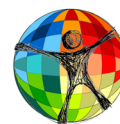


# **“God Is Not Dead, At Least Not Here”: Ethical Understanding as a Basis for Improving Engagement Between Multilateral Health Organizations and Faith-based Organizations**

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# ABSTRACT

In Uganda, a country where over 97% of the population identifies as religious, faith-based organizations (FBOs), which can be defined as organizations that obtain inspiration and guidance for their activities or mission from the teaching and principles of a particular faith, play an important role in filling in the gaps left behind by Uganda's troubled public health care system. In spite of the important role FBOs play in supplementing Uganda's national health care system, they have historically been neglected by multilateral health organizations, which, for the purposes of this paper, are defined as organizations formed between several nation states to work on health issues relevant to each of them. These organizations, which include, for example, the World Health Organization, generally hold a liberal secularist worldview, and are thus skeptical of organizations, like FBOs, which mix theology with health programming, policy and service delivery. However, in spite of their differences, multilateral health organizations are beginning to recognize that engagement with FBOs is critical to the implementation of health development interventions in many low-middle income countries (LMICs), including Uganda. While the relationship between these two actors has traditionally been challenging due to their vastly different worldviews, this paper argues that a better understanding of the ethical codes guiding multilateral health organizations, on the one hand, and FBOs, on the other, allows for the identification of shared values. The process of identifying shared values can, in turn, lay the foundation or at least serve as a first step for more effective engagement between these two key actors in advancing health generally, and sexual and reproductive health, in particular.

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## Introduction

It has been said that in Uganda “religion reaches more people than health care.”<sup>1</sup> Indeed, like many countries in sub-Saharan Africa, the health system in Uganda is weak and faces many challenges due to a high burden of life-threatening communicable and non-communicable diseases, high rates of poverty, and a lack of basic sanitation services.<sup>2</sup> The fragility of the system is exacerbated by the fact that it operates under severe resource constraints, making it very difficult for the system to meet the basic health needs of the Ugandan population.<sup>3</sup> Despite population rates continuing to grow by 3% each year, government spending on the health sector remains at 7.2%, not even half way to reaching the 15% target that African Heads of State pledged to in the Abuja Declaration in 2001.<sup>4</sup> The weakness of Uganda’s health care system is reflected in its poor performance on key health indicators, which are measures designed to summarize information about health system

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<sup>1</sup> Anne Perkins, “Religion and Sex in Uganda: The Power of the Pulpit” *The Guardian* (13 October 2008), online:

<https://www.theguardian.com/society/katineblog/2008/oct/13/sexandreligion>

<sup>2</sup> See World Health Organization, “Country Cooperation Strategy at a Glance: Uganda” (2018), online:

[https://apps.who.int/iris/bitstream/handle/10665/136975/ccsbrief\\_uga\\_en.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/136975/ccsbrief_uga_en.pdf?sequence=1); See also World Health Organization, “The African Regional Health Report: The Health of the People,” (2014), *Bulletin of the World Health Organization*, online: <https://www.who.int/bulletin/africanhealth/en/>; See also Annie Kelly, “Healthcare a major challenge for Uganda,” *The Guardian*, (31 March 2009), online: <https://www.theguardian.com/katine/2009/apr/01/healthcare-in-uganda> [Kelly].

<sup>3</sup> See Yoswa M Dambisya, Mulalo Manenzhe & Allie B Kibwika-Muyinda, “Faith-based health services as an alternative to privatization: A Ugandan Case Study,” (2014), Municipal Services Project Occasional Paper No 25 at 3 [Municipal Services Project]; See also Jon O’Brien, “Can faith and freedom co-exist? When faith-based health providers and women’s needs clash,” (2017), *Gender & Development* 25:1 at 38 [O’Brien].

<sup>4</sup> *Ibid*, Municipal Services Project, at 4; For more information about the Abuja Declaration, see World Health Organization, “The Abuja Declaration: Ten Years On” (2011), online: [https://www.who.int/healthsystems/publications/abuja\\_declaration/en/](https://www.who.int/healthsystems/publications/abuja_declaration/en/)

performance and population health.<sup>5</sup> The latest health systems data indicates that in 2015, there were 0.1 physicians per 1,000 people (compared to 2.6 per 1,000 people in Canada)<sup>6</sup> and in 2010 there were 0.5 hospital beds per 1,000 people (compared to 2.7 per 1,000 people in Canada).<sup>7</sup> While the data is limited, some reports indicate that more than half of the country's population does not have any contact with public health care facilities at all.<sup>8</sup> Of particular concern, however, are population health indicators relating to sexual and reproductive health. The country's maternal mortality ratio is staggering at 343 deaths per 100,000 live births (compared to 10 per 100,000 in Canada).<sup>9</sup> Furthermore, fewer than 50% of mothers deliver their children in health facilities, a statistic closely linked to the lack of geographic and financial access to proper health services.<sup>10</sup> Overall, Uganda's health care performance has been ranked as one of the worst in the world by the World Health Organization (WHO).<sup>11</sup> Given the troublesome picture illustrated by these indicators, it is perhaps unsurprising that most Ugandans identify as religious and feel the need to turn to God for His help.<sup>12</sup>

The poor state of Uganda's national public health system has resulted in other organizations, namely the private not-for-profit sector, which is largely made up of faith-based organizations (FBOs), filling in the gaps that the public system has

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<sup>5</sup> Canadian Institute for Health Information (CIHI), "Health Indicators," (2019), online: <https://www.cihi.ca/en/healthindicators#:~:targetText=A%20health%20indicator%20is%20a,can%20track%20progress%20over%20time>.

<sup>6</sup> World Bank Data, "Physician (per 1,000 people), Uganda", online: <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=UG>

<sup>7</sup> World Bank Data, "Hospital beds (per 1,000 people), Uganda", online: <https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?locations=UG>

<sup>8</sup> *Supra* note 2, Kelly.

<sup>9</sup> United Nations International Emergency Children's Fund, "Maternal and Newborn Health Disparities: Uganda," (2019), at 2.

<sup>10</sup> Norman Mukasa, "Uganda Healthcare System Profile: Background, Organization, Policies and Challenges," (2012), *Sustainable Regional Health Systems* 1, at 9.

<sup>11</sup> World Health Organization, "The World Health Report 2000 – Health Systems: Improving Performance," (2000) at 181, online: [https://www.who.int/whr/2000/en/whr00\\_en.pdf?ua=1](https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1)

<sup>12</sup> Ionnis Gatsiounis, "Uganda: Debating God in a God-Fearing Country," (27 October 2010), *Time Magazine*, online <http://content.time.com/time/world/article/0,8599,2027416,00.html>.

left unaddressed.<sup>13</sup> While FBOs do not have a generally accepted definition, for the purposes of this paper, they can be broadly defined as "organizations that derive inspiration and guidance for their activities from the teaching and principles of a faith or from a particular interpretation or school of thought within that faith."<sup>14</sup> FBOs encompass a wide variety of organized groups, including religious congregations (e.g. churches, mosques, synagogues, temples); health facilities established by members of a particular faith; charities sponsored or hosted by religious congregations; non-profit organizations founded by a religious congregation or based upon a particular faith; and coalitions that include the organizations listed above.<sup>15</sup> In Uganda, many FBOs play an important role in both health services delivery and health promotion through grassroots mobilization. Indeed, they have been identified as being active in a wide range of public health initiatives, including those targeting immunization uptake, antimalaria initiatives, and child and maternal health services.<sup>16</sup>

In spite of the important role they play in supplementing Uganda's public health system, FBOs have historically been neglected by multilateral health organizations, which, for the purposes of this paper, are defined as organizations formed between several nation states to work on health issues relevant to each of them.<sup>17</sup> These organizations, which include, for example, the WHO, generally hold a liberal secularist worldview, and are thus skeptical of organizations that mix theology with health programming, policy and service delivery.<sup>18</sup> However, in spite of their differences, multilateral health organizations are beginning

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<sup>13</sup> *Municipal Services Project*, *supra* note 3 at 25.

