

<b>MISCELLANEOUS TOPICS</b>
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## **WHAT DO THESE NUNS WANT IN OUR HOSPITAL? HOW STAKEHOLDERS PERCEIVE RELIGIOUS SISTERS IN UGANDA**

*Sr. Dr. Najjuka Justina Liliana Lucy Geraldine, General Surgeon, Nsambya Hospital*

### **Abstract**

*The Church in general claims a role in the provision of health care, being to continue the healing mission of Christ. However, the role of religious congregations in that mission has not been investigated in Uganda. Many congregations of religious women work in the health sector in various responsibilities. The study investigates the perceptions of the stakeholders of Catholic hospitals about Sisters working in their hospitals and the perceptions of the Sisters themselves. It also investigates the managerial practices in this important health sub-sector in Uganda. It finds that the stakeholders expect a lot from the Sisters, ranging from clinical provision of care to praying for the patients. Sisters engage in a number of activities in the hospitals and have wide-ranging powers. A number of basic managerial requirements like terms of reference on appointment and inclusion on the organisational structure are not implemented thus breeding potential conflict in the hospitals. The Sisters are not involved much in the spiritual life of the patients. The ownership of the hospitals is also not clarified, thus leading to further misunderstanding of the roles of the Sisters. It is recommended that the stakeholders hold regular joint meetings to define the hospital structures and to review their performance, as well as improving managerial procedures like recruitment and posting of staff, and increasing the Sisters' participation in the spiritual care of the patients.*

### **Introduction**

Congregations of religious women play a big role in health care in Uganda. They work in many health units of varying levels throughout the country and in various positions of service and responsibility. According to the 2003 report of the Health Commission (HC) of the Uganda Catholic Episcopal Conference (UEC), 107 (45.7%) of the 234 health units run by the Catholic church in Uganda have Religious Sisters on the staff. Of these, 28 health units are even declared "owned" by religious congregations. Out of the many congregations of religious women in Uganda, 21 have 340 members working in health units founded by the church. They work as nurses, doctors, administrators, community health nurses and tutors in training schools. Some work in other responsibilities like estates management, catering services and all social aspects of health institutions.

In the large part, this presence of religious personnel in health units started with expatriate missionaries. In many places, the trend was that the Catholic priests would establish a parish and invite religious Sisters who would establish health services and schools. In Ghana, the Catholic Church started the provision of health care as far back as 1828. In Uganda, the first religious missionary health units were founded by protestant missionaries in the late 1800s. Mengo Hospital, the first hospital in Uganda, was founded in 1897 by CMS missionaries, soon followed by Nsambya Hospital in 1903 by the Irish missionary Sisters (Louis, 1964).

However, even after the departure of the missionaries, Dioceses have continued to undertake the establishment of new health units and bishops have often

called upon a local religious congregation to work in the units, probably to establish or to maintain an obvious Catholic identity. After all, although not all congregations oblige them, congregations of Catholic religious women are the only denominational group in Uganda that wears an external identity of their religion on a permanent basis. Currently, the Sisters run quite a number of diocesan health units on behalf of the Dioceses under a loose agreement, the *Modus Operandi* of the Health Commission of the Episcopal Conference (UEC, 2003). The collaboration between the Local Church (Dioceses) and Religious Congregations in the healing ministry in Uganda is deeply rooted in the tradition of the Universal Church and of the Catholic Church in Uganda.

In church tradition, missionary Sisters usually founded hospitals and other health facilities. Thus, the religious charism and the missions of the hospitals found common ground in the same fundamental Mission: that the sick "may have life and have it to the full". This is emphasised in the mission statement of all Catholic founded health institutions in Uganda (UEC, 1999). The Sisters play a part well as other stakeholders.

In general, the individuals or groups that have an interest in and are affected by the goals, operations and activities of the hospital or the behaviour of its members are diverse (Mullins, 2002). These may be the owners, the managers, the sources of finance, the patients and their relatives, the community around, and the government, among others. Any hospital is for its stakeholders and all activities should be designed to balance and meet the interests and expectations of the stakeholders. Among these stakeholders, some give to the hospital and others receive from the hospital. The Sisters fall largely under the former category, only that they give themselves in form of service than material assistance. Quite often, especially in the past, they have sought material assistance for the hospitals from abroad.

