CCIH
Christian Connections for International Health

Contribution of Faith-Based Healthcare Facilities and Organizations to Primary Health Care

Part 2: Uganda Intensive Landscape

Abbreviations & Acronyms

FB	Faith-based
FBHFO	Faith-based health facilities and organizations
MOH	Ministry of Health
NGO	Non-governmental organization
PHC	Primary health care
PNFP	Private-not-for-profit
PPP	Public-private partnerships
RBF	Results-Based Financing
UCMB	Uganda Catholic Medical Bureau
UPMB	Uganda Protestant Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UOMB	Uganda Orthodox Medical Bureau
UHC	Universal Health Coverage

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Cover Photo: Namutamba Health Centre

Executive Summary

Faith-based organizations are an essential part of national health systems, including Uganda. Historically, they have provided care in rural and remote locations and to populations with limited access to services. They are integral to the delivery of HIV/AIDS services, managing epidemics, and innovating in community-based services.

As global interest in primary health care (PHC) rises, health system planners need access to accurate data regarding the scope and location of Faith-Based (FB) health facilities to incorporate them into planning and resource allocations. Significant gaps exist in the data and description of FB health facilities. This study, through DHIS2 analysis and key informant interviews, explored two learning questions:

1. In what ways are FB health facilities contributing to a resilient PHC system?
2. How can we improve inclusive planning and coordination with FB health facilities toward national goals of improved access to timely, high-quality PHC services?

This is the second of two reports, an intensive Uganda case study. The first report provides a global landscape of FB health facility contributions to PHC. FB health facilities are a historic, 125-year-old part of Uganda's health system. They are, for the most part, organized under faith-based medical bureaus, i.e., the Uganda Catholic, Protestant, Muslim, and Orthodox Medical Bureaus. The analysis reported below shows that these bureaus include 735 facilities (62 hospitals and 673 health centers), constituting 33% of Uganda's hospitals and just under 10% of Uganda's outpatient health centers.

There are several hundred more private non-profit health facilities, some of which identify as faith-based but are not part of the medical bureaus.

The analysis of DHIS2 carried out by this project indicates that:

- Representation of FB facilities is higher than national averages (86% for FB facilities versus national rates of 53% for all public, NGO, and private-not-for-profit (PNFP) services).
- FB facilities provide 8.7% of all PHC services, and other PNFP facilities provide another 5.8% of PHC services, for a total PNFP contribution of 14% of PHC services. These rates vary somewhat from year to year.
- FB or PNFP facilities see fewer patients yearly than public and other facilities.

Key informants for this project shared that:

- PHC conditional grants provide non-wage support plus commodities, but only cover 12-60% of the cost of PHC in PNFP and FB health facilities.
- FB health facilities charge user fees to make up the difference in operating costs, but these do not meet the long-term costs of expanding staffing and renovating capital.
- Government efforts with Results-Based Financing (RBF) helped HC III and HC IVs and gave added flexibility.
- Commodity allocation and distribution are smoother compared to public services.
- Uganda's strong legacy of public-private partnerships ensures strong coordination.

Recommendations from this report landscape include:

1. Improve DHIS2 data reporting and data quality.
2. Continue advocating for the role of PNFP and FB in PHC services.
3. Attend to staffing shortages with improved planning for the overall health system.
4. Continue exploring health insurance as a mechanism for the sustainable delivery of healthcare.
5. Renew and expand Results-Based Finance.
6. Maintain strong and routine collaboration between the PNFP/FB and the government.
7. Ensure faith-based actors are stepping up to changing expectations of the national system.
8. Ensure that FB and Government representatives co-plan transitions in PHC.

This study should be expanded and replicated in other countries. The analysis of DHIS2 data alongside key informants provides valuable insights into the health system.

Namutamba Health Centre

Introduction

Primary Health Care (PHC) ensures timely access to health services. Early management of illnesses and risky pregnancies is vital to safeguarding health and reducing and managing costs. Faith-based actors and partners play an essential role in the delivery of services throughout the world.

Unfortunately, strategic gaps or misunderstandings about the scope and role of FB health facilities hamper efforts by global and national health system planners to strengthen PHC. To address these issues, the following key questions were raised:

1. **In what ways are FBHFOs contributing to a resilient PHC system?**
    - What are the breadth and types of PHC services provided by FBHFOs?
    - How do FBHFOs support core PHC processes at national and subnational levels?
    - How do FBHFOs sustain and grow their provision of PHC?

2. **How can we improve inclusive planning and coordination with FBHFOs toward national goals of improved access to timely, high-quality PHC services?**
    - How (if at all) are FBHFOs' efforts connected to the public ministries of health?
    - Imagine a future where faith-based PHC fully engages in national goals and strategies. What would have to change to get us to that point?

