



Analysis

Resilience and high performance amidst conflict, epidemics and extreme poverty

The Lacor Hospital, northern Uganda

Volker Hauck

A case study prepared for the project 'Capacity, Change and Performance'

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Study of Capacity, Change and Performance

Notes on the methodology

The lack of capacity in low-income countries is one of the main constraints to achieving the Millennium Development Goals. Even practitioners confess to having only a limited understanding of how capacity actually develops. In 2002, the chair of Govnet, the Network on Governance and Capacity Development of the OECD, asked the European Centre for Development Policy Management (ECDPM) in Maastricht, the Netherlands to undertake a study of how organisations and systems, mainly in developing countries, have succeeded in building their capacity and improving performance. The resulting study focuses on the endogenous process of capacity development - the process of change from the perspective of those undergoing the change. The study examines the factors that encourage it, how it differs from one context to another, and why efforts to develop capacity have been more successful in some contexts than in others.

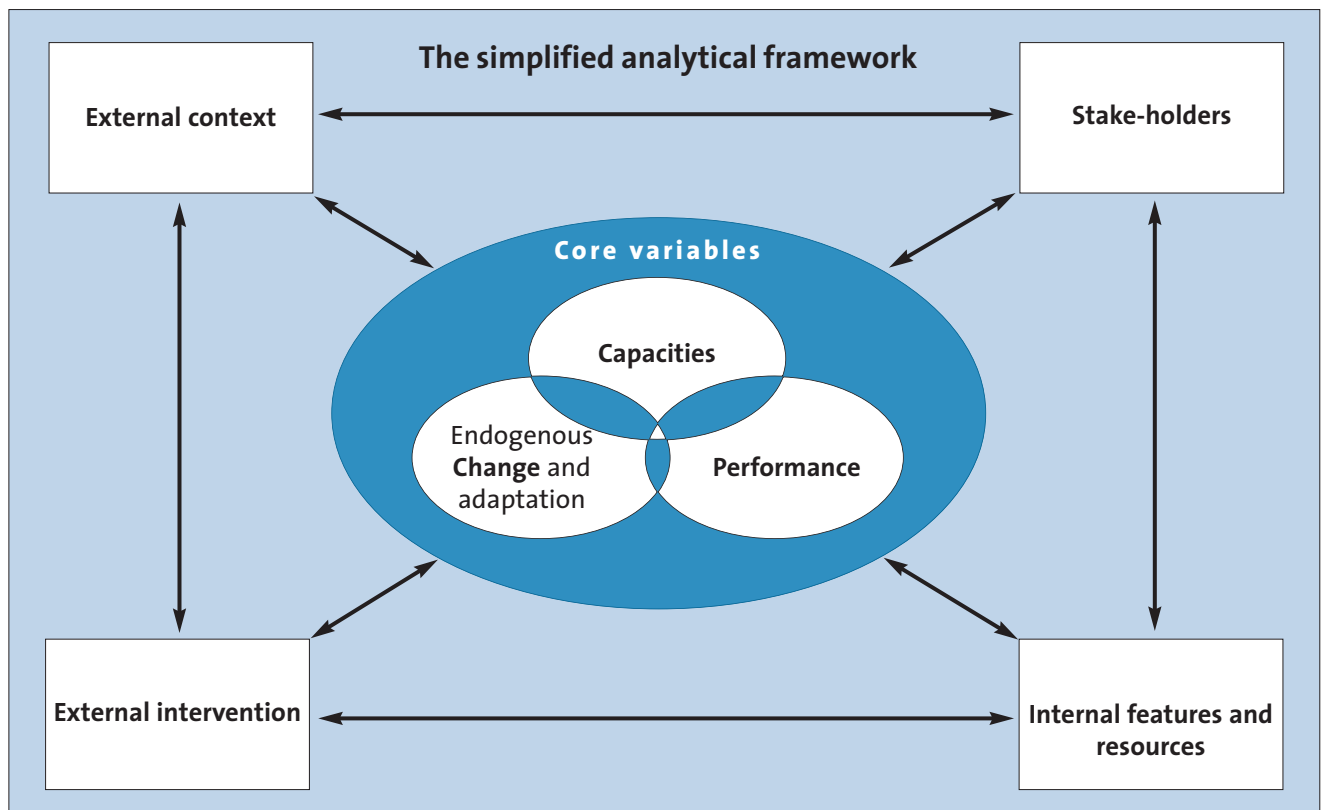
The study consists of about 20 field cases carried out according to a methodological framework with seven components, as follows:

- Capacity: What are the components of capacity, i.e. the capabilities, in a given context?
- Endogenous change and adaptation: How do processes of change take place within an organisation or system?
- Performance: What has the organisation or system accomplished or is it now able to deliver? The focus here is on assessing the effectiveness of the process of capacity development rather than on impact, which will be apparent only in the long term.

- External context: How has the external context - the historical, cultural, political and institutional environment, and the constraints and opportunities they create - influenced the capacity and performance of the organisation or system?
- Stakeholders: What has been the influence of stakeholders such as beneficiaries, suppliers and supporters, and their different interests, expectations, modes of behaviour, resources, interrelationships and intensity of involvement?
- External interventions: How have outsiders influenced the process of change?
- Internal features and key resources: What are the patterns of internal features such as formal and informal roles, structures, resources, culture, strategies and values, and what influence have they had at both the organisational and multi-organisational levels?

The outputs of the study will include about 20 case study reports, an annotated review of the literature, a set of assessment tools, and various thematic papers to stimulate new thinking and practices about capacity development. The synthesis report summarising the results of the case studies will be published in 2005.

The results of the study, interim reports and an elaborated methodology can be consulted at www.capacity.org or www.ecdpm.org. For further information, please contact Ms Heather Baser (hb@ecdpm.org).



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Acronyms

AISPO	Associazione Italiana per la solidarietà tra i Popoli
DAC	Development Assistance Committee (OECD)
DHA	district health authorities
ECDPM	European Centre for Development Policy Management
IMF	International Monetary Fund
LRA	Lord's Resistance Army
NGO	non-governmental organisation
PNFP	private not-for-profit
OECD	Organisation for Economic Cooperation and Development
SWAp	sector-wide approach
TA	technical assistance
UCMB	Uganda Catholic Medical Bureau
UEC	Uganda Episcopal Conference
UMMB	Ugandan Muslim Medical Bureau
UPMB	Ugandan Protestant Medical Bureau

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A word of appreciation goes also to the staff of the logistics office of the Lacor Hospital in Kampala, who provided efficient support in organising the interviews and the author's visit to Lacor in May 2004. A final word of thanks goes to the ECDPM core team for the wider study on Capacity, Change and Performance, to Heather Baser, ECDPM Programme Coordinator, and to ECDPM Associates Peter Morgan and Tony Land. They accompanied this research and provided stimulating comments and reflections prior to and during the writing of this report. Valerie Jones has been a most patient and capable editor.

While this study contains many inputs from Lacor Hospital stakeholders and the study team, the sole responsibility for the interpretation of data and their analysis rests with the author.

Preface

The idea to undertake this study of St Mary's Hospital, known locally as Lacor Hospital, was born during an informal encounter in Milan between the author and Dr Dominique Corti. She is the daughter of Dr Piero Corti and Dr Lucille Teasdale, who arrived in Uganda in 1961 with the vision to build and to run a medical centre of excellence to serve the poor in the north of the country. The encounter in Milan provided for a first exchange on the Lacor Hospital, which seemed to be an extraordinary example of resilience and high performance amidst conflict, epidemics and extreme poverty. It was followed up by a more structured exchange of information and documents, from which it soon became clear that a study of the Lacor Hospital could serve three purposes.

First, it could provide inputs for a wider programme of the European Centre for Development Policy Management (ECDPM), entitled *Capacity, Change and Performance*, which seeks both to provide practical guidance on capacity and capacity development and, more specifically, to foster a better understanding of the interrelationships between capacity, organisational change and performance. Undertaking a case study of Lacor Hospital was seen as a unique opportunity to understand what it takes to perform effectively in a fragile environment characterised by conflict, epidemics and extreme poverty.

Second, using the methodology of the overall study - based on the principles of *appreciative enquiry* (Whitney, 2003) - the results of this case study could provide feedback for the hospital. While feedback was a general aim at the beginning of the exercise, hospital staff members interviewed assessed this study as such a positive experience that they now want to expand it, to involve more hospital staff and to turn it into a learning experience for the entire organisation. They want to stimulate a process of thinking that could lead to greater awareness of past and present achievements and the values that have been shaped in the hospital over the years. Consequently, the hospital management, staff of the Uganda Martyrs' University (known locally as Nkozi University) and ECDPM have developed a plan to encourage such reflection. It will be implemented during the course of 2004/2005.

Third, the results of this case could be communicated to an international audience concerned with the design of policies and strategies aimed at conflict prevention and the stabilisation of fragile environments. The Lacor case is important for two reasons. First, it is the example of a private organisation that stands at the front line in the effort to combat poverty, misery and despair, and which supplements insufficient government services. Being located in the centre of a civil war in a region that has been severely destabilised by the Lord's Resistance Army rebels and not far from war-torn southern Sudan, it is an outpost of hope for the Ugandan people and provides some stability to the region. The case also highlights the consequences of the Ugandan health reform and the change in donor policy on the funding of organisations like Lacor. While the hospital management and the board expressed full agreement with the government's health policy, which aims to extend and harmonise health services throughout the country, they feel the negative impact of changing donor policies with regard to budget support. They are also aware of the fragility of a new aid policy that takes for granted that recipient governments will include non-state actors in the policy process (see the Epilogue). This policy seems to overlook that in a country like Uganda, with a developing region in the south and a fragile environment in the north, a mix of support instruments needs to be in place in order to respond effectively to the challenges of a highly volatile environment. In conclusion, this case underlines the need to recognise the potential strategic role that organisations like the Lacor Hospital could play in the context of combating poverty and implementing global and regional security policies.

Summary

St Mary's Hospital, known locally as the Lacor Hospital, in Gulu district of Northern Uganda, formerly an isolated Catholic missionary hospital, is now fully integrated into the Ugandan health system. The case study describes how the hospital has grown into a centre of excellence, setting an example for the rest of the health system and helping to build health care capacity for the whole country. With 474 beds, Lacor is the second largest medical centre in Uganda. It is an extraordinary example of capacity development, adaptation and performance in a region characterised by an 18-year civil war, extreme poverty and outbreaks of virulent epidemics.

The Italian Dr Piero Corti and his Canadian wife, Dr Lucille Teasdale, began to build up the Lacor hospital in the early 1960s. Dr Corti formulated a clear objective for the hospital: to offer the best possible service to the largest possible number of people at the lowest possible cost. Dr Teasdale imprinted on the staff an attitude of care and love for the patients. Their tireless dedication and hard work set an example for the staff and developed into a value system that still guides the hospital.

The full case study analyses the key capabilities that underpin the hospital's excellent performance. The five most important are the following:

- The *ability to transfer the founders' values to others in the organisation*. This internalisation process takes place primarily on the job, through the power of example and regular staff meetings. It is supported by an incentive package and a management approach that shares responsibility and involves staff at all levels.
- The *ability to reproduce the organisation*. A core of 15 to 20 people supervise new staff members and act as the guardians of the hospital's working culture and values. In addition, on the technical side, the hospital makes an enormous investment in training, partly as a means of attracting staff to an otherwise unappealing location. In 2002-03, 11% of

the operating budget was devoted to training, both in-house teaching and outside training.