In the Ugandan context, the Uganda Catholic Medical Bureau (UCMB), the technical arm of the Health Commission, defines stakeholders of diocesan hospitals as the owners, Boards of Governors, the Management Teams which may contain managing organizations, the founders, the government, the staff (including the Sisters) and patients, (UEC, 2003a; UEC, 2003b)

The religious congregations and individual Sisters have largely been involved in provision of health care services often in accordance with the qualifications they hold. Once appointed, they work side by side with the lay personnel they find in the health units. The provi-

sion of qualified Sisters to hospitals by the religious congregations is therefore similar to government appointment of qualified personnel. If the Sisters are in hospitals just for the mere provision of medical services, then their roles are the same as everybody else. Some Sisters work in the health units as individuals and others as representatives of their congregations. However, the full range of roles played by the Sisters in the hospitals is not known or it is not always clear to every stakeholder. Therefore, we conducted this study to find out what they actually do and what the stakeholders think they do.

In the past, religious Sisters were mainly nurses and may be it is from this that the nursing profession got the title nursing 'Sister'. With the emerging challenges to healthcare service and a more liberal approach to the religious vocation, the Sisters have progressively expanded their competencies into other fields within healthcare and currently occupy different positions in health establishments.

With progressively better qualifications, the Sisters are involved and work in different departments within the hospitals, as medical superintendents, financial controllers, administrators, doctors, matrons, nurses, tutors, cateresses, providers of pastoral care, Chairpersons of Boards of Directors and many others as the need arises (Providence Health Care Society, 2003). Due to this, and due to their practices, various perceptions have been conceived about their role in health units, especially in the hospitals.

It has been noted in several forums that the health sector of the Catholic Church faces many major challenges. These include inadequate the attraction, recruitment and retention of professional and skilled staff and a functional organogram in the health units, that takes into account congregational/religious structures (GIMPA, 2003). Lack of a functional organogram leads to lack of clear communication lines, defined roles and responsibility of staff. Since the Sisters work in Catholic hospitals just like other staff this situation may affect them too. Other challenges that have been identified include the lack of Catholic values such as compassion, discipline, commitment and devotion, presence of unskilled personnel in managerial positions leading to increased workload on other staff and unusually very high expectations by the clients (GIMPA, 2003).

The work that the Sisters do is often the same as what other staff members do. One may wonder therefore whether there is anything exceptional about the Sisters or whether they are just like any other

employees of the hospitals and whether their presence is a liability or an asset to the hospitals. It is necessary to find out if the Sisters have any roles in the hospitals at all, and what the stakeholders think about them. If the Sisters have any special role in the hospitals, this role had not been documented though the Sisters were serving and some were even in positions of responsibility. With undefined roles, there may be a tendency of assuming the roles of other staff members.

### **Purpose of the study**

The study sought to fill a knowledge gap regarding the expectations that stakeholders have of Sisters who work in their hospitals. Such expectations shape their eventual perceptions of the Sisters and may be used a yardstick for perceptions of quality of care offered by the hospitals. Once known, it was hoped that these expectations and perceptions would help the relevant authorities to shape and define the roles of the Sisters and streamline the organograms of the Catholic health services in Uganda.

The study had three main objectives, which were: to find out the perceptions of the stakeholders of Catholic hospitals in Uganda regarding the Sisters who work in those hospitals; to find out the perceptions of the Sisters regarding their own work in Catholic hospitals; and to compare the perceptions of the stakeholders and those of the Sisters, with a view to looking for common grounds for strengthening and divergent grounds for redressing.

### **Catholic Church involvement in health**

The Catholic Church considers service to the sick as an integral part of its mission and assumes it as an expression of its ministry. The church has always seen medicine as an important support of its own mission. In fact, the Catholic bishops of Uganda state that "...service to man's spirit cannot be fully effective unless there is service to his psycho-physical unit as well...." (UEC, 2002; UEC, 2003a). Efforts of the church since Vatican II have evolved around promoting the integral welfare of a human being: body and soul, heart and mind, conscience and will (AMECEA, 1989). However, these have only been to reaffirm what was taking place long before the Council. For long, the missionary health workers had already put a lot of emphasis on curative services, maternal and child health care and much effort on building hospitals, maternities, dispensaries and aid posts (AMECEA, 1989).