This paper provides an intensive case study of Uganda. This is a companion to a global landscape review also carried out by the same project, which included a literature review and interviews with global key informants. That work sets the general context for faith-based inclusion.

This project focuses exclusively on Uganda. The study was conducted in 2024 and utilized data from DHIS2 and interviews with faith-based and government health system leaders in Uganda. All interviews were approved by both the global and Uganda-specific Institutional Review Boards. Data are summarized here, and any data gathered in interviews are only shared with the respondent's permission.

Background on Uganda's Health System

The Ministry of Health (MoH) serves as the steward of the Ugandan health system, working closely with other line ministries, such as the Ministry of Finance, Planning, and Economic Development (MoFPED), and local governments (LGs). Over the years, Uganda has developed a mixed health system with the government and private sectors contributing to health service delivery.

Uganda's public health care system is decentralized. At the district level, health care is delivered by health care workers, four levels of health centers (HC II to HC IV), and hospitals under the stewardship of local governments. Semi-autonomous regional and national referral hospitals provide specialized care.

Uganda's private health sector is diverse, encompassing private not-for-profit (PNFP) providers, private for-profit health providers, and traditional and complementary medical practitioners. The faith-based health facilities extend to the level of the general hospitals, with some of the FB health facilities being the highest levels of care in some districts and making substantial contributions to the district-level referral system.

Uganda's primary source of general healthcare financing is the Health Sub-Programme grants to LGs and health facilities. These grants fund service delivery to achieve Universal Health Coverage (UHC), emphasizing access, quality, and affordability.

The government provides non-wage recurrent PHC "Conditional Grants" to fund PHC service delivery operations by the private not-for-profit (PNFP) facilities. These grants help fund prevention, promotion, supervision, management, curative, and epidemic preparedness. The government began these conditional grants in the late 1990s, and they are "conditioned" based on patient volume and level of care.

Uganda also piloted Results-Based Financing (RBF) through a World Bank-supported program launched in 2003. This program was renewed in the mid-2010s, paying PNFP health facilities based on performance data. RBF differs from PHC grants in that it incentivizes service delivery operations by government and PNFP health centers III and IV. This allowed health facilities the flexibility to use some of the RBF funds to motivate staff, pay staff salaries, carry out renovations, or other activities that were not possible under PHC Conditional Grant funding. RBF was, and remains, donor-dependent, potentially limiting its sustainability.

History and Scope of Uganda's Faith-Based Health System

Uganda's first formal (Western) medical services came just before 1900 with Anglican and Catholic medical missionaries. Anglican missionaries Albert and Mary Cook established Mengo Hospital and the first medical and nursing programs in Kampala in 1897; this was soon followed by a Catholic hospital in Lubaga in 1899. Since then, missionaries have established hospitals and healthcare missions throughout Uganda and are responsible for a substantial share of inpatient, outpatient, and community-based services.

Uganda's government health system also grew in the early 1900s, through Independence in 1962, up to political upheavals that beset the country from the 1970s to the 1990s. During these upheavals, faith-based health facilities and organizations (FBHFOs) rapidly expanded as the local church and missionaries sought to fill gaps as the governments of the time struggled.

Uganda's religious medical bureaus have coordinated their expansions. These include the Uganda Catholic Medical Bureau (UCMB) (est. 1934), Uganda Protestant Medical Bureau (UPMB) (est. 1957), Uganda Muslim Medical Bureau (UMMB) (est. 1999), and Uganda Orthodox Medical Bureau (UOMB) (est. 2021). Currently, these bureaus have the following:

Table 1 shows that the composition of networks is different. UCMB has more hospitals and HC IVs (50 total) compared to 32 in UPMB and 9 in UMMB. On the other hand, UPMB has more lower-level health centers: 131 HC II compared to UCMB's 54 and UMMB's 24 facilities.

Table 1: Faith-Based Health Facilities in Uganda's Bureaus and Portion of the Health System

Bureau	Hospitals	Health Centers	Total
UCMB	33	275	308
UMMB	5	76	81
UOMB	1	15	16
UPMB	23	307	330
Total FB	**62**	**673**	**735**
Total National	186	6937	7123
% FB	**33.30%**	**9.70%**	**10.30%**

Source: Analysis of the number of health facilities reported by FB Medical Bureaus, as well as analysis of DHIS2 data for Uganda, 2020-2023.

Uganda's faith-based health system also includes supply chain and health worker training institutions.

1. Joint Medical Stores (JMS) was established "jointly" by the UPMB, UCMB, and UOMB. JMS complements the government's supply chains by procuring for FBHCOs, private NGOs, and other providers.
2. Universities and colleges such as Islamic University in Uganda, Uganda Christian University, Uganda Martyrs' University, and Bishop Stuart University train physicians, nurses, clinical officers, and other health professionals. They offer a range of diplomas to advanced training.

