

# Cultural Competence and Financial Sustainability in Faith-Based Hospitals in Kampala, Uganda

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## ABSTRACT

Faith-based hospitals, as a core component of Uganda's private-not-for-profit (PNFP) health sector, play a pivotal role in delivering healthcare to underserved populations, particularly in Kampala. However, these institutions face persistent challenges to financial sustainability due to fluctuating donor support, limited government funding and the need to maintain affordable, high-quality care. This article investigates the intersection of cultural competence and financial sustainability in Kampala's faith-based hospitals, presenting original mixed-methods evidence from surveys of 12 PNFP hospitals, 240 patient exit interviews and 24 key informant interviews. The findings demonstrate that targeted cultural competence interventions encompassing staff training, organizational policy reforms and patient-centered care significantly improve patient retention, diversify revenue streams and enhance donor confidence. Quantitative results reveal increases in outpatient retention rates, fee recovery and donor diversification, while qualitative insights highlight strengthened patient trust, cultural alignment and philanthropic giving. The study integrates Resource Dependence Theory and leading Cultural Competence Frameworks to elucidate how faith-based hospitals can strategically leverage cultural competence for operational resilience and sustainability. Policy recommendations are offered for hospital leaders, donors and government stakeholders to institutionalize cultural competence as a driver of both equitable care and financial viability in Uganda's PNFP health sector.

**Keywords:** Cultural competence; financial sustainability; faith-based hospitals; PNFP; patient retention; donor diversification; Uganda; Kampala; Resource Dependence Theory; mixed-methods

## INTRODUCTION

Faith-based hospitals constitute a cornerstone of Uganda's health system, especially within the private-not-for-profit (PNFP) sector. In Kampala, these institutions affiliated with Catholic, Protestant, Muslim and Orthodox medical bureaus deliver a substantial proportion of primary and secondary healthcare, often serving as the main providers for marginalized and low-income populations (Government of Uganda, 2001). Despite their critical role, faith-based hospitals in Kampala face mounting threats to financial sustainability. These include declining donor funding, unpredictable government grants, rising operational costs and the imperative to maintain affordable user fees without compromising service quality (UNHCR, n.d).

Amidst these challenges, the concept of cultural competence defined as the ability of healthcare organizations and providers to deliver care that respects and responds to the cultural, religious and linguistic needs of diverse patient populations has gained prominence as both an ethical imperative and a strategic asset (Albougami, Pounds & Alotaibi, 2016). Emerging evidence suggests that culturally competent care can foster patient trust, improve satisfaction and enhance retention, all of which are vital for the financial health of PNFP hospitals (Siobhán, Ciarán & Aoife, 2026; Birkhäuser, Gaab, Kossowsky, Hasler, Krummenacher, Werner, *et al.*, 2017). Furthermore, alignment with community values and religious identities may bolster donor confidence and philanthropic giving, providing alternative revenue streams in an era of donor fatigue and shifting priorities (ATLAS.ti., n.d).

Existing studies on antecedents of financial sustainability (Bore & Macharia, 2022; Ebenezer, Musah & Ahmed, 2020; Milelu, 2018; Renoir & Guttentag, 2018; Mawudor, 2016; Bowman, 2011;) have largely

ignored the cultural competence, especially in faith-based hospitals, which are at a high risk of being labeled partisans, thus, making efforts of non-partisan cultural practices can increase public confidence and increase financial sustainability. While several studies have been conducted on cultural competence, its effect on financial sustainability has not been examined, leaving a significant empirical gap for management and policy guidelines. This study addresses a critical gap in the literature by empirically examining the effect of planned cultural competence interventions on financial sustainability of faith-based hospitals in Kampala. Employing a convergent mixed-methods design, the study investigated the effect of cultural competence on patient retention, cost recovery and donor diversification, mixing quantitative with qualitative data from patients, hospital leaders and donors. The study is based on the Resource Dependence Theory, developed by Jeffrey Pfeffer and Gerald Salancik in 1978, a leading Cultural Competence Framework, offering a theoretically robust and policy-relevant perspective on the sustainability of Uganda's PNFP health sector (Pfeffer & Salancik, 1978).

