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Faith-based health services as an alternative to privatization?

A Ugandan case study

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ABOUT THE PROJECT

The Municipal Services Project (MSP) is a research project that explores alternatives to the privatization and commercialization of service provision in electricity, health, water and sanitation in Africa, Asia and Latin America. It is composed of academics, labour unions, non-governmental organizations, social movements and activists from around the globe who are committed to analyzing successful alternative service delivery models to understand the conditions required for their sustainability and reproducibility.

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EXECUTIVE SUMMARY

This study examines the delivery of health services by faith-based organizations (FBOs) as a possible alternative to privatization in Uganda, where these not-for-profit health providers have been servicing communities since the second half of the 19th century. Their facilities focus on primary care and operate in rural, under-serviced areas, charging affordable user fees, while also treating those who cannot pay.

Based on literature reviews and more than 30 key informant interviews with stakeholders from the Ministry of Health, hospitals, health centres, faith-based medical bureaus, and one district administration, among others, this research finds that FBOs promote solidarity through multi-stakeholder engagement and through cross-subsidization using mechanisms such as community health financing schemes that protect the community against catastrophic health expenditure. There is equitable access to FBO health services from all denominations without discrimination on the basis of religion, ethnic group or place of origin.

The FBO sector fosters the development of a strong quasi-public ethos in service delivery, with local ownership and representation on the governing boards of the facilities all promoting their "publicness". The FBOs not only provide health services but often are engines of rural development, facilitating the extension of amenities such as electricity and water.

Hence, FBOs are crucial quasi-public organizations, especially at the primary level of the Ugandan health system. They are key health policy implementation partners, receiving 7 per cent of the national health budget to offer services guided by the National Health Plan. The sector is coordinated through faith-specific organizations: the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau and the Uganda Orthodox Medical Bureau. The Catholics and Protestants operate nearly 70 per cent of the FBO sector facilities. These bureaus participate in the formulation and development of national health policy as members of the Health Policy Advisory Committee, and in joint planning and priority setting for the health sector at the Joint Review Meeting and Annual Health Assembly.

Funding for FBOs comes from donors, user fees, the government's primary health care grant and secondment of staff. Some facilities raise funds from those who are able to pay, through mechanisms such as donations and "private wing" services that are charged at higher rates to subsidize indigent patients. External funding has declined due to the global economic crisis, at the same time as the government grant has stagnated at 2006 levels, putting the sustainability of the sector in question.

The government has designated some FBO facilities as district or sub-district facilities. This raises questions for those communities that lose out on having government facilities in their vicinity since FBOs, unlike government facilities, charge user fees. Even though the study did not raise any evidence to suggest limited access to services where such rationalization has happened, in principle it remains inherently unfair for government not to establish its own facilities in all parts of the country.

In addition, the powerful role of religious groups in health provision should not obscure their ideological and in some cases anti-liberal positions on questions such as contraception, homosexuality and divorce, which can have an impact on health outcomes.

The Uganda FBO sector is integrated in the health system, and is embedded in the national psyche; it has stood the test of time for more than 150 years, and it has the support and involvement of both the state and the community at various levels. Yet, it is questionable whether state funds should flow to services provided by religious groups. Sustainability of the FBO model as an alternative to privatization is also in question in the global context of neoliberalism where welfare states are offloading functions onto civil society. The knock-on effects of the global financial crisis have been experienced in Uganda as well, leading the more capable of the facilities to explore ways to generate resources internally, thereby pandering to market forces that are inherently antithetical to the FBO public ethos.

In conclusion, FBOs in Uganda presently contribute to more than a quarter of all health services, including the training of health professionals. They face challenges in attracting and retaining staff, and resource constraints due to reduced external funding. Yet they may be considered successful alternatives to privatization on the dimensions of equity, solidarity, quality of services, quality of the workplace, participation and transparency. Over the years, the sector has embraced democratic principles, putting in place more transparent governance structures, accountability mechanisms and fostering effective participation of many stakeholders.

It is our view that the FBO model can be replicated in other African countries due to the strong religious attachments of many communities on the continent, and should be promoted to complement government efforts as an alternative to privatization.

Acronyms

FBO	Faith-based organization
HUMC	Health Unit Management Committee
MoH	Ministry of Health
PHC	Primary Health Care
PNFP	Private not-for-profit
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau

Introduction

Health systems in sub-Saharan Africa (SSA) face multiple challenges due to the high disease burden and health needs associated with the fragile economies of the region, creating a vicious circle of poverty and poor health. Most governments in the sub-region operate under severe resource constraints and are unable to meet the basic health needs of their population. For example, almost 15 years after the African Heads of State pledged to allocate at least 15 per cent of total government expenditure to health financing in Abuja (OAU 2001), most countries are falling short of that target, many unable or unwilling to devote a significant part of their gross domestic product to the health sector as recommended by the Commission on Macroeconomics and Health (CMH 2001).

In many developed countries with far lighter disease burdens than SSA, per capita expenditure on health is much higher (Preker et al 2004). In the SSA context, even committing 15 per cent of government budgets to health would mean low per capita expenditure. WHO (2009) data indicate that about 10 per cent of the region's expenditure on health comes from external development assistance. Civil society groups in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) called for the building of universal, redistributive and people-centred health systems going beyond the Abuja commitment and increasing per capita spending, supported by debt cancellation. Further, the network is promoting the "People's Abuja" goal of at least 25 per cent of government spending in health allocated to primary care and community-level health systems (EQUINET 2009).

Fiscal constraints at the national level are made worse by poverty at household levels resulting in low ability to pay for health services. Per capita incomes of most countries of the sub-region are below US$1,200 per year at purchasing power parity and health expenditure per capita fails to meet the minimum standard of US$34 set by the CMH (2001). Moreover, levels of household out-of-pocket payments are extremely high for some countries in the sub-region including Côte d'Ivoire (73%), the Democratic Republic of Congo (70%), Guinea (84%), and Tanzania (38%) (WHO 2006). Household health costs in the region are catastrophic and constitute a major source of impoverishment (McIntyre et al 2006; Xu 2005; Xu et al 2003).

Uganda has a high disease burden, poor health indicators and low health sector financing. Nevertheless, Uganda has made gains in areas such as reduction in HIV infection rates and extended access to HIV-AIDS services, a drop in childhood mortality and increased access to family planning services. Some of those gains may be partly attributable to effective partnerships between government and the private not-for-profit sector, especially faith-based organizations (FBOs) that are responsible for a significant component of health services in the country.

The Municipal Services Project (MSP) is exploring viable alternatives to privatization and commercialization of health services, to ensure services reach most of the population in greatest need. Conceptually, the MSP understanding is that an alternative is any service delivery system that is explicitly designed to improve services without the involvement of the for-profit private sector and

that is oriented to principles of equality and social citizenship (McDonald and Ruiters 2012). Within the health sector, a number of alternatives that have been explored as part of this conceptualization include community-based health insurance, mutual health organizations, community-based health funds, national health insurance and FBOs.

