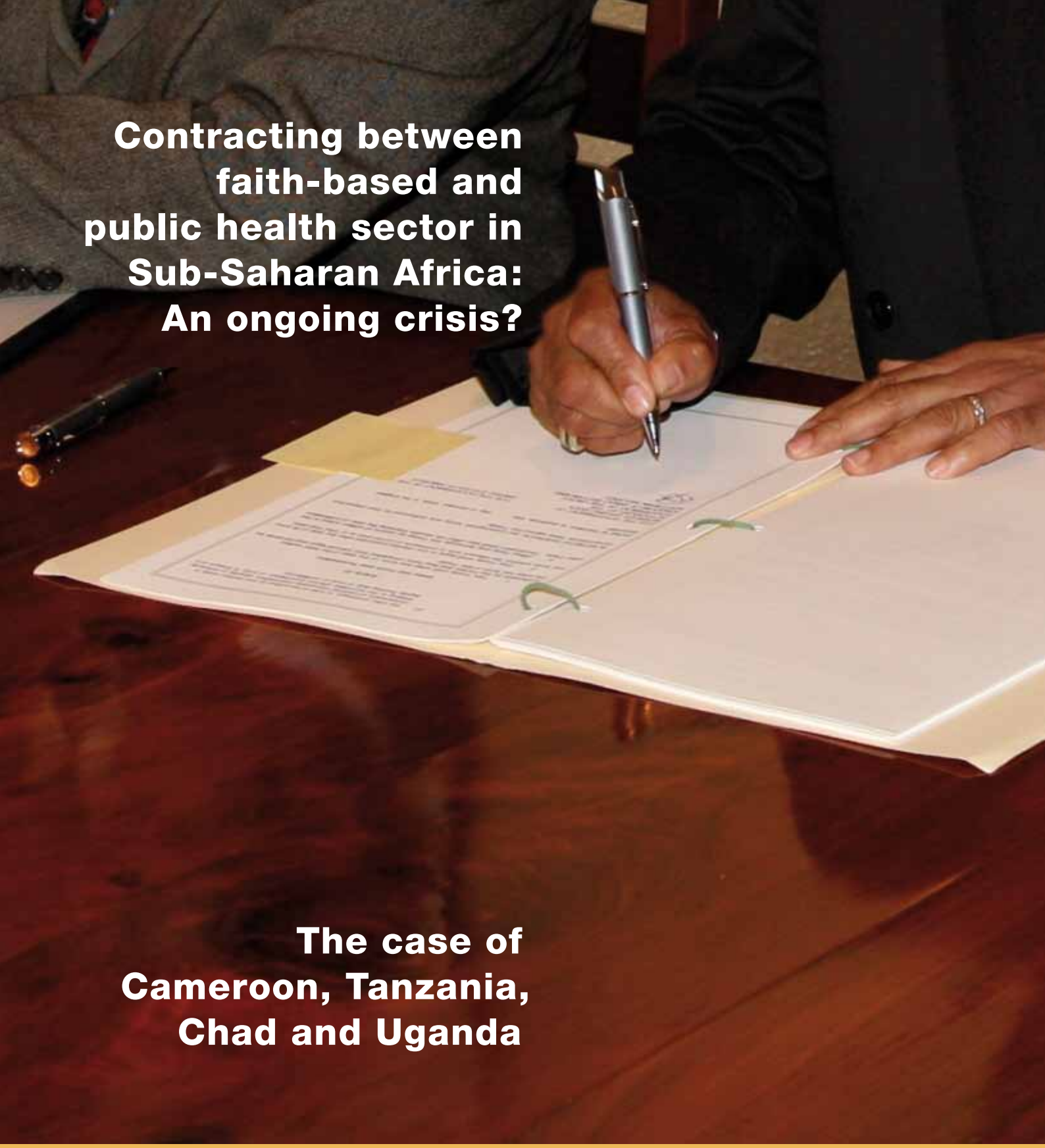

Contracting between faith-based and public health sector in Sub-Saharan Africa: An ongoing crisis?

The case of Cameroon, Tanzania, Chad and Uganda

Report, May 2009

medicus mundi international network

INSTITUTE OF TROPICAL MEDICINE ANTWERP

Contracting between faith-based and public health sector in Sub-Saharan Africa: an ongoing crisis? The cases of Cameroon, Tanzania, Chad and Uganda

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Sharing knowhow and joining forces towards Health for All

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Foreword

"Contracting NGOs for Health" – This has been more than a slogan, but a strategic priority of the Medicus Mundi International Network (MMI) over the last years: the promotion of the integration of private not for profit health institutions in national health systems. We have been strongly and successfully advocating the development of contractual arrangements between private not for profit facilities and Health Ministries. In order to promote this approach, Medicus Mundi International organized, in 1999, a meeting on "Contracting NGOs for Health" as a side event to the 52nd World Health Assembly. Finally, in May 2003, the World Health Assembly adopted a resolution on "The role of contractual arrangements in improving health systems' performance" (WHA 56.25).

But when one promotes a technical approach to address a public health issue, one also likes to be ensured whether it works. Therefore we mandated the Institute of Tropical Medicine Antwerp (ITM) to conduct a study on the experiences with contracting in Sub-Saharan Africa, focusing on faith-based institutions. Now we know the results, we publish them in this report - and we are rather concerned with what we learnt.

Contracting between private not for profit institutions and public health authorities in Africa faces a crisis. This is the main conclusion of the study conducted by the ITM researchers in Cameroon, Chad, Tanzania and Uganda. In spite of the wide variety of contexts and experiences, the different case studies show that contracting between the State and the faith-based district health sector has run into great difficulties.

To make matters worse, there is no general awareness of the crisis, certainly not among the public sector actors.
Unless correcting measures are taken, this almost hidden crisis risks to jeopardize in the medium-term the important contribution which the faith-based health institutions – many of them supported by members of the Medicus Mundi International Network – make to the provision of healthcare in Africa.

The dysfunctioning of contractual arrangements is explained in the study by a number of factors: the lack of information and inadequate

preparation of the actors, the almost systematic absence of support mechanisms adapted to the reality and needs of the field, the lack of monitoring and evaluation systems for the contracting experiences and the fact that a management culture, that would integrate the lessons of the past in matters of contracting in current policies and tools, is lacking. Last but not least, the State does not always respect its commitments.

A rather unexpected issue is provided by the contracts between the US "Presidential Emergency Plan for Aids Relief"(PEPFAR) and the faith-based hospitals in Uganda. Although the study does not deny the danger of a selective and vertical approach in healthcare provision and the risk of bypassing public and faith-based central government structures in contracting, these contracts obviously offer interesting avenues for improving "classic" contracting relations between the public and faith-based sector. Indeed, these contracts can be considered as benchmarks for contracts characterized by a great extent of specificity and predictability, by the quality and sustainability of the monitoring, steering and evaluation mechanisms, and, last but not least, by the donor's respect for commitments. The management of the district faith-based hospitals has explicitly voiced its appreciation of these positive aspects.

Now that we know the study's results and its recommendations – which are shared by ourselves – what are we going to do with them?
Let us be clear: the situations investigated in this study do not question the validity of a support policy to contracting. We believe that contracting remains a most valid option. The study rather emphasizes that the strengthening of such a policy is urgent. The study clearly showed that the different field actors field actors involved in the contracting processes feel the necessity for steady, close and personalized support, adapted to the local context. It is most unlikely that this observation would not hold for other than the countries and cases studied.
The Medicus Mundi International Network intends to play a role here. The experience of our Network's members - in terms of their support to contracting and knowledge of the faith-based health sector – is an asset to exploit.

We will start with sharing the results of this study in each of the surveyed countries (Cameroon, Tanzania, Chad, Uganda) aiming to induce relevant and sustainable changes in the field. This dissemination process will take place within the next months and involve actors from all sectors and levels: the public and religious health authorities at central and peripheral level, the care providers and the community representatives.

Regarding the organization of these local restitutions, we decided to leave the lead to the organisations in the countries themselves: their choices and preferences will determine the format as well as Medicus Mundi International's degree of involvement, taking the Network's and its members' capacities into account.

As MMI commissioned the study, we also have a role to play in the further dissemination of its results in order to contribute to the development of a general awareness of the situation and of the urgency of the need for change, and this not only in the countries and cases concerned, but also with international cooperation actors.

We will encourage our member organisations to implement the lessons learnt. As operational actors very much in touch with the field, these organisations are likely to play a significant support role, in particular with the faith-based bodies and facilities involved in the contracting process.

We will also disseminate these lessons to international organizations (such as the WHO) able to convey the message to the Ministries of Health in the field. Finally, the donors' attention should also be drawn to the problems identified in the study. Our launch event in Geneva, in May 2009, is a first step in that direction.

The survival of the faith-based health sector depends in part on the professionalization of its management: only then will it be able to face and respond to the changes taking place in the health sector. The complex developments of the African health policies and the need of facilities, already short of resources, to make themselves credible in the eyes of ever more demanding partners, require more elaborate technical skills. Far from being incompatible with an idealistic health mission, this professionalization is an obligatory requirement. In the end this professionalization will take place through the complete delegation by the Church of its management responsibilities and by leaving the definition of the sector strategy to qualified and competent technical managers.

We also will have to pay attention to new developments in the field of contracting. The increasing influence of performance contracts (of which the PEPFAR contracts are only one but maybe a rather extreme example) seems an irreversible trend, which will in the short term become much more widespread. It is therefore important to be aware of the lessons which may be drawn from the positive effects of these arrangements, without blindly ignoring

their potentially negative aspects. In any case, a status quo, only taking into account the traditional contracting experiences, would be even more dangerous as their analysis shows that there are many shortcomings in their functioning: guiding the field actors efficiently implies being fully in touch with the reality of the current developments.

So let us look back – and then go ahead.

Guus Eskens, President
Medicus Mundi International Network
The Hague/Basel/Geneva, May 2009

Medicus Mundi International is a Network of private not-for-profit organisations working in the field of international health cooperation.

The Network members fight global poverty by promoting access to health and health care as a fundamental human right ("Health for All").

The Network aims at enhancing the quality and effectiveness of the work of its members and their partners through sharing know-how and joining forces.

List of acronyms

ACERAC	*Association des Conférences Episcopales de la Région de l'Afrique Centrale*
AFD	*Agence Française de Développement*/French Development Agency
AMCES	*Association des Œuvres Médicales Privées Confessionnelles Et Sociales au Bénin*
ART	Antiretroviral Therapy
BAKWATA	National Muslim Council of Tanzania
BCC	Behavior Change Communication
BELACD	*Bureau d'Etudes, de Liaison des Actions Caritatives et de Développement*
BOG	Board of Governors
C2D	*Contrat de Désendettement et de Développement*
CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital
CENC	*Conférence Episcopale Nationale du Cameroun*
CEPCA	*Conseil des Eglises Protestantes du Cameroun*
CET	*Conférence Episcopale du Tchad*
CHMT	Council Health Management Team
CIDR	*Centre International de Développement et de Recherche*
CMO	Chief Medical Officer
CoU	Church of Uganda
CRS	Catholic Relief Services
CSI	*Centre de Santé Intégré*
CSSC	Christian Social Services Committee
CSSC/Z	Christian Social Services Committee/Zonal Coordination Office
CVS	*Comité Villageois de Santé*
DCOOP	Direction de la Coopération
DDH	District Designated Hospital/Hôpital *dit* de district
DED	District Executive Director
DM	Moïssala District
DMO	District Medical officer
DOSS	*Direction des Organisations du Secteur Social*
EB	Executive Board
ELCT	Evangelical Lutheran Church of Tanzania
FALC	*Fondation Ad Lucem au Cameroun*
FBO	Faith Based Organisation
FBH	Faith Based Hospital
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHF	Geneva Health Forum
GHI	Global Health Initiative
HBC	Home Based Care
HC	Health centre
DH	District Hospital
HSSP	Health Sector Strategic Plan
HTok	Tokombéré Hospital
JAHSR	Joint Annual Health Sector Review
KH	Kabarole Hospital
LGO	Local Government
MOH(SW)	Ministry of Health (and Social Welfare)
MSD	Medical Stores Department
NDDH	Nyakahanga District Designated Hospital
NHP	National Health Policy

NSSF	National Social Security Fund
NUMAT	Northern Uganda Malaria Aids and Tuberculosis
OCASC	*Organisation Catholique de la Santé au Cameroun*
PASS	*Programme d'Appui au Secteur de la Santé/* Health Sector Support Program
P4P/ PFP	Pay For Performance
PBF	Performance Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PMORALG	Prime Minister's Office for Regional Administration and Local Government
PNFP	Private not for profit
PPP	Public Private Partnership
RCC	Roman Catholic Church
RMO	Regional medical officer
SJH	Saint Joseph's Hospital
SSA	Sub-Saharan Africa
SWAP	Sector Wide Approach
TASO	The AIDS Support Organization
TCMA	Tanzania Christian Medical Association
TEC	Tanzania Episcopal Conference
TGPSH	Tanzania Germany Program to Support Health
UCMB	Uganda Catholic Medical Bureau
UPHOLD	Uganda Program for Human and Holistic Development
UPMB	Uganda Protestant Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UNAD	*Union Nationale des Associations Diocésaines*
VA	Voluntary Agency
VCT	Voluntary Counselling & Testing
WHA	World Health Assembly
WHO	World Health Organisation

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Executive Summary

In 2007, Medicus Mundi International (MMI) commissioned the Institute of Tropical Medicine (ITM) to conduct a study with the intention of updating its knowledge on contracting between faith-based district hospitals and public health authorities in Africa.

MMI's interest in contracting is not new. In fact it is one of its strategic priorities in the debate on the repositioning of faith-based facilities within existing health systems. MMI organized, in May 1999, a technical meeting on "Contracting NGOs for Health", as a means to integrate not for profit facilities in national health systems. This meeting was a side event to the 52nd World Health Assembly (WHA). In May 2003, under the impulse of MMI, the World Health Assembly adopted a resolution on "The role of contractual arrangements in improving health systems' performance" (WHA 56.25). In the same year, MMI also published an Operational Guide to Contracting. The results of the present study should provide elements that can feed and guide future policy decisions of MMI and its member organisations in the area of contracting. The study makes an in-depth analysis of 4 main research questions: are the observed contracting experiences a success? For which party (or parties) is this experience a success or a failure? Which elements have contributed to this and which mechanisms or processes explain the relative level of success, if any, of these experiences?

The methodological basis for this study rests on an analysis of a number of case studies. The countries and cases were selected in close consultation with MMI's Executive Committee. We decided from the start to include English as well as French speaking countries because of their specific historical and medical culture background. The study was carried out between September 2007 and December 2008 and is based on a documentary analysis and field work (about 4 weeks) for each of the cases.

We managed to study four countries in this period: Cameroon and Chad for Francophone Africa and Tanzania and Uganda for Anglophone Africa. The first three cases are examples of rather "classic" contracting agreements. In other words, situations in which the faith-based hospitals have taken on the role of district hospital (like in the case of the Catholic Hospital of Tokombéré in Cameroon or the Anglican Hospital of Nyakahanga in Tanzania) or else, cases where a faith-based organization is entrusted with the management of a health district ((*Bureau d'Etudes et de Liaison des Activités Caritatives et de Développement* (BELACD) of Sarh and the district of Moïssala in Chad). The case of Uganda differs from the others as the study focuses on the contracts signed between the faith-based hospitals and PEPFAR (President's Emergency Plan for Aids Relief) recipients. The inclusion of this new contracting model - booming at the moment - was approved by MMI and its partners in Uganda because of its obvious important learning potential. The emergence of these new partners and their influence has brought about substantial changes in the health sector. We studied the cases of two Ugandan hospitals (St. Joseph-Kitgum and Kabarole Hospital).

For the different study countries we used a mainly descriptive and inductive methodology, based on two pillars. First, a substantial number of semi-structured interviews was carried out at all levels of the health system (central, regional and district) with actors from the public and the faith-based sector or in the case of Uganda, from the PEPFAR network. These included current participants and historical witnesses - both local and national - in the contracting process. Overall more than 100 semi-structured interviews were held. Furthermore, a considerable number of shorter and more informal interviews were carried out to clarify some specific aspects or approach particular types of participants (health centre staff for example). Second, a detailed documentary analysis was made for each study country (official policy documents from public and faith-based sources, monitoring reports, routine health information system documents, etc.). The wealth of gathered information enabled triangulation of the data but also allowed us to highlight aspects that are constant beyond the mere scope of this study.

The main results of the study are as follows:

In Cameroon

The contracting experience in Cameroon presents an ambiguous picture with both encouraging and alarming signals. The fact that Tokombéré hospital achieved the main objective of the contract (it operates as a district hospital) is more due to substitution than to complementarity between the partners. The district hospital functions in spite of the fact that the state does not respect its commitments and thanks to an exceptional situation, marked by regular access to external resources. The contract document guarantees here mainly a status quo.

The fact that the decentralization process was never finished in Cameroon has a negative influence on the contracting experience. The decentralization policy initiated in 1996 was never fully implemented: the intermediate and local levels of responsibility exist but operate in a strong climate of centralization which complicates the management of the relationship. The contracting relationship with the central level suffers from the contradictions that exist between the different authority levels: the district and the provincial representatives do not properly fulfil their go-between role at the MOH although the MOH becomes more and more a distant partner in the contracting relation. A poor flow of information is one of the first consequences, together with an obstruction in the decision making process. The problems the hospital might encounter in the context of the contracting relation can only be resolved with difficulty. Therefore, the quality of interpersonal relations, the level of implication of some people and individual skills continue to largely determine the quality of the contracting relationship and influence its development. The further institutionalization and operationalisation of the decentralization process appears to be a necessary condition for improving and optimizing the implementation of the contracting relationship.

If the need and the theoretical advantages of contracting are recognized by most actors, its mechanisms and set up still need to be improved. The need for training remains evident for the people in charge in the denominational and public sector and at all levels of the pyramid; this is particularly the case for the peripheral level, where new contracts are being considered and developed. People at peripheral level also need to be initiated into current developments of the contracting framework at national level. The regulatory framework - developed as a result of the *Contrat de Désendettement et de Développement* (C2D) - does not take into account the earlier protocols signed between the hospitals, the dioceses or NGOs and the MOH. There is a need to think about the possibility and ways to integrate these experiences in the new partnership strategy, notably through their update and adjustment to the current formats developed. The notions of performance introduced by the new partnership strategy and the convention models are a great improvement and the earlier protocols could greatly benefit from these. The integration of all contracts in the national framework depends on whether they can be traced more easily: at the moment, nobody - public or faith-based actors - seems able to put a figure on the existing protocols. This is a result of a multiplication of controlling public authorities. Financing the partnership (and contracting) strategy currently depends on the C2D project (5 years): beyond this five-year time span, the continuity and extension of the initiative could become an issue, more in particular for its operational stage.

In Tanzania

The contracting model in Tanzania stands out by its level of generalisation and continuity but needs to be adapted today to the evolving context. The practical difficulties encountered by the District Designated Hospitals (DDH) on peripheral level have revived the partnership dynamic on central level, thanks to the lobbying of Christian Social Services Commission (CSSC) on behalf of the different religious denominations. A number of questions still need to be resolved however:

- The partnership dynamic is still mainly limited to the central level and the partnership policies, their tools and the spirit of cooperation are not circulated enough, which hinders the generalisation of the process. Personal relations and their quality - particularly at peripheral level - remain the key to success for collaboration experiences.
- In general, the decentralisation process of authority remains incomplete and this obstructs the implementation of the contracting process and the development of PPP at district level. Several components need to be improved:
    - The distribution and acceptance of responsibilities
    - The knowledge and the understanding of the policies
    - The communication lines
    - The different contradictory strata of the regulations (contracts signed on central level in a context of authority that is supposedly the local government's)

The contracting tools are being improved but their implementation remains incomplete:

- The operational performance contracts are a real improvement (in form and content) but do not apply to the DDHs.
- The application of the new DDH contract model remains limited to the new agreements. This document presents moreover few improvements in comparison to the original model and seems not very well known on peripheral level.
- The mechanisms for revision of the contracts are not explained in the documents in force at the DDH; the mechanisms are not at all known at peripheral level, both in the faith-based and in the public sector.

The growing financial difficulty of the Church, worsened by a substantial decrease in external support, carries the seeds for a deterioration of the partnership climate and projects the risk of withdrawal by the Church. At the moment, the MOH puts emphasis on the development of public health facilities at the lower administrative health level. However, this could potentially have a negative influence on the budget reserved for the faith-based sector and add to the difficulties that some DDHs face at the moment.

In Chad

Contrary to other countries studied, Chad has a complete and functional regulatory framework. However, this framework is only partially implemented: the contracting agreements made before 2001 have not necessarily been revised and informal relationships continue to exist in the field on the basis of framework agreements signed on central level.

The example of Moïssala shows nevertheless that the ambitious model adopted by Chad can work if the means are available. In this sense, the contract of delegation of the district management to the *Bureau d'Etudes de Liaison des Actions Caritatives et de Développement* (BELACD) has achieved the objectives that were set out. In an institutionally very fragile country, this system of delegation to experienced organisations emerges as the way to realize the development of health districts and improve geographical and financial access of the population to good quality health care.

However, this experience falls outside the framework developed in 2001: the relationship between BELACD and the central State authorities seems to work better than the more recent experiments which involve the local government. In the latter cases, the shaky collaboration with the authorities (in particular the administrative powers) is likely to undermine the established contracting relationship and with it also the developments achieved so far.

An analysis of the contracting relations shows a certain extent of disengagement of the State: the financial and operational burden of the contracts weighs mainly on the contracting NGOs and the future of the experiences remains dependent on the existence of a continued influx of external financial support. The involvement of the State in these matters remains extremely limited in spite of an undeniable willingness to help.

In any case, the political context (in terms of contracting and decentralisation policy) does not offer enough solutions. Although the texts exist, in general the central level seems not very inclined (or able) to seek pro-actively concrete solutions to the problems submitted by contracting NGOs.

In Uganda

The analysis of the contracting relationships that exist in the context of agreements between faith-based district hospitals and the President's Emergency Plan For Aids Relief (PEPFAR) programmes does not completely confirm the negative a priori perception that surrounds these set-ups: the important differences in perception between the central and peripheral level show at the very least that a more nuanced analysis is necessary. The comparison of the *Kabarole Hospita*l and *St Joseph Hospital* cases shows that there are definitely risks hidden in the existing contracts, but that they largely depend on factors that have no absolute link with the nature of the PEPFAR contracts nor with the approach that characterizes them.

The differences in perception, understanding and knowledge of the contracts established between PEPFAR and faith-based district hospitals are proof of the dysfunction of the communication mechanisms that exist between the central and peripheral level. The compartmentalization and fragmentation of the different intervention levels make clear that the decentralization process is still not fully implemented.

Besides, the different PEPFAR programmes can not all be considered completely equivalent: the system is characterized in fact by multiple intervention mechanisms. The way of operating of programmes such as the *Uganda Program for Human and Holistic Development* (UPHOLD), *Christian Relief Services* (CRS) and *The Aids Support Organisation* (TASO) shows important differences in terms of degree of cooperation with the local authorities, flexibility and involvement of beneficiaries in the definition of the objectives, and in terms of knowledge and understanding of the local situation.

Furthermore the arrangements proposed definitely include potentially important benefits for the structures that have to implement them: the acquisition of general management and monitoring skills, or the relative degree of security due to the predictability of the arrangements established.

