



A multi-country study on the contracting experiences of faith-based district hospitals in Sub-Saharan Africa: preliminary results from Uganda.

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- A study commissioned by Medicus Mundi Internationalis (MMI)
- MMI has been strongly advocating the development of contracting arrangements between PNFP facilities and Ministries of Health as a means to develop the integration of Private Not For Profit (PNFP) hospitals in general, and FBHs in particular, in district health systems.
- In order to up-date its policies, MMI has commissioned a descriptive study of contracting experiences in four countries: Cameroon, Chad, Tanzania and Uganda.
- We will focus on the preliminary results of the Uganda case-studies: Contracts between Faith-based hospitals (Saint Joseph, Catholic and Kabarole hospital, Protestant) and a number of PEPFAR recipients



Research objectives

- Improve MMI's understanding of processes behind and effects of contracting experiences, through a number of case studies, selected on the basis of their learning potential.
- The methodology consists of a documentary analysis and a series of semi-structured interviews with key informants.
- The Ugandan case studies deal with an emerging form of contracting in low income countries, i.e. between faith-based district hospitals and Global Health Initiatives.



Context at central level

General background:

- A frozen Public/ Private not for profit (PNFP) partnership process
- Financial difficulties of the Faith-Based (FB) sector

With regards to PEPFAR funding:

- Knowledge and control on these resources and partners are low as:
 - PEPFAR funding target the district level (project basis)
 - A contract has been signed between the Ministry of Finance and PEPFAR but the document is unavailable to the stakeholders
 - The system is highly fragmented
 - Recipients have little up to no contact with both MoH and the FB medical bureaus (exception: CRS)
- => The central level therefore characterizes by suspicion towards the donor and the feeling of being bypassed



- **ST JOSEPH HOSPITAL:**
 - Founded 1942: an 'institution' in the area
 - Located next to Kitgum district hospital but attracts the majority of patients in the catchment area
 - The hospital receives a grant from the MoH but can also rely on important donors (AVSI, EU, WFP) and user fees
 - 3 contracts with PEPFAR recipients (CRS, TASO and UPHOLD)
 - UPHOLD (2003-2007)
 - TASO (2005/...)
 - CRS (2005/...)



- **KABAROLE HOSPITAL:**
 - Founded 1903 but revived only in 2001 after a period of difficulties
 - Located next to 2 other hospitals: a public, regional referral hospital (Buhinga) and a Catholic hospital (Virika)
 - A relatively small facility in a growing faze; relies entirely on user fees and the Public grant for its all-round activities
 - 1 contract with CRS (ART + VCT)



- The need for comprehensive HIV-AIDS care (esp. ART) can only be addressed through extra funding
- Both hospitals were relatively inexperienced with HIV-AIDS related activities before signing the contracts, but for some counselling and testing
- In both cases, PEPFAR moneys are entirely focused on HIV-AIDS care and support, with an (financial) emphasis on ART (CRS/ Aids Relief Program)
 - HTC/VCT (UPHOLD)
 - HBC/BCC (TASO)
 - ART (CRS)



A complex situation : multiple, layered contracts

- The access to PEPFAR funding varies from individual application from the hospital (St Joseph: UPHOLD) to an identification, assessment and enrolment fully managed by the donor
- Each PEPFAR recipient holds its own policy, regulations, approach, accounting- and reporting system
- The involvement of district health authorities also presents strong variations:
 - Co-signatories (TASO)
 - Channelling organization: UPHOLD
 - No involvement: CRS⇒ But the factual involvement remains little in all cases
- The same can be said about Church authorities (Dioceses) as owners:
 - They may not be involved as co-signatories (legal issue)
 - Their understanding and personal involvement is often very limited



- The contracts are highly welcomed as enabling the hospitals to fulfil part of their mission
- The Public alternative, especially with regards to ART, is waived due to perceived unreliability
- The relationship is generally perceived as satisfactory:
 - At the donor side: the hospitals respect their obligations, the targets are reached
 - At the beneficiaries side: expectations are globally met



Perception of contracts at facility level (2)

Some specific benefits are also identified by the hospitals:

- The high level of support (CRS, UPHOLD)
- The positive influence of monitoring, reporting and evaluation duties on the overall professional attitude and capacity



Perception of contracts at facility level (3)

Negative aspects are also identified though minimized with regards to benefits:

- The 'blueprint' character of contracts and their non adaptation to the local context
- The lack of flexibility of agreements, especially with regards to the use of financial resources
- The mobilization of human resources : existing qualified staff shifted from general activities to HIV/Aids focused activities
- The enhanced workload
- The sustainability of developed programs: 1 year, reconductible contracts also depending on allocations in Washington

Do those contracts result in distortion in the offer of care?



- A main concern for the medical bureaus at central level
- Waived by the hospitals, as creative solutions are set up to lessen those potential effects (task-shifting; standardization of salaries?)

BUT:

- Distortion exists as far as resources are considered:
 - SJH depends for 52% on donor moneys (2006/07)
 - An ever increasing trend since 2001/02 : + 15%
 - Part of PEPFAR moneys is major
 - ex: CRS funding 2007-08 = 387,2 M UGX
 - = 22 % of total hospital income (FY 2006-07)
 - In KH, the CRS contract accounts for 50% of the annual budget
- => Implied moneys are strictly earmarked

Do those contracts result in distortion in the offer of care? (2)



- Programs tend to function as isolates despite of task-shifting and standardization of salaries:
 - Some of the staffs remain dedicated
 - Financial and infrastructural means clearly differ
 - Possible effect on the quality of care as :
 - The programs absorb the most skilled and experienced staffs
 - Developed activities tend to attract more patients and thus enhance the workload in general activities
- ⇒ Effects are largely downplayed by the hospitals (limited to the implementing period)
- ⇒ An impact study should be conducted as to adequately measure the effects of signed agreements

Conclusion (1)



- The central and peripheral levels of both public health authority and Church-related organs have a different perception of the relationship with PEPFAR
 - The overall negative perception present at central is largely absent at district level
 - The global picture needs therefore to be balanced as from the beneficiaries perspective
 - This discrepancy largely mirrors differences in knowledge level, involvement and benefits



- This discrepancy may be symptomatic of a dysfunction in the overall health system that is further aggravated by PEPFAR's approach of direct targeting of the district level:
 - The knowledge and information present at peripheral level do not manage to reach central authorities and modify their perception
 - An incomplete decentralization process?
 - The same problem applies to faith-based health network, but seems specific to the issue of PEPFAR – and other donors - funding



Conclusion (3)

- Next to their possible effects on the facilities themselves, of PEPFAR contracts raise the issue of integration of FB facilities in the health system:
 - They may contribute to the failure of the Public/ PNFP partnership by :
 - Stimulating misperceptions from the Public sector towards Church-based facilities ('better off'; lack of transparency)
 - But also diminishing the relevance of Public sector support at facilities level
- Further on, their rise may result in the weakening of the relationship between facilities and the medical bureaus at central level:
 - The information on PEPFAR contracts is not communicated unless requested for
 - Choice of 'working' partnerships implying measurable (and personal) benefits instead of pursuing partnership with the public sector