<sup>14</sup> See United Nations Development Program, "Guidelines on Engaging with Faith-based Organizations and Religious Leaders," (2014), at 5 [UNDP Guidelines], citing Clarke G and Jennings, M (2008). *Development, Civil Society and Faith-Based Organizations: Bridging the Sacred and the Secular*. Basingstoke, UK: Palgrave Macmillan.

<sup>15</sup> *Ibid* at 5.

<sup>16</sup> O'Brien, *supra* note 3, at 38.

<sup>17</sup> See Danyel Harrigan, "What is a Multilateral Organization?" (25 July 2017), *The Borgen Project Organization*, online: <https://borgenproject.org/what-is-a-multilateral-organization/>

<sup>18</sup> See Jill Olivier et al., "Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost and satisfaction," (2015), *The Lancet*, Vol 386, 1765 at 1772 [Olivier et al.].



to recognize that engagement with FBOs is critical to the implementation of health development interventions in many low-middle income countries (LMICs), including Uganda.<sup>19</sup> In fact, according to the United Nations Development Program (UNDP), “faith-based groups are playing a critical role in advancing development goals around the world.”<sup>20</sup> Given their strong role in Uganda’s health sector, FBOs have undoubtedly contributed to the country’s recent achievement of reaching 33% of its Millennium Development Goal (MDG) targets, including reducing income poverty in the country by two-thirds and cutting the child mortality rate in half.<sup>21</sup> While Uganda’s overall MDG achievements are significant, it still has a tremendous amount of progress to make in order to achieve the global goals set out by the new era of Sustainable Development Goals (SDGs).<sup>22</sup> Of particular concern in this paper is SDG three – *to ensure good health and wellbeing* – and more specifically, due to the high rate of maternal mortality in Uganda, the targets relating to sexual and reproductive health.<sup>23</sup>

In order to achieve the ambitious sexual and reproductive health targets set out by SDG three, it is imperative that multilateral health organizations and FBOs work together in partnership. While the relationship between these two actors has traditionally been challenging due to their vastly different worldviews, this paper argues that a better understanding of the ethical codes guiding multilateral health organizations, on the one

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<sup>19</sup> See Jill Olivier & Quentin Wodon, (eds) “Faith-Inspired Health Care Providers in Sub-Saharan Africa and Public-Private Partnerships: A Brief Overview” in *The Role of Faith Inspired Health Care Providers in Saharan Africa and Public-Private Partnerships*, (2012) at 1; See also Michel Sidibé, “Religion and Sustainable Development,” (2016), *The Review of Faith & International Affairs*, 14:3, 1 at 1.

<sup>20</sup> See United Nations Development Program, “Faith-based groups play key role in advancing development goals, UNDP chief says,” (3 May 2013), online: <https://www.undp.org/content/undp/en/home/presscenter/articles/2013/05/03/faith-based-groups-play-key-role-in-advancing-development-goals-undp-chief-says.html>.

<sup>21</sup> See United Nations Development Program, “Final Millennium Development Goals Report for Uganda 2015” (2015), at i, iv [MDG Report for Uganda].

<sup>22</sup> *Ibid*, at i.

<sup>23</sup> For more information about the sexual and reproductive health targets set out in SDG three, see targets 3.1, 3.2, 3.7 and 3.8 at the United Nations website: <https://www.un.org/sustainabledevelopment/health>

hand, and FBOs, on the other, allows for the identification of shared values. The process of identifying shared values can, in turn, lay the foundation or serve as a first step for more effective engagement<sup>24</sup> between these two actors.

*Part I* of this paper will introduce a brief history of FBOs in Uganda and will explain their current role in Uganda’s health care system. *Part II* will then discuss the controversial role FBOs have played in the advancement of health, by drawing on two case studies. *Part III* will highlight the ethical tensions between the secular worldview of multilateral health organizations and the faith-based worldview of FBOs and will suggest a way in which these tensions might be mitigated. Finally, *Part IV* will demonstrate how the identification of shared values between FBOs and multilateral health organizations can serve as a foundation for more legitimate and effective collaboration towards the advancement of sexual and reproductive health and rights.

## **Part I: The Role of FBOs in Uganda’s Health Care System – Then & Now**

FBOs are not a new phenomenon in Uganda. In fact, as is true in many LMICs, FBOs have played a historic role in health service provision dating back to the early colonial era. Indeed, Christian Missionary Hospitals and Islamic Hospitals were among the first modern health-providers to be established in Uganda, especially in more rural areas.<sup>25</sup> Their historical role in health service provision is connected to the fact that during this time, most colonial government hospitals and dispensaries were located in urban areas, serving only a very small proportion of Uganda’s primarily rural population.<sup>26</sup>

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<sup>24</sup> In this context, “engagement” is defined broadly to mean anything ranging from dialogue and consultation to the establishment of intimate partnership collaborations.

<sup>25</sup> Olivier et al, *supra* note 18, at 1765.

<sup>26</sup> See Shane Doyle, “Missionary Medicine and Primary Health Care in Uganda: Implications for Universal Health Care in Africa,” Chapter 9 in Medcalf A, Bhattacharya S, Momen H, et al, (eds) *Health For All: The Journey of Universal Health Coverage*, (Hyderabad (IN): Orient Blackswan, 2015) at 73 [Doyle].

After independence, new national governments took a strong governance role and through a series of health sector reforms, the public health system expanded.<sup>27</sup> The post-independence Ugandan national health care system is decentralized, consisting of both public and private sectors. The public sector is comprised of government health facilities, which are overseen by the Ministry of Health, and the private health sector consists of private not-for-profit providers (including FBOs), private for-profit facilities and traditional medicine practitioners.<sup>28</sup>

Despite the establishment of a more extensive national public health system, the prominence of FBOs in health service provision has continued to be strong in the country for several reasons. First, post-independence Uganda was plagued by political instability and economic decline, limiting the country's ability to provide adequate social services.<sup>29</sup> As a result, religious hospitals and clinics, which tended to have greater access to external income and medical provisions due to donations, expanded their activities. For example, during the dictatorship of Idi Amin, FBO operated leprosy hospitals opened their doors to general outpatients, becoming the leading health care providers in those districts.<sup>30</sup> Second, economic neoliberalism, largely experienced through structural adjustment policies, forced the government to focus on trade and production instead of on social services, thus leading to reduced state spending on health care. As a result, the role of FBOs in health service provision increased as they served to fill the gaps created by a drawback in government health care services.<sup>31</sup> Finally, the presence of FBOs has remained strong in Uganda due to an increase in funding from international donors, including most notably, the US religious

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<sup>27</sup>Olivier et al, *supra* note 18 at 1767.

<sup>28</sup>Municipal Services Project, *supra* note 3 at 6–7.

<sup>29</sup> Doyle, *supra* note 26 at 75.

<sup>30</sup> *Ibid* at 75–76.

<sup>31</sup> See Nathan Grills, "The Paradox of Multilateral Organizations Engage with Faith-based Organizations," (2009), *Global Governance*, 15:4 505 at 509 [Grills]. For more information about the impact of structural adjustment programs on the wellbeing of Africans, including Ugandans, see Kata Gogo Kingston, "The Impacts of the World Bank and IMF Structural Adjustment Programmes on Africa: The Case Study of Cote D'Ivoire, Senegal, Uganda and Zimbabwe" (2012) *Sacha Journal of Policy and Strategic Studies* 1:2:, 110 to 130.

right.<sup>32</sup> For example, in 2006, 12 per cent of the President's Emergency Program for Aids Relief (PEPFAR) funding, an initiative started by President George W. Bush that allegedly favoured religious groups with conservative evangelical ideologies, was channelled through FBOs.<sup>33</sup>

Today, FBOs provide approximately 30% of all health care provision in Uganda.<sup>34</sup> They typically finance their services through a combination of user fees from patients, development assistance from multilateral and bilateral donors, and government partnership agreements.<sup>35</sup> Partnership agreements between the Ministry of Health and FBOs usually state the terms of a reciprocal relationship, whereby FBOs agree to support public sector goals and priorities in exchange for governmental financial support.<sup>36</sup>

The importance of FBOs in supporting public health service provision is not unique and has occurred elsewhere in other LMICs. For example, in post-independence India, there was a proliferation of health non-profits coinciding with a decrease in public sector funding as a result of increased privatization stemming from structural adjustment programs. Grills argues that the outsourcing of health service provision to non-profits is becoming the new paradigm for health service delivery in LMICs.<sup>37</sup> It is therefore becoming increasingly critical for multilateral organizations seeking to improve global health, to acknowledge the role of FBOs in health care and to make efforts to establish strong, meaningful partnerships with these groups.

