2005. Furthermore the rather strong income source from contributions (in terms of reliability) has been maintained (8% of the total income in 2004 and 9.1% in 2005). However, UCMB is far from able to cover the 'skeleton' costs (see footnote 14) from locally generated income. Sustainability and in a lesser case 'predictability' of income (in the sense that donor funds and other income are relatively predictable) is, however, quite good: traditional donors are more than willing to continue their partnership in the foreseeable future while 'legitimacy' (which is a key aspect of organisational sustainability) is unquestioned: both internal and external stakeholders highly appreciate the existence of UCMB and the relevance and quality of its contributions to the achievement of a better equipped Ugandan health system.

More concern should be given to the absorption capacity. Under spending is at about 15-20% and solutions in the area of increasing staff productivity seem to have reached a ceiling[33].

Some targets on the technical capacity of hospitals in the areas of Social Welfare, Palliative Care and Mental Health[34] have not (yet) been achieved. Possible providers of training in this area did not seem to be interested (under the conditions offered). No one of the persons met referred to this omission, which puts a question mark on the relevance of these targets.

Disaster preparedness plans are only seen in the form of hospital contingency plans to cope with the dwindling resources and strict government guidelines for utilisation of the conditional grants.

Innovative approaches and research (also seen in the Operational Plan under 'Overarching Objectives') got limited attention.

Lastly the planned development of a new Strategic Plan and the replacement of the Executive Secretary in 2005 were, for reasons beyond the control of UCMB, and after consultation with the Catholic Secretariat and UCMB's core donors, postponed to later in 2006.

3.2 UCMB's Contributions to these Improvements

Some quotations from key informants:
"…….. significant contribution"
"…….. always at the fore front"
"…….. significant presence"
"…….. greatly appreciated"

Although hard evidence on which one of the above mentioned developments and improvements to attribute to UCMB, what to the joint efforts of the PNFP sub-sector (in which UCMB plays a dominant role), what to other actors and factors and what to a

[33] See 2005 Annual report, p. 76.
[34] See p. 33 2005 Annual Report.

combination of all this, can not be given, it is confirmed by almost all persons met that UCMB greatly contributed to or triggered these changes. This section tries to shed some light on the question: how did they do that?

Advocacy and lobbying
About one third of the total working days in 2005 were spent on contacts with government[35]. During the Operational Plan period UCMB (often on behalf of the whole PNFP sub-sector) has continuously kept government and others alert on the rationale and intentions of the PPPH concept, as well as on the actual implementation. Furthermore lobbying - with others - was (in 2004) successfully done on the lowering of entry criteria for candidates to Enrolled Comprehensive Nurse training.
The availability of relevant and up to date data greatly supported the quality of the presentations and statements.

Capacity Building
This area also required about one third of the total number of working days.
Reviewing constitutions and developing employment manuals clarified the lines of authorities and accountabilities and the roles and responsibilities of the different categories of staff. The approach taken in this (model text of a constitution, training, followed by hands-on, tailored support) has been more important than the tangible results as such (the documents): the approach (which was to build on the existing strengths and to follow the pace of the facility/the management team) empowered management ('reported as 'self confidence') and strengthened team spirit as reflected in the appreciation of the contributions of each of the 'disciplines', including administration, although this is not a guaranteed outcome of the UCMB efforts!
Charters for the Diocesan Office revitalised the diocesan structures and helped LLU's management and Board to understand their roles.

The UCMB investments in facilitating the collection and analysis of performance data at both the facility and overall UCMB level, and the feedback and assistance for facility staff and management in reading the data provided by the Bureau[36] and discussing the implications and possible actions, indicate that UCMB and its affiliated facilities take (improvement of) performance seriously. UCMB and the facilities show themselves to be genuinely interested in the core question: are we really serving our purpose? The feedback given by the UCMB advisors to the facilities on their performances on the four performance criteria: access, equity, quality and efficiency in the form of easy to read tables and graphs (data), the questions for the facilities to think over, accompanying these tables and graphs and the assistance in finding answers to these questions have been of critical importance. This level of data collection and analysis, rather easy to adopt by facility management, even at the LLU level is fairly unique in the Ugandan (and even Sub-Saharan African) Health Sector.
UCMB installed ICT facilities, developed adequate, high standard tools (mentioned by many people outside the programme with some envy) and trained facility management and staff to formulate and answer the core questions on the level of performance themselves. The comparative (hospital and diocesan office level) analysis, presented during technical workshops and annual general meetings seem to have triggered facility management, boards and other responsible officers to find ways of improving. It facilitated and enhanced self-reflective capacity.

The financial support helped the facilities as well as the Bureau to understand cost behaviour and think over possible improvements to increase cost-effectiveness / efficiency and to establish capital development plans.
UCMB promoted and facilitated the change from cash-based to cost- (or accrual) based accounting (income and expenditures are replaced by resources and costs on the basis of cost centres) through the development and instalment of appropriate software for this (called FiPro modules[37]) and trained (including in-house tailored training) and assisted (support visits as well as distance support through e-learning,

[35] See p. 91 of the 2005 Annual Report.
[36] Directly by the UCMB data management advisory unit as well as through the other advisors who use this information as an entry for OD processes.
[37] FiPro consists of four modules in addition to the Basic Module: 1. Fixed Assets, 2. Stores, 3. Salary and 4. Transport.

e-mail and skype meetings, help functions in the computer programme and user guides) staff to use this software (data collection and entering and analysis).
The UCMB Model Manual of Financial and Materials Resource Management[38] enabled the facilities to develop their own tailor made manual. In addition UCMB developed a tool for self-assessment of progress in this area.

Start up project funding for Diocesan Offices, including hands-on support in problem identification, proposal development and monitoring and evaluation, enabled some dioceses (Hoima and Lira) to access other funds. For example Hoima and Lira dioceses whose diocesan health offices had been exclusively facilitated by UCMB managed to obtain additional funds to the tune of 20,160,000/= (Hoima) and 38,323,100/= (Lira) from PEPFAR's Orphans and Vulnerable Children (OVC) and the Global Fund's malaria round 2 projects respectively.

Proposals of four dioceses are approved. One of them also succeeded in getting additional funds for HIV/Aids and OVC activities. Three of the other dioceses will soon submit a proposal. It is, however, not that easy for the diocesan offices to attract donors since very few donors are interested in the diocesan level. Support from the diocese is sometimes missing, communication is difficult and short-term pilot project (one year) is rather too short to show effects.

Scholarships for staff of affiliated facilities contributed to the increased percentage of qualified staff[39] although the effect could have been stronger in case more control over retention / attrition would have been possible.

Twice a year technical workshops are organised for hospital management staff and representatives of Boards and for Diocesan Health Coordinators. Sometimes the invitation is extended to UPMB and UMMB affiliated hospitals. These workshops provide access to information, provide a forum to share concerns, identify issues, develop possible solutions and a joint stance on internally and externally defined issues, such as the secondment of staff from the public sector to the PNFP facilities. Access to information is also facilitated through the UCMB bulletin.

UCMB assisted in establishing and fostering constructive external relations through the development of model MoUs with external parties, backed by the earlier mentioned improved transparency and accountability.

UCMB every year agrees with the affiliated facilities on specific accreditation criteria. Meeting these criteria is a pre-requisite for eligibility of support for UCMB. The outcome of the accreditation process (based on a combination of self scoring and advisors assessments) is reported during the technical workshop (October/November); the outcomes (without names of the hospitals) published in the Bulletin (December) and discussed again during the Annual General Meeting (March). This UCMB invented accreditation process greatly enhanced the understanding of the importance of adhering to (as UCMB identified and agreed upon) quality criteria. It gives the UCMB facilities a head start as accreditation will sooner or later be part of the health quality assurance mechanisms.

3.3 Consistency, Relevance and Appropriateness of the Strategies

UCMB in its Annual Report 2005 indicates the rather low pace of improvements in the institutional and managerial capacities of the facilities. It was assumed that the interventions could be characterised as "technical only". However, it became quite obvious that changes at the level of procedures and systems, such as the introduction of cost centres (the 'technical' dimension of an organisation) shake the 'people's or

[38] Modules on salary, fixed assets, transport and stores.
[39] See the graph presented in the End of Period Report of the UCMB Operational Plan 2001 – 2003 of the Executive Secretary UCMB to the Health Commission, November 2003: increase of percentage of qualified staff in UCMB Hospitals from 53% in 2001/02 to 62% in 2002/03 and in (an sample of 111) UCMB LLUs from 41% in 2001/02 to 62% in 2002/03. More recent data were not found.

'spiritual' dimension of an organisation as well[40] i.e., behavioural norms (how things should be tabled and discussed, how problems should be brought forward, how solutions are to be generated etc.) and in particular the way people relate to each other (level of team work, power distances etc). Reluctance to implement new techniques and systems and even sabotage can often be understood from this perspective.

As UCMB has no hierarchical power over the facilities, coordination relies on non-hierarchical mechanisms. Management guru Henry Mintzberg identified the following mechanisms: mutual adjustment, direct supervision (authority), standardisation of work processes, standardisation of outputs, standardisation of skills / knowledge, and standardisation of norms (shared values / ideology).[41] It is evident that UCMB itself can use and actually uses all these mechanisms except for direct supervision over the facilities as this is not in their mandate.[42] In terms of sources of influence (or 'power') UCMB heavily relies on 'power of knowledge', 'charisma' and 'dependency' (as most UCMB facilities depend on the advocacy and lobby efforts of the Bureau in terms of subsidies negotiated with government and in terms of access to additional funds, although UCMB avoids to be used as a 'messenger boy' or broker).

Much emphasis is seen on 'putting the own house in order', which provides a model and adds to (or even is a pre-requisite for) the credibility of UCMB as change agent for others.

Appropriateness of organisational change strategies
The strategies used are appropriate for organisational change processes, facilitated by external change agents (outside the organisational management hierarchy).

Change strategies (methodologies to enhance organisational learning and change) noticed are: start with awareness raising or sensitisation ('rational strategy'), followed by training and hands-on support ('educational strategy') and eventually a more 'gentle pressure' strategy (strict deadlines and accreditation with the outlook on exclusion from services). This is the right order for the planned change processes. UCMB has no power/mandate for more forceful strategies. However, a more direct involvement and stronger backing of the legal owners (Church leaders) could have accelerated the process.
For diocesan level, these strategies (rational, educative and 'gentle pressure') were completed with a 'facilitating' strategy in the form of project funds. Facilitation in terms of further influencing the conditions for improving performance, such as the embedding of the Diocesan Health Office (DHO) and LLUs in the diocesan health structure just started.
Furthermore a combination of technical (mainly on the level of improving PME practices, such as HMIS, FA/FM and HRM systems) and more people-oriented strategies (training, hands-on support) is noticed, which is also appropriate for the changes envisaged.[43]

The combination of demand and supply driven approach is well chosen: supply driven as to raise awareness and through that eagerness to find out about alternative ways of operating, and demand driven as to guarantee ownership and responsibility for the change process.

Of recent a more comprehensive, integrated capacity strengthening approach is taken, which replaces the discipline oriented approach where each advisor mainly looked at his/her own area of expertise, be it human resource management, financial management, data management, while only the organisation development advisors took more of a holistic (or systemic) approach. Currently, hospitals are assessed by a two member advisors team, based on an extensive checklist of the various

[40] See for more explanation of the two dimensions of an organisation: 'Organisation Development of NGOs: a Matter of Balance', www.icconsult.nl
[41] See Henry Mintzberg: 'Mintzberg on Management', The Free Press, 1989, p. 101.
[42] Some people interviewed suggested to revisit this situation as to enable UCMB to play a more powerful role vis-à-vis the affiliated facilities.
[43] See for more information on change strategies: 'Organisational Culture and Change', Ria van Hoewijk, September 2003, www.icconsult.nl

organisational aspects (the UCMB home-grown 'quick scan'), which prepares them to identify for themselves their strengths and weaknesses.

Till now the approach has been quite advisor dependent, although recently self-assessment tools are developed. Less use is made of other less advisor dependent strategies, such as peer reviews or focussed exchange visits, collegial feedback ('Critical Friend' methodology), joint action research.

Emphasis is placed on technical and managerial skills, less on 'soft skills' or leadership skills (such as fostering teamwork and keeping the mission alive) and orientations, attitudes and skills needed to operate in a context of conflicting interests - even a hostile environment sometimes -, such as a systemic and long term view (sensitive for action – reaction effects), thinking in terms of scenario's, communicating and 'win-win' negotiating.

The soft ware modules and guidelines are sometimes perceived as too sophisticated or complex, and not very user friendly. In particular not for the LLUs and many of the DHOs. It requires a rather high level of understanding of accountancy practices which is often not present at these levels. Although hospital accountants are trained in the International Accounting Standards, bookkeeping skills are not yet sufficient. However, UCMB's approaches and tools reflect tomorrow's demands on financial accountability and cost-consciousness can only be achieved with an accrual based instead of cash based system.