### **Involvement of Sisters in health care**

Although in Africa the church in Ghana was involved in health care as early as 1828, probably the oldest recorded involvement in health care by religious sisters was in Alberta, Canada, in 1860 by the Grey Sisters. They started the convent dispensary of St. Bruno and are always remembered for their contribution during the influenza and typhoid outbreaks at the time. Since then, other congregations of religious women have been involved, both missionary and local.

Anthony Joseph Cardinal Bevilacqua, the former Archbishop of Philadelphia, reaffirmed the role played by religious Sisters in health care saying "The Catholic health care apostolate throughout the world has been shaped and advanced largely by religious congregations and Sisters. These dedicated religious, inspired by the charism of their founders, developed ministries of healing and service for the vulnerable, sick, orphaned, widowed and poor in society. Their legacy continues to be a living expression of God's love and mercy in our world carried on from generation to generation in the religious vocation" (Bevilacqua, 2000).

### **Perception formation**

It is said that individuals form perceptions about any organization by looking at the organization. They form an implicit psychological contract with it and then decide whether they should trust the organization. Perceptions about the performance of the organization depend on its human resource policies, which reflect the attitudes of its top management (Sharkie, 2004). For missionary organisations, especially hospitals, the formation of the contract involved the physical visualization of missionaries in the health units. With time, however, due to a number of factors, the numbers of missionaries reduced. Such factors included the maturing of the local church, which was capable of producing its own local evangelizers and the reduction in recruitment of missionaries in the home countries. This led to an evolution in missionary health care services resulting into what we see today: local religious Sisters working in the hospitals. Their numbers not being adequate to manage the workload, more and more lay people have over time, joined the medical profession and thus they currently work side by side with religious people. This transition to local management and provision of health care services was, however, complicated by the continued involvement of religious orders and their founders in the building and running of the hospitals. Initially, the missionaries

retreated from the wards to the management, eventually quitting the hospitals altogether. At times, this involvement created a tension between the spiritual orientation of the hospitals and the secular nature of modern medicine. The Sisters were seen as reverent, self-sacrificing and working for the good of society. This general perception resulted even in a reluctance to allow lawsuits against hospitals even when ordinarily culpable offences were committed in the hospitals. The public viewed such proceedings as being against the self-sacrificing Sisters who ran the hospitals - until recently.

In the past, only men were considered physicians while all women (including Sisters) on the hospital personnel were considered nurses irrespective of their true qualifications (Richards, 1995). Many people never imagined females (or worse still Sisters) becoming doctors or midwives. This social construct was not restricted to African thinking only. Mother Kevin O.S.F had to ask for special permission from the Catholic Bishop to allow her and her Sisters train and conduct child deliveries (Louis, 1964). However, this has now changed and the Sisters have not only become doctors but have widened their vision to all fields of health.

There is a commonly held perception that women's motivation and attitudes to work are different from men's. Beliefs about women and their roles tend to focus more outside their work place. Studies have shown that because most of the time women marry and have children some people question their being employed as permanent staff (Mullins, 2002). Others question the importance of investing in their training and their ambition for senior positions. Those women who made it to top posts in the recent past had social pressure concerning their obvious visibility and uniqueness. The religious Sisters, as women, have not escaped some of these views about them from some stakeholders.

### **The challenges of running a modern hospital to the religious**

A religious establishment running modern health care services is faced with a number of challenges. These are ethical, economic and social. Ethical challenges include end-of-life decisions like euthanasia and termination of pregnancy, family planning, equitable provision of care and others. Economic challenges include the introduction of user-fees and sustainability of the services, while social challenges include gender balance at work. Modern health care also provides the challenge of integrating the principles of business

management with the work of the gospel. "Recent trends in health care have given rise to particular concerns for the future of faith-based care givers. This great work of the church is at risk in the face of the current ethical, economic and social challenges (ethical, economic, and social) facing Catholic health care" (Bevilacqua, 2000). Thus, the Sisters have a duty to their religious profession and beliefs as well as to their ordinary hospital work.