Other faith-based health assets complement the work of the medical bureaus and their associated facilities, including:

1. Other private, nonprofit health centers that are faith-based in orientation may be privately owned or supported;
2. Faith-based NGOs that provide contracted medical services, e.g., for agencies that serve Uganda's sizable refugee population; and
3. Local or international NGOs that operate community health promotion and services.

Because many other PNFP health facilities are faith "named" or possibly church-aligned, this landscape includes data on both the PNFP sector generally and, where possible, data on FB-specific facilities attached to the bureaus.

[1.] https://mengohospital.org/about-us/ accessed in 2 May 2025.
[2.] https://lubagahospital.org/about-us/ accessed 2 May 2025.
[3.] Doyle S. Missionary Medicine and Primary Health Care in Uganda: Implications for Universal Health Care in Africa. In: Medcalf A, Bhattacharya S, Momen H, et al., editors. Health For All: The Journey of Universal Health Coverage. Hyderabad (IN): Orient Blackswan; 2015. Chapter 9. Available from: https://www.ncbi.nlm.nih.gov/books/NBK316272/
[4.] Ssennyonjo A, Namakula J, Kasyaba R, Orach S, Bennett S, Ssengooba F. Government resource contributions to the private-not-for-profit sector in Uganda: evolution, adaptations and implications for universal health coverage. Int J Equity Health. 2018 Oct 5;17(1):130. doi: 10.1186/s12939-018-0843-8. PMID: 30286757; PMCID: PMC6172798.

DHIS2 Data on PNFP and FB PHC in Uganda

This project analyzed Uganda's DHIS2 data for four years (2020-2023), focusing on the following services:

- Outpatient,
- Antenatal,
- Post-natal,
- Immunization, and
- Family planning visits.

This data includes facility-level service data, including service descriptors (e.g., name, district, and whether the facilities are government-owned, private non-profit, coordinated by one of the faith-based bureaus, or privately owned). Data on the number of facilities and patient visits were tabulated to generate percentages by year and on average over the study period (2020-2023).

Concerns About Data Completeness and Quality

The actual quality and completeness of DHIS2 data are unknown. For example, anecdotal information from key informants and project consultants indicates that facilities of all types may over-report immunizations. This analysis did not explore the completeness of data for hospitals compared to outpatient services; some facilities may only report outpatient data if they provide those services.

Gaps likely exist in outpatient DHIS2 data from outpatient service providers. These include:

- Facilities themselves may underreport data, especially if they are very rural.
- Data processing remains manual, especially in lower-level health facilities.
- Untimely reporting of data:
  - Accuracy of the data being reported may be compromised, and
  - Not all districts may submit PNFP data, likely due to late reporting by the PNFPs.

Nevertheless, the data reporting rates in faith-based systems exceed those of all facilities, and DHIS2 data is the best available general data source. It was reported that Uganda's MOH is working on a plan to improve DHIS2 data to include Village Health Teams, the backbone of community health and promotion. This is related to another goal, to phase out Level II health centers, upgrading them to Level III where possible.

Facilities Reporting in DHIS2 Over the Study Period

Analysis of DHIS2 data shows that Uganda's health system includes 3807 health facilities that reported outpatient service data to DHIS2 between 2020 and 2023 (see Table 2). Of these 3807 facilities, 993 facilities (26% of all facilities) are "private not-for-profit (PNFP);" among those are 634 facilities that are "assigned" (64% of PNFP, or 17% of all outpatient providers) and are "assigned" to one of the faith-based medical bureaus.

Among the remaining 36% of PNFPs "not assigned" to a medical bureau, many have a religious name, suggesting they were established or operate as independent "faith-based" facilities. For this reason, most of the following analysis includes all PNFP data.

More of the FB health facilities are recorded in DHIS2 than non-FB facilities.

Table 2: Number of Facilities and Representation in DHIS2 Data

	Total Facilities	Facilities in DHIS2 Outpatient Data Extract	Percent Represented in DHIS2 Outpatient Data
UCMB	308	298	96.70%
UMMB	81	49	64.50%
UOMB	16	3	18.80%
UPMB	330	284	86.10%
Faith-Based	**735**	**634**	**86.30%**
All Health Facilities	**7123**	**3807**	**53.40%**

Source: Analysis of Uganda DHIS2 Data, 2020-2023

Outpatient Services in FB and PNFP Facilities

Over the study period of 2020-2023, Uganda's health facilities averaged 103.8 million outpatient service visits per year. FB facilities averaged about 9 million visits (8.7% of all visits), and unassigned PNFP another 5.94 million, raising the PNFP contribution to 15.0 million patient visits or 14.5% of all outpatient services (Table 3).

