Is religion relevant in health care in Africa in the 21st Century? – The Uganda experience

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Abstract

Involvement of religion in health is a compliance with Scriptures. In Uganda the Anglican and Catholic Churches founded the first health facilities (1897 and 1899 respectively) and were later joined by the Muslims and other churches.

Uganda's first Public-Faith Based Organisations (FBO) partnership for health was in 1955 with gazetting of Protestant then Catholic medical Bureaus. It was reactivated in 1997-98 with resumption of budget subsidy to FBO (Private-not-for-profit or PNFP) facilities.

PNFPs have been part of the Sector Wide Approach (SWAp) arrangement since 1999 and contribute to policy and systems-related dialogue. While a draft Public-Private-Partnership for Health Policy awaits approval Uganda's health system has greatly benefited from involvement of religious health providers. PNFPs contribute 39% of Uganda's 127hospitals (43% hospital bed capacity), 25% of lower level facilities, over 60% of nurses and midwifery training schools. Majority of facilities are in rural poor areas. 75% of PNFPs belong to 3 religious medical networks / bureaus that account for 30% of combined Public – PNFP health workforce. 7% of government health budget goes to PNFPs (making about 19% of PNFP annual budget). But PNFPs produce 35%-40% of facility-based health outputs.

Religious health facilities were a source of resilience to health care during reign of Idi Amin 1972-1978 and the current northern and north-eastern conflicts. Communities see them as part of and belonging to them, consistent with their values, credible and acceptable even in such moments. Besides, different organisations react differently to situations of instability hence the need for a mix of providers. Public-PNFP partnership has created mutual learning that benefits the system and allows for required flexibility especially in situations of emergency.

Facility-based FBOs have been credible partners to government providing value-for-money for subsidies received. Stagnation and even drop in support to them is affecting sector-wide performance indicators.

FBOs especially non-facility based ones are better in reaching grass-roots. They operate as CSOs or NGO making remarkable contribution especially to prevention and mitigation of effects of HIV/AIDS but are mainly invisible. Mechanism of coordinating, attributing and recognising this big contribution is needed.

In conclusion, sustaining and strengthening systems and services delivery of religious health assets is not a question of whether but how. Without FBO contribution a very large gap in health services delivery would be created.

Introduction

For the purpose of this discussion, a religion refers to an entity whose primary purpose or that of the larger organisation to which it belongs is the building and nourishing of faith in God based on the Scriptures. This paper focuses on the efforts

of such bodies to provide health services. Involvement of religion in health is a compliance with Scriptures, both bible (*Deuteronomy 32:39; Exodus 15:25-26*, *Luke 4:38-40; 5:12-15*) and the Qurán. Jesus' healing ministry was holistic but was not facility-based. Evidence of buildings devoted to health care are only found beginning with the Christian era (Harold G. Koening, Michael E. Cullough, David B. Larson – quoting Granshaw 1993 pg 1181). It is reported that in Uganda health care similar to the Western practice could have occurred for long before introduction of Western health care into the country. A British traveler, R. W. Felkin, is reported to have witnessed a cesarean section performed by Ugandans in Kahura (Western Uganda) in 1879, eighteen years before western medical care started in the country (Fielding H. Garrison 1913). They reportedly used wine as semi-intoxicate and as disinfectant. Metallic clips were used to close abdomen while uterus was not sutured. The woman was reported to have recovered. While the first hospital buildings were established in Asia Minor as early as around 370 A.D. by the Eastern Orthodox, in Uganda the Anglican and Catholic Churches founded the first health facilities (1897 and 1899 respectively) and were later joined by the Muslims and other churches.

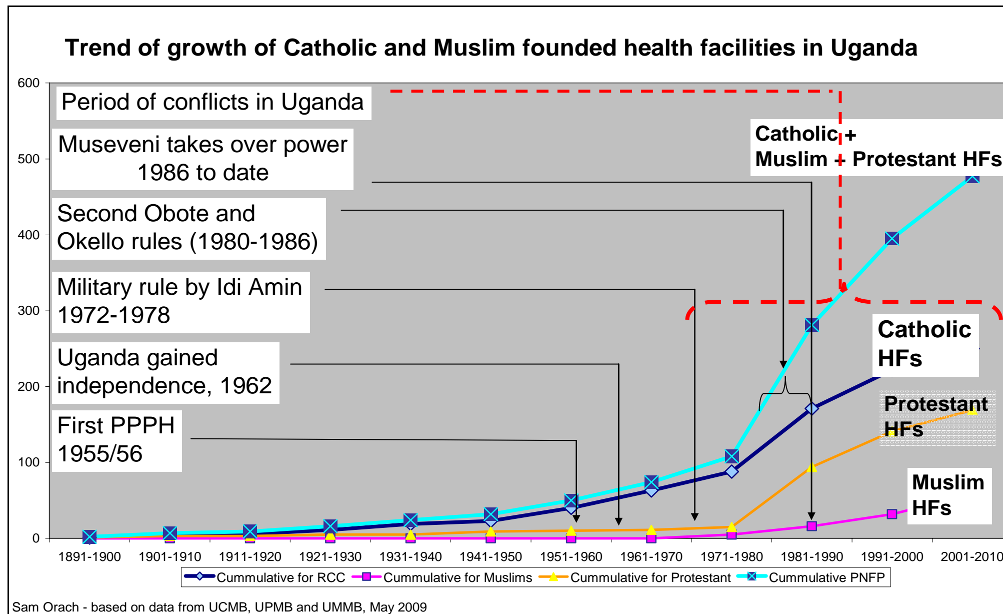
At the invitation of the Anglican Bishop Tucker, Dr. Albert Cook and his wife Katharine Cook started work on February 22nd 1897, three days after arriving in Kampala at what is now Mengo hospital (W.R. Billington 1970). The Roman Catholic Church opened what is now Rubaga hospital two years later in 1899 (UCMB records)[1] and in 1903 opened Nsambya hospital by the works of the Franciscans Missionary Sisters. Dr. Albert Cook's work on syphilis led to the construction of the main treatment centre for venereal diseases on Mulago hill, that later grew into the present day Makerere University Hospital (W.R. Billington 1970). What is now Makerere University Medical School (situated at Mulago hospital) was in fact first started in Mengo by Cook in February 1917 (W.R. Billington 1970; John Iliffe) to train African staff as medical assistants as pressure mounted from casualties from the East African campaign of the first world war. It was handed over to the government some years later. Even training of nurses and midwives was introduced into Uganda by the Missionaries. The first midwifery school was started by Mrs. Katharine Cook in Mengo in 1919 while the Catholic Franciscans Missionary Sisters in the same year opened the first nursing school in Nsambya hospital. Mrs. Cook later opened a training wing for nurses at Mengo in 1928.