- The *ability to adapt*. The hospital's guiding principle is to respond to the demands of its key stakeholders. This implies learning processes that enable the hospital to acquire knowledge, to reflect and to apply the lessons of experience. It also means a rejection of dogmas, old habits and outdated procedures.
- The *ability to self-regulate*. Although Lacor has established formal administrative and professional standards, the management prefers to encourage the staff to take responsibility for their own performance. Control systems play a secondary role.
- The *ability to network and collect intelligence*. Throughout the life of the hospital, contacts with the outside world have been essential to understand the broader environment and to survive in very different and at times exceedingly difficult political periods. In addition, the hospital has been able to build contacts that have proved valuable in raising funds to subsidise its operations.

This set of competences has evolved slowly over the years and is tightly linked to the deeply rooted value system. It has helped the organisation to survive even during the most difficult times. Lacor was one of the few hospitals in the world to deal successfully with Ebola, even though it resulted in the deaths of 78 of the 150 patients admitted and of 12 experienced staff, including Dr Corti's designated successor. The hospital's staff and board are aware that they can overcome such adversities only by further developing their key capabilities, maintaining their core values and stabilising their finances. Funding agencies and the Ugandan government can learn from this case about the contributions such an organisation can make to fighting poverty and despair, the stability it can bring to a war-torn region, its contribution to wider health sector development, and about the adverse effects of well-intended budget support policies on excellent social service providers.

1 Introduction

This case study looks at the experiences of the St Mary's Hospital in Lacor, near Gulu, the capital of Gulu district in northern Uganda. It draws attention to the factors that have played a role in shaping the hospital's capability to perform effectively in an environment characterised by conflict, epidemics and extreme poverty. The study focuses on the last 10 years, although occasional references are made to earlier periods to provide for a better understanding of the case.

This analysis is retrospective, but it is not an evaluation. In line with the methodology for the wider ECDPM study, this case intends to record the strengths and successes of the Lacor Hospital in shaping the capabilities that enable its excellent performance. It concentrates on 'what' happened, 'why' and 'how'. It is only in the final section that the challenges and key questions for the hospital's future are listed - those were mentioned by the staff and board members and need to be addressed to guarantee that the needs of the poor in the region are met in the future. This analysis is therefore explanatory and makes no recommendations or proposals for the future functioning of the hospital, although some of the insights gained might be helpful to identify important issues for the future.

This analysis looks at the development of the Lacor Hospital as an organisation. It makes occasional reference to the network of other private not-for-profit (PNFP) health providers in Uganda with which it is linked. The functioning of this network and its role in shaping and informing health policy in Uganda is an interesting case in itself, and potentially important for the wider ECDPM study. Shortages of resources and time, however, did not permit attention to these issues in this study.

ECDPM learned about the Lacor Hospital at a conference in Milan, Italy. The hospital immediately indicated its interest in collaborating in the research and provided invaluable background material. After a detailed review of documents, the study team decided to include this case in the wider research programme.¹ This report is based on a desk study in which books, reports and internal Lacor Hospital documents were consul-

ted, and interviews with hospital staff, board members and stakeholders in the Ugandan health system. Due to the security situation in Gulu district at the time of the initial research in July 2003, interviews with staff members were held in Kampala. Some of them took place when staff members were visiting the capital for other reasons; others specifically travelled to Kampala to meet for interviews.

The draft report was sent to several interviewees to provide comments, and to verify the information and impressions articulated by the author. In May 2004, the author presented the draft report at the Lacor Hospital's strategic workshop in Gulu. Based on comments received during this workshop, and on complementary interviews held at the hospital, the report was verified and finalised.

Why is the Lacor Hospital an interesting case?

In most developing countries, the major hospitals are situated in the capital. They are reasonably well equipped and generally perform according to regionally, some even to internationally accepted standards. But a preliminary review of information on the Lacor Hospital provided reasons to be curious. It is situated 350 km north of Kampala, in an area that has experienced civil war, outbreaks of severe epidemics - including Ebola in 2000 - and appalling poverty for more than 17 years. Nevertheless, the 474-bed hospital has managed to build up a reputation as a centre of excellence that is able to deliver a wide range of services that very few other hospitals in Uganda can provide.

Formerly an isolated missionary hospital, Lacor has survived periods of severe crisis and setbacks and has slowly been integrated into the national health system. Over the years it has adapted itself in order to respond to challenges that also threatened to destroy the organisation. Core values shaped and nurtured over time emerge as the key factors that have the hospital running and performing 'well'.

This report is structured as follows. Section 2 provides background information on the Lacor Hospital. Sections 3-5 discuss the external context, internal organisational

Notes

- 1 Lacor is not the only NGO hospital in Uganda that is performing well. The Ministry of Health/ KPMG study (1998) identified this and three other PNFP hospitals as potential regional referral hospitals.

features and the influence of external stakeholders. Section 6 offers a preliminary analysis of the underlying strategies that explain the hospital's resilience and performance over the years, and sections 7 and 8 highlight the complex interrelationships between these different dynamics in order to understand why the hospital so far has had the capacity to perform. Section 9 provides some final comments on the challenges for the future. As noted in the Epilogue, some recent developments in the Ugandan health sector could have a big effect on the future of the hospital.

With regard to terminology, 'capacity' is used to refer to the ability of the organisation or system *as a whole* to perform. As such, it is not equated with any subsidiary element such as a particular 'capability'. That term refers to a specific ability of the organisation to do something in particular, such as to facilitate, to learn or to manage projects. Most of this case is about 'capability' as opposed to 'capacity' development. Finally, 'performance' is used to mean accomplishment or execution or delivery (Morgan, 2003b).

2 Background

In the early years of the last century, Catholic missionaries arrived in Northern Uganda. A regional diocese was established 7 km outside the district capital of Gulu, which provided a medical dispensary run by brothers of the Italian Comboni Congregation.² In 1959 the dispensary was converted into a 30-bed ward, and in 1961 into a hospital, St Mary's Hospital Lacor, when the Italian Dr Piero Corti (a specialist in paediatrics, radiology and neuropsychiatry) and his Canadian wife Dr Lucille Teasdale arrived. Both were committed to spending their lives setting up and running a professional hospital that would be able to provide medical services to the highest possible standards. By 1983 the hospital had grown to approximately 200 beds, but the civil war that began in the 1980s placed tremendous demands on the hospital. By 1993, it had increased to 450 beds (see Annex I).

Dr Lucille Teasdale, a surgeon, contracted AIDS during an operation that she likely performed in 1979, but she continued to work at the hospital selflessly until her death in 1996. Dr Piero Corti died in 2003. Both were

honoured with several laureates and distinctions, including the Order of Merit of the Italian Republic and the Sasakawa Prize of the World Health Organisation, and Dr Lucille Teasdale was appointed a Member the Order of Canada in 1991. Their lives were documented in a biography (Arseneault, 1997) that provides detailed insights into their work, their motivation to keep the hospital running despite threats to their lives during the civil war, and their commitment to providing the best medical services possible, in a cost-effective way, to the poor and needy.

The success of the Lacor Hospital can not be understood without recognising the tremendous efforts and achievements of the Cortis over a long period in shaping the organisation.³ The focus, however, is on the decade to 2003, which was a period of growing political stability in Uganda. The public administration was rebuilt and reformed to an extent previously unknown. After the formulation of a preliminary health strategy, in the 1990s the Museveni government systematically began to rebuild the health sector and to integrate the various government and non-governmental health providers into one national health system.⁴

The 1990s marked a watershed in the organisation's development. It had to adapt from being an externally funded missionary hospital, following its own systems and procedures, into a private not-for-profit health provider integrated into the health system, partially funded by the Ministry of Health. The 1990s were also characterised by the continuing civil war and extreme poverty in the northern districts. Moreover, the outbreak of Ebola in 2000 had a devastating effect on the organisation and nearly destroyed it. When the epidemic hit the region, there were 393 confirmed cases with 193 deaths. At the hospital, 150 cases were confirmed, of which 52% died. Among the hospital's 100 volunteer staff, 12 died, including Dr Matthew Lukwiya, a brilliant medical specialist who had been earmarked as the future director of the hospital.⁵

Notes

- 2 For more information about the Comboni Brothers, see www.combonimissionaries.org
- 3 Although the Cortis built up the hospital, the support of the Comboni missionaries has been of vital importance for its effective functioning.
- 4 In 1991/1992, the Ministry of Health issued a white paper on health reform that addressed core policy issues, such as how to integrate the private profit and non-profit sectors into the health system, although it took until 1996/1997 to implement them.
- 5 Lacor was the first and so far only hospital in the world where such a large number of Ebola patients were attended to exclusively by medical personnel. In other hospitals, medical staff delegated physical contact with patients to relatives.

3 External context and integration into the national health system

Integration and networking

The absorption of the Lacor Hospital into the national health system can be dated to 1996/1997 when all former missionary hospitals were integrated as private not-for-profit health providers.⁶ Since 1999, Lacor has received around 16% of its funding through the health basket funding provided by donor organisations to the Ministry of Health.⁷

In this context it is important to highlight the link between the Lacor Hospital and the Uganda Catholic Medical Bureau (UCMB). Created in 1956 to support Catholic medical services, the UCMB went through different phases and changes in mandate. In the early 1990s, at the start of the reforms to the health system, a number of then missionary hospitals, including Lacor, came together and urged the UCMB to take up a networking function to coordinate the different demands of the hospitals and to act as an intermediary between them and the health authorities (Giusti *et al.*, 2004).

The UCMB's networking efforts became an important element of the change process for Lacor and helped to ensure that its concerns and proposals for change reached the national level. The hospital management gave high priority to this network and joined the task force of the Health Commission of the Uganda Episcopal Conference, which was coordinated by the UCMB. The task force met regularly between 1996 and 1998 to monitor the formulation and introduction of the new health policy. More recently, a desk dealing with public-private partnerships was established at the Ministry of Health to facilitate exchanges about health policy with the UCMB, other faith-based medical bureaux and their networks.

Decentralisation and links to government

In line with the government's decentralisation policy, Lacor is administered by the Gulu district health autho-

rities, through which it receives state funds. Gulu municipality has 115,000 inhabitants, and Gulu district 480,000. The Gulu Hospital, just 7 km from Lacor, has about 250 beds and is the regional referral hospital. In Gulu town, a private hospital with 30 beds opened recently, and provides specialised services for better-off patients. The approach of Lacor Hospital, similar to other PNFP health providers, is to offer services that the national health system can not adequately provide. With the introduction of health reform in the mid-1990s, national and district authorities increasingly recognised the value of pluralism and accepted the complementary role of non-governmental health organisations,⁸ which now deliver about 60% of health services. Of these, 30% are provided by the PNFP hospitals and health centres.

Ebola

Ebola is a severe, often fatal fever in humans and nonhuman primates (monkeys, etc.). The natural reservoir of the virus is unknown and the manner in which the virus first appears in humans at the start of an outbreak has not been determined. People can be exposed to the Ebola virus from direct contact with the blood and/or secretions of an infected person; or through contact with objects such as infected needles. The incubation period ranges from 2 to 21 days (www.cdc.gov). For more information about Ebola haemorrhagic fever, see www.who.int/inf-fs/en/fact103.html

Bausch (2001), one of six experts from the Centers for Disease Control and Prevention (CDC) who assisted at Lacor during the Ebola outbreak in 2000, described the effects as follows:

'An Ebola outbreak in a community causes complete upheaval to virtually all facets of society. It is an event that divides time into a 'before' and an 'after'. After, whether you personally were infected or not, nothing can ever again be the same - no person is left unaffected, no emotion unturned. The individual agony of those stricken with Ebola is readily apparent, but the losses run much deeper. Scared neighbours, sometimes even family members, refuse to let convalescent patients back into their homes, sometimes burying their belongings or their entire hut. Deep-rooted African customs regarding burial of the dead are disrupted. ... Later, as the destruction wears on, fear takes over ...'