## **Part II: To What Extent do FBOs Frustrate or Facilitate the Advancement of Health in Uganda**

The role of FBOs in the provision of health care services is considered by many to be controversial.<sup>38</sup> In some instances FBOs have served as advocates for the vulnerable and have provided

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<sup>32</sup> O'Brien, *supra* note 3 at 39, 46.

<sup>33</sup> *Ibid* at 46.

<sup>34</sup> Doyle, *supra* note 26 at 76.

<sup>35</sup> Olivier et al, *supra* note 18 at 1769.

<sup>36</sup> *Ibid* at 1770.

<sup>37</sup> Grills, *supra* note 31 at 509.

<sup>38</sup> *Ibid* at 511.

access to health care services; however, in other cases, religious doctrines and moral positions have had a negative effect on health promotion.<sup>39</sup> A greater understanding of the social, cultural and moral nuances that affect how FBOs have approached and continue to approach certain health issues in Uganda, such as those discussed in the case studies that follow, is critical for establishing a better understanding of how FBOs and secular multilateral health organizations can work together to improve health.<sup>40</sup> This section of the paper will, therefore, discuss to what extent FBOs facilitate and frustrate the advancement of health, and more specifically, sexual and reproductive health, in the context of Uganda.

### To What Extent do FBOs Facilitate the Advancement of Health in Uganda?

While the role of FBOs differs depending on the nature of their services, their mission, and the context in which they are located, there are several reasons why FBOs are considered critical to efforts seeking to advance health in Uganda: (i) they serve hard to reach populations; (ii) they offer culturally relevant and sustainable services; and (iii) they are trusted and have legitimacy in the eyes of the local population.<sup>41</sup>

#### i. FBOs Serve Hard to Reach Populations

FBOs play a particularly important role in providing health services to those living in hard to reach and under-served parts of the country.<sup>42</sup> These efforts are extremely important in Uganda, where 76% of the population lives rurally.<sup>43</sup> In these regions, public health services are very limited, and even if available, are often too costly due to high levels of rural poverty. To address this gap in services, FBOs have therefore set up large networks of well-distributed rural health units and community-based health

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<sup>39</sup> See Otolok-Tanga et al, "Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda" (2007) *African Health Sciences* 7:1 55 at 55 [Otolok-Tanga et al].

<sup>40</sup> See Tomkins et al, "Controversies in faith and health care," (2015), *The Lancet*, 386 1776 at 1782 [Tomkins et al].

<sup>41</sup> Grills, *supra* note 31, at 509, 511; See also O'Brien, *supra* note 3, at 40.

<sup>42</sup> Olivier et al, *supra* note 18, at 1770.

<sup>43</sup> World Bank Data, "Rural population (% of total population), Uganda", online: <https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=UG>

organizations that provide more geographically and economically accessible health services.<sup>44</sup> FBOs primarily offer primary care services, focusing on disease prevention and treatment; however, many FBOs also offer more specialized skills, including maternal and child health care services, and provide access to much-needed pharmaceuticals.<sup>45</sup> While FBO facilities will usually charge affordable user fees, they will also often treat those who are unable to pay.<sup>46</sup>

ii. FBOs Offer Sustainable & Culturally Relevant Health Services

The strong grassroots presence of FBOs is especially important in areas of Uganda, like the North, where conflict has been protracted. Unlike humanitarian actors, FBOs tend to remain in the region post-conflict, ensuring sustainability of health and other community-based services.<sup>47</sup> It is therefore unsurprising that local communities tend to trust faith-based groups and leaders more than government actors and international bodies, whose presence is more intermittent. Moreover, a number of surveys have indicated that the quality of services in FBO facilities is higher than in public health facilities.<sup>48</sup> In particular, respondents reported that in FBO facilities there was increased availability of staff to attend to patients, a more regular supply of prescription drugs, and higher quality culture of service and work ethic among employees. Better quality of services is also reflected in objective outcomes such as lower maternal mortality rates at FBO hospitals compared to public health facilities. For example, Kibuli Hospital, which is under the auspices of the Uganda Muslim Medical Board, has achieved high standards in maternal health through the implementation of community-oriented services and efforts to

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<sup>44</sup> Municipal Services Project, *supra* note 3, at 11.

<sup>45</sup> O'Brien, *supra* note 3, at 40-41.

<sup>46</sup> Municipal Services Project, *supra* note 3, at 2.

<sup>47</sup> UNDP Guidelines, *supra* note 14, at 7.

<sup>48</sup> Municipal Services Project, *supra* note 3, at 13; For more information on the surveys cited, see UCMB, UPMB, and UMMB, "Facts and figures of the PNFPs: Knowing and understanding the facility-based PNFP subsector in Uganda" (2007), (Kampala: UCMB, UPMB, and UMMB), online: <https://www.ucmb.co.ug/files/UCMBdocs/Reports/ARTICLES/Facts%20and%20Figures%20about%20the%20PNFP%20sub-sector%20-%20August%202007.pdf>

improve hygiene standards.<sup>49</sup> FBO facilities also tend to have a strong understanding of the local context, wider reaching infrastructure and significant funding streams as a result of donor funding.<sup>50</sup> Given the consistent and trusted presence of FBOs in local communities, it is critical that multilateral health organizations seeking to implement initiatives that are sustainable and culturally appropriate gain their acceptance.<sup>51</sup>

### iii. FBOs Have Legitimacy Among Local Communities

Through delivering more accessible health care services, FBOs have earned the trust of local populations, including more vulnerable groups, such as the rural poor.<sup>52</sup> Representatives of FBOs, including religious leaders, are often seen as opinion leaders and are, in most cases, more trusted than government actors or international agencies.<sup>53</sup> Indeed, because of their legitimacy, the statements of religious or spiritual leaders often have more impact than awareness-raising interventions led by value-neutral development organizations, like the WHO.<sup>54</sup> FBOs, therefore, have tremendous capacity to influence cultural norms and change behaviours, making them vital stakeholders in health development.<sup>55</sup>

It is clear from the above that FBOs have a number of strengths and can therefore add significant value to initiatives seeking to improve health in Uganda. The following case study, which discusses Uganda's response to the HIV/AIDS pandemic, provides more practical insight into some of the ways in which FBOs have helped facilitate the advancement of sexual and reproductive health in the country.

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<sup>49</sup> *Municipal Services Project*, *supra* note 3 at 14.

<sup>50</sup> O'Brien, *supra* note 3, at 40

<sup>51</sup> Grills, *supra* note 31, at 511; See also Bob Tortora, "Africans' Confidence in Institutions – Which Country Stands Out?," (18 January 2007), which highlights a 2006 survey indicating that in sub-Saharan Africa, people trusted FBOs more than their own national governments.

<sup>52</sup> *Municipal Services Project*, *supra* note 3, at 25; See also UNDP Guidelines, *supra* note 14, at 3.

<sup>53</sup> UNDP Guidelines, *supra* note 14, at 7.

<sup>54</sup> *Ibid.*

<sup>55</sup> *Ibid* at 3.