Table 3: Total Outpatient Visits in Uganda, 2020-2023 (millions of visits)

All OP Visits	2020	2021	2022	2023	Total	Average
Faith-Based	8.01	8.88	9.85	9.55	36.28	**9.07**
Other PNFP	7.32	4.88	6.14	5.44	23.78	**5.94**
Total PNFP	15.33	13.76	15.99	14.98	60.06	15.02
Total National	95.86	93.87	131.03	94.6	415.36	103.84
FB %	8.40%	9.50%	7.50%	10.10%	**8.70%**	8.70%
PNFP %	16.00%	14.70%	12.20%	15.80%	**14.50%**	14.50%

Source: Analysis of Uganda DHIS2 Data, 2020-2023

HIV testing in Namayingo, Uganda. Photo: UPMB

Over the study period, FB facilities had an average of 14,308 outpatient visits per facility, which is slightly less than all PNFP (15,121 visits per facility) and about half that of all facilities (27,276 visits per facility) (Table 4). However, after excluding family planning, visit rates per facility were higher than other PNFP for outpatient, antenatal care, postnatal, vaccination, maternity, and admissions, but still only about half the rate seen in total national services.

Table 4: Average Number of Outpatient Attendance by FB Bureau, PNFP, and Total 2020-2023

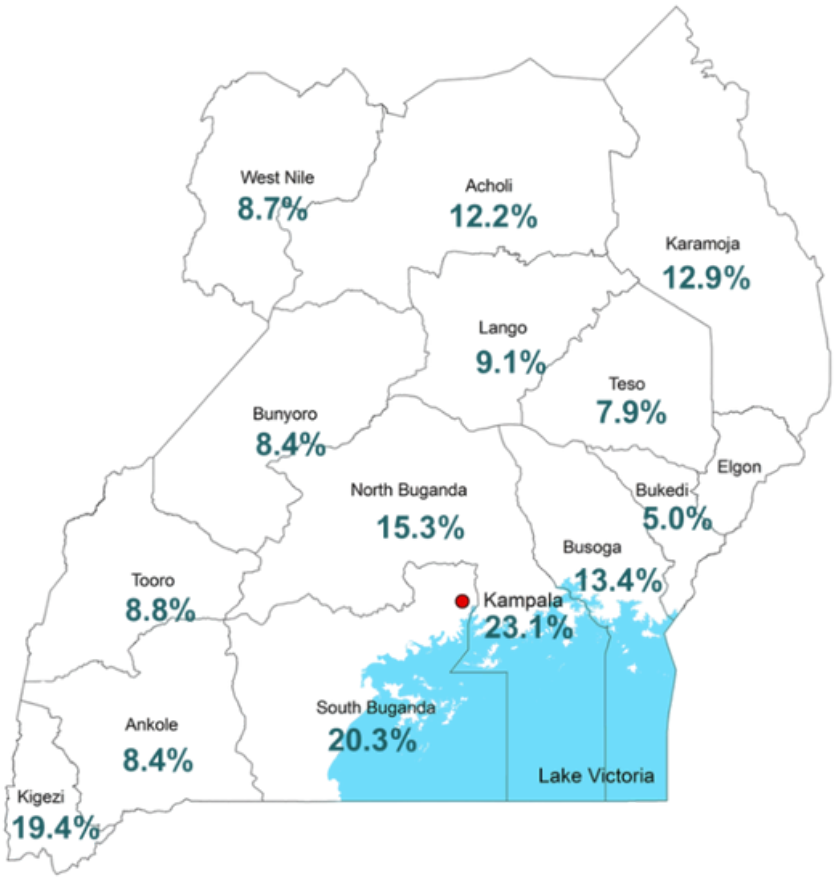
	N	Outpatient Attendances	Antenatal	Postnatal	Vaccination	Family Planning	All OP Visits
Unassigned	359	4,805	402	163	671	10,516	16,558
UCMB	298	7,639	1,557	891	2,256	228	12,571
UMMB	49	4,625	613	431	1,279	4,122	11,070
UOMB	3	4,020	641	285	1,327	1,640	7,912
UPMB	284	5,482	838	414	1,588	8,433	16,756
FB Total	634	6,423	1,157	639	1,877	4,211	**14,308**
PNFP Total	993	5,838	884	467	1,441	6,491	**15,121**
All Facilities	3807	11,813	1,687	642	2,312	10,823	**27,276**

Source: Analysis of Uganda DHIS2 Data, 2020-2023

Further analysis of DHIS2 data indicates that:

- FB facilities had fewer family planning attendances per facility (4210) than other PNFPs (10,516) or all facilities (10,823). This is because UCMB (Catholic) facilities averaged 228 attendances per facility, which is less than 2% of the rate seen in other FB facilities.
- Some regions have more PNFP and FB facilities and, therefore, more services than others. Outpatient attendance averaged 12.9% nationwide (excluding other PHC services besides outpatient); this varied from 5.0% in Bukedi to 23.1% in Kampala (see Map 1).