Notes

- 6 With new dynamics in the health sector as of the mid-1990s, the PNFP hospitals asked the Ministry of Health to accept them as an integral part of the health system.
- 7 About 50% of the health budget is funded by donors through project and budget support. This dependence on external funding is characteristic of other social sectors, such as education.
- 8 This process took a long time in Gulu district. The originally cool stance of the district health authorities towards Lacor has more recently turned into more openness, comprehension and cooperation.

The surrounding environment

The day-to-day operations at the Lacor Hospital are very much shaped by the demands of the local population. Despite the availability of free medical services at the government's referral hospital in Gulu town, many patients continue to vote with their feet and to pay for treatment at Lacor. Approximately 20% of the hospital's operating costs are financed by user fees.

Gulu is the largest Roman Catholic centre in northern Uganda. The Archbishop of Gulu oversees four dioceses. Lacor Hospital has been built on land owned by the diocese and is situated close to several other Catholic organisations, including a convent, the Comboni Brothers mission of, a teacher training centre, primary and secondary schools and Gulu cathedral. This wider Catholic infrastructure provided important resources and logistical support during the early years, but its importance has gradually declined with the integration of the hospital into the national health system. Lacor's Catholic identity remains, however, and provides access to substantial external funding from Catholic sources.

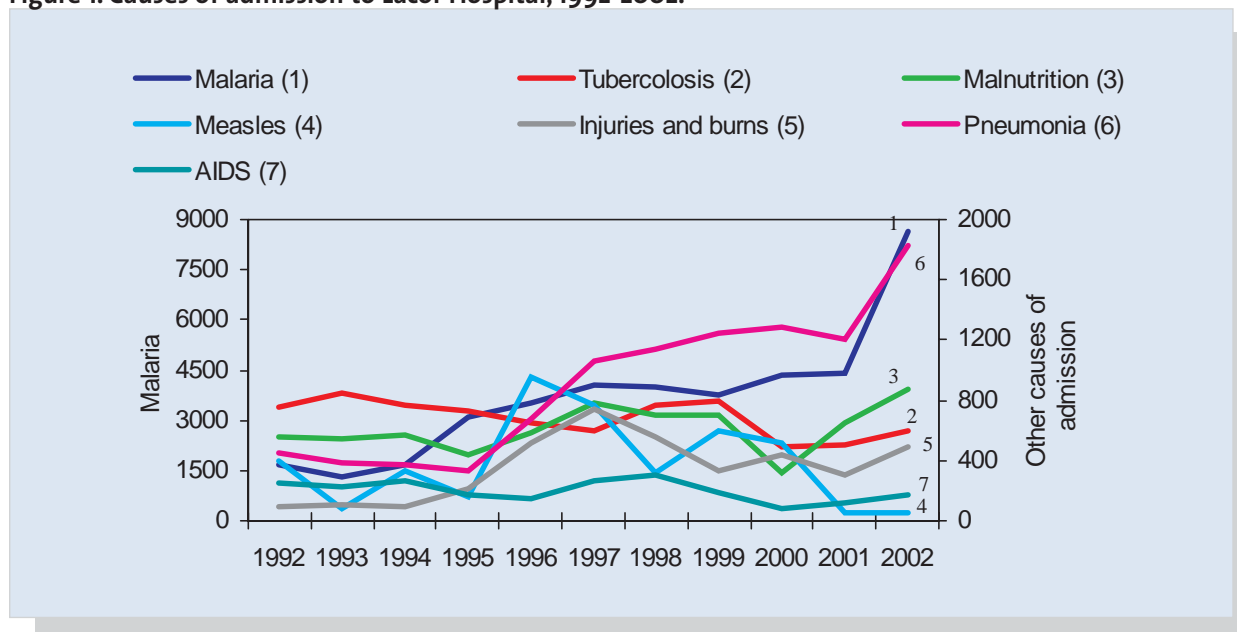
Lacor operates in a very difficult political and economic environment. Since 1986 Gulu district has been battered by civil war and unrest, and the Lord's Resistance Army (LRA), led by Joseph Kony,⁹ has brought suffering and despair. The hospital has been looted and its staff

threatened. In 1989, the late Dr Lukwiya was taken hostage and the hospital had to close for six weeks.¹⁰ There are many locally displaced in the district who have abandoned their villages to stay in camps. Although Lacor is not supposed to be a camp for those fleeing the civil war, more than 2000 people took refuge in the compound until they were relocated in March 2004. During May 2004 the hospital also provided refuge for some 10,000 'night commuters' from surrounding communities, mostly women and children seeking to avoid nocturnal attacks and kidnapping. The hospital also accommodates some 800 patients plus carers (totalling 2000) each day, as well as 2500 family members of employees. The presence of these thousands of people on the compound every night places an enormous additional burden on the hospital infrastructure, especially water and sanitation facilities.¹¹

Economics and poverty in Gulu district

The civil war and the activities of the Lord's Resistance Army have devastated the economy of northern Uganda. Most social indicators for Gulu district are well below the national average. For example, life expectancy is 39 for males, and 41 for females. The infant mortality rate is 172 per 1000 live births, compared with 109 for Uganda as a whole.¹² The main cause of death for children under 4 years is malaria (43% of cases), while for 15-35 year olds it is AIDS.

Figure 1. Causes of admission to Lacor Hospital, 1992-2002.



Source: Dr Massimo Fabiani, Italian National Institute of Health, Rome.

Approximately 11% of adults in Gulu district are infected with HIV/AIDS, compared with a national average of 6%. As in other conflict regions, the high incidence of HIV/AIDS in northern Uganda can be explained by violence against women and the large number of displaced persons. Although the figures on AIDS are dramatic, the prevalence of HIV/AIDS in Gulu district stabilised between 1992 and 2002 (see Figure 1).¹³

With 540 employees and some 120 temporary workers, Lacor is the second largest employer in northern Uganda after the government. As such, it is important economically - 95% of employees are from Gulu district, and they account for 24% of the local tax revenues (Uganda Martyrs University, 2003). Paradoxically, Lacor has been negatively affected by the improving economic conditions in other parts of Uganda. Costs such as salaries and insurance follow the national economy, but local cost recovery has become more difficult because of the dire economic conditions and the limited ability of patients to pay for services.

4 Internal organisational features

The present organisational structure of Lacor Hospital can be best explained by referring to some key changes within and outside the organisation over the last 20 years or so. There have been three periods:

The first period, 1983-92, saw the emergence of the rebel movement and the start of the civil war until the region came under the control of the Museveni government. After the elections in 1989, the country entered a period of extensive reconstruction and development, although to a lesser extent in the north than elsewhere. In 1983, Dr Corti recruited medical graduates in Kampala to enter an internship programme, some of whom were earmarked as future leaders of the hospital. The management (i.e. the Cortis) realised that continued reliance on external technical assistance (TA) for medical specialists was not sustainable. The organisation had to prepare Ugandans to take over when they retired. With the start of the civil war, the demand for medical services increased. The internship programme was extended and remains a crucial means of developing in-house capacity.

In the second period, 1992-2000, Ebola hit the region and threatened to destroy the hospital. This was a period of integration, formalisation and consolidation. With the fundamental changes in public administration, which also affected the health sector, the hospital management had to strengthen its ties with the Ministry of Health and with the network of Catholic health providers coordinated by the UCMB. Within the hospital, Ugandan doctors took on greater responsibility. In particular, the late Dr Lukwiya became Lacor's main 'antenna' to register signals from the new administration. He became a member of the task force coordinated by the UCMB to assist in formulating a new Ugandan health policy.

Formalisation and consolidation became major features with the arrival in 1992 of the present director, an Italian technical assistant who had previously worked for 10 years in a Tanzanian government hospital. Originally recruited to provide medical services, he

Notes

- 9 Although the name of the rebel movement suggests a religious background, this is misleading. Kony is a ruthless leader, determined to fight 'evil', who has managed to destabilise the region severely. Funding for the LRA supposedly comes from the Sudanese government. The Ugandan government is said to be financing rebel movements in southern Sudan, either in retaliation, or causing the Sudanese government to support the LRA - the assessment of the situation depends on the view of the respective side (*The Economist*, 6 September 2003). national mediators and the Ugandan government have attempted to resolve this issue, but the Sudanese government has not fully responded, despite its rhetoric that suggests otherwise.
- 10 Since then the hospital has not been threatened - the LRA realised that the closure of the hospital had a negative impact on its own operations and its local support.
- 11 For an outsider it is difficult to imagine how the hospital copes with so many people in terms of sanitation. There are rows of pit latrines inside the compound, which teams of cleaners disinfect each morning to allow the hospital to function again.
- 12 See www.worldbank.org/poverty/health/data/indicators/imr1.pdf
- 13 This has been attributed to the hospital's integrated approach to the epidemic, including inpatient, outpatient and outreach home care, which reflects a different pattern of the use of resources from that in other African hospitals (Accorsi et al. 2002). The decline in HIV/AIDS in Gulu corresponds with national trends. Despite its limited resources, Uganda has shown a 70% decline in the prevalence of HIV/AIDS since the early 1990s, linked to a 60% reduction in casual sex (Stoneburner and Low-Beer, 2004).

soon became the driving force behind the formalisation of internal systems and procedures, and the establishment of a functioning board, which had previously been only rudimentary. In view of the Cortis' imminent retirement, there was a need to formalise, consolidate and put in place more sustainable management structures. Moreover, the government required the integration of Lacor into the health system, and there was growing pressure from funding agencies that the hospital improve its financial accountability.

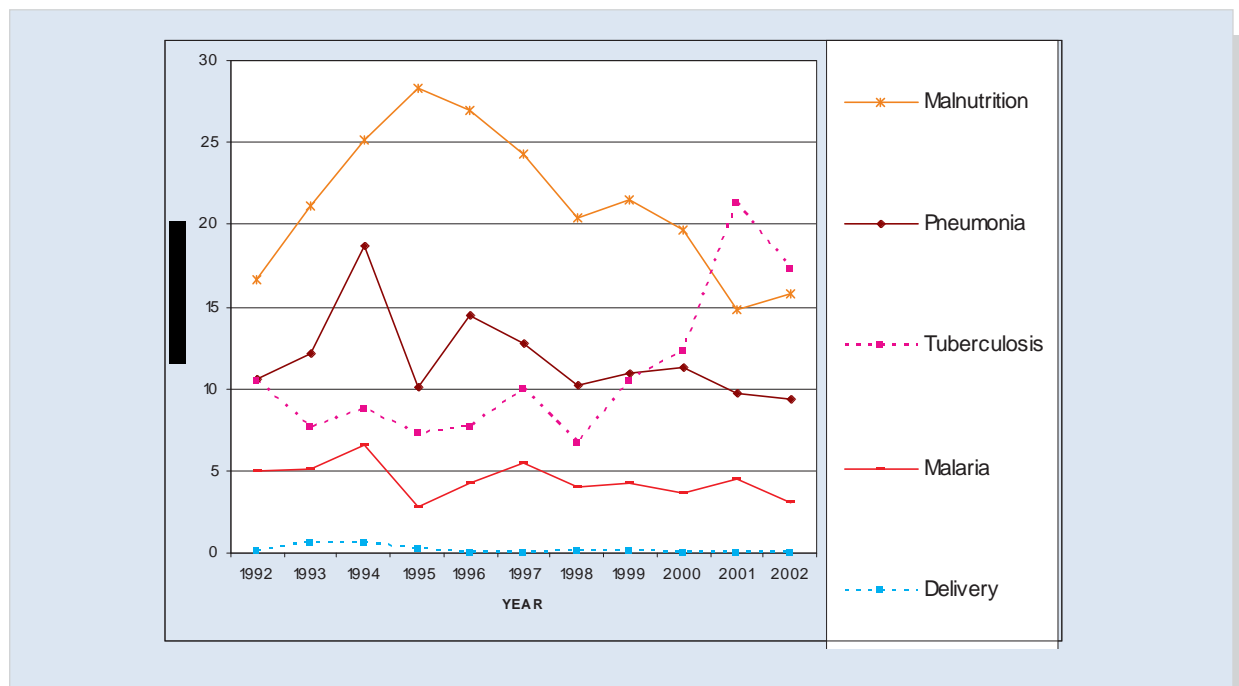
In the third period, from 2000 to the present, the focus has been on overcoming the effects of the Ebola crisis. The hospital had to replace 12 staff members who had died, and to deal with growing costs due partly to Ebola, and partly to the process of integration into the health system. This has also been a time of increasing transparency and interactions with stakeholders (three strategic workshops have been held to discuss the future of the hospital), as well as of institutional strengthening, with a board that started to take strategic decisions.