Case Study I: The Role of FBOs in Uganda's HIV/AIDS  
"Success Story"<sup>56</sup>

While at one point an early epicentre of the disease, Uganda is today often cited as sub-Saharan Africa's HIV/AIDS "success story" due to its dramatic reduction in the prevalence of HIV/AIDS between 1990 and 2003.<sup>57</sup> In response to the epidemic, Uganda adopted a multisectoral approach, involving the active participation of many groups and organizations, including FBOs, which have been recognized as playing a significant role in reducing the spread of infection in Uganda.<sup>58</sup>

The scale and nature of HIV/AIDS meant that multilateral health organizations, such as the WHO, were impelled to engage with FBOs given their prominent role in Uganda's health system, especially in rural regions.<sup>59</sup> A study carried out by Otolok-Tanga et al., indicates that initially many religious groups in Uganda were not supportive of HIV/AIDS patients. In fact, it was reported that many FBOs contributed to perceptions that those infected with the virus had sinned and therefore deserved their punishment.<sup>60</sup> However, through HIV/AIDS trainings led primarily by international organizations, FBO's obtained better information about the disease and the effect that discriminatory and stigmatizing attitudes could have on perpetuating its spread.

Indeed, over time, many FBOs developed greater openness and acceptance towards condom use as a means to reduce the spread of disease. Many FBOs also became more

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<sup>56</sup> O'Brien, *supra* note 3 at 40

<sup>57</sup> According to data from Uganda's Ministry of Health, the prevalence of HIV among pregnant women has declined consistently since the early 1990s. UNAIDS estimates that the prevalence of HIV peaked in 1991 at 15%, and then fell to as low as 5% in 2001. For more information on declining HIV prevalence in Uganda, see Jane A Hogle, "What Happened in Uganda? Declining HIV Prevalence, Behaviour Change, and the National Response," U.S. Agency for International Development, online: <https://www.unicef.org/lifeskills/files/WhatHappenedInUganda.pdf>

<sup>58</sup> Otolok-Tanga et al, *supra* note 39 at 56.

<sup>59</sup> Grills, *supra* note 31 at 511.

<sup>60</sup> Otolok-Tanga et al, *supra* note 39 at 55.



accepting of the people who were infected with the virus and used their influential voices to mitigate stigma.<sup>61</sup> As noted by Freji:

“when religious leaders are properly briefed and trained by respected religious scholars and trusted health professionals, they become powerful agents of social change and are able to shift their community’s opinions”.<sup>62</sup>

Efforts to work with FBOs in order to increase their knowledge about the disease and how it spreads were critical given the centrality of religion in Uganda. FBOs, which were recognized as trusted entities, were able to influence the cultural norms of their congregations and were thus able to combat stigma against those with HIV/AIDS and promote healthy behaviours. FBOs further contributed to the containment of the spread of disease by providing care, prevention services, treatment and support to people infected with the virus, especially in areas with poor public health infrastructure.<sup>63</sup>

As this case study illustrates, FBOs, which tend to have legitimacy in the eyes of local populations, can play an important role in spreading messages of disease prevention because they have influence over the communities that they serve. While FBOs certainly have the potential to facilitate the advancement of sexual and reproductive health in Uganda, the following sub-section of the paper will discuss ways in which FBOs have served as a barrier to health promotion.

#### To What Extent do FBOs Frustrate the Advancement of Health in Uganda?

Despite the advantages of working with FBOs in order to advance health development agendas, multilateral health organizations are often hesitant to engage with faith-based

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<sup>61</sup> *Ibid* at 57.

<sup>62</sup> See Leah Sawalha Freij, “Muslim Religious Leaders as Partners in Fostering Positive Reproductive Health and Family Planning Behaviors in Yemen: A Best Practice” (2009), at 1 online: <https://www.faithtoactionnetwork.org/resources/pdf/Muslim-Religious-Leaders-as-Partners-in-Fostering-Positive-Reproductive-Health-and-Family-Planning-Behaviors-in-Yemen-A-Best-Practice.pdf>.

<sup>63</sup> Otolok-Tanga et al, *supra* note 39 at 59.

groups for several reasons.<sup>64</sup> First, they worry that by partnering with FBOs, they will be perceived as condoning the faith ideologies, motives or worldviews of these groups, which are at times in conflict with human rights.<sup>65</sup> For many, if not most FBOs, the provision of health services is part of their mission to help others, and not to convert; however, in some cases, FBOs have been connected to controversies around health care provision with the intent to proselytize.<sup>66</sup> Second, multilateral health organizations have concerns about the fact that some FBOs apply conservative interpretations of religious scriptures or teachings in order to deny access to critical care or preventative services.<sup>67</sup> For example, in the context of sexual health, it has been reported that rather than delivering comprehensive prevention messages such as using protection, some FBOs will focus solely on abstinence or faithfulness as disease or pregnancy prevention strategies.<sup>68</sup>

The following case study, which discusses the issue of unsafe abortion in Uganda, highlights some of these concerns by describing the role that faith-based actors, including FBOs, have played in influencing policies and socio-cultural worldviews that can be at odds with the sexual and reproductive health and rights of women.

#### Case Study II: The Role of FBOs in the Unsafe Abortion Crisis in Uganda<sup>69</sup>

Uganda has the second youngest population in the world with a median age of 15 years.<sup>70</sup> According to Uganda's 2016 Demographic and Health Survey, nearly 25% of girls and young women between the ages of 15 and 19 had begun childbearing.<sup>71</sup> Consequently, it is perhaps unsurprising that Uganda has an annual

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<sup>64</sup> Grills, *supra* note 30 at 511.

<sup>65</sup> *Ibid* at 514.

<sup>66</sup> Olivier et al, *supra* note 18 at 1765; See also Tomkins et al, *supra* note 40, for examples of faith-based controversies in health care.

<sup>67</sup> O'Brien, *supra* note 3 at 38.

<sup>68</sup> *Ibid* at 45.

<sup>69</sup> O'Brien, *supra* note 3 at 2.

<sup>70</sup> See Kemigisha et al, "Sexual health of very young adolescents in South Western Uganda: a cross-sectional assessment of sexual knowledge and behaviour," (2018), *Reproductive Health* 15:148 [Kemigisha et al].

<sup>71</sup> *Ibid* at 2.

rate of 54 induced abortions per 1000 women—the highest rate in Africa and double that of Burkina Faso, Rwanda and Ethiopia.<sup>72</sup> Given that abortion is in almost all instances illegal in Uganda, it tends to take place under unsafe conditions in covert, illegal clinics, resulting in high rates of abortion related morbidity and mortality.<sup>73</sup> In fact, unsafe abortion constitutes one third of all maternal deaths, approximately 46 000 women die every year as a result of unsafe abortions, and as many as 5 million are either permanently or temporarily disabled due to abortion related complications.<sup>74</sup>

The high rates of unsafe abortion in Uganda are often attributed to conservative legislation that criminalizes abortion. Section 142 of the *Penal Code Act* has had a particularly harmful effect on women. According to the provision:

“[a]ny woman who unlawfully administers to herself any poison or noxious things or uses any force or other means on herself or even permits such a thing to be used on her can be punished upon conviction with imprisonment of 7 years.”<sup>75</sup>

While the *Penal Code Act* does not specifically provide for situations where abortion is permitted, it does allow certain defenses (for example, where having the baby will threaten the mother’s life). Article 22(2) of the *Constitution of the Republic of Uganda* also prohibits the deprivation of the life of any person, including an unborn child, unless authorized by law.<sup>76</sup> However, since the enactment of the *Constitution* in 1995, Parliament has failed to put in place any law that prescribes instances in which a person can be permitted to terminate a pregnancy. Therefore, the

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<sup>72</sup> See Ann Moore, Richard Kibombo, and Deva Cats-Baril, “Ugandan opinion-leaders’ knowledge and perceptions of unsafe abortion,” (2014), *Health Policy and Planning*, 14:29, 893 at 894 [Moore et al].

<sup>73</sup> Centre for Health, Human Rights and Development (CEHURD), “Facing Uganda’s Law on Abortion,” (2016), at 1 [CEHURD].

<sup>74</sup> See Sofia Larsson et al, “The discourses on induced abortion in Ugandan daily newspapers: a discourse analysis,” (2015), *Reprod Health*, 15:58 at 1–2 [Larsson et al].