Since the opening of Mengo and Rubaga health facilities, religious health facilities have grown in numbers and capacity and played a fundamental role in the provision of facility-based health care as well as in prevention (especially in HIV) in the country.

Figure 1 below traces the growth in cumulative numbers of health facilities of the Catholic and Protestant Churches and that of the Muslims since the start of the first health facility in 1897. It was not possible to get comparable data on trend of growth of government facilities at the time of writing this paper.

[1] UCMB is the body that coordinates Catholic Health Services in Uganda on behalf of the Uganda Episcopal Conference.

Figure 1: Trend of Growth (cumulative numbers) of Religious (Catholic, Protestant and Muslim) health facilities in Uganda[2]



Growth of religious-founded facilities seems to have been stimulated and accelerated in response to certain situations in Uganda, usually situations of vacuum created by decline in public health care service and instability. Religious bodies started up health facilities when and where there was none but were also source of resilience to health care during the reign of Idi Amin 1972-1978 and the subsequent northern and north-eastern conflicts that have continued to present days. Communities see them as part of and belonging to them, neutral, appealing to their values, credible hence generally acceptable even in such difficult moments. They provided alternatives and continuity of services where and whenever government and other providers (including private-for-profit) could not withstand conflict, other instabilities and their consequences. But to date they also provide some semblance of ethical practice and image to the health sector at a time when it is widely accused of corruption and unethical behaviours of health workers particularly in public facilities.

Public-Private-Partnership for Health (PPPH) in Uganda

Since religious bodies introduced the "western" style of health to Uganda, they have always worked with government. Informal public-private-partnership for health (PPPH) or better still public-FBO partnership for health therefore started in Uganda right at the introduction of "Western" medicine. But formal PPPH came much later with a lot of benefits but also a lot of challenges. Still a lot happens to compliment government efforts outside formal partnership.

[2] Records at UCMB and UPMB did not have dates when a few facilities were started. It is however believed this can not change the general trend of growth in numbers of FBO facilities in relation to events of the different times.

Government partnership with facility-based PNFP

Even in the absence of a formal and specific legal framework, the most known and visible public-private-partnership for health (PPPH) is between government and the facility-based Private-Not-For Profit (PNFP). Over 75% of the latter belong to three religious umbrella bodies, Catholic, Protestant and Muslim medical bureaus that have been part of the Sector-Wide Approach (SWAp) arrangement since 1999, contributing to policy and systems-related dialogue and formulations. However formal partnership first started in 1955 when the Frazer Commission (1954) recommended that public subsidies be introduced for the "voluntary health sector" because the colonial government appreciated the work done by these facilities to complement government efforts. The Uganda Protestant and the Uganda Catholic medical Bureaus were then formed and gazetted as channels for disbursing grant in aid to church-owned health facilities. This formal partnership died in the mid 1970s during the reign of Idi Amin who took over government in 1971 following a military coup.

But faith-based facilities continued to grow even faster in response to the growing need amidst gaps and anarchy created by the then military government. In 1986 after the coup that brought Yoweri Kaguta Museveni to power the Health Policy Review Commission (Prof. Raphael Owor and others 1987) recommended that the collaboration between Public and Private Providers be revived. The partnership was reactivated in 1997-98 and budget subsidy to FBO (Private-not-for-profit or PNFP) facilities was resumed. The development was reaffirmed by the government White Paper of 1993. In 1999 representatives of the PNFP health sub-sector participated in the launching of the Sector-Wide Approach (SWAp) in WHO Geneva; in the same year the National Health Policy declared as one of its principles that "The existing collaboration and partnership shall be strengthened between the public and private sectors in health, including NGOs, private and traditional practitioners, while safeguarding the identity of each" (MoH 1999). In 2000 representatives of the Bureaus became members of the Health Policy Implementation Committee (HPIC) now Health Policy Advisory Committee (HPAC) and participate in the formulation of the first Health Sector Strategic Plan (HSSP I).

Over the years representatives of non-facility-based PNFPs have also become available in HPAC. The first Health Sector Strategic Plan (MoH HSSP I, 2000), referring to NGO health care providers (in practice referring to the PNFP facilities, also acknowledged the ongoing collaboration and stated that "the plan envisages strengthening this collaboration through the development of service contracts and increasing subventions to the NGOs". In return the PNFP units agreed to increase the scope of the service provided, improve the remuneration of their staff, and reduce fees. Since then subsidies increased and extended to lower level units (LLUs) which are health centres and clinics. LLUs Credit lines for Essential Drugs were eventually opened at Joint Medical Stores (JMS), a supply chain management facility owned jointly by the Catholic and Protestant Medical Bureaus for PNFP health units. All the outputs of the PNFP units reflect in the HSSP outputs and contribute to the outcomes. In every issue of the Health Sector Performance report this contribution is accounted for. Budget subsidy continued to increase till 2003/04 when it started stagnating and eventually dropping.