Map 1: PNFP Outpatient Services as Percent of Total, By Region. Outpatient attendance only, average annual visits 2020-2023



Note. No PNFP service centers from the Mt. Elgon region were identified in the DHIS2 data.

Uganda Key Informant Perspectives

Interviews with key informants (KIs) at the national and regional levels add insight to the DHIS2 data. The following are results from interviews conducted with national stakeholders (from the FB medical bureaus, MOH, and NGOs), FB health facilities, and district health authorities in five sampled districts.

National Level Key Informant Perspectives

Government and user fees are the primary sources of PHC financing for Uganda's PNFP facilities, according to KIs.

Generally, the share of Uganda's health sector in the national budget consistently averages 7%, according to KIs. This demonstrates the government's commitment to improving the health needs of its population. Informants felt that this falls below the Abuja Declaration, a commitment by the African Union member states to allocate at least 15% of their national budgets for health. This funding to the health sector directly affects the size of conditional funding to the faith-based health facilities in the country.

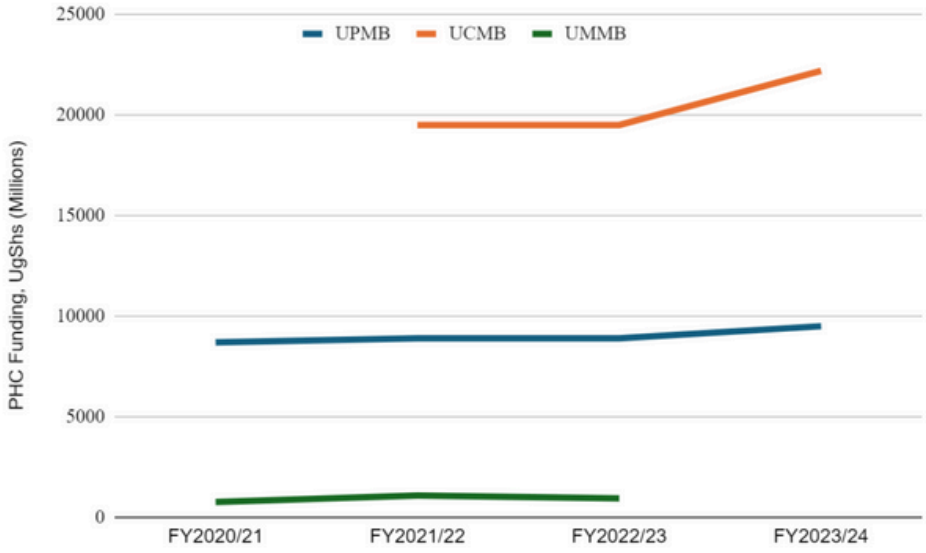
The PHC Conditional Grants are the primary source of government funding for PHC Services in PNFP facilities. The government's decentralization strategy included leaving districts in charge of setting grant levels based on DHIS2 reports provided by facilities. PHC funding to the faith-based health facilities comes in two forms: commodities distributed through credit lines to the Joint Medical Stores and non-wage grants through the district health offices. Informants believe the government recognizes that the FB sector is unique and well-placed to provide health care to communities not reached by the government's public health facilities; they complement government efforts in healthcare delivery.

On the other hand, the counterpart public health facilities have access to wage, non-wage, and development grants, which cover their operational costs and enable them to offer free services to a great extent. Unlike the public health facilities the government fully funds, the faith-based sector has to find other means of financing its services, including charging user fees, donations, and local revenue. Government incentives for PNFP HC IIIs and HC IVs, through Results-Based Financing, have helped.

PHC funding for the faith-based sector has increased, but it is not enough to cover the total costs.

Three of the four FB medical bureaus shared the total PHC funding for their facilities. This data was not consistently available from 2020 to 2023 (see Figure 1). Still, revenue analysis reveals that the PHC allocation has been progressive over the years. KIs report this increase was only in non-wage recurrent conditional funding.