<sup>75</sup> *The Penal Code Act*, 1950, Government of Uganda, s 142.

<sup>76</sup> *The Constitution of the Republic of Uganda*, 1995, Government of Uganda, art 22(2).

*Penal Code Act* remains the authority on circumstances in which abortion is or is not allowed.<sup>77</sup>

The Ministry of Health has put in place Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights in an attempt to provide clarity as to the general rules and regulations governing abortion. These guidelines and standards also attempt to go beyond the current legal grounds for abortion provision, including allowing it in cases of defilement, rape and incest. However, these policies are not a binding force on the courts of law.<sup>78</sup> Overall, Ugandan laws on abortion – including when it is permitted and not permitted – are imprecise and often interpreted incoherently.<sup>79</sup> As noted by Moore et al., the common interpretation of the law by Ugandan health providers and policymakers is that abortion is illegal on all grounds.<sup>80</sup>

The opaque and inconsistent legal framework surrounding abortion in Uganda is a reflection of the country’s social and cultural context. Indeed, in Uganda, religion is central to the social, cultural, moral, and even political, fabric of local communities. It is therefore critical to understand the role of religious opinion leaders, including FBOs, in influencing debates over sensitive health issues like abortion.<sup>81</sup> While FBOs do not have any official power in the country, many have strong influential control, both socio-culturally and politically.<sup>82</sup> To illustrate, in March 2003, the President of Uganda introduced a set of teacher manuals that included a chapter on safer sex. The chapter highlighted condom use as a means to avoid unwanted pregnancy and ultimately, unsafe abortion. However, upon publication, these manuals were strongly criticized by conservation and religious advocacy groups, and as a result, they were withdrawn from the curriculum.<sup>83</sup>

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<sup>77</sup> CEHURD, *supra* note 72 at 2.

<sup>78</sup> *Ibid* at 4; See also Moore et al, *supra* note 71 at 894.

<sup>79</sup> Larsson et al, *supra* note 73 at 2.

<sup>80</sup> Moore et al, *supra* note 71 at 894.

<sup>81</sup> *Ibid*.

<sup>82</sup> Larsson et al, *supra* note 73 at 2.

<sup>83</sup> See Racheal Ninsiima, “Ignorance increasing abortions among adolescents,” (23 November 2011) in *The Observer*, online: [https://www.observer.ug/index.php?option=com\\_content&view=article&id=15989:ignorance-increasing-abortions-among-adolescents](https://www.observer.ug/index.php?option=com_content&view=article&id=15989:ignorance-increasing-abortions-among-adolescents).

This example demonstrates how conservative religious teachings can serve as a significant barrier to accessing family planning services that can help prevent unintended pregnancy.<sup>84</sup> Some religious groups teach that the use of contraceptives will lead to promiscuity, while others, including the Catholic Church, teach that couples should only use natural family planning methods through restricting sexual intercourse.<sup>85</sup> Moreover, some religious health care providers have reported that although they are aware that sexual activity is common among Ugandan youth as young as 15 years of age, they do not feel comfortable providing unmarried young women with effective contraceptives because their religious beliefs teach that it is a sin to have sex before marriage, especially at such a young age.<sup>86</sup> As a result, many women have limited access to contraceptives, resulting in a high rate of unwanted pregnancies, and ultimately unsafe abortions.

Religious leaders and FBOS are also influential in the policy making sphere in Uganda. For example, while some policy makers have demonstrated their support for more progressive or liberal abortion laws, they are reluctant to articulate their views publicly, due to the heavy influence of religion in their communities.<sup>87</sup> In conducting research on the issue of unsafe abortions in Nigeria, a very religious country that has abortion laws equally as restrictive as those in Uganda, Okonofua et al. found that the main reasons cited by policy makers for non-support of abortion liberalization were religious and moral considerations. They note that:

“[...] policy makers have little incentive or encouragement to address abortion as a public health issue; policy makers, being politicians and career officials, generally do not wish to jeopardize their careers, and therefore tend to align

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<sup>84</sup> O'Brien, *supra* note 3 at 38.

<sup>85</sup> See Friday Okonofua et al, “Perceptions of Policymakers in Nigeria toward Unsafe Abortion and Maternal Mortality,” (2009), *International Perspectives on Sexual and Reproductive Health*, 35:4 192 at 197 [Okonofua et al].

<sup>86</sup> See Jenipher Twebaze Musoke and Bianca Tolboom, “Uganda Country Report: Needs Assessment on Safe Abortion Advocacy,” (n.d.) Commissioned by International Federation of Gynaecology and Obstetrics (FIGO) at 11.

<sup>87</sup> Larsson et al, *supra* note 73 at 2.

with the most vociferous public opinion on controversial issues."<sup>88</sup>

In many African countries, "the most vociferous public opinion" is generally the Church.<sup>89</sup>

As this case study illustrates, the conservative ideologies of some FBOs in Uganda can negatively affect efforts to improve access to family planning services, reduce rates of unsafe abortion, and promote reproductive and sexual health. However, while it is true that some FBOs have strongly rooted ethical beliefs that are at odds with the goals and objectives of multilateral organizations seeking to advance global health, and sexual and reproductive health rights in particular, this is not true of all FBOs. Moreover, differences in worldview should not mean that any efforts at collaboration between these two actors are utterly useless. As will be argued in the next section of this paper, understanding the ethical tensions between FBOs and multilateral health organizations can serve as a first step towards identifying shared values and principles, which can, in turn, lay the foundation for more effective engagement.

### **Part III: Ethical Tensions Between FBOs and Secular Multilateral Health Organizations**

While many multilateral health organizations recognize the practical benefits of partnering with FBOs in countries with fragile health systems, like Uganda, engaging with these groups may conflict with their impartial identity as representatives of sovereign states.<sup>90</sup> Indeed, multilateral health organizations generally rely on member states for financing, many of which are secular and do not recognize a place for religion in health service provision or policy making.<sup>91</sup> By partnering with FBOs, multilateral health organizations risk being seen as representing FBO interests

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<sup>88</sup> Okonofua et al, *supra* note 84 at 200; See also Geoffrey York, "Abortion's veil of silence threatens Ugandan women," (6 November 2011), *The Globe and Mail*, online: <https://www.theglobeandmail.com/life/health-and-fitness/abortions-veil-of-silence-threatens-ugandan-women/article4249025/>.

<sup>89</sup> Moore et al, *supra* note 71 at 895.

<sup>90</sup> Grills, *supra* note 31 at 511–512.

<sup>91</sup> *Ibid* at 512.

and thus, as undermining the secular foundations of the states that contribute to their funding.<sup>92</sup>

The tension between the secularity of multilateral health organizations and the religiosity of FBOs is a key barrier to the establishment of meaningful engagement between these two actors. These ethical tensions are driven by the fact that multilateral health organizations and Western foreign policy elites generally adhere to Enlightenment liberalist philosophies, believing that logic and reason should replace religious dogma in public policy and international affairs.<sup>93</sup> Indeed, the Enlightenment movement had such an effect on reducing the centrality of God in Western European civilization that the 19<sup>th</sup> century German philosopher, Friedrich Nietzsche famously stated “God is Dead!” in his 1882 work *The Gay Science*.<sup>94</sup> The minimization of religion in public life in Western nations is reflected by the separation of church and state, and, at a more individual level, by the increasing number of people in Western countries, including Canada and the United States, who identify as religiously *unaffiliated*. However, the reality is that in many, if not most LMICs, including Uganda, God is *not* dead. In fact, a 2007 UN Fund for Population Activities State of the World Report indicates that despite the advent of rationality and secularism, the prominence of religion has continued to exist.<sup>95</sup> Not only do a growing majority of people in LMICs practice a religion, but the influence of religion in the public domain is also becoming more obvious.<sup>96</sup> This reality is reflected by the fact that in Uganda’s 2014 census, 97% of respondents identified as religious.<sup>97</sup>

While multilateral health organizations are hesitant to partner with FBOs, many FBOs are equally as reluctant to engage with Western secular organizations because they are resistant to

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<sup>92</sup> *Ibid.*

<sup>93</sup> *Ibid.*

<sup>94</sup> Friedrich Nietzsche, “The Gay Science” (1887), Book Three, sec 125 at 181.