Management, board and services

The day-to-day management of the hospital is now in the hands of four people: the deputy director, the medical superintendent, deputy medical superintendent (all Ugandan nationals who were recruited as interns in the 1980s and 1990s) and the logistics officer, an Italian Comboni brother. The Italian director is not part of the management team, but has a supervisory mandate, assigned by the board in an effort gradually to shift responsibilities to the young Ugandan doctors. After the Ebola crisis these doctors were asked to step in and to lead the organisation through a team approach.¹⁴

The board has been strengthened over the past ten years with the addition of new members and improved links with the region. Since the Ebola crisis, it has also taken on a more strategic supervisory role. The Archbishop of Gulu chairs the board of 11 members, five of whom form the executive (see Annex III). In order to expose the management team to broader strategic questions, the board decided to include three doctors, plus the head of administration (currently vacant) in its biannual meetings. The board was enlarged

Figure 2. Case fatality rates (CFRs) for selected diseases at Lacor Hospital, 1992-202. There has been a general decrease in CFRs for the five leading causes of admission (except for TB).



Source: Accorsi et al. (2002).

ged by cooption. All members serve in their personal capacity and all Ugandan members are from the local Acholi tribe - their background is seen as a motivating factor to sustain and improve the functioning of the board. During interviews, these board members commented that they saw their voluntary work as a way for them to bring 'some good to their own people'.

The hospital is a major enterprise, as can be seen from Annex I, with some 540 staff members working in a wide range of services, including general paediatrics, obstetrics and gynaecology, surgery, general medicine and a TB ward. In financial year (FY) 2002/2003 the hospital treated some 31,000 patients, and had some 213,000 outpatient contacts.¹⁵ The annual budget is about EUR 1.8 million, 60% of which is spent on personnel.

The hospital is well aware of the pollution a hospital can cause to its environment. A lagoon was constructed in the early 1990s, which ensures that used water is filtered and cleaned before it is discharged. Lacor is one of the very few hospitals in the region to have such a water treatment facility.

The hospital carries out and promotes research on clinical as well as managerial aspects of health care delivery. The aim is to contribute to the general development of the health system and to improve its medical expertise and services. Figure 2 provides indications of the success of the hospital's efforts to improve its professionalism.

Personnel management and incentives

The hospital staff interviewed for this study characterised the Cortis' management style as highly effective,

but informal, unstructured and building on personalities. Despite their respect for the work of the Cortis, many of them felt more secure and guided after the introduction of clear standards, rules and procedures for staff management and staff development.¹⁶ The formalisation was essential, and is regarded as the most important achievement of the current leadership. The systematisation of staff development became pressing in order to ensure the gradual handover of the organisation to Ugandans.

But there were also other factors pushing formalisation. Although the hospital originally offered salaries substantially above the national average, the health reform in the 1990s resulted in increased national salaries and Lacor was no longer competitive. Government salaries are on average 5% higher, and the Ministry of Health offers an attractive pension scheme and regular working hours. To compensate, the hospital emphasises career development (training and studies) combined with other attractive employment conditions such as competitive and punctual payment; free medical treatment for staff and their families; contributions to HIV treatment for staff; access to a credit and savings cooperative; and an attractive professional environment (availability of materials and equipment, employment regulations ensuring fair treatment of staff, etc.).¹⁷

Internal norms and values

The hospital's value system plays a key role in its daily operations. Dr Cortis' management approach - pragmatic, entrepreneurial and needs oriented - is still followed today. The needs of patients have always determined the focus of the organisation. Equally important was Dr Lucille Teasdale's dedication to the patients. 'If you choose to live with the poor, you will love them', she was quoted by a nurse during an interview who had worked with her for many years. Against this background, founded on Catholic humanism¹⁸ and an attitude of working hard and leading by example, a working norm was shaped which is composed of three basic principles, which one doctor summarised as: excellent care to be given to the patient, dedication to work and willingness to work hard, and a culture of good ethics in which loose morals and corruption have no place. Those who follow these principles are welcome, as long as their professional work meets acceptable standards.

Notes

- 14 Dr Cortis remained director of the hospital until close to his death, although he had gradually reduced his involvement since the mid-1990s. Before the Ebola outbreak the management was in the hands of the deputy director (now director) and the medical superintendent (Dr Lukwiya).
- 15 The hospital has too few beds (474 in 2003) to host all patients. During the author's visit, about 1000 patients were staying at the hospital, most of them children with malaria who could have been treated at peripheral health centres and health posts - but these had been destroyed or abandoned during the civil war.
- 16 An employment manual was finalised in 2001, and has been adopted by other PNFP health providers.
- 17 Despite this package, Lacor is not immune to the workings of the labour market. Recently, 14 nurses left to join the government services. The risk of losing the best doctors is lower - after a one-year internship, the most promising doctors are offered a three-year contract, and are eligible for sponsorships or scholarships for post-graduate training.
- 18 The hospital was attached to the Catholic church, but has remained open to other religious groups and communities. The late Dr Lukwiya was a Protestant.

5 The influence of outside stakeholders

A health organisation so centrally placed in an environment of enormous needs and poor health services has many stakeholders, with a web of interrelated stakeholder demands and supplies that has been carefully woven over the years. This has steadily increased with the ongoing integration into the national health system. Interesting to note is the two-way relationship between the hospital and its stakeholders. There are at least four stakeholder groups that have a distinct influence on hospital operations - the patients and 'night commuters', the national and local health authorities, the Roman Catholic health system in Uganda (which are in turn also partially influenced by Lacor), and external funding agencies.

1. Patients and 'night-commuters'

During interviews, all staff and board members emphasised that the hospital's key responsibilities were to serve the poor in need of medical services and to respond to the demands of stakeholders by adjusting their operations. Formulated by Dr Corti in the early days, Lacor's objective - 'to offer the best service possible to the largest number of people at the lowest cost possible' - has guided the organisation ever since.

The increase in the number of patient contacts and treatments over the years provides clear evidence that the staff have responded to the demands of its stakeholders. The number of patients rose from 142,000 in 1995-96 to 184,000 in 2001-02. In addition, the hospital has also dealt with outbreaks of epidemics and diseases, including Ebola, meningitis and tuberculosis, providing services that governmental structures could only partially provide. Patients pay an average of 20% of the cost of treatment, despite the availability of free medical services in the government-run referral hospital in Gulu, some 7 km away. The continuous flow of patients is the main source of the hospital's legitimacy.

In addition, there are the thousands of 'night-commuters' who seek refuge in the compound each night to avoid being kidnapped by the rebel army for military training, or to be sold into slavery. Throughout 2003 and early 2004 there were some 5000 'night commu-

ters,' but the situation worsened dramatically in May 2004 due to LRA massacres around Gulu town, when the number rose to 10,000, most of them women and children under 16.

2. National and local health authorities

The Ministry of Health and the Gulu district health authorities (DHAs) have had a direct influence on the Lacor Hospital. In particular, with the reform of the health sector its recurrent costs¹⁹ and annual statutory costs have increased substantially.²⁰ With its integration into the national health system, the hospital receives government funds - via the health sector basket fund of the Ministry of Health and the DHAs - but it has had to revise its administrative systems to meet excessive demands for central reporting and accounting. The relationship between the DHAs and the hospital is mainly administrative.

3. Roman Catholic organisations in Uganda

The Uganda Episcopal Conference (UEC) of the Catholic church has also had an influence on the hospital and on the type of operations it undertakes. According to the hospital's mission statement, 'In fulfilling its mandate, the Hospital shall always follow the medical ethics and the moral teaching of the Roman Catholic Church and shall follow the Mission Statement and Policy of the Catholic Health Services in Uganda, as approved by the Bishops' Conference in June 1999' (St Mary's Hospital, 2001).

The UEC sets policy, which it entrusts for implementation to the Health Commission of the UEC and its permanent executive secretariat, the UCMB. The UCMB thus functions as the coordinating body for all Catholic medical services and supervises hospital operations to ensure that standards and performance are in harmony with the teachings of the Catholic church and with the policies of the Ministry of Health. At the same time, the UCMB functions as an important forum for discussion and policy preparation for the network of Catholic not-for-profit health providers. A workshop held in March 2000 is an example of this (UCMB, 2000).

Notes

¹⁹ Staff costs increased from US\$600 million in 1997/98 to US\$1800 million in 2001/02, due to the increased government salaries for health workers and the need to remain competitive.

²⁰ Recurrent costs include the obligatory payments to the government's revitalised National Social Security Fund, or for Workmen's Compensation. For Lacor these payments increased from US\$14 million in 1997/98 to about US\$300 million in 2001/02.

A mutual relationship shaping performance

The Lacor Hospital also influences its stakeholders, in particular the Ugandan health authorities and the community of Catholic health providers. Due to its unique position and resources it is able to test new approaches, procedures and practices, which have proven beneficial to the entire Ugandan health system. Its intern programme for young doctors, for example, has set national standards for professional quality. The hospital organised two strategic workshops in 2002 and 2003, which the UCMB sees as models for other hospitals. The UCMB also recognises that Lacor is a centre for learning that is needed by the entire network of Catholic not-for-profit health providers.²¹

The staff of the hospital are aware of their unique position in the Ugandan health system and recognise that the interactions with stakeholders have started to influence internal behaviour and performance. Since the Ebola crisis, staff are aware that Lacor has to be among the best in terms of clinical services, and of managerial capabilities. There are also high expectations for their own performance; as one staff member noted, 'The outside looks at us, there are expectations raised and we need to deliver'.

4. External funding agencies

The Lacor Hospital was not an externally designed project. It was founded by the Comboni missionaries and developed into a full-scale hospital because of the vision of two individuals who adopted a pragmatic and entrepreneurial approach. The hospital needed funding that was not available locally, but would be forthcoming only if performance was excellent and obvious to potential funding agencies. The incentive for performance was strong.

Over the years external funding agencies have remained supportive, and cover about 65% of the hospital's recurrent costs.²² Despite this dependency on external funding, the hospital has sufficient space to fulfil its mandate and to test new approaches. The decision to engage in networking with other Catholic health pro-

viders to safeguard a future place within the Ugandan health system in the early 1990s, was taken internally. More recently, the hospital management and board jointly decided that the hospital should improve its interactions with stakeholders, and to hold strategic workshops to discuss its future.

Although financial auditing is still in vogue among development agencies, performance accounting is unknown to many. Only the Italian Episcopal Conference and Terre des Hommes (a Dutch NGO) provide long-term support and core funding. The Italian Cooperation is important for its substantial long-term commitments, but its support is project related, as are the funds received from other agencies. Like many organisations, Lacor suffers from the preference of development agencies to fund short-term projects that serve particular purposes.²³ Some agencies also press for capital expenditures on specific projects but pay little attention to the organisation's running costs. This has had little effect on the Lacor Hospital's approach. It has apparently developed relationships with donors in which they play the role of investor - they are able to observe but not intervene in the process.