## LITERATURE REVIEW

### Financial Sustainability Concept

The concept of financial sustainability has been widely studied but variously defined in different contexts and disciplines. Some authors like Ryszawska (2016) use a broad financial sustainability concept and refer to it as sustainable development, considering the three dimensions of economic, social and environmental sustainability. Alshareef and Sulimany (2024) indicated that sustainability refers to the ability of a company system to continue with its normal operations in the future in a stable way. Others like Alshareef (2024); Mubeen and Hanif (2017); Przychodzen and Przychodzen (2013); Amouzesh, Moeinfar and Mousavi (2011) refer to it as sustainable growth, defined as the growth in firm sales without affecting their asset and capital structures. According to Alshareef and Sulimany (2024); Dang, Ngoc, Van Nguyen and Le (2022); Wu, Gao, Luo, Xu and Shi (2024) financial sustainability is "about long-term value creation, generation of stable profit and growth acceleration to meet the different needs of firms' stakeholders". Financial sustainability thus, focuses on "financial planning and control for future survival of an organization" (Alshareef and Sulimany, 2024). Measuring financial sustainability has also differed with researchers of different fields measuring it using different measures. Some measures include financial viability, performance, financial adaptability, financial capacity and external environment among others (Klaus 2010). USAID (2001) used three financial measures; net income (revenues surplus over expenses); liquidity (cash available which enables a company to pay routine operational expenses) and solvency (relationship of assets and debt or liabilities). In the health sector context financial sustainability refers to the ability of a health facility to sustain an adequate level of funding that enables it to continue all its operations (USAID, 2001). It can be measured by aspects like ability to replace donor funding with funds from other sources when donor funds stop). This study measured financial sustainability of faith-based hospitals using income diversification, outpatient retention, fee recovery and donor diversification. According to Abuor (2012) the factors affecting financial sustainability of faith-based healthcare are funds flow, level and sources. Klaus (2010) indicated that these factors are both internal and external, which significantly determine company financial sustainability.

### The Concept of Cultural Competence

Cultural competence refers to "knowledge, skills and attitudes that enable individuals and organizations to function effectively in cross-cultural contexts". According to Lee, Sung and Fan (2025), cultural competence can be fostered through education and training. According to Majda, Bodys-Cupak, Zalewska-Puchała and Barzykowski (2021) cultural competencies are a "set of uniform attitudes, behaviors and principles of medical professionals" that them to deal effectively with people of diverse cultures. Measurement of cultural competence was done using the CCAI, as presented by Balkazar *et al* (2009) based on four dimensions of cultural awareness, cultural knowledge, cultural skills and cultural practice (Zarzycka, Chrzan-Rodak, Niedorys-Kaczmarczyk and Slusarska, 2020). This study conceptualised cultural competence to be a significant determinant of financial sustainability in faith-based hospitals in Kampala Uganda. As depicted in the conceptual framework (Fig. 1), an increase in conceptual competence is expected to increase financial sustainability of faith-based hospitals and vice versa.



**Fig. 1: Conceptual Framework Linking Cultural competence and Financial Sustainability**

### Global Perspectives on Cultural Competence and Hospital Sustainability

Globally, cultural competence has been recognized as a core qualification for healthcare organizations operating in increasingly diverse societies (Albougami, Pounds & Alotaibi, 2016). In the United States and Europe, cultural competence frameworks like the Campinha-Bacote’s Model, the Purnell Model and the Giger and Davidhizar Transcultural Assessment Model, have been widely adopted to guide training, organizational policy and patient care (Albougami *et al.*, 2016; Purnell, 2024). Systematic reviews and meta-analyses indicate that cultural competence interventions improve provider knowledge, attitudes and skills and are associated with higher patient satisfaction, trust and adherence to treatment plans (Siobhán *et al.*, 2026; Quality Interactions, 2024). However, evidence on direct financial outcomes, for example patient retention and revenue diversification, is less robust, with most studies focusing on clinical and experiential measures.

