



Contracting between faith-based and public health sector in sub-Saharan Africa

HIGHLIGHTS FROM THE STUDY RESULTS

Delphine Boulenger, Basile Keugoung & Bart Criel
Institute of Tropical Medicine,
Department of Public Health, Antwerp

General objective of the study

Update Medicus Mundi International's insight on policies of contracting between faith-based organisations and public health authorities in Africa

Research questions

Does contracting work? If it works, how does it work and what makes it work? If it doesn't, why doesn't it work? And which lessons can be drawn from these findings?

Methods (1)

- Focus on faith-based Private Not For Profit (PNFP) health care facilities at district level
- 5 case studies in 4 different countries chosen on the basis of
 - Diversity of situations
 - Activities of MMI members in countries surveyed
- Inductive approach, mainly qualitative methods (interviews, documentary analysis, focus groups)
 - More than 100 interviews carried out
 - Approx. 3-4 weeks of fieldwork per case study

Methods (2)

- Selection of cases based on
 - Diversity of experiences
 - Experiences in both Anglophone and Francophone countries
 - Experiences covering Catholic as well as Protestant faith-based organisations
- **Cameroon** (Tokombéré hospital): Delegation of a public mission to a faith-based hospital
- **Tanzania** (Nyakahanga Hospital): Idem, but in a context of institutionalised contracting agreements
- **Chad**: Management of an entire district (Moïssala) delegated to a faith-based organisation
- **Uganda**: HIV-AIDS control service agreements between 2 faith-based district hospitals (St Joseph hospital in Kitgum and Kabarole hospital) and PEPFAR recipients

Findings (1): Cameroon

- The district hospital functions in spite of the State not fulfilling its expectations, but thanks to strong leadership of the management and regular access to external resources
- Contract documents are incomplete and have not been adapted to the more recent model
- Good personal relations remain key to successful contracting experiences
- Need for training at all levels of the system and need to learn from previous contracting experiences
- Process of decentralisation within the health system unfinished: important obstacle to optimal implementation of contracting policies

Findings (2): Tanzania

- Generalized contracting model that goes back in time: needs however adaptation to evolving context
- Incomplete decentralization obstructs the contracting process
- Revived partnership dynamic, but mainly concentrated at the central level
- Good personal relations remain key to successful contracting experiences
- Contracting tools are often incompletely implemented
- The growing financial difficulties of the Church negatively influences the partnership climate and carries the risk of withdrawal of the Church

Findings (3): Chad

- A complete and functional regulatory framework, but only partially implemented
- The case-study shows that the ambitious Chadian model can work if means are available... It however relies on continuous financial influx of external financial support
- More recent experiments – involving local government instead of central authorities – seem less positive
- Current difficulties, combined with increasing problems in accessing external funding, may lead to the ending of experiments at peripheral level
- The current arrangements are more the result of substitution by faith-based organisations, than the expression of a genuine partnership with the State

Findings (4): Uganda

- Both MOH and faith-based medical bureaus generally bypassed by PEPFAR in its process of contracting with faith-based health facilities
- Great difference in the perception of PEPFAR contracts between the central and peripheral levels
- Risks are there... but also positive impacts
- The relative success of PEPFAR arrangements at peripheral level may well bode ill for the already uncertain future of partnership between the MoH and the faith-based health sector in Uganda

Cross-cutting analysis: findings (1)

- A silent crisis, but with a lack of awareness of it at the central level of the public health system
- The actors involved in contracting are poorly prepared, proper monitoring and evaluation systems are lacking, contracting documents are often incomplete and do insufficiently take into account previous experiences
- The incomplete decentralization process of national health systems hinders the optimal development of contracting experiences

Cross-cutting analysis: findings (2)

- The State does not always respect its commitments
- The contracting crisis fits in – and contributes to – the general malaise of the faith-based health sector
- The particular case of PEPFAR contracts in Uganda is an interesting contrary point of reference with positive and negative aspects to it

Recommendations to the donor community

- Help building a reliable institutional memory on contracting experiences so as to allow learning from the past (via documentation and information centres)
- Contribute to adequately address the training needs of the field actors involved in contracting (in the format of continuous and tailored support systems)

Conclusions

- There is a widespread crisis in the domain of contracting between faith-based and public health sector
- This crisis is rooted in a set of common factors
- The more recent agreements between PEPFAR and faith-based facilities have of an important learning potential
- The dissemination of the present study is a priority for MMI and will hopefully lead to more awareness about the current situation and to local change