Hospital stakeholders and determinants of success In general, hospital stakeholders include patients, staff, donors or shareholders, volunteers, board of directors and the outside stakeholders i.e. politicians and the media (Kay, 2003). For Ugandan Catholic-founded hospitals, the UCMB defines their stakeholders as the Owners, the Governance (BOG) and the Management team - which may contain a managing organization, (UCMB, 2003a; UCMB, 2003b). The other stakeholders include the Founders, Donors, Government, the Managing Organization, staff and patients. (For Ugandan Catholic-founded hospitals, to qualify as a managing organization, the occupants of these four key positions in the hospital must be members of the congregation: the Medical director, the Administrative director, the financial director and the Principal Nursing Officer). The success of the hospital depends on the roles played by each of its stakeholders.

Apart from the involvement of the stakeholders, the success of a hospital typically requires a number of other factors. Its mission needs to be well communicated, believed in, consistent through all its communications vehicles, including general and targeted advertisements, public relations, all printed and electronic information, the signs over the entrance, the look of the lobby and even the way receptionists answer the hospital telephone and staff receive patients (Kay, 2003). All these should reflect the hospitals' mission built on solid foundation and promoted by all its stakeholders.

### **Organizational structure and identity of Catholic Hospitals**

The Uganda Catholic hospital organization structure in which the religious Sisters work is based on the one recommended in the Catholic Hospitals' Charter (UCMB, 2003a) and UCMB Bulletin June (UCMB, 2003c). However, although the Managing Organization concept has been around for long, the latter organogram is conspicuously silent about this organ and its position. In practice therefore, the religious Sisters work at any level provided they meet the requirements and have academic qualifications.

Missionary organizations are held together by the standardization of their norms i.e. the sharing of beliefs and values among their members. Because of this, the members simply act in accordance with the perceived beliefs. There is a tendency of having no formal rules and regulations, not much planning or formal control, and so hardly any technical structure or hierarchy of authority. Professional skills may be discouraged in the missionary organization or may be seen as incompatible with the missionary ideology of simplicity and no competition (Mintzberg, 1981). The organization usually prefers to remain small so as not to lose personal contact and influence on stakeholders. The presence of the Sisters working in the Catholic hospitals brings in yet another factor peculiar to these hospitals namely, the religious spiritual beliefs. Thus the religious and technical work, run side by side. It is a common finding to see symbolisms evidence of Catholicism in the wards like pictures, rosaries and blessed water. This coupled with attendance of daily prayer services, beginning the day's activities with prayer and presence of Catholic priests bear witness to religious affiliation of the hospitals.

While closing 'the International conference on Catholic Health Care in Africa' (AMECEA, 2003), the Bishops once more reaffirmed the healing ministry as part and parcel of the overall Mission of the church and those involved in the service were encouraged to pursue professionalism in health care delivery, transparency and partnership with other stakeholders. Elsewhere, a similar message has been declared. "I acknowledge the efforts of all the religious congregations/Sisters operating health care facilities and encourage them to remain steadfast in their fundamental mission of compassionate service and care to the sick and infirm." This address by Anthony Joseph Cardinal Bevilacqua, to the American religious Sisters is still valid to all religious Sisters working in Catholic hospitals throughout Uganda (Bevilacqua, 2000).

## Methods

We carried out a qualitative descriptive cross-sectional study in Ugandan Catholic-founded hospitals. Religious Sisters work in only 24 (88.9%) of the 27 Catholic-founded hospitals. Only those hospitals with nuns formed our population. We purposively selected twelve hospitals from among them basing on congregation, ease of access and unique features. The hospitals were first stratified basing on the congregation of religious women operating in them. There were 10 congregations working in hospitals. The Little Sisters of St. Francis (LSSF) predominated, working in seven hospitals while some hospitals like Nyakibale and

Kitovu had several congregations. We picked one hospital per congregation, choosing the easiest to access by public means. For the LSSF, we selected two hospitals with specific characteristics: Nkokonjeru whose ownership is disputable between the diocese and the congregation, and Kamuli, which has a midwifery training school. We specifically excluded Nsambya Hospital where the researcher works. Those eventually selected were Mutolere, Nyakibale, Ibanda, Kyamuhunga, Kilembe Mines, Virika, Nyapea, Kamuli, Nkokonjeru, Kisubi, Rubaga and Kitovu. Kilembe Mines Hospital was included because it has a tripartite management: the diocese, the Mines and the government.