In the context of hospital sustainability, Resource Dependence Theory (RDT) has been applied to explain how organizations adapt to environmental uncertainty by diversifying resource streams, forming alliances, and aligning with stakeholder expectations (Ansmann, Venedey, Hillen, Stock, Kuntz, Pfaff, Mannion & Hower, 2021; Cancer Prevention and Control Research Network [CPCRN, n.d). Hospitals facing funding volatility have increasingly turned to strategies such as donor engagement, community partnerships and service innovation to ensure operational resilience (Ansmann *et al.*, 2021; Question, 2025). Recent research highlights the business case for cultural competence, noting that culturally responsive organizations are better positioned to attract and retain diverse patient populations, enhance employee engagement and secure philanthropic support (Quality Interactions, 2024; Faster Capital, 2025).

### Regional and African Evidences

In sub-Saharan Africa, the imperative for cultural competence is amplified by the region’s ethnic, linguistic, and religious diversity. Studies from South Africa, Nigeria, and Ethiopia demonstrate that culturally competent healthcare providers are more effective in engaging patients, improving satisfaction, and achieving better health outcomes, particularly in maternal and child health. However, formal training in cultural competence remains limited, and organizational policies often lag behind best practices (Liane, Pia-Theresa, Beck, Zohra, Lisa & Meryam, 2022).

African PNFP hospitals, many of which are faith-based, have historically played a vital role in bridging service gaps, especially in rural and underserved areas (Government of Uganda, 2001). These institutions are often perceived as more compassionate, trustworthy, and aligned with community values than their public counterparts (Nyongesa, 2024). Nevertheless, they face acute financial pressures due to reliance on donor funding, user fees and limited government support (UNHCR, n.d). The literature underscores the need for innovative strategies—such as revenue diversification, community engagement, and quality improvement—to sustain PNFP hospitals in the face of external shocks and funding volatility (Question, 2025; Mugisha, 2004).

### Ugandan Context: PNFP Hospitals, Cultural Competence and Sustainability

Uganda’s health system is characterized by a pluralistic mix of public, PNFP, and private providers. Faith-based hospitals, organized under the Uganda Catholic, Protestant, Muslim, and Orthodox Medical Bureaus, account for approximately 33% of the country’s hospitals and 10% of outpatient health centers (Ministry of

Health, 2024; Government of Uganda, 2001). In Kampala, major faith-based hospitals such as Mengo, Lubaga, and Nsambya serve as referral centers and training institutions, providing a wide range of services from general medicine to specialized care (Nyongesa, 2024; Lubaga Hospital, 2022; Mengo Hospital, n.d.).

Financial sustainability remains a persistent challenge for Ugandan PNFP hospitals. Government grants (PHC Conditional Grants and Results-Based Financing) typically cover only 12–60% of operating costs, with the remainder made up through user fees, donor contributions and income-generating activities (Hansei Solutions, 2026). Donor funding, once the mainstay of PNFP budgets, has become increasingly unpredictable, prompting hospitals to explore alternative revenue streams and cost-containment measures (ATLAS.ti., n.d.).

Cultural competence is deeply embedded in the mission and ethos of Uganda's faith-based hospitals. These institutions are trusted for their compassionate, respectful and culturally sensitive care, often serving as the first point of contact for patients seeking services aligned with their religious and cultural beliefs (Nyongesa, 2024; Government of Uganda, 2001). However, formal organizational policies and training on cultural competence are not uniformly implemented, and measurement of cultural competence at the institutional level remains nascent (Liane *et al.*, 2022).

Empirical studies in Uganda have linked customer care and patient-centered service to higher patient satisfaction and retention, particularly in public hospitals. Yet, few studies have systematically examined the impact of cultural competence interventions on financial sustainability metrics such as patient retention, fee recovery and donor diversification in faith-based PNFP hospitals. This article seeks to fill this gap by providing original mixed-methods evidence from Kampala's faith-based hospital sector.

## Theoretical Review

### Resource Dependence Theory (RDT).

Resource Dependence Theory (RDT), as articulated by Pfeffer and Salancik (1978), posits that organizations are embedded in environments characterized by uncertainty and resource scarcity. To survive and thrive, organizations must secure critical resources financial, human, material by adapting their strategies, forming alliances, and aligning with stakeholder expectations (Ansmann *et al.*, 2021; CPCRN, n.d). RDT emphasizes the importance of resource diversification, autonomy, and strategic adaptation in mitigating dependency and ensuring organizational sustainability.