<sup>95</sup> UNFPA, “State of the World Population: Unleashing the Potential of Urban Growth” (2007), at 26.

<sup>96</sup> Grills, *supra* note 31 at 506.

<sup>97</sup> See Uganda Bureau of Statistics, “The National Population and Housing Census 2014 – Main Report” (2016), Kampala: Uganda at 19, online: [https://www.ubos.org/wp-content/uploads/publications/03\\_20182014\\_National\\_Census\\_Main\\_Report.pdf](https://www.ubos.org/wp-content/uploads/publications/03_20182014_National_Census_Main_Report.pdf).

the imposition of neocolonialist value-neutral worldviews on their communities, which are generally very religious.<sup>98</sup> Indeed, in a country like Uganda, where religion is central and arguably inseparable from development issues, it is problematic for Western multilateral organizations to come in and impose their secularist beliefs without any understanding of or appreciation for the faith-based worldview of FBOs and the communities in which they operate.<sup>99</sup>

In order to address these ethical tensions, it is useful, as a *first step*, for multilateral health organizations and FBOs to obtain a better understanding of the ethical codes and sources that underpin one another's vastly different worldviews. Through this process, it is possible to gain insight into the moral values and sources that typically influence ethical decision making, especially in the context of health care.<sup>100</sup> While FBOs differ tremendously, most tend to believe that sources of morality and epistemological authority come from divine revelation through scriptures and teaching, usually interpreted or preached by faith-grounded experts, such as Priests or Imams.<sup>101</sup> Religious ethical theories are often referred to as "duty-based" or "deontological" because ethical principles tend to derive from divine commandment or religious law.<sup>102</sup> In other words, those who adhere to a religious code of ethics, will typically obtain guidance from religious sources, like the Bible or the Koran, which articulate sacred principles, including the sanctity of life, compassion and quality of life, among others.<sup>103</sup>

In contrast, secular multilateral organizations tend to adhere to a code of ethics that is principle-based and that obtains

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<sup>98</sup> Grills, *supra* note 31 at 513.

<sup>99</sup> *Ibid.*

<sup>100</sup> See Ionut Stefan, "Arguments for and against abortion in terms of teleological and deontological theories," (2014) *Social and Behavioural Sciences* 149 927 at 934.

<sup>101</sup> Tomkins et al, *supra* note 40 at 1776.

<sup>102</sup> See Seven Pillars Institute, "Kantian Duty Based (Deontological Ethics)," (29 January 2013), online: <https://sevenpillarsinstitute.org/kantian-duty-based-deontological-ethics/#:~:targetText=The%20theory%20of%20deontology%20states,steal%2C%20lie%2C%20or%20cheat.>

<sup>103</sup> See Robert D Orr, "Incorporating Spirituality into Patient Care" (2015) *American Medical Association Journal of Ethics* 17:5 409 at 410 [Orr].



authority from human reason, logic and/or experience.<sup>104</sup> One of the most well-known principle-based theories is utilitarianism, a form of consequentialism, whereby the right or wrongness of an action is based on the utility of its outcomes.<sup>105</sup> However, principle-based theories can be based on more than just one principle. For example, the humanist approach, which tends to guide secular medical ethics, is rooted in principles of autonomy, beneficence, non-maleficence and justice, and values human freedom and the protection from harm and suffering.<sup>106</sup> UNESCO's Universal Declaration on Bioethics and Human Rights is an example of a principle-based code of ethics, as it refers to multiple ethical principles, including the benefit to the patient (Art. 4), respect for autonomy (Arts. 5–7) and justice (Art 10).<sup>107</sup>

Although religious and secular ethical systems differ in their account of the ontology of ethical norms, sacred principles often overlap with secular principles.<sup>108</sup> For example, it could be argued that, at their core, religious codes of ethics guiding FBOs and secular codes of ethics guiding multilateral health organizations have the same goal of determining what human actions are right and wrong in medicine.<sup>109</sup> Both codes of ethics appear to share values of compassion, human integrity and do no harm. The existence of these shared values is perhaps best illustrated by the fact that the Hippocratic Oath, an oath historically taken by all physicians, is a commonly shared set of principles that is put forward by both mainstream religious ethicists and secular bioethicists.<sup>110</sup> As noted by Veatch, the Hippocratic Oath demonstrates that "...the ethics of health care can be

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<sup>104</sup> See Robert M Veatch, "Hippocratic, religious and secular ethics: The points of conflict" (2012), *Theor Med Bioeth* 33 33 at 40 [Veatch].

<sup>105</sup> Julia Driver, "The History of Utilitarianism" (2014), *Stanford Encyclopedia of Philosophy*, online: <https://plato.stanford.edu/entries/utilitarianism-history/>

<sup>106</sup> Tomkins et al, *supra* note 40, at 1776; See also Veatch, *supra* note 102 at 40 for other examples of principle-based theories.

<sup>107</sup> See United Nations Educational, Scientific and Cultural Organization (UNESCO), "Universal Declaration on Bioethics and Human Rights" (19 October 2005), online: [http://portal.unesco.org/en/ev.php-URL\\_ID=31058&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html)

<sup>108</sup> Orr, *supra* note 102 at 411.

<sup>109</sup> *Ibid* at 410.

<sup>110</sup> Veatch, *supra* note 103 at 41.

grounded in a core normative ethics" or some kind of "common morality."<sup>111</sup>

The common morality theory, originally put forward by Beauchamp and Childress, asserts that there is a set of principles or norms that is accepted by all "morally serious" people (i.e. all people who intend to be moral), regardless of whether they identify as secular or religious.<sup>112</sup> For example, most people, regardless of their belief system, know that there is something wrong with lying, causing pain or disability or killing. According to the theory of common morality, these universally shared insights are examples of "raw data" that can be drawn on by actors who adhere to different codes of ethics in order to collaborate more effectively.<sup>113</sup> The concept of a *universal* common morality stands in contrast with the morality of specific cultural, religious or institutional groups.<sup>114</sup> The set of universal norms that the common morality theory suggests exist, can be expressed in various ways, whether in the language of human rights or moral virtues.<sup>115</sup> For example, the universal norm that killing other humans is wrong may be articulated differently depending on one's worldview – some might refer to the sacredness of life as a reason not to kill, while others might refer to a right to life as a reason not to kill.<sup>116</sup>

Critics of the common morality theory argue that there is a lack of empirical evidence supporting the suggestion that all "morally serious" people agree on a basic set of universal moral norms.<sup>117</sup> It is certainly true that some principles or values are more absolute, and thus difficult to change; however, it could be argued that others, and in particular, those related to

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<sup>111</sup> *Ibid.*

<sup>112</sup> See Tom L Beauchamp, "A defense of the common morality," (2003) *Kennedy Institute of Ethics Journal* 13: 259–274; See also Robert M Veatch, "Is there a common morality?" (2003) *Kennedy Institute of Ethics Journal* 13:3 189 [Veatch, *Common Morality*].

<sup>113</sup> *Ibid.*, Veatch, *Common Morality*, at 189.

<sup>114</sup> See Robert M Veatch, "Secular Ethics and Professional Ethics" in *Hippocratic, Religious and Secular Medical Ethics* (Washington, DC: Georgetown University Press, 2012) at 153 [Veatch, *Secular Ethics*].

<sup>115</sup> *Ibid.*

<sup>116</sup> Veatch, *Common Morality*, *supra* note 111 at 190.

<sup>117</sup> *Ibid.*; For a more in-depth critique of the Common Morality Theory, see also David DeGrazia, "Common Morality, Coherence, and the Principles of Biomedical Ethics" (2003), *Kennedy Institute of Ethics Journal*, 13:3 219–230.

nonmaleficence, including compassion, do no harm, and respect for human life, can be interpreted with more flexibility and balance.<sup>118</sup> Indeed, these common universal norms can perhaps serve as a much needed starting point for engagement between FBOs and multilateral health organizations.