Using interview guides and checklists, for each hospital we set out to interview the Bishop, the Superior General of the congregation in the hospital and the Chairperson of the Board of Governors. We also wanted to interview the medical director / superintendent, the Principal/Senior nursing officer, the Administrator, outpatients, in-patients, the hospital chaplain and the Sister Superior of the hospital convent. Finally, we wanted to interview some members of the UCMB office.

## Findings

We interviewed a total of 179 respondents distributed in different categories as follows:

**Table 1: Distribution of respondents by category**

Respondent Category interviewed	Number
Bishop	4
Superior general	4
UCMB staff	3
Hospital chaplain	4
Superior of hospital convent	8
Member of hospital Board of Governors	12
Sisters working in hospitals	48
Lay staff members	48
Patients	48
<b>Total</b>	<b>179</b>

We interviewed them about the following issues: hospital ownership; hospital management; the role of Sisters; what the Sisters do in the hospitals; the posts they hold and the position of the Managing Organization. Others were: stakeholders' expectations of the Sisters; Sisters expectations of other stakeholders; the selection of the Sisters to work in

the hospital; Sisters' involvement in the management of hospital finances; Sisters' terms and conditions of service; their appointing authority and other suggestions regarding the Sisters' work in hospitals.

**Do the Sisters manage the hospitals?**

We wanted to find out how many congregations had their Sisters in all the 5 topmost positions of the hospitals, to qualify to be called a 'Managing Organization' as per the standards of the Health Commission of the Episcopal Conference. We found that in all the 12 hospitals studied, no congregation had all the five positions. This included Nyakibale, Mutolere and Kitovu, which have mixed congregations. The findings were as follows:

**Table 2: The distribution of the Sisters in administrative positions in the hospitals**

Hospital	Medical Director	Principal Nursing Officer	Administrator	Finance Director	Principal Tutor
Nkokonjeru		X	X		
Kamuli		X	X		X
Kisubi		X	X	X	
Rubaga		X	X	X	X
Nyapea		X			
Kyamuhunga		X			
Mutolere					X
Kilembe		X	X	X	
Virika		X	X	X	X
Ibanda		X	X	X	
Kitovu		X		X	
Nyakibale		X			
<b>Total</b>	<b>0</b>	<b>11</b>	<b>7</b>	<b>6</b>	<b>4</b>

Most congregations had a Sister as the Principal Nursing Officer of the hospital.

**What role do the Sisters play in the hospitals?**

The majority of the respondents expressed an appreciation of the presence and contribution of the Sisters in the hospitals. They reported that the presence of the Sisters was important because "... it blends spiritual work with physical work and makes the healing process complete" (one bishop).

However, for the most part, their role in the hospitals was not clearly understood. Some respondents thought that they own the hospitals in which they work while

others thought that they are just the managers. In particular, the question of hospital ownership was most unclear. The findings were as follows:

The majority of the respondent categories, especially the patients, were not unanimous about the ownership of the hospitals. However, other categories including the Superiors General of congregations and the members of the Boards of Governors also had divergent views on the ownership. The local Convent Superiors unanimously thought that the hospitals belong to their congregations.

**What are the individual Sisters expected to do in the hospitals?**

There was a mixture of opinions on the expected roles of Sisters in the hospitals, reflecting a lack of clarity.

The majority of the respondents who volunteered an opinion unanimously stated that they expected the Sisters to have three main roles: to work as other staff, to work as the employers and to work as co-owners of the hospitals. One bishop thought that their role is to "... keep in mind the Catholic Church's mission in the healing ministry of Christ. They should safeguard the objectives of the Foundation Bodies and the Dioceses. They should be attentive to the complaints and expectations of the patients..." (one bishop). Another bishop expected the Sisters to integrate pastoral care in the day to day running of the hospitals as well as implementing the policies of the BOG. In addition to these roles, he expected them to furnish the BOG with the relevant information required to determine new policy directions.