High staff turnover and lack of adequate hand-over processes result in an ongoing demand for training in the use of this soft ware (the 'Guidelines' do not replace that).

It is questionable if the Bulletin serves its purpose related to the costs. It has been difficult to find contributors for the Bulletin and no one of the people talked to mentioned it spontaneously as an important mechanism to access and exchange information.

Appropriateness of lobbying and advocacy strategies
In a context of (partly) conflicting interests, interdependency, fragile and more and more strained relations between public and private sector (the PPPH context), how can the UCMB lobbying strategies used so far be evaluated?
For that we could look at different methodologies for conflict resolution as even where government and the PNFP share ambitions (make quality health services accessible for all) the limited resource envelope inevitably also generates different interests. It is furthermore clear that decrease in performance and other problems in either the public or the PNFP sub-sector will have mutual effects.

What is noticed in the UCMB strategies? UCMB started from 'problem solving' or 'collaboration' (win-win) with an effort to avoid 'fighting' or 'forcing' (win-lose). Currently the approach UCMB takes in the budget allocation/human resources issue is perceived by many (within the Catholic Health Sector as well as outside) as moving towards 'fighting' ("too aggressive" etc.) which most likely will generate a similar reaction from government side leading to a downwards spiral with respect to the partnership. It will boomerang one day or the other on the PNFP sub-sector. It also gives ammunition to sceptics (still widely seen at the decentralised levels) on the viability of the PPPH.
Most people met from different corners plea for a more problem solving / collaborative approach (in conjunction with UPMB and others).

Influencing the rules of the game at national level: lobbying and advocacy, is mainly done via a rational strategy, relying on facts and figures. However, the dynamics in the Health System, and broader in the relationship between Government, Development Partners and the non-state providers of social services have a rational as well as a political and an emotional component. Although this is acknowledged by UCMB at the conceptual level, in the actual approach, mainly the assumption of human beings as only rational creatures is reflected: "If they have the correct information on what is really happening on the ground and on how PNFP contributes, etc. they will adjust their budget allocations or policies." Much emphasis is seen on the presentation of validated facts and figures, which should 'convince' policy makers and managers to do the right things. But are they not doing the right things (from the perspective of UCMB) because

they don't know? Or is it that UCMB assumes that pinning them on this information - on paper - will force them to change their choices? It worked some 10 years back. Does that guarantee that it will work again? By that time the economy was improving, at present prospects are less favourable.

UCMB showed a high trust in problem solving strategies which is quite adequate in relations which will last beyond today. Those strategies could in potency have a strong impact as they were backed by adequate and reliable data. In the current situation where government budgets are tight, UCMB should not just defend their own piece of the cake but, hand in hand with Government and Development Partners, identify core issues and contribute to generating feasible, sustainable solutions without giving in on the mission.

3.4 Critical Success Factors and Risks

How has UCMB been able to deliver these results? In other words; what are UCMB's critical success factors? In identifying these factors it should be kept in mind that a critical success factor is – paradoxically – often close to a risk.

a. Both the advocacy and lobbying strategies (including the Health Commission stances and decisions) and the organisational capacity building efforts rely heavily on the *quality of data management* (relevance and accessibility), which has been outstanding as confirmed by internal and external people talked to. This level of achievement and stability can allow a progressive withdrawal of UCMB and a more responsible management by the Hospitals and by the Dioceses. The system is working, is stable, is manageable and its management is at very low and affordable cost.

   UCMB strategic decision communicated to the Hospitals was to decentralise the running of this e-mail system and have it fully shifted under the Hospitals' and Diocesan Health Offices' management. This will be effective from July 2006. The risk here is that UCMB still relies on the professional skills and knowledge of an ex-pat staff member, seconded by an Italian NGO (AVSI). It is not certain when and if this staff member will be able to bring his Ugandan counterparts to the required level. It will require enough time to be spent by the ex-pat adviser with the junior staff. AVSI commitment has been expressed until the end of 2007 and hopefully relations with IICD can also be maintained for the near future.

   At peripheral level the question of quality of data and processed information is still a big question mark. The strategy adopted by UCMB in the past 4 years was to build some capacity in training institutions that would have turned to be able to continue offering trainings and refresher courses on topics like data management, HMIS and other relevant issues. These attempts were with Uganda Management Institute, Uganda Martyr's University (UMU) and Uganda Institute of Information and Communication Technologies (UICT). Currently there is a clear intention to strengthen the collaboration with UMU in the area of HMIS and data management/analysis while with UICT there is also room for expanding collaboration as the Institute is also a partner of IICD in many training initiatives. The work of UCMB in providing content to training institutions as far as data management and data analysis are concerned should continue in order to maintain / expand the level of competences reached by the Hospitals and by the Dioceses. Strategic alliances with well identified training partners should be sought so as to hand over completely as soon as they are able to deliver high quality training and support.

b. UCMB's *reflection and learning capacity and willingness* is extraordinary. UCMB shows in its annual reports, in discussions and workshops a genuine interest in finding avenues to improve on what they did and (not fully) achieved: "Did we do the right things and did we do these things right?" seems to be a natural question that is tabled regularly in different forms and fora. The PME (planning, monitoring and evaluation) system, facilitating evidence-based reflection on these questions is well developed. However, the effectiveness of a system - although computerised where possible - depends on its users. At present the log frame

underlying the 2004- 2006 Operational Plan (47 objectives, 71 targets and 112 indicators) can hardly serve as an adequate monitoring (and evaluation) guide. Sight on the key objectives and indicators is easily lost with the risk that monitoring and evaluation is only done once a year in preparing the annual report and the next year's work plan, while it should be in-built in the daily management and leadership practice. It also relies heavily on the more than average capacity of the ES (who will soon be replaced by somebody else) to deal with complexity. UCMB furthermore taps (temporarily) from international knowledge via the presence of internationally experienced staff and through internet (using relevant gate ways and search engines, such as 'google').

c. There is a clear *balance between the 'technical' and the 'spiritual' dimension* of UCMB as an organisation[44]: structure, procedures and systems seem to be adequate for the responsibilities the Bureau has agreed to take up, while sight on the vision and mission of the Bureau is kept alive. Church related social values are married with professionalism. Everybody seems to know what he/ she is supposed to contribute beyond the level of his/her own strict job description. This balance - as always - is a rather fragile one. Donors in general (see next point) tend to overemphasise the importance of systems and procedures while costs for measures to upkeep the spirit are often questioned. Moreover - in the UCMB case - the balance also seems to be fostered by the present ES.

d. UCMB managed to attract a *good mix of high profile professionals, committed, well skilled support staff and competent management*. They all seem to have the vision and mission of UCMB close to their heart and are very competent in translating this into strategies and approaches which meet international standards without losing touch with the reality on the ground and the priorities set by the 'clients'. As retention of this calibre of staff is not that easy and two ex-pats (the OD and the FM advisor) are preparing the termination of their contracts after handing over to local staff, this critical success factor can easily be lost.

e. *Dedication* for the work is high and sometimes possibly even too high, as reconciling private and work commitments is not always easy and 'going for the better' easily ends in perfectionism that does not serve its purpose any longer (see the 112 indicators and the sophisticated financial administration modules). The present ES seems to set the norm in this.

f. *Funding mechanisms* enable UCMB to set priorities based on a thorough scanning of the internal and external environment, followed by a genuine dialogue with the core donors instead of just going with the donor's agenda. Both volume (although absorption remains a concern) and modalities (flexibility and support for institutional strengthening for instance) are *adequate*.

g. Last but not least we should mention the *backing from the church leaders* for the process of further improvement of the performances of the RCC health sub-sector. Here UCMB should be alert: it takes possibly extra efforts to ensure continued backing.

Overall it can be noted that UCMB's core risk or weakness lies in its strength: UCMB has shown to be a key factor in the success of the RC health sector (and even beyond as UCMB has been recognised as leading in the PNFP sub-sector) mainly due to the level of professionalism and commitment. However, this professionalism and commitment is - as always[45] - dependent on people. Most of the core people in UCMB will sooner or later, but certainly within the coming two years, leave the organisation. It is – with UCMB – hoped that the same calibre of personnel can be found willing to devote their time (and life as this is the case with some key staff at present) to UCMB and its cause.

[44] See footnote 41.

[45] Vision, mission and value statements and organisational systems, procedures, rules and regulations can back professional orientation and commitment but not guarantee this in professional bureaucracies, such as UCMB (see Mintzberg).

4 CONTEXT

In which context does UCMB operate and what are the tendencies that will impact on the opportunities and challenges for UCMB and - combined with the critical success factors and risks - input UCMB's strategic issues and directions?

Economic hardships
Uganda has registered steady economic growth in the recent years but is currently going through a period of increased economic hardships. Part of this is due to higher world oil prices, but the situation has been further aggravated by a prolonged drought in the region, with resulting loss of electricity generation capacity from the hydro power dams in Jinja. The energy crisis has forced the government and donors to focus attention on alleviating the problem of power shortage which necessitated cuts in the budgets of some sectors, with health experiencing more dramatic cuts than the others (see table 4).

Table 4: Sectoral Shares as Projected in the Medium Term Expenditure Framework

Sector	2005/06 Budget	2006/07 Projected	2007/08 Projected	2008/09 Projected
Security	10.1%	9.6%	9.5%	9.0%
Roads and Works	10.1%	11.3%	12.7%	11.9%
Agriculture	4.0%	3.5%	4.5%	4.8%
Education	17.1%	18.3%	19.0%	19.3%
Health	13.7%	9.7%	8.4%	9.6%
Water & Sanitation	3.0%	2.6%	2.6%	3.6%
Law and Order	4.9%	4.8%	4.9%	5.0%
Accountability	4.7%	4.7%	4.4%	4.3%
Economic Functions and SS	11.1%	15.5%	12.8%	12.2%
Public Sector Magt	6.0%	6.2%	6.6%	6.7%
Public Administration	7.6%	6.8%	6.5%	6.2%
Interest Payments Due	7.8%	7.0%	8.1%	7.5%
Total (excl. unallocated)	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: National Budget Framework Paper for financial years 2006/07 – 2008/09

The budget framework paper states that sectoral allocations for Security, Agriculture, Health and water and sanitation are declining mainly on account of the decline in direct project aid, which cannot be fully compensated for (Uganda MoFPED, 2006).
In addition there is the 20 year old insurgency in the North which continues to drain the country's resources. All this has meant that the health sector in general has experienced a decreased resource envelope. The information from Finance is that PNFP budgets have not been cut but there were widespread reports of delayed releases having been experienced. The government has put a cap on health spending due to concerns about macroeconomic stability. Funds coming to health from global initiatives were initially additional to budgetary sources but Finance cannot guarantee that this will continue and risks to displace budgetary funds to maintain health expenditure within the Medium Term Expenditure Framework (MTEF) ceiling.

Fragile PPPH
Although the National Health Policy (NHP) and Health Sector Strategic Plan (HSSP) documents contain explicit statements that the health sector will pursue a policy of active engagement with and involvement of the private sector (PNFP and PHP), the enabling PPPH policy stalled on its way to Cabinet due to the desire by the government

to have a more comprehensive policy document that includes traditional and complementary medicine sub-sector. This document has stalled for the last two years and it is envisaged it will take another one year to push it through the cabinet approval process. The next step would be a robust legal framework that addresses issues among others that affect PNFP operations like provision of public funds to pay salaries and wages of non-public sector employed health workers.
The impression of our team is that the partnership, which had started rather well a few years ago, is currently quite fragile with an apparent breakdown in communication between the PNFP sub-sector on the one hand and the government (particularly the MOH) on the other. The officer assigned to oversee the PPPH desk is rarely seen and is reported to be ambiguous in his support for the policy. The officer who in practice runs the desk is rather too young and junior in the hierarchy to have the kind of clout that is needed to mediate between the central government, district local governments and the PNFP bureaus.
The shortage in health care workers and competition between the government and PNFP for the limited pool of health workers has not helped the sense of common purpose, although there are strong indications that the matter has started to be taken seriously, and there are reports that an additional supplemental budget to help cushion the PNFP against attrition are being put in place.
There is a feeling among the government people and other stakeholders that the PNFP sub-sector is only concerned with its own facilities and staff, and does not appreciate the fact that government has continued to provide grants at the same level even if government budget has been stagnant or reducing. On the other hand, the PNFP partners have the feeling that the government is no longer dealing with the issue in a transparent and collaborative way. An example of the breakdown in communication is the fact that the previous practice of announcing grants provided to the different districts and PNFP facilities in newspapers has not been happening since about two years ago[46].