Figure 1: Total PHC Income for 2020-2023, in Millions of Uganda Shillings

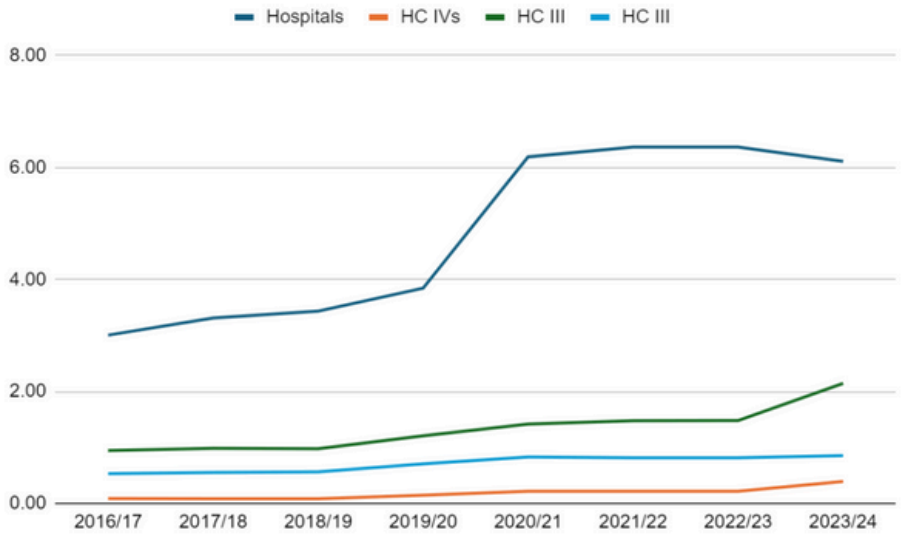


Source: Analysis of PHC Income provided by UPMB, UCMB, and UMMB Informants

To explain revenue further, UPMB informants also provided detailed data on PHC funding for this report. Year-over-year change was modest except for hospitals that received a 60% increase in PHC funding in 2020 (see Figure 2 and Table 5). In the past year, PGHC Conditional Grants accounted for 50% of public funds to PNFP PHC. A credit line from JMS to UPMB also accounted for 40% of PHC income. RBF accounted for less than 10% overall but was targeted at HCIV and HC III. Figure 2 also shows that PHC revenue is higher in hospitals than in lower levels of care. Informants explained that this is primarily due to several factors:

- The overall cost of hospital-based services
- Additional outpatient service options that exist at hospitals compared to lower-level centers
- Need to ensure the viability of hospitals

Figure 2: PHC Income in UPMB Facilities, 2016-2023, in Billions of Ugandan Shillings



Source: Analysis of PHC Revenue Data Provided by UPMB

Table 5: PHC Revenues in UPMB Health Facilities, 2023 (millions of Uganda Shs)

	JMS Credit Line	PHC	MOH RBF	Total PHC	Facilities	Average
Hospitals	2,417.10	3,557.10	137.2	6,111.40	23	265.7
HC IV	86.3	89.7	215.9	391.9	9	43.5
HC III	826.1	772.6	545.3	2,144.00	167	12.8
HC III	435.2	418.1	0	853.3	131	6.5
Total	**3,764.60**	**4,837.40**	**898.4**	**9,500.40**	**330**	**28.8**

Source: Analysis of Uganda Protestant Medical Bureau PHC Revenue Data

[5] https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf accessed 5 May 2025

Government funding only covers a portion of the total PHC costs.

At best, PHC conditional grants covered only a portion of the total cost of PNFP health services. Non-wage PHC funding to faith-based health facilities through commodities and non-wage grants is provided annually. The PHC funding varies by size, but on average, KIs report it is between 12% and 60% of what is required to run the health facilities, depending on the level of care. Higher-level health facilities receive more funding than lower-level ones due to both higher patient volumes and that they provide more healthcare services.

Faith-based HFs have also received in-kind support from local district governments when partners like WHO, UNICEF, and USAID provide in-kind donations to the districts.

Informants emphasize that although PHC funding has progressively increased, FBHFs struggle to meet operational costs. PHC only covers health promotion, disease prevention, hygiene, and sanitation activities, and the implementation of PDM health-related activities that align with the health sector's strategic shift to strengthen the community health program and community involvement. However, some KII informants reported a reduction in PHC funding this year.

FBHFs charge user fees to meet their operational costs and sustainability. However, some informants consider user fees a barrier to accessing health care, especially in rural and semi-rural areas where communities are impoverished, including those in hard-to-reach populations. Even with seemingly low user-fee charges, patients from poor communities cannot afford them. In some instances, some KII reported that some patients escape from the hospitals before clearing their bills, while others negotiate for installment payments, with a high percentage defaulting.

Even user fees are insufficient to cater to capital construction and other forms of development that PHC facilities require. The FB Bureaus and religious institutions sometimes have to mobilize additional resources to support HF operations. However, some of the funding acquired is restricted to specific services like HIV, Nutrition, and MCH.

> *"We are grateful to the government for PHC grants; although small, they enable us to charge low user fees. Our user fees are very minimal in this health facility because it is in a rural area; we know patients cannot afford them, and yet we must charge to meet our costs. Even with this little charge, we offer our best to the patients. Because we are Church-based HF, patients expect to be offered treatment with whatever they can afford,"* **KII in HF in Namayingo**

> *"We have seen a surge in the number of patients escaping before clearing their bills, even when they haven't healed completely, due to fear of being detained by the health facility. This has led to a loss of revenue. We sometimes try to apprehend the caregivers but release them when we know they won't raise the money anyway. These days, we insist on a significant down payment for inpatient services before we admit them to minimize the risks,"* ***KII, Lira***

Results-Based Financing helped Level III and IV Health Centers.