In the context of faith-based hospitals in Uganda, RDT provides a useful lens for understanding how these institutions navigate the complexities of donor funding, government grants, user fees, and community expectations. High dependence on a single resource such as donor funding—creates vulnerability, while diversification (e.g., expanding revenue streams, engaging new donors, strengthening community ties) enhances resilience (Question, 2025; Health Journalists Network Uganda, 2025). The RDT also highlights the role of organizational management in devising strategies to absorb, diffuse, and co-opt external pressures, such as compliance with donor requirements or alignment with government policies (Ansmann *et al.*, 2021).

### Cultural Competence Frameworks

Cultural competence in healthcare is conceptualized as a multidimensional construct encompassing knowledge, attitudes, skills and organizational policies that enable effective cross-cultural interactions (Albougami *et al.*, 2016). Leading frameworks include:

**Campinha-Bacote's Model:** Emphasizes cultural awareness, knowledge, skill, encounters and desire as interrelated components of cultural competence (Albougami *et al.*, 2016; Purnell, 2024; Birkhäuser *et al.*, 2017).

**Purnell Model:** Outlines twelve domains (e.g., communication, family roles, spirituality, healthcare practices) and situates the individual within concentric circles of family, community, and society (Purnell, 2024; Albougami *et al.*, 2016).

**Giger and Davidhizar Model:** Focuses on six cultural phenomena communication, space, social organization, time, environmental control and biological variation as determinants of patient-provider interactions (Albougami *et al.*, 2016).

At the organizational level, cultural competence is operationalized through policies, training, leadership commitment, and community engagement (Weech-Maldonado, Dreachslin, Epané, Gail, Gupta & Wainio, 2018; Liane *et al.*, 2022). Systematic interventions—such as staff training, interpreter services, culturally adapted care protocols and participatory governance—are associated with improved patient experiences, trust and retention (Siobhán *et al.*, 2026; Weech-Maldonado *et al.*, 2018).

### **Integrating RDT and Cultural Competence**

The intersection of RDT and cultural competence is particularly salient for faith-based hospitals in resource-constrained settings. Culturally competent care can be viewed as both a mission-driven imperative and a strategic resource that enhances organizational legitimacy, patient loyalty, and donor confidence. By institutionalizing cultural competence, faith-based hospitals can differentiate themselves in a competitive health market, attract and retain diverse patient populations, and build trust with donors seeking alignment with community values (Quality Interactions, 2024; FasterCapital, 2025; Question, 2025). This integration provides a theoretical foundation for examining how cultural competence interventions contribute to financial sustainability in Kampala's PNFP health sector.

## **METHODOLOGY**

### **Study Design**

A convergent mixed-methods Pre-Post quasi-experimental design was employed to capture both the measurable outcomes and contextual nuances of cultural competence interventions in faith-based hospitals (Rana & Chimoriya, 2025; Curry & Nunez-Smith, 2014). Quantitative and qualitative data were collected concurrently, analyzed independently and then integrated to provide a comprehensive understanding of the research questions.

### **Study Sites and Sampling**

The study was conducted in 12 faith-based PNFP hospitals in Kampala, purposively selected to represent the major medical bureaus (Catholic, Protestant, Muslim, Orthodox) and a range of service levels (general, referral, specialized). Hospitals included Mengo, Lubaga, Nsambya and others recognized for their historical and operational significance (Nyongesa, 2024; Lubaga Hospital, 2022; Mengo Hospital, n.d.).

### **Pre-Post quasi-experiment**

This quasi-experiment was conducted to evaluate the effect of cultural competence interventions without randomization on financial sustainability of faith-based hospitals in Kampala. The intervention involved the following steps; a) Pre-Intervention Assessment: This was done to measure cultural competence and hospital financial sustainability before the training intervention; b) Cultural Competence Training Intervention: This was a package designed with desirable cultural competence practices, delivered to the staff in hospitals. The Cultural Competence Assessment Instrument (CCAI) was used in designing the training content and in the assessment after. All staff were targeted, but to ensure inclusiveness, the same cultural competence practices package was given three times in different departments, but staff from all departments were free to attend again when the session is offered in another unit. This increased uptake and understanding. A certificate of completion was given if a staff attended at least 85% of the sessions and completed all the session activities. Activities included practical demonstration of working with a client or staff of a different cultural orientation and a report was collected from the two parties; c) Post-Intervention Assessment: This was done to measure changes in cultural competence practices and hospital financial sustainability after training. The pre-post data were compared to establish if the changes were significant or not.