Tendency towards global initiatives
Following a widespread concern in the international community that some of the priority disease and health problems were not getting adequate attention and funds from governments and donors, the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM) was introduced and is active in a number of countries including Uganda. This was followed by the Global Alliance for Vaccine Initiatives (GAVI). GFATM and GAVI are multi-lateral initiatives with contributions from many donors. These have more recently been followed by the American Government funded President's Emergency Plan for AIDS Relief (PEPFAR) and even more recently another American funded Presidential Malaria Initiative (PMI).
These global initiatives often have set up parallel administrative structures and are largely quite vertical in their operations and may undermine or introduce unhealthy competition with existing mechanisms. Such funding arrangements are often not answerable in-country to democratically elected representatives of the people and their operations are only indirectly regulated by the government. Their effect has been to effectively weaken the Sector Wide Approach (SWAp) process that had started reasonably well in Uganda. Like a self-fulfilling prophesy, the critics have sometimes turned around and pointed out that SWAps have failed. There is a move among some donors (9 at the time of writing this report) who are expected to join the World Bank led Uganda Joint Assistance Strategy (UJAS) which will operate with leadership of the MOFPED. This will have the effect of reducing individual donor direct involvement with health sector-specific issues and partners.
As stated above, the breakdown in communication between government and PNFP has left the PNFPs feeling that the government has become less committed to the Partnership and less transparent about its intentions. There are concerns that the new development assistance strategy of passing through UJAS might further weaken the ability of PNFP to dialogue with and negotiate with government.[47]

[46] We established from MOFPED that this ceased to be their responsibility two years ago when it passed to the Local Government Finance Commission.
[47] See also the concern of civil society in general on aid harmonisation: 'Aid Harmonisation: Challenges for Civil Society, Ontrac, no. 33, May 2006.

Increasing health care costs
It is anticipated that the global energy crisis which is already fuelling general price rises will also affect the health sector. There are already evidences of increasing costs of providing health care. The situation is of course made worse by rising labour costs, aggravated by the continued brain-drain to the developed countries. Many pharmaceutical products depend on petro-based combinations and could rise in costs due to increased oil prices. The costs for transportation and other technologies manufactured in the developed economies will also increase health care costs in Uganda.
Furthermore health care costs in general have the tendency to rise resulting from higher demands by the public.

Pressure to achieve targets
There is growing international pressure to accelerate progress towards the achievement of the Millennium Development Goals (MDGs). Some countries (including Uganda) do not seem to be on the right track in achieving these targets. Likewise, a number of bilateral partners are beginning to feel that the SWAp mechanism may not deliver results quickly enough and that MDG and HSSP targets may not be met.
This fear, coupled with pressure from the home country governments in donor countries is likely to further undermine the faith in SWAp and lead to more project oriented funding. These pressures may once again shift the balance in favour of more vertical projects. This tendency is already being observed with some partners.

Perception of corruption
High level corruption, as evidenced by the recent Commission of Inquiry into the mismanagement of the Global Fund to Fight HIV/AIDS, TB and Malaria, and others regularly reported in the newspapers, has led to increased perceptions of corruption among the general public, donors and even from within government itself. This has contributed to reinforce the tendency towards project mode/verticalization of donor funding.

Commitment of (traditional) donors to support UCMB
The combined Cordaid, Cordaid/PSO, AVSI and IICD support (financial and technical) which was supposed to have installed systems and procedures at both the facility and UCMB level, achieved a higher technical and managerial quality in the hospitals and the diocesan health departments and offices. The support was also expected to contribute to a more PNFP favourable environment at the policy level, so as to enable UCMB to continue on a 'skeleton' basis in a foreseeable period (2007/8). This, however, turned out to have been too optimistic (see chapter 3 on Progress).
UCMB's current donors are, in principle, willing and even eager to continue their support on a more or less comparable level and under the same or comparable funding arrangements for the coming 3 to 4 years with an outlook on an even longer term commitment.

5 CONCLUSIONS

This section summarises the main conclusions that can be made about the key achievements in line with the five strategic objectives as well as the key issues that remain.

The RCC Health Services occupy a place in the National Health System that is befitting to the needs of the population and their mission.

This strategic objective has largely been achieved. The place of the RCC health services in the National Health System is well recognised and appreciated at the national level. Government, development partners and to some extent local authorities (mainly districts) take the involvement of the RCC health sub-sector, and the importance of continuing to provide government and donor subsidies to the PNFP in general, as an established fact. It is evident that the UCMB and affiliates are integral parts of the national health system and opting out is not a feasible option. However, UCMB and affiliated facilities can play an active role while protecting, to a large degree, autonomy under the current policy framework. An issue that remains is to strengthen the inter linkages with partners at the operational health sub-district and district levels.

Improved Quality and Sustainability in Faithfulness to the Mission Statement

To a large extent the review noted that the RCC health services have made a conscious effort to maintain quality of care while maintaining efficiency, and keeping fees charged to patients stable. This means that the fees were actually lowered in real terms (taking into account inflation). The pro-poor focus remains evident in the documents reviewed as well as from interactions with all UCMB staff and affiliates in the hospitals and diocesan health offices visited. While the UCMB and affiliates have made a strong case that there is a basic cost of providing services of a defined quality, it remains unclear as to whether this message is getting across to the other stakeholders and if so, how the shortfall in meeting the package of care will be met. The alternative is to provide care with less qualified staff. The team noted encouraging signs that the issue of human resources is being addressed through a supplemental budget and it will be important to follow this through.

Increased Dynamic and Transparent Management

There has been significant progress in achieving performance targets. The availability of timely and accurate information on activities and targets achieved, as well as use of financial and human resources are clearly done in a transparent and accountable way to the main stakeholders and funding sources (donors and government). Areas to be strengthened include continued emphasis on cost-consciousness, including clear plans for scaling down in the event of reduced funding (already started by at least one hospital), as well as completing the transition to accrual based accounting. In addition, involvement of groups representing users of the facilities could be strengthened so as to lend additional credence and weight to the efforts to lobby government and donors for continued and even increased funding.

Improved cohesive internal organisation and external organisational arrangements

The UCMB has clearly been at the forefront of efforts in the RCC health services to strengthen internal organizational arrangements and structures, as well as external relations. Structures such as health facility management boards/committees and diocesan health boards and offices have been put in place where they did not exist or strengthened. Policies and procedures have been streamlined with documentation of expected standards and an accreditation system put in place. Although not having a direct implementation or supervisory mandate over the hospitals and LLUs, the facilitatory and/or catalytic role of UCMB was crucial in this. It is evident that some facilities and DHOs remain relatively weak and will need additional support. The relations with central government and local authorities still need careful attention and

balancing to keep an active role in the national health system while maintaining autonomy and faithfulness to the mission. In this regard, relations with the government through the PPPH desk of the MOH and other levels e.g., HPAC should be maintained and strengthened. Efforts to revive the functionality of the PPPH desk at the MOH will benefit from the passing of the new PPPH policy, and UCMB could lend its weight to this. The prior agreement for districts to appoint focal persons to liaise with PNFP still needs to be taken up again.

Improved advocacy

The notable success under this strategic objective was the acceptance, by the government and the Uganda Nurses and Midwifes Council, to lower the entry criteria for candidates entering the Enrolled Comprehensive Nurse training programme. There has been a perception by the PNFP of lack of commitment to the partnership on the part of government. The review team concludes that this is probably not the case and that other overriding constraints in the national economy seem to be more prominent. The UCMB needs to continue a constructive engagement in a win-win scenario, showing that in fact the UCMB preferential option for the poor, and the government's own commitment to increasing access of quality care to all its citizens, are in fact overlapping and complementary.

6 WAY FORWARD

6.1 Strategic Directions

Merging the context analysis in chapter 4 with the critical success factors (see 3.4) results in the following suggestions for the next strategic plan period.
These suggestions should not be seen as very different from current strategies and methodologies. As concluded before: UCMB is relevant and its current strategies and methodologies are well chosen, effective and appreciated. Dilemmas, in terms of faithfulness to the mission or going with the mainstream, are inherent in the current political and economic situation and cannot be solved leaning towards one or the other end of the dilemma. UCMB has somehow to strike a balance and cope with a situation of dilemmas. However, the following might provide some direction so as to find a balance and complement and sharpen current approaches.

Dialogue within the PPPH partnership
It is necessary to re-invigorate the partnership through renewed efforts at dialogue at the national level. This might require UCMB and the PNFP in general to play a catalytic role in reviving a collaborative spirit with the central government. The existing structures e.g., the Health Policy Advisory Committee (HPAC) and the Health Development Partners Group (HDPG) could be a starting point. Advocacy and lobbying efforts could also be directed to speeding up the cabinet approval process for the PPPH policy.
For the local government (district and municipality) levels, there are reportedly wide differences in levels of collaboration between the authorities and the PNFP. Dialogue is almost non-existent in some places while there are good working relations in others. Efforts should be made towards kick-starting a process at the district/local authority level similar to the HPAC arrangement at national level. The participation by PNFP personnel e.g., Diocesan Health Co-ordinators and hospital managers in the District Health Management Team (DHMT) which is charged with joint planning and co-ordination of health services could be a start. In this regard PNFP personnel need to play a rather pro-active role, supported by UCMB. Their participation in the DHMT is already guaranteed by national policy and the HSSP. They should not be shy to exercise that right and responsibility.

Strengthen old and build new alliances
Some strategic alliances have been very supportive such as with Cordaid, AVSI and IICD. UCMB should continue to invest in these relations as to ensure their future support.
It is also necessary to revisit some other existing alliances such as with the Martyr's University on the training courses for health unit management and where possible to build new ones at national and international levels. Nationally, the goodwill of HDPs and a number of government officers should be a good starting point. Internationally, UCMB ought to be able to dialogue with traditional donors (e.g., CORDAID, Italian Episcopal Conference and others) to continue mobilising resources from without to support the systems development efforts that have been initiated but are by no means stable at the moment. It will be a good investment to continue to build these systems for the long run.
At the local district/health sub-district levels, PNFP personnel should take advantage of the existence of a number of donor-supported projects aiming to develop good governance and improved service delivery. Such projects include those supported by SNV, a Dutch development organization aimed at capacity building, the World Bank funded Northern Uganda Social Action Fund (NUSAF) and various USAID and UNDP supported initiatives. Civil society organizations may also have locally relevant programmes, such as programmes to enhance the claim making power of communities in order to demand affordable, quality health services. Within the Church itself, there are other departments like Caritas whose efforts could be synergistic with those of PNFPs.

Revival of PPPH Desk

It is of paramount importance to revive the institutional mechanism that is already in place to facilitate the public private partnership, i.e., the PPPH desk in the MOH. The current physical location of the office outside the mainstream MOH could be an advantage. Rather than operate as a part of the MOH, the PNFP could advocate for it to assume a more neutral interlocutory role as facilitator of the process of implementing the policy on PPPH. This means both the government (MOH) and the PNFP (and eventually the traditional and complementary medicine sub-sector) should feel that the office is an un-biased operator, open to all views and answerable to HPAC rather than to Commissioner Planning.

A sensitive matter is the role of the Italian Co-operation which funded the establishment of the office. The Italian Co-operation should be encouraged to transition from its current proprietary role to a less directly involved promoter. This would have the advantage of opening up the interest and participation of other HDPs which could result in freeing up additional resources to strengthen the office.

In the meantime UCMB, together with UPMB and UMMB could install a PNFP counterpart for the PPPH desk so as to facilitate this revival process, to be phased out as soon as the existing office can operate as a more neutral interface. Experiences from other countries such as Malawi might give some direction on how to go about this.

Invest in 'soft' skills

While there have been great achievements in more technical skills e.g. generation and use of data , financial administration, this has opened a new area that will become increasingly important next to the technical skills which will need continual attention. PNFP staff are operating in an environment with other stakeholders who may be envious or competing for the same resource envelope. The vision of the health sector as one serving all of society regardless of religious or political affiliation is not yet entirely appreciated. There are feelings that "these are our facilities" and "those are theirs". It is clear that PNFP and government staff alike especially at the local level will need to acquire and/or develop a new set of skills to strengthen communication in general, advocacy and lobbying and constructive/strategic negotiating. This will enable them to articulate the case for a fair share of the resources available as well as being able to present their activities and achievements in a way that is perceived to be collaborative and non-threatening by the other (especially government) stakeholders.