New approaches to aid management

Two new approaches to aid management are worthy of note. First, in the early 1990s, the Italian Cooperation put pressure on all projects, including Lacor, to improve their accounting of funds received over the previous six years. Other funding agencies also pressed for better financial accounting, and insisted that the hospital set up a professional financial management system and follow standard reporting and contracting procedures.

Second is the move in the late 1990s to a sector-wide approach (SWAp) in the health sector. Funding agencies increasingly channelled their funding into a basket managed by the Ministry of Health to support a national programme. This has had two impacts on Lacor. On the one hand, the Ministry's contribution to the hospital budget increased from zero in 1999 to 16% in 2002, but on the other, direct contributions from foreign governments and NGOs decreased. Some other hospitals have had to reduce their services substantially as their funding from donors stopped, but Lacor was in a somewhat different situation. The Italian Cooperation only partially followed the SWAp

Notes

- ²¹ Dr Giusti, UCMB Executive Secretary, personal communication; see also section 7.
- ²² In FY 2001/02, 19% of recurrent costs were covered by user fees, and 16% by the Ministry of Health (primarily from the health sector basket fund). The Ministry also provides 10 medical specialists, who are on a separate payroll of the Ministry of Health.
- ²³ The hospital receives funds from USAID, some Italian NGOs (AISPO, CCM, etc.) funded by the Italian Cooperation, DANIDA, the European Commission, Austrian Cooperation, and the Autonomous Province of Bolzano.

approach and has continued to channel substantial funds directly to the hospital. The funds the hospital receives from the Ministry of Health are entirely used for expenses resulting from the introduction of the health reform, i.e. increased salaries and annual statutory costs. In parallel, direct project funding from those donors now contributing to the SWAp decreased. Thus, the costs of integration into the national health system have offset the benefits to the organisation.

The hospital's difficult financial situation - more than 80% of the annual budget needs to be raised from non-governmental sources - were discussed extensively during the workshop in 2002. The principal questions raised were the extent to which the hospital could maintain its 'pro-poor' focus (should user fees be increased or not?), and whether it could continue to offer such a broad range of services in the future.

The Corti Foundation

In 1993, Dr Corti established the Piero and Lucille Corti Foundation to buffer possible setbacks in income. The Foundation played a crucial role in FY 2001/02, when the hospital had to meet around 43% of its annual costs from its own resources.²⁴ It is not expected that the Foundation will need to contribute such substantial amounts in the next few years (nor has it the means to do so), but the sharp increase in general costs will demand more structural funding from the Foundation in the future. The board has recognised the importance of the Foundation and has offered it a seat.

Technical assistance

The Italian Cooperation and Italian NGOs are the principal sources of technical assistance (TA). In mid-2004 eight expatriates were working at the hospital, including four physicians, a laboratory technician and a pharmacist, who will stay for two to three years on average. The director is also Italian and has worked at Lacor since the early 1990s. TA is recruited through the Associazione Italiana per la solidarietà tra i Popoli (AISPO), an Italian NGO. The chief logistical officer is a Comboni brother, and is considered a lifelong TA (unless he is transferred to another duty station by the Comboni Congregation).

Lacor also receives short-term volunteers and TA for research and to provide technical advice through several international medical institutes. Most notable have

been the partnerships between Lacor and the Istituto Superiore di Sanità, Rome (which dates back to 1992) and the San Raffaele Hospital in Milan. Board members consider the contributions of both short- and long-term TA to be indispensable for the functioning of the hospital and an important element in building up the capacities of the organisation.

6 Endogenous change and adaptation

The Lacor Hospital has managed to adapt and change in order to cope with severe crises and to revitalise itself after setbacks within a reasonably short time. This has been achieved in spite of different approaches to management, ranging from the rather informal style of the Cortis to the recent more structured and institutionalised approach.

The hospital has no formal written strategy, but a set of principles related to the objective formulated by the Cortis, to offer the best service possible to the largest number of people at the lowest possible cost. This objective helped to bring together different individual motivations, ranging from the desire 'to do good' in accordance with the teachings of the Catholic church, to more specific ambitions, such as to help alleviate poverty or to gain professional experience in a particular medical discipline.

In addition, Lacor saw a number of 'happy coincidences' that were to be key factors in the success of the organisation. In terms of organisation, the Catholic church in Gulu district played a supportive and facilitative role, while staying in the background and avoiding involvement in internal hospital matters. The arrival of the present director was also timely in view of the perceived need for a more structured and formalised approach in harmony with the late Dr Lukwiya's vision for the hospital. Some underlying strategies or elements of a strategy can nonetheless be highlighted - some long-standing, others articulated more recently. The following set of implicit strategies appears to have shaped a process of performance-focused endogenous change and adaptation.

Listening and responding to needs

The hospital has been shaped by many needs - arising mainly caused from the civil war, epidemics and the general emergency situation of the region. These needs called for a flexible approach to fill the gaps that the government was unable to fill. The hospital's responsiveness to the needs of the population created new demands and challenges when it became clear that the government could not step in. Meanwhile, Lacor continued to offer a broad range of medical services, partially financed by minimal user fees. All respondents indicated that the dedication to the needs of patients has been internalised by staff as the core value of the organisation. Recent management and board decisions have been taken against this background and will form the basis for future decisions as well.

Building up human resources

The hospital needs skilled professional staff who meet the required medical and technical standards, are willing to live in a remote area among the poor, and have a positive and compassionate attitude to their work. During difficult periods in the past, capable human resources were not always available. A training school for nurses was therefore set up in the 1970s, followed by an intern programme for young doctors. This in-house approach to staff development has been a success, and has become the backbone of the organisation since the 1980s. Some 11% of the operating budget is now spent on training for nurses and laboratory staff, intern programmes, and postgraduate studies for medical specialisations. The approach is justified by the extremely difficult environment. The Ebola and AIDS epidemics have claimed several staff members, and new medical staff who have not been exposed to the working culture - requiring a 'patient first' attitude and availability outside working hours²⁵ - are difficult to integrate. The civil war also makes the region unattractive to staff from outside the region.

All key Ugandan staff have gone through the tough school of the past and have internalised the 'rhythm' and the spirit of the organisation.²⁶ Young staff can

advance within the hospital, as long as their older colleagues consider them able and willing to 'fit' into the hospital's working environment.

Maintaining productive links with national authorities

Throughout its history the Lacor Hospital has tried to maintain good and productive relationships with the national health authorities. As a consequence, the hospital was left untouched, even during the difficult years of the Idi Amin regime. With the arrival into power of the current government, the hospital immediately responded to the government's policy objectives for PNFP health providers to integrate and to become active in the national health system. The hospital adheres to the government's rules and procedures and complies with its legal requirements.

The staff are aware of being part of the national health system and are happy to be seen to be playing an essential role in contributing to the well-being of the Ugandan people. However, they are also very critical of the government health services and see themselves as professionally more advanced than their colleagues. The recent departure of 14 nurses to join the national health service confirmed their view that their professional capabilities are in great demand. This mix of integration into and competition with national health services continues to shape organisational behaviour and performance. So far, there has been sufficient 'space' to combine the two. But the departure of the nurses confirmed Dr Cortis's view that Lacor had to be better than other health centres in order to compete successfully for resources.

Becoming a learning organisation

The biography of the Cortis as well as the interviews shows that the hospital has always been a place for openness and exchange. Any form of rejection of new ideas, or religious dogmatism was alien to them.²⁷ Recently, this openness led to the organisation of three strategic workshops on the future of the hospital. Due to the rise in costs due to the health reform and the Ebola crisis, the board and management needed more information on the economic functioning of the hospital, and to discuss with stakeholders strategic options for organisational change. For the first workshop in 2002, studies were carried out by the Martyrs University in Nkozi, Mpigi District (St Mary's Hospital, 2002). Two

Notes

- ²⁵ Lacor is said to be one of the few hospitals in the country that is open 24 hours a day.
- ²⁶ Dr Lucille Teasdale was the origin of this 'patient-first' attitude. Apparently, she could be extremely hard on staff for unprofessional behaviour, but was loved for her genuine concern for the wellbeing of the patients. Several respondents felt that this attitude and its integration into the working culture were her biggest achievements.
- ²⁷ As one respondent explained, 'The Cortis created a culture of work based on hard work, honesty, no compromise on patient issues, good relationship and friendship, and being with the people. But praying was not a priority'.

more were held in 2003 and 2004, and there are plans to hold further workshops in the future. The workshops helped to facilitate internal communication and transparency (an aspect taken for granted by staff). More important, however, they enabled the hospital to explain the outside world that it does not make a profit (as regularly claimed by local authorities and politicians). All respondents believe that the workshops contributed to the credibility of the hospital, improved relations with stakeholders, and internal learning.

The need to learn from analysis and diagnosis is probably more obvious to a medical organisation than to many others. The management thus suggested that what physicians do as part of their day-to-day work should also apply to the organisation. In order to understand the cause of a disease, research and learning is essential, according to one staff member.

Finally, to enable the hospital to provide the best possible services, it was essential to incorporate ideas and new medical knowledge from interns and external TA. Working with foreign TA is seen in a strategic perspective. Medical specialists and volunteers are recruited to bring in new learning and to expose the organisation to new medical developments. Most TA are recruited for limited periods and for particular specialist functions.

Networking and sharing for professional development

In line with its focus on openness to learning, the hospital has established links with medical faculties in Kampala and Mbarara (see below) and with hospitals and research centres outside Uganda. It also gave high priority to networking and sharing inside Uganda, when the network of former missionary hospitals started to formulate their concerns. This continued engagement in exchange and networking, in particular through the UCMB, is seen as essential to ensure the sustained functioning of the hospital.

Gradual 'Ugandanisation' of the leadership

The launch of the intern programme in the 1980s set the path for the transfer of the leadership of Lacor to Ugandan nationals. Since then, young doctors showing the ability to take on responsibility have been integrated into the management. However, the death of the designated future Ugandan leader due to Ebola showed how painfully thin were the capacities to manage

such a complex operation successfully. The subsequent restructuring of the organisation was intended to install a new group of doctors into leadership positions, gradually to entrust them with growing management responsibilities, and to allow the current director to supervise their work. But with this approach to capacity development it will take time to build the needed human resource base. The board fully supports this approach, but is aware that foreign TA will be needed to co-manage the hospital in the years to come.

Shaping the board into an effective instrument

The formalisation of the Lacor Hospital in the early 1990s also required a functioning board, to which committed individuals with a regional background would be co-opted. Any 'politicisation' of the board was to be avoided. The organisation wished to develop a capable and effective board that would be able gradually to take up supervisory responsibilities and to take consistent decisions based on standards and rules.²⁸ The board has demonstrated its ability to act and to take tough decisions, including laying off 68 staff members after the 2002 workshop,²⁹ but it still needs to grow in order to better guide the management. The recent inclusion of additional executive board members is seen as an important step towards enhancing mutual understanding and interaction between the staff and the board.

External fundraising

External fundraising has always been essential for the functioning of the hospital - the lack of national funds in the past left no other choices. With the introduction of the health reform and the health sector basket fund, the need for external funding has even increased. The 2002 and 2003 workshops sharpened the awareness that fundraising is essential to the survival of the organisation until peace and stability come to the region. Since increased funding through the Ministry of Health is unlikely in the near future,³⁰ the hospital has no option but to step up its own fundraising activities, and through the Corti Foundation, run by the Cortis' daughter Dominique and a group of volunteers. Efforts are now under way to build up in-house capacities on how to work with funding organisations.

Notes

- ²⁸ Although the statutes foresee the creation of a hospital council to represent the interests of stakeholders, so far no council has been created. It is expected that the strategic workshops will help to identify stakeholders to be represented in the council.
- ²⁹ The hospital had to lay off 68 staff members to cut costs after the Ebola crisis.
- ³⁰ In fact, the government can not afford to pay for the level of services provided by the hospital. For macroeconomic reasons, the Ministry of Finance and the IMF have set a ceiling on donor funds that can be channelled into the national economy, and thus into individual sectors, including health.