Important risks remain however; they are specifically linked to the nature of the politics governing the programmes, the importance of the programme priorities and the "power" that the sheer amount of the provided funds grants to the donor. The weight of PEPFAR's contribution to the prevention of HIV-AIDS in Uganda results in the central authorities allowing the development of autonomous strategies that are largely dominated by the priorities of the donor; this is even more the case for the peripheral level. The legal framework of the agreements is decided outside the country they are implemented in, and is not negotiable. It considerably reduces the bargaining power and influence of the field actors. The extreme fragmentation of the system, its complexity and lack of transparency of its organs make it difficult to get an overall picture. Both the actors of the faith-based and the public sector testify that their knowledge and understanding of the situation is incomplete. The policy of excellence preached and practiced by the programmes leads to the creation of double standards in terms of norms, costs, and quality. Ultimately, the low reproducibility of the systems results in the problem of sustainability, all the more crucial as the programme is mostly short and medium term whereas the nature of the activities is often long term.

The fact that the faith-based health platforms are systematically bypassed in these arrangements endangers the quality of the relations which they maintain with the facilities of their respective networks. It diminishes the role they could play in the coordination and guidance of the hospitals, and so prepare them for the signing of such contracts and train them to anticipate the risks inherent in this set up. The reticence of some hospitals to provide their

organisation with information on the contracts signed bilaterally with the donors is an indication of a breakdown which should not be ignored.

Finally, the relative success of the contracting arrangements with PEPFAR on peripheral level could well bode ill for the already uncertain future of the partnership between the MOH and the faith-based sector in Uganda. The worsening human and financial resources crises and the absence of a real response from the public sector are likely to undermine the basis for a continued partnership: they could well induce faith-based facilities to progressively shed the partnership project pursued at the central level by the *Uganda Catholic Medical Bureau* (UCMB) and the *Uganda Protestant Medical Bureau* (UPMB), and might lead to a multiplication of direct relations with the donors instead. Indeed, the latter offer instant and operational solutions to the immediate survival needs of the facility. If they can deliver what they promise, this might prove to be the more tempting option.

A cross-cutting analysis of these four country studies leads to the following findings:

A synoptic table was constructed which methodically classifies the data collected in each country according to a limited number of large information categories considered significant for the analysis of contracting. We also conducted a *Strength-Weaknesses-Opportunities and Threats* (SWOT) analysis. These tools allowed us to extract a number of cross-cutting factors:

– In spite of the wide variety of contexts and experiences, the different case studies show that **contracting between the State and faith-based district health sector faces great difficulties**.
– The current situation can be labelled a crisis; to make matters worse, **there is no general awareness of the crisis at central level**, awareness remains largely confined to the faith-based and peripheral sector. Without rapid intervention, the existing experiments might fail in the medium or even short term and could no doubt call into question the efforts put in at central level in most countries.
– The dysfunction of the contracting experiences rests on a number of common elements. Both **public and faith-based actors are badly prepared for the issues at stake in the contracting relationship, as they have no previous experience, received no adequate training, and the information flow is far from timely and continuous**. In general, the contracting experiences develop in a context marked by limitations and information asymmetry. Contracting documents are often incomplete and not well integrated in the existing national framework (partnership and contracting policies). These documents are moreover seldom revised. The State does not always respect its commitments in terms of the allocation of financial and human resources. The problems mentioned all essentially relate to these issues which are fundamental stakes in a general context of limited resources. The contracts that work are contracts that "have resources" as shown by the first contracts for Chad or a fortiori the examples of PEPFAR in Uganda. There is also a systematic absence or disrespect for monitoring and evaluation mechanisms.
- More generally, **the development and implementation of partnership and contracting policies and initiatives do not fully draw the lessons of the past**. No advantage is taken of previous experiences and this leads to a heterogeneous contracting landscape, composed of diverse historical strata that are often contradictory.
- **This balkanisation of the contracting landscape and the dysfunction of the formal partnership experiences at peripheral level expose the imperfection of a decentralization process** that began around the end of 90s, early 2000s. The dichotomy between the central and peripheral level greatly weakens the follow-up opportunities of the arrangements and the set up of structural solutions to address the difficulties met. It also explains the predominant role of interpersonal relations, to the detriment of institutional solutions.
- **This crisis of contracting experiences fits in with the general crisis in the faith-based sector and also contributes to this crisis**. The financial crisis in the faith-based health facilities is accompanied by a crisis in human resources. Although the state admits that

these difficulties exist, the current contracting experiments provide at best a very inadequate answer. The size and escalation of the crisis are ignored. In fact, the Church's health system still has a strong reputation and seems a stable, unchanging feature in the landscape. Unfortunately this does not exactly correspond to the reality of the field.

- **The particular case of Uganda and the analysis of contracts between PEPFAR and the faith-based hospitals provide a valuable and contrary point of reference, that we can contrast with the observed dysfunction of the "classic" contracting experiences between the public and faith-based sector**. The importance of the resources injected in these contracts, their "exogenous" nature and especially their extreme targeting are not without risks for the benefiting structures, and could distort the provision of care. There are however also some positive aspects which are appreciated by the beneficiaries. The analysis of these advantages displays almost the inverse picture of the contracting relationships between the faith-based structures and the State: their degree of specificity and predictability, the quality of the monitoring, steering and evaluation mechanisms, their efficiency and the donor's respect of the commitments.
- **These aspects might provide interesting avenues for a rereading and improvement of the contracting relations between the Church and the State**. The contracting approach is very different for the two types of relations: the PEPFAR contracts continuously encourage and stimulate the relationship, while in the case of contracting between the faith-based facilities and the Ministry of Health great efforts are only made during the preparation stage for the set-up.
- Rather than creating conditions for the development and strengthening of the relationship on the basis of innovative objectives, **the contracting arrangements between the faith-based sector and the public sector essentially confirm a factual situation**: the arrangements are often static and create the basis for an imbalanced relationship, which mainly benefits the State.
- Overall, **the situation reveals a real risk of disintegration of the partnership between the public and the faith-based sector in health in Sub-Saharan Africa in the future**. The disappointing experiences of district religious actors lead some to prefer bilateral relations with external donors - with direct but often not sustainable results; elsewhere, the breakdown of relations induces certain peripheral facilities and organisations to move away from signed contracts (Chad) or threaten to withdraw (Tanzania); finally some churches already call into question the very notion of partnership or the conditions set by this notion for participating in the health sector (Uganda).

Based on these different observations, we can formulate recommendations, first of all for the organisation that commissioned our research, then for the different levels - support, decision-makers and actors - of the contracting process.

1. For international actors: donors and NGOs:

The partnership between the public and faith-based health sector should be strengthened through the **set up of a collective institutional memory**. This should not only summarize and give the overview of the regulatory frameworks that exist but also provide a centralized historical archive of these frameworks, the contracting documents and the expertise of each country. Such an approach should be planned in the near future to prevent documents and testimonies that are key to the understanding and analysis of earlier experiences from disappearing. Documentation and information centres could be created where all actors from the Public Private Partnerships are represented on a pluralistic and nonpartisan basis.

In a more distant future, these country resource centres could form the basis of a **Pan African information and exchange network for Public Private Partnerships and contracting**.

Before this network can be set up, country databases have to be created on the basis of more or less compatible models and systems.

It remains essential as for now to respond to the specific training needs of the field actors. Contracting workshops could thus be regularly organized upon request. They should have a content adapted to the local situation and the level and role of the participants in the contracting process. The set-up of such workshops could benefit from the input from local faith-based platforms[1]. It is also essential that they are organized in consultation with the Ministry of Health and systematically involve public and religious actors: moreover, besides a training opportunity, these events could also become a platform for dialogue and participate in the dissemination of experiences and their perception.

2. For the field: public and religious actors:

The streamlining of the contracting landscape should be a priority in all the study countries. The monitoring and evaluation, and eventually the success of existing contracting experiences requires that they be adapted to a coherent and legible framework at all levels of the health system. Besides the integration of all the existing relationships in the national framework developed (contracting policy, framework agreement models and service agreements), this harmonization should be an ongoing process, through regular revisions of the contracting documents. This approach, not pursued at the moment, is one of the means to overcome the gap between the framework of contracting relations and developments in the health policy. In the short term the harmonisation of the experiences would allow to redefine unambiguously the competent levels of authority for the contracts that are rather blurred now as a result of the decentralization process.

Specific recommendations per country

In Cameroon

The first question seems to concern the **integration of the contracting experiences outside C2D in the newly developed partnership and contractual framework.** This necessitates better tracing of the contracts and their concentration in one place: at the moment, the contracts are to be found in as many different places as their controlling public authorities i.e. a variety of vertical programmes, the Directorate of Cooperation, the minister's cabinet, etc.

As a result, there is not a single body, at the Ministry (DCOOP) nor on the denominational side (OCASC, CEPCA for the hospitals and their respective networks), that seems able to put a figure on the existing protocols. Integrating these contracts - even through revision - in the recently developed plans, would ideally enable drawing up an exact overview and typology and ensure systematic filing.

This step is even more needed since attention has been turned away from these experiments by the implementation of the C2D: outside the framework, the actors of earlier protocols in the private not for profit sector (as is the case for the Tokombéré hospital) run a strong risk of facing ever greater difficulties in finding structural answers to the problems they meet. On top of everything else, they only have a fragmented knowledge of what is going on and therefore only limited means of defending their own case. It is obvious moreover that contracts, like the Tokombéré contract, merit a review and the integration of proper monitoring and evaluation mechanisms. The notions of performance introduced by the new partnership strategy and the convention models are a great improvement and the earlier protocols could greatly benefit from these.

[1] Organizations such as AMCES in Benin, UCMB and UPMB in Uganda, CSSC in Tanzania, UNAD and BELACD in Chad are very experienced in training actors of the faith-based networks (and often also of the public sector). Their links with the field make them indispensable networks for the definition of needs to consider.

The reintegration of these experiments in the present process should be advocated with the denominational platforms and the MOH; if not possible, their future integration should be scheduled. Where the process and its implementation remain too concentrated on a national level, decentralisation (partnership on intermediate and peripheral level) would allow the uniform dissemination of information and help the actors of earlier protocols find the means for integration with their controlling authorities.

It is moreover essential to take into account the issue of the government's real support to its faith-based facilities contracting partners. In this respect, Tokombéré is the result of an exceptional situation. It would be dangerous to generalize this case to the rest of the sector. Very few facilities benefit from regular external support like in our case study. It is obvious that the financial crisis affecting the faith-based sector (and proved by the debt levels identified through the C2D[2] project) has even more important implications on the Church's ability to operate and maintain the majority of peripheral facilities if the State only partly respects its commitments: **a simplification of financial support mechanisms, their transparency and knowledge by the beneficiary facilities** are important prerequisites for improving the situation. It is moreover **essential that the level of support, its limits and conditions are clearly pointed out in the contracts**. This is only partly the case in the contracting documents signed outside the C2D project.

Also, the harmonisation of the contracting landscape needs to be accompanied by a **clarification of the respective role of the central, intermediate and peripheral levels of the public health authorities.** It is one of the key elements in the operation and improvement of the support mechanisms of the State and certainly dependent on a **continuation of the decentralisation process** initiated in 1996.

In Tanzania

The **development of new DDH contracts and the systematic revision of existing contracts** is planned by the Public Private Partnership (PPP) Technical Working Group but cannot be carried out in the short term due to a lack of resources. Therefore we have to wait for a standardization of the present agreements. It seems rather urgent that this project becomes operational in order to adjust all experiments to the regulatory framework (decentralisation, PPP) and ensure proper methods of monitoring and evaluation. This is a prerequisite if real threats to the sustainability of the partnership are to be avoided. According to us, this process should take place parallel with the dissemination of operational contracting experiences that began when the Service Agreements (SA) were put in place. Awaiting their impact in a geographic setting as large as Tanzania and keeping in mind the limitations of the available human and financial resources would certainly put off their implementation for many more years.

A **review of the conditions for allocating public resources to District Designated Hospitals (DDH)** ought to accompany the standardization of the agreements: the support for the DDH of the first generation and the Voluntary Associations (VA) is currently often calculated on databases that are often out of date and not reflecting the reality of the field (particularly the number of beds). The viability of the facilities depends in part on such a revision and the opportunity to plan their budget on transparent databases: it is therefore imperative that they get information about the amount and distribution of support committed by the central or the local level.

The government has begun to implement its plan for improving the health services through a programme of primary care (MMAM[3]). The aim is to bring the health services closer to the people: "We intend to reach the rural population as they represent 80% of the residents and

[2] FINORG, Definition of the operational conditions of contracting relationships between the actors in the Cameroon health sector - Final report IV, 2004.
[3] Mpango wa Maendeleo ya Yfya ya Msingi (MMAM).

they are the ones who do not have access to health services; we hope to achieve access for each village by 2017". (Declaration of the Health Minister, Pr. David Mwakyusa during his inauguration speech at the 71st TCMA assembly). A considerable number of field actors in the faith-based sector fear the emphasis thus put on the development of public health structures at the lower administrative levels scale, as it could eventually endanger the part of the budget reserved for the faith-based facilities.

The capacity of the Christian Social Services Committee (CSSC) to intervene efficiently as a lobby -organisation in the partnership issue is essential here. Strengthening this capacity means that the organisation can improve the level of its assessment of current experiments and obtain concrete data to bolster its case on central level. Without any doubt this will happen through **systematic analysis of the present experiments and the acceleration of the decentralization process of CSSC through zonal coordinations**: this coordination remains problematic because of the vastness of the territory to be covered and the limitations in terms of human resources - the coordinators are only employed part-time, a situation which should soon be corrected by the appointment of a permanent secretary.

In this sense, the **decentralisation of the partnership fora**, planned by CSSC through the zonal delegations could contribute to a better understanding of the reality in the field and could on peripheral level advance the climate of cooperation that exists on central level. The fora are also a potential tool for improving the knowledge of the actors. It is striking for example that CSSC is an unknown acronym for the local administrative authorities in the Karagwe district! The (newly created) Afya Mtandao website[4] could in due time become an instrument for collecting data with regard to the contracting experiences, if it is actively consulted and exploited by the field actors. At the very least it is an interesting effort to stimulate exchange between the field actors.

The **strengthening of the partnership and the capacity of the faith-based authorities to actively participate in the health policy decisions taken at local level also necessitates better representation of these authorities in the decision taking bodies of the district**. This representation and involvement remain for the moment dependent on the type of agreement signed with the public authority: contracts of the first generation are signed at the central level, but the administrative split up and definition of representative bodies are by now made deficient by the decentralisation policy. The ignorance of the regulatory framework in force induces an underrepresentation of faith-based actors in the existing organs.

We may well wonder finally whether the harmonisation of the situation should not be achieved through the **set up of a consistent regulatory framework specific at the central level**: the formulation of a Contracting Policy (or Partnership Policy) as such, on the condition of being regularly adjusted to possible changes in the regulatory context, would doubtlessly allow greater visibility for the principle and the facilitation of its acceptance by local authorities. In the current situation, the fragmentation of the principles within the body of documents and declarations is one of the causes of the sustained ignorance of the mechanisms and principles governing the collaboration between the State and the private sector.

In Chad

It is very unlikely that the State on its own is able to resolve the difficulties identified through the existing experiences in the medium term. Hence, the restricted budget and the important national shortage of qualified staff make it indispensable to **integrate the contracts in a long term external aid policy**. The ability of the facilities and organisations to fulfil their part in the contracting arrangements obviously depends on the availability of adequate means. The amount of resources available is currently very much undermined by the operational disengagement of the State and the diminishing influence of traditional sources of support for the Church. At

[4] www.afyamtandao.org

stake here are the sheer existence (and thus survival) of the faith-based health structures as well as the quality of care they provide.

More specifically, the key role played by the *Union Nationale des Associations Diocésaines* (UNAD) in coordinating the BELACDs and representing the interests and advocating for the faith-based sector with the State and international organisations can only be assured if the organisation has **a functional and dynamic medical coordinator at its disposal**. The restoration of this post, abolished as a result of a lack of human and financial means, is more than urgent as the examples of Doba and Donomanga prove. There is a real risk that the faith-based organisations withdraw from the contracts at local level if there are no additional external means available to them.

It is furthermore essential to harmonize the contracting landscape by systematically **integrating all experiences from before 2001 in a centrally defined contracting framework.** This should be achieved through revision, negotiation and the signing of new agreements. It is also important that primary and secondary contracts (objectives of the public-faith-based relationship on the one hand and provision of external financial and technical means on the other) are clearly distinguished from each other in order to guarantee the sustainability of both the contracting relationship and the joint search for means to continue in spite of the uncertainty of external sources of support.

An **overall assessment of the ongoing experiments in Chad** is needed to be able to judge the representativeness of the conclusions of this report and the possible need to modify the monitoring and evaluation mechanisms of the contracting relationships.

In Uganda

The research team found that in Uganda one of the main difficulties in the contracts between the faith-based health sector and the PEPFAR recipients lies in the actors' ignorance of one another. This can be observed at all levels of the health sector and is also the case between the State, the Church and the donors. This lack of mutual understanding is a result of the opaqueness of the donor's implementation mechanisms, the focus on the operational level of the district, the lack of a sufficiently high degree of professionalism of the facilities and the Church authorities in the district and the fact that the decentralisation process is not yet completed.

It seems thus essential that the faith-based medical platforms continue to **look proactively for a way of getting together, if not with the higher echelons of the PEPFAR representations, then at least with the main recipients effectively involved in the contracting relations with the health facilities of the various Church networks**. It seems clear that quite a number of PEPFAR's principal recipients are not aware of the scope and the real importance of the role played by the different *bureaus* in the health facilities. The benefit of such a rapprochement is shown by the specific case of CRS: the set up of a dialogue with the faith-based platforms has in fact permitted to partly reorient the approach of the donors and show some consideration for the preoccupations of the sector. These closer relationships would no doubt lead to a greater understanding by the faith-based platforms of the real benefits that their facilities can draw from their relationship with PEPFAR. It would allow them to steer these and exploit them in the larger partnership context of the MOH and the Church in health.

But these **platforms also have a preventive role to play with the facilities of the network**, in order to limit the real risk of 'bilateral' contracts signed with PEPFAR: in particular by integrating – with full knowledge of the facts – the aspect of technical support to the hospitals in this type of contract. This support could be translated into specific and regular training in the contracting process and through more specific activities for the development of the facilities' negotiation skills. The example of Virika Catholic Hospital in Fort Portal shows in fact that the hospitals benefit from a certain room for negotiation when such contracts are set up (with CRS in this instance), but only on condition that they can hold solid and well-argued

discussions with the donor. The development of specific skills certainly has to be integrated in the policy of capacity strengthening and professionalism of the sector in which UCMB and UPMB are already involved; it also has to involve the Church authorities and encourage the development of professional and functional diocesan coordination bodies, able of efficiently guiding the implementation of possible contracting arrangements in the facilities.

Furthermore, in the specific case of PEPFAR arrangements, it is also imperative that **a successful dialogue between the MOH and the faith-based platforms** be restarted. This should unblock the contracting process. Hence, the public authorities need to become aware very soon of the financial and human resources crisis that the faith-based sector is facing. The research team hopes that this study will make a contribution to this and support the case that the Medical bureaus have been making for several years now. Not only the survival of a sector is at stake here, but also the preservation and further development of the national health coverage.

Take-home messages

1. Contracting between faith-based district hospitals and public health authorities in Africa faces a crisis. In spite of the wide variety of contexts and experiences, the different case studies show that contracting between the State and faith-based district health sector has run into great difficulties. To make matters worse, there is no general awareness of the crisis, certainly not among the public sector actors. Unless correcting measures are taken, this almost hidden crisis risks to jeopardize in the medium-term the important contribution which the faith-based facilities make to the provision of care in Africa.

2. The dysfunction of the contracting experiences can be explained by a number of factors: the lack of information and inadequate preparation of the actors, the almost systematic absence of support mechanisms adapted to the reality and needs of the field, the lack of monitoring and evaluation systems for the contracting experiences and the fact that a management culture, that would integrate the lessons of the past in matters of contracting in current policies and tools, is lacking. Finally, the State does not always respect its commitments.

3. The contracts between the Presidential Emergency Plan for Aids Relief (PEPFAR) and the faith-based hospitals in Uganda provide a valuable and contrary point of reference. Although we do not underestimate the risk of a selective and vertical approach in contracting, nor do we intend to hide the fact that public and faith-based central government structures in health are mostly bypassed by PEPFAR, these contracts offer interesting avenues for improving "classic" contracting relations between the public and faith-based sector. Indeed, these contracts are characterized by a great extent of specificity and predictability, by the quality and sustainability of the monitoring, steering and evaluation mechanisms, and, last but not least, by the donor's respect for commitments. The management of the district faith-based hospitals appreciates these positive aspects.

4. The results of this study should be presented in each country (Cameroon, Tanzania, Chad, Uganda) if we want to achieve relevant and sustainable changes in the field. This dissemination process should be well prepared and steered and has to involve actors from all sectors and levels: the public and religious health authorities at central and peripheral level, the care providers and the community representatives.

5. Generally the field actors involved in the contracting processes feel the necessity for steady, close and personalized support, adapted to the local context. Without any doubt, this observation can also be made in other than the countries and cases studied. Consequently, the elaboration of technical manuals, such as the one developed by Medicus Mundi International (MMI) in 2003, is not very useful.

Introduction

The issue of contracting between the public and private (not for profit) sector is part and parcel of the political situation, public systems and international health programmes of sub-Saharan Africa.

Over the last years, some new and often innovative experiments have emerged, which shed a new light on the currently existing corpus of formal reflections on this subject.

One of the strategic priorities of the Medicus Mundi International (MMI) action plan 2007-2010 is a repositioning of church-based health facilities within the health systems. Furthermore, MMI has always been very interested in developing contracting relationships between faith-based health facilities and public health authorities in sub-Saharan Africa. They invested heavily and put considerable energy into promoting contracting in international health policy circles. To this end, in 2003 MMI prepared a technical guide to support private not for profit facilities with the development and the set up of such contracting arrangements with the Ministry of Health in the various countries. In other words, contracting was and is one of MMI's priorities.

Since MMI wished to update its contracting promotion strategies, it asked the Institute of Tropical Medicine (ITM) in Antwerp in 2007 to carry out a study in sub-Saharan Africa to obtain a better insight in the way contracting policies and operational experiences present themselves today in the African private not for profit and public sector. The need for an update on the issue had been made clear by regular demands from MMI's field partners.

This study looks at the results from three different perspectives:

1. First of all from an **operational** perspective: to generate new knowledge, allowing a better understanding of the phenomenon and the means to grasp it. This will most likely benefit MMI, its member organizations and the field actors in sub-Saharan Africa.
2. An **institutional** and **political** perspective: to feed the thought process and help develop partnership policies by providing national and local decision makers with an analysis of the contractual context and some specific experiences of contracting in their country.
3. Finally a **research** perspective: to help feed scientific reflection and thought on contracting by shedding new and additional light on the work carried out so far.

From the very beginning, we opted together with MMI to focus the research on contracting experiences between public health authorities and faith-based facilities or organizations in the district. We did so because most of the health care in Africa is provided by these organizations and because it also provides some consistency to the study.

The subject was approached through a wide range of general questions:

- Does contracting work?
- What does this mean for the various stakeholders and field actors involved?
- If contracting policies work satisfactorily or fail to do so, which elements have then contributed to this success or failure?
- If contracting does not function very well, which obstacles have prevented a harmonious development of contracting relationships between church-based facilities and the public health authorities?
- Which lessons can be learnt from this new knowledge? Does it mean that MMI should revise the form and modalities of its commitment to contracting? If so, how should this be done? Should MMI adjust its support to its partner institutions in the field?

In an annex, this study also tries to answer the question of dissemination, pertinence and use of the Guide to Contracting written by MMI in 2003. The organization wanted an assessment of the impact of this publication, as significant costs and effort were involved when drafted.