Support the strengthening of the system as a whole

While the PNFP in general and UCMB facilities in particular have played a key role in the development of the health sector and continue to provide services of reasonable quality, these improvements are not often matched by similar level of performance by the public facilities. It is clear that a one-sided development could result in the burden of providing health care shifting ever more onto the PNFP shoulders. It is thus of interest to the PNFP themselves that the government facilities also improve and offer services of reasonable quality. Many performance assessment tools and indicators as well as feedback techniques have been developed by the PNFP and UCMB in particular which could offer a valuable learning to the public facilities. A good starting point for mutual learning could be in the PNFP that are health sub-district (HSD) leaders e.g., Nkozi Hospital, Aber Hospital and others. These facilities are responsible for supervision of the lower level health units in their areas (both PNFP and public). Tools and techniques developed for the PNFP could also be applied on pilot basis to public facilities, of course with the consent of district health authorities. This could offer an important mutual learning opportunity with public adopting good practices from PNFP and PNFP also benefiting from innovations in the public sector when they occur. This would benefit the system as a whole and would help promote the spirit of collaboration and mitigate the feelings of envy and accusations that PNFP only care for their own facilities. The results of such efforts could be communicated to and shared with authorities at district and national levels so that other areas could benefit as well.

Special focus on the North

There are strong indications that the humanitarian situation in Northern Uganda is getting higher and higher on the national and international agenda. There are already increased resources flowing to the North and more are expected. This means that UCMB should prepare for an enhanced role in Northern Uganda where a number of UCMB affiliated facilities are offering badly needed services and in some cases are the

only providers. Moreover, some of the facilities in the North and East are among some of the weakest even though the need for their services is greatest there. Strengthening a presence in the North e.g., through the presence of a regional co-ordinator or advisor could ensure a more relevant and timely support to reinforce the achievements of UCMB.

Strengthen systemic approach
It is clear that the systems approach taken by UCMB should continue and be strengthened.
Vertical programmes and projects are currently and will remain a reality for the foreseeable future. The level of funding going through vertical programmes/projects and its consequences on the rest of the system cannot be ignored by UCMB and affiliated facilities. This means there is a need for UCMB to develop capacity to support facilities to be able to selectively engage in some vertically funded programmes/projects while not losing sight of the overriding imperative to develop, strengthen and maintain functional systems. UCMB will need to continue its role of providing support to develop and strengthen the system as a whole as well as provide technical advice on how hospitals can participate in projects while maintaining a systems orientation. In order not to lose the momentum with hospitals and diocesan health offices, it will be important for UCMB to maintain a dedicated officer to help in sourcing and following up projects as is currently the case under GIFMU.

Implications
The discussions above and conclusions have some practical implications for the way UCMB might organise itself for the future. A regional role, closer to facilities, that would enable the provision of more targeted and customised support, while maintaining a nationally representative role for advocacy, lobbying and resource mobilization for the benefit of all will be needed.
UCMB which already has acquired a high professional profile will need to maintain this for the medium term to allow the innovations that have been introduced to take firm root. This will allow for additional learning and experience in institutional strengthening.
The current Executive Secretary is well positioned to transition into a behind-the-scenes supportive role. This role could for instance take the form of high level analysis of policies and their implications for UCMB and its affiliated facilities. He could offer general strategic guidance and liaison with the Church authorities to ensure adherence to the mission and protection of autonomy while functioning as an integral part of the national health system.

6.2 Short Term Improvements

The following suggestions are in line with the above presented strategic directions, but could be followed from today on, and do not need to await the outcome of the strategic planning process.

a. Stay alert on the quality of the PPPH both on the national and the decentralised level; keep in mind that the partnership is a *conditio sine qua non* and responsibility for the quality of the relation is equally shared by government and PNFP sub-sector. Where deterioration of the quality of the communication is noticed, try to find ways to discuss this observation on the meta level before entering into an eagerness to resolve the issue at hand in favour of the PNFP (UCMB) sub-sector. Avoid burdening the government with a problem they cannot handle as they feel their hands are tied. Offer assistance in exploring possible solutions, for instance on the human resource issue, which will benefit the whole sector and more over the people of Uganda.
b. Strengthen the recently decided focus for the OD advisors on (the position of) the diocesan offices (vis-à-vis the hospital if existing in that diocese, as well as vis-à-vis the Caritas department of the diocese), and through these offices on the LLUs[48]; develop context specific coordination mechanisms[49]/structures to enhance coordination at the diocesan level. As the bishops play an important role in this (church as legal proprietor of the facilities) UCMB (Health Commission)

[48] See 2006 work plan OD advisors, e.g. development of modalities for embedding LLUs in the diocesan health structure.
[49] See 3.3 on coordination mechanisms.

should strengthen its relation with the bishops conference (UEC). Not so much in terms of structures and procedures, but more in the form of 'walking together' and personal closeness.

c. Continue the systemic (OD) approach on the hospital/Diocesan Office level; complete the hospitals' comprehensive organisational assessment exercise in order to provide baseline 'data' to assess any future improvement; align this assessment (tool) with the financial administration / management assessment (tool) as well as attune the exercise with the accreditation procedures so as to avoid confusions on the relation between the two exercises (assessment and accreditation).
d. Continue the interdisciplinary OD / management development approach as team of UCMB advisors; consider the possibility to work as 'account managers' which means that each advisor has a prime responsibility for a number of dioceses (hospitals and Diocesan Offices) and calls in the other advisors where needed, to enhance cost effectiveness as well as to promote and demonstrate the inter-linkages between the core processes of an organisation (organisation as a system)[50]. Exclude the senior advisor from this as she should give guidance to the overall process and assist where needed in more complex situations.
e. Strengthen the contextualised, tailor made OD (including financial management) approach as hospitals and DHOs are at different levels with regards to their governance and management capacities.
f. Continue support for contingency planning for those hospitals and Diocesan Offices for which this is more appropriate at this moment in time, instead of embarking on a full fledged Strategic Plan for every facility; where possible and relevant, support strategic planning (scenario planning) on the facility level from the perspective of the bigger picture (local, national and even international 'landscape').
g. Continue the exercise to review and renew agreements (MoUs) between UCMB and its 'clients'. Replace 'pushing' strategies by 'pulling' in the sense of rewarding self-initiated, self-supported, pro-active, innovative and future oriented searches for constructive solutions; replace needs assessment by 'asset or capacity' assessments; strengthen the contextualised, tailor-made approach based on a sensitive, but at the same time result-oriented reading of the specific context (which requires 'sensing' skills more than just expert knowledge) and terminate the support where a sufficient level of 'self-renewal' organisational capacity can be noticed.
h. Replace gradually trainer or advisor-dependent methodologies for professional development of management by more peer-based methodologies, such as joint action research, peer reviews (or 'visitations' as this is called in the higher education sector) and the methodologies based on a one-to-one collegial basis, such as 'PAL' (peer assistant learning) or 'Critical Friend'. Peer reviews could be the (merged) replacement of accreditation (largely dependent on self-assessment) and the advisor based comprehensive assessments.
i. Review time allocation of staff to different objectives as to find out if and how more staff/advisor time can be made available to search for avenues to achieve the objectives that got less attention (assuming these are still relevant), such as enhancing the capacity to deliver holistic services, therefore increase knowledge and skills on mental health care, palliative care and social welfare.

6.3 Suggestions for the Upcoming Strategic Planning Process

It is advised to organise the Strategic Planning process as a capacity strengthening and learning experience for the UCMB membership and staff. Use can for instance be made of the methodology of strategic planning, developed by professor Annemieke Roobeek (lecturer in 'Strategy and Transformation', University Nyenrode, Netherlands)

[50] See for instance the core processes as defined by I/C Consult and broadly used by Cordaid in appraisal of the organisational capacities: 'doing' (core business), 'organising' (resulting in 'being', referring to staffing, organisational culture and management style, internal budget allocations and control and other procedures and systems), 'relating'(external relations) and 'thinking and learning' (evidence based reflections on the core question: are we serving our purpose taking into consideration the broader picture? See 'Looking at Organisations', www.icconsult.nl

titled ‘Strategic Management from the Bottom Up’. Critical concepts in this methodology are the pro-active, interactive dialogue with the environment by “representatives” of every layer in the organisation and the merging of strategic planning with strategic management[51]. In most cases a Task Force is formed with representatives from the various staff categories (professional staff, support staff and management) who in active dialogue with their own environment, gather relevant information which is analysed by the whole group and transformed into advices on the new strategic directions which can then be validated in a stakeholders and experts group, before it is endorsed by the Health Commission and thereafter translated into a Strategic Plan.
It is, however, equally important to provide the Task Force, before the start of the exercise, with a framework indicating the boundaries so as to guarantee that suggestions for strategic directions and priorities fit with the overall UCMB (and Catholic Secretariat) mission and vision, assuming that these are still valid.

[51] The latter is a more permanent attitude of every staff to regularly scan the internal and external environment as to be alert for unforeseen and unplanned opportunities and threats, communicate the findings and act on the conclusions.

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR THE REVIEW

END OF TERM REVIEW OF THE "UCMB 2004-2006 OPERATIONAL PLAN"
Terms of Reference
Daniele Giusti, 7.2.2006

Preamble
UCMB is the health office of the Catholic Church and the technical arm of the Episcopal Conference's Health Commission. It operates as department of a larger organization, the Uganda Catholic Secretariat.
UCMB was established in the mid 50ies with the main purpose of liaising with government, of streamlining the disbursement of funds to the then voluntary health sector and to develop nurses training. Later UCMB was incorporated in the newly established Catholic Secretariat, under which frame is operating nowadays.
One of the major past achievements of UCMB was the establishment of Joint Medical Stores, in cooperation with the Protestant Medical Bureau. JMS, a drug's procurement agency, ensured a regular supply of essential goods to the voluntary health sector during the years of unrest when both government organization and trade collapsed, thus permitting a minimum of service to the people.
Towards the end of the 80ies, in order to face the challenge posed by the AIDS epidemic and the development of primary health services required by the Country, UCMB established two specific desks to assist the Executive Secretary on issues related to AIDS and PHC. At the same time, considering the growing number of catholic health units, their relevance and the need of a better co-ordination, UCMB facilitated the establishment of Diocesan Health Coordinator in most dioceses.

Towards the mid 90ies it became progressively apparent that the challenges posed by the re-organization of Government, by decentralization, and by health sector reforms, required a new change at UCMB. The difficulties posed by the changes in the environment were compounded by the increasing financial constraints faced by the voluntary health sector, perceivable also at UCMB in terms of decreased contributions from the units. It is worth of notice that in this period UCMB with UPMB negotiated with Government a revival of the forgotten support of Government to not-for-profit health sector units.
The main funding agency of that time, Bilance, commissioned an assessment by a team of public health experts whose results prompted the Health Commission to appoint a committee charged with the task of studying "avenues for reform of UCMB and the sustainability of its role". The conclusions of the study made by the Committee highlighted the need of a higher professional profile of the Bureau and the trimming of its size, accompanied by a shift from a coordinating role (thought it was from an implementation role to a coordinating,) (to a) service provision role, and representation role. The Episcopal Conference accepted the Committee suggestion and gave mandate to UCMB to enter into the restructuring process. A further consultancy commissioned by Memisa (which in the meanwhile took over from Bilance the support of UCMB), taking into account the ongoing process of restructuring of UCMB, discussed with the Executive Secretary of UCMB and the Committee the terms of a way forward plan, which resulted in an Operational plan 1998/2000 that started on 1st January 1998, under Memisa funding.

In March 2000 a workshop involving the major In-Country and External stakeholders took place, during which a Strategic Plan 2001-2005 was outlined and agreed upon[52]. Within the frame of the agreed strategy an Operational Plan 2001-2003 was implemented with support of multiple funding partners among whom Cordaid is the most important. The implementation of this plan was reviewed in November 2002 with

[52] The rationale being that a Strategic Planning exercise would take place every 5-6 years and include an assessment of the Mission. Operational Planning would occur every three years and allow a certain degree of time overlap between one plan and the following. The mid-term review of each Operational plan would constitute the basis of adjustments of the plan nearing its end and of the next mid term period planning.

a positive assessment and the main recommendation to pay more attention to the monitoring of key indicators in the implementation phase.
In November 2003 several partners (including funding agencies) attending a "Consensus Conference" received an extensive "near term" self assessment of the implementation of the Operational Plan, along with a proposal for a new plan for the period 2004/6, articulated in two scenarios) [53].. They all agreed that the Bureau should continue scaling up its activities in the light of the increasing demand of service from the affiliated unit. The Plan was hence approved and funded to levels close to its ideal scenario. The Operational Plan 2004-6 maintained a strong "systemic" approach to operations, similar to the previous Operational Plan.

The entire Strategic Plan 2000-2005 indeed aimed at "building the system" but in 2003 it was already clear that new, more "vertically oriented" approaches were emerging, that were not present in the year 2000 when the strategy was outlined. This notwithstanding the choice of the Consensus Conference was clear: UCMB should maintain its focus on "building systems" and favour the establishment of other units within the larger organization (Catholic Secretariat) to address "vertical" program issues. While this strategic option has been very clear at UCMB, in the course of the implementation of the current plan UCMB has been asked (mostly – but not exclusively - by international parties) to opt for a more clear "disease approach" and to become channel for funds to lower levels. The pressure towards "re-verticalisation" has become so strong that a good proportion of the time of UCMB top executive is spent in "defending" the strategic systemic approach.
In the meantime the main funding agency (Cordaid) has also defined its policy and Strategic Plan for the period 2006-2010 and this fact may have implications for the continuity of the support and partnership.