On their part, the majority of the lay staff interviewed did not know the exact roles of the Sisters and many (10/48) thought they had no role at all. Some thought they were recruited to work in management posts while others thought that they were for supervisory and advisory roles. Other roles perceived included bringing sacraments to the patients, providing education to the children of staff and 'being an arm of the Catholic Church in the hospital' (lay staff, Rubaga Hospital) and 'ensuring the continuity of Catholic health values of compassion and service to all' (lay staff, Ibanda Hospital). The opinions of the members of the BOG can be grouped into four categories: administrative,

**Perceived owners of the hospitals**

Respondent category	Perceived owners					
	Diocese	Bishop	Sisters	Medical Superintendent	Community	Government
Bishops	X					
Superiors General	X		X			
Sisters	X		X			
BOG Members	X		X			
Lay Staff	X	X	X			
UCMB staff	X					
Patients	X	X	X	X	X	X
Chaplains	X					
Convent Superiors			X			

nursing, managerial and provision of pastoral care. The members of the Management Teams interviewed unanimously mentioned three roles for the Sisters i.e. administration, patient care (clinical work) and training.

The patients had the widest range of opinions about the role of the Sisters. Although the majority said they did not know the roles of the Sisters, those who responded mentioned that the Sisters played the following roles: spiritual guidance to the hospital, praying for the patients, as an example of hard work to the lay staff, encouraging patients to pay their bills, supervision of the nursing care and control of hospital funds.

The members of the UCMB interviewed said the roles of individual Sisters were clear as per their appointments in different roles in the administration, patient care and training. However, they emphasised that the roles of congregations in the hospitals were not clear. The Superiors General reported that individual Sisters were deployed according to their competence in different positions in the hospitals. The individual Sisters working in the hospitals thought that their roles were to give selfless, generous and professional services in nursing the sick and managing hospital staff and equipment; to be exemplary in honesty and justice; to provide pastoral care to the patients and staff; to prevent misallocation of resources meant for the poor and to be transparent in decision making.

**What is the role of Managing Organisations in the hospitals?**

When the bishops appoint a congregation of religious women to take over a hospital, they are designated as

a 'Managing Organisation'. We asked the respondents what they perceive to be the role of this structure. First, it was not clear to most of the stakeholders where they fitted in the hospital organogram and what the Sisters are expected to do in the hospitals as a Managing Organisation. As a result, there was a mix up in their roles as hospital owners, managers, staff or representatives of the first two. No respondent seemed to be very clear on what a Managing Organisation should do.

According to one bishop, the Sisters were managers, employees and co-owners. According to another, they were the link between the BOG and the hospital. The function of the Managing Organisation was not clear to all the members of BOG interviewed, the Superiors General, the lay staff and the patients. One staff member of the UCMB expected the role of the Congregations to be to provide an apostolic community and be stewards of the hospitals. The rest thought that the role of the congregations was not clear at all. The members of the Management Teams interviewed, however, thought that the Managing Organisations should exercise full authority in leadership, innovation, monitoring, evaluation and formulation of a way forward for the hospitals while being accountable to the dioceses. Some members of this category however insisted that these were roles for the Management Team and that the congregations had no role whatsoever. They reported that the presence of the unclear structure 'Managing Organisation' had actually contributed negatively to the management of the hospitals.

Instances were cited where the presence of congregations in the hospitals had contributed to poor management practices. These included backdoor appointment of unqualified Sisters to key managerial

positions in the hospitals without recourse to the normal Board and Management structures and procedures, fomenting conflict between the BOG and Management Teams and abrupt withdrawal of key qualified staff without due notice to the hospitals. Others included lack of answerability of the Sisters to the lay Management structures and lack of open and clear terms of service and contracts for the Sisters. In general, there seemed to be no physical monitoring, follow up, evaluation and communication to and from the purported managing organization and the hospitals. This made management and proper accountability in these hospitals difficult. Some religious congregations had not yet built the capacity to run and manage hospitals and, as a result, they did not have the personnel to fill all top posts in the hospitals. Because of this, some lay hospital staff felt that they were in the hospitals just to cover up this perceived deficiency of the Sisters. Only in one hospital was there a positive compliment to the role of the Sisters: they had brought about improvement in staff punctuality through example.

The financial relationship between the hospitals, religious congregations and individual Sisters was of concern to some stakeholders. They felt that lack of transparency in financial issues led to some staff perceiving the Sisters as amassing property at the expense of the hospital or using hospital funds for private and congregational use.