Tripartite memoranda of understanding were to be signed by PNFP facilities, the respective district local governments and the Ministry of Health. PNFPs and a number of districts signed these annually for a number of years but the Ministry of Health did not. The reason was that it did not have the legal framework and mechanism to enforce sanctions for non-compliance. The Ministry most likely feared the consequence in case it was the non-compliant partner. The second Health Sector Strategic Plan (MoH HSSP II, 2005) recommitted the Ministry of Health to strengthening partnership with the private sector and extending it beyond the PNFP to include the Private Health Practitioners (PHP) (previously called Private-for-Profit) and the Traditional and Complementary Medicine Practitioners (TCMP), civil society and representatives of principal consumers. In particular it committed to finalizing the National Policy on Public Private Partnership for Health and implementing the policy guidelines for the PNFP and PHP sub-sectors and to promote the partnership at lower / Local Government level. To date, seven years after the policy was first drafted, it is yet to be presented to the Cabinet for approval although it was finally endorsed by the Ministry of Health top management in 2008.

Government partnership with non-facility-based PNFP

Local faith-based organisations (FBOs), operating as non-facility-based civil society organisations (CSOs) have also made remarkable contribution especially to prevention and mitigation of effects of HIV/AIDS but are mainly invisible. There are also faith-related NGOs like AVSI, World Vision, CUAMM, AMREF etc that work with the local ones. Unlike the case of the FBO health facilities that operate within the national health systems there is no mechanism of systematically coordinating, attributing and recognising the big contribution of non-facility-based entities especially relating to prevention activities in the community. An inventory of agencies with HIV/AIDS activities and HIV/AIDS inventions in Uganda taken in 2001 (AMREF, July 2001) found that 16.2% of the agencies were faith-based. The Program Manager for the AIDS Control Program (ACP) in the Ministry of Health, Dr. Zainab Akol, estimates that the FBO facilities handle about 40% of the patients on anti-retroviral therapy FBOs together (mainly the non-facility-based ones) provide about 60% of prevention related services[3].

Traditional medicine and spiritual healing

It is not known precisely how many traditional medicine practitioners and spiritual healers are operational in Uganda. A study in one central Ugandan county of Gomba, Mpigi district in 1991 (Lwanga J. 1992) found a population of 160,000 was served by 518 traditional healers(THs) and 8 preventive and curative health units including a health centre. That is a ratio of 1 THs to 309 people, far better than can currently be imagined for formal health workers in such an area. The THs were willing to work with health workers and participate in joint workshops on health.

Some THs (mainly herbalists) have formally come together to collaborate in doing research by forming an organisation called THETA (Traditional and Modern Health Practitioners Together Against AIDS), in what is seen as a mutually respectful collaboration between the two groups of practitioners in the fight against AIDS.

[3] Personal communication (April 2009) - with authorisation to quote.

The draft Uganda policy on public-private-partnership for health (PPPH) includes partnership with traditional and complimentary medicine practitioners, this being mainly in the area of regulation and research.

But is the role of religious organisation in provision of health services still relevant in the 21st Century?

The 21st Century has brought to Africa more providers of health services but also more complex challenges that could destabilise the religious approach to health services. First despite all and foremost, for religious organisations the provision of health services is a fulfilment of scriptures. However the experience of Uganda shows that on one hand the heroism of religious bodies in initiating and providing health care especially in difficult situations and on the other hand the capacity of the government to single-handedly provide the services are challenged by the complex factors of this century. For Uganda and probably most African countries the question is not whether the role of religious bodies in health services is still relevant. The question rather is how they can remain or become more effective and efficient and sustainable. In many African countries situations of instability similar to the one Uganda has gone through exist, macro-economic pressures and mistrust of government health systems by both the citizens and the donors is common. Many ordinary Ugandans especially the poor still consider the religious health facilities and community-based health programs the beacon of hope as accusations of inefficiency, poor work ethics and corruption against public systems persist or even increase. Government is also unable to sufficiently reach all corners of the country with curative as well as preventive health services. In these circumstances, it is important that multiple players remain on stage because different organisations are affected differently and respond differently to challenges or difficult situations as seen in Uganda. They have different comparative advantages while working for the same goals.

The ability and freedom of individuals and communities to play roles in planning, managing and securing health care for themselves or influence government decisions and processes are also parts of a democratic process. Religious bodies have a presence in all communities and categories of the population in the country, a picture common to probably all African countries. Most African communities rally more easily around religious organisations than government. We have seen that supporting the democratization process in such communities through providing support to facility-based PNFPs and other funding to non-facility based PNFPs working with communities has benefitted the health sector in Uganda. The benefit government has received from the partnership with PNFPs (75% being religious) in itself also makes it equally strong reason in the same circumstances to ensure continued partnership with religious health service providers. PNFPs contribute 39% of Uganda's 127 hospitals (43% hospital bed capacity)[4], 25% of lower level facilities, over 60% schools training nurses and midwives.[5] About 85% of PNFP facilities are in rural poor areas. 75% of

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[4] Source: Office of the Commissioner for Health Services (Ministry of Health). It includes the private-for-profit hospitals. Data was last updated in 2006.

[5] Data from Ministry of Education and spots show that by January 2009 there were 32 schools for training nurses and midwives, 19 of whom belonged to the three FBO medical bureaus, 5 belonged to private individuals / organisations and 11 belonged to government.