This study explores examples and lessons with regard to FBOs as an alternative to privatization in the delivery of health services in Uganda. The country has had a long history of FBO involvement in all aspects of health, including service delivery and training of health professionals. Research methods broadly aimed to test the Ugandan FBO experiences against a set of criteria for successful alternatives to privatization, including efficiency, quality, accountability, sustainability, solidarity and the integration of services into the national health system.

The main research questions were: To what extent do FBOs in Uganda meet the definition of an 'alternative to privatization' and fulfill key 'criteria for success'? Can and should the FBO model be replicated elsewhere? Accordingly, the objectives of the study were to establish the profile of the FBO sector involved in health service delivery in Uganda, assess existing FBOs as an alternative to privatization, and evaluate their success or otherwise.

Methodology

Uganda was selected as the case study in SSA due to the long history and significant contribution of FBOs in the delivery of health services. Three main research strategies were employed:

- Reviews of primary and secondary literature on the overall health care situation in Uganda, the debates about public versus private health care in the country and about FBO involvement.
- Interviews with 36 key stakeholders and players, including FBO management; workers at selected facilities from at least three of the four main religious denominations (Catholic, Protestant, Muslim), including training institutions; Ministry of Health (MoH) officials responsible for liaison with FBOs and those responsible for human resources (see Table 1).
- Analysis of relevant documents from the FBOs including policy documents, governance mechanisms, meeting agendas and minutes, and tariffs for various services, largely to supplement information obtained during the interviews.

In addition, we observed service delivery and other activities to get a feel of the operations of the various facilities. These included observation of a lecture at one school, observation of out-patient department activities at three facilities, review of the patient attendance register at one facility and a tour of a pharmacy at one tertiary hospital. For ethical reasons, no patients or students were interviewed during the study.

TABLE 1:
Key informants interviewed

Category	Number interviewed
Ministry of Health officials	6
Officials at the medical bureaus and Joint Medical Stores	4
Training institution officials (head of school, head of department)	4
Health workers	12
Church leadership (Archbishop)	1
Health facility officials	8
Political leadership (district chairman)	1
Total number interviewed	36

Whereas various denominations and levels of facilities and training institutions were represented in the study, no attempt was made to cover the whole country. For limitations of time and funding, the facilities selected included those in the capital city of Kampala, and a few in the eastern part of the country.

Interview notes were processed for content analysis using major themes from the interview guide to reflect the areas of interest for evaluation of the FBOs. Information from document reviews was also evaluated along similar themes and used to complement data from the interviews. The results are presented in narrative form, with illustrative quotes, as appropriate.

Overview of Uganda's health system

Uganda has a national health system composed of both public and private sectors. The public sector includes all government health facilities overseen by the MoH as well as health services managed by the ministries of defense (army), education, internal affairs (police and prisons) and local government. The private health sector consists of private not-for-profit providers (PNFPs), private for-profit facilities that include private health practitioners, private hospitals, pharmacies and drug shops, and the traditional and complementary medicine practitioners. The PNFPs are largely made up of FBO service providers. The distribution of facilities by ownership is shown in Table 2. Uganda has roughly 5,230 health facilities, excluding private clinics and pharmacies or drug outlets, of which 16.7 per cent belong to the PNFP sector, mainly FBOs.

TABLE 2:
Health units by level and ownership type

Level	Public	Private not-for-profit	Private for-profit	Total
National Referral Hospitals	2	0	0	2
Regional Referral Hospitals	14	4	0	18
General Hospitals	52	53	23	128
Health Centre IV	170	16	8	194
Health Centre III	937	272	70	1279
Health Centre II	1,692	529	1,387	3,608
Total	2,867	874	1,488	5,229

Source: MoH and WHO 2013.

The private health care system

The private sector as a whole delivers roughly 45 per cent of health services in Uganda, and covers about 50 per cent of the reported outputs. It is noteworthy that in 2008-2009 private funds from households, PNFP organizations, local NGOs and private firms made up half of total health expenditure (49% in 2009-2010), while public funds made up only 16 per cent (15% in 2009-2010). Households contributed the largest proportion of health expenditure, mainly through out-of-pocket payments. Other funds came from donors, international NGOs and global health initiatives up to 34 per cent in the same year (36% in 2009-2010) (MoH 2013).

The Government of Uganda subsidizes the PNFPs and some private hospitals. They are considered as key partners in the *Health Sector Strategic and Investment Plan* (MoH 2010a, 33) that recognizes that:

> [T]here remains a significant inequality in access to health care… In an effort to increase access to health care, the Government of Uganda subsidizes PNFPs and its training institutions and a few private hospitals that should in turn reduce user fees. The reduction in user fees could further enable the poor to access services in PNFPs and PHPs.

Worryingly, out-of-pocket payments remain the largest form of payment for health services despite large inflows of donor monies, government funding through public health facilities, and subsidies

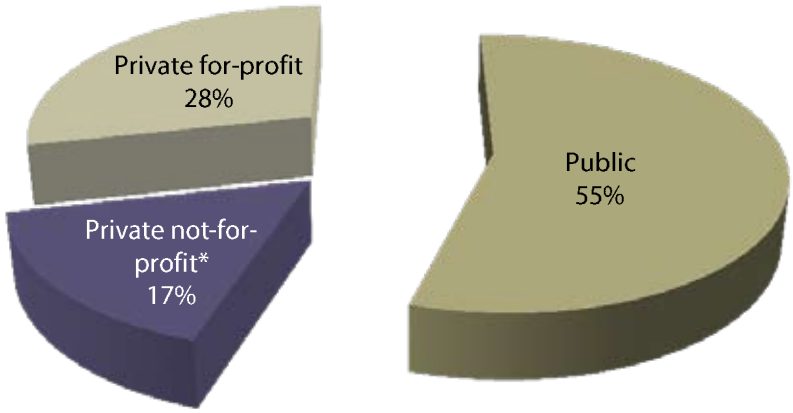
for PNFP health services (MoH 2013). As noted in the National Health Accounts, "the vast majority of this expenditure takes place in the private for profit sector, including private clinics, drug shops and traditional healers. Households also make financial contributions towards the costs of Government of Uganda and PNFP health services" (MoH 2013, 7).

Private not-for-profits

The PNFP sub-sector is divided into two categories: facility-based and the non-facility-based services. The facility-based PNFPs provide both curative and preventive services while others mainly provide preventive, palliative and rehabilitative services. The former account for 41 per cent of the hospitals and 22 per cent of the lower level facilities complementing government ones, especially in rural areas.