This report is based on five case studies, carried out in four different countries: Cameroon, Tanzania, Chad, and Uganda. We will first set out the research methodology used for this study by justifying the selection of the cases and outlining the limitations. The characteristics of each case study will be presented in Part II. The experiences will be described in the order mentioned above, i.e. from the most classic to the most atypical example. Two case studies were conducted in Uganda; they will also be presented in this section. Part III of the study is dedicated to the analysis of the study results: we will first make a synthesis of the results and then draw some important lessons in a cross-cutting analysis going beyond the specific context of the countries investigated.

Our study ends with a series of recommendations to actors in the contracting field (local players - public as well as religious - international organizations, donors and NGOs). In addition to this report, a separate volume of annexes provides more detail on the participants, interview grids, documents collected and copies of the contracts for each of the case studies.

Research Methodology

General methodology

METHODOLOGICAL FRAMEWORK AND APPROACH

The general methodological framework of this study is based on the realistic evaluation[5] method, but we did not follow this method in a very rigorous way. We selected this methodological approach as it seemed suitable for the objectives of our research and the analysis of interventions in complex systems such as the health systems. The aim of realistic evaluation is to construct a theory that explains non linear phenomena and interactions in complex systems. It postulates that there are interactions between: an intervention *mechanism* (contracting and its tools), the *context* in which this intervention takes place (in this case the public and the faith-based health sector - and in the case of Uganda the PEPFAR programme[6]) and the *outcomes* (success or failure of the contracting experiments, the integration of faith-based facilities or organizations in the national health system).

In practice, realistic evaluation aims to reveal gradually patterns, the recurrence of fcts or instances, through analysis and confrontation of a number of case studies. The phenomena and mechanisms observed and produced as a result of the interventions in the systems are then encapsulated in an explanatory theory.

The realistic evaluation used in this study combines the inductive and deductive methods. The approach is inductive in the sense that we did not a priori start from a contracting theory. It is nevertheless also deductive as the literature review and the preliminary discussions with MMI and other key actors led to the elaboration of a grid to analyze contracting experiences (*cf.* Volume 2, Annex 3) *before* the case studies were set up. This grid includes a series of elements considered *a priori* appropriate for research about contracting policies. The framework has steered the collection of data in the field, guaranteeing a certain logic and systematism.

We opted for a largely inductive approach where explanations and a theory would progressively be generated through a stringent and very detailed observation of the field experiences. We tried to find the response to the initial research questions through the contextualization of contracting experiences (to shed a 'historic' light in a wider sense), and the evaluation of the perception key actors (public/private faith-based) have of these contracting experiences. The data analysis was a two step process. In a first instance, an analysis was made of each case study (intra country): we extracted and highlighted the key elements which played a role in the relative success of the particular contracts (essentially inductive analysis) and studied in more detail some specific aspects of the case.

In a second stage, this allowed us to link (inter-country) the country analyses we had carried out, aiming to emphasize possible constant factors. The latter would in turn feed a theoretical reflection on the modalities for success or failure of contracting experiences. For this second stage we performed a cross-cutting analysis of the five case studies. This analysis was more systematic, as we developed a grid on the basis of analysis criteria defined in advance. This framework allowed us to distil the factors that might explain the relative success or failure of the observed experiences; gradually, this grid has been completed over the course of our research. The criteria have then been divided into different categories[7], analysed and compared one by one according to what could be said about them on the basis of case studies. In addition, for

[5] Pawson and Tilley, 1997
[6] Presidential Emergency Plan for Aids Relief
[7] See Table 2

each of the case studies a SWOT analysis has been performed, of which the results were represented in a grid[8], in order to be able to compare them systematically.

Gradually, patterns emerged which allowed us to put forward some factors relative to the context and the set-up of arrangements, the monitoring mechanisms and the systems involved (public and confessional health systems, global initiatives, communities). All of these seem particularly important in the contracting environment. These factors and aspects mainly came out of the field; they did not emerge from an a priori defined theoretical framework. They have contributed in substantiating the conclusions of this report and served our attempts to formulate a conceptual framework for the success of contracting experiments.

SELECTION OF CASES

The countries were selected on the basis of following criteria:

- The ability to reflect as much as possible the geographical field of intervention of MMI member organizations;
- The actual existence of possible solid support/local networks to facilitate the preparation and conducting of field studies;
- The relative representativeness in terms of the historical, organizational/institutional and (geo)political diversity of the African continent[9];
- The existence of a contractual "tradition" and/or contracting experiences on district level.

Based on these criteria, we selected Uganda, Cameroon, Chad and Tanzania. Other options (DRC, Benin and Rwanda) were abandoned for reasons of feasibility, in particular in the light of the time constraints of this study. We carried out one case study in Cameroon, Chad and Tanzania and two different case studies in Uganda. In each of the cases, the choice of these experiences was based on the distinctive features and the wealth of information (purposefulness) which could be obtained from them through analysis. The questions and the methodology used (which data, collected in which manner) have been adapted to the specific situation in the chosen case studies, the nature of the available sources and the interest expressed by the field actors. Our main concern has been to remain open to demand initially: the opinion and needs of local interlocutors have been taken into account in the decision making process and have at least to some extent directed our research. In a first move we selected only relationships which directly, through an explicit contract, linked a facility of a faith-based health network to the public authorities in this particular country. Expressions of informal partnership relationships[10] have been excluded from this study, to guarantee a consistent and well documented base for comparison.

In a second stage a literature review allowed us to fine-tune the desired "profile" for the case studies on the basis of following characteristics: first, classic contractual initiatives, that include the delegation of a public service mission (at district level) to private not for profit faith-based hospitals, or else their downright integration into the local national health system.; second, innovative or atypical contractual initiatives, either in their theory, or in their application modus:

- Experiences of delegation of management (over the whole district);
- Specific experience of P4P[11], applied if possible to a "classic" situation[12].

[8] See Table 3.

[9] West/East/Central Africa; Francophone/Anglophone areas; centralization or decentralization of power; political stability, post conflict environment.

[10] Example: faith-based hospitals exercising de facto or by default the role of public district hospital.

[11] P4P: Pay for Performance.

[12] Public/private faith-based contracting partnership with delegation of public service mission or integration in the national health system.

The cases retained according to these criteria were the following:

- In Cameroon: the contracting arrangement studied links the Diocese of Maroua Mokolo (North Cameroon) to the Ministry of Health and confers the status of district hospital on the Catholic hospital of Tokombéré;
- In Tanzania: the contract researched links the Anglican hospital of Nyakahanga (Lake Victoria region) to the Ministry of Health by giving it the status of District Designated Hospital (DDD);
- In Chad: we have investigated a number of contracts through which the management of the district of Moïssala (Southern Chad) has progressively been entrusted to one of the decentralized bureaus[13] of the national Catholic platform.

The particular case of Uganda merits some explanation. In this case study we opted not for the classic contracts, but for an analysis of contracts drawn up between the faith-based hospitals and the Presidential Emergency Plan For Aids Relief (PEPFAR), one of the leading (international) global initiatives in Africa today. This choice can be justified easily: the study of such types of contracts is very rewarding and interesting in itself and Uganda offers obviously opportunities to gain more insight in them. This proposal was first submitted for validation to MMI and got unanimous support from our Ugandan participants at the faith-based facilities.
Two hospitals were selected on this basis:

- The Catholic hospital of St. Joseph, Kitgum (Northern Uganda) with contracts linking it to three PEPFAR recipients[14];
- The Anglican hospital of Fort Portal (Kabarole Hospital) linked by contract to CRS.

All contracts we investigated are connected to the set up of specific HIV-AIDS prevention activities.

Specific methodology: Case studies

We collected mainly qualitative field data for the examples in this report. Each case study lasted about 3 weeks on average and we used a mixture of:

- Interviews with key actors[15] at the different levels of the health system and for all sectors: faith-based, public and - in the case of Uganda - donors (PEPFAR);
- Collection and analysis of documents, with similar coverage criteria (levels and sectors of the health system).

The selection of interviewees follows the same principles and was defined beforehand for all case studies. Some small changes were however made for Chad and Uganda. In Chad the delegated district management meant we had to include other categories of interviewees (health centres (CS), a higher number of district officials) whereas in Uganda the PEPFAR component had to be taken into account. The profile of the participants is made up of following recurring elements:

- For the public and the faith-based sector (and PEPFAR): participants of central and peripheral level, intermediate level if relevant;
- Interviews with historical witnesses (at central and peripheral level), where possible;
- Public sector: officials of the Ministry of Health (MoH) (partnership unit, and planning and health policy unit in particular); district health officials (in particular the district medical officer) and where possible administrative managers;
- Faith-based sector: directors at the central level of the faith-based health platforms; church leaders of the religious denomination involved in the case study (central and peripheral level); hospital staff (chief medical officer, administrator, financial director, chief nursing

[13] *Bureau d'Etudes et de Liaison des Actions Caritatives et de Développement* (BELACD) of Sarh, the decentralised representatives of the *Union Nationale des Associations Diocésaines* (UNAD).
[14] Catholic Relief Services (CRS), Uganda Program for Holistic Development (UPHOLD), The AIDS Support Organisation (TASO).
[15] See a detailed list of interviews held in annex 6.

officer, other clinician); if needed, representatives of the civil servants seconded to the faith-based facility;

- PEPFAR: representatives (central, intermediate and peripheral level) of the different recipients[16] identified through the contracts. Ideally, national representatives for PEPFAR (USAID in particular).

The majority of semi-structured interviews were held with the help of a standardized questionnaire (see Volume 2, Annex 3); in Uganda this questionnaire was slightly adapted to the country's specificities. The interviews lasted on average 1h30 but those with 'historical' witnesses generally lasted longer (up to 3hrs) and were often split up into two sessions.
Occasionally a simplified questionnaire (see Volume 2, Annex 3) was used for particular categories of participants (nursing staff in Tanzania; health centres in Chad): these interviews lasted only about 30 minutes on average. Besides these two kinds of interviews, we held a substantial number of informal discussions. These depended on the circumstances or specific needs and were generally a result from particular questions that came up during the interviews or from consultations of secondary sources which called for more clarification.

The list of documents collected per country can be found in the annex[17] of this report and can be categorized as follows:

- Contracting documents: main and secondary contracts, monitoring and evaluation reports; letters and manuals produced for the contracting and partnership relationship.
- Regulatory documents: partnership and/or contracting policies; models of framework and service agreements; service agreement manuals; the main documents of the health policy (National Health Policy; decentralized health policy, district health policy, etc.).
- Faith-based contextual documents, more in particular relating to the history of the organizations or facilities investigated, or to their organization.
- Routine documents stemming from the Health Information System: annual reports from the hospital in particular listing relevant quantitative data.

Overall, more than 100 people were contacted and interviewed, about 30 interviews per case study. The abundance of material thus collected, together with the importance of the documentary information gathered from field missions, allowed a triangulation of data and thorough cross-cutting analysis.

The division of interviews per case study is as follows. Except for specific cases (cf. limitations), the participants are just about equally divided between the faith-based and public sector[18].

In Cameroon we carried out 17 interviews of which 5 took place at central level, 4 at intermediate level and 8 at peripheral level. We talked to a village committee in the hospital's catchment area. The specificity of this organ (several participants) meant that we had to use the focus group technique and a simplified questionnaire with 9 points. Five informal interviews (central level) completed the information thus gathered.

In Tanzania: 18 semi-structured interviews were held of which 10 at peripheral level (two of which were short interviews with a simplified questionnaire), 2 at intermediate level and 6 at central level. 14 informal interviews were also carried out during the meeting of the Tanzania Christian Medical Association (TCMA)[19], and also with the staff of the Christian Social Services Commission (CSSC), the MOH and at peripheral level.

In Chad we carried out 14 semi-structured interviews, of which 4 took place at central level, 7 at intermediate and 4 at peripheral level. We carried out 2 informal interviews with the

[16] CRS (Catholic Relief Services), TASO (The AIDS Support Organisation), UPHOLD (Uganda Programme for Holistic Development.
[17] See Volume 2.
[18] In the case of Uganda there is an imbalance due to the donors (PEPFAR). Cf. limitations.
19 The annual meeting of the TCMA coincided with the first week of the field mission. The meeting brings together the majority of key actors from the faith-based health sector and a substantial number of representatives from the public health sector. CSSC invited us to attend. This opportunity greatly facilitated the preparation of the interviews on central and peripheral level.

managers of 5 district health centres in the district of Moïssala and with a representative sample of the different actors of the health district[20].

For Uganda we held 15 interviews - similar to a great extent for the two case studies - at central level. The 3 interviews at intermediate level[21] were all held at St Joseph Hospital. For the peripheral level, the interviews are equally divided between St Joseph Hospital (8) and Kabarole Hospital (9). In total 35 interviews were conducted, with an extra 5 informal interviews.

Limitations of the study

Our study has 4 general limitations: a first limitation is related to the perception of the research topic among the actors we met: allowing for exceptions, the interviews have clearly shown that there is confusion in the mind of most actors between partnership and contracting. This confusion is partly due to the fact that in all the countries, processes of partnership development and contracting followed each other chronologically, and sometimes even occurred simultaneously. However, the mix-up of these types of processes is also symptomatic of the limited or even miscomprehension of concepts. We will elaborate on this further in this report. Finally it also indicates a weakness of the contracting phenomenon in all 4 cases: the generalist notion of 'partnership' tends to supplant the specific and well-defined objectives of a functional contract, at least in the minds of contracting parties.

The material collected has its limits: it was not possible to fully exploit the richness of the material under the terms of the study. Therefore, in line with the methodological framework chosen we favoured the qualitative data, but this was obviously to the detriment of the quantitative material, provided among others by the routine documents of the hospitals. Similarly, the use of qualitative analysis of software (NVivo 8) was limited to the definition of a tree structure for the analysis criteria (basis of the grid for analysis and interviews) and encoding of part of the data.

A third limitation touches upon the quality of the documentary collection: the deficiencies in the filing systems - when they exist - are often huge, sometimes abysmal. This is particularly the case on peripheral level, especially for data older than 10 years, definitely in the public sector (district health authorities), to a lesser extent also for the faith-based sector (hospitals). The difficulties in the collection and identification of the existing documentation are in proportion to this. The recourse to secondary sources (literature, interviews) has largely compensated for these difficulties, without however totally eliminating the risk of omissions.

Finally, the perspective of the patients could only superficially be touched upon, either through indirect testimony or to a lesser extent through the documentary sources (attendance of services).

Some specific limitations need to be mentioned:

In **Cameroon**: the under representation of the public sector on peripheral level. The interviews are limited to the Chief District Medical Officer of the District (DMO) as we lacked other operational participants. The DMO was interviewed in Europe where he undertook a one year Master course. He was not really replaced during his absence, which made the collection of documents quite difficult.

In **Tanzania**, a whole lot of documents remained inaccessible by the research team because of the language barrier (Swahili): mainly hospital documents (annual reports, reports of the director's committee meeting, etc.) as well as regulatory documents of the Ministry. They were

[20] Catholics, Protestants, Baha'is, community officials and public sector. Only Muslims are not included due to the geographical remoteness of the only health centre they manage in the Moïssala district. The inclusion of the Catholic HC (Béboro) has allowed us to clarify the history of the contracting process: the management contract of the Moïssala district has in fact been preceded by a contracting transfer of the activities of the Béboro health centre at public hospital level in the district (*cf.* 2, Characteristics of the case studies, Chad).

[21] UPHOLD representative and Catholic Bishop of Gulu.

nevertheless collected, so that possible future translations remain an option. This may allow fine tuning of our analysis and the correction of probable inaccuracies. The difficulties we met to get in touch with some of the MOH staff (Chief Medical Officer, Director of Planning, etc.) or of PMORALG[22] led to an imbalance in the number of interviews at central level in comparison to the peripheral level. The exceptional level of collaboration and availability of the hospital staff at Nyakahanga reinforced this impression. Finally, the collection of older documents, justified by the longer contracting experience in Tanzania, proved difficult. No document about the specific status of the District Designated Hospital has for example been found at the Ministry of Health, this in spite of the quality of the online information recently made available by the MOH and the PMORALG.

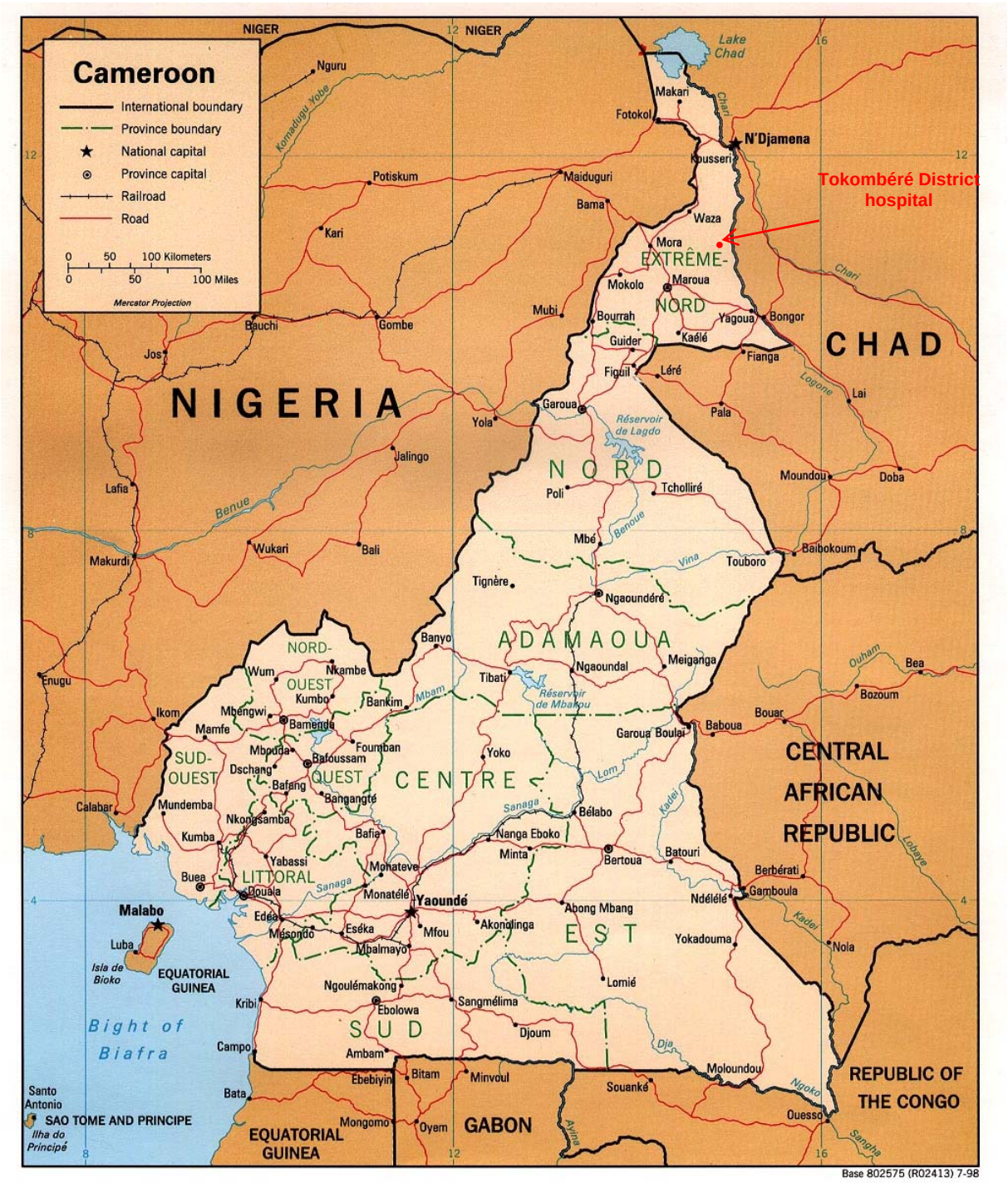
The field mission in **Chad** had to be considerably shortened due to the local political circumstances. A week of interviews and document collection on central level was lost as a result. However, the work carried out on peripheral and intermediary level proved quite satisfactory. The circumstantial gaps which resulted will have to be filled in the future. It was not possible to make up for this as we were unable to carry out an extra mission. It would have been interesting to look into the question of health committees and management committees[23] set up at peripheral level in the framework of the PSSP[24]. Due to lack of time we opted to address these issues via HC interviews. In order to further fine-tune our analysis, it would have been necessary to administer questionnaires to the Management Committees (COGES) and the Health Committees (COSAN) of these centres. These surveys will have to be organized, if it is decided to continue the present research work. We were not able to contact the administrative authorities of the district directly.

In **Uganda**, the main limitations were a result of the difficult access to the data on PEPFAR and its local representatives; this problem came up several times and forced the research team to rely on secondary sources (other interviews held, in particular with certain representatives of recipients; secondary literature and documents provided by internet sites of PEPFARWatch and the US Government Accountability Office[25]). Information on the contracting documents themselves was sometimes difficult to obtain, especially on the financial data. This was a result of the reluctance of some of the recipients and beneficiary facilities to provide these.

[22] Prime Minister's Office for Regional Administration and Local Government.
[23] COSAN, GOGES.
[24] Primary Health Care Policy.
[25] www.PEPFARwatch.org; www.gao.gov

Summary of case-studies

Cameroon


Cameroon
International boundary
Province boundary
National capital
Province capital
Railroad
Road
0 50 100 Kilometers
0 50 100 Miles
Mercator Projection
Tokombéré District hospital
NIGERIA
CHAD
CENTRAL AFRICAN REPUBLIC
REPUBLIC OF THE CONGO
GABON
EQUATORIAL GUINEA
SAO TOME AND PRINCIPE
Bight of Biafra
Lake Chad
N'Djamena
Maroua
Garoua
Ngaoundéré
Yaoundé
Bertoua
Batouri
Abong Mbang
Moloundou
Ouesso
Base 802575 (R02413) 7-98

General context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

According to figures of the MOH, the private sector represents 40% of the national supply of care. The lion's share is held by three faith-based organizations, in order of importance[26]: *Organisation Catholique de la Santé du Cameroun* (OCASC), the Conseil *des Eglises Protestantes du Cameroun* (CEPCA) and the Fondation Ad Lucem[27] (FALC).These facilities are mainly located in rural areas and open to all categories of the population. They complement the public service, or even compensate for the absence of state health facilities. The development of partnerships in the Cameroon health sector is largely explained by the importance of the faith-based sector in the national health supply. OCASC, CEPCA and the FALC are the main partners in this set up and their facilities participate actively in various health policy initiatives (fight against HIV/AIDS, vaccination campaigns, etc).

PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL[28]

Until recently (2006) no national framework existed for a Public-Private partnership in the health sector. Nevertheless, the formalized partnership between the MOH and a number of faith-based hospitals has its roots in the past[29].

At the time of the independence, the faith-based organisations largely dominated the sector in numbers and in quality. The situation was redressed as public facilities were progressively set up but faith-based facilities remained superior in terms of distribution[30], equipment, personnel and reputation. The State's supervision was mainly theoretical at this time. For their part, the faith-based organizations were not really involved in the drafting of health policy and the control of the public sector on these facilities remained very limited.

As in colonial times, the state continued to allot subsidies to faith-based facilities but the system did not function very well anymore[31]. However, this sorry state of affairs did not substantially affect faith-based facilities[32].

The adoption in 1993 of a Primary Health Care Reorientation Policy and set up of a district health system encouraged the development of a silent partnership between the MOH and a number of faith-based hospitals. These took on the task of district hospital in places where there was no public equivalent. However, this status was not confirmed officially and had no legal basis.