PNFPs belong to 3 religious medical networks / bureaus[6] that account for 30% of combined Public – PNFP health workforce. Seven percent of government health budget goes to PNFPs (making about 19% of PNFP total (at national level) annual budget). Under the partnership or SWAp arrangement, the health sector strategic plan (HSSP)[7] is jointly monitored by the Ministry of Health and other stakeholders including religious health networks. Out of the combined public and PNFP outputs, the PNFPs produce 35%-40% of facility-based health outputs which is a good bargain for the 7% of government's health sector budget. This effective and efficient use of resources was also observed by Ritva Reinikka and Jakob Svensson (2003) who studied the religious non-profit (RNP) facilities and concluded that there was element of voluntarism and altruistic concerns that drove these facilities. They observed that financial aid led to more and better quality of services in religious non-profit facilities only, concluding that working for God matters. Facility-based FBOs have thus been non-competitive and credible partners to government providing value-for-money for subsidies received and supporting the initiation and growth of the health sector systems for many years.

So then, what is needed for continued role of religious health assets in complementing government efforts in health?

At least twelve lessons may be learnt from the Ugandan experience.

1. It is clear that religious health assets, both facilities and non-facility-based ones remain important to the health sector in Africa.
2. Formal and informal partnerships have characterised any success seen in the Uganda's health sector.
3. Working independently is no longer sustainable and is not beneficial to the communities as well as to the government and the religious bodies.
4. Strengthening the existing partnership is therefore the best thing to work for now
5. Given that it is equally important for government, religious organisations and other non-state actors to work together to provide services, it is imperative that they align their work and approaches to the common goals while respecting and protecting the individual identities. This means having shared vision, goals, and objectives. It also means working within one national health system. It requires participation in fora for discussion or dialogue on policy mattes, joint planning, and distribution of resources available to the nation. Equitable access to services by the community especially the poor through the use of facilities or networks of all partners and the pulling together of outputs and joint assessment of performances is important. In Uganda the creation of the HPAC as a SWAp mechanism was very important. It has helped, but not necessarily ensured, the understanding of the roles of non-state partners like organised religious health bodies beyond the Ministry of Health but also by development partners. It is not easy to get to the table where important discussions and decisions are made, and so continued evidence based advocacy is needed. Religious bodies should guard against being forced to change values, vision and goals simply in exchange for easy access to resources. Rather the recognition of their important contribution and values in addition to shared vision and goals should form the basis for continued dialogue and partnership in health.

[6] Source: Computed from the list of PNFP facilities used by MOH in the allocation of government subsidy from Primary Health Care Conditional Grants.
[7] The first HSSP (HSSP I) was from 2000/01 to 2004/05. HSSP II is to run from 2005/06 to 2009/10.

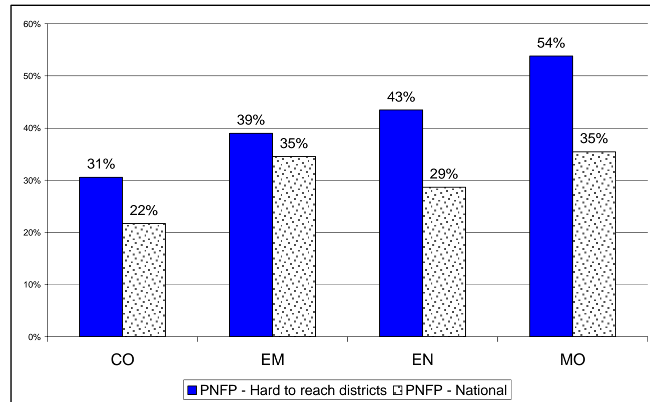
6. For there to be credible and successful public–private partnership for health, visionary leadership and positive commitment is required from all sides. Deliberate strategic decisions need to be taken by the leaders recognising the richness of pulling all possible players into providing services under that leadership. While the public-PNFP partnership had the very strong backing of the then Minister for Health in the late 1990s, the political leadership and even many technical new comers to the Ministry of Health in Uganda have increasingly shown a lack of desire for such partnership despite often announcing the benefits of the good work of PNFPs. Similarly, while the religious leaders in Uganda have appreciated the benefit of working more closely with government, much of the actual interaction has been between the health technocrats. It is felt that early involvement and continued engagement of the religious leaders with the country's political leadership is very important for maintaining and strengthening the commitment and vision. Such engagement and advocacies need to be proactive both at national and lower (districts) levels.
7. The presence of strong coordinating bodies focused on health system strengthening has been of great benefit. The UCMB, UMMB and UPMB coordinate health facilities. Lessons may be drawn from their work to coordinate and strengthen non-facility based religious health entities.
8. An agreed legally protected framework is needed. In Uganda a draft Public-Private-Partnership for Health Policy awaits approval by the Cabinet. Meanwhile, the absence of such a specific policy as a legal framework for the partnership and the failure to implement the service level agreements have meant that the implementation of the partnership both at the national level and the district level depended on the understanding and appreciation of partnership by individuals in key positions and the will of such leaders and they come and go. Consequently some unilateral decisions by government have undermined the religious health networks / PNFPs.

Such lack of consultations on critical issues especially about human resources has strained the PNFP-Government relationship (MoH. HRH Policy 2006). PNFP facilities are faced with increasing costs of service delivery mainly because of rising human resource cost. Yet government has been reluctant to increase budget support to the PNFP facilities over the last 5 years despite all the benefits the nation has got from increasing such support in the past. The government seems to care little about the consequences on the sector performance if the PNFP sub-sector is weakened. Concern for equity rises with fear of increasing user fees that could affect utilisation. This is largely due to increasing salary differential between government and the PNFP.