In these years the Bureau has opted to build its own (in house) capacity – and carrying out its own operations - by having recourse to expatriate and local technical assistance (mainly with short terms contracts) and by accompanying them with junior professionals employed on longer terms, in view of providing an institutional embedding to the TA's expertise. It has already proven that the transfer of competencies occurs at a much slower pace than anticipated. The same consideration applies to the transfer of competencies from the Bureau to the cadres operating at a lower levels (hospitals and diocesan coordinations). The Human Resource scarcity (in terms of numbers and competencies) all across the board is perhaps the most critical problem the Bureau has to take into account and, to some extent, address. This poses questions about the necessity to continue with an increased scope of operation (for the Bureau) for a longer time than earlier foreseen and raises the paramount question of sustainability of the current levels of operation. It has to be kept into account, among others, that the ES, a pivotal function in the Bureau, is due for replacement at the end of 2006.

The current (near) End of term Review occurs with a certain delay with regards to the plan's foreseen Mid term Review. This delay occurs for a series of reasons that the Bureau feels are thoroughly justified, and brings the Review much closer to the end of the Operational Plan, to the revision of the Mission/Policy and the formulation of the new Strategy 2006-10. This delay thus offers the opportunity to enlarge the scope of the Review extending it from the assessment of the effectiveness of the implementation of the Plan (followed by the formulation of recommendations aiming at improving effectiveness) to the identification and assessment of other contextual issues to be kept into account for the longer term. Specifically the issue of systemic approach versus "re-verticalisation", and the question about the opportunity/wisdom for the Bureau to further scale-up to meet the new challenges along with the old ones – or rather stabilize if not scale down - would need attention as well as the methods used for the institutional capacity building.

UCMB feels that the Review should also take in questions like:

[53] UCMB had prepared two proposals: a conservative scenario implying the scaling down of operations in the course of the Plan, and an ideal scenario entailing a sustained accelerated level of operations for the period.

- Is UCMB, with its systemic approach, still on the right track, considering the evolution of global and local scenarios?
- Is UCMB really contributing to building the system? (i.e. is it using the best approaches in building the capacity of the institutions / organizations at the lower levels or are there better ways to do it?)
- Will the present trend in international policies remain or should we just whether the storm until everyone has come to their senses again?
- Must the increasing demands posed by appearance of new challenges be met or not?
- Etc, etc , etc

Broad Objectives of the Review

A. To assess the effectiveness of the implementation of the UCMB Operational Plan 2004-2006, in meeting its operational objectives, advancing the pursuance of the underlying strategy and recommend issues that can be addressed before the end of the Plan's period to assure maximum achievement of the still pertinent objectives.
B. To identify issues emerging in the ever-changing external/internal environment that may require substantial modification of the Mission and Policy of RCC health services and the related Strategic Plan 2006-2010, fundamental strategic options[54] and provide pertinent recommendations.

Specific Objectives of the Review

1. To assess the progress of the implementation of the Plan against its stated objectives and targets for the period 1.1.2004 to 31st December 2006.
2. To asses the consistency of the methods and activities undertaken to achieve the operational objectives and their relevance vis-à-vis the strategy.
3. To assess to which extent the methods and strategies used to develop the management capacities at the level of the health units and diocesan office are appropriate, or whether these require adjustments, specifically in an environment where human resources, with the necessary qualifications, are scarce.
4. To assess perceptions of the relevance of the activities and objectives of UCMB vis-à-vis the expectations of the various stakeholders, with a specific focus on those of the beneficiary constituency (RCC health Services and Diocesan Co-ordination).
5. To identify areas of need/focus which are emerging and which are not adequately provided for in the Operational Plan, nor by the additional activities, developed since the start of implementation.
6. To assess the financial aspects of the plan, so far implemented, and their consistency with the stated objectives and future sustainability.
7. To assess the format for financial reporting and its consistency with the requirements of the different fora of accountability.
8. To assess format for narrative activity / progress reporting – including indicators – and its consistency with the requirements of the different fora of accountability.
9. To review the current organization and staffing of UCMB and assess its consistency/adequateness vis-à-vis the stated objectives.
10. To suggest actions/measures that may be necessary to correct areas of focus/need not adequately provided for so far, or for newly emerging issues.
11. To suggest actions/measures that may be necessary to correct slow implementation, with reference to objectives and resources (human, physical, financial).
12. To ponder and suggest feasibility/possibility or re-sizing of the Bureau downwards in view of a higher level of self-reliance/sustainability.
13. To assess the actions, foreseen in the operational plan, and the adequateness of measures, taken thus far, to achieve increased sustainability of the Bureau.
14. To assess the risks for future funding of UCMB which emerge from changing donor policies and priorities

[54] The overarching question emerging is: can the Bureau, given the evident shift towards a more vertical/disease oriented approach, maintain that it will continue operating with a systemic outlook, refraining from any attempt to accommodate within its modus operandi niches of vertical approach (e.g. specific diseases oriented program/projects)?

15. To assess avenues/options for the substitution of the current ES at the end of his term of service.
16. Provide recommendations on ways, means, and actions to be implemented in the last semester of the plan.
17. To assess the evolution of the concepts at global and national level with regards to development assistance and its consistency / possible influence on the (Mission) Policy of RCC Health Services and Strategy of UCMB.
18. Provide recommendations regarding policy and strategic directions that need to be considered in the formulation of a new (Mission) Policy, and Strategy.

Methodology

1. The National Consultant will interact with the international consultant in order to agree on the modus operandi before the start of the joint consultancy.
2. He/she will entertain a (focus group) discussion with managers of Hospitals and Diocesan Health Coordinators in the course of the respective Technical workshops (during weeks 10 and 16), prepared by a suitable series of questions circulated beforehand (prepared in consultation with the international consultant). Option is given to the national consultant to attend a meeting of the Health Commission of the Episcopal Conference as observer on 31st March 2006
3. He will plan for, arrange appointments and organise the meetings with the relevant Government and Development partners officials to be held during week 17 and 18th. UCMB will assist by accrediting the consultant(s) through a letter of introduction or, if requested, through direct contact will the selected partner.
4. UCMB will arrange appointments and otherwise be of assistance in establishing the contacts with the Diocesan, Hospital and other Church related stakeholders in Kampala and in the field according to the plan presented not later than the end of week 14
5. Jointly, the national and international consultant, according to agreements independently reached beforehand and communicated to UCMB not later than the end of week 14 will, in the course of weeks 17 and 18

- visit UCMB and review/examine documentary material (Plan, reports, minutes of meetings, accounts etc.) in order to assess the progress of implementation against stated specific objectives and timeframe.
- hold discussions with the UCMB staff and other relevant actors at Catholic Secretariat (Secretary General, Health Commission/Executive Board, selected Hospitals'/Health units' and Diocesan Co-ordination representatives).
- visit a selection of affiliated hospitals and diocesan co-ordination.
- organise meetings and interact with relevant Ministry of Health official(s), selected Development Partners and other partners in order to obtain supplementary information concerning perceived relevance of the UCMB work and services, and possibly form an independent opinion about Ministry of Health and Development Partners' intentions in the forthcoming period
- examine policy statements of the Ministry in order to form a better view of the environment in which UCMB is operating.

Parties to be contacted

- UCMB staff
- Secretary General UCS
- HIV/AIDS Focal point of UCS and GIFMU
- Executive Board of UCMB (if need be in joint session with Finance and Planning Committee)
- Selected members of the Health Commission
- Diocesan Health Co-ordinators and Hospital Managers (it may be possible to organize a focus groups discussion – perhaps preceded by a questionnaire – in the course of the usual Technical Workshops that will take place during weeks 10 and 14 respectively)
- Ministry of Health Officials at the level of the PPP Partnership desk and Directorate/Commissioner Health Planning Unit.
- Development partners' representatives (the most relevant at the moment seem to be SIDA, DFID, Danida)
- Relevant Cordaid officials
- Uganda Protestant Medical Bureau (UPMB)

- Joint Medical Stores
- Other local partners of UCMB (Cuamm, AVSI, IICD)
- Uganda Martyrs' University – Faculty of Health Science
- Selected Hospitals and Diocesan Co-ordinators (according to agreed modality)

Documents to be provided locally (or by e-mail)
- RCC Health Services Mission and Policy 1999
- UCMB Strategic Plan 2000-2005 cum Operational Plan 2001-3
- UCMB Operational Plan 2004-2006
- UCMB Strategic Plan 2000-5 Consensus Conference Report March 2000
- UCMB Operational Plan 2001-3 MTR Jan03
- UCMB Operational Plan 2004-6 Consensus Conference Report Nov2003
- UCMB Operational Plan 2001-3 Annual Report 2003
- UCMB Operational Plan 2004-6 Annual Report 2004
- UCMB Operational Plan 2004-6 Annual Report 2005
- *UCMB Statements of Accounts 2004 –hard copy only*
- *(UCMB Statements of Accounts 2005 – hard copy only not yet ready)*
- UCMB Minutes of Meetings of Health Commission and Committees 2004
- UCMB Minutes of Meetings of Health Commission and Committees 2005
- *(MoH Health Policy 1999) hard copy only*
- MoH HSSP 1 2000 (draft)
- MoH HSSP 2 vol1 (2005) draft
- MoH MTR of HSSP 1 draft report Mar03
- MoH MTR Overwiev (PP Presentation)
- *(MoH Health Sector Performance Report 2003-4) – hard copy only*
- MoH Health Sector Performance Report 2004-5
- Joint Review Mission IX Aide Memoire 2003
- Joint Review Mission X Aide Memoire 2004
- Joint Review Mission XI Aide Memoire 2005
- Cordaid Strategic Plan 2003-6
- Any relevant file on request

Time schedule
Meetings with Hospital and Diocesan stakeholders ½ day each during weeks 10 and 16 respectively
Weeks 17-18th of the year (between 23rd April and 10th May)

Expected Output
An assessment report of max 50 pages excluding annexes providing:
- An analysis of the current progress
- Areas/issues in need of urgent address (objectives, methods, activities, and resources)
- Emerging areas/issues to be considered under a new strategic outlook
- Financial, material and human resource implications for any change deemed necessary
- Modus operandi for the formulation of a revised Policy and Strategic plan
- Avenues for continuation and strengthening of the Partnership with Cordaid and other donors? (e.g. foster a wider network to limit dependence?)
- to be submitted within the end of week 20 in its draft form and by 31st May 2006 in its final form (electronic plus 1 hard copy)

Profile of the Consultants
One, of national level, with an expertise in health, with extensive knowledge of the local (health) policy environment and informed of the evolution of health development agendas at global level to be the lead consultant.

One, of international level, with an expertise in the area of institutional / organizational capacity building by national size network organizations to bring in (in addition to the rest) the specific assessment of the capacity building and organisational growth/scale down outlook.

Timeframe of the consultant activities

National consultant

Max 18 days: 3 day preparation, 2 days discussion with HM and DHC's, 1 day briefing, 8 days assessment, 1 day debriefing, 3 days report writing

International consultant

Max 19 days with travel: 2 days travel, 4 days preparation, 1 day briefing, 8 days assessment, 1 day debriefing, 3 days report writing

Budget

National Consultant @ 368 Euros per day per 18 days (300+50+18 tax)	€	6,624
Other personal costs (tel & C)	€	150
TOTAL gross	€	6,674
TOTAL net of taxation deduction at source	€	6,350

Organisational costs of meetings and vehicle cost up-country are organised and covered by UCMB. Transport in Kampala is included in the per diem and personal cost provision and is self organised.