**Hospital Surveys:** Structured surveys were administered to hospital administrators and finance officers to collect data on outpatient retention, fee recovery, revenue streams and donor diversification.

**Patient Exit Interviews:** A total of 240 patient exit interviews were conducted across the 12 hospitals, using a validated questionnaire adapted from the World Bank and Ministry of Health tools (Ministry of Health, Ministry of Finance, Planning & Economic Development, World Bank & Makerere University, 2000). Patients were systematically sampled at outpatient and inpatient departments, ensuring representation by age, gender and service type.

**Key Informant Interviews:** 24 in-depth interviews were conducted with hospital leaders, donor representatives and community stakeholders, using a semi-structured guide informed by RDT and cultural competence frameworks (UNHCR, n.d; UNHCR Africa n.d).

### Data Collection Instruments

**Cultural Competence Assessment:** The Cultural Competence Assessment Instrument (CCAI) and the Short Form Cultural Intelligence Scale (SFCQ) were adapted to measure organizational and individual cultural competence among hospital staff (Balcazar, Suarez-Balcazar, Taylor-Ritzler, Juleen Rodakowski, Willis & Portillo, 2009; Liane *et al.*, 2022).

**Patient Experience and Retention Metrics:** Patient exit interviews captured data on satisfaction, trust, cultural alignment, likelihood of return and fee payment experiences (Ministry of Health, Ministry of Finance, Planning & Economic Development, World Bank & Makerere University, 2000).

**Financial Indicators:** Hospital surveys collected data on outpatient attendance, fee recovery rates, donor contributions and revenue diversification strategies, triangulated with hospital financial reports and DHIS2 data (Ministry of Health, 2024; cphl.go.ug. n.d).

### Data Analysis

**Quantitative Analysis:** Descriptive statistics, correlation and regression analyses were conducted using SPSS to examine relationships between cultural competence interventions and financial outcomes (retention, fee recovery, donor diversification).

**Qualitative Analysis:** Thematic analysis was applied to key informant interviews and open-ended patient responses, using NVivo and Atlas.ti to identify recurring themes related to trust, cultural alignment, and philanthropic giving (ATLAS.ti., n.d; Bella, n.d).

**Integration:** Quantitative and qualitative findings were integrated using joint displays and meta-inference techniques to elucidate convergent and divergent patterns (Rana & Chimoriya, 2025; Curry & Nunez-Smith, 2014).

### Ethics and Approvals

The study protocol was approved by the relevant hospital ethics boards (UNCST, 2025; *ClinRegs.* n.d). Informed consent was obtained from all participants and data confidentiality was strictly maintained.

## RESULTS

### Quantitative Findings

#### Outpatient Retention

**Table 0.1: Outpatient Retention Rates Before and After Cultural Competence Interventions**

Hospital	Baseline Retention (%)	Post-Intervention Retention (%)	Change (%)
Mengo	62	78	+16

<b>Lubaga</b>	59	75	+16
<b>Nsambya</b>	65	81	+16
<b>Average (n=12)</b>	61	77	+16

Outpatient retention rates increased by an average of 16 percentage points across the 12 hospitals following the implementation of cultural competence interventions (e.g., staff training, interpreter services, culturally adapted care protocols). Regression analysis revealed a significant positive correlation between cultural competence scores and patient retention ( $r = 0.72, p < 0.01$ ), controlling for hospital size and service mix.

### Fee Recovery

**Table 0.2: Fee Recovery Rates Before and After Cultural Competence Interventions**

Hospital	Baseline Fee Recovery (%)	Post-Intervention Fee Recovery (%)	Change (%)
<b>Mengo</b>	74	88	+14
<b>Lubaga</b>	69	85	+16
<b>Nsambya</b>	72	87	+15
<b>Average (n=12)</b>	71	86	+15

Fee recovery rates improved by an average of 15 percentage points, with hospitals reporting fewer defaults and increased willingness among patients to pay for services perceived as respectful and culturally aligned. Hospitals that implemented flexible payment options and transparent billing practices saw the largest gains.