As a result, as costs of services increase PNFPs are unable to pay salaries to the level of government. An additional disincentive for PNFP health workers is poor work habits in the public sector characterised by high levels of absenteeism yet getting higher and higher salaries for less and less work. Because of these attrition from the PNFP has increased. Over 60% of the leavers join government employment where threat of industrial action lead to unilateral salary increments for the public sector workers almost yearly. A few others go to very high paying projects, mainly related to HIV/AIDS. In 2007/08 the attrition rate in the religious health networks (UCMB, UPMB and UMMB) for the Enrolled Nurses and Enrolled Midwives for example, these being the commonest cadres, was 32% in hospitals and 46% in the lower level facilities. Facilities have to recruit rapidly to replace the rapid loss (high turnover

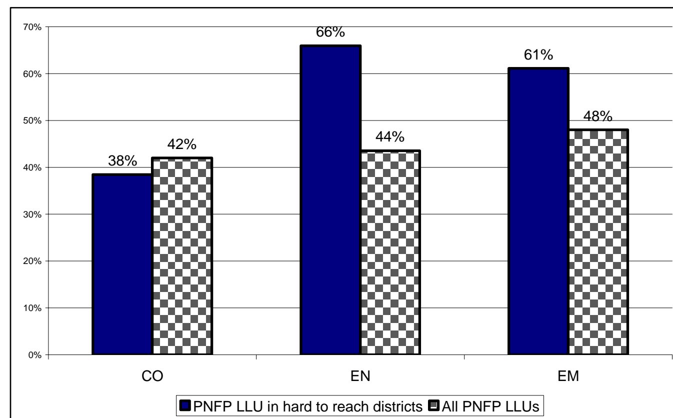
rates). The situation was worse in the 12 districts considered hard-to-reach. In hospitals of the religious networks in those districts attrition was 39% for Enrolled Midwives, 43% for Enrolled Nurses (MoH AHSPR October 2008).

Figure 2: Attrition in PNFP Hospitals in hard-to-reach districts compared to national figures for key cadres in 2007/08



The situation was further worse in the lower level facilities where attrition was 66% and 61% for Enrolled nurses and midwives respectively.

Figure 3: Comparison of attrition in PNFP LLU facilities in hard-to-reach districts against overall PNFP attrition (national) 2007/08



Advocacy by the FBO medical bureaus drew the sympathy of the Ministry of Health and the Health Development Partners in the country a few years ago. Support to PNFP salaries became the top priority among undertakings from the annual Joint Review Missions for three consecutive years but was never fulfilled. However it appeared to have increasingly become a difficult issue for the Ministry of Health that was at the same time fighting for budget increase to the public sector in. Two years ago it was dropped from the priority list. The impression is that there are quarters that wish government to provide sector wide leadership but also wish resources received for the whole sector to be retained for use by only the public sector. Fortunately there are still some good willed persons in government, especially Ministry of Health, who wish to see a better partnership including in the use of national resources.

The willingness or unwillingness of government to increase budget subsidy apart, creation of national budget ceilings under the mid-term expenditure frameworks (MTEFs) and long term expenditure frameworks (LTEF) defies the principle of additionality of such increased donor funds. It means that even if government receives more money from outside, it can not easily translate into increased budget allocation including support to religious bodies. The objectives for Uganda's expenditure frameworks are the avoidance of macroeconomic instability through maintaining of low inflation, reducing fiscal deficits by raising domestic revenues and

improving external public debt sustainability indicators, increasing private sector credit and private investment, increasing exports and maintaining foreign exchange reserves at a minimum of five months of imports of goods and services. By implication therefore, if the country receives more money that goes beyond the budget ceiling within the MTEF, the "excess" could be absorbed by displacing other available monies. The displaced monies could fulfill the last objective of maintaining foreign exchange reserves. Uganda has in the last close to a decade, received a lot of money but mainly for the global health initiatives to fight HIV/AIDS, TB and Malaria. These are non-fungible monies. To make them fit into the MTEF they displace fungible monies, this is reason why despite increased funding to government, little increases to the health sector budget including the religious health services has been observed. John Odaga and Peter Lochoro (2006) suggest that the other reasons for the budget ceilings seem to be the need to ensure budget discipline in government, avoid dependence on donor support that might effectively reduce Ugandan ownership of the development agenda and to improve efficiency by forcing sectors to spend on cost-effective health priorities. It is possible there that there are also more reasons why government might not want to give more support.

Countries that are early in their public-religious partnership or are planning to go into it therefore need to ensure that the legally accepted cooperative arrangements are taken care of early. These need not be too tight or stringent, business like, because then they create mistrust and build no long-term relationships. All that are needed are clear policies preferably jointly proposed to Parliament for enactment, memoranda of understandings and specific service-level agreements.

9. Situations as described above require that the sector has a stronger voice in allocating resources taking note of where it sees cost-effectiveness. It also requires that there are adequate opportunities for dialogue between the partners in that sector. The shift by donors from directly supporting service provision by civil society to sector budget support and now to general government budget support is in principle good and aligns with the Paris Declaration. But general government budget support moves the sectors and more still the other partners such as religious bodies further away from the allocation table. Religious health providers therefore need to build stronger evidence-based advocacy. There is a need to find allies among other civil society organisations, as well as among development partners, whose vision, goals and objectives to not contradict that of religious providers.