## **Part IV: Towards Reconciliation: Why Finding Shared Values for Engagement Matters**

Some might argue that engagement between multilateral health organizations and FBOs is not necessary, and that what is really needed are efforts to challenge the existing laws infringing sexual and reproductive health and rights. However, as demonstrated in Case Study II, it is unlikely that, in Uganda, efforts to advance sexual and reproductive health and rights through the court system will, on their own, be sufficient. Sensitive issues like reproductive and sexual health are deeply interwoven with religious and cultural beliefs about what is good moral conduct. Many of the influential religious groups in Uganda do not support family planning methods, such as contraception, and certainly do not permit abortion. As a result, efforts to try and legalize or even liberalize abortion would likely have a limited effect on unsafe abortion rates because religious and cultural pressures would result in women being too ashamed to seek a safe abortion through a public institution, even if available.

The issue with liberalizing legislation without first engaging with the local population to understand their needs and worldviews is well illustrated by the current situation in Kenya, an East African country that neighbours Uganda. While access to abortion has been *liberalised* in Kenya by legalizing it in instances where the mother's life is at risk or in other specified cases of emergency, the practical reality is that access to safe abortion remains limited due to the fact that most hospitals are under the control of faith-based health systems, which are opposed to the practice of abortion and thus do not offer the service.<sup>119</sup> As a result, most women in Kenya are still required to resort to dangerous unsafe abortions carried out by illegal practitioners.<sup>120</sup>

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<sup>118</sup> Orr, *supra* note 102 at 412.

<sup>119</sup> O'Brien, *supra* note 3, at 44

<sup>120</sup> *Ibid.*

Sadly, this reality is not unique to Kenya. The limitations of focusing solely on changing abortion policy, without any consideration of the socio-economic and political context, have also been noted in other African countries, including Ethiopia, Tanzania and Zambia.<sup>121</sup>

The Kenyan example reasserts the important point that it is neither practical nor beneficial to exclude influential non-state actors, such as FBOs, from health development initiatives. As alluded to earlier, in Uganda, the capacity of FBOs to deliver critical health services, earn the trust of vulnerable people, mobilize grassroots support, and influence social norms are all features that give them a certain legitimacy that multilateral organizations simply do not have.<sup>122</sup> This legitimacy is an important tool required for changing social and cultural perspectives on sensitive issues related to sexual and reproductive health because people are more likely to listen to actors who are trusted and embedded within the community. Without a change in social and cultural norms, efforts to liberalize sexual and reproductive health policies in Uganda will continue to be limited. Multilateral health organizations must therefore work with FBOs in order to effectively and *legitimately* address barriers to sexual and reproductive health.

As demonstrated by the following case study discussing the promotion of vaccination uptake in Sierra Leone, building legitimacy through engagement with well-respected actors, such as FBOs, is critical for bringing about social change necessary for the advancement of health.

#### Case Study III: *Marklate* – Working Together to Prevent Disease in Sierra Leone

In the 1970s, Sierra Leone introduced a UN supported “Expanded Programme on Immunization”. However, within just a few years, it ground to a halt due to high levels of illiteracy, a lack of mass media, and religious-based resistance, especially among the Muslim population. In 1986, a new immunization programme

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<sup>121</sup> See Blystad et al, “The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia” (2019), *International Journal for Equity in Health* 18:126.

<sup>122</sup> UNDP Guidelines, *supra* note 14 at 3, 6.

was implemented called *Marklate* – meaning “vaccinate” in the local language. The goal of *Marklate* was to immunize at least 75% of children with 6 antigens by 1990. Twenty-six per cent of the resources allocated to the program were dedicated to social mobilization and training, and strategies were decided to engage with all sectors and levels of society. Indeed, the UNICEF national social mobilization team, in collaboration with the Ministry of Health, formed action groups to promote the program among political bodies, but also among farmer associations, market women and importantly, religious groups, in order to spread health education messages to the general public.

Initial attempts to include religious leaders in *Marklate* involved inviting representatives from *all* religious in Sierra Leone to a leadership workshop. However, these efforts were relatively unsuccessful because the workshop sessions resulted in participants debating their different beliefs, rather than trying to find common ground on how to prevent the spread of disease. Several months later, the UNICEF team – recognizing that Muslims were the largest segment of the population, and that vaccination rates were lowest among this group – organized a three-day workshop involving Islamic faith leaders, organizations and businesses. As a result of this workshop, the Islamic Action Group was formed, a not-for-profit that became an important vehicle for disseminating messages about the benefits of vaccination.

Many of the religious leaders were initially resistant to the idea of vaccination, either because they viewed the practice as anti-Islamic, or because they were wary of UNICEF’s motives. In response to these concerns, the UNICEF team drew on quotations from the Koran – which identified support for child survival – in an effort to find common ground between religious teachings and UNICEF’s objective to increase vaccination rates. Eventually, many of the religious leaders who were at first skeptical of the programme adopted the *Marklate* campaign as their own, explaining to their congregations that parents have a duty to ensure the welfare of their children. Imams included message promoting child survival and development in their sermons, and in some cases, even announced dates and locations of immunization sessions.

This case study illustrates two key ideas. First, it highlights that in order to address sensitive issues, like vaccination uptake, multilateral health organizations must engage with influential

groups like FBOs, who have legitimacy in the eyes of local communities. Second, it demonstrates that through obtaining a better understanding of the ethical codes underpinning FBOs, which, as explained previously, are generally derived from religious scripture such as the Koran, it is possible for multilateral health organizations to identify commonalities with their own secular principle-based codes of ethics.

Indeed, the identification of shared ethical values and principles can lay the foundation for more effective collaboration and engagement between FBOs and secular multilateral health organization for three key reasons: i) it leads to an improved understanding and increased trust between partners; ii) it allows for the identification of strategic entry points; and iii) it facilitates the translation of human rights into local terms.<sup>123</sup>

i. Building Understanding and Trust

Understanding and trust are critical factors for the establishment and maintenance of any meaningful and impactful partnership, but they are especially important for one involving actors who adhere to significantly different codes of ethics and who are thus, inherently wary of one another’s agendas. Through identifying shared values and principles, FBOs and multilateral organizations can, at the very least, find a common starting point for collaboration on certain issues, even if significant differences in worldview remain. As noted by the UNDP, “sound partnerships are built on honest dialogue about what each party hopes to achieve and whether there is common ground for action.”<sup>124</sup> The goal should not be to make multilateral organizations’ viewpoints more religious or conversely, to persuade FBOs to adopt a more secular worldview.<sup>125</sup> Both actors must demonstrate respect, and in doing so, must recognize their own prejudices and assumptions about the other party and their beliefs. When engaging with one another, it is imperative that they maintain a non-judgmental

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<sup>123</sup> UNDP Guidelines, *supra* note 14, at 12–13; See also Sally Engle Merry, “Transnational Human Rights and Local Activism: Mapping the Middle” in Rene Provost and Colleen Sheppard (eds) *Dialogues on Human Rights and Legal Pluralism* (Springer: 2013) 207-228 [Engle Merry].

<sup>124</sup> UNDP Guidelines, *supra* note 14, at 13.

<sup>125</sup> *Ibid.*

attitude about beliefs and practices that may not coincide with their own.<sup>126</sup>

ii. Identification of Strategic Entry Points for Collaboration

Efforts to recognize shared values may also enable FBOs and multilateral health organizations to identify strategic entry points for collaboration. For example, as demonstrated in Case Study III discussing vaccination uptake in Sierra Leone, UNICEF and the Imams were able to identify the shared value of promoting child survival, which served as an entry point for their effective collaboration in promoting the uptake of vaccinations.<sup>127</sup> Even if the entry point is narrow, a shared viewpoint that creates any amount of space for discussion about how to address health issues that are contentious can present an important opportunity for engagement.