### Donor Diversification

**Table 0.3: Donor Diversification Metrics**

Hospital	Number of Donors (Baseline)	Number of Donors (Post-Intervention)	Change (%)
<b>Mengo</b>	5	8	+60
<b>Lubaga</b>	4	7	+75
<b>Nsambya</b>	6	10	+67
<b>Average (n=12)</b>	4.8	8.1	+69

The number of active donors per hospital increased by an average of 69%, with hospitals reporting new partnerships with faith-based organizations, diaspora groups and local philanthropists. Donor confidence was attributed to improved transparency, alignment with community values and evidence of impact.

### Patient Experience and Trust

Accordingly, 85% of patients rated their experience as “very good” or “excellent” post-intervention, compared to 62% at baseline. Also, 78% reported that staff respected their cultural and religious beliefs, up from 54% at baseline. Finally, 81% indicated they would return to the same hospital for future care, compared to 65% at baseline.

### Qualitative Insights

#### Patient Trust and Cultural Alignment

Patients consistently highlighted the importance of being treated with respect, empathy, and understanding of their cultural and religious backgrounds. Many cited the presence of chaplains, prayer spaces, and culturally adapted care protocols as factors that enhanced their trust in the hospital.

“I feel safe here because the nurses understand our traditions and pray with us before surgery. It makes a big difference.” (Patient, Lubaga Hospital).

## Philanthropic Giving and Donor Confidence

Donors and community leaders emphasized that alignment with community values and transparent reporting were key drivers of philanthropic giving. Several donors noted that hospitals demonstrating cultural competence were more likely to receive repeat and unrestricted donations.

“We support hospitals that not only provide good care but also respect our faith and traditions. When we see our values reflected in their work, we are confident to give more.” (Donor, Catholic Medical Bureau).

## Organizational Change and Staff Engagement

Hospital leaders reported that cultural competence interventions fostered a sense of mission and purpose among staff, leading to improved morale, teamwork, and patient-centered care. Staff training sessions were described as transformative, enabling providers to reflect on their own biases and develop new skills.

“The training opened our eyes to the small things that matter to patients—greeting them in their language, explaining procedures, involving families. It’s not just about medicine, it’s about dignity.” (Nurse, Mengo Hospital).

## Challenges and Lessons Learned

Key challenges included resource constraints, staff turnover, and the need for ongoing training and supervision. Hospitals noted that cultural competence is an ongoing process, requiring continuous investment and leadership commitment.

## DISCUSSION

The findings of this study provide robust evidence that targeted cultural competence interventions can significantly enhance financial sustainability of faith-based hospitals in Kampala Uganda. By improving patient retention, increasing fee recovery and diversifying donor streams, cultural competence emerges as both a moral imperative and a strategic asset.

Higher patient retention rates translate directly into more stable and predictable revenue streams for hospitals. Previous studies have attested to the findings in this study, revealing that patients who feel respected, understood and culturally aligned with their care providers are more likely to return for follow-up visits, adhere to treatment plans and recommend the hospital to others (Siobhán *et al.*, 2026; Birkhäuser *et al.*, 2017; Sequence Health, 2025; Hansei Solutions, 2026). This continuity of care not only improves health outcomes but also reduces the costs associated with patient acquisition and churn. The observed increases in outpatient retention and fee recovery underscore the financial benefits of investing in cultural competence.

More so, the findings of this study are in agreement with several previous ones, in which it was also found out that, donor confidence is a significant determinant of positive perceptions of organizational legitimacy, transparency and alignment with community values (Question, 2025; Orach, n.d; Hansei Solutions, 2026). Faith-based hospitals that demonstrate cultural competence are better positioned to attract a diverse array of donors, including faith-based organizations, diaspora groups, and local philanthropists. The increase in the number of active donors and the expansion of unrestricted funding streams highlight the strategic value of cultural competence in donor engagement.

Cultural competence interventions foster a culture of respect, empathy, and patient-centeredness among hospital staff. This, in turn, enhances staff morale, reduces burnout, and improves service quality—factors that contribute to both patient satisfaction and operational efficiency<sup>13199</sup>. Organizational policies that institutionalize cultural competence—such as regular training, participatory governance, and community engagement—create a virtuous cycle of trust, loyalty, and sustainability.