In spite of all the risks, it is on one hand important to align with some of these changing national and international policies and agendas; but it is also equally important to advocate for the makers of these policies to align with the local situations in Africa including the important roles of civil societies in general. A typical example is the Paris declaration on Aid Effectiveness. It is a good declaration that seeks to put national governments in the driving seats of development agenda, ensure alignment of aid with country systems and processes, create harmonisation of aid arrangements or procedures, focus on frameworks for result oriented support – transparent and monitorable performance assessment, and mutual accountability. But with regard to civil society this declaration only commits the developing country governments to "Take the lead in co-ordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector". Nowhere does the declaration explicitly impress on counties

to recognise the important roles of civil societies including religious as service providers[8], and to support their participation in complementing government by providing access to funds obtained on behalf of the citizens. It totally leaves the civil societies at the wills of individuals in governments.

The mounting negative macroeconomic pressures could severely affect the survival of religious health services to the detriment of most African populations. Advocacies therefore need to reach beyond the country leadership to the international arena where donors who give funds for health services make strategic decisions some of which by default negatively affect the religious health providers and the civil society in general.

10. Strengthening or supporting only the public system does not strengthen the sector. There is reason to align investment to the sector-wide need so that the whole sector. Weakness on one side will inevitably affect the whole sector. Because religious facilities have demonstrated that they have non-conflicting objectives with government and are efficient in use of resources, many donor organisations would like to work with them under the common saying "using existing systems". But while donors easily give almost blank cheques to government (which does not necessarily translate into increased support to religious facilities as we have seen above), they are extremely directive to religious facilities and mainly support components that increase the load of work on the systems of the religious facilities without paying attention to the corresponding need to strengthen the local capacity and systems. When support is given towards "systems strengthening" it instead often refers to systems at the national level (Ministry of Health) or simply workshops for the existing staff to do more and more. The real brunt of interventions on systems is felt at the sharp end, the service delivery point. In working as partners religious health bodies need to get both government and donors to appreciate the need to always look at sector-wide and whole-column or top-to-bottom system strengthening and not one-sided or one layer support.

Today the medical bureaus find it increasingly difficult to align demands of different donors who come to "support" the network facilities with the systems that are in place. Ministry of Health should in the first place enforce such alignment of systems. Typical examples are parallel data and information management and reporting systems that sometimes even bypass the management of the hospitals directly to the donors, parallel accounting systems. For example having 5 different donors in one facility may mean having 5 different databases for Anti-retroviral therapy, for example. They multiply work but also make data difficult to use for strategic management and governance decisions.

As stated earlier, it is important to align resources to the need and objectives of the whole sector. Resources that are available should be well placed to close the gap that would otherwise create imbalance among the partners. In Uganda the relatively better performance of the PNFP facilities compared to public facilities as perceived and reported by users has instead to some extent become counterproductive to the partnership, especially the sharing of national resources meant for sector-wide provision of services. It has often become a point for political leaders as well as some

[8] Many governments only see civil societies as watch dogs and not service providers.

technocrats to argue against budget subsidy to PNFPs. They suggest that PNFPs must provide free services even though government support meets only about 19% of PNFP expenditures. On the other hand salary increments to the public sector as well increases in funds for other recurrent budgets have not translated into any improved performance except in a few districts with good leaders and managers. The opposite was observed of PNFP facilities (Reinikka, R. and Svensson, J. 2003). Indeed PNFP networks have argued that investment of government money into their facilities have resulted into good reward from PNFP facilities in terms of output and efficiency.

11. Partnership requires that the potential partners must be well organised. Some rallying point that creates cohesion and harmonisation for the group on each side of the partnership is important. In the case of Uganda, the creation of Uganda Catholic Medical Bureau and Uganda Protestant Medical Bureau (and much later the Uganda Muslim Medical Bureau) was a critical factor in the strength of faith-based facilities and providing the forum for the partnership with both the colonial and later national governments. Such bodies should not be formed and imposed on supposed to be network members; neither should they start to recruit from above but must be generated and mandated from the bottom.

Although it has been public knowledge that a big problem that has weakened the health sector in Uganda for long is that of weak leadership and management, for the first time this was publicly acknowledged at the Mid-term review of the HSSP II and the Joint Review Mission in 2008 (MoH Aide Memoire 2008). By contrast the UCMB and UPMB, for example that do not own the facilities, are mandated by the respective religious structures (diocesan Bishops through the respective Bishops' Conferences) to coordinate the facilities owned by the dioceses and the religious congregations, provide guidance on policy matters, and have for about decade concentrated on strengthening governance and management of the facilities, strengthening capacity to provide services mainly through supporting training, be the liaison on behalf of the network with government and other partners, carry out some quality assurance and generally pulling the network facilities towards common vision and mission[9]. The core function of the bureaus is systems strengthening, and not direct coordination of services provision. On the other hand, many national and international organisations that have worked with non-facility-based health structures in the community for long have kept the individuality of these community-based organisations (CBOs). The CBOs have weak, if existent, governance and management systems. Many of these CBOs that may be aligned to some religious bodies have sprung up in recent years especially in response to the fight against HIV / AIDS. A good number, often localised, are actually linked to the many smaller churches that have similarly sprung up in the last decade or so. They sometimes take one health intervention for a short time depending on the funds available, report to the donor and transform their priority to something else. In this way the small organisations remain invisible for ever and remain more vulnerable.