The PNFPs currently employ an estimated 12,000 people and operate 70 per cent of health training institutions. More than three-quarters of the facilities operate under four umbrella FBOs: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Muslim Medical Bureau (UMMB) and the Uganda Orthodox Medical Bureau (UOMB). Nearly 70 per cent of the facilities are affiliated to the Catholics and Protestants. The non-facility-based PNFP sub-sector is diverse and less structured, comprising of hundreds of NGOs and community-based organizations that mainly provide preventive health services including health education, counselling, health promotion and support to community health workers (MoH 2010a).

FIGURE 1:
Distribution of health units between the public and private sectors



*Note: 70-75% of private-not-for-profit facilities belong to the three religious bureaus: UCMB, UMMB and UPMB.
Source: Based on data from MoH and WHO 2013.

Private health practitioners and traditional medicine

By 2010 it was estimated that the private health practitioners constituted 22.5 per cent of healthcare providers, with 9,500 health professionals estimated to be working exclusively in the private sector, including more than 1,500 doctors (MoH 2010a). More than four in five doctors were employed within the central region and the major municipalities nationwide. These health professionals have a significant urban and peri-urban presence and provide a wide range of largely curative services, mainly in primary and secondary care.

In addition, it is estimated that up to 60 per cent of Uganda's population seeks care from traditional and complementary medicine (e.g. herbalists, traditional bone setters, traditional birth attendants, hydro-therapists, spiritualists and traditional dentists) before and after visiting the formal health sector. Most of this sector has no functional relationship with public and private health providers, which often results in late referrals, poor management of various medical, surgical, obstetric conditions and high morbidities and mortalities. Non-indigenous traditional or complementary practitioners such as the practitioners of Chinese and Ayurvedic medicine have emerged in recent years as well.

Faith-based health services

Faith-based health services have a long track-record in Uganda – and Africa in general. As stated by the Archbishop of the Catholic Church during the study:

> For us the mission has always been clear. Following in Christ's footsteps means we care for the whole person, the body, the soul and the mind. So from the outset we included the development of the mind through schools and of the body through health service, in addition to our primary role of winning the souls for Christ.

That view was supported by other key informants who emphasized that evangelization was always accompanied by health, education and social care. The story was that the first missionaries carried small stocks of medicines to cater for themselves and shared these with the "natives" who assisted them and other inhabitants. That apparently helped ease their acceptability into the new communities, and in some cases the success of their medicines was attributed to their "God".

However not all scholars share the heroic narrative of colonial religious medicine in Africa (see Arnold 1988; WHO 1983 for a critique of racist medicine). Missionary medicine sought not only to care for the body but also to cleanse the "savage soul" and cast out devils (Butchart 1998, 79).

Key informants at Muslim facilities (and UMMB) conceded that the first Islamic establishment was perhaps more concerned with converting people to Islam, and less about their intellectual development and health. Hence, there were fewer schools established by the Islamic faith, and even fewer health facilities, and yet the Islamic reach preceded Christianity in Uganda. As stated by a key informant from UMMB: "The irony is that Islam got to Uganda way ahead of the Christians, and yet the Christians were smarter and knew how to get the people to like them."

The first facility was established by the Anglican Church in 1897 (Sir Albert Cook at Mengo), followed by a second by the Catholic Church in 1899 (Lubaga Hospital). The sector expanded over time, and bureaus were established to coordinate the activities within the facilities affiliated to the various faiths: the Uganda Protestant Medical Bureau (UPMB in 1955), the Uganda Catholic Medical Bureau (UCMB in 1956), the Uganda Muslim Medical Bureau (UMMB in 1996), and more recently the Uganda Orthodox Medical Bureau (UOMB in 2009).

On the occasion of the centenary celebration of Lubaga Hospital (1999), the Archbishop of Kampala Emmanuel Cardinal Wamala wrote about the original mission of the White Sisters: "[The Redeemer] had instructed them to 'cure the sick, raise the dead, cleanse lepers, drive out demons' Mt10:7. It was in this spirit that they immediately started treating the sick here in Lubaga."

Colonial period FBOs also pioneered the training of health professionals, starting with nurses in Mengo in 1917 by Sister Katherine Timpson. Indeed, the Makerere University Medical School had its foundations at Mengo where Sir Albert Cook started training "native assistants".

The sector has grown partly through government support. As noted at the 100 years celebration of one of the oldest hospitals in the country, "it was the Buganda King (Kabaka)'s government that sent dug-out canoes across Lake Victoria to bring the six nuns that included the first 'nurse' who set up Lubaga Hospital … with the help of a government grant, a maternity ward was built during 1936 and 1937" (Lubaga Hospital 1999).

Key informants affirmed the origins of the current health services as rooted in the work of the early Christian ministries beginning in the second half of the 19th century. According to a commissioner of health services, "[t]he missionaries always had dual purposes: to evangelize the population, and also to care for their physical health. In some cases it started with looking after the people that worked for the mission, then their families, and then the community, until this grew into a health facility."

The FBOs continue to play an important role in the health system in Uganda. The MoH now provides their facilities with a PHC grant to support activities such as immunization and health promotion, especially at lower level facilities. It was remarkable to learn that in times of civil disturbances, for instance during the civil war in northern Uganda, in most places the FBO facilities remained open, while the government facilities were closed or vandalized. In such situations the FBO facilities were the only alternative for the population. Apparently the FBO facilities were trusted as neutral in the conflict, and were instrumental in negotiations that led to the cessation of conflict and in the subsequent rehabilitation efforts. As one interviewee from the MoH noted: "The mission hospitals served the rebels, served the government forces, and served the local community which was then displaced and had no money. All groups trusted them implicitly."

At the time of study, the UCMB had 282 accredited facilities, including 32 hospitals and 250 lower level health units, coordinated through 19 Diocesan Health Coordinating Offices. The UPMB had over 260 accredited facilities, while the UMMB had 47 accredited not-for-profit facilities (including five hospitals) and 15 for-profit ones affiliated for accreditation and quality assurance purposes. UCMP and UPMB affiliate and accredit only those facilities that belong to parent churches and are therefore not-for-profit.

FBOs have facilities countrywide, with a large network of well-distributed rural and urban health units providing a wide range of services, including primary health care, specialist services, and training for various cadres of health workers such as nurses, midwives and laboratory technicians (UCMB, UPMB and UMMB 2007). Others include facilities affiliated to the UOMB, the Abayudaya Medical Services, facilities belonging to Pentecostal Churches not affiliated to UPMB, humanitarian organizations and community-based healthcare organizations.

The majority of faith-based health facilities remain predominantly rural and therefore cater to otherwise under-serviced communities (MoH 2010b). There is a high concentration of these facilities

in the north and to some extent in the west of the country, which are more remote areas. While this statement may be self-serving, the three bureaus have argued that (UCMB, UPMB and UMMB 2007):

> Nobody who wants to make a business out of health care would dream of placing a hospital far from towns or in the areas of the Country with poorly monetized economies: those who founded PNFP health units did exactly what no business oriented mind would ever do. Evidently they had in mind the dire need of service of the rural poor.