APPENDIX 2

LIST OF PARTICIPANTS/RESPONDENTS IN DISCUSSIONS WITH MEMBERS OF DIOCESAN HEALTH OFFICES AND HOSPITAL MANAGERS

Attendance list for Meeting of Diocesan Health Co-ordinators 6th - 9th March 2006

No.	Name of Participant	Designation	Diocese
1	Regina Bakite	DHC	Kampala
2	Turyahabwa Hellen	Ass. DHC	Kabale
3	Frances Nassuna	Focal point	Nababa
4	Sr. Cecilia Najjigo	DHC	Kiyinda - Mityana
5	Rose Orach	DHC	Nebbi
6	Fr. J. Kirungi	Asst. Focal person	Kasese
7	Denis Bakomeza	DHC & FP	Lugazi
8	Fr. Emmanuel Katabaazi	DHC	Masaka
9	Sr. Ernestine Akulu	DHC	Kasana – Luwero
10	Fr. Kaahwa Leopald	Focal Point	Fort Portal
11	Sr. Anastazia K	Ag. DHC	Fort Portal
12	Sr. M. Goretti Nakate	DHC	Hoima
13	Ilse Dhondt	Technical Assistant	Kasana – Luwero
14	Sr. Margaret Katyoko	DHC	Mbarara
15	Kiconco Annet	DHC	Mbarara
16	Birungi Charles	HIV/AIDS FP	Hoima
17	Sr. Dinavence J	DHC	Moroto
18	Sr. Natalina Mowo	DHC	Kotido
19	Sr. Jacinta Abalo	DHC	Lira
20	Fr. John Lule	HIV/AIDS FP	Kiyinda - Mityana
21	Fr. Ayelangom Jovenale	FP	Nebbi
22	Govule Philip	Ag. DHC	Arua
23	Rosemary Kairie	Asst. DHC	Tororo
24	Sr. Ednah Kanda	Focal person	Moroto
25	Sr. Angela Amutebi	Asst. DHC	Kampala
26	Kule Denis Muthabali	DHC	Kasese
27	Asindu Philip	DHC	Arua
28	Egou Augustine	DHC	Soroti
29	Monica M	Asst. TA	Lugazi
30	Sr. Euphrasia Masika	DHC	Fort Portal
31	Kasujja Ashraf	Head Data	Masaka
32	Dorcus A. Musubaho	Ag. DHC	Jinja

Attendance list for UCMB Senior Managers Technical Workshop 17th - 20th April 2006

No.	Name of Participant	Designation	Station
	HOSPITALS		
1	Dr. David Kitala	for Medical Director	Aber
2	Mr. George Abeto	Ag. Administrator	Aber
3	Dr. B.R. Wadria	Rep. Medical Director	Angal
4	Sr. Emmy A.S.	SNO	Angal
5	Dr. Arach Proscovia	Ag. Medical Director	Buluba St. Francis
6	Mr. Okula Charles	Administrator	Buluba St. Francis
7	Dr. E.K. Byaruhanga	Medical Director	Ibanda
8	Mr. Alex Obonyo	Administrator	Kalongo Ambrosoli Memorial
9	Ms. Teddy F. Abor	Deputy Principal Tutor	Kalongo Ambrosoli Memorial
10	Fr. James Kabonghe	Member/BoG	Kamuli Mission
11	Mr. Samuel Babinga	Accountant	Kamuli Mission
12	Ms. Monica Watuvamu	Asst. SNO	Kamuli Mission
13	Dr. Francis Mugume	Medical Director	Kilembe Mines
14	Sr. Faustine Kyakyhaire	Administrator	Kilembe Mines
15	Mr. Pascal Baita	Member/BoG	Kilembe Mines
16	Dr. Robert Asaba	Ag. Medical Director	Kisubi
17	Sr. Christine Kizza	Administrator	Kisubi
18	Sr. Max Nambasiira	SNO	Kisubi
19	Dr. Lawrence Ojom	Medical Director	Kitgum St. Joseph
20	Mr. Alex Oloya	Administrator	Kitgum St. Joseph
21	Sr. Angelina Cabrin	Director	Kitovu St. Joseph
22	Sr. M. Regina	SNO	Kitovu St. Joseph
23	Mr. C. Bankunda	Administrator	Kyamuhunga Comboni
24	Sr. Getrude Alone	SNO	Kyamuhunga Comboni
25	Dr. Martin Ogwang	Ag. Medical Director	Lacor St. Mary's
26	Mr. Pier Paul Ocaya	Administrator	Lacor St. Mary's
27	Dr. Allan Mpairwe	Medical Director	Lwala
28	Mr. John Euku	Administrator	Lwala
29	Dr. Paul Aido	Medical Director	Maracha St. Joseph
30	Ms. Assumpta Ginamia	Administrator	Maracha St. Joseph
31	Dr. Stefano vincentini	Medical Director	Matany St. Kizito
32	Dr. Jerome Mugisha	Medical Director	Mutolere St. Francis
33	Sr. Kemirembe M.Jovita	Asst. Administrator	Mutolere St. Francis
34	Dr. K. Kigoonya	Medical Director	Nagalama St. Francis
35	Mr. Denis Kibuuka	Administrator	Nagalama St. Francis
36	Dr. Rogers Kabuye	Medical Director	Nkokonjeru
37	Sr. Ambrose Kibuuka	Administrator	Nkokonjeru
38	Dr. Martin Ssendyona	Medical Director	Nkozi
39	Sr. Josephine Nasuuna	Administrator	Nkozi

No.	Name of Participant	Designation	Station
40	Dr. Martin Nsubuga	Medical Director	Nsambya St. Francis
41	Ms. Donny Ayero	Asst. PNO	Nsambya St. Francis
42	Ms. Magdalene Nakalyango	HR/Administrator	Nsambya St. Francis
43	Mrs. Teo Rwomushana	Deputy/PNO	Nsambya St. Francis
44	Mr. Herbert Ssemakula	Purchasing Officer	Nsambya St. Francis
45	Dr. Joseph Baguma	Medical Director	Nyakibale Karoli Lwanga
46	Mr. Caiola Jeff	Administrator	Nyakibale Karoli Lwanga
47	Mr. Deus Kamanyire	Member/BoG	Nyakibale Karoli Lwanga
48	Dr. Paul Onzubo	Medical Director	Nyapea Holy Family
49	Fr. Robert Ngageno	V.C/P - BoG	Nyapea Holy Family
50	Dr. N.W. Onyanchi	Medical Director	Nyenga St. Francis
51	Ms. Theresa Nambuya	SNO	Nyenga St. Francis
52	Dr. J.M. Bukenya	Medical Director	Rubaga
53	Mr. Fred Lwanga	Administrator	Rubaga
54	Sr. Imelda Mary Nakitto	PNO	Rubaga
55	Dr. Ivan Kamya	Medical Director	Tororo St. Anthony
56	Ms. Hellen Ademun	SNO	Tororo St. Anthony
57	Dr. M. Male-Kawuma	Medical Director	Villa Maria
58	Sr. M. Gorretti Namuwulya	Administrator/Burser	Villa Maria
59	Dr. Deogratius Munube	Medical Director	Virika
60	Sr. Theresa K. Kamugole	Administrator	Virika
	HEALTH CENTRE IV		
1	No representative		Bukwa
2	Dr. Stephen Waiswa	Administrator	Dabani
3	Mr. John Egesa	Chairperson/HUMC	Dabani
4	Fr. Expedict Kitto	Administrator	Kyamulibwa
5	Sr. Anne Nassimbwa	In-Charge	Kyamulibwa
6	Dr. J.B. Waniaye	Administrator	Magale St. Elizabeth
S	Fr. J.P. Ochwo	Chairperson/HUMC	Magale St. Elizabeth
8	Sr. Bibian Anena	Asst. Incharge	Morulem
9	Fr. Samuel D. Lotuk	Chairperson/HUMC	Morulem

APPENDIX 3

LIST OF DOCUMENTS REVIEWED

Cordaid Files on UCMB

Cordaid, Health and Care policy paper 2003 – 2006, October 2003

Enyimayew, Nana and Everd Maniple, Transforming UCMB for the challenges of Uganda's Health Sector Reform: A mid term review, January 2003

Giusti, Daniele, The Experience of the Private Not-for-Profit Health Sector in Uganda, Berlin Workhop Series, WB, 2004

GoU, Aid-Memoire, 11th Health Sector Joint Review Missions and the 3rd National Health Assembly, 25-29 October, 2005

Javier Martinez and Liz Collini, A Review of Human Resource Issues in the Health Sector, DfID Health System Resource Centre, 1999

Makerere University Institute of Public Health in collaboration with Ministry of Health and London School of Hygiene and Tropical Medicine, Health Systems Development Program, Research Dissemination Workshop, 31st October, 2005

Memorandum, Addressed to the Participants in the Workshop of Hospital Managers of PNFP Hospitals in Uganda, Cardinal Nsubuga Leadership Training Centre Nsambya, 20th April 2006

MoH, Annual Health Sector Performance Report, Financial Year 2004/2005, October 2005

MoH, Consequences of a Low Government of Uganda Budget for the Health Sector, unpublished notes, received March 2006

MoH, Financing Health Services in Uganda 1998/1999 – 2000/2001, National Health Accounts, June 2004

MoH, Health Sector Strategic Plan II, 2005/06 – 2009/2010, Volume I

MoH, Human Resources for Health Policy, April 2006

MoH, Overview of Performance of the Concluded First Health Sector Strategic Plan (HSSP !, 2000/01 – 2004/05 (distributed via the national Newsletters in April 2006)

MoH, The Health Sector Budget Framework Paper 2006/07 – 2008/09, December 2005

Nebbi District, Memorandum of Understanding between Nebbi District Local Government and Nyapea Hospital for the Use of Delegated Funds and for the Financial Year 2004/2005 for the Delivery of Health Services within the District of Nebbi, 30th June, 2004

Strategic plan – UCMB financial management programme, draft text 06-04-06 (AB)

UCMB Commission and Committee Meetings 2004 and 2005

UCMB files of Health Commission, Executive Board of the Health Commission and Finance and Planning Committee Meetings, 2004 and 2005

UCMB Files on Nkozi Hospital, Aber Hospital, Diocesan Health Office Lira and Diocesan Health Office Kampala

UCMB Office of Organization Advisors: a)Planning for the period December 2005 – January 2006; b) Planning for gradual taking over by Godfrey Bazira Wabwire

UCMB, Accounting for and Documenting Faithfulness to the Mission, UCMB 2001 – 2003 Operational Plan, End of Period Report of the Executive Secretary UCMB to the Health Commission, November 2003

UCMB, Bishops Conference in Uganda, Mission Statement and Policy of Catholic Health Services in Uganda, 1999

UCMB, Consultation Conference, Faithfulness to the RCC Mission in the third Millennium: Challenges and perspectives for the Second Phase of the Strategic Plan, Consensus for the Operational Plan 2004-2006, November 26th – 28th, 2003

UCMB, Financial Statements for the Year ended 31 December 2005

UCMB, Focusing Our Work Better for Faithfulness to the Mission, Report of the First Technical Workshop for Diocesan Health Coordinators, March 7 to 10, 2005

UCMB, Going the Extra Mile to realise Faithfulness to the Mission, Report of the Second Technical Workshop for Diocesan Health Coordinators, October 17 – 20, 2005

UCMB, Guidelines and Check List for Hospital Visists 'Quick Scan', February 28, 2006

UCMB, Investing in Faithfulness to the Mission, Strategic Plan 2001 – 2005, Operational Plan 2004 – 2006, Final version adjusted with the outcome of the Stakeholders Consensus Conference, February 2004

UCMB, Investing in Faithfulness to the Mission, Strategic Plan, 2001-2005, Operational Plan 2004-2006, February 2004

UCMB, Manual of Management of Financial and Material Resources for Catholic Hospitals in Uganda, no date

UCMB, Narrative and Financial Report for the period 1st January 2004 – 31st December 2004

UCMB, Narrative and Financial Report for the period 1st January 2005 – 31st December 2005

UCMB, Report of the Meeting of Representatives of Board of Governors and Chief Executive Officers of Hospitals with Government Seconded/Posted Medical Personnel, 9th September 2005

UCMB, Strategic Plan 2001 – 2005, Operational Plan 2001 – 2003, April 2000

UCMB, Technical Workshop for Hospital Managers and Representatives of Board of Governors, 3rd to 5th October, 2005

UCMB, Technical Workshop for Hospitals Managers and Representatives of Boards of Governors, 3-5 October 2005

UCMB, UPMB, UMMB, Joint PNFP Hospital Managers Workshop, 1st – 3rd March, 2005, Workshop Report, April 2005

UCMB, Work Plan 2006 Appendix 4: Summary of Key Results from Focus Group Discussion Participants and Respondents of Self-administered Questionnaires

SELECTED KEY FINDINGS FROM DIOCESAN HEALTH CO-ORDINATORS AND HOSPITAL MANAGERS

Selected Notable Quotes from Focus Group Discussions

Place of PNFP in the National Health System

"The PNFP facilities fit quite well, some units lead health sub-districts, which should have been role of government, some are district hospitals, conducting operations and doing what a government hospital would do, doing it better. For example when a drug is prescribed it is available. We are managing with less resources but supporting government efforts, we are following government policies." **A Hospital Manager.**

"If grants from government were not there it would be a total disaster, some of our facilities would close". **A hospital manager.**

"The community also knows that the government is supporting these hospitals so they were also surprised when they heard government was going to reduce support to PNFPs". **A Hospital Manager.**