The contracting process took off in the health sector in the early 2000s; at the time a national strategic framework was still lacking. Hence, the pilots were isolated cases developed with very limited interaction between the Ministry and the local church authorities. They addressed identified needs and arose because the state was unable (financially) to set up its own facilities there. These contracts recognized the essential role played by the faith-based hospitals[33] - they got the status of district referral hospital - and defined the scope of their collaboration with the MOH.

It was only from 2000 onwards that the conditions were gradually fulfilled for a formalized contracting policy: a collaboration framework (2001), health sector strategy (2001-2010), the

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[26] OCASC is the most important of these with 13 hospitals, 229 health centres; it employs around 3000 people. It is followed closely by CEPCA, which stands out due to the large number of hospitals it manages (31 and 165 health centres). The *Fondation Ad Lucem* - of Christian background but non denominational - runs 10 hospitals and 25 health centres.

[27] Organisation of Christian background but non denominational.

[28] Cf. Figure 1.

[29] 2002 for example in the case of Tokombéré, the hospital that was retained in Cameroon for this study.

[30] Public structures evolved initially mainly in urban areas.

[31] Small amounts and irregular support, in particular since the economic crisis in the 80ies.

[32] Support from the mother congregations and user fees.

[33] i.e.: Tokombéré.

creation of a sub-directorate for national partnership (2002) and then progressive collaboration of the sector partners in the Cooperation Directorate (DCOOP) of the MOH in order to develop a more comprehensive partnership approach. The process was speeded up by the arrival of the C2D project, which gave support to the private not for profit sector through contracting: the work of drawing up a partnership strategy, started in 2003, was finished in 2006. Models for framework agreements and implementation contracts were finally ready at the end of 2007.

CHARACTERISTICS OF THE CASE SELECTED

Tokombéré is one of the districts of the Mayo-Sava department in the extreme North province of Cameroon. The hospital chosen is a private Catholic institute affiliated to the OCASC and owned by the Diocese of Maroua-Mokolo. It was founded in 1960 and was for a long time the only health facility of any importance in the region. It adopted a PHC project[34] in 1976 and became a national pilot centre in 1978. This system still exists today and explains in part why Tokombéré hospital (HTok) was able to hold on to its position during the crisis, before the adoption of a reorientation policy of PHC, when other faith-based hospitals were faced with ever growing difficulties. Since 1975, the same expatriate chief medical officer[35], a man with strong leadership skills, has worked in this hospital and attracted important external support[36]. These factors have contributed to a climate in which the staff is totally committed to the project.

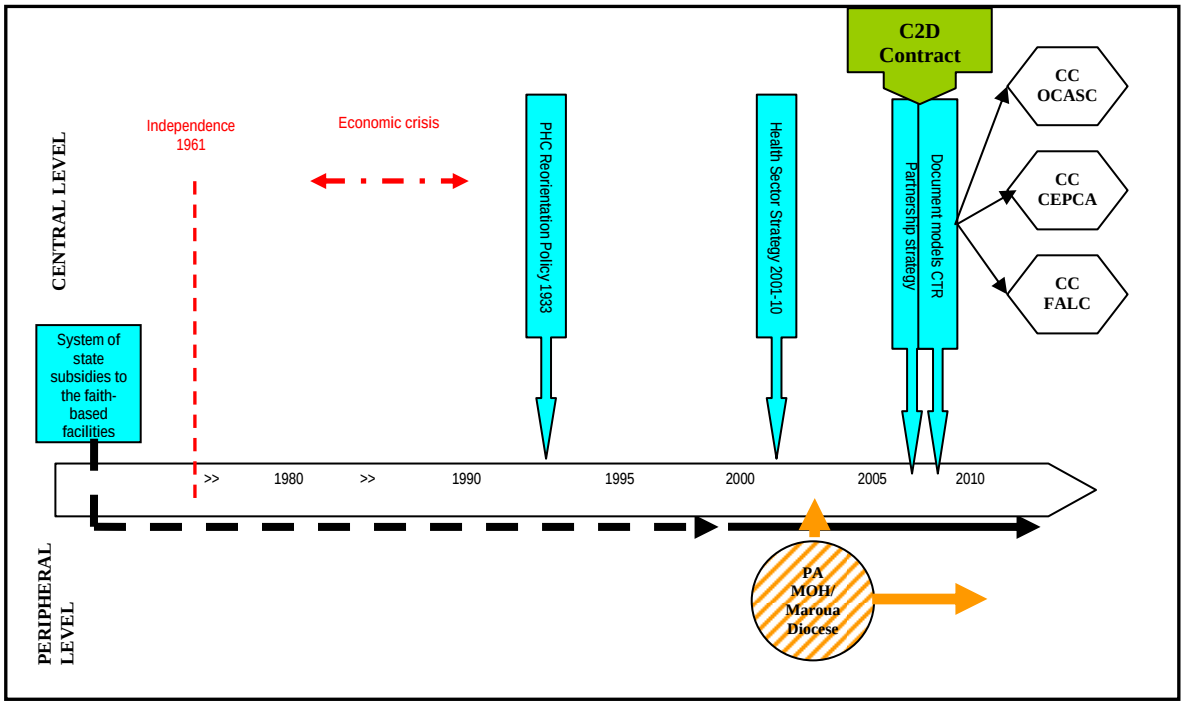
As a result HTok enjoys an excellent reputation which ensures the loyalty of the local population (implicated in the PHC project through the Village Health Committees). The hospital has a target population that goes well beyond the borders of the province (Chad, Nigeria). This reputation owes a lot to the active follow-up of the PHC project and the decentralized activities organized by qualified hospital staff. Its unique position and the initial absence of a public hospital, explain why HTok has played de facto the role of district hospital since 1993 and has done so in a climate of excellent understanding with the Ministry of Health. The close personal relations of the chief medical officer with the authorities have doubtlessly contributed to this positive climate. This informal situation continued until 2002, when a partnership contract was signed between the diocese of Maroua-Mokolo and the MOH that confirmed and formalized the existing cooperation.

[34] Project for Human Promotion, in Tokombéré.

[35] Father Christian Aurenche.

[36] *Fondation Christian Aurenche* and the Parish of St Germain-des-Prés in Paris provide the hospital with funds, equipment, expatriate staff, drugs, etc.

Figure 1. The contracting process in Cameroon



LEGEND

CC Framework agreement
C2D Debt reduction contract
SC Faith-based facility
PHC Primary Health Care
SSS Health Sector Strategy

PA Agreement protocol
MOH Ministry of Health

Framework agreement

Service agreement

Public Sector

Faith-based Sector

Donors

Formal relationship

Relation between central and peripheral level

Informal relationship

Results of the interviews and the documentary analysis

CENTRAL LEVEL

The progressive extension of the dialogue and the participation of the private not for profit sector (first through the health sector strategy) brought about the transformation from distant collaboration to a true partnership. Nevertheless, it still took 8 years (from the health sector strategy to the publication of the partnership strategy and framework agreement models) to go through the process of drawing up a legal framework. If the partnership strategy was the result of sector wide collaboration, the final phase of the process, speeded up by the set up of the C2D in Cameroon, was essentially the work of the three main religious actors: OCASC, CEPCA and FALC. The relative weight of these actors in the health sector makes them the first beneficiaries of the health section of the C2D debt reduction policy project.

The C2D priorities frame the formalization process of the partnership. This constraint - also an opportunity because of the money involved - explains why the development of contracting (as a partnership strategy instrument) largely proceeded without referring to former contracting experiences: those that came into being at decentralized level between health facilities and the MOH since 2002, a number of which[37] only precede narrowly the formulation and signing of framework documents. The people approached at central level - from the public as well as the faith-based sector - link this contracting process in their discourse to the debt reduction contract, relegating to second plan the earlier operational cooperation experiments.

The most important documents are the agreement protocols signed between the MOH's main partners (OCASC, CEPCA, FALC) and the MOH within the framework of the C2D. In this study we will concentrate by way of example on the framework convention signed between the MOH and OCASC. This document serves as a standard contract, applied without modifications, for all partners alike. It is moreover accompanied by a service agreement, the execution contract.

The tools of contracting are currently being implemented: some are already operational, while others still haven't been put in place. This situation is partly explained by the delay in the disbursements of C2D. Thus, the steering committee foreseen by the partnership strategy and instrument for its set up is not yet operational as such. Its tasks are nevertheless temporarily assumed by the steering committee of the health sector strategy.

The framework agreement and the execution contracts with the three principal partners were signed in 2007 and marked the starting point for the implementation of the partnership strategy.

These contracts foresee in regular follow-up meetings, production of written reports by the private partners (e.g. justification of the use of the funds paid) as well as regular monitoring (every 3 to 6 months), to check the progress and decide on possible adjustments. The MOH has in this context the right to come and check: its power to carry out supervisions and do the follow-up in the field constitutes an additional administrative instrument next to the contracting tools as such.

At this stage, it is difficult to assess whether these different tools are efficient and in how far they are used. The partnership strategy is still in a very early stage of implementation indeed. The recent payments of the first C2D funds should help speed up the process but only after some time we will be able to assess the situation. Currently all actors emphasize the quality of the relationship, although for the denominational partners this is tempered by worries about the delay in access to the funds promised[38]. They also stress the quality of communication: a smooth transfer of information from faith-based facilities to the Public sector; a dialogue

[37] For example, the agreement protocol signed in November 2007 between the MOH and the private hospital of Petté, managed by the *Fondation Sociale Suisse* in North Cameroon.

[38] The recent payment of the first C2D funds may have decreased their worry. During our field trip though, this sentiment prevailed in the faith-based sector.

climate ensuring that the available information is up to date. We have to point out however that in the absence of a specific steering committee, able to centralize and add up the wealth of information, the relations between the public and private sector tend to develop in a rather "bilateral" fashion, at least for the time being.

On national level, a series of elements have positively influenced the implementation of the contracting process.

Structural elements:

- The important share (40%) of the private not for profit sector in the national provision of care;
- The reputation of quality, the (mainly) rural presence and the strong appeal of the faith-based facilities in comparison to their public counterparts.

Economic elements:

- The general burden of debt and the reduction of the health budget as a result of the economic crisis of the 80s: this situation affected both the public and the private not for profit sector and added to the difficulty of the MOH to ensure financing and adequate coverage of the sector;
- The (commitment to) economic reforms meant that Cameroon could benefit from the Heavily Indebted Poor Countries (HIPC) Initiative. The Programme's debt relief funds are used to finance public and private social projects;
- The cash problems of the faith-based sector created by the decrease in support from traditional sources and the effect of the economic crisis led to a growing inclination to collaborate with the government;
- A common concern to overcome stalemate situations that existed on peripheral level and resulted from competition and old conflicts.

External and short-term aspects:

- The pressure and support from donors and international organizations to integrate the private sector in the general offer of care: the WHO in the initial phase of the intersectoral dialogue on the set up of the partnership strategy followed by the C2D project in the framework of the HIPC initiative (bilateral logic);
- An undeniable advantage in the 90s was the presence of key MOH people who encouraged the public-private partnership.

Political elements:

- The introduction of the decentralization policy[39] which gave more autonomy to the local entities to manage social issues such as health, education, local development.

"Emotional" aspects:

- The need of religious actors to get recognition for their contribution to the health of the population in addition to or in replacement of the public services. Public actors were largely in favour of addressing this need.

Although the contracting process has reached a relatively advanced stage by now, it was a rather long process, as a result of a number of factors which even now continue to play a role:

- The strong centralization of the level of decision making, the heavy bureaucracy with results that mainly depend on people and not on legal mechanisms;
- A high level of corruption made worse by the complex financial management procedures. This leads the private actors to a deep distrust of the State as a result of earlier negative experiences and a fear that the government will again fail to keep its commitments;

[39] Constitution of 18 January 1996.

- The limited financial capacity of the MOH to support the development of the partnership and contracting process. The HIPC Initiative completion made it possible to boost the process once again as the French debt remission programme (C2D) included a health contracting component;
- The extremely slow payments by the C2D programme which in turn slow down the implementation of the new legal framework. The media hype surrounding the signing of the framework agreements with the three main religious organizations played against the latter, as it made them suspects of pocketing funds which in reality they had not even seen yet[40];
- The novelty of the concept of contracting and the absence of any preliminary training for the actors involved in its implementation;
- Furthermore, the knowledge of the mechanisms, the tools and their implications is mainly limited to the central level: the actors in the district remain largely in the dark.

On the whole, the actors agree on the good quality of the relationship during the whole process, expressed through:

- The relative absence of resistance in the faith-based sector to the take-over of their sector by the state and to the state's supervision of the private not for profit facilities.
- The criticism is mainly about the last phase of developments, i.e. those that in the framework of the C2D resulted in the elaboration of the partnership strategy and contracting document models: the slow process, the cumbersome bureaucracy and the little respect by C2D of the initial payment timeframe were deplored by the faith-based sector.

INTERMEDIATE AND PERIPHERAL LEVEL

In 2002 a protocol of agreement was signed between the MOH and the diocese of Maroua-Mokolo. It designated the HTok as a district hospital, confirming the existing situation (since 1993) and the set up of a district system. The proto-contracting stage took place when the power in Cameroon was strongly centralized. The informal collaboration that existed between the MOH and the hospital was made easier by the chief medical officer's good relations with the MOH authorities on the one hand and the hospital's reputation on the other. The faith-based sector carries out national policy in the management of its hospital i.e. the organization of the district system and more specifically the PHC programme. It was in fact the implementation of the PHC project at HTok which served as an example for the development of a national contract model (1978). This decision is strong indirect proof of the State's recognition of the role played by the hospital. The direct support of the State remained limited (inherited from colonial times) and was again not formalized.

The possibility of a contracting relationship was discussed from 2000 onwards at the initiative of the public authorities: the provincial representative (DP) of the Extreme North Province considered HTok a model of public-private partnership and tried his utmost to convince the Diocese of Maroua-Mokolo and the Chief Medical Officer that a contract would ensure the continued existence of the relationship and benefit both parties. The distrust of the religious authorities, anxious to see their facilities taken over completely by the state, had to be overcome. There was a setback in the process in the middle of the 80s with the creation of a public health centre on the doorstep of HTok and the perspective of this hospital becoming a district hospital: a doctor was in fact appointed and the facility, although not operational, rapidly drained the public funds to the detriment of HTok. Furthermore, the hospital was forbidden by the District Chief Medical Officer to carry out its decentralized activities (PHC) in the public facilities. As a result, relations between HTok (its head doctor) and the local elite became rather tense.

The process ended in 2002 after two years of negotiations. The model contract developed by the provincial representative was discussed in detail, for the most part with the chief medical

[40] Even within the faith-based sector itself and in particular on peripheral level.

officer of HTok. Once signed, implementation started rapidly. The slowness of the contracting process is caused mainly by the following two issues:

- The resistance of the religious authorities because they feared losing control and autonomy but also the reputation of corruption and bad governance by the State. Once the chief medical officer of HTok was convinced, he actively assisted the DP in persuading the diocese of the opportunities offered by the set up.
- The need to resolve the conflict between the chief medical officer of the HTok and the local elite, who wanted to maintain the public facilities. This local elite had to be convinced, support had to be obtained from the chief medical officers of the hospitals and a reclassification solution needed to be found for the public hospital.

These negative elements are largely compensated by a substantial number of positive elements:

- The resistance of the population, alarmed by the possible retreat of the HTok staff from the public health areas[41] has paradoxically led to the start of a multi-sector discussion forum on the issue of the coexistence of the two hospitals;
- The active involvement of the DP and later the Chief Medical Officer of HTok. Thus, the start of the decentralization lend support to the initiative of the DP by giving him the authority to submit a proposal to the central authorities for a partnership contract between the MOH and the diocese;
- The state was forced to integrate the faith-based sector in the health map, in the aftermath of the economic crisis of the 80s and due to its poor financial resources;
- The leading role played by HTok[42] in an enclave with no real public equivalent;
- The wish of the religious authorities and the Chief Medical Officer of HTok to get recognition for the role they played, i.e. redress the current 'aberrant situation' in which the facility was not integrated in the district health system, ensure support according to the activities carried out in the hospital and obtain legal status and legitimacy;
- The pressure of the donors[43] to align with the National Health Policy and towards greater transparency vis-à-vis the state.

The contract signed in 2002 by the diocese of Maroua-Mokolo and the MOH remains vague in its objectives, and focuses both on the official recognition of HTok as main hospital and on issues related to the organization of the district. Neither of these elements is clearly put forward as the principal objective; this objective has to be decoded through careful reading of the clauses. As the majority of the clauses are about the district hospital, the partnership actors consider the formalization of this status as the subject of the contract. The diocese is responsible for the faith-based side: in this sense the document responds to the formal requirement to involve the legal owner of the hospital in the signing process. The Chief Medical Officer is not a signatory but the content of the document was mainly discussed with him.

The Ministry of Health represents the public side. This is paradoxical in the light of the decentralization policy of 1996 but reflects the persistence of the (extremely) centralized Cameroon system. The legal reference framework is clearly stipulated (Framework law n° 96 in the Health sector; Development plan; Health sector strategy). However, these elements are somewhat outdated since there has been no revision of the contract since 2002. The document cannot make reference to any partnership framework or contracting tools, since these were developed after the document was signed.

[41] Decision by the District Chief Medical officer, see above.
[42] Tokombéré Hospital has the technical capacity, staff and means. The quality of care and the dynamic Human Promotion Project (of which the PHC forms the health part) lead to a high attendance rate.
[43] Belgian Cooperation.

The obligations of the State are twofold:

- On the one hand the clauses that relate to the organization of the health district include the recognition of private health centres "as centres responsible for the health zones within their area of location", the appointment of a chief medical officer, the allocation of means to the health facilities i.e. staff and financial support (loans), and keeping up the dialogue.
- On the other hand, the recognition of HTok as district hospital.

These obligations remain nevertheless extremely general. They do not specify the allocation mechanisms (financial means and human resources) and thus lead potentially to problems of interpretation or application.

HTok did not receive the formal authority to supervise the health centres in the area. The private Catholic health centres are being supervised though by HTok, in a tacit manner. The contract makes no mention of the specific nature of the facility (religious identity) except for a reference made to HTok as "private hospital of Tokombéré".

The obligations of the diocese concern the hospital of Tokombéré:

- The delivery of a minimum package of activities (MPA);
- Accept the right of public authorities (MOH) to carry out supervisions and the obligation to report (quarterly reports of the hospital);
- The integration of personnel seconded by the public sector.

The contract foresees the installation of a Steering Committee (CP) which has to monitor the contract implementation in their annual meeting (cf. contracting tools in Part 2). This clause is not accompanied by any specific mechanism. The contract is for one year with a tacit renewal possible. There is no clause specifying a revision of the document. The cases in which termination is possible are modelled on the normal legal formulas. The question of resolving possible conflicts is not touched upon, nor the law that is meant to govern this.

The only tool mentioned and really perceived as a management instrument for the contracting relation is the Steering Committee (CP). This committee gathers in principle twice a year the different levels of the hierarchic pyramid (central, intermediate and peripheral) to assess the contracting relation. Possible difficulties that arise in the various settings when implementing contracting are discussed and solutions put forward. Its theoretical usefulness is unanimously recognized. In practice the committee's functioning is hampered though by several aspects:

- The number of times the committee gets together (once a year) is not sufficient;
- The operational mechanisms and the respective responsibilities are not defined;
- The central level (MOH) systematically delegates its responsibility to the provincial representatives: the communication between the intermediate and the central level is largely dependent on the level of competence and above all on the goodwill of the provincial representative;
- There is no feedback from the MOH on the reports from the DP. These reports which have to be drafted by the DP tend to be produced and distributed with considerable delay. The same is true for the financial and activity reports of the hospital. The resolution of problems is thus difficult: as the MOH is supposed to remain the ultimate decision maker, the resolution of conflicts is its responsibility.

The bishop and/or the Chief Medical Officer intervene sometimes directly in Yaoundé with all the difficulties that a lack of knowledge of the mechanisms at work and the absence of privileged interlocutors at central level entail. The communication is therefore often one-sided, from the hospital to the intermediate and central levels. The coordination meetings at district and provincial level are considered a useful addition but do not really allow taking up specific contract questions. Overall, these difficulties often considerably hamper the progress of the relationship[44].

The perception of the relationship depends on whether the declared objectives of the contract were reached but also on the respective expectations of the parties involved. For the

[44] In practice, the same difficulties are repeated every year without a concrete solution being found.

public side, these expectations are the improvement of health coverage, the care for the population through the integration of the health system. For the faith-based sector the contract is seen as an instrument for official recognition by the state of the skills and the role of the Church and more particularly of Tokombéré hospital. The access to state support (exemptions, subsidies, training, and take-over of staff) is only of secondary importance[45]. In this category, it is mainly the support in HR that is appreciated, doubtlessly because the hospital can bear to put up with limited support from the state[46] because of its external resources. Public authorities and denominational actors acknowledge unanimously that the hospital fulfils its obligations. The only reservation made by the public authorities is about the poor knowledge of the hospital (or the faith-based authorities) of MOH procedures.

There is also unanimity about the fact that the state does not respect its obligations, perceived as a major obstacle to the implementation of the contract:

- The subsidies are paid irregularly and the amount is limited. There has never been an investment budget allocated to the hospital in spite of repeated complaints. It is striking that this, although seen by the hospital as a secondary motivation to enter the contract, is paradoxically perceived as the main reason why the relationship is to some extent problematic. Most of the bishop's and the Chief Medical Officer's efforts focus on this issue (letters, approaches to the DP, trips to Yaoundé, etc.).
- Although the state allocates staff to the hospital, this personnel is generally perceived as being of bad quality. The secondment of staff is moreover made without any consultation, and does therefore not always meet the real needs of the hospital. There are complaints about the lack of professionalism. Finally, this category of staff is difficult to manage because they fall under the authority of the district and the provincial representative.
- Finally, the official recognition of HTok as district hospital was introduced by the agreement protocol but does not figure in any particular nor official declaration in spite of complaints from among others the chief medical officer to the MOH.
- In terms of organization of the district, the collaboration on public health activities between the HC and the hospital is weak.
- The relationship also suffers from the heavy bureaucracy in the state mechanisms: the procedures are complex (notably in matters of getting financial support) and insufficiently grasped by the hospital.

Public authorities perceive the effects of contracting as largely positive:

- Fewer conflicts to manage;
- The existence of a legal collaboration document and a dialogue with the private sector;
- An improvement of the district health information system (greater transparency of the hospital; quality of the information provided);

[45] The public actors tend to consider on the contrary that these advantages are the principal motivation of the faith-based sector.

[46] The part of the subsidies of the state constitutes only about 10% of the HTok budget.

For the denominational side the changes reside mainly in:

- The acquisition of legitimacy[47] which is an advantage in consultations with possible donors;
- The allocation of financial resources[48], equipment (ad hoc) and subsidized drugs (vertical programmes) are much appreciated benefits, in spite of their relative insufficiency. The secondment of state personnel has provided the hospital with a doctor and three extra nurses;
- A better level of collaboration: the hospital has a better visibility for the activities of the second line; a referral/counter referral system has been set up; the hospital can take part in meetings organized on provincial level, in a number of training programmes and is generally integrated in the provincial health system.

More negatively, the hospital mentions the negative influence on the behaviour and morale of faith-based staff (professional ethics, feeling of injustice due to differences in treatment) by the introduction of public staff.

[47] The status of operational unit (UPEC) for the fight against HIV/AIDS is added to the status of district hospital.
[48] 15 millions FCFA subsidies, 14 millions FCFA credit.