FBO health care as an alternative to privatization

The FBO sector in Uganda mostly operates on a not-for-profit basis, and therefore qualifies as an 'alternative to privatization' (McDonald and Ruiters 2012). The question is whether its operations represent a successful model of progressive alternative. In an effort to answer this question we looked at the following criteria: equity, quality of services, efficiency, quality of the workplace, affordability, solidarity, financial and political sustainability, public ethos, participation and transparency, as well as transferability.

Equity

FBOs contribute to equitable access to health services through reducing geographical barriers for rural and remote areas of the country, as exemplified by renowned hospitals such as Kalongo, Matany, Kisizi, Ngora and Lacor that for long were the only health service providers to large populations. The network of FBO facilities is still predominantly rural and composed of primary level facilities accessible by the majority of the population (UCMB, UPMB and UMMB 2007). Partly due to the network of FBO facilities, the majority of the population is within a five-kilometre radius of a healthcare facility (MoH and WHO 2013).

FBOs pioneered and rendered specialized services for conditions especially afflicting the poor, including tuberculosis and leprosy, and care for the deaf and blind. Church-based facilities such as Buluba and Kumi Leprosy Hospitals, Ngora School for the Deaf and Iganga School for the Blind remain renowned names in this respect. FBO facilities are also at the forefront in the provision of HIV-AIDS services (MoH 2010c; Otolok-Tanga et al 2007).

The equity dimension of FBO services was evident during periods of prolonged war in the north and north-east of the country, as noted above. The FBO facilities of all denominations did not

discriminate on the basis of religion, ethnicity or place of origin. To this day all patients accessing services at FBO facilities are reportedly treated equally, and there are triage systems to ensure those who need urgent care are first attended to.

However, FBOs charge user fees, unlike government facilities, and some communities have argued that this puts them at a disadvantage. They have insisted on equitable access to government health facilities. That was the case in Kamuli District where the government had to build a general hospital close to the existing faith-based Kamuli Mission Hospital. However, that kind of reaction was reportedly not common, according to key informants from the MoH:

> On the contrary, the people welcomed the upgrading of the PNFP facilities in their region, the issue of user fees did not feature in the discussions. You have to know that people will pay for quality, and the communities knew their facilities would provide good services. But it was the intention of government to help these facilities reduce user fees by supporting them … through secondment of staff … and provision of supplies [e.g. anti-malarials and ART], which should be free at point of service.

Quality of services

The general perception is that the quality of services in FBO facilities is high. That is borne out by a number of surveys that have shown that services provided by FBOs are of excellent quality and in many cases better than those provided in public health facilities (Orach 2007; UCMB, UPMB and UMMB 2007). The most oft-cited aspect is the positive attitude of health workers in FBO facilities. Similarly, the availability of staff to attend to patients as well as regular supply of prescribed drugs suggest good quality care. In the words of a key informant from the MoH: "Medicines are always available and absenteeism rates are very low compared to public health facilities. Even where they use low cadre staff, the FBOs tend to be more efficient than government services because they have guidelines on how to use available resources."

FBO hospitals have been integrated in the Health Sector Performance Review and Reporting Mechanism. By way of example, Lacor (in Northern Uganda) was among the top 10 performing hospitals in the country. There would therefore appear to be both subjective and objective evidence of the high quality of services (MoH et al 2012).

When questioned about the differences between the two sectors, key informants variously touched upon the ethos and work ethic of the FBO facilities, the fact that the newly employed know what to expect, that those who trained at FBO institutions are presumably inculcated with the culture of service above all, and once on the job, the mission of the place grows on the employees who increasingly focus on service above reward. This was expressed clearly by a key informant at Kampala

Hospital: "It's about the dedication of the staff, and it's not about how much we pay them, it is about the ethos of the place. You work in a mission hospital, you approach your work differently."

Organizational culture is valued highly by the sector, as stated by the three bureaus (UCMB, UPMB and UMMB 2007). It has been noted that performance in the FBO sector was associated with "working for God", "sacrifice", and the strong institutional culture among FBOs (Ritva and Svennson 2002; Ssengooba et al 2002). A more recent study found that intrinsic motivation among health workers was linked to a high degree of religiosity, regardless of which sector the health worker was employed in (Ogrodnick et al 2011).

Better quality services are reflected in outcomes such as lower maternal mortality rates at FBO hospitals than in most public health facilities. Kibuli Hospital (under UMMB) is a case in point; according to key informants at this facility, it is has achieved high standards in maternal health by incorporating outreach and community-oriented services with strict care and hygiene standards. In addition, other UMMB-affiliated institutions offer incentives for women to seek pre-natal care, which helps identify at-risk mothers early and refer them to appropriate levels of care.

It is unclear to what extent FBO facilities are accountable to end users, but well-established facilities such as Lacor Hospital report back to the community during open house days. In Jinja Diocese, client satisfaction processes are built into results-based financing, and a firm has been contracted to conduct electronic exit interviews using smart phones, the results of which are provided to facility management and staff for quality improvement.

Efficiency

One of the main findings in the study was the fact that FBOs are able to use lower skilled staff to accomplish tasks that are undertaken by higher level cadres in government facilities, without compromising on quality of care due to adequate supervision and support. Therefore, the unit cost of service delivery is lower than in the public facilities (UCMB 2012; UCMB, UPMB and UMMB 2007). According to key informants, staff in the FBO sector also work longer hours than their counterparts in government facilities.

There was no evidence to suggest that the efficiency gains were at the cost of other positive outcomes, such as health and safety, particularly of the health workers who often take on heavy loads and long hours. Uganda is among the countries with a long experience of task shifting, and the system fully prepares those to whom tasks are delegated, so there is no risk of dilution of the services (Chu et al 2009; Dambisya and Matinhure 2012; Pereira et al 1996). With respect to the heavy workload, one hospital administrator stated that those who join the FBO sector know what to expect and adjust accordingly.

Quality of the workplace

FBO facilities are perceived to have better work environments, with discipline strictly enforced. Interviewees noted that the problem with the public sector was that the workers were permanently employed and, whether they worked or not, their pay was guaranteed. On the other hand, the FBO facilities enforce discipline in very stern ways. According to the director of a Muslim hospital interviewed for this study: "We don't tolerate nonsense; sometimes we have to move from tough to rough to ensure that our staff remain disciplined".

This raises questions of possible abuse of workers' rights, but according to key informants at various facilities, the health workers know the disciplinary code and procedures upon taking up employment. On the whole, management of FBO facilities, in spite of recent democratic tendencies remain largely hierarchical; for instance when the Bishop speaks no challenge is expected. For the workers, there may be a sense of autocracy, but for the patients that may translate into good quality service from apparently dedicated staff. There have been recent studies on the association between high levels of faith and greater compassion, empathy, and patience for health facility patients, which may lead to higher levels of client satisfaction (Ogrodnick et al 2011). The question might be whether that is a justifiable trade-off given the importance of democratic structures for progressive public services.