"We provide services irrespective of our religious affiliation and we follow government's Health Sector Strategic Plan (HSSP II) in broad agreement with government policies". **A Hospital Manager.**

"PNFPs are involved in the delivery of the Uganda National Minimum Health Care Package". **A Diocesan Health Co-ordinator.**

Role of UCMB in supporting PNFP/Most useful support received from UCMB

"They link us to the MoH, they talk for us, they meet donors on our behalf, they get for us scholarships". **A Hospital Manager.**

"Improvement in communication system, the diocesan health co-ordination office and hospitals have been provided with computers and Internet services". **A Diocesan Health Co-ordinator.**

"Health units under UCMB are very involved in national work i.e., provision of quality and cheap health services according to national health policy guidelines. They are guided by the national health policy." **A Diocesan Health Co-ordinator.**

On why staff are leaving PNFPs

"One of the key issues is the workload. In PNFP staff works for 8 hours compared to 2 hours in government, where staff even get paid more. They are getting paid more for doing less. The government has so many workshops and seminars which adds to their income. They have no time to work". **A Hospital Manager.**

"Degenerating morals is a big issue. The staff these days have no feeling for the patients. Some don't want night duties. Most of the young nurses don't want to work in the villages where most of the PNFP are located." **A Hospital Manager.**

"Strictness in mission hospitals. They (staff) want a lax environment. They don't want to follow professional ethics. Somebody may complain of a heavy workload in government but has a heavy workload in his/her own clinic". **A Hospital Manager.**

"The majority of staff have left because of poor remuneration compared to that of their colleagues working with government". **A Diocesan Health Co-ordinator.**

"In most cases it is as a result of low wages, poor accommodation, delay in payment of salaries, attitude of the supervisors and poor living conditions". **A Diocesan Health Co-ordinator.**

"Staffs claim that there is no job security under UCMB facilities and very little career development". **A Diocesan Health Co-ordinator.**

On involvement in district planning committees

"In theory yes, we are involved but in practice it is something else. They make sure you don't get the information in time, sometimes you get the information when the meeting is going on". **A Hospital Manager.**

On future collaboration with government

"We have to go back to basics, to improve communication with those in authority. The people we are serving are the responsibility of government". **A Hospital Manager.**

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Selected Relevant Indicators from Interviews with Diocesan Health Co-ordinators and Senior Hospital Managers

No.	Indicator	Diocesan Health Co-ordinators		Hospital Managers	
		n	%	n	%
1.	Rated UCMB support as good/very good	21	100.0	58	96.6
2.	Activities of unit/office enhance strength of the National Health System much/very much	19	94.7	58	94.8
3.	Personally participated in UCMB organised capacity building in past 2 years	20	90.0	55	78.2
4.	A member of this office/unit participated in UCMB capacity building in the last 2 years	16	75.0	57	89.5
5.	UCMB staff visited your unit/office in the last one year	18	100.0	56	91.1
6.	Staff left unit/office in last one year	14	35.7	52	84.6
7.	New staff joined unit/office in last one year	13	38.5	51	86.3
8.	Unit/office/organization relates and/or exchanges information with similar counterparts in other denominations in the area	16	81.3	54	90.7
9.	Staff from lower units/departments participated in UCMB organised capacity building in last 2 years	19	89.5	19	89.5
10.	UCMB staff visited lower level units/departments in last one year	18	50.0	17	70.6

APPENDIX 5

LIST OF KEY INFORMANTS INTERVIEWED

List of Key Persons Interviewed for the UCMB Review of Strategic Plan (24th April to 6th May 2006)

The following persons were interviewed:

A. Health Development Partners

1. Claes Örtendahl – Sida
2. Flavia Mpanga –Irish Aid
3. Peter Okwero – World Bank
4. Juliet Nabyonga – WHO
5. Peter Ogwang – DANIDA

B. Government

Ministry of Health

1. Dr. Nelson Musoba – PPPH Desk.

Ministry of Finance Planning and Economic Development

1. Rogers Enyaku – Senior Economist, I/C Health Desk

C. Academic Institutions

1. Maniple Everd Bikaitwoha – Uganda Martyrs University, Nkozi

D. Other Key Partners/Stakeholders

1. Lorna Barungi Muhirwe – UPMB
2. Donna Kusemererwa Asiimwe – JMS
3. Paula Mommers – CORDAID
4. Mgr. Francis Ndamira - Health Commission
5. Everd Maniple Bikaitwoha – Health Commission
6. Filippo Ciantia – AVSI
7. Peter Lochoro – CUAMM
8. Fr. Robert Binta – Finance and Planning Committee (Administrative Overseer)
9. Sr. Goretti – Finance and Planning Committee
10. Diocesan Health Co-ordinators (actual list to be added)
11. Hospital Directors (Medical and Nursing, list to be added)
12. Hospital administrators/managers (list to be added)
13. Hospital Board Members (list to be added)

E. UCMB Staff/programmes

1. Daniele Giusti – Executive Secretary
2. Sam Orach – Assistant Executive Secretary/formerly GIFMU Co-ordinator
3. Marieke Verhallen – Organizational Development Advisor
4. Albert Beekes – Financial Management Advisor (via e-mail and telephone)
5. Godfrey Bazira – Assistant Organizational Development Advisor
6. Florence Bamenya – Accountant/Administrator
7. Harriet Hope Akidi – Assistant Financial Management Advisor
8. Isaac Kagimu Mpoza – Human Resources Advisor
9. Andrea Mandelli – Information and Data Management Advisor

F. Diocesan Health Co-ordinators

1. Regina Bakitte – Kampala Archdiocese
2. Sr. Jacinta Abalo – Lira Diocese
3. Sr. Hellen Akongo - HIV/AIDS Focal Person, Lira Diocese

G. Staff of PNFP Hospitals Visited/interviewed

1. Dr. Martin Sendyona – Medical Director, Nkozi Hospital
2. Sr. Elizabeth Nalumansi – Outgoing Senior Nursing Officer, Nkozi Hospital
3. Sr. Clare Thadeus Nabikolo – In-coming Senior Nursing Officer, Nkozi Hospital
4. Dr. Humphrey Okechi, Ag. Medical Director, Aber Hospital
5. Sr. Maria Kharono – Senior Nursing Officer, Aber Hospital
6. Dr. Lawrence Ojom – Medical Director, St. Joseph's Hospital, Kitgum

H. District Health Officials

1. Dr. Alan Ahimbisibwe – Ag. DHHS, Mpigi
2. Dr. Quinto Okello – Deputy DHHS, Lira/Chairman, Lira Diocesan Health Board

Appointments were unsuccessfully sought with the following persons more than once:

Ministry of Health

1. Sam Zaramba – Director General of Health Services
2. Francis Runumi Mwesigye – Commissioner for Planning

Academia

1. Dr. Olico Okui – Makerere University IPH (he was out of town)

APPENDIX 6

KEY ACHIEVEMENTS AS REPORTED BY UCMB

UCMB Annual Report 2004

1. Almost totally successful funding of the Operational Plan 2004-6 in its ideal scenario
2. Formulation of a proposal for the support of the Plan by the European Union, for the period 2006-8 or 2007-9[55]
3. Identification and formalisation of agreements with new partners for the current plan implementation
4. Renewal of all the statutory organs of the Health Commission of the Episcopal Conference, including the Commission itself
5. Successful taking off of the UCMB/UPMB/JMS project "Equipment initiative for enhanced quality in PNFP LLUs" (supported by Cordaid through JMS)
6. The establishment and operationalisation of the Global Initiatives' Fund Management Unit
7. Launching of the programme for the introduction of (computerised) cost centre accounting in Hospitals
8. Identification of options for an accelerated training of RCC managers (short course of Certificate in HSM at UMU), palliative care, CPE
9. Sustained involvement of the Diocesan Co-ordinators in the Pull drugs system
10. Sustained operation of the ICT network with identification and planning of new solutions for improvement of performance
11. Increased presence of UCMB staff in the field to an extent never reached before
12. Completion of the surveys on drugs' prescription practices and patients' satisfaction
13. Support provided to dioceses and hospitals with re-organisation process started in 6 hospitals
14. The high rates of accreditation of both LLUs and Hospitals
15. Installation, launching and support of the Task Force on the future of the PNFP HTIs
16. Lowering of entry criteria for candidates to Enrolled Comprehensive Nursing
17. Organisation and facilitation of the Conference of Bishops holding health portfolio in the English Speaking Countries of Africa
18. Complete revision of the accounting procedures of UCMB, with the introduction of a Financial Management Manual and the computerisation of the accounts
19. Completion of the UCMB Website (to become operational in early 2005).

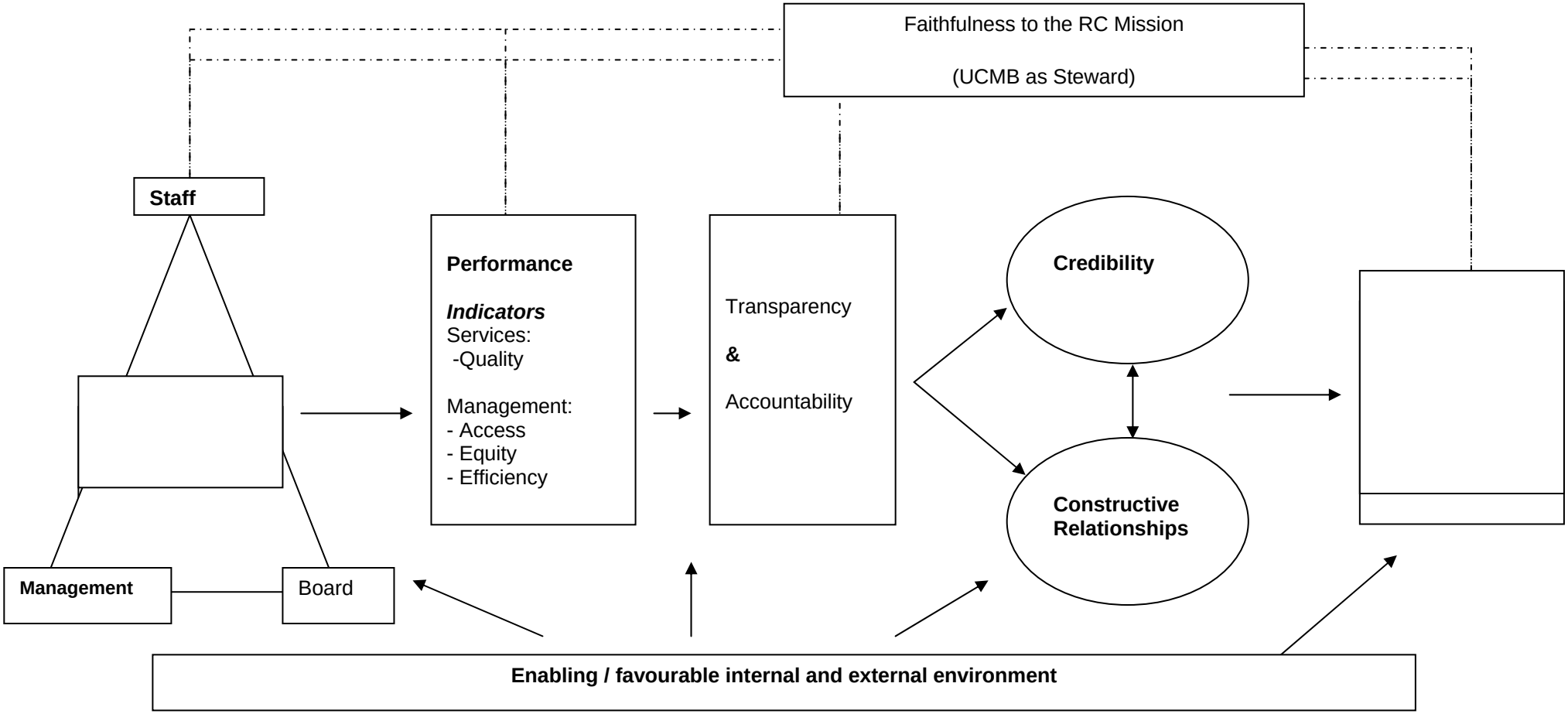
Annual Report 2005

1. Launching of the UCMB Website (http://www.ucmb.co.ug)
2. Installation of the Interim Executive Board of the PNFP Health Training Institutions Partnership
3. Recruitment and employment of the ICT System Administrator, junior Organisation Advisor and junior ICDM Advisor
4. Sustained support to training
5. Successful facilitation of the AMECEA Conference
6. Launching of the Strategic Planning Workshops
7. Identification of approaches for future self financing of important areas of technical assistance (ICDM and FM)
8. Reached consensus among hospital managers about secondment of public servants to UCMB hospitals
9. Launching of the courses of Certificate in Health Services Management and Promotion and Education, respectively
10. Clear evidence that, despite the many constraints, health units keep moving towards an increased Faithfulness to the Mission.