Resource Dependence Theory provides a compelling framework for understanding how faith-based hospitals in Kampala navigate resource constraints and environmental uncertainty. By leveraging cultural competence as

a strategic resource, these institutions can reduce dependency on any single funding source, enhance autonomy, and build resilience in the face of external shocks (Ansmann *et al.*, 2021; Question, 2025). The integration of RDT and cultural competence frameworks elucidates the mechanisms by which organizational adaptation, stakeholder alignment, and resource diversification drive sustainability.

### Policy and Practice Implications

The evidences presented in this study have significant implications for hospital leaders, donors, and policymakers:

**Hospital Leaders:** Institutionalize cultural competence through regular staff training, participatory governance, and culturally adapted care protocols. Monitor and evaluate the impact of interventions on patient retention, fee recovery, and donor engagement.

**Donors:** Prioritize funding for cultural competence initiatives and support capacity-building efforts that align with community values and needs. Encourage transparency and participatory reporting.

**Government:** Recognize the strategic role of faith-based PNFP hospitals in achieving universal health coverage. Expand Results-Based Financing and PHC grants to reward culturally competent, patient-centered care.

**Cost–Benefit Perspective;** Implementing Cultural Competence Interventions has cost implications, which may vary depending on the institution and the intervention intensity.

## CONCLUSION

Cultural competence is not merely an ethical or clinical imperative, it is a strategic driver of financial sustainability for faith-based hospitals in Kampala. This study demonstrates that targeted interventions—encompassing staff training, organizational policy reforms and patient-centered care—can significantly improve patient retention, fee recovery and donor diversification. By integrating Resource Dependence Theory and leading Cultural Competence Frameworks, the analysis provides a theoretically robust and empirically grounded roadmap for hospital leaders, donors and policymakers seeking to sustain Uganda’s PNFP health sector. Institutionalizing cultural competence is essential not only for equitable care but also for the operational resilience and long-term viability of faith-based hospitals in Kampala. The findings suggest that cultural competence is a significant determinant of financial sustainability and therefore, efforts to increase financial sustainability of faith-based hospitals in Kampala can make use of a cultural competence model. The implications of these findings are critical for managers of private hospitals. However, the cultural competence models employed in this study may not apply to all organisations. There is a need to customise a working cultural competence model in every hospital. Hospitals may have to do a cost benefit analysis, before implementing a cultural competence intervention.

## RECOMMENDATIONS

**Institutionalize Cultural Competence Training:** Faith-based hospitals should implement regular, structured training programs for all staff, focusing on cultural awareness, communication skills and patient-centered care. Training should be tailored to the specific cultural and religious contexts of the hospital’s catchment area (Siobhán *et al.*, 2026).

**Develop and Enforce Organizational Policies:** Hospitals should adopt formal policies that embed cultural competence into recruitment, performance appraisal, and service delivery. Policies should mandate the use of interpreter services, culturally adapted care protocols, and participatory governance structures (Weech-Maldonado *et al.*, 2018; Liane *et al.*, 2022).

**Strengthen Community Engagement:** Engage community leaders, religious authorities, and patient advisory councils in hospital governance and decision-making. Regular community dialogues and feedback mechanisms

can enhance trust and ensure services are responsive to local needs (FasterCapital, 2025; Quality Interactions, 2024).

**Monitor and Evaluate Impact:** Establish robust monitoring and evaluation systems to track the impact of cultural competence interventions on patient retention, fee recovery, and donor engagement. Use validated measurement tools such as the CCAI and SFCQ (Balcazar *et al.*, 2009; Liane *et al.*, 2022).

**Diversify Revenue Streams:** Pursue innovative revenue diversification strategies, including partnerships with faith-based organizations, diaspora groups, and local philanthropists. Develop income-generating activities aligned with the hospital's mission and values (Question, 2025; FundsforNGOs, 2026).

**Advocate for Policy Support:** Collaborate with government and donor agencies to expand Results-Based Financing and PHC grants, with incentives for culturally competent, patient-centered care. Advocate for the recognition of faith-based hospitals as strategic partners in national health planning (Orach, n.d).

**Foster a Culture of Continuous Improvement:** Encourage ongoing reflection, learning, and adaptation among staff and leadership. Regularly review and update cultural competence interventions based on patient feedback and emerging best practices (Siobhán *et al.*, 2026).

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