Conclusion

The contracting experience in Cameroon presents an ambiguous picture with both encouraging and alarming signals. The fact that Tokombéré achieved the main objective of the contract (it operates as a district hospital) is more due to substitution than to complementarity between the partners. The district hospital functions in spite of the state not respecting its commitments and thanks to an exceptional situation, marked by regular access to external resources. The contract document guarantees here mainly a status quo.

The fact that the decentralization process was never finished in Cameroon has a negative influence on the contracting experience:

- The decentralization policy initiated in 1996 was never fully implemented: the intermediate and local levels of responsibility exist but operate in a strong climate of centralization which complicates the management of the relationship.
- The contracting relationship with the central level suffers from the contradictions that exist between the different authority levels: the district and the provincial representatives do not properly fulfil their go-between role at the MOH although the MOH becomes more and more a distant partner in the contracting relation.
- A poor flow of information is one of the first consequences, together with an obstruction in the decision making process. The problems the hospital might encounter in the context of the contracting relation can only be resolved with difficulty.
- Therefore, the quality of interpersonal relations, the level of implication of some people and individual skills continue to largely determine the quality of the contracting relationship and influence its development.
- The further institutionalization and operationalisation of the decentralization process appears to be a necessary condition for improving and optimizing the implementation of the contracting relationship (increased autonomy of the decentralized levels notably for questions linked to resources; improvement of the flow of information).

If the need and the theoretical advantages of contracting are recognized by most actors, its mechanisms and set up still need to be improved:

- The need for training remains evident for the people in charge in the denominational and public sector and at all levels of the pyramid; this is particularly the case for the peripheral level, when new contracts are being considered and developed. People at peripheral level also need to be initiated into current developments of the contracting framework at national level.

- The regulatory framework - developed as a result of C2D - does not take into account the earlier protocols signed between the hospitals, the dioceses or NGOs and the MOH. We need to think about the possibility and ways to integrate these experiences in the new partnership strategy, notably through their update and adjustment to the formats developed. Outside the framework, the actors of earlier protocols in the private not for profit sector (HTok) run a strong risk of facing ever greater difficulties in finding structural answers to the problems they meet.
- The notions of performance introduced by the new partnership strategy and the convention models are a great improvement and the earlier protocols could greatly benefit from these.
- The integration of all contracts in the national framework depends on whether they can be traced more easily: at the moment, nobody - public nor faith-based actors - seems able to put a figure on the existing protocols. This is a result of a multiplication of controlling public authorities.
- Financing the partnership strategy (and contracting) currently depends on the C2D project (5 years): beyond this five-year time span, the continuity and extension of the initiative could become an issue, more in particular for its operational stage.

Tanzania

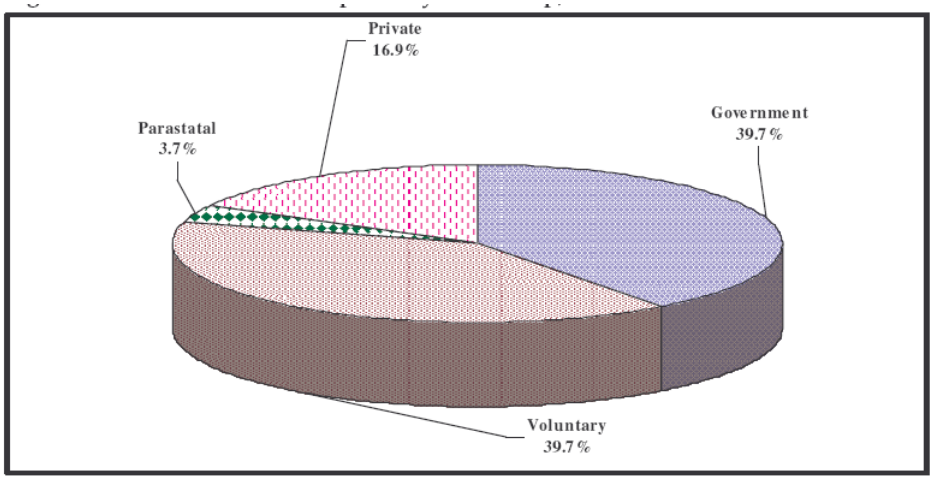
Nyakahanga Hospital

General context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

At the time of independence in 1961, half of the hospitals were run by missionaries. According to most recent statistics, the private not for profit (voluntary) sector - in which the faith-based facilities make up the overwhelming majority - is the second biggest provider of health care in the country. The voluntary sector holds 17,7% of the health infrastructure (against 64,2% for the state), but 39,7% of hospitals, equal to the MOH figure. In total, 41% of hospital beds, according to an official census, belong to faith-based structures. Hence they constitute an indispensable addition to the care provided by the public sector.

Figure 2. Number of hospitals by owner - continental Tanzania 2004-2005 (MOH, ASA 2006)



PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL[49]

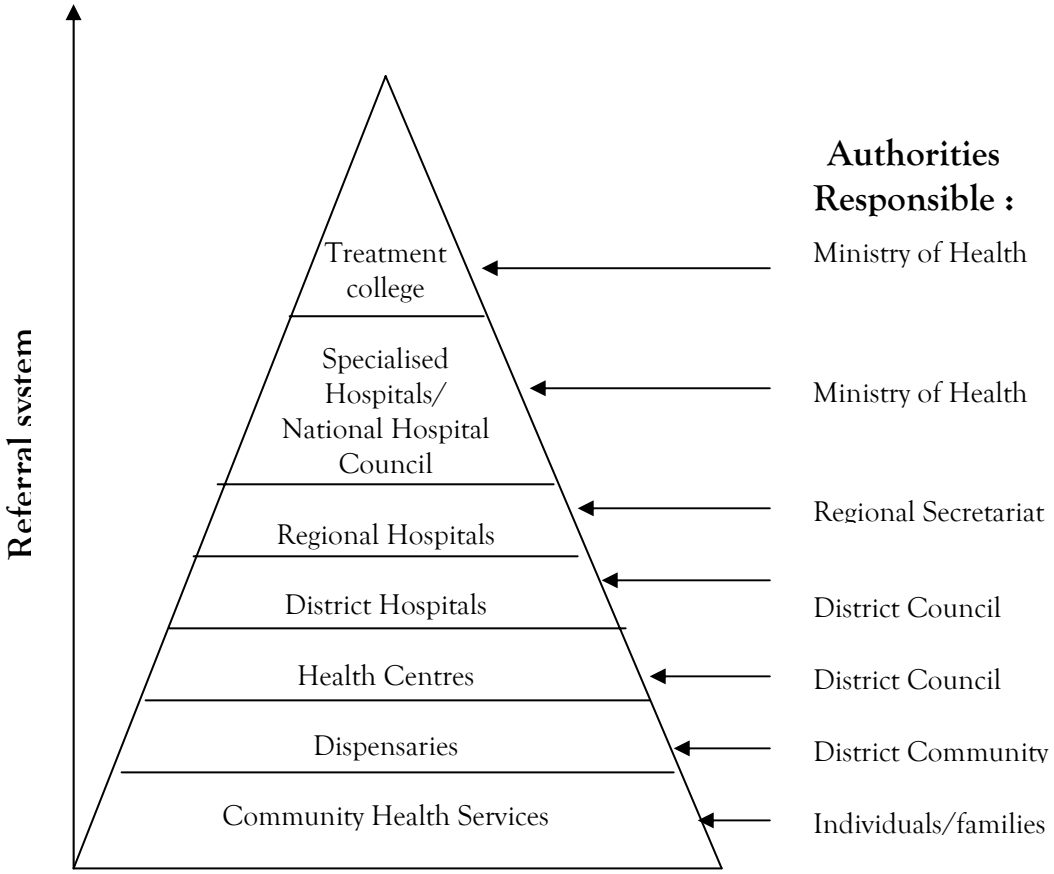
State overtures to the Church started during the colonial period and continued through the active involvement of some of the religious authorities in theorizing on the independence and the recognition of liberation movements. The rapprochement culminated at the time of Independence under Nyerere. The particular interpretation of socialism (Ujamaa) that was typical for Tanzania laid the foundation for a closer relationship while maintaining religious liberties but also reinforcing the control of the state. This system - although creating tensions in the field - marked the origin of the *Tanzanian model* of collaboration between the Church and the State. Today people still have this cooperation model in mind. The validity of this concept is one of the issues treated in the study.

In the health sector the collaboration between the State and the Church rests on a recognition of the crucial role played by the faith-based health facilities (rural, located in enclaves) in covering the territory. This recognition was initially implicit and a result of the adoption of the Principles of primary health care in 1967 by the Arusha Declaration.

[49] Cf. Figure 4.

The process reached a climax in 1972 with the implementation of a decentralized pyramidal health system and a contract model which elevated a number of faith-based hospitals to the rank of District Designated Hospital (DDH).

Figure 3. Organisation of the Tanzanian health system
(Source :MOSW, Tanzania. www.moh.go.tz)



The main objective of the MOH was to compensate for the shortage of public facilities, while at the same time trying to avoid duplication in places where the Church already had hospitals. The Agreement allowed the faith-based facilities to request state funds to cover their current expenditures including the salaries of qualified staff. Only investments and recruitment of staff remained at the owners' expense (diocese, congregation). The first DDHs established a relation with the central authorities (MOH). Sometimes the contract formalizing this relationship was not immediately signed. This was the case for Nyakahanga hospital, described more in detail in this study.

The Churches[50] negotiated in 1992 an agreement (Memorandum of Understanding, MoU) with the new Tanzanian government. The document officially recognized the role played by the Churches in the health sector and established the principle of additional financial support through funds from external financing sources. It also offered protection against future

[50] Protestants of the Christian Council of Tanzania, CCT and the Catholics of the Tanzanian Episcopal Conference, TEC.

nationalization attempts[51]. The MoH approved also the creation of a new social Christian platform, the Catholic Social Services Commission (CSSC). At the same time, the public private partnership concept made its official debut in the health sector: the first National Health Policy (PNS, 1990) introduced the cooperation principle with the private sector, which was then consolidated through the 2003 PNS, the health sector strategy (2003-2008) and the gradual creation of specific bodies (national partnership forum, technical PPP working group and the partnership unit at the MOH).

In recent years new contract models were developed together with private partners:[52]

- In 2005, a revision of the DDH contract model in accordance with the decentralization policy (signed at district level);
- In 2007 a new type of operational contract was finally introduced (Service Agreement, SA). It applies in principle to all health facilities, private and public, delivering public services. This new contract concerns mainly the faith-based facilities (Voluntary Agencies, VA) with the exception of the DDH.

CSSC has begun to decentralize 5 coordination areas, setting up a decentralized system of regional partnership fora. The idea is to implement this also on the district level somewhere in the future. Anyhow, until today Tanzania has no specific documents on partnership policy or on contracting policy.

Faith-based hospitals in Tanzania: Voluntary Agencies (VAs) and District Designated Hospitals (DDH)

All private not for profit health formations that registered with the MOH[53] are in principle marked on the national health map. Within this group, hospitals benefit from direct state support.

We distinguish three different cases:

- *The Voluntary Agencies (VAs) under which category all accredited faith-based hospitals a priori fall. These VAs have only potentially been involved in the contracting process since 2007 and the creation of service agreements (SA). The latter define a series of operating criteria linked to state benefits dependent on achieving fixed objectives (performance indicators). If there are no SAs, the VAs are only entitled to limited support from the Basket Fund managed by the local government.*
- *The DDH are VAs officially designated (by contract) by the MOH as district referral facilities. DDH benefit simultaneously from 1) a Block Grant of the Ministry of Health and 2) a part of the local Basket Fund.*
- *The faith-based network has also two national referral hospitals[54].*

CHARACTERISTICS OF THE CASE SELECTED

The Tanzanian case study mainly focuses on the example of the Nyakahanga District Designated Hospital (NDDH). NDDH hospital belongs to the Evangelical Lutheran Church of Tanzania (ELCT) and is located in the North West of the country (Lake Victoria) in the Kagera region, in the district of Karagwe, near the small town of Kajanga. The Kagera region is special in Tanzania because faith-based health facilities are in the majority there: 10 out of 13 hospitals (2005) belong to the church. This figure covers the total number of referral centres in the district[55]. Only the Kilimanjaro region shows a comparable distribution, although the "domination" of the church is less outspoken there.

Created in 1912 as a simple first aid post, the hospital Nyakahanga is the only hospital in the district and has operated as a referral centre since 1972, at first in an informal way. The

[51] Many private Faith-based facilities were nationalized between 1967 and 1970. These were mainly educational institutions but also some hospitals, such as the Kilimanjaro Christian Health Center (KCHC).

[52] CSSC for the faith-based sector.

[53] Registry of Private Hospitals, MOH.

[54] KCMC for the North and Bugando Medical Centre (BMC) for the West. These two facilities belong to the Catholic Church.

[55] See the table below (distribution of hospitals and HC by region and ownership): we note the distribution of hospitals between the government and VAs over the regions of Kagera and Kilimanjaro.

context (the recent wave of nationalisations and the fear of dispossession by the State) explains why the Church leaders did not show much enthusiasm for entering into a contract. Only in 1992 a contract would be signed between the Diocese of Karagwe and the Ministry of Health after a phase of regular meetings between the Church and the State.

A model contract was signed without amendments or revisions. A climate of understanding and relative harmony between the diocese and the MoH characterizes this period. The positive experience of an informal partnership and the exchanges preceding the signing can explain the shift in the church's position. The basics and the modalities of the contracting relationship have not changed, but the climate has: there is a good basis for trust now. It seems that the Church, anxious to ensure the continuity of the status of NDDH as well as the benefits linked to it, understands the advantage which a legalization of the situation brings.

Side-cases

Two other DDHs - Sengerema and Tosamaganga - have also been studied in order to test the representativeness of the NDDH case and extend the framework of the study. It also seems necessary to present their main characteristics although their contracts were only analysed on the basis of one interview.[56]

The Catholic hospital of Sengerema is located in the Sengerema district and the Mwanza region, near Lake Victoria. The hospital is owned by the Diocese of Geita. The hospital was founded in 1959 by two Dutch[57] congregations and became a district hospital (DDH) in 1976, when the Sengerema district was created. The hospital's contract probably dates from this time, although we were unable to get a copy (the original is with the diocese and the hospital did not have a duplicate). The agreement is a result of the excellent relations which the hospital maintained with the public authorities, both on central and local level.

The role of the congregations in the hospital remains important. The Chief Medical Officer belongs to the Congregation of the sister founders. As the Chief Medical officer is an expatriate, the hospital still benefits from direct links with organizations and individuals in Europe and benefits also from a variety of sources of support[58]. Officially, the hospital has 244 beds, but with the opening of a new maternity ward in 2007 this has increased to 281.

[56] With their respective Chief Medical Officers.
[57] Brothers of Mercy of St. Joannes de Deo and the Sisters of Charity of St. Charles Borromeo.
[58] The most important ones are Cordaid (The Netherlands), Danida (Denmark), Blankendaal Foundation, AMREF and more recently CRS in the framework of the AIDS Relief Programme (PEPFAR).

Table 1.Distribution of hospitals and HC by region and owner (2004-05)

Region	Hospitals					Health Centers				
	Gvt	Vol	Par	Pvt	Total	Gvt	Vol	Par	Pvt	Total
Dodoma	5	2	0	0	7	18	2	0	1	21
Manyara	4	2	0	0	6	4	7	0	0	11
Arusha	3	7	1	1	12	16	5	2	6	29
Kilimanjaro	**5**	**9**	**1**	**3**	**18**	**21**	**4**	**1**	**6**	**32**
Tanga	5	4	0	3	12	18	7	0	0	25
Morogoro	5	4	1	2	12	21	5	3	2	31
Coast	5	1	1	0	7	15	1	0	1	17
Dar es Salaam	4	2	2	19	27	5	7	2	9	23
Lindi	5	3	1	0	9	13	1	0	1	15
Mltwara	4	1	0	0	5	12	2	0	0	14
Ruvuma	3	5	0	0	8	8	3	0	0	11
Iringa	5	6	0	4	15	19	14	1	0	34
Singida	3	6	0	0	9	11	2	0	1	14
Mbeya	6	8	0	2	16	20	7	0	1	28
Tabora	4	3	0	0	7	12	2	0	1	15
Rukwa	2	1	0	0	3	20	8	0	0	28
Kigoma	3	2	0	0	5	13	4	1	0	18
Shinyanga	5	1	1	1	8	23	2	0	1	26
Kagera	**2**	**10**	**0**	**1**	**13**	**17**	**11**	**0**	**2**	**30**
Mwanza	6	6	0	1	13	32	3	0	4	39
Mara	3	4	0	0	7	13	4	0	3	20
Total	**87**	**87**	**8**	**37**	**219**	**331**	**101**	**10**	**39**	**481**

The Catholic hospital of Tosamaganga[59] is located in the Iringa district and region. It has 164 beds and is managed by two female mission congregations under the authority of the Iringa Diocese. Until recently, this facility was run as a simple *voluntary agency*.

As a hospital was lacking in the district, the state granted the Catholic hospital the status of *Council Designated Hospital*[60] (CDH) in July 2007, on the basis of the new contract model developed in 2005. This contract was signed with the local government which makes for an interesting comparison with the situation of Nyakahanga.

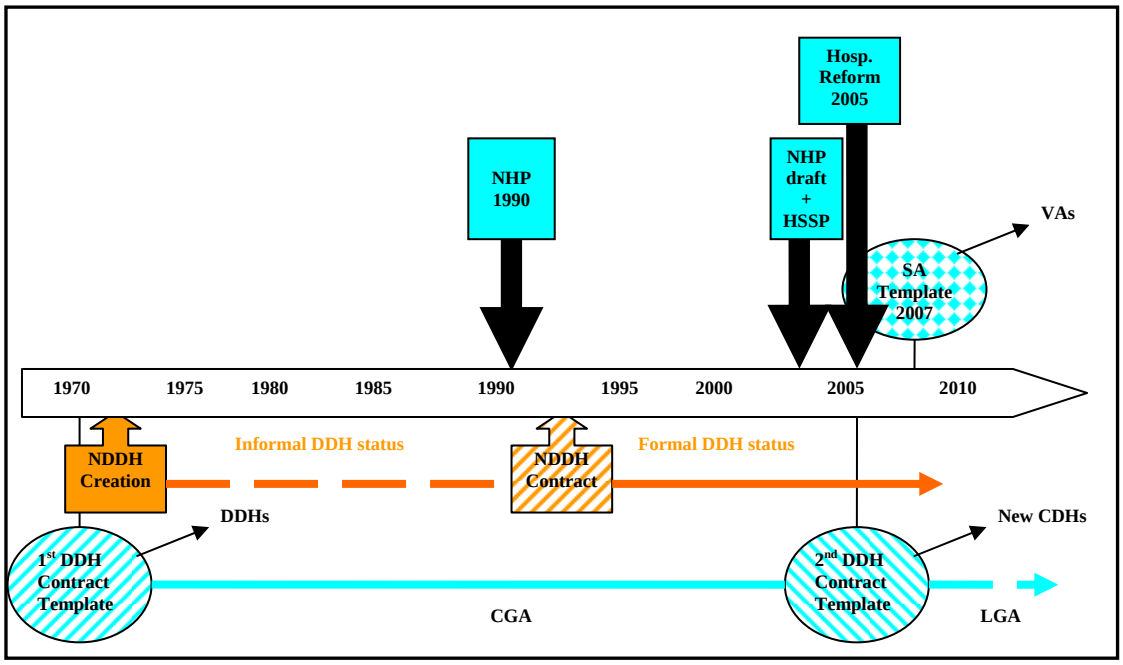
The examples of Tosamaganga and Sengerema show that the context can have an important influence on the destiny of contracting relationships. In Sengerema, the quality of the relations with the district helps to resolve some of the difficulties the NDDH is faced with. The hospital, which benefits from external resources, also takes a more positive stance towards the state. This example shows to which extent the interpersonal relations continue to dominate the debate and determine the chances of success of the relationship that is set up. The contract itself only plays a secondary role in Sengerema. The hospital does not even have a copy of the contract. The situation of Tosamaganga is more difficult to assess, because the relationship is only recent: receiving DDH status is very much appreciated by the facility as before it was just a simple VA, so it only got limited support from the state. We hope to be able to evaluate in more depth the quality of the contracting relationship in time. NDDH is, in spite of the clearly

[59] We do not know when this hospital was founded, but Tosamaganga is an ancient mission post which already existed quite a long time before Independence.

[60] New label replacing that of District Designated Hospital in the context of a revised contract model (2005).

more negative nature of its relations with the public sector, largely representative of the difficulties currently met by a growing number of DDHs. To a large extent these difficulties were expressed in the framework of the meeting of the Tanzania Medical Association in September 2008.

Figure 4. The contracting process in Tanzania



LEGENDE

CDH	Council Designated Hospital
CGA	Central Government Authority
DDH	District Designated Hospital
HSS	Health Sector Strategy
LGA	Local Government Authority
NDDH	Nyakahanga District Designated Hospital
NHP	National Health Policy
SA	Service Agreement
VA	Voluntary Agency

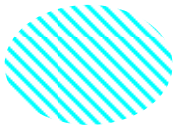
Documents or MOH intervention

Document of the hospital

Contract models

Contracting between the local government and the faith-based facility

Contracting relationship between the MOH and the DDH



Contracting relationship between the local government and the DDH

Ongoing Relationship

Formal Relationship

Informal Relationship

Result of the interviews and the documentary analysis

CENTRAL LEVEL

The main chronological stages of the formalization process of the relationship between the Church and the State have been touched upon in the section outlining the partnership context. The regulatory context does not include any framework document on the contracting policy: the principles are set out in a number of separate and often contradictory documents (PNS, Health Sector Strategy, Decentralization Policy, etc.). The cooperation modalities are mainly defined on an operational level therefore, through three contract models which govern the relations between providers of hospital services and the state.

The DDH contract model (1972?)

We refer here to the analysis of the Nyakahanga hospital contract, because this model holds without any changes for all District Designated Hospitals created before 2005. The exact date of this model is not clear, but goes without any doubt back to 1972; seven years after the first DDHs were created. From this we can infer that the concept and its implementation appeared well before a formal model was drafted. The first experiments were probably developed on the basis of informal relationships and were gentlemen's agreements so to speak.

The CDH contract model (2005)

This new model is the result of the work of the PPP Technical Working Group (PPP-TG) and responds in part to the need to revise the DDH contracts in line with developments in the Health policy and the adoption of new regulatory options. The main change is the adaptation of the model to the health decentralisation context: in this way, the local government authorities are appointed as representatives of the public authorities on behalf of the Ministry of Health. Hence the denomination of the hospitals is changed into *Council Designated Hospitals* (CDH) according to the new administrative set up. A number of significant improvements are made:

- The model includes a definition of the main concepts to which the document refers.
- The principle of monitoring/evaluation is mentioned, without specification of how this monitoring would be carried out and who is responsible for it (reference to the 'current legislation').
- The set up of a management team for the representative bodies (the Hospital Committee in particular, which replaces the former Board of Governors).
- The basis for calculating the salaries taken over by the state is mentioned (framework of 1999, possibly revised).
- The reporting obligations are somewhat specified for the hospital, without any detail however on how this should be done.
- The current legislation and the principles of conflict management are described, but only superficially.

As for the rest, the document remains to a large extent a copy of the initial contract model. It takes over the latter's structure, the main wording and as a result also the same mistakes. Its revision, although contemplated, has so far not been undertaken. In fact, no DDH agreement signed before 2005 has to our knowledge been revised in accordance with the new contract model.

The Service contract model (Service Agreement, SA) (2007)

This model is also the result of the cooperation between the State, the Church and other government partners in the context of the PPP-TG. This model is operational since 2007.