Results-Based Financing has been promoted as an innovative mechanism to improve the performance of health systems in achieving universal health coverage. Several results-based financing models were implemented in Uganda between 2003 and 2015. According to KII from the district health offices and FB health facilities, RBF played a significant role in delivering services and infrastructure development due to its flexibility.

Unlike the PHC grants that were non-wage conditional, the RBF funding was considered flexible, incentivizing staff who were, in turn, motivated to work hard and provide better care. It increased efficiency by enabling streamlined services, reducing waste, and optimizing resource use. However, the RBF was seen to come with preconditions, covering specific services and not institutionalized, so when it stopped, the numbers dropped. Further, there is the risk of cherry-picking, where some FBHFOs focus on easier-to-reach populations or more straightforward health interventions.

> *"With RBF, FBHFs were able to incentivize staff and allocate some funds towards infrastructure improvement. Staff also worked hard because they knew they had something more at the end of the month. RBF also enabled us to recruit additional staff. However, RBF was not institutionalized and only covered specific services."* ***KII, FB Partner, Kampala***

District-Level Key Informant Perspectives

PNFP/FB providers and public health services coexist and collaborate

The public and private sectors co-exist in Uganda's health system, and each plays a critical role in service provision. Government financing of the health care service delivery through PHC grants contributes to increasing service coverage by subsidizing FBHFs. The FBHFs are seen to provide services to communities that cannot access health services from public health facilities due to several barriers, including, among others, cost of travel, poor infrastructure, and poverty.

> *"FBHFs exist where the Public HFs don't; as such, they bridge the gap and offer services to communities. The district recognizes this, and it's the reason we have increased PHC funding to the FBHFs, especially those that service large catchment populations,"* ***KII, District Official, Mbale***

FB facilities are trusted for quality, compassionate care, serving the underserved, and the rural poor.

FBHFs are said to be trusted and consistent in health care delivery. Some respondents said the FBHFs offer compassionate care in line with the core values of the religious institutions. Faith-based health facilities work to provide health services to the most vulnerable population. They utilize small resources to get the best results and reach a significant population.

> *"FBHFs deliver health care based on the mission and objectives of their founding religious organizations. The communities tend to trust service providers and believe they are compassionate, respectful, and kind,"* ***FBHF KII, Mbarara.***

There is a strong legacy of partnership between the government and PNFP/FB facilities.

The key informants from both the local government and faith-based confirmed improved collaboration in the context of public-private partnerships (PPPs) and recognition of the FB contribution in the health sector. It was reported that, increasingly, the district health offices support immunization efforts of the health facilities by providing cold chains to strengthen immunization outcomes, solar panels to improve lighting at the HFs through direct purchase or as a donation from one of the government partners like UNICEF, USAID, and WHO from time to time. In some instances, where there are shortages of critical staff like midwives and medical officers, the district health office is said to place such staff in FB health facilities that are fully paid for by the district to improve service delivery.

Informants indicate that strong linkages between district officials and religious health coordinators (e.g., from local church dioceses) enhance cooperation. Access to religious leaders is critical socially and politically.

Access and Use of Commodities

Strong commodity supply chains in PNFP and FB facilities help improve continuity and reduce stockouts. Uganda's Joint Medical Stores (JMS) is positioned with regional warehouses and can leverage its lines of credit to procure based on projected local demand. In implementing the PHC commodity grants, JMS also bases data on annual projections with quarterly updates to prevent stockouts. Informants indicated that PNFPs can, if need be, be procured directly from manufacturers. PNFPs enjoy flexibility compared to national medical stores, which some informants associate with occasional supply disruptions.

What remains unknown, however, is whether all commodities are utilized as they are intended. There are occasional reports of facilities charging patients for commodities they received for free or misapplying them to purposes that were not intended. District audits and a potential new electronic tracking system should improve upon this. Reports of potential misuse are anecdotal and occasional rather than seen as a widespread challenge.

Inadequate staffing remains a serious challenge to PHC.

The challenge of inadequate staffing remains. The staffing norms in the FBHFOs are consistently insufficient to meet the required standards. This is mainly due to resource constraints - the revenues generated from user fees are inadequate to recruit and retain the necessary staff according to government health service delivery standards. This contributes to work overload and compromises service quality at times. Moreover, there has been a high attrition rate over the years, with staff moving from the FBHFOs to public health facilities due to better terms and conditions of service.

FBOs provide training. Universities and diploma-granting colleges exist in Uganda's Protestant, Catholic, and Muslim systems. While graduates from these institutions may be destined for work within their respective institutions, the comparatively low wages available may contribute to high turnover.