Accreditation criteria for FBO facilities include inspection and registration with the Uganda Medical and Dental Practitioners Council, with a focus on the workplace – adequate infrastructure, land ownership and clear management structures. The buildings in many of the facilities, though reportedly old, were said to be well-maintained, at least much better than government facilities. As observed by a key informant at MoH headquarters: "Even if the buildings are old, you will find them well maintained and clean, and the compounds are always well kept." This state of cleanliness was evident during the visits to the various FBO facilities during the study.

Key informants credited FBO facilities with better inter-personal relationships among the staff than in the government facilities. They cited factors such as a culture based on faith, with practices such as morning prayers and fellowship, presumably on a voluntary basis. When the question was raised regarding those of a different faith, the response was always to the effect that they are accommodated and given time off for prayer. At one UPMB-affiliated training institution, the principal stated: "We allow our Muslim students time off for prayers on Friday. We don't expect them to participate in the morning prayers for the Christian students."

Concern was expressed about the pay for staff at FBO facilities. Except for doctors, the salaries in FBO facilities are reportedly below government levels, raising issues of morale, attrition of health workers, and loss of organizational culture (UCMB, UPMB and UMMB 2007). In mitigation, the sector has incentives, for instance free housing and medical treatment for staff and their immediate family, and opportunities for professional development, such as those offered through the UCMB Scholarship

Fund that includes management courses. Another incentive cited by staff was the ability to execute their professional duties due to availability of drugs and other supplies. Also, as observed by key informants at one upcountry facility, workers stay because of loyalty and commitment to their establishment.

Affordabilty

FBO facilities keep user charges low partly due to the government PHC grant (7% of the health sector budget) (Tashobya et al 2006). The grant does not cover payment of staff salaries, but government has 117 medical officer (doctor) positions for secondment to the FBOs, and some districts also second staff to FBOs. It is estimated that government support to the sector covers roughly a fifth of FBO expenditure (MoH 2010c). Furthermore, government and donor agencies (notably DANIDA and USAID) provide a credit line for essential medicines for the FBO facilities through the Joint Medical Stores (Lochoro et al 2006).

Following the government rationalization policy, some FBO facilities (e.g. Maracha Hospital) were designated as "Health Centre IV" and given "Health Sub-district" status. The understanding was that the FBOs would reduce fees for agreed services, but this did not happen due to their constrained financial position. Imposing user fees for PNFP provision after the abolition of the same in government facilities may be seen as inequitable, especially in areas where the community does not have access to government facilities. It should be recognized, however, that the charges at FBO facilities are low and in some cases are not enough to cover the operating costs (Amone et al 2005; Pariyo et al 2009; UCMB 2012).

The question of user fees and their effect on access is vexing because, with declining donor and government support, there is more reliance on such fees for the sustainability of the FBO facilities (Rookes and Rookes 2012). This was illustrated at one upcountry hospital, Kamuli Mission Hospital. The hospital is dependent on user fees, the PHC grant and donations from friends and well-wishers (Friends of Kamuli Mission Hospital). The hospital charges minimal fees for outpatient and inpatient services, with flat rates for patients above 65 years of age at UGX 2,500 per visit (US$1), and normal delivery at UGX 10,000, which represents only 20 per cent of the costs for the service . The story was similar elsewhere.

The principle reiterated throughout the study was that patients cannot be turned away because of inability to pay. Thus, whereas the facilities depend on user fees for their operations, the fees are kept low and affordable to the majority of the population. Moreover, those who are economically well-off can access "private wing" services at higher cost, and in the process support care for the indigent, although this opens additional questions around equity.

It has been reported that overall choice of health provider in Uganda is mainly determined by accessibility, shorter waiting times and longer hours of operation, and least of all by cost (Konde-Lule

et al 2010; Kruk et al 2008). As explained by Konde-Lule et al (2010), the issue of cost is not such an important consideration presumably because there is a cost incurred by the patient even for government facilities, such as transport and out-of-pocket payments that may be formal or informal, including bribes and under-the-table payments.

Solidarity

The FBO sector practises solidarity with the communities where it operates. According to the Executive Director of UPMB, their facilities are part of the community, and are deeply rooted as they often arose as community initiatives. Many facilities are located in under-serviced areas, demonstrating solidarity with marginalized and disadvantaged communities.

Part of the solidarity work is through the care for indigent patients, and the FBO facilities reportedly have a mechanism for exempting those unable to pay from user fees. Among the strategies mentioned were donations to the Good Samaritan Fund, "fast lane" fees for non-emergency cases, and "private wing" services that are billed at higher rates, to offset what the facility may forego on account of treating those who cannot pay.

UPMB in Western Uganda has also piloted facility-based community health financing schemes through which communities pool resources. These schemes are community-driven with the health facility acting as facilitator and provider of services; pooled funds are deposited with the facility to stock drugs and meet other operational costs for the benefit of the scheme members and the community in general. The members are covered for a defined range of services, including health promotion activities such as mosquito nets and safe water supply. UPMB is planning to scale up the pilot schemes so other parts of the country may also benefit from the solidarity-based pooling of funds.

The communities themselves also look out for the good of the facilities, as exemplified by some of the measures taken to avoid abuse of cost exemptions for patients who claim they cannot pay. At one facility, it was related that the community members on the Health Unit Management Committee (HUMC) verify whether a person truly cannot pay, or may be able to recover the outstanding amount, based on which assets they may have to sell (typically cash crops or livestock) after discharge from the hospital. It may seem intrusive of the HUMC to undertake this function, but in most rural communities everybody knows everyone else's business, so it is more about fairness than about discovering what assets others own.

Further, one interviewee noted how a hospital was protected during the insurgency by the local community as well as the rebels, and continued operating at full capacity, despite being in a war zone. This squares with reports by others that FBO health facilities in other parts of Africa have a reputation for enhancing community cohesion, social support and solidarity during times of personal and health challenges (Ogrodnick et al 2011; Rutebemberwa et al 2009; WHO 2007).

Political leaders, ranging from the president, vice-president, prime minister, ministers and the local government leadership, have also shown their support through visits and pledges or donations to various FBO facilities. The facilities, communities and political leadership all seem to share the desire to see the FBO facilities thrive and stay operational.

Financial sustainability

Arguably the greatest challenge faced by FBO facilities is sustainable financing. Traditionally, FBOs relied on international donor funding, donations or government grants to keep their services affordable. As the facilities expanded, and the demand for their services grew, it became difficult to sustain the services on donor aid. The global financial crisis has meant that donor support has shrunk. It is estimated that the total income for the sector in 2007 was 39 per cent from donor aid, of which more than two-thirds was tied to HIV-AIDS services (UCMB, UPMB and UMMB 2007), 38 per cent from user fees and 23 per cent from government subsidies, including the PHC grant (Orach 2007). Most informants indicated that government subsidies had stagnated at 2006 levels, a view conceded by government in the Second National Health Policy (MoH 2010b).