It represents a fundamental leap in the collaboration process between the State and other health service providers, by bringing up for the first time the issue of formalization of the

relationship between the State and VAs through a service contract. The texts also allow for application of the model in the relationships between public authority and public health facilities.

This marks a considerable improvement in terms of form and completeness of content: this model is very different from the preceding DDH and CDH contracts because it takes into account their main gaps and flaws and corrects them:

- The document refers clearly to the framework documents governing the relationship. There are numerous annexes which allow immediate recourse to this regulatory framework.
- The document has an introduction which states the objectives, user instructions and benefits expected from the agreement.
- The duration of the contract is defined and the conditions for an extension or for breaking the contract are equally mentioned.
- The responsibilities of the different parties are clearly described, especially questions related to the contract management.
- The main text of the agreement is completed by 6 annexes specifying: 1) the details of the services expected from the signing health facilities, 2) the conditions of service creation and their price setting, 3) the level of quality expected and the standards that apply, 4) the detail of how the contract should be managed, 5) financing details (the costs carried by the State and an acknowledgment of other resources that can be used) and 6) payment exemptions for the patients and reimbursement modalities for service providers.

The most important change brought about by the SA lies in the introduction of a system of monitoring and evaluation linked to performance criteria. This marks the passage from a relationship that was mainly founded on mutual confidence to an organized and professionalized system, backed up by a solid legal framework, and to a large extent inspired by the performance contract models. It also includes the take over of the operating expenditure of the VAs concerned. This model is being tested at the moment in a limited number of facilities and excludes the DDH and CDH. So there is a risk of creating a two speed system as no fast harmonization of the current contract models is carried out.

The regulatory framework in Tanzania was progressively strengthened over the last years: this can be derived from the implementation of new CDH contract models and the set up of SAs. These contract models are the principal relationship tools and we have seen their limits. There exists however no specific framework document on the partnership policy or the contracting policy.

The principles of the partnership are summarized in the national policy documents and the sector strategy; there is no framework convention that governs the relationship between the State and the faith-based sector. All efforts put in on central level were concentrated on the development of operational contract models (DDH, CDH and SA). The tools of the partnership dynamic reside therefore in fora that bring together public and religious partners: mainly the Joint Annual Health Sector Review (JAHRS) and the PPP technical working group. It is in this context that the faith-based sector participates in the elaboration of the health policy, that information is shared and a number of key documents are developed[61].

The Church plays an active role in the decision-making process at central level, mainly through the communication and lobbying efforts of the CSSC with the public authorities. This resulted in the resolution of the VA issue[62] through the creation of a SA model. In general, CSSC is invited to participate in all the main meetings about health sector matters. Similarly, the participation of the state in the annual meetings of the Tanzania Christian Medical Association (TCMA) is an excellent opportunity for the VAs, the DDHs and the CDHs to point out their difficulties to the MOH.

[61] The document "Strengthening PPP in Tanzania" (2007) is a recent example; it was published jointly by MOH, CSSC, TGPSH and APHFTA (Association for Private Health Facilities in Tanzania.

[62] These facilities which depend on external and their own funds for their activities are faced with growing financial problems.

The positive evolution, i.e. the fact that consultative structures are getting stronger at central level, is proof that the relationship is on the right track. This positive trend was also confirmed by both public and denominational actors. The input of the church in health matters has long been recognized by the MOH through the State's financial support to the facilities. Moreover, the share of the health budget given to the sector grows faster than many other budget items.

For the faith-based sector (CSSC and the religious authorities, both Catholic and Lutheran), the future clearly lies in a gradual strengthening of the relationship. The efficient performance of the PPP technical working group compensates thus for the shortcomings of the PPP unit of the MOH. The latter is difficult to access and not at all inclined to address the complaints of a sector of which they question the legitimacy. The negative attitude of this unit contrasts with the generally upbeat discourse of MOH.

Overall, difficulties expressed relate mainly to how current problematic situations are dealt with at peripheral level, more particularly the ever growing financial and operational difficulties of faith-based facilities: the problems of staff costs[63] and 'flight' of faith-based staff to the public facilities[64] especially.

INTERMEDIATE AND PERIPHERAL LEVEL

The formalization process in Nyakahanga happened in two main stages. The first stage (1972-1992) occurred when the hospital obtained the status of DDH and, with it, the authorization to act as district hospital. Independent from any contract, it became thus able to enjoy state benefits. The second phase (1992-?) saw the legalization of the status through a contract. In both cases, the State took the initiative but it got the approval of the Church, reluctantly in 1972 but full-heartedly in 1992.

The Nyakahanga contracting document dates from 1992[65] and has never been revised. There are three problems with it:

i) Problems in form and content. There are a number of redundancies in the document and it lacks a logical structure (succession of clauses). In terms of content, the model has quite a lot of flaws:

- The concepts used in the body of the text are not defined;
- There is no clear reference to the political framework that applies;
- The question of conflict resolution is not touched upon, the law governing this issue is not mentioned;
- The responsibilities (people, mechanisms) are badly defined;
- A system of monitoring and evaluation (tools and mechanisms) is not planned; the reporting and information requirements are not mentioned;
- The duration of the contract is not specified and conditions for revising it are not sufficiently made clear;
- The cost of services and the question of who takes care of what (mechanisms, how, etc.) are not properly defined;
- The human resources issue (whose responsibility) is only superficially brought up.

ii) The document is out of date and needs to be revised as a result of a number of developments:

- The faith-based hospitals are losing a growing number of staff to public sector facilities: the issue of HR should be looked into again;

[63] For example, the salary increases approved centrally tend to be implemented a lot later for faith-based staff employed in the DDH. The facilities themselves have to take care of the salary cost in the case of the VAs, except for the few that have signed a service agreement (SA) with the State.

[64] Motivated in particular by the large gap that exists in terms of terminal benefits between the two sectors.

[65] See Part II, annex 5.

- The social protection funds (NSSF, NHIF, PPF, etc.) were created only after the contract was signed: the contract therefore does not tackle the question of equal salary between civil servants and private not for profit staff;
- The development of activities, the expansion of the hospital and its target population call for a revision of the contract's financial terms and the level of state support.

iii) Nyakahanga is a DDH from the first generation and therefore:

- The public signatory of the contract is the MOH. Hence, the mechanisms linking the hospital to the public sector are outdated in the context of decentralization of power and the cause of dysfunctions;
- The DDH contracts made after 2007 (for example the contract of Tosamaganga hospital) were signed by the local governments and therefore better adapted to the present situation;
- Until now, no DDH of the "first generation", including Nyakahanga, has signed a revised contract in line with the 2005 model.

The main tool of the relationship should be the contract itself. However, since the hospital had until recently no copy, the contract could not be used as a reference. We have seen the limitations of this. The Board of Governors (BOG) is therefore the main tool for monitoring the relationship, even if its powers are not those of a contract steering committee. The board convenes in principle four times a year and consists of the management team of the hospital, the religious authorities, the representatives of the local government (DMO), the intermediate level (RMO) and central authorities. Its aim is to ensure respect for both the National Health Policy and the principles governing the faith-based facility. This is the only occasion where those in charge of public and faith-based facilities at different levels can meet and where they can address the actual problems in a structural way. If its efficacy is confirmed by the historical witnesses for the first period of the relationship (1992-2000), today the Board's role seems to have decreased due to following reasons:

- The Board only meets once every year due to lack of funds[66]. This considerably limits its ability to monitor[67].
- The central level representation is systematically delegated to the intermediate level. The contract is under the authority of the MOH and is signed with it. Consequently, the problems sprouting from decisions taken on that level are difficult to resolve. The intermediate (RMO) and peripheral levels refuse to act as a substitute for the MOH and do not always transmit all information to the central authorities[68].
- The problems of the local and intermediate level (mainly questions which do not involve other financial resources than those managed by the district in the context of the Basket Fund) seem to be treated in a straightforward manner though.

The only other monitoring tools are routine supervisions of the central level. These should inspect the execution of the PMA:

- The supervisions by the district management team remain few and far between and limited in scope: the visits are short, only interested in checking the administrative and financial documents of the facility and feedback is given orally. The hospital staff considers them useless.
- Supervision on central level is limited to an evaluation of the vertical programmes and only involves analysis of routine documents. The hospital receives no report about this.

[66] The cost of paying the participants comes entirely out of the hospital budget.
[67] The latest Council Comprehensive Health Plan (CCHP) decided to allocate part of the Basket Fund to the financing of the meetings.
[68] The communication between the intermediate and central level happens indirectly, through the PMORALG (Prime Minister's Office for Regional Administration and Local Government).

The hospital's management team and the bishop have a rather negative perception of their relationship with the district authorities. The contacts with the technical levels (office of the DMO) are quite good but these contacts lead only to limited concrete results, as the administrative authorities, who tend to have a political agenda, often interfere. In fact, a lot of the authorities' decisions tend to favour the public health sector to the detriment of the DDH, often against the advice of the DMO whose powers are limited. The overriding sentiment in faith-based circles is that they are not heard, especially on the lack of financial and human resources. As these shortcomings are pointed out by the ECD supervisions, the frustrations grow ever deeper. In general, the hospital counts more on the intervention of CSSC at central level to find a structural solution for their difficulties.

The interviews held with the technical and administrative management largely confirm the problems that exist. The discourse of the administrative authorities shows a deep ignorance (faked?) of the hospital's difficulties. The positive analysis they make of the quality of the partnership is also exemplary of the gap that exists between the two sides. The DMO has a far more qualified view of the situation: it recognizes the problems that exist but points out that the district is unable to provide a solution: in the mind of the public side, it is up to the central level to come up with solutions since the contract, governing the NDDH, was signed with the MOH and not with the district.

The religious actors deplore the lack of feedback given by the different levels of public authority, mainly central, on the reports provided. This problem occurs particularly in budget matters. The hospital projects annually its budget; the lack of feedback on this preliminary budget is made worse by the fact that the amount of the subsidies allocated is not communicated; in practice this amount is much lower than the needs expressed and irregularly paid out. The hospital is therefore unable to implement the budget foreseen. The growing financial strain is intensified by the great number of exemptions[69] included in the health legislation for which there is no financial compensation system[70]. About 75% of the NDDH patients are treated free of charge.

The provision of drugs to NDDH should benefit from MOH support but there are frequent stock disruptions in the Central Pharmacy (MSD)[71]. In practice the NDDH is obliged to buy locally at very high prices and to use up the resources provided by the Basket Fund and a large share of the hospital's own resources. The drugs themselves have to be sold to the patients, while the medicines provided by the MSD are free of charge. The situation is not understood by the patients and harms the reputation of the facility.

These different issues are not without consequences:

- The hospital is faced with a situation of growing financial strain (deficits in 2007 and 2008).
- The available financial resources are used for care, which hampers a regular policy of investment. In the long term, this constraint weighs on the quality of care provided (lack of space, beds, outdated equipment, etc.).
- The differences in employment conditions between the public and faith-based sector leads to a growing number of staff resignations in the faith-based sector. Since 2006-2007 the HR problems have been getting worse: more and more staff resign, looking for better conditions in the public sector (retirement policies, training and promotion opportunities). The lack of financial resources in the hospital does not allow the management to offer the staff prospects (promotions in particular) attractive enough to keep them loyal to the facility. This might aggravate the trend in the short term.

[69] HIV-AIDS, Tuberculosis, malaria, chronic diseases, etc. The patients treated for these conditions have to be treated free of charge.
[70] Only the drugs are theoretically paid for.
[71] Medical Stores Department.

- The management team is fully aware of the limits of the current contract, but is not in a position to remediate this, as it is not correctly informed[72].
- The dysfunction of the Board of Governors and the difficulties experienced to solve the problems identified undermine the trust of the church leaders (owners of the hospital) in the future of the contracting relationship. In desperation, the bishop is considering to threaten the public authorities with closure of the hospital in a last-ditch effort to get what he wants. Recently about 16 faith-based dispensaries have closed down for similar reasons in the Kagera region (according to the faith-based authorities) without provoking any reaction from the public bodies. This initiative is therefore not without risks.

[72] The existence of a new contract model was for example not even known until the visit of the research team (sic!).

Conclusion

The contracting model in Tanzania stands out by its level of generalisation and continuity but needs to be adapted today to the evolving context. The practical difficulties encountered by the DDH on peripheral level have revived the partnership dynamic on central level, thanks to the lobbying of CSSC on behalf of the different religious denominations. A number of questions still need to be resolved however:

The partnership dynamic is still mainly limited to the central level:

- The partnership policies, their tools and the spirit of cooperation are not circulated enough, which hinders the generalisation of the process. The personal relations and their quality - particularly on peripheral level - remain the key to success for collaboration experiences.
- In general, the decentralisation process of authority remains incomplete and this obstructs the implementation of the contracting process and the development of PPP on district level. Several components need to be improved:
  - The distribution and acceptance of responsibilities
  - The knowledge and the understanding of the policies
  - The communication lines
  - The different contradictory strata of the regulations (contracts signed on central level in a context of authority that is supposedly the local government's)

The contracting tools are being improved but their implementation remains incomplete:

- The operational performance contracts are a real improvement (in form and content) but do not apply to the DDHs.
- The application of the new DDH contract model remains limited to the new agreements. The document presents moreover few improvements in comparison to the original model and seems not very well known on peripheral level.
- The mechanisms for revision of the contracts are not explained in the documents in force at the DDH; the mechanisms are not at all known on peripheral level, both in the faith-based and in the public sector.

The growing financial difficulty of the Church, worsened by a substantial decrease in external support, carries the seeds for a deterioration of the partnership climate and projects the risk of withdrawal by the Church. At the moment, the MOH puts emphasis on the development of public health facilities at the lower administrative health level. However, this could potentially have a negative influence on the budget reserved for the faith-based sector and add to the difficulties that some DDHs face at the moment.

Chad

Moïssala

General Context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

Chad represents a particular case in the context of this study as Christian churches have only recently settled in the country. The Catholic Church in Chad was founded after the Second World War[73] and counts 7 dioceses[74], all located in the South of the country. This young and dynamic church is still largely dependent on other countries, especially at the level of its management structures: the majority of prelates are Europeans[75]. Faith-based care represents about 20% of national health coverage and 10% is provided by facilities of the Catholic network, the *Union Nationale des Associations diocésaines* (UNAD)[76] (Vridaou 2005): 80 health centres and 3 district hospitals[77]. For the Protestants, the EEMET (i.e. the Association of Evangelical Churches and Missions in Chad) is the most important provider with a network of 84 health centres and 1 hospital. All facilities appear on the health map since the administrative division into districts (district policy 1990-1991).

The role of the churches in the health sector was limited at first but extended rapidly after 1979 and the start of the civil war. As the South of the country was pretty much left to its own devices by the public authorities ("punitive" measures), the faith-based sector stepped in with health centres and hospitals. Even today the faith-based health centres and hospitals are still concentrated in this region.

PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL[78]

Chad's contracting policy in the health sector started early. A contracting policy document (PC)[79] was elaborated from 2001 on, in line with the National Health Policy of 1999[80]. The Chad legal framework is without any doubt much more advanced[81] than the framework in the other study countries. It is moreover the only example we have come across in this study of a strategy that has been effectively translated into action. The case also allows us to look back, so it makes an evaluation possible. Finally, the type of formalized contracting that exists in Chad is very ambitious: it does not just allow for the delegation of the mission of public service[82] to health facilities (hospitals) but potentially also to the districts themselves (the case of Moïssala, Donomanga and Doba). The contracting model can be applied to all potential partners within the not for profit sector: national or international NGOs (faith-based or not), bilateral cooperation and multilateral cooperation agencies. The present contracts include mainly faith-based organisations (belonging to UNAD or EEMET in particular) as well as a certain number of international NGOs (MSF). More recently, pilot experiments have been set up in the drug sector, whereby the management of regional pharmacies (PRA) has been entrusted to private organisations[83].

Generally speaking, central level interviewees display a lot of goodwill in their discourse; moreover, the goodwill is matched by appropriate documentary tools. Even, the contracting

[73] Decree of Rome, March 1946.
[74] To which the Archdiocese of N'Djamena is added.
[75] 5 out of 8 bishops.
[76] i.e. the National Union of Diocesan Associations. This is the Catholic platform and coordination organ of diocesan, social activities of the Church, including healthcare. EEMET (see further below) is its Evangelical counterpart.
[77] Figures from 2005.
[78] Cf. Figure 5.
[79] Volume 1: contracting with the private not for profit sector, MOH, N'Djamena, 2001.
[80] Contracting is one of the strategic orientations of the NHP of 1999.
[81] The contracting policy document is accompanied by an operating manual and a framework contract model, signed at central level by the different partners. The content of the operational contracts depends on the characteristics of the local situation.
[82] Provision of health services and/or administrative tasks.
[83] Pilot Pharmacists without borders in the Regional Supply Pharmacy (PRA) of Abéché, launched in 2007-2008.

policy is based on the decentralisation of authority to intermediate and peripheral levels; the prefectural health representatives (DPS) in particular are responsible for setting up operational contracts at their level. The decentralisation process is nevertheless not fully completed at the moment[84].

The Catholic Church itself is organised according to the decentralised model: for the social sector (health, education, other charity activities, etc.), there is an overarching structure (UNAD[85], created in 1986) responsible for the coordination of the BELACDs[86], at the diocese level. The BELACDs are technical facilities which manage districts on behalf of the dioceses if the State assigned this task to the latter.

The Church structures are currently short of means due to a substantial decrease in external support and the difficulty of mobilizing new resources. Since three years UNAD gets no more external financial support and as a consequence the post of Health Coordinator no longer exists.

CHARACTERISTICS OF THE CASE SELECTED

The case study we selected concerns the contracted delegation of the health district of Moïssala to the BELACD of Sarh. It is a peculiar situation since the contracts in this case were made before the contracting policy and its tools were developed. The district of Moïssala is located in the South of the country in the health prefecture of Mandoul. The management is entrusted by contract to the BELACD of Sarh, located at about 200 km from Moïssala, the district capital. The whole situation is the result of a process that began in 1992 when the Catholic[87] hospital of Béboro was transferred (according to the contract) to Moïssala (TRABEMO project). In the beginning the objective was to revitalize the moribund public medical centre of Moïssala, and create a district hospital there. This initial stage was followed by successive contracts through which the BELACD of Sarh was given the management over and the development of the district hospital and then the district itself. All along, the process was accompanied and made possible by the financial and technical support of external partners (Medicus Mundi Navarra[88] and later Misereor).

Two similar cases of delegated district management have been included in the study to allow a comparison, necessary for the validation of our working hypotheses:

1. The case of the district of Donomanga, entrusted through a contract to BELACD/Diocese of Laï. The district is located in the South-West of the country, in the region of the Tandjilé. The contract, signed in 2004, ended in 2008 and was not renewed. It included the district management and the construction of and equipment for the district hospital (St Michel Catholic hospital).
2. The case of Doba in the Eastern Logone, entrusted to BELACD/Diocese of Doba. The management of the district has been taken up by BELACD since 2003 but this was never formalized. In this case there is a public hospital for a district (Doba) which does not function properly. In practice, a Catholic Hospital, St. Joseph, Bébédja, carries out its duties.

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[84] The theoretical replacement (on intermediate level of the administrative pyramid) of the 14 existing health prefectures by 28 departments is not yet implemented.

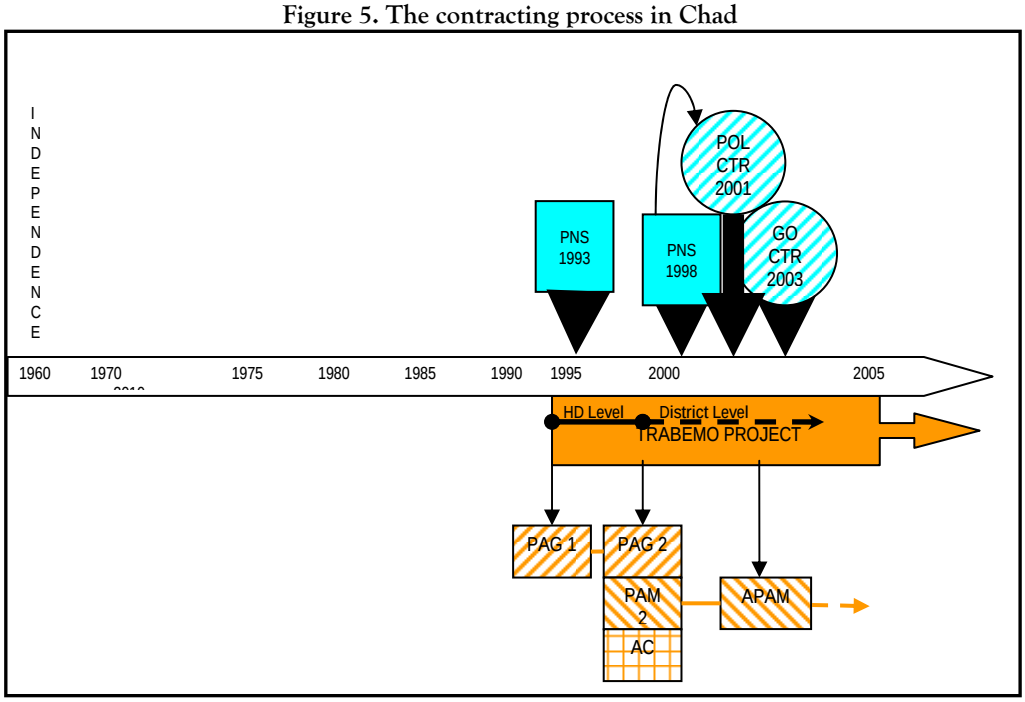
[85] *Union Nationale des Associations Diocésaines.*

[86] *Bureau d'Etudes et de Liaison des Actions Caritatives et de Développement.*

[87] It was in fact a health centre, led by a doctor, which offered health referral services to the population in the district.

[88] MMN.

Figure 5. The contracting process in Chad



LEGEND

AC	Cooperation Agreement
APAM	Amendment to the Agreement Protocol with the Ministry of Health (MOH)
PA	Agreement Protocol
PAG	Agreement Protocol with the Chad government
PAM	Agreement Protocol with the MOH
PNS	National Health Policy
POL-CT	Contracting Policy (Document) for the Health Sector
GO-CTR	Operational guide for Contracting in the Health Sector

Level 1: Signing with the Chad government

Level 2: Signing with the MOH

Level 3: Signing with the donors (MMN)

Legal documents of the MOH

POL CTR 2001

Contracting framework documents - central level

PROJECT

Contracting relationship district level

Result of the interviews and the documentary analysis

CENTRAL LEVEL

The Chadian contracting process, i.e. the formalization (in mutual consultation) of the relationship between the private not for profit sector and the state, was preceded by more informal collaboration. The collaboration was a direct result of the role the faith-based sector played at the time of the civil war, particularly in the South of the country[89] and during all the conflicts of the post colonial history in Chad. The facilities set up in this era were put on the health map from 1993 onwards when the district policy was implemented (PHC).

Three year activity plans submitted by the BELACD for approval (by the Permanent secretariat of the NGOs (SPONG) to the Ministry of Planning (MDP)[90]) triggered the identification of facilities and the start of a dialogue. The integration of the church facilities was the consequence of an active demand from the religious authorities. The State reacted positively, in some cases providing the facilities with infrastructure and personnel. The decade preceding the set up of the contracting policy saw a systematic legalisation of Church structures (UNAD, BELACDs, health facilities) and the signing of the first contracts (Moïssala).