7 Emerging capabilities

The previous sections provided insights into the internal functioning of the Lacor Hospital, and how it has positioned itself in an often difficult environment with different stakeholders, interventions and interests. Over the years a set of implicit strategies has shaped and guided the process of endogenous change. While this information is relevant to understanding the management, the strategy and the broader context in which the organisation operates, it ignores the underlying capabilities that have enabled the organisation to run and perform throughout different periods.

There is ample evidence that the hospital is responsive to the demands of its stakeholders and that it has the capability to deliver high-quality services from a technical point of view. This is realised through a complex set of core capabilities that are in continuous exchange - sometimes closely linked, sometimes in tension or even conflict. As in most organisations, some capabilities are rather 'soft', others 'hard'. The Lacor case shows how a healthy mix of these capabilities has been shaped - some have been nurtured over time, while others have emerged in response to more recent changes in the local environment and operational context. It is too early to say whether all of these capabilities will remain intact in the future. Some of them are fragile, others are deeply rooted in the organisation, but all have been essential over the last 15 years or so, and there is good reason to assume that they will remain so in future.

The analysis identifies five core capabilities that appear to have emerged from the collective efforts. All are interrelated and of equal importance, and so are difficult to prioritise.

The capability to adapt and change

Following the overall vision of Dr Corti, the hospital's guiding principle is to respond to the demands of its stakeholders. This genuine concern has forced the organisation to become more open, to acquire knowledge, and to reflect on and apply the lessons of experience. Any conservatism such as clinging to dogmas, old habits, or existing procedures or structures has always been alien to the organisation - otherwise it

would have entered a downward spiral, with the loss of patients and efficiency, as has been the case with some other former missionary hospitals in Uganda³¹. Internal 'sensors' prevented this from happening. Meanwhile, internal mechanisms to register the need for change and self-control, including weekly departmental meetings and the strategic workshops, have become an integral part of the hospital's functioning.

Organisational reproduction

Throughout the history of the organisation one of its strengths has been its ability to develop a supply of human resources. This has guaranteed a smooth operation, but more importantly, it has provided a core group of some 15 staff members (out of 520) who constitute the pillars of the organisation. Spread throughout the hospital at different levels in the hierarchy, this group is seen as crucial in keeping the organisation together. They are regarded as the guardians of the working culture, and play an important role in the identification of new staff members who will uphold the hospital's values and ethics. Such assessments are made as part of formal appraisal procedures, and also play an important role during informal discussions about a candidate's behaviour and suitability for the organisation.

The importance of organisational reproduction is also reflected in the budget, as mentioned above. Some 11% of the operating budget is reserved for in-house teaching and further training elsewhere. This is combined with an incentive package for staff, which allows for career development and personal growth, guided by formal regulations such as the employment manual. Although Lacor has put in place a functioning system to allow for organisational reproduction, the Ebola crisis, as well as the attractive labour market for qualified medical staff have meant that it has had to continuously nurture and refine this system. Getting the 'right' people into crucial positions, and retaining them, will remain key challenges in the future.

Internalisation of values

According to all respondents, one of the Cortis' biggest achievements was to establish a set of values that still determines the thinking and attitudes of hospital staff. Meanwhile, the organisation has managed to create a certain capability to transfer values to the next generation, and to internalise them into its day-

Notes

³¹ According to one observer, in the past five years this downward trend has been reversed in most Catholic hospitals in Uganda.

to-day operations. Not surprisingly, this internalisation process is piecemeal, unstructured and primarily done on-the-job, through leading by example (commitment to work) and as part of regular staff meetings. It is supported by an elaborate and clearly defined incentive package, and a management approach that aims to share responsibility and, to the extent possible, to involve staff at all levels - an approach that follows the subsidiarity teaching of the Catholic church. Whether the organisation has the capacities to sustain this internalisation of values remains to be seen. But staff members recognise their crucial role in ensuring the future of the organisation and see the transfer of values to the new generation as their biggest challenge.

Self-assessment and self-regulation

While the organisation has to account for funds from funding agencies or the government, no external authority or agency has forced upon it a particular process or project. Strategic and operational decisions are taken within the organisation based on its own insights and patients' demands. This process of taking responsibility for its own destiny has also led to the creation of a fairly coherent culture of self-assessment and self-regulation.

At the institutional level, the management and the board have both shown their capability to take the initiative, to monitor progress, and to take difficult decisions as and when necessary.³² At the individual and group levels, there are signs that a culture of problem identification and self-regulation has been developed and internalised. This is explained through shared responsibility for all aspects of the organisation (subsidiarity principle) and has resulted in ownership, commitment and dedication - such as the 'patient first' attitude. This self-regulatory process is complemented by a set of control systems, although the focus on the individual or group dealing with problems, with systems coming into play only if needed.

Networking and intelligence

Finally, over the years the hospital has developed two closely linked capabilities - networking and intelligence - that have been essential for its successful adaptation to changing governments and substantial health reforms.

The organisation's capability to network and to link up with national government, stakeholders and external funding agencies have been essential for its survival. Local channels provided Dr Corti access to promising young doctors from the region. With the outbreak of civil war in the mid-1980s, the increasing demand for medical services meant that the hospital had to establish a wide network of contacts with funding agencies to meet its financial needs. Intense external networking to raise funds remains a principal task of management.³³ This networking approach was elaborated during policy exchanges between the UCMB and other non-for-profit health providers and the Ministry of Health in the 1990s. A major outcome of this process was the recognition of the former missionary hospitals as essential players in the Ugandan health system. In addition, the workshops of 2002 and 2003 provided important forums for networking and strategic exchanges with stakeholders.

Second, the hospital has developed the capability to register, analyse and absorb the 'changing waves of time'. 'Keeping the antennas open' was essential prior to and during the introduction of the health reform of the Museveni government in the 1990s when the late Dr Lukwiya gathered 'policy intelligence' on behalf of the hospital.³⁴ Today, the former approach of openness and information gathering is still followed and staff members have many opportunities to exchange and interact with government and non-governmental actors in the health system.

Notes

- ³² The management has often demonstrated its ability to react and to take strategic decisions. After the 2002 workshop, however, the board took over this role, and acted on behalf of the institution on substantive matters such as staff lay-offs.
- ³³ Good networking capabilities have been developed for contacts inside Uganda. For fundraising, however, management and the board are aware that special efforts are needed to ensure that local staff are more knowledgeable and experienced to interact successfully with donors.
- ³⁴ Respondents indicate that it was Dr Lukwiya's individual brilliance, combined with his Ugandan educational background, that allowed him to recognise the signs of change far ahead of other management members. His views on the role of the former missionary hospitals in the Ugandan health system were strongly supported when the present director arrived.

8 Performance

The Lacor Hospital accepts a workload that is beyond expectations. At the same time, it is highly effective and efficient, despite a short period of decreased efficiency during the Ebola crisis in 2000. This section examines the factors that drive the hospital's overall performance, and offers some reflections on the internal factors that may explain its resilience.

1. Overall performance

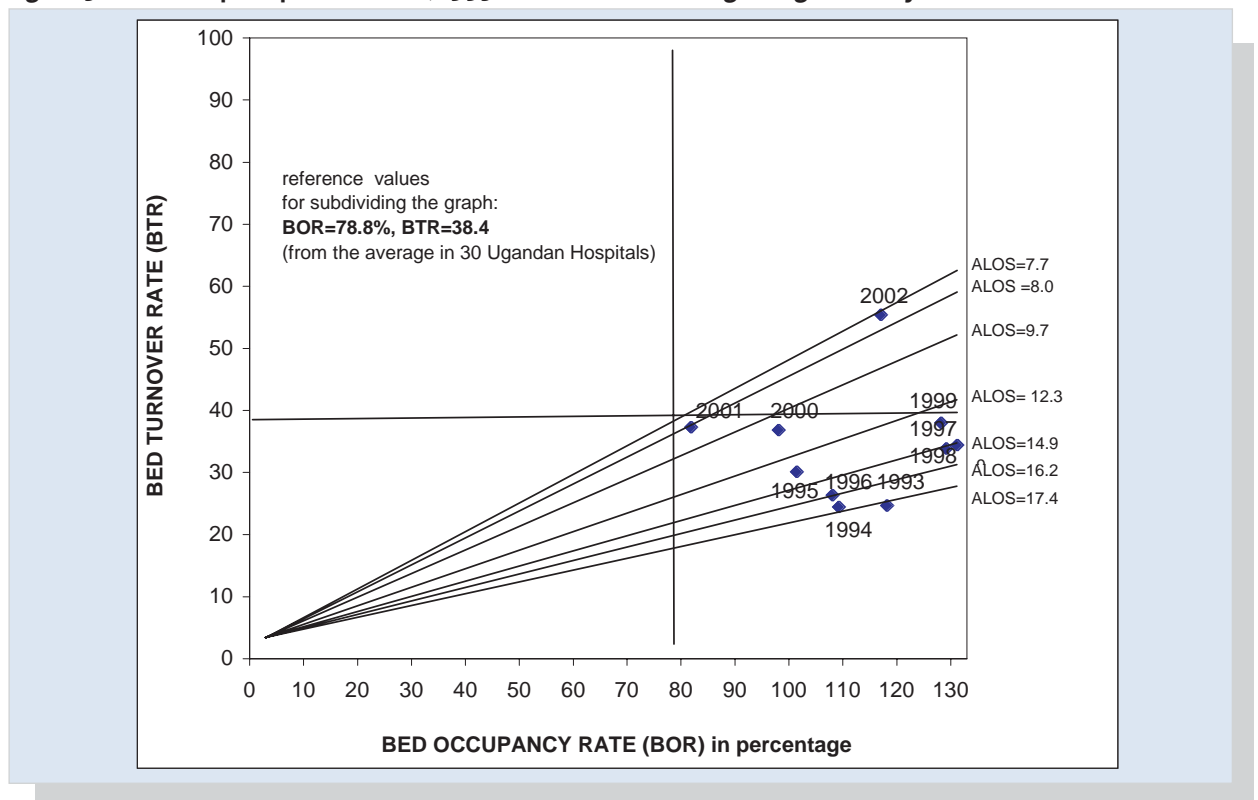
Statistics show that the hospital's performance has been above average since 1997 (see Figure 3), and that the fatality rates for selected diseases have fallen (see Figure 2). In comparison with other PNFP health providers in Uganda, Lacor scores above average on indicators such as the number of patients admitted or outpatient contacts, while user fees are a third lower than

the national average. Overall expenditures per unit of output have been also lower than average (figures compiled by UCMB, in St Mary's Hospital, 2002). Because of the increased expenditures on additional staff and materials during the Ebola crisis, staff productivity fell sharply in 2000, but has started to increase and move beyond the sector average after cost-saving measures were initiated in 2002 (Murru *et al.*, 2003).

The hospital's good performance was also recognised in a joint report of the Ministry of Health and KPMG (1998), which analysed the role, structure and management of regional referral hospitals. The report concluded that four NGO hospitals, including Lacor, were better qualified to become referral hospitals than government hospitals.³⁵

The evidence of Lacor's contribution to the overall development of the Ugandan health system and its

Figure 3. Lacor Hospital performance, 1993-2002. ALOS = average length of stay.



Source: Accorsi *et al.* (2002).