Thus, increasingly FBOs should have to rely on user fees due to inflation and soaring costs of healthcare provision, especially for drugs and staff salaries. The reality, however, is that the majority of people within FBO health services' catchment areas are poor and cannot afford higher fees, so the fees have generally stayed low.

Urban facilities such as Nsambya, Lubaga and Mengo (all within Kampala) are self-sustaining on user fees and other income they generate, while smaller facilities in towns and rural areas reportedly struggle due to high operating costs. A common concern among key informants was the irreconcilability of rising operational costs against the need to keep the services affordable.

There were suggestions made for sustainable funding through government support, where it is most needed in order to maintain the facilities. The three bureaus called for the government grant to be made unconditional, and also for government to support the wage bill for the FBO facilities (UCMB, UPMB and UMMB 2007). A more controversial suggestion has been the call for contracting health service delivery to the FBOs using a market-related argument of "value for money" since output indicators show that the FBO sector has higher efficiency and productivity (Orach 2007). That may, however, cost the sector its "soul" as it would have to pander to private sector principles associated with for-profit health services.

Interestingly, the literature review conducted for this study showed that part of the threat to the sustainability of some facilities was due to the success of health promotion measures, such as malaria and measles control activities in which FBOs were involved, resulting in lower utilization of facilities and lower user fees collected, putting the viability of some facilities at risk (UCMB 2012).

A number of key informants suggested that government should support results-based financing for FBOs. Other suggestions included: expanding the private wing operations where they exist so as to subsidize those unable to pay; consolidating services; discouraging further expansion; vigorously mobilizing resources through discussions with development partners; consolidating existing partnerships with government and other key players in the health sector; and fostering more community participation.

The danger with more pronounced "market-related" activities is that it could prove a slippery slope, with partial privatization of care leading to more and more of it until the original intent of the FBO sector is diluted. By contrast, a review of experiences in 13 countries showed that whereas FBOs continued to charge user fees, most attempted to subsidize poorer patients through measures such as a 'poor fund' to reduce operating costs by focusing on lower facility or basic hospital services, excluding expensive diagnostic investigations (Rookes and Rookes 2012). That is an approach the FBOs in Uganda need to explore.

In the case study, there were examples of stronger partnerships in some hospitals to fill the gap due to loss of donor support. A case in point is Lacor Hospital where the "Friends of Lacor" initiative was launched; the hospital holds annual general meetings during which management presents a "state of the hospital" report to stakeholders including donors and benefactors, outlining the achievements, challenges and plans. Through this mechanism, Lacor Hospital has been able to stay operational without the financial constraints experienced by other rural facilities. A similar approach has been used by some other facilities.

Another challenge faced by the sector is staffing. For long, FBOs relied on missionaries who offered *pro bono* services, in addition to a local team of health workers. As the services expanded, so did demand for health workers with different skills and qualifications. In parallel, whereas previously the spirit of volunteerism contributed to community involvement with the facilities, according to the Archbishop interviewed during the study: "We can no longer count on the selfless spirit among the people. Now people are very materialistic and will be looking for compensation. It means we have to find money for almost everything." More worryingly, the FBOs are unable to compete favourably in the health labour market hence the large loss of experienced staff every time government recruits health workers. For instance, during the recruitment in February-March 2013, some FBO facilities reportedly lost as much as 70 per cent of their staff to government facilities because government pays better. Earlier, when government had introduced a modest lunch allowance for health workers – consolidated to UGX 60,000 (US$20) per month – FBOs had also lost health workers to the state (MoH 2010a; UCMB 2012; UCMB, UPMB and UMMB 2007).

The FBO sector thrived in settings of scarce services, and were often the only facilities available. There has been an expansion of the private for-profit sector, however, and its penetration into rural areas is a major challenge to the sustainability of the FBO sector. Apparently, as the competition

within the private sector became stiffer, private practitioners were forced to reduce their fees in order to attract clients from the FBO facilities. For the FBOs lower attendance rates mean less income. This was made particularly clear by key informants from St Anthony's Hospital in Tororo, which was experiencing a tough situation at the time of the study:

> We don't get as many patients as we used to; government has opened many health centres in the villages, and there are many private clinics in town now; there is even a private hospital next door. The government clinics are free and they often have drugs, so people don't have to come to town. The private clinics keep their prices low also.
>
> It gets so bad we sometimes go without salary for three to four months, the worst time we were not paid for almost six months... The reason? Few patients, low collections, we couldn't even afford drugs from the Joint Medical Stores... Then we lost many of our staff. Once word gets around that there are no medicines, and there are no staff, the patients don't come, which means it is even harder for the hospital.

Those health professionals have seen better days, when the hospital had skilled staff, drugs and other supplies, and was the best in the area. They have seen donations and other support wane. In their view, the hospital will need to "get a donor" to recover its previous standing. The St Anthony's scenario illustrates the link between patient numbers, incomes and retention of the health workforce, all of which have implications for sustainability. It also shows the caprices of a liberalized health sector where market forces determine what prevails.

The government policy geared toward universal health coverage, through the Uganda minimum package of health services, creates a further level of complexity. This policy calls for removal of barriers to access to health care including user fees, and for the FBO sector it renews the call for government to adopt a grant-in-aid approach, instead of the conditional PHC grant mechanism. At the time of the study there were ongoing discussions to that effect. The designation of FBO facilities as health sub-district headquarters augurs well for the financial sustainability of such facilities since government channels all support at this level through those facilities.

The FBO training institutions on the other hand did not seem to face a similar financial crunch. There is high demand for the available vacancies at those schools, in fact most have to turn away the majority of applicants. The schools are funded via tuition, and where challenges are reported they relate to access to experiential learning sites outside the primary teaching facility/hospital. The future of the schools appears even brighter due to the high demand for the graduates of FBO-affiliated training institutions by the FBO sector, by government, and by the private for-profit sector, due to the perceived good quality training and work ethic associated with these institutions.

Political sustainability

There is great respect for religious institutions and diversity in Uganda, and most political figures are associated with one religious faith or another (Mudoola 1996). The politicians are interested in the contributions the FBO facilities make to diversification and improvement in access to health care. The downside could be that in the presence of FBO facilities government may not feel the need to provide additional services to populations served by the FBOs.

The policy framework acknowledges their key role as exemplified by the original Legal Notice No. 3 of 1963, which first recognized the FBOs, and the recent adoption of the Public-Private Partnership for Health Policy. Both the National Health Policy and the Health Sector Strategic and Investment Plan clearly recognize the contribution of FBOs in the delivery of health services as partners, and not competitors, with government. That seems to extend to the district and lower levels of the polity, as one district chairman stated: "Those are our partners in development, and we worry when they are not doing well. The Health Centre IV we have here cannot take care of all patients, so we need the mission health centre open and functioning."