The formalisation process of the contract was set in motion in 1998 when Chad began revising the National Health Policy paper (PNS): an intersectional round table was set up, in which the Church participated. The resulting document sets out the principle of a partnership between the public and the private sector and contracting appeared as one of the strategic orientations. There are a number of factors that influenced the matter favourably:

- The battered state of the health system at the end of the war (lack of human resources, infrastructures and funds);
- The fact that a dialogue existed already;
- The recognition of the role of the Church in the sector (complementary to the State) and its specific characteristics (offer and quality of services, managerial and organisational skills, transparency);
- The active support of international organisations: the World Bank gave part of the PASS funds to the development of the Public Private Partnership (PPP) and the WHO was a committed promoter of contracting.

The development of contracting tools moved in step with the elaboration of the National Health Policy and involved all partners:

- The Contracting Policy paper, drafted with the help of the WHO, was approved in 2001;
- UNAD (bishops, BELACDs) made systematic sensitization efforts together with the MOH (management and partners);
- An operational manual was published to facilitate the set up of contracting experiences;
- A training session was organised for the main actors (Catholic Church, MOH) in 2004 by UNAD, Cordaid and CIDR, based on the manual published by MMI in 2003.

Chad offers a complete arsenal of operational and regulatory frameworks which are the result of a vast sector consensus: the framework agreements signed on central level between the MOH and the partners govern the service agreements signed on district level.

[89] The faith-based sector ensures 40% of the care in the South of Chad.

[90] This procedure is followed since the mid eighties. Even at that time the health activities planned by the BELACD were submitted for technical advice to the MOH.

For UNAD there is:

- A signed agreement with the Episcopal Conference of Chad (CET) regulating the set up of UNAD.
- An agreement protocol (1990) authorising the import of drugs and medicines and full exemption of all custom duties and other taxes, signed between UNAD and the Ministry of Planning;
- A convention with the Directorate of the NGOs (DONG);
- A framework agreement signed between UNAD and the MOH in 2001 which refers more specifically to the modalities of contracting.

Consensus decision-making led to these documents, on the basis of proposals first made by the Church. The obligations of the State towards UNAD include:

- Support with human resources, infrastructures and exemptions;
- Access for private sector staff to training given by the public sector.

The Church commits itself in turn to implement the National Health Policy in its facilities and in all management delegation contracts which might be signed between its social services (BELACD) and the State.

The Chad legal framework contains nevertheless some weaker points:

- The second, originally scheduled section of the contracting policy (Drug sector), still needs to be worked out further.
- Former experiences are only superficially touched upon in the legal documents: revision of former documents and their adjustment to the adopted framework are not planned in the context of the PC developed in 2001;
- The decentralisation policy developed by the prime minister's office and aiming to replace the health prefectures by departments, more modest in size, is still not put in place in 2008. This means that there is an important de facto distance between the district centres and the prefecture authorities, who sign the public part of operational contracts implemented after 2001.

The National Health Policy, the Contracting Policy and the Operational Guide to Contracting (GOC) are the basic tools that govern the contracting relationship between the PNFP sector and the State and the elaboration of new contracts. The Directorate of the Social Sector Organisations (DOSS) at the MOH approves these contracts based on an evaluation grid suggested by the operational manual. The framework agreements and conventions which define the cooperation methods form the second level. Other more operational tools were also worked out during the drafting stage of the PC but have disappeared now: a monitoring committee for the contracting policy on the one hand, for dealing with technical questions and managed by the DOSS; a steering committee for validating framework documents and the orientation of the contracting policy. Although the involvement of the PNFP sector in the elaboration of a sector policy and the National Health policy is strictly speaking not foreseen in the contracting regulatory arsenal, the sector still participates in the development of the partnership on central level. The same is true for the involvement of the State cadres in some of the meetings organised by the private faith-based sector.

The different partners in the relationship believe in the system. But there are nevertheless some weaknesses:

- The contracts are submitted to a double reference authority[91] which complicates matters when there are problems and there is a need to appeal to the central authorities;
- The lack of resources strongly affects the capacity for monitoring and evaluation of the DONG and the DOSS;

[91] DOSS for the Ministry of Health and the DONG for the Ministry of Planning.

- The participation of the Church in sector meetings was very active at first but ended when the job of medical coordinator for UNAD was abolished. In practice, the Church is no longer represented in the ministerial meetings, except on questions about HIV/AIDS.

The mutual perception of the actors at central level is excellent: willingness, commitment, trust are the characteristics most readily cited by public and faith-based actors. The public sector particularly values:

- The managerial and operational skills of the Church;
- The important share of the faith-based sector in the provision of care;
- The quality of its services.

The Church for its part stresses:

- The open-mindedness of the Chad government and the warm welcome its partnership projects receive. This is seen as proof that its skills, place and role are officially recognized;
- The quality of the principles governing the contracting relationship;
- The means of support provided by the contracts and through the operational contracts;
- The custom duties exemption measures accorded by the central level and the permission to import medical products.

It is interesting to note that the central level commits itself very quickly when invited to get involved in the partnership reality - operational contracts make up the obvious place for the further development of a contracting policy. It is also here that the positive tone of the discourse is tempered: the theory is good and partnership experiments pop up in many places but in practice we see some real weaknesses. These mostly concern the state's respect of its commitments:

- In terms of financial support: the problem of reimbursement of the investments paid in advance by the church; indirect and limited nature of the aid that is provided (exemptions, salary of the civil servants seconded).
- The monitoring and evaluation component (DOSS and DONG): this explains why an assessment of existing experiences has not been carried out so far. Obviously this precludes a thorough assessment of the reality in the field and the formal "success" of existing arrangements.
- The Church points to the difficulties encountered with the representatives of the State[92] in the districts and with whom the diocese associations have to work on a daily basis. They tend to see the Church as a "donor".
- Due to a lack of correct information, the BELACDs do not always fully benefit from the contracting relationship. They lack the knowledge or are not aware of the opportunities that exist on central level. UNAD is unable to deal with this information gap as they no longer have a medical coordinator.

The overall assessment at central level is positive and shows a satisfying degree of openness, awareness and capacity for self criticism. The results of the collaboration and its progressive formalisation are tangible:

- A full and operational regulatory framework, which stimulates the set up of new service agreements on district level;
- A recognition of the role of the Church in the health sector which places it firmly on the national health map;
- A climate of consensus where the Church appears as an active partner and in case of new operational projects, often as the actor demanding and initiating the collaboration.

[92] Mainly administrative authorities.

Some issues cause a problem however:

- The lack of capacity (financial, coordination) on State level;
- The absence of an overall and regular assessment of existing experiences: the real extent of operational problems does not seem to be acknowledged, certainly not on ministerial level. Developments are underway which might improve matters: an evaluation workshop planned for end 2008-beginning 2009 on FED[93] financing will create a better appreciation of the contracting reality in the health sector.

INTERMEDIATE AND PERIPHERAL LEVEL

The basis for collaboration which underpins the TRABEMO project dates back a long time: the Catholic dispensary of Béboro was founded in 1974 and had a tacit agreement with the State which occasionally seconded staff to the dispensary and gradually authorized it to carry out minor surgery. As a result of the civil war and the chaos at Moïssala public hospital, Béboro took over the hospital activities of Moïssala. The creation of a district system (1993) corrected this situation and led to a reorientation of hospital activities back towards the centre and Moïssala as capital of the district.

The factors that helped set up the project were:

- The existence of an old, although informal, relationship and a consensus of the Catholic Church and the State on the project;
- The need for a functional hospital facility in Moïssala;
- The half-hearted commitment of the State in the south of the country;
- The experience of the Church (Goundi hospital) and the absence of other candidates;
- Béboro is proof of the Church's skills as it provides a good level of health care in the district;
- The commitment and investment of key personnel[94];
- The fact that there existed already a relationship between BELACD and the State through UNAD;
- The immediate availability of an experienced doctor for the post of Chief Medical Officer;
- The support of donors: Medicus Mundi Navarra (MMN) and PASS[95].

The obstacles to the project seemed less significant:

- The opposition of the beneficiary population in the Béboro area, much more behind the scenes than expressed;
- The potential risk for the Church to take over a district that is not entirely Catholic and thus provoking the suspicion or opposition from the other players (fear of religious domination).

The contracting arrangements for the TRABEMO project can be divided into two stages[96] and include 6 different contracts. In this study we are interested in the 4 basic contracts[97] between BELACD and the State of which the last two date from the same time as the national contracting policy. Some general observations can be made here:

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[93] European Development Fund. Some remaining funds of the 8th FED have been unblocked for organizing a workshop according to the terms of reference to be developed by the DOSS together with its partners.

[94] The provincial health delegate (DPS) of Moyen Chari and the Bishop of Sarh.

[95] Support project to the health sector, financing by the World Bank.

[96] 1) The actual transfer of Béboro hospital to Moïssala (1992-1996) and 2) development of the Moïssala health district (1996-2006).

[97] The two others are accompanying contracts: 1) a contract between BELACD and MMN put down the conditions for collaborating between the diocese and the donor in the context of the second stage of project; 2) a second contract signed between MOH staff seconded to the project and the project itself. It details the measures taken by BELACD to give these personnel an advance on their salary.

- The public signatories of the contracts vary considerably with each signing: the Ministry of Planning, Finance, the MOH (co-signatory of all contracts, as is the SPONG), the Ministry of Development and Economic Promotion. This carries the risk of a disintegration of authority.
- The two last contracts (much later than the PC), continue to include the central level of public authority as a contracting party rather than the provincial Delegation as foreseen in the national legal framework.

Contract 1: Project TRABEMO

The three year[98] contract about the transfer Béboro-Moïssala describes the activities that are planned and stipulates the principle of collaboration between the MOH and BELACD in order to achieve all this. It sums up the respective commitments of BELACD and the State, and also cites a series of specific clauses[99].

The commitments of BELACD are:
- Moïssala has to conform to the hospital standards (development of infrastructures, recruitment of staff, implementation of the PMA);
- Supply of means: drugs and medical provisions, logistics[100];
- Communication of information (reports, carry out planned evaluations);
- Collaboration with the public authorities (DPS, health committee of the prefecture);
- Development of a cost recovering policy for the district;
- Supervision of health staff in the area.

The latter two clauses anticipate in fact on the second stage of the project. The commitments of the State are mainly indirect:
- Hand over of the health facilities in the area;
- Payment of salaries and replacement of public staff already there;
- Support to the activities carried out in the context of specific programmes (PEV for example);
- Tax exemption when buying drugs and the authorisation to import pharmaceuticals.

Overall, the biggest share of the responsibility and the financial burden rests with BELACD. It must fulfil its obligations mainly through its own resources and with the support of its partners (MMN).

Contract 2: Project TRABEMO, 2nd stage, development of Moïssala health district

The 1997 contract takes over the structure of the first agreement and refers to the objectives that have been achieved. The scope of the initial contract is extended to the development of health centres (renovation and construction) and the provision of the logistics needed for these structures and the activities of the district.

There are two additional components:
- Active participation in the activities of the health delegation;
- The appointment of a Chief Medical Officer for the Project (MCP) and a Head of the district's Human Resources Division.

[98] The project has been extended by one year.
[99] Duration of the contract, modification procedures, termination, conditions of unilateral termination.
[100] The contract includes a list of equipment needed for the project.

The obligations of the State remain the same as well. No additional financial support is foreseen: the partners need to jointly look for external financial support for the final stage of the project.
These two contracts do not contain any clauses on the resolution of conflicts.

Contracts 3 and 4: Development and management of the Moïssala district

Contract n° 3 (2001-2005) distinguishes itself from the two previous ones. It benefits from a financial input from PASS[101] in the last phase of the project (2002-2006). The objective is to increase the number of HC in line with the development of the district. The document is far more detailed, partly as a result of the requirements of the donor (specific clauses about the administrative aspects of the funds and the justification of expenses, reporting obligations, etc.). The introduction and general layout of the contract give an overview of the previous stages of the project (history, commitments, targets achieved). The specific requirements substantially complement those included in previous contracts:

- Introduction of the objective of improving quality of care and the principle of strengthening community participation;
- Improving the definition of responsibilities and the coordination and management mechanisms that apply (organization chart of the district, management tools for the two categories of staff, etc.);
- Learning from past experiences (coordinated secondment of public staff, efforts to inform BELACD).

However, the main change lies in the financing mode of this phase: the funds are transferred from BELACD and its own donors to the State through the PASS budget.
This contract[102] goes a step further than its predecessors but falls nevertheless outside the framework of the PC of 2001 to which it only refers indirectly (side reference at the end of the introduction). Following aspects in particular are missing:

- The terms of reference and a timetable;
- The indicators for monitoring and evaluation;
- The identification of monitoring mechanisms;
- The conditions for making amendments or renewal (this is in fact a provisional project which depends on PASS financing);
- The specific mandate of each of the signatories.

The amendment n° 1 that expired end of 2006 was not followed by a new agreement between BELACD and the Chad state. Nevertheless, the diocese association continues to run the district of Moïssala until today.

Tools for managing the district exist and are implemented. None of them applies specifically to the contracting project, however they all contribute to the verification of whether the objectives are achieved and the obligations respected.

Supervisions are carried out by the different echelons but their frequency is lower than foreseen due to lack of resources and targets mainly HC which have reported problems:

- Monthly supervision ('training supervisions') of the HC by the District Chief Medical Officer, CD or the CDZ (Chief Medical Officer of the Area);
- Supervisions of BELACD[103].

[101] Initial budget of 2 billion CFA increased by an amendment to 50.000.000 CFA over the last year?
[102] The amendment (contract N°4) repeats the terms of reference of the main contract by adjusting the level of the budget.
[103] Administrative supervisions carried out by the director of BELACD; supervision of the HC by the Medical Coordinator of BELACD.

Assessment reports are produced:

- On a monthly basis by the HC and the hospital: these reports are passed on to the CDZ and from there to the DPS and BELACD;
- The HC also draft half yearly reports, which the CDZ compiles into an annual report (health statistics) and sends to the MOH and the Delegation[104].

Various meetings are organised:

- A three monthly meeting of all actors, gathering everybody who is responsible for the HC and discussing whether the objectives set out were reached;
- A half yearly meeting of the Director's committee where a review and synthesis of the activities is organized.

Beyond this, BELACD can be called upon when needed. It remains the first party to inform in all circumstances. These tools are in general considered efficient and satisfactory. The relationship between BECLACD, the other actors, authorities and public agents is generally positively evaluated in Moïssala. This is illustrated by the fact that the relationship has lasted this long:

- The State appreciates the efforts of BELACD
- The district staff feel they belong to the same family

Issues, if they exist, are raised by a minority of public sector staff[105] and are mainly about the strict management of human resources issues (flexibility in obtaining holidays; gaining 'credits', etc.). This opposition and discontentment are followed up by the unions and have sometimes caused serious tensions. They led to the 'spontaneous' resignation of one of the Chief Medical Officers of the project and of the HR manager due to the relentless pressure of denigrating letters, and even personal threats. The beginning of the project (Béboro) was disturbed by a number of general strikes as a result of important delays in civil service salaries. The situation was resolved by the signing of a convention giving the public staff employed by the district an automatic advance on their salary, which the state later reimburses to BELACD. These actions of BELACD have helped to establish its authority.

The real difficulties concern:

- The issue of (the absence) of cost recovery (fixed price per episode) which puts a strain on the financial balance of the hospital and indirectly on the balance of the HC;
- The growing problem of disruptions in the supply of drugs which forces the hospital to acquire supplies from the Regional Pharmaceutical Depots (PRA) at a very high cost;
- The lack of qualified staff (in particular doctors), due to limited supply on the Chad market and the low attractiveness of Moïssala (disloyalty of staff seconded by the State);
- The problem of hospital equipment: the hospital still functions on outdated and decrepit material from Béboro;
- The fact that the hospital is geographically far away from BELACD (there is a distance of more than 100 km between Sarh and Moïssala and the roads are bad) means that the recourse opportunities of ECD are limited.

The religious authorities consider contracting as a protection measure (guarantees) as well as a means to access advantages. The relations with the technical management (MCD, DPS) are considered to be excellent; there is a climate of full collaboration basically. The relations with the administrative authorities are cooler: there is a certain mistrust of "politics" and the tendency of some individuals to protect their own interests, particularly financial interests. The BELACD 'culture' has imposed itself and even blurs the divisions between public and BELACD staff. We find that even in the interviews there is a characteristic unity of purpose.

[104] The annual report is effectively drafted but is not always passed on to the central level.
[105] A number of public agents.

Moreover, BELACD people are present in 6 public health centres, and their presence is not considered a problem.

Overall the assessment of the HC is positive. Those HC integrated in the project as first line of the district health system have fully accepted the project[106] and were informed on it from the very beginning. They are able to define the role played by BELACD[107] and to identify clearly the effects of the project, even if their knowledge of the contract remains fundamentally intuitive. Nearly all participants know the role of BELACD. Their vision is clearly influenced by the activities of BELACD which highlighted the implementation of the NHP through the district system and the Primary Health care policy:

- The set up of the COGES and COSAN;
- The system of supervision (district through the MCD and the CDZ; DPS);
- The access to training organized in the public sector;
- Dialogue through district meetings;
- The referral system.

The specificity of the situation (delegation of management) is made clear through:

- The system of cost recovery by fixed prices (payment per episode) which contrasts with the system of *'paiement à la molécule'* (payment per drug) is still very common in Chad;
- The BELACD supervisions;
- The particular management modus of the referral system: the costs for outpatient care are included in the fixed price paid by the patient at the HC. The latter reimburses the costs for the hospital (consultation, treatment).

In general, the management of BELACD is positively evaluated:

- The system is very beneficial for the population, it guarantees access to care and treatments (fixed price and referral system)[108];
- The supervision of BELACD, although strictly technical, preserves the identity of the HC;
- There is generally a climate of good relations with many opportunities for exchanging views; the HC do not function anymore as isolated entities;
- The system is really operational, due to means injected by BELACD;
- The COGES/COSAN system is a guarantee for transparency and a considerable help for those responsible for the HC.

Some reservations are nevertheless formulated:

- The referral system weighs heavily on the HC finances and compensation through the sale of drugs is no longer possible;
- The supply of drugs and medical products is ensured by BELACD but is submitted to specific quotas[109] disrupted by the increase in attendance figures at the HC. The health centres have to buy additional supplies and charge these to the population. Understandably, people are not very happy about this; the situation is also a heavy burden on the budget of the HC;
- The staff salary is paid with the limited COGES funds which limits recruitment possibilities and worsens the already bad human resources situation;
- The weak support from the state in terms of equipment particularly;
- The sustainability risk of the system if BELACD were to withdraw and the State had to take over the responsibility for the district.

[106] In particular because they were able to keep their identity. Only the religious authorities (non Catholic authorities), owning the HC, have shown a certain resistance: their "conversion" took some effort.
[107] Only the HC ignore what it is about (drugs) but this is maybe due to their recent creation.
[108] The district attracts a large number of external patients to its area, even from outside the country.
[109] Specific quota for each HC.

The state support is appreciated and the state generally keeps its commitments: the secondment of staff increases steadily (33 public staff against 37 BELACD staff in 2008), specific support is supplied (motorbikes), the exemptions are implemented and the import of drugs is permitted. Nevertheless, the state subsidies fall well below the needs they are supposed to cover and this money is difficult to come by because of the deductions on the intermediate levels[110]. The compensation for the loss of earnings rests entirely on the shoulders of BELACD and contributes to the dependence of the project on external donors and this more and more so, as the area further develops.

In general, BELACD is perceived as assuming well the responsibilities it is attributed. All actors make a positive assessment of the project, as it is seen to bring real results. The viability of the project rests nevertheless nearly entirely on the support of BELACD's donors[111] because of the feeble financial commitment of the State. Its continuation is currently in danger because the Misereor contract ended at the end of 2008, which forced BELACD to start restructuring its activities. Therefore it is not surprising to see the Church (but also the district management) plead for a greater share out of the financial burden of the district through:

- The take over of the hospital equipment;
- A realistic revaluation of the budget and an improvement of its management;
- An implementation of the decentralisation: the means are lacking although the administrative entities and the staff are there;
- The systematic integration of BELACD staff in the civil service to alleviate the costs of salaries in the project.

Generally speaking the scope of this experience is positive. But it needs to be qualified as Doba and Donomanga show a very different situation. The relationship that exists there is not with the central level but with the district management according to the PC of 2001:

- The contract signed by the diocese of Laï (2004) for the management of the district of Donomanga expired in 2008 and has not been renewed because of the dissatisfaction of the diocese;
- In Doba, the management of the district happens on an informal basis without any contract to formalize it. Here the Church is also considering abandoning its responsibilities.

In these two cases, the bad relations with the local (administrative) authorities are singled out for criticism:

- Local authorities tend to deal with matters among themselves and systematically omit to involve BELACD/diocese, although these are 'responsible' for the district management. The delegation of management remains thus fundamentally theoretical;
- The Church feels it is treated as a milking cow (use of facilities, vehicles, per diem, etc.) without benefiting from any support in return;
- Problems of management, secret accounting.

[110] In 2007, only about 6 million could be acquired from a total budget of 22 million FCFA.
[111] MMN, then the PASS through the State and currently Misereor.

Conclusion

Contrary to other countries studied, Chad has a complete and functional regulatory framework. However, this framework is only partially implemented: the contracting agreements made before 2001 have not necessarily been revised and informal relationships continue to exist in the field (for example in the district of Doba) on the basis of framework agreements signed on central level.

The example of Moïssala shows nevertheless that the ambitious model adopted by Chad can work if the means are available. In this sense, the contract of delegation of the district management to BELACD has achieved the objectives that were set out. In an institutionally very fragile country, this system of delegation to experienced organisations emerges as the way to realize the development of health districts and improve geographical and financial access of the population to good quality health care.

However, this experience falls outside the framework developed in 2001: the relationship between BELACD and the central State authorities seems to work better than the more recent experiments (Doba, Laï) which involve the local government. In the latter cases, the shaky collaboration with the authorities (in particular the administrative powers) is likely to undermine the established contracting relationship and with it also the developments achieved so far.

An analysis of the contracting relations displays a certain extent of disengagement of the State: the financial and operational burden of the contracts weighs mainly on the contracting NGOs and the future of the experiences remains dependent on the existence of a continued influx of external financial support. The involvement of the State in these matters remains extremely limited in spite of an undeniable willingness to help.

In any case, the political context (in terms of contracting and decentralisation policy) does not offer enough solutions. Although the texts exist, in general the central level seems not very inclined (or able) to seek pro-actively concrete solutions to the problems submitted by contracting NGOs.

Uganda

St Joseph's Hospital, Kitgum District

Kabarole Hospital, Kabarole District, Fort-Portal

General context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

Up to 30% of care facilities in Uganda belong to the private not for profit sector: 44 hospitals (42,3% of the total) and 558 health centres, the majority in rural, very remote, areas. There are furthermore 21 health training centres (60% of the training for health officers: nurses and others). The Catholic and Protestant Churches own the majority of the faith-based facilities. They are united in denominational health platforms, respectively UCMB and UPMB[112] (see below). The presence of Muslims in the sector grows steadily, but is still rather marginal.