### **Should the Sisters be paid?**

Most respondents felt that Sisters should be paid if they are professional and appointed to positions where they are competent. This would enhance their faithfulness and commitment to the mission of care as well as clear any suspicion from the public about their sources of income. Moreover, it would help them meet their needs since, unlike expatriate missionaries, most of them are faced with the same problems of having to look after extended families like their lay colleagues. A few respondents however felt that Sisters should not be paid since it is their calling to live a life of poverty, dedication and service. In such a case, they suggested, the hospital would provide for their basic needs.

### **How can the role of the Sisters in hospitals be enhanced and streamlined?**

Since the question of ownership of the hospitals was not clear to all and sundry, it was suggested that the relevant stakeholders clarify the question openly, using the appropriate sections of Canon Law

governing the ownership of church property. The discussion should not be legalistic but take into account, among other things, the contribution of each stakeholder either as the current manager, or as the founder or as the chosen heir to the founder.

Some respondents advised a careful evaluation by the Sisters of the reasons and mission why they are appointed as Managing Organisations vis-à-vis the mission of the church in health care even before they take up the appointment. It was felt by most respondents that the bishops need to have a common understanding of the need for, the meaning, the position and the duties of a Managing Organisation before they appoint one. These should then be properly written down for future reference and communicated to all the stakeholders of each diocesan hospital. All respondents suggested a need for clarification of the relationship between the Sisters and the owners, hospital BOG, management teams, staff, and patients. This would avoid the feeling creeping in the stakeholders of the Sisters and the Superiors General taking over the roles that would be for the management teams, the BOGs and owners or vice versa. Most respondents suggested the holding of regular meetings between the owners, the Sisters congregations, the Boards of Governors and the management Teams, to revisit, review and evaluate their relationship

In order for all professional employees of the hospitals (including the Sisters and other religious personnel) to be able to focus and work together for the same hospital missions, it was deemed necessary that they all have the same appointing authority. All the other parties need to be notified of the appointment of new staff and the withdrawal of others, with due notice according to the established regulations. Mostlay respondents and the UCMB staff felt that, as much as possible, the Superiors General need to appoint qualified and competent Sisters to the hospitals because this would enhance their performance and respect in the work environment. Even religious staff needs to be appointed on clear terms of reference within the existing hospital structure as this would make the management of personnel more professional, easier and better.

Regarding financial management, the respondents suggested that the owners, Superiors General, hospital BOGs and hospital Management Teams need to work together to streamline the financial relationships between the Sisters, hospitals, congregations and owners. This would clear suspicions of impropriety while supporting each other.

Many respondents, especially the patients, felt that, for Sisters to meet their expectations, they need to train formally in pastoral care. They also felt that the Sisters working in the hospitals, whether professional medical personnel or not, need to play a more active part on the spiritual aspects of the patients. In working with the chaplains where available, they need to be involved more in activities like preparation for sacraments, organizing prayers for patients and staff and providing objects of dedication in the hospitals.

A final recommendation was that if a religious congregation is appointed as a Managing Organisation of a diocesan hospital and does not have the Sisters with the relevant qualifications and experience for the job at hand, it could contract a Sister from another congregation. This recommendation means that the religious congregations could work through umbrella organisations like the UCMB, the Association of the Religious in Uganda (ARU) to create a registry of competencies from which their member organisations could shop.

### Conclusion

Although the work of the Sisters in the hospitals is acknowledged and appreciated, the study brought to the surface awareness about the lack of clarification of the role they are expected to play. Stakeholders had different expectations ranging from provision of quality health services through good management to praying for the patients. The study also uncovered a weakness in the organisational structure of the Catholic hospitals, whereby the organ Managing Organisation was created in practice but was never positioned vis-à-vis other hospital organs, thus leading to overlapping of roles, misconceptions and avoidable conflict. It is recommended that some of the recommendations generated during the study, in particular those relating to the organisational structure and recruitment of staff be studied and those considered feasible implemented.

### Conflict of Interest

The researcher was a religious nun belonging to one of the congregations working in the hospitals under study. This could have biased the responses in favour of the Sisters. However, we went ahead to conduct the study in the hope that since some key respondents were religious people, they would feel more free to talk about religious people to a fellow religious person, "one of their own", than to lay researchers. The researcher also worked with one of the hospitals

potentially under study. This biased the selection of the hospitals because we purposively avoided that particular hospital and we could have missed important information.

The author can be contacted through this journal.

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