Notes

³⁵ This recommendation was not implemented. First, it was not acceptable to the Ministry of Health, whose policy stipulates that referral hospitals must be government owned. Second, two of the hospitals - one of them Lacor - were not eager to take on this role. Lacor argued that a referral hospital already existed nearby, and that it sees itself as a health provider whose functions complement those of government health services.

role as a facilitator of change is primarily anecdotal. According to respondents, the hospital played a leading role in the policy dialogue process in the 1990s, and introduced standards and procedures (in an employment manual) that have since been adopted by other PNFP health providers. The recent workshops held at Lacor are seen as a model for other hospitals in Uganda by the UCMB. Last, but not least, a substantial number of doctors and other medical staff trained at Lacor have been integrated into other government health institutions after leaving the hospital.

Another indicator of performance is the hospital's capability to adapt to cope with the Ebola crisis and its resilience thereafter. Ebola was more than just an epidemic - it attacked the core of the organisation and threatened to destroy what had been built up over many years. The shock of losing nearly 3% of its staff, including experienced senior nurses and the designated future leader of the hospital within a few months was severe. After the crisis, there was a danger of a split between the 'heroes' (about 100 staff who volunteered to deal with the epidemic) and 'non-heroes', but through careful management the organisation recovered and regained its momentum.³⁶ The staff were willing to continue and to take up the legacy - indeed, the epidemic mobilised resources and energies that no one had thought possible. There were no resignations, and younger staff members took over from their deceased colleagues.³⁷

2. Drivers of performance

What makes this organisation tick and perform despite the many difficulties and setbacks? Referring back to the issues discussed in previous sections, the following five ingredients emerge after a first analysis.

Pragmatic leadership

The demand-led approach required the management to be entrepreneurial and pragmatic. Dr Piero Corti brought these attitudes to the organisation and led the way in their implementation. Examples of this pragmatism today are its growing institutionalisation, its integration into the national health system, and its ability to take tough strategic decisions in order to remain competitive. Similar to thousands of other analyses of successful organisational development, this case shows that exemplary and extraordinary leadership is a key ingredient. The organisation created space to nurture such leadership and to let new members of

management or the board take decisions. But there is more to successful organisational performance than leadership.

Institutional culture and value system

Within the hospital, different capabilities needed to be developed, adjusted and harmonised over a long period. Respondents repeatedly referred to the hospital's inner value system, which originated in the moral values of Dr Lucille Teasdale, based on Catholic humanism and embedded in a Catholic environment. Based on this value system Lacor is clearly an institution that is capable of setting its own standards, working norms and ethics. It has contributed not only to the welfare of the local population, but also to the enhancement of health services and standards throughout Uganda. This institutional culture also comprises the willingness to work hard, and even very hard, whenever required.

Guiding principles rather than explicit strategies

The hospital's capabilities evolved over time, but are derived from the principle set by Dr Corti: to offer the best service possible to the largest number of people at the lowest possible cost. The beauty of this principle was that individuals with different humanitarian, religious and professional motivations could be teamed up and melded into a whole. In addition, the Cortis' life-long commitment, based on a humanitarian/Christian vision, and their investment in individuals, clearly helped to provide a fertile environment for the development of these capabilities.

Although some implicit strategies emerged that can be traced back to the early days, neither the management nor the board has ever attempted to define or to formulate them explicitly. Obviously, there was no need for them in the past.³⁸ There was a well-conceived image of the organisation, which the Cortis, and in particular Dr Piero Corti, wanted to see emerge, but there was no clear sense of how they wanted to get there.³⁹ But there were windows of opportunity that

Notes

- ³⁶ The volunteers received no reward in terms of financial compensation or promotion, and all staff were treated equally afterwards.
- ³⁷ This was a difficult decision for some, since they did not feel qualified enough to take over jobs with greater responsibility. But, as one respondent said, '... the victims carried the cross for us, and we wanted to do something backing return, since they had died on our behalf'.
- ³⁸ With the growing institutionalisation, however, the board is considering setting out a strategy, based on internal discussions, to orientate the organisation in the future.
- ³⁹ This was indirectly confirmed by the Cortis' daughter, who stated that 'the hospital probably became much more than what my father had expected'.

were successfully explored and made use of, such as the integration of promising individuals into the organisation, or the participation in discussions on health reform that led to the hospital's integration in the health system.

Medical professionalism and legitimacy

At the core of the hospital's functioning are its outstanding medical services and its ability to reproduce professional and personal skills that are in great demand in the region. The growing numbers of patients and their preference to visit Lacor rather than other health services serve as indications. Professionalism is enhanced with an incentive package that staff can rely on, and is encouraged through the principle of subsidiarity, which attributes responsibility throughout the organisation. As a result, Lacor has developed into a national and regional centre of excellence.

The outstanding professional performance has created a form of legitimacy that neither Idi Amin's dictatorship, nor the Lord's Resistance Army have been able to ignore or destroy. In the late 1980s the new Museveni government recognised Lacor as a key institution in the future reform of the national health system. This powerful legitimacy has helped to knit the members of the organisation together, to reinforce the organisational identity around a common purpose, to shape awareness that the hospitals' good name can not be out-competed by others, and to reproduce the complex capabilities explained above.

Commitment

Another driver of performance has been the commitment of staff and board members to contribute to the success of the hospital. Staff members are loyal to the organisation and stay for many years. An ownership has developed, although this was seriously tested after the Ebola crisis. During interviews, staff and board members commented that their motivation stems from their desire to help their own Acholi people.

The informal contacts, group dynamics and private interactions among actors play important roles in shaping this commitment. During the time of the Cortis, the organisation was very informal. Medical and management issues were discussed over tea in the evening, while the board basically existed on paper

and played no role in guiding the organisation. This has clearly changed, but the informality has remained an important pattern for the new generation of management. Functioning in a difficult environment under continuous stress and with few opportunities for distraction and leisure activities, a closely knit team has formed and is fighting the challenges of the day.

'Tacit learning' as the underpinning factor explaining capacity?

Has a particular learning style emerged over the years that contributed to this repeating pattern of resilience, adaptation and high performance? As noted in section 6, the hospital's implicit strategy to become a learning organisation has been an important factor, yet there seems to be something more deeply rooted that advances the organisation. We won't call it organisational learning, since this general term is often associated with an intended process, initiated by management or key members of an organisation. Rather, we would call it 'implicit', or as organisation science calls it, '*tacit learning*' (Nonaka and Takeuchi, 1995), to describe the non-codifiable knowledge, or 'silent' embedded information that underlies what people actually do. In an organisation it can be transferred through observation and practice, learning by doing, or through social interaction between tacit and explicit knowledge.⁴⁰ Some religious observers might interpret this as a divine gift. But the aim here is not to create a mystery, or to shape a legend, but to look more carefully at the processes that underlie the cause. It is difficult to grasp or define the process in which the different components are shaped into an overall capacity. But traces of this tacit learning - exchange, openness, self-assessment or reflections on values - are to be found everywhere. Numerous factors have contributed to make this tacit learning happen. Without providing an exhaustive list, one could mention the repeated 'emergence of dramatic events' from the outside that have forced the organisation to change and to respond. In a way, the hospital was driven forward by waves of change and staff members internalised the need to adapt to them.

Then there is the issue of '*space*', which has helped the learning process to emerge and lead to autonomy and legitimacy. The absence of other health providers in the region allowed for experimentation, trying out and learning-by-doing for those who were professionally curious and interested in developing their personal capacities.

Notes

⁴⁰ Although in the literature 'tacit learning' is usually associated with individual learning, it is used here to refer to a collective learning process. This observation is likely to be an issue for discussion since it can not be substantiated by the findings of the study. For further reading see Durrance (1988).

Last, but not least, the '*spirituality*' that provides the moral base needs to be mentioned. The presence of the Catholic church and the inputs it has provided to Lacor have shaped the spiritual frame from the earliest days. This frame was explicit but not dogmatic, and it helped to create a set of rules, regulations and a sense of security to endure difficult times. Within it, a community with a shared value system could emerge that facilitated exchange, collective learning and action.

9 Final comments

Without doubt, this case provides food for thought and discussion among Lacor's stakeholders, as well as within the wider policy community dealing with health and conflict prevention in destabilised environments. This section raises some issues and questions for discussion.

Issues for Lacor Hospital

This case study focused on the hospital's strengths, its achievements and the reasons for its above-average performance. Thus, there are reasons to assume that the hospital is different from other health providers in Uganda, as one board member commented. But both staff and board members are aware of the organisation's weaknesses, and the challenges it will face in the future. Performance is clearly above average, but considerable efforts need to be made to sustain it and to justify the expectations that are projected onto the institution.

First, building and reshaping the human resource base needs continuous attention. As identified during interviews, Lacor clearly needs to enhance local capacities for general management and administration, and in particular to understand the world of fundraising and working with development agencies. In order to maintain the current level of health service provision, supplementary funding from external agencies will be indispensable as long as the Ugandan economic situation remains poor and the government is unable to increase the subsidies to health providers.

Second, the board needs to be more involved in monitoring and co-directing the direction of Lacor. If the

financial situation does not improve, some key issues will need to be addressed, including the extent to which the hospital can maintain its 'pro-poor' orientation (increased user fees?), and its ability to respond to emerging problems and to function as a substitute for the national health system (can Lacor continue to offer such a broad range of services?). In addition, its future role in the national health system needs to be clarified in view of the growing competition from other health providers in the region.

Third, there is the challenge of continuing to integrate the institutional culture and values into more formal systems of management and operation, even though this might threaten to regulate, bureaucratise and stifle individual initiative. The issue is thus to provide space for a continuation of the basic values but with modifications where needed to suit changing circumstances. At this stage, individual staff members do pass on their acquired knowledge and attitudes to new arrivals, but the organisation has not yet addressed the issue of 'values' from an institutional perspective. There is a risk that the younger generation may lose awareness of the origin of the organisation and adopt attitudes that are not conducive to the future excellent functioning of the hospital.⁴¹

While these big questions need to be addressed, there are sufficient signs that the hospital is able to respond to crises and to mobilise resources that no one had expected, as the Ebola tragedy showed. Obviously, the epidemic helped to strengthen the organisation in terms of confidence and self-esteem. To quote one young doctor: 'We realised that we had been fighting on the front line. Our pride came back since we had won the battle. We realised that we had done what no other hospital in the world had done before. We then knew that if we can handle Ebola, we can handle other crises as well'.

It is now up to the board, the UCMB and the Ministry of Health to build on this enhanced confidence as expressed by hospital staff, and to make sure that managerial experience and maturity are developed to ensure that the younger generation will also be able to look at the broader picture from a systemic perspective, and be ready to fully take over in the future.

Notes

⁴¹ The staff members interviewed for this study assessed it as a very positive exercise and proposed to expand it to involve more hospital staff. This was discussed after the strategic workshop in 2004 and resulted in a plan to explore the value system, and to encourage wider learning and awareness in 2004-5. This plan will be implemented by the staff and students of Nkozi University.

Issues for the government and funding agencies

This case looked at an organisation located in a volatile and conflict ridden environment from the viewpoints of change, capacity and performance. The research explicitly refrained from examining the impacts of national health policies, such as a focus on preventive health care, the role of a hospital in an unstable environment, and the consequences of the unplanned development of a medical facility in a remote region for the sector as a whole, etc. Had the hospital been dependent on a well-planned and structured national health policy, it probably would not have been situated in remote northern Uganda.⁴² But it was this very absence of regulatory structures, combined with the availability of 'space' that allowed the organisation to develop its capacity and to perform. The isolation, in turn, encouraged its excellence. This is an achievement from which the entire Ugandan health sector has benefited.

The case also provides for discussions on another intensely debated policy issue: the use of technical assistance (TA) for strategic gap filling. Lacor shows that the use of TA can benefit an organisation as long as decisions on resource use are based on a wider plan or (implicit) strategy formulated by the leadership. It also shows how some funding agencies played a supportive role in buffering the hospital from the vicissitudes of the local environment without dominating the decisions.