Whether the model of FBOs as an alternative to privatization is sustainable in the global context of neoliberalism is an open question, but it has stood the test of time for more than a century in Uganda and at all levels political stakeholders and communities are involved.

Public ethos

The FBO model may enable the development of a stronger public ethos around service delivery. The facilities are owned by and have representation from the church/mosque, which can be seen as the body of the people, the HUMCs include the community, and governing boards are composed of a diversity of stakeholders, all of which promote the "publicness" of the FBO facilities. A recurrent message emerging from interviews is that FBO facilities are a public good, the population trusts them and they relate to the services as coming from a reputable organization.

The FBO sector has also opened up to more public scrutiny through the establishment of HUMCs. The parent religious organizations retain nominal control and ownership, but the day-to-day governance is in the hands of the management team and board. It was clear from the study that the smaller facilities tend to have more direct involvement from religious leaders, while the larger ones are run along the lines of a public trust with the church/mosque as the main trustee.

Where the model is lacking is in the involvement of the workers in the control of the facilities or sector. Health workers at FBO facilities participate through various mechanisms, such as staff meetings and representation on management committees. However, unionization is not the practice – a trend for most health workers in the country, with less than one in 10 nurses and midwives belonging to a union for example (NOTU 2011; VSO and HEPS 2010; see also Nuwagaba 2012). The staff are

expected to be loyal, meek and humble, in the fashion of the early missionaries who were driven by service to humanity or Islamic notions of public modesty. As the guiding ethos, service with obedience and service to humanity are at odds with the workers taking control of the facilities/services.

Nevertheless, the FBO model implicitly opposes the market values of privatization and commercialization. It does so through operating on a non-profit basis and in a humane manner, keeping out-of-pocket costs to a minimum. One observation from the study is the adaptability of the system over the years. The fact that FBOs offer services for all and are embedded in communities poses a challenge to western liberal ideas about how the state and religion interface.

Participation

The FBO facilities are typically owned by the Diocese or District Muslim Office, which constitute the Boards of Trustees. In turn, these bodies appoint the Board of Governors that oversees each of their facilities through a management team. The Board of Governors includes members of the community, and care is taken to ensure gender equality among community representatives. The executive management team is responsible for the recruitment of staff at the facility and for its day-to-day operations. This was true of hospitals and training institutions affiliated to all three bureaus that were part of the study.

The lower level health centres are required to have a HUMC, which is typically chaired by a prominent member from the community, and includes the officer in charge of the health centre, the parish Priest or local Imam and two representatives from the community (one male and one female). The HUMC is mandated to meet quarterly, and during such meetings the local political leadership is invited.

Community involvement assures quality of service and enforces discipline. An instance was cited in one upcountry hospital where UPMB was supporting a program: "The doctor was always missing from the work station. The community mobilized themselves and resolved to send away the errant doctor and sourced for another one. The program was successfully implemented."

From the interviews, it would appear that the FBO sector has democratized its processes to include effective participation of various stakeholders, including the community, founding religious bodies and health workers. Part of this drive for transparency reflects requirements for greater accountability from funders and donors, as well as from government as a condition for the PHC grant. The key informants were of the view that it was a useful development for the FBO facilities to have such governance structures as they contribute to quality improvement, ensure efficiency in resource utilization and credibility for resource mobilization. It was not clear whether or not resources were uniformly adequate for the active participation of the stakeholders, but in none of the facilities was this raised as an issue of concern.

Transparency

As noted above, the FBO facilities operate under structures that include community and political leaders. The executive director of UPMB explains:

> Most health facilities affiliated to UPMB are community-driven and based on the church structure involving the spiritual, education and health well-being of the community. They start small and grow with time and with the community. They are therefore an integral part of the community and this ensures continuous interaction and transparency.

There were reportedly some challenges when the line between the board and management got blurred, or when accountability mechanisms were either unclear or not followed. Interviewees said this was more common in lower level rural facilities where the local church authorities may impose their will on the health facility. A case was cited of one health centre where all monies collected were given to the parish priest and the money was lost. A proper management committee was then established. At the larger facilities the accounts are externally audited and presented to the boards of governors and of trustees. The FBO sector is building capacity in this regard as facility managers are trained in modern management approaches, as intimated by the executive secretary of UCMB in an interview.

Discussion with political leadership in one district pointed to reluctance to disburse government money to the FBO facilities, which run their finances as a closely guarded secret:

> As district chairman, I am accountable for every shilling I receive for the district from central government. But when we send the PHC grant to the health centre, the Sisters do not want us to follow it up to ensure that it is being put to the correct use. So tell me, how do I account to the Auditor General?

In a number of areas, where the transparency mechanisms have been distorted, there have been fewer services offered by the facilities and less patients. In one UCMB-affiliated hospital, the congregation of nuns that was running the hospital ran it down and left the facility highly indebted to the extent of being unable to pay staff salaries. The parent Diocese instituted inquiries into the operation of the hospital, but, according to a key informant, the Sisters simply abandoned the hospital. The Diocese was in the process of restructuring the management and administration of the hospital. One option was to lease it out to one of the religious orders to run as their own, on a non-profit basis.

The service delivery itself is done in a transparent manner: the range of services and the charges for such services are easy to obtain from the facilities and are often displayed on public notice boards. The FBO sector has embraced modern and transparent methods of administration, and

participation of various stakeholders. There remain some unwritten rules – for instance, a Catholic facility is unlikely to have a Muslim as chair of the committee, but the communities themselves apparently accept that practice and there have been no direct complaints in that regard. That, however, does not stop a Muslim doctor from being the medical superintendent of a Protestant hospital as is the case at one such hospital in eastern Uganda. A celebrated story from Lubaga Hospital was their collaboration with Dr. Ahmad, a Muslim, who provided voluntary service at the hospital for many years in the formative stages.

Transferability

The study would answer the question of the transferability of the Ugandan FBO model in the affirmative, noting that there is an important debate about how the state, church and secular entities are related to largely western-centred understandings of what is "public". There is also the question of whether public monies should be allocated to religious groups (Glenn 2000; Monsma 2000). FBOs have thrived even in adverse conditions, including in wartime, as noted earlier. In the conflict zone in Northern Uganda, the region most affected in the country, the rebel forces were purportedly of a Christian religious inclination (called the Lord's Resistance Army), and spared FBO establishments. Even beyond the theatre of operations of the LRA, the Church-affiliated facilities have been safe havens.