Community-based religious health structures (that mainly carry out preventive and support services) need to start coming together, develop documentation and reporting system and feed their outputs formally into the national health systems through the

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[9] The UMMB has functions similar to that of UCMB and UPMB but has different network structure across the country

district health systems and through their umbrella religious bodies. Another concern is that today there is a trend of many donors and intermediary agencies wanting to work directly with the facilities and CBOs, bypassing the national coordinating bodies, the bureaus, under the argument of reducing management cost. They disregard the importance of national coordinating bodies in the sustainability of the lower level organisations and of the services they provide. These agencies seem not to recognise that they are able to work with the facilities because for years earlier the bureaus strengthened them and held them together. Working with the facilities under a "divide and rule" fashion and thus destroying their national cohesion is detrimental to the future of faith-based health networks. It is also detrimental to the sustenance of the projects that work with them. If religious health services – facilities or non-facility-based PNFPs– should continue to be there to support government in the future, deliberate effort must be made to work with their mandated national bodies and also strengthen these bodies to be able to cope with the increasing challenges and demands of the environment on the networks.

12. As partnership with government and other stakeholders or donors is inevitable for the continued ability of religious assets to exercise their much needed role in health services, it is important that the religious health assets (RHAs) continuously demonstrate their relevance. There is need for them to strengthen their Health Management Information System especially in the PNFP as the evidence base and tool for advocacy. In Uganda the capacity of the PNFP to monitor its performance was a direct outcome of the partnership. It was a result of both an internal recognition of the importance of information for management and governance and the pressure to reassure the partner (government) that the investment it was making with the PNFP subsector was well spent. It made the PNFP develop a more sophisticated system of data collection, analysis and utilisation ahead of the public sector but out of the same national health information management system. PNFP networks have in due time provided information. Unfortunately it has not translated into better understanding and appreciation of their contribution to the sector and the worth of supporting and strengthening it. Sharing information and knowing each other is a key factor in partnership. Partnership requires abundant information, soliciting of information, sharing of information, analysis of information and use of the information. Not the lack but probably the relative over abundance of information in the PNFP (compared to public sector) may be blamed for "shortage" of information required for partnership in the health sector in Uganda[10]. The mid-term review of HSSP II (MoH 2008) observed that the functionality of the HMIS was far better in the PNFP facilities network than in the public health sector.

Conclusion and Way Forward

At least three conclusions may be made. The first is that the role of religious health assets (RHAs) in health is still very relevant in Africa. Religious bodies have historically taken the lead in health services in many countries including Uganda. It is an unquestionable fulfillment of scriptures. Secondly, public-religious partnership, formal or informal, which has historically existed as a normal transformation from the originally religious founded health initiatives, is still the way to go. Partnership for health continues as factor for resilience in local health systems ensuring health

[10] Partnership requires information from all partners

services both in terms of availability, quality, and efficiency despite many difficulties. Existence of multiple providers including the religious assets is of unquestionable need and relevance in Africa but the known benefit of these services is threatened by macroeconomic changes, unfriendly government policies and attitude. The difficult economic situation dictates that religious organisations need to save and make better use of their capacity where possible as more players emerge in the partnership such as the private health providers (PHP). At this moment religious health providers need to concentrate on saving what they have built over many years, consolidate them and try to do what they already do better. Duplication should be avoided where other players are already doing a good work. But only workable partnerships are good for sustainability of these services and the RHAs themselves. These may be intrafaith or interfaith partnerships; they may be partnership with government, donor agencies or other non-state actors. In all these strong internal cohesion is important. Finally, the question of relevance of RHAs is a threat to the whole health system in Africa and not just to religious health networks. Religious bodies need to defend themselves and the society they serve against that threat. This requires informed advocacy by religious leaders and technocrats together. Religious leaders need to come forward and engage actively in the "political" advocacy.

But what makes a partnership workable?

From the experience of Uganda, for the partnership to work a few things are necessary and RHAs should look out for these ingredients:

- Organisations getting into partnership need to have developed interest in one another and gotten to know one another very well. A good number of people in government and even among the donors think they know the religious health providers and end up prescribing "solutions" that do not work for partnership. This learning takes time and should be on-going as all in the partnership evolve. Learning each other improves communication, builds trust and brings partners much closer and much longer.
- Partnership of convenience should be avoided. Potential partners need to assess and agree that they truly share values, vision, mission and objectives. If there are major points of disagreement, it is may be better not to get into direct partnership in a hurry. Alternatively it may be a targeted and short-term partnership. Huxham and Macdonald (1992) said partnership works if "something is achieved which could not have been achieved without the collaboration". It is therefore useful that in this process reflection should be made on what the country or partners would not have achieved without this partnership and appreciate what the partnership has enabled. In other words, define what each partner stands to benefit or lose.
- Partnership may even work where not everything is shared provided a significant part of the vision, goals and objectives are shared and provided the partnership is within the areas of commonalities and points of difference are not emphasized. This requires that partners accept and respect one another for whom and what they are (identities) and try not to impose values, goals and objectives.
- Respect in partnership also means avoiding taking deliberate decisions or making policies that harm existence or performance of the other partner (s).
- Where there were shared values, vision, mission etc at the beginning, it is important to periodically get back and reassess if status quo exists. Years down the road as new people come onto the scene or take charge of an already existing partnership, some may not have understood the factors that caused and enabled the

partnership; some old players may simply have lost sight of this for various reasons, or one of the partners may have changed its vision, mission and goals. For this reason the PNFP medical bureaus in Uganda have in the last two years made presentations to the Ministry of Health's new Permanent Secretary, have explained to the Health Development Partners new leadership, have made presentation to the Parliamentary Committee for social Services and other stakeholders.

- Agreement on clear and fair expectations of one another in the partnership should be reached early and revisited from time to time. If it becomes clear that the expectations are outlived, then they should be redefined and agreement reached on how to fulfill the new ones. In the case of Uganda, for example, having a contractual approach to the government support to PNFPs could have addressed the unrealistic expectation of PNFPs providing increasing or even free services with reducing support and rising costs.
- Where financial support is involved in the partnership, there should be clear and workable agreements in form of memoranda of understandings, service level agreements between legally authorized persons in the partnership.
- All in the partnership must be interested in the sustainability of the systems of one another for mutual benefit. Deliberate efforts should be made to learn from one another, help the weaker partner overcome its identified weaknesses, and avoid interventions that overwhelm or distort the partners systems. As much as possible integrate into existing systems of the implementing partner but help it to improve as may be necessary instead of creating parallel systems.