> *"The FBHFOs are like a nursery bed for the public sector, with staff moving from PNFPs to the government for better pay. With little pay, staff in FBHFOs still perform their duties well until they find better opportunities in the Government HFs; this is something we have to contend with,"* ***KII Medical Bureau, Kampala.***

The bureaus are involved in national-level advocacy at the highest levels.

All the medical bureaus are members of most of the health technical working groups and the Health Policy Advisory Committee (a high-level policy forum for health). They are, therefore, well placed to engage with the MOH to increase the allocation of PHC funding to the faith-based sector. There is enough evidence that the FB sector contributes a substantial share of health services to Uganda's needy populations. Moreover, the FBHFOs serve the underserved, poor, and vulnerable communities that cannot afford even the subsidized cost of care.

H.E. William W. Popp, US Ambassador to Uganda, views HIV commodities at the Joint Medical Store warehouse.

Discussion and Recommendations

PNFPs and FBHFOs specifically are substantial parts of Uganda's health system. They provide valuable access to communities and prioritize reaching underserved populations. They rely heavily on government funding but must also raise funds from user fees to meet the needs of populations. Strong relationships with FBOs exist in each district included in this study. The FB bureaus are also involved in the highest-level consultations and policy bodies at the MOH, which points to a legacy of strong cooperation.

Still, the population's needs exceed current health system capacities. Any effort to strengthen health services, including PHC, must identify ways to solidify and expand PNFP and FB capacity and services. Here are a few recommendations:

1. **Improve data reporting and data quality.** Right now, DHIS2 drives all PHC Conditional Grants and is the data source for providing descriptions of services. Gaps remain in how many FB facilities report to DHIS2, and informants are concerned with incomplete and poor-quality data. Inaccurate or incomplete data can skew the understanding of local health services. Efforts to improve DHIS2, including Village Health Teams and community data, will help. But at the same time, PNFP and FBOs need help with staffing on data, internet access, and equipment.

2. **Continue advocating for the role of PNFP and FB in PHC services.** They are an essential part of the health system and help meet the needs of underserved communities. There are occasional opportunities to expand services, and when private facilities are viewed as getting "excess" from other support, it limits their ability to grow.

3. **Address staffing shortages with improved planning for the overall health system.** Insufficient staff are available in PNFPs, mainly due to limits in the overall availability of PHC funding. In addition to considering ways to subsidize salaries, explicit efforts can be made to strengthen capacity, improve continuous professional development, and support staff upgrading. This can help align staffing and services around modern, evidence-based care.

4. **Continue exploring health insurance as a mechanism for the sustainable delivery of healthcare.** User fees, the mainstay of PNFP and FB services, are sometimes unaffordable to people in great need. This is a serious concern in communities where PNFP or FB facilities are the only providers available. Insurance will help improve timely access to services and prevent unnecessary delays in care.

5. **Renew and expand Results-Based Financing**. RBF helped health facilities partly because it was flexible—it incentivized changes that produced results. It helps when managed alongside insurance.

6 **Maintain strong and routine collaboration between the PNFP/FB and the government.** Uganda's legacy of strong relationships can be put at risk when misunderstandings arise at local or regional levels or as development resources become scarce. Allocations of resources and health facility development can continue based on a "one health system" mentality. The government's role in meeting the nation's health needs includes engaging each relevant asset and ensuring each has access to the training and support it needs. Uganda is an excellent example of a robust PPP, and its reputation needs to be protected and enhanced.

7 **Ensure faith-based actors are stepping up to changing expectations of the national system.** How will they protect their reputation for credibility, integrity, compassion, and quality? Understanding and following guidelines is a critical part of that. Globally, there are concerns that FB health facilities operate "outside the control or oversight of governments." In Uganda, informants are concerned that some FB facilities do not follow guidelines for using funds and commodities. Even if occasional or sporadic, those weaken the case that PNFP/FB are excellent partners. Non-health system actors, like local churches or mosques, can also be helpful partners.

8 **Ensure that FB and Government representatives co-plan important transitions in PHC.** First, Uganda's effort to transition HC II to HC IIIs and HC IIIs to HC IVs can be discussed and planned, including financial and staff implications. How will VHTs and community programs be included in concert with FB organizations? Globally, there is pressure to integrate HIV into PHC. PNFPs and FB facilities need specific discussion on who bears the burden, the implications, and the costs of policy changes.

Conclusion

This landscape study demonstrated with statistics and key informant reports that the PNFP and FB sectors complement government services to address the overall health needs of Uganda. The struggle to introduce new funding remains a barrier to expanding PHC efforts in the PNFP and FB facilities. Efforts to maintain open communication with the government and donors are vital.

This landscape was primarily focused on the current situation in Uganda; future efforts should be proactive and test alternative funding and service provision scenarios—e.g., climate change, pandemics, or other shocks to the system. It also highlighted methods for data extraction and interviews that can be replicated in different contexts.

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