The Global Interfaith and Secular Alliance, known as GISA, is an excellent example of how secular and faith-based organizations have used a better understanding of shared values, principles and objectives to identify strategic entry points for collaboration. GISA is a coalition of faith-based and secular organizations from around the world working to counter religious extremist forces that seek to limit global progress, specifically with respect to reproductive and sexual health rights.<sup>128</sup> Through this initiative, secular and faith-based groups have identified shared values of equality and justice, which have proved to be flexible enough to serve as an entry point to establish a joint agenda to meet women's health care needs.<sup>129</sup>

iii. Translation of Human Rights into Locally Resonant Terms

The identification of shared values between FBOs and multilateral health organizations can also serve as a critical step for *translating* global human rights into terms that resonate with

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<sup>126</sup> *Ibid*, at 12.

<sup>127</sup> UNICEF, *supra* note 122, at 24.

<sup>128</sup> O'Brien, *supra* note 3, at 48; For more information about GISA, see also Catholics for Choice, "GISA", online: <http://www.catholicsforchoice.org/global-interfaith-secular-alliance/>.

<sup>129</sup> O'Brien, *supra* note 3, at 49.

individuals of a particular context.<sup>130</sup> According to Sally Engle Merry, translators play an important role in transmuting global human rights ideas or concepts into local contexts. Effective translation requires that human rights ideas be *framed* in terms of local norms, values and practices.<sup>131</sup> Framing involves packaging an idea in a way that generates shared beliefs and produces a change in individual consciousness about an issue or problem.<sup>132</sup> Therefore, without a strong understanding of the local context, and the values that local communities embrace, it is difficult to be an effective or legitimate translator.

In many ways, multilateral health organizations seeking to advance sexual and reproductive health rights in Uganda act as translators between global human rights norms and the local population. It is therefore critical for them to understand the context of Uganda, and accordingly, to recognize the role of FBOs in health service provision and in influencing social norms and public policy. By obtaining a stronger understanding of the codes of ethics guiding many FBOs, multilateral health organizations are in a better position to be able to more persuasively frame human rights in a way that resonates with local Ugandans and policy makers. Indeed, the more resonant the frame with the culture, the greater the likelihood that the translation process will be successful.<sup>133</sup>

However, the process of translating global human rights into local contexts in a way that successfully generates shared beliefs and motivates collective action is by no means straightforward. As noted by Sally Merry Engle,

“...the translator occupies a position of both power and vulnerability. She has the power to define and articulate issues for audiences beyond the local community, yet as she struggles to satisfy the expectations of people in different and possibly incompatible worlds, she risks appearing

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<sup>130</sup> Engle Merry, *supra* note 123, at 211.

<sup>131</sup> *Ibid* at 212.

<sup>132</sup> *Ibid*.

<sup>133</sup> Engle Merry, *supra* note 123 at 212–213.



as a traitor or collaborator with one side rather than the other.”<sup>134</sup>

Human rights workers, including those representing multilateral health organizations seeking to engage with FBOs in Uganda, will inevitably occupy this position of power and vulnerability. In many ways, they will be required to have one foot in a powerful secular world and the other in a more vulnerable religious one. As noted by Grills, this creates a difficult paradox whereby, in order to be accepted, human rights have to be tailored to the local context, but to be part of the secular human rights system, they must also emphasize autonomy, choice, equality and other ideas embedded in legal documents that constitute human rights law.<sup>135</sup> As a result, meaningful collaboration often feels superficial unless either the religious or secular actor adopts some element of the other’s identity.<sup>136</sup> Indeed, while focusing on what resonates with the local context may increase the likelihood of engagement, engagement is meaningless if it is unlikely to produce actual change that will advance health. Therefore, as noted by Engle Merry “translators must assess to what extent they can challenge existing modes of thinking and to what extent they must package radical ideas into familiar boxes.”<sup>137</sup> In order to conduct this assessment, it is first necessary for multilateral health organizations to understand which values are flexible and which are non-negotiable among FBOs.

Despite these obvious challenges, the process of analyzing one another’s ethical codes as a means to identify shared values can be a useful starting point for establishing a foundation for collaboration between FBOs and multilateral health organizations. While it is unlikely that collaboration will be perfect, or even neat, FBOs have such influence in Uganda’s health sector, both among everyday people and among political actors, that not engaging with these groups is unwise for any international agency intending to reach the targets set out in SDG three.

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<sup>134</sup> *Ibid*, at 215.

<sup>135</sup> Grills, *supra* note 31, at 513.

<sup>136</sup> *Ibid*.

<sup>137</sup> Engle Merry, *supra* note 123, at 213.

## Conclusion

Religion is quite literally embedded in the seven hills that make up the expansive landscape of Kampala, Uganda’s capital city: Lubaga Hill is assigned to the Catholics and remains the seat of the headquarters of the Catholic Church in Uganda; Namirembe Hill is assigned to the Protestant Church and is home to Saint Paul’s Cathedral; and Kibuli Hill, the site of the Kibuli Mosque, is assigned to the Muslims. However, religion reaches far beyond the topography of these hills. It embeds itself into all aspects of life in Uganda, affecting individual viewpoints and community perspectives on various issues, including those related to health.<sup>138</sup> Indeed, FBOs and religious leaders play a particularly important role in influencing social norms and policies related to health and wellbeing, especially when it comes to more sensitive topics related to sex and reproduction. In some circumstances, FBOs in Uganda have facilitated the advancement of health, but in other cases the religiously guided ideas and agendas they propagate have frustrated its advancement and have proved to be at odds with global human rights, including most notably, sexual and reproductive health rights. The controversial nature of FBOs and their role in advancing health can be problematic for secular multilateral health organizations, which, despite recognizing FBOs as critical partners for achieving the health development goals set out in SDG three, fear that engagement with these groups will undermine their impartial identity and will conflict with their commitment to human rights norms.<sup>139</sup>

The purpose of this paper was not to identify a magic-bullet solution that will enable FBOs and multilateral health organizations to work together perfectly or even neatly. Rather, it seeks to suggest that a greater understanding of the different ethical codes underpinning FBOs and multilateral health organizations can serve as a foundation for more effective engagement. Indeed, through obtaining a better understanding of the ethics guiding FBOs, on the one hand, and secular multilateral organizations, on the other, it is possible to identify shared values,

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<sup>138</sup> Tomkins et al, *supra* note 40, at 1776.

<sup>139</sup> Grills, *supra* note 31, at 511.

including compassion, do no harm and human dignity, and to become aware of those values that are non-negotiable. The process of identifying shared and non-negotiable values has the potential to lay the foundation for more meaningful collaboration because it leads to improved understanding and increased trust among actors; it allows for the identification of strategic entry points for engagement; and it facilitates a better understanding of local context and thus the translation of global human rights into more resonant terms.<sup>140</sup>

As noted by the World Bank President, James Wolfensohn, in 2002, “half the work in education and health in sub-Saharan Africa is done by the church...but they don’t talk to each other and they don’t talk to us.”<sup>141</sup> It has been well-known now for nearly two decades that FBOs play a significant role in the health sectors of many LMICs, and especially those, like Uganda, where governance structures are weak.<sup>142</sup> It is therefore imperative that FBOs and multilateral health organizations move beyond their secular silos and carefully look at the potential for engagement.<sup>143</sup> Despite the undeniable challenges that will come with collaboration, it is only by moving out of their discrete disciplines and by working together that health development workers, policy makers and faith leaders will be able to advance sexual and reproductive health in Uganda. Without meaningful engagement between these critical actors, it is unlikely that the sexual and reproductive health targets set out by SDG three will be met and women will keep dying, turning to God as their only source of hope for survival.

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<sup>140</sup> UNDP Guidelines, *supra* note 14, at 12–13; See also *supra* note 123, Engle Merry, 211–213.

<sup>141</sup> Olivier et al, *supra* note 18, at 1765.

<sup>142</sup> UNDP Guidelines, *supra* note 14, at 3.

<sup>143</sup> Tomkins et al, *supra* note 40, at 1782.

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