Cross-cutting into all is the need for governments and donors alike to support and strengthen health religious assets in order to compliment the respective national health services. But the RHAs also need to become more assertive in obtaining recognition, in influencing micro and macro policies as well as budgetary allocative decisions. Strong health management information systems and studies are needed to provide evidence for advocacy.

Donors and governments also need to acknowledge strengths of religious assets and incorporate such into national systems and RHAs must get to participate in the formulation of national health plans. Opportunities for common learning and exchanges need to be created. But religious assets need to learn from their own networks as well. Such possibilities exist, for example, within the African Christian Health Associations (ACHA).

Sustainability of religious health assets also depends on their holding together and getting better coordinated, having strong governance and management systems. Strengthening and working with national umbrella bodies that support and coordinate religious health assets in respective countries is very important for long-term sustainability. Coordination of facility-based religious health networks by medical bureaus in Uganda could provide some example from which to conceive structures for the coordination of religious non-facility based health assets.

Finally against the background of increasing economic hardship and question of sustainability, it is important that religious assets focus on consolidation of what they have and only make very calculated scale-ups. This is both in terms of multiplicity of entities and scope of services. There should be careful choice of technologies to

reduce escalation of costs. In addition, they also need to save on costs by avoiding duplication.

References

1. AMREF-Uganda and The Uganda AIDS Commission Secretariat July 2001. Inventory of agencies with HIV/AIDS activities and HIV/AIDS interventions in Uganda.
2. Iliffe J. 1998. East African Doctor : A history of the Modern Profession
3. Fielding Hudson Garrison 1913. An introduction to the History of Medicine, with medical chronology, bibliography and test questions. Harvard University (Publisher: W.B. Sanders, 1914) http://books.google.com/books?id=tHASAAAAYAAJ&pg=PA25&sig=9L59OMmGwGy3BgUIMEYqjE9h3S0
4. Harold G. Koening, Michael E. Cullough, David B. Larson. Handbook of religion and health. http://books.google.com/books?id=h8F3OmblmH4C&pg=PA31&lpg=PA31&dq=Hospitals+in+Asia+Minor+by+Eastern+Orthodox&source=bl&ots=0kXLm0vc_Z&sig=0PP1U4VwMd4ZmhEI8QktNPPwz6I&hl=en&ei=meEsSqbBF5eMtgfiiaWoCA&sa=X&oi=book_result&ct=result&resnum=1#PPT1,M1
5. High Level Forum, Parish Feb 28th – March 2nd 2005. Paris Declaration on Aid Effectiveness – Ownership, Harmonization, Alignment, Results and Mutual Accountability. http://books.google.com/books?id=Btb667glnuIC&dq=East+Afrcan+doctors&printsec=frontcover&source=bn&hl=en&ei=jVApSo_ZBJfCMuGqtOMJ&sa=X&oi=book_result&ct=result&resnum=4#PPR7,M1
6. John Odaga, Peter Lochoro (Caritas Uganda) 2006. Budget ceilings and health in Uganda.
7. Lwanga J. 1992 Traditional healers baseline survey in Gomba County (Uganda). Technologies for Health Care [PRITECH], 8, 37. Popline Document Number 083658 (http://www.popline.org/docs/1013/083658.html)
8. GoU (Under chairmanship of Prof. Raphael Owor) 1987. The Report and Recommendations of the Health Policy Review Commission
9. Uganda Ministry of Health Oct. 1993. White Paper on Health policy Up-date and Review
10. Uganda Ministry of Health Sept. 1999. National Health Policy.
11. Uganda Ministry of Health 2000. Health Sector Strategic Plan I 2000/01 – 2004/05
12. Uganda Ministry of Health, 2005. Health Sector Strategic Plan II 2005/06 – 2009/2010.
13. Uganda Ministry of Health, April 2006. Human Resource for Health Policy.
14. Uganda Ministry of Health, October 2008. Annual Health Sector Performance Report 2007/08.
15. Uganda Ministry of Health, October 30th 2008. Aide Memoire - 14th Health Sector Joint Review Mission of Government of Uganda and Development Partners
16. Reinikka, R. and Svensson, J. 2003. Working for God Evaluating Services Delivery of Religious Not-for-profit Care Providers in Uganda. *World Bank Policy Research Working Paper No.3058.*
17. Chris Huxham Siv Vangen 1992. What makes partnership work? In *Stephen P. Osborne – Ed. Public Private Partnership: Theory and Practice in International Perspective (http://books.google.com/books?id=HxI0MFJCHogC&pg=RA1-PA293&lpg=RA1-PA293&dq=What+makes+Partnership+work%3F&source=bl&ots=oAeyEk-rye&sig=Vq6DlIfmBr5jceP6pbkwmGaXy3w&hl=en&ei=qr8vSsW4CcKX_Ab4xJDOCg&sa=X&oi=book_result&ct=result&resnum=5#PPR15,M1)*
18. National Institute of Health. Cesarean Section – A brief History. *History of Medicine.* U.S. National Library of Medicine, 8600 Rockville Pike, Bethesda, MD 20894 (http://mplus.nlm.nih.gov/exhibition/cesarean/part2.html)
19. W. R. Billington 1970. Albert Cook 1870-1951: Uganda pioneer. *British Medical Journal, 1970, 4, 738-740.*