Finally, this paper provides a number of entry points for discussions on policies to support fragile regions. While some might argue that this structure is too heavy, or too costly for the Ugandan health system, the author believes that this case highlights the strategic importance of a niche activity like Lacor in conflict prevention. Clearly, the support to such activities should not undermine the common goals for a national health system. Lacor's leadership subscribes to this premise and accepts that the Ministry of Health can not finance more than 16% of Lacor's budget out of the health basket funding provided by various external agencies. But being situated at the front line of efforts to combat misery, despair and terrorism, it has the potential to help in bringing peace to an unstable region. Ultimately, support to such projects might turn out to be far cheaper and perhaps more effective than

sending national or international military personnel to deal with conflicts.

Moreover, a niche activity such as Lacor can serve as a beacon of hope in an otherwise devastated area. As the analysis of the economic impact of Lacor on the region has shown, it contributes to economic activity in its surrounding environment. Besides, the hospital has had an impact on public health - such as the stabilisation of HIV/AIDS - and provides a small, though important mechanism to feed into the achievement of the Millennium Development Goals in a region where few other organisations have effective access.

In light of these issues, one may question to what extent the IMF can justify its adherence to a stringent ceiling on funding for a sector as important as health. Although the policy itself might be beneficial to the country, it risks bypassing the flexibility needed to deal with issues of key importance to conflict prevention. Rather than limiting the funds that can flow into a particular sector, and the national economy as a whole, the discussion should focus on to what extent some flexibility could be deployed in terms of going beyond the stringent caps set by the IMF and the government for the health sector, without shifting funds from other national budget lines. Additional funding for activities of strategic interest could help to prevent the further deterioration of districts such as Gulu, which could in turn precipitate the economic and social decline of the country as a whole.

While this case provokes reflection, it has no ambition to provide answers to all of the complex issues raised. Clearly, more knowledge, exchange and learning are needed and should be incorporated into the agenda of the policy community.

Notes

⁴² This is of course speculative. But given the scarcity of resources in Uganda, one would expect that a health facility of this size and sophistication would be located in a more densely populated area where it could function as a referral hospital for lower level health facilities.

Epilogue

While the author was finalising the text of this report, the government of Uganda made an announcement that could seriously affect the functioning of all PNFP health providers in Uganda, including the Lacor Hospital. In the annual budget presented to parliament in early June 2004, the health budget includes an expected 25% salary increase for health civil servants,⁴³ but without increasing budget allocations to the PNFP health providers. In addition, the government will continue to recruit health workers as planned.

A position paper prepared by the three Ugandan PNFP medical bureaux for the Health Sector Working Group (26 April 2004) outlined a worst-case scenario that is now likely to materialise:

- Substantial increases in government salaries without compensating the PNFP health providers will most likely cause a major outflow of qualified staff from them to the national health service.
- Almost 30% of health services in Uganda are provided by PNFP health providers. If they try to counter this development by increasing user fees, this will have significant negative effects on the pro-poor policy of the country.
- Since the Ministry of Health established the public-private policy health desk in 1997/98 the development of the public-private partnership for health between the Ministry and the PNFP health providers and their bureaux had been promising. The credibility of the partnership is now seriously threatened. The Ministry announced the planned salary increases through the media and not through established partnership structures. Also, the budget was prepared without consultations with the bureaux, despite their repeated efforts to be heard.

For the Lacor Hospital, located in one of the poorest parts of the country, there is very little potential to increase user fees to a level that could compensate for these adverse plans. The population of this already heavily deprived region will suffer more, whether through increased user fees, the provision of fewer (less well qualified) services, or - as the worst-case scenario suggests - the closure of service units. Ironically,

organisations like Lacor, which have managed to survive war, epidemics and death, risk being crippled through an ill-considered budget decision.

This story also carries a message to the international development community. In recent years, development partners have increasingly entrusted their funding for social services to the Ugandan government at the expense of direct project support to selected institutions. In view of this obvious case of a breakdown in the dialogue on public-private partnerships, which is an essential element of SWAPs or other poverty-focused budget support mechanisms, the fragility of these concepts has become transparent. Questions that immediately arise include whether the development partners have any contingency plans in case things turn sour? How will they deal with governments that do not fully engage non-state actors in the development process, despite international commitments such as the EU-ACP Partnership Agreement,⁴⁴ to which the Ugandan government is a signatory? Finally, NGOs in Uganda will have to evaluate whether their strategies in terms of collaboration, coalition building and devising strategies to ensure their access to the policy dialogue have been sufficiently targeted and elaborate enough.

Notes

⁴³ Based on the limited information provided by the Ministry of Health so far, the PNFP medical bureaux are assuming an increase of a minimum of 25%. In fact, it could be more than this. The bureaux are the Ugandan Catholic Medical Bureau (UCMB), the Ugandan Protestant Medical Bureau (UPMB) and the Ugandan Muslim Medical Bureau (UMMB).

⁴⁴ For a summary of the Partnership Agreement between the European Union and African, Caribbean and Pacific countries, see the *Cotonou InfoKit*, ECDPM, January 2001 (www.ecdpm.org).

Annex I: Fact sheet Lacor Hospital

Overview of services, output, staffing, fees and social relevance, compiled by the management of Lacor Hospital (July 2003).

St Mary's Hospital Lacor is a complex including three main sections:

Hospital	Training	Peripheral health centres of Pabo and Opit
<ul style="list-style-type: none"> - Hospital diagnostic and curative services - Primary health care activities 	<ul style="list-style-type: none"> - Enrolled nurses - Registered nurses - Comprehensive nurses (as of Nov. 2003) - Laboratory assistants - Anaesthetic assistants (rotations from Gulu RR Hospital) - Internship medical doctors - Radiography (rotations from Mulago Hospital) - Postgraduate students (rotations from Mbarara University) - Postgraduate students of Uganda Martyrs' University (operational research) 	<ul style="list-style-type: none"> - Basic diagnostic and curative services - Primary health care activities

Range of services

The hospital has 474 beds, as follows:

General medicine	85	Obstetrics & gynaecology	65
TB ward	30	Surgery 1	62
General paediatric	106	Surgery 2	63
Isolation	20	ICU	6
Nutrition	40	Total	474

Clinical and support services

Emergency room (round the clock)
 Adult outpatients (6 days a week)
 Under-fives clinic (7 days a week)
 Antenatal clinic (5 days a week)
 Prevention HIV vertical transmission
 AIDS clinic (twice a week)
 Surgical clinic (twice a week)
 Obst. and gyn. clinic (daily)
 Dental clinic (6 days a week)
 Oral surgery
 VVF surgery
 Clinical laboratory, serology, blood bank, microbiology
 Anaesthesia and ICU
 X-ray, ultrasound, contrast radiology
 Endoscopy, bronchoscopy
 Physiotherapy
 Pharmacy and production of IV fluids
 Refrigerated mortuary

Outreach clinics
 Community-based health care programme
 School health
 Vaccinations in the static units and by mobile teams
 Health education
 Voluntary testing for HIV
 Surveillance site for HIV
 Counselling
 Medical records
 Documentation and research unit
 Automated laundry
 Tailoring
 Incinerator
 Treatment plant for waste water
 Technical workshop
 Construction unit
 Transport unit
 Power house

Service output (financial year ended 30 June 2003)

Patients admitted

Hospital	28,925	
Health centres	2,626	
Total		31,551

Outpatient contacts

Hospital	173,226	
Health centres	40,282	
Total		213,508

Total in- and outpatient contacts **245,059**

Selected services

Major operations	3,626	Deliveries	1,625
X-ray and ultrasound exams	34,512	Caesarean sections	249
Laboratory exam.	208,412	Dental treatments	4,285

Students who qualified in the year ended 30 June 2003

Intern doctors	6
Nurses	60
Laboratory assistants	9
Total	75

Vulnerable groups

Out of the total attendance of the hospital and health centres, 52% are children below 6 years, and about 82% are children and women.

Hospital fees (as of May 2002)

More than 80% of the fees charged by Lacor are subsidised. In the current financial year user fees should not exceed 17% of the hospital's total costs. In order to improve access, the hospital charges flat rate fees, which include investigations and drugs, and there is no time limit on bed occupancy. Further, as a way to encourage people to use lower-level health units, the health centres supported by Lacor charge even lower fees, with only token charges for treatment for children and pregnant mothers.

Staff level (June 2003, including expatriate staff)

Doctors	31
Nurses and paramedics	195
Support staff	316
Total	542

Social relevance

Lacor offers a wide range of health services for the local population at affordable, subsidised prices. The constant flow of patients and the reports of social researchers confirm that these services are needed and appreciated. The hospital carries out or promotes research on clinical as well as on the managerial aspects of health care delivery, thus contributing to the development of the health system as a whole. It offers a variety of training programmes, which contribute to solving the problem of the shortage of qualified human resources in the health sector, and enable young local people to gain professional qualifications. The hospital employs a large number of staff and, through their local purchases, injects a sizeable amount of money into the economy of one of the most disadvantaged areas of the country. It also channels significant foreign financial resources into the area, which would otherwise not reach Gulu, since they originate from private donors. In sum, these activities contribute to social stability, development and poverty alleviation in a region that has for long time suffered the consequences of insecurity and has therefore only marginally benefited from the general economic growth of the country.

Annex II: Individuals interviewed

Rev. Sister Grace Abeja, Radiographer, X-Ray Department, Lacor Hospital, Gulu
 Sr Angioletta Apio Anyai, Head of Paediatric Ward, Lacor Hospital, Gulu
 Dr Bruno Corrado, Director, Lacor Hospital, Gulu
 Dr Dominique Corti, President Corti Foundation, Milan
 Brother Elio Croce, Head of Technical Services, Lacor Hospital, Gulu
 Dr Isaac Alidria Ezati, Surgeon, Mulago Hospital, Kampala
 Justice Galdino Okello, Judge of the Court of Appeal of Uganda, Kampala, and board member of Lacor Hospital
 Dr Daniele Giusti, Executive Secretary, Uganda Catholic Medical Bureau, Kampala
 Sr Among Millie, Senior Nursing Officer, Lacor Hospital, Gulu
 Mr Pier Paul Ocaya, Hospital Secretary Lacor/ Diocesan Health Coordinator Gulu
 Rt Rev. John Baptist Odama, Archbishop of Gulu, and Board Chairman, Lacor Hospital (brief encounter only)
 Dr Emintone Ayella Odong, Deputy Medical Superintendent, Lacor Hospital
 Dr Cyprian Opira, Deputy Director, Lacor Hospital
 Mr V. Opio Lukone, Permanent Secretary to Cabinet, Office of the President, and Board Member Lacor Hospital
 Dr Martin Ogwang, Medical Superintendent, Lacor Hospital
 Mr Cesareo Omona, Gatekeeper, Lacor Hospital

Annex III: The Board of Lacor Hospital

Composition

Chair, Archbishop of Gulu

Senior members (in their personal capacity)

- Permanent Secretary to the Cabinet, Kampala
- Judge of the Court of Appeal of Uganda, Kampala
- A Comboni Missionary and former Lacor Hospital Administrator, now retired
- Diocesan health coordinator
- A representative of the Corti Foundation (Italy)
- A representative of the Italian Cooperation
- Deputy Medical Superintendent
- Head of Administration

Executive members

- Director
- Deputy Director
- Medical Superintendent
- Deputy Medical Superintendent
- Head of Administration

Legally, the Lacor Hospital is a private organisation; Ugandan law does not require a member of government to sit on the board. Formally, the chair of the board appoints new members; new members are included by co-option.

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The results of the study, interim reports and an elaborated methodology can be consulted at www.capacity.org or www.ecdpm.org. For further information, please contact Ms Heather Baser (hb@ecdpm.org).

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