[55] This EU project is rejected.

APPENDIX 7

OVERVIEW AND FLOW OF ACHIEVEMENTS
End Term Evaluation UCMB - Debriefing Session - Saturday May 6, 2006



FORWARDING NOTES OF THE UCMB TEAM TO THE HEALTH COMMISSION OF THE EPISCOPAL CONFERENCE

NB: These complementary notes are the fruit of the common work of the UCMB Team. They are not to be attributed to the Reviewers.

UGANDA EPISCOPAL CONFERENCE
(CATHOLIC SECRETARIAT)
HEALTH COMMISSION

UGANDA CATHOLIC MEDICAL BUREAU

Tel. (+256 41) 510 576 – 269 705 (direct)
Fax. (+256 41) 510 575
E-mail: dgiusti@ucmb.co.ug

P.O. Box 2886
KAMPALA
Uganda

Our Ref:
Your Ref:

Date: 24th August 2006

Right Reverend
Bishop Egidio Nkaijanabwo
Chairman of the Health Commission
Uganda Episcopal Conference
P.O. Box 412 - Kasese

Dear Lord,

Re: Report "Review of the UCMB Operational Plan 2004-6

I am pleased to forward copy of the Review of the UCMB Operational Plan 2004-6, carried out by Ms Ria van Hoewijck from I/C Consult (The Netherlands) and Dr George W. Pariyo from Makerere University – Institute of Public Health.

The team of UCMB has attentively studied the review and has "**perceived it as complete, according to the terms laid down, offering the desired orientation for the strategic planning exercise. The UCMB team is happy for the extremely valuable and stimulating professional exchange with the reviewers and for the largely positive assessment expressed by them: it accepts their report without reservation."**

In addition the team of UCMB has greatly appreciated the Review for the high professional standard of the reviewers, their interesting and friendly approach coupled with the necessary frankness. It considers it the review learning experience, from which they have greatly benefited.

To clarify issues further for members of the Commission, also at the light of events that have occurred after the review, the UCMB team has prepared complementary notes, attached here for documentation, specifically in view of the ongoing planning exercise.

This report is offered to Your Lordship and to the Health Commission to account for the work done and as input in the ongoing Strategic Planning process for the period 2007-2011.

Yours Sincerely,

Daniele Giusti
Executive Secretary

COMPLEMENTARY NOTES OF THE UCMB TEAM TO THE "REVIEW OF THE UCMB OPERATIONAL PLAN 2004-6"

24 August 2006

The team of UCMB has greatly appreciated the Review for the high professional standard of the reviewing team, their interesting and friendly approach coupled with the necessary frankness. It considers it a learning experience, from which they have greatly benefited.

The report "Review of the Operational Plan 2004-6" is perceived as complete, according to the terms laid down, offering the desired orientation for the strategic planning exercise. The UCMB team is happy for the extremely valuable and stimulating professional exchange with the reviewers and for the largely positive assessment expressed by them: it accepts the report without reservation.

The team desires to add the following notes to express some comments, to broaden the understanding of the statements made in the report, to correct understandable slightly asymmetric perceptions of the reviewing team, all this as complement to the report. As life is highly dynamic, more things have happened after the review that may be useful to the reader of the report: notes are provided here when they are deemed to cast a new light onto the assessment/suggestions made by the Reviewers. There are also few comments regarding the UCMB team position on some of the suggested strategic directions.

Comments aiming at clarification:

At Page 3, concerning Performance of health facilities.

The Reviewing team did not have access to historical data concerning quality, nor of updated information. As is the case for the assessment of the progress in the degree of completeness of the delivery of the MHCP, the findings of previous baseline surveys of patients' satisfaction and drugs prescription practices will be compared, before the end of 2006, to findings of surveys that were ongoing at the time of the review.

At Page 3, concerning targets not fully met.

The reviewing team seems to suggest that, the effort made in the alignment of the PNFP HTI, is the main cause for the non achievement of all targets. While it is true that a lot of work went into the alignment of the PNFP HTI, it has to be clarified that the year as a whole and the entire period since early 2004 has been characterised by important changes of direction in the national and international front: the "critical accident" of the salary of civil servants occurred in early 2004 and has kept the Bureau unusually busy, without resulting in a solution. The magnitude of the impact of Global Initiatives (with their new demands and inherent confusion of initiatives) is the second main reason of diversion of the Bureau focus, hence of the failed targets. To some extent, the PNFP HTI intervention, has had a more "physiological" and less frantic development.

At Page 4 and 29, concerning critical success factors and risks, point b)

The UCMB team totally agrees that the plethora of indicators for targets to monitor that characterises the Operational Plan 2004-6 has the risk of becoming and end in

itself, creating an un-necessary burden. This excess is in some ways related to the previous Mid-term Review, which lamented the scarcity of quantifiable indicators of progress in the plan 2001-3. At the same time monitoring and evaluation has not been left for the end of the year report. It has been done very often albeit not systematically and not as a common exercise (it is done by the advisors for the areas of specific competencies and shared with the Executive). The real point the team wishes to retain is that M&E needs to have a defined form, a short periodicity and be carried out as team activity.

At Page 15, Table 1.

The balance carried forward at the end of the year is not attributed to any source and skews the interpretation of data. When attribution is done the picture is the following:

	Cordaid/PSO	AVSI COWA M&P	Local	IICD	SVFOG	Cuamm	DKA Ecosan	DKA
2004	**67%**	**8%**	**8%**	**4%**	**4%**	**4%**	**2%**	**3%**
2005	**56%**	**13%**	**9%**	**8%**	**4%**	**2%**	**6%**	**1%**
2006 projections	**66%**	**7%**	**9%**	**10%**	**5%**	**2%**	**0%**	**1%**

At Page 21, Footnote 28.

The team has tried to identify where the Government HMIS uses indicators for sustainability to no avail.

At Page 24 and 34. Concerning Advocacy and lobbying.

The reviewing team attributes to UCMB the success in lowering the entry criteria for ECN. While it is true that UCMB did strongly advocate for it, it is a shared opinion of the UCMB team that the achievement (which is not in any case totally secured) is mainly due to strong political influence. UCMB is happy for having been among the first if not the first to strongly voice concern on the issue.

At Page 34, concerning the mention of "Encouraging signs that the issue of human resources is being addressed through a supplemental budget....".

Unfortunately, this was the information available and hope raised at the time of the review. It has not been so. The supplementary budget has not materialised.

Elaborations on suggested way forward

At Page 5 and 36. Concerning "Dialogue within the PPPH Partnership".

The team of UCMB has no doubt that a sustained participation in all the structures of HPAC (and its working groups) is necessary. Concerning the recommended participation in the Development Partners meetings, the team has a less definite conviction. The participation of UCMB to the DP group is historical and related (also) to the expressed need of some members of the group to know better this other actor

(i.e. the PNFP) that, despite its importance at the grass-root, had always had an "elusive" visibility in the processes at the centre. UCMB, exactly for its visibility and pro-active role, was the best placed representative of the entire sub-sector. With the passage of time, the participation of the Bureau in the DP meetings has not been pursued for advocacy purpose. Most of UCMB advocacy is done in other fora (HPAC, TRM, JRM, open fora). The DP meeting retains undoubted importance for UCMB as unique source of information about the ongoing processes. Had it not been for its presence in this forum, UCMB would not have been able to understand, read and interpret the flow of events. In this sense, the relative importance (for UCMB) of the DP meeting as source of information points at the weakness of HPAC. If HPAC were the type of forum it should be, UCMB would not need – now - to sit at the DP meeting. On the other hand, the Bureau is aware that its participation in the DP meeting is not positively viewed by some Ministry quarters, and doubts that its continuation is strategically wise. On the other hand, at the moment there is no alternative to the DP meeting as source of information. In the course of the next Operational Plan this dilemma will have to be sorted out. The UCMB team wishes to retain a reservation on the opportunity of continuing its participation in the DP working group, awaiting a necessary discernment.

At Page 5 and 37. Concerning "Revival of PPPH Desk".

The UCMB team totally agrees that the PPPH Desk is necessary and has to be revived. It has a different perception about the most convenient placement of the Desk. Its physical location outside the Ministry of Health premises has had undoubted advantages (there is very little physical space available in the Ministry HQs). It has also somewhat forfeited the possibility of fostering a sense of "belonging" that, in the opinion of the UCMB team, is one of the major reasons of its lack of effectiveness. Perhaps it has also strengthened the perception of the "proprietary role" exercised by the Italian Co-operation on the desk, reported by the Reviewers. Along this line, the UCMB team fears that a further dilution of the "identity" of the desk as Ministry office will limit further the Desk's capacity to embed PPPH issues in the Ministry's mainstream. Along the same line, the team feels that installing a temporary PNFP own desk, to foster the Partnership, may prove contra productive.

At Page 5 and 37. Concerning "Support the strengthening of the system as a whole".

The way forward suggested for this point meets with an undivided agreement of the UCMB team. The choice for partnership with the public sector has never been out of expedience but out of conviction, at least as far as the Bureau is concerned, and has never been a question of "money only". Hence the creative investment in the implementation of the National HMIS, the creation (with UMU) of courses of Health services management with a strong systemic orientation (attended in larger proportion by pubic servants), the opening of the services of JMS to Government institutions (public facilities now fall behind accredited units only by few percentage points as clients of JMS), the acceptance of HSD headquarters functions without proportionately adequate support from Government (hence partly financed by the concerned hospitals/units).

The catholic network and the Bureau have not been "mean" in this direction. The question the Bureau feels more pertinent, at this stage, is how being relatively well performing partners in the system can be turned into an asset rather than a liability.

Unfortunately the prevailing perception in Government circles and quite often among the development partners is that the public sector is in dire need of support, while the PNFP sector performs already so well that it does not need it.
The UCMB team feels is convinced that this strategic direction needs to be maintained, out of principle and in the interest of the people served.
However, the team has reservations regarding the expected benefits of extending the present efforts of the Bureau and RC institutions towards more deliberate and new actions to strengthen the systems as proposed by the consultants. The financial constraints, but certainly the above prevailing perceptions, will hardly allow the declared (desired) effect of "promoting the spirit of collaboration and mitigate the feelings of envy and accusations that PNFP only care for their own facilities" to materialise.

At Page 5 and 37. Concerning "Special focus on the North".

The need of strengthening the presence in the North is strongly shared by the UCMB team. The modalities of its realisation are less clear. Although the Reviewing team did not enter in details, the formulation in the text seems to suggest that a sort of "deconcentration" of the Bureau in the Northern Region should occur. If the Reviewers intended to suggest that the Bureau should open its own office in the Northern Region and man it, the UCMB team feels that this is not a desirable/desired modality. There are other ways that need to be explored, more aligned with the principle of subsidiarity and with the general principle of creating partnerships and alliances, that the Bureau is determined to pursue, although time frames of implementation may be longer than expected.

Page 6 and Page 39. Concerning "Short-term Improvements" – Implications.

The Reviewers stress the need to enhance the contextualization of the support to the RC institutions by the Bureaux. To this effect they suggest that the Bureau opt for a more pronounced "decentralization" to be closer to the units. The UCMB team deems the recommendation as very valuable and feels challenged to implement it. However the team is less convinced that the establishment of a regional presence of the Bureau (a further extension of the suggested approach of the North) is a suitable option. The major perplexity is deriving from the fundamental choice of the Bureau to respect the principle of subsidiarity: the Bureau must work so as to enable the institutions to take up their own responsibilities. The risk being that Institutions would more easily "delegate" to the (regional) Bureau a role and tasks belonging to them. Besides, this option would have heavy financial implications.
Concerning the installation of account managers per region (one of the technical assistants is appointed as first contact person for all the member institutions of a region) as short term solution, the largest obstacle is that the capacities and experiences of the advisors differ too much to ensure effective support. This option is anyhow retained for the mid to long term, if the cross fertilisation of capacities hopefully occurring in the team UCMB will succeed in successfully build a larger scope of competencies in the junior advisors. This will be verified in time.

At Page 5 and 38. Concerning "Strengthen systemic approach".

The Reviewers suggest that UCMB should "maintain a dedicated officer to help in sourcing and following up projects….". While the Bureau's team strongly agrees with the views and suggestions given with regard to the need of "Strengthening systemic

approach”, it has reservations on the need of a dedicate staff for this task. The assumption being that the Focal Point for HIV/AIDS and, more specifically, GIFMU, are fully operational, the role of the Bureau is to collaborate with these units in the Catholic Secretariat in such a way that they are both influenced by the systemic approach. Recourse to a dedicated officer would occur only if this first selected approach fails, and would mean for the Bureau a much stronger presence (through a deployed person?), in the GIFMU. But this would be a last resort option.