Thurston and de la Mata (2009) have ascribed the spread of FBO facilities to the fact that the vast majority of Ugandans affiliate with a religion (84% identify as Christian and 12% as Muslim). In parts of Africa, and other developing countries with largely religious populations, FBO services range from 25 per cent (in India) to 50 per cent or more (in Zambia and Papua New Guinea) (Ascroft et al 2011; Green et al 2002). It therefore may be plausible to draw on the lessons from Uganda in considering the development of health services through religious organizations. As the Uganda case study has shown, it is possible for government to partner with the FBO sector in the delivery of its national mandate. Countries such as Lesotho, with its strong Christian Health Association of Lesotho (CHAL), Malawi, through the Christian Health Association of Malawi (CHAM), and Tanzania, where some FBO hospitals have been designated district hospitals in the absence of a government facility, provide additional evidence on this kind of engagement (Ascroft et al 2013; Barugahara et al 2008; Gilson et al 1994; Lawson et al 2008; Leonard and Masatu 2007; Mamdani and Bangser 2004; Mtei et al 2012). CHAL has a Memorandum of Understanding with government to eliminate salary discrepancies between staff working in public and FBO facilities (Ramashamole 2011), which was partly responsible for flight of health workers from CHAL facilities to the public sector (Dambisya 2007). Uganda may also benefit from lessons on how to retain health workers in the FBO sector.

The FBO model in Uganda reveals equity gaps because user fees, even if minimal, may pose a

barrier to access for the poor. This situation is made worse by declining funding, which means facilities rely increasingly on user fees (Amone et al 2005; Ascroft et al 2013; Rookes and Rookes 2012). A number of authors (e.g. Guisti 2002; Mtei et al 2012), however, suggest that it would be economically prudent for governments to support FBO facilities, especially those in remote areas or serving vulnerable communities, to avoid duplication and guarantee services to poor communities. Such support would also improve population coverage (Ascroft et al 2013; Guisti 2002; Mtei et al 2012). It has also been argued that overall there are equity, access, quality and efficiency benefits for the health sector that can arise from strengthened collaboration between FBOs and governments (Lochoro et al 2006; Mtei et al 2012).

A broader question in evaluating the FBO option is the risk of government ceding its responsibility. Where FBO services have grown to offer a significant part of the services it has been a historical progression, mostly developing to address gaps in service delivery in rural and remote areas where the government was absent (Ascroft et al 2013). The absence of the government in health in many areas so many years after independence reveals the failure of liberal notions of the "public" as an aggregate of individuals (Mamdani and Bangser 2004) or the idea that "public" equals "state" (see Newman 2007).

The need to explore the FBO model as an alternative is further informed by the post-2015 health agenda that is set to promote universal health coverage (UHC; see Evans et al 2013; Vega 2013). UHC includes equitable access to health services, especially for the most vulnerable populations, with the three main requirements being that services be physically accessible, financially affordable and acceptable to patients (McManus 2013; Vega 2013). A model of non-profit health services available across the country and ready to operate within the national health plan is one that should be recommended for transfer to other settings. The findings in the present study support the view that the FBOs would contribute to the realization of UHC in Uganda.

Conclusions

Over time FBOs have acquired a lot of experience in the governance and delivery of accessible, equitable, efficient and community-focused primary health services, especially in remote areas. One of their major successes has been their ability to train and retain their staff through sponsorship and bonding as well as providing non-monetary incentives.

Diminishing external support on account of the global financial crisis has led to new thinking on how to finance the facilities, and how to keep the staff motivated to work on lower pay than what they could get in government facilities. The sector has adopted more modern methods of management with transparency and increased community participation.

Government appreciates the contribution of the sector, and offers support in various forms. In addition, there is cooperation between government and the FBO sector on matters of policy and operations in the execution of one national plan, guided by one national health policy. The FBOs seem to have learned to be flexible in order to survive.

Most of the suggestions for improvement relate to the survival and sustainability of the facilities in the face of financial constraints and difficulties in retention of staff, as well as governance issues. One suggestion was for FBO facilities to identify their niche areas and specialize where they have comparative advantages. This view is problematic because it suggests that the FBOs should become exclusive rather than being at the grassroots, as they have been from their inception. A middle ground would be to pursue specialization only in higher level facilities in urban areas; the majority of FBO facilities would then remain accessible and community-linked. In this vein, two specialist FBO hospitals – Benedictine Eye Hospital in Tororo, specializing in eye care and community-based rehabilitation, and CURE Childrens' Hospital, Mbale, with expertise in neurological disorders in children – are centres of excellence not only for Uganda but the entire East African region and continue to attract sizeable funding and other support from internal and external sources including government. They would appear to support the case for some level of specialization.

Regarding financing, there were recommendations for the sector to explore results-based financing and community financing schemes on a wider scale, to improve fundraising activities and to make a stronger case with international partners for further support. It was also felt that government should channel more of the health budget through FBOs since the latter offers services to the population in many areas where there are no government facilities. There were some specific suggestions made for better fee collection to ensure that the contribution from user fees is not lost in the process.

A major criticism of FBO operations is their "authoritarian, undemocratic" governance approaches (Rush 1983; Sebastian 2010). But what the case study showed was that over the years, the sector has embraced democratic principles, with transparent governance structures and effective participation of many stakeholders. Moreover, for the facilities to be accredited by the various medical bureaus, they have to show that they have both clear governance and financial management systems. The quality of services and the quality of the workplace are generally judged as better than in government facilities too.

The FBOs in Uganda struggle to attract and retain staff, a challenge experienced in other countries as well (Songstad et al 2012). This has been addressed partly by government seconding medical officers and specialists to FBO hospitals. The plea from the FBOs is that government start extending this to other cadres beyond doctors. There is a precedent in Malawi where the government took over and is paying all the salaries for all the staff in the FBOs, a move that was necessitated by failure

of the sector to meet its wage bill (Kalungwe 2008). In the Malawi case, that was done as part of the Emergency Human Resources Plan, which was supported by external partners. Uganda could borrow a leaf from Malawi.

Among incentives suggested for the sector to attract and retain staff were providing housing with free water and electricity, attempting to match, if not surpass, government pay scales, offering opportunities for further studies, and motivating staff through workplace improvement and availability of equipment and supplies. In most of these areas (except pay) it was felt that the FBOs were doing better than government, but that they could do even more.

In conclusion, Uganda has a long history of FBO health services; indeed the history of modern medicine in Uganda is in part that of FBO health services. The sector has survived for more than a century, and has grown to contribute to more than a quarter of the services, including the training of health professionals. The comparative advantages of the FBO facilities include efficient delivery of community-based primary services that should be used to leverage more support and funding from government and external source (Lipsky 2011). It is our view that the sector represents an important alternative to market individualism and privatization on account of being run on a not-for-profit basis, and embracing principles of equitable community access while maintaining quality of care and quality of the workplace, and that it represents a partner for any government seeking to deliver UHC as envisioned in the post-2015 health agenda.

The FBO model can be replicated in most African countries due to strong community religious attachments (Christian or Islamic). Most communities have contributed to such facilities, and they should as such be promoted as a short-term solution until state services can be provided, notwithstanding the challenges to sustainability, attracting and retaining staff, limits on trade unions and reduced external funding. We suggest that such challenges are surmountable through mobilization of domestic resources, increased government support and pooling of resources within the FBO sector.

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