Figure 6. The PNFP health sector structure in Uganda.
(Source: UPMB Annual Report 2004/05)

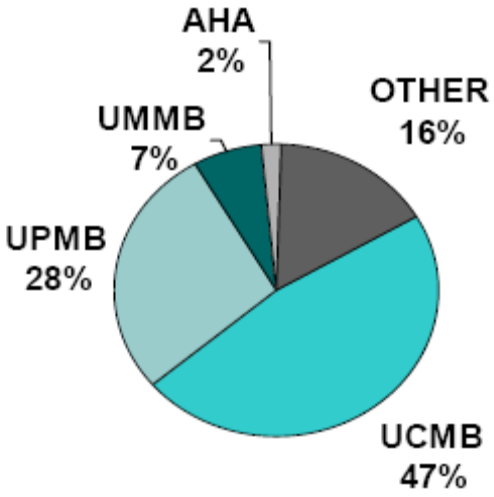
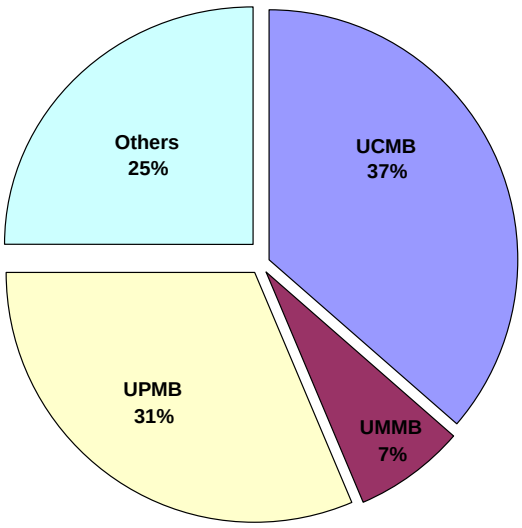


Figure 7. Distribution of the health facilities between the different coordinating PNFP organisations
(Source: UPMB Annual report 2004-05)



[112] Uganda Catholic Medical Bureau (UCMB); Uganda Protestant Medical Bureau (UPMB).

The relationship between the public and faith-based sector

The relationship between the faith-based network and the MOH goes back to pre-colonial times but remained rather minimal until the end of the nineties. The collaboration was not formalized and consisted mainly of State subsidies[113] to the health organisations of the Church[114]. There was however a progressive evolution towards a more structural partnership[115]. The financial difficulties of the faith-based sector, as a result of the gradual decline in funding from traditional donors and a substantial decrease in revenue, induced UCMB and UPMB to openly ask structural help from the State in order to keep up its services.

This led in 1997-1998 to a Memorandum of Understanding (MoU) at central level, which broadly defined the collaboration between the MOH and the Church and the objectives of the support. This document was a first effort to formalize the relationship between the Churches and their public partner and led to a considerable increase in the financial support from the State[116] to the Voluntary Agencies and the signing of a number of operational contracts[117] between the religious health structures and the MOH. Joint action of UCMB and UPMB led them, in 2003, to submit to the state an outline of a partnership policy, with the intention of establishing a long lasting relationship and a legal framework.

This partnership and contracting process could not be continued in spite of continued lobbying by the Church authorities with the government. The 2003 document never acquired official approval and thus all further contracting experiments were halted at peripheral level. Since three years this has been a source of intense frustration for the faith-based sector which furthermore suffered heavily from the freeze in state subsidies and a serious crisis in human resources[118]. Today, the financial support of the State to the hospitals represents only 15% on average of the total revenue of the Church (*cf.* Figure 8).

UCMB and UPMB were founded in 1957[119] to act as a liaison between the Ugandan government, the donors and the hospitals of the network, to channel the State grants and ensure the development of training for nurses. Today, the organizations have committed themselves to supporting health facilities of their respective networks[120] and representing the network in discussions with the Church and State authorities.

UPMB and UCMB[121] collaborate intensively to meet the challenges faced by the faith-based health sector today. Their strategy is aimed at obtaining official[122] and formalized recognition of the role the Church plays in the health sector. This would lead to a real integration of the religious health facilities in the national health system and force the State to look for a structural solution for the threats that endanger their survival:

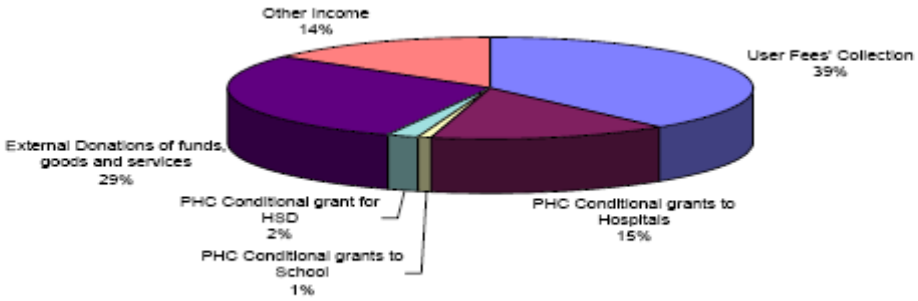
- The financial crisis which results from the gradual reduction in the support of the traditional donors, the fact that the State contributions have remained 'frozen'[123], a

[113] "Grants in Aid" voted by the Frazier Commission in the 50s. This system was retained during the post colonial period; only during the economic crisis in the middle of the 70s this was not the case.
[114] Voluntary Organisations.
[115] Report of the Health Services Review Commission (middle of the 80s); "White Paper" (1991).
[116] The funds allocated increased from 800 million to 17 billion of shillings between 1999 and 2004.
[117] Service Level Agreements (SLA).
[118] A substantial revaluation of the public salaries in 2005 only contributed to worsening the situation.
[119] Government Notice N° 672.
[120] The UCMB network has 72 hospitals and 234 HC; the UPMB network has 15 hospitals and 241 HC belonging to 7 different denominations of which the Anglican *Church of Uganda* (CoU) is one.
[121] And more recently the *Uganda Muslim Medical Bureau* (UMMB).
[122] Through the approval of the Draft Partnership Policy of 2003.
[123] Their share in financing the health activities of the faith-based sector has dropped from 36 to 32% between 2002-2003 and 2005-2006.

decrease in the user fees[124] charged to patients and an increase in the fixed costs of the facilities and particularly in human resources[125];

- The crisis in human resources is mainly a consequence of the low attractiveness of the salaries in the faith-based sector and the massive recruitment campaign of the MOH.

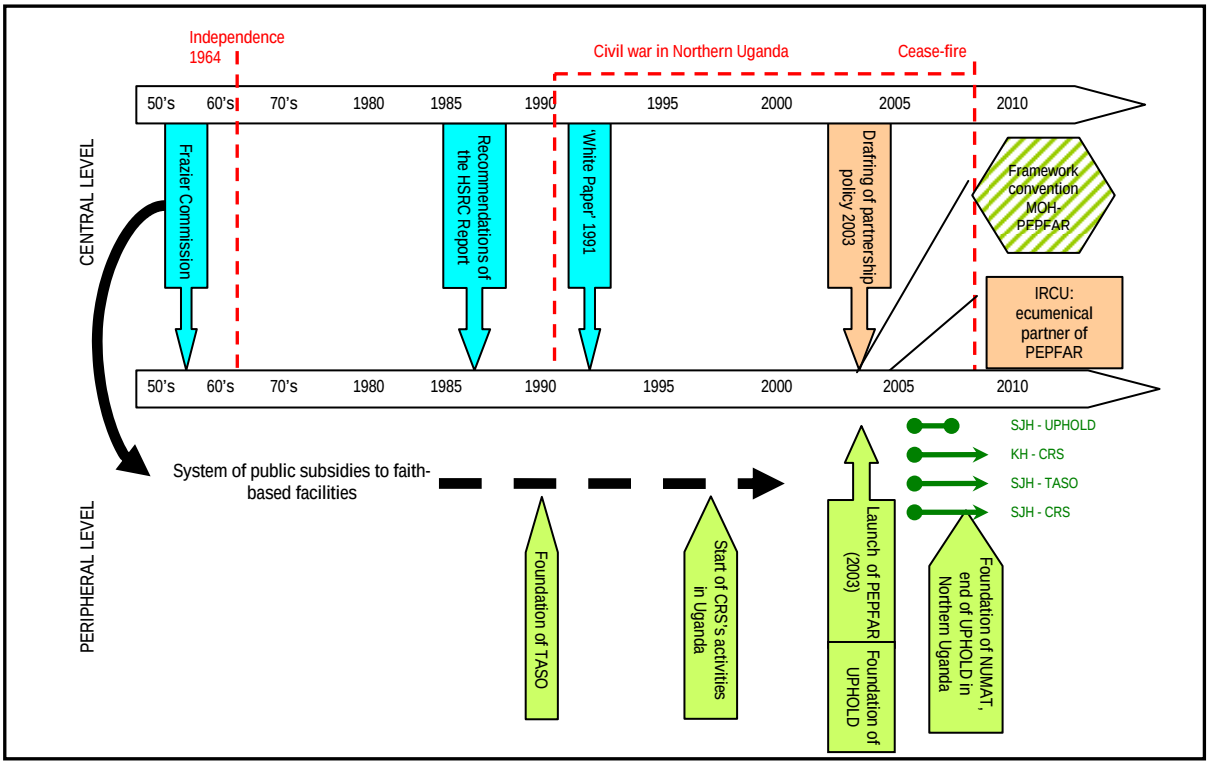
Figure 8. Structure and division of income from financial contributions to the faith-based health sector. (Source: UCMB,UPMB,UMMB, 2007)



[124] This decrease follows a request of the State and is a result of the fact that the faith-based sector applies the National Health Policy.

[125] HR represent on average 44% of the total costs of the facility. The subsidies of the State do not cover the salaries. The Church was forced to increase the salaries as a result of the revaluation of those of the public sector. It is interesting that an analysis of faith-based platforms establishes a direct link between the increase in the share of HR in the operational costs of the health facilities and the growing strength of "global initiatives" (such as PEPFAR) which are not keen on financing the costs of the healthcare system and certainly not the salaries.

Figure 9. The contracting process in Uganda



LEGEND

HSRC	Health Sector Review Committee
MOH	Ministry of Health
PEPFAR	President Emergency Plan For Aids Relief
CRS	Catholic Relief Services
UPHOLD	Uganda Program for Human and Holistic Development
TASO	The AIDS Support Organization
IRCU	Inter Religious Council of Uganda
KH	Kabarole Hospital
SJH	St Joseph's Hospital

Public sector

Faith-based sector

PEPFAR

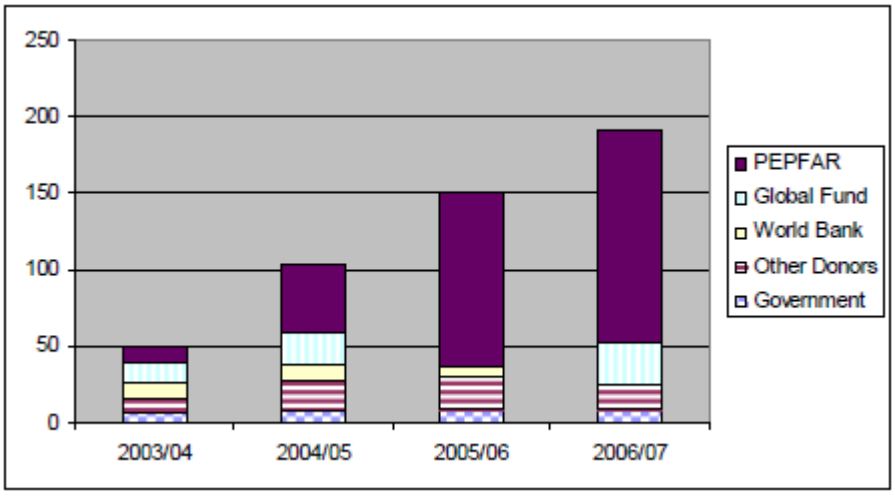
End of contracting relationship

Ongoing contracting relationship

PEPFAR and the faith-based sector

Uganda was one of 15 countries chosen by the President's Emergency Initiative for AIDS Relief (PEPFAR) and has received support for a large number of HIV-AIDS relief, treatment and care projects since 2004. The total amount of PEPFAR funds given to Uganda is officially estimated[126] at 283,6 million dollar (2008). The size of these funds puts PEPFAR in the lead[127] of organizations helping Uganda with the HIV-AIDS pandemic. Moreover, the initiative vaunts the Ugandan "model" of fight against HIV-AIDS and claims it has a significant influence on the development of its strategies.

Figure 10. Health funding in Uganda.
(Source: Oomman N, Bernstein M and Rosenzweig S, 2007)



The government authorities of the partner countries are not very involved in the conceptualization, planning and management of PEPFAR activities. The rules and procedures for managing the funds remain specific to the programme and are governed by criteria dictated by the American Congress. The management and supervision are also taken care of by US representatives[128]. Finally the beneficiaries are mostly NGOs, often foreign ones. Although there is a *PEPFAR Board* in Uganda, in which the government and the private sector are represented, it only allows them limited room for manoeuvring.

The PEPFAR policy generally favours a direct link with the peripheral level which partly explains the weak involvement of the central level[129]. Recipients and sub-recipients are mainly selected on the basis of their ability to achieve the targets set out and spend the funds allocated as quickly as possible. In general, the PEPFAR system is extremely strict[130] and the financial data are not very transparent: thus only the budgets allocated country per country to the recipients are made public[131]. The figures about field programme results are also very difficult to access.

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[126] 2008 Country profile, Uganda. Consulted on www.PEPFAR.org

[127] In 2006, 73% of the available funds in the context of the fight against HIV-AIDS in Uganda came from PEPFAR. See also the figures below.

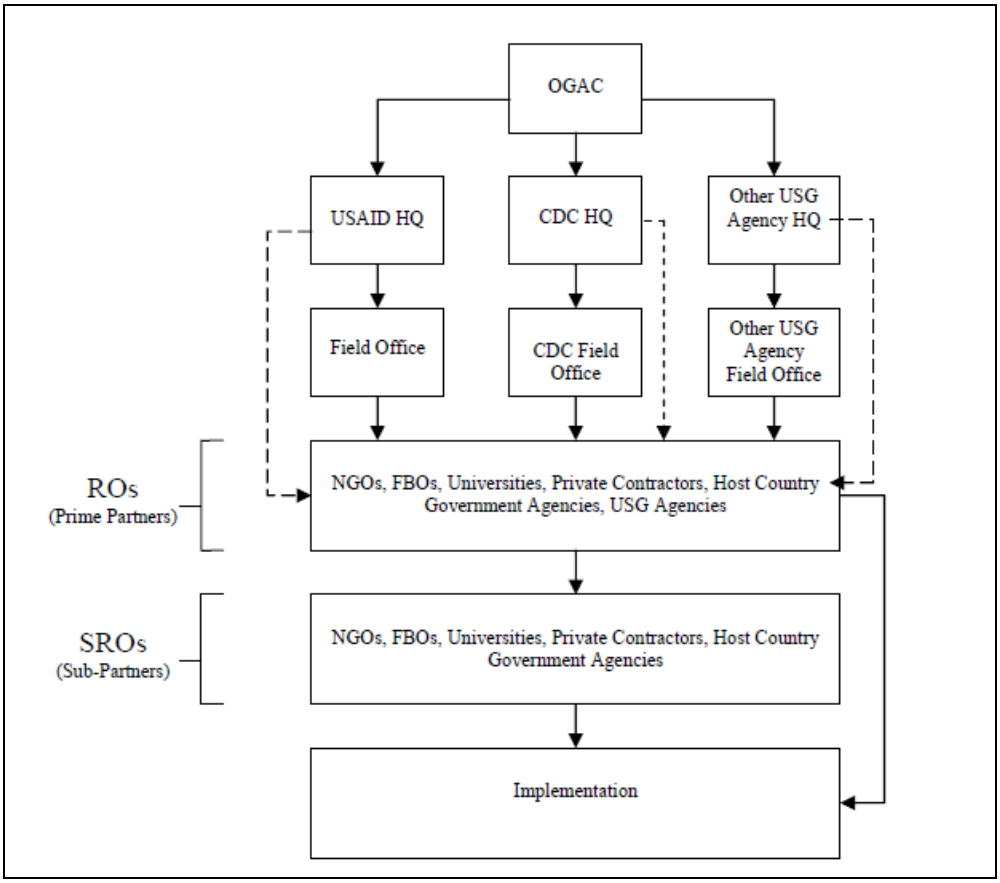
[128] Through the Office of the Global Aids Coordinator (OGAC) in the US, and in the field through Embassies and Agencies such as USAID and CDC.

[129] Capacity strengthening and institutional support are far less important objectives for PEPFAR than for the Global Fund and the World Bank.

[130] Earmarking of the funds.

[131] Financial data on the real payments made are not accessible to the public, the recipient governments or even some of PEPFAR's staff members. The data about the distribution of funds by programme area and the list of funds allocated to the sub-recipients are collected by PEPFAR but are again not accessible for the public.

Figure 11. System for the distribution of PEPFAR funds.
(Source: Oomman N, Bernstein M and Rosenzweig S)



It seemed important to present also three of PEPFAR's main recipients in Uganda: the Catholic Relief Services[132], the Uganda Program for Human and Holistic Development (UPHOLD)[133] and The Aids Support Organisation (TASO)[134]. All three are signatories of contracts which interest us in the context of this study.

CRS is the official relief and development agency of the US Episcopal conference and a member of Caritas. It has been operational in Uganda since 1965. The organisation was put at the head of the consortium responsible for the AIDS Relief programme of PEPFAR and implements most of its activities in Uganda under this label. CRS supports 18 care facilities in 11 districts[135].

The UPHOLD programme is very well represented in the field in Uganda[136]. This programme was launched in 2003 as an initiative of the American organisation *John Snow Incorporated* (JSI). The programme focuses on strengthening community and institutional participation in the development of better quality education and health services, in particular in the context of the fight against HIV/AIDS. From 2005 on, the activities have been placed under PEPFAR, which became the major financing source for the programme. UPHOLD works closely together with the local district governments.

[132] www.crs.org
[133] www.uphold.jsi.com
[134] www.tasouganda.org
[135] According to figures provided by CRS, its activities care for more than 62.400 people, of which 21.000 people are on ART.
[136] At the peak of its activities it covered 34 districts. The creation of the Northern Uganda Malaria AIDS & Tuberculosis Program (NUMAT) has led UPHOLD to withdraw from the North of the country, leaving the number of districts supported at 28.

TASO (1987) is the leading Ugandan organisation and one of the most important African organisations involved in the support of people living with HIV-AIDS (PLHIV). It works in close collaboration with the Ugandan government[137] and is obviously a major partner for PEPFAR and one of its main recipients. The activities carried out for the PEPFAR programmes in the districts are 'sub-contracted' to competent institutions or facilities[138].

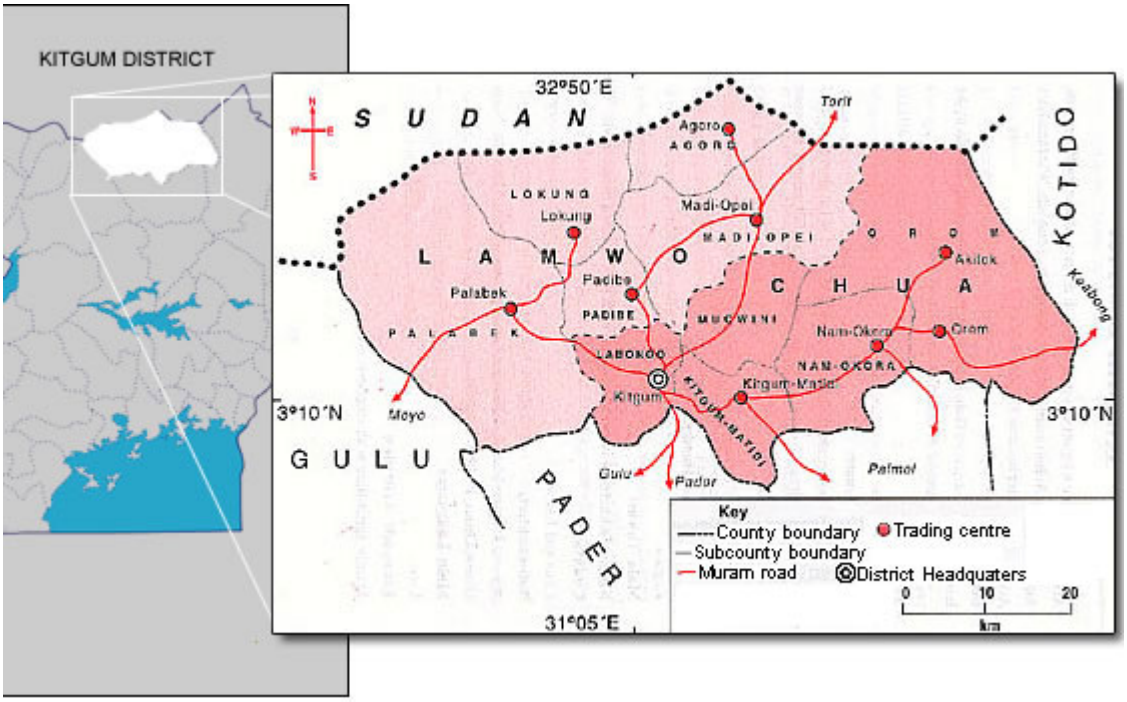
The partnership context has to be looked at on two levels in this study: the partnership between PEPFAR and its representatives on the one hand and the State and the Church on the other hand. We were unable to get an interview with the PEPFAR representatives at the US Embassy and USAID, so we have very little information on the links between the state of Uganda and PEPFAR, also because information was scarce at the MOH. We were not able to get hold of a copy of the agreement protocol signed between PEPFAR (Washington) and the Ugandan State for the launch of the programme: we were not able to find a trace of the document and we believe therefore that the document is classified.

There is no convention moreover at central level between PEPFAR and faith-based platforms in spite of the fact that many facilities of the network are involved in the implementation of the programme. The contacts between the Ugandan faith-based sector and PEPFAR happen on central level through an interreligious body: the *Inter-Religious Council of Uganda* (IRCU). This body, chosen by PEPFAR to coordinate most of its interventions with the faith-based sector, had in origin a spiritual mission. It is not very legitimate in the eyes of UCMB and UPMB as they are not represented in this council and IRCU does not bother to communicate with them.

Of the three recipients we studied, CRS is the only one to have a relationship (not formalised) with UCMB and UPMB. TASO and UPHOLD communicate exclusively with IRCU and largely ignore the fundamental role played by the faith-based health platforms. As a result UCMB and UMPB have only scant information about the number of contracts actually signed by "their" hospitals with IRCU or other PEPFAR recipients. This lack of information is aggravated because often the facilities themselves are also reluctant to communicate on the subject. The efforts made by UCMB and UPMB to get a dialogue going with IRCU and obtain answers to their preoccupations have remained largely unheeded up to now.

[137] The MOH and the National AIDS Commission (NAC).
[138] Sub-recipients such as for example the District of Kitgum or Kabarole Hospital.

Figure 12. Kitgum District.
(Source: www.coreinitiative.org)



St. Joseph's Hospital (SJH)

St. Joseph's Hospital is located in Northern Uganda in the district of Kitgum. The facility was founded in 1942 as a health post by the Italian Sisters of Comboni. It became a hospital and was handed over to the Diocese of Gulu in the beginning of the 70s. Today the facility has 350 beds and operates in a very poor region which suffered badly from twenty years of civil war[139]. SJH is accredited by UCMB and boasts an excellent reputation.

The hospital is situated nearby a district public hospital (Kitgum Hospital, 200 beds), only two kilometres away. SJH unofficially plays the role of district referral central, attracting not only patients from the district but also from further away. Part of the explanation for this situation lies in the civil war: SJH stayed in business throughout the war and continued to look after an ever increasing number of patients[140] to the detriment of the almost moribund district hospital (HD). The years of conflict also explain the large presence of international NGOs and the extensive external support which SJH received at that time[141]. These relationships are or have often been underpinned by contracts (AVSI[142], UE, WFP). The hospital benefits furthermore from solid technical support from UCMB. This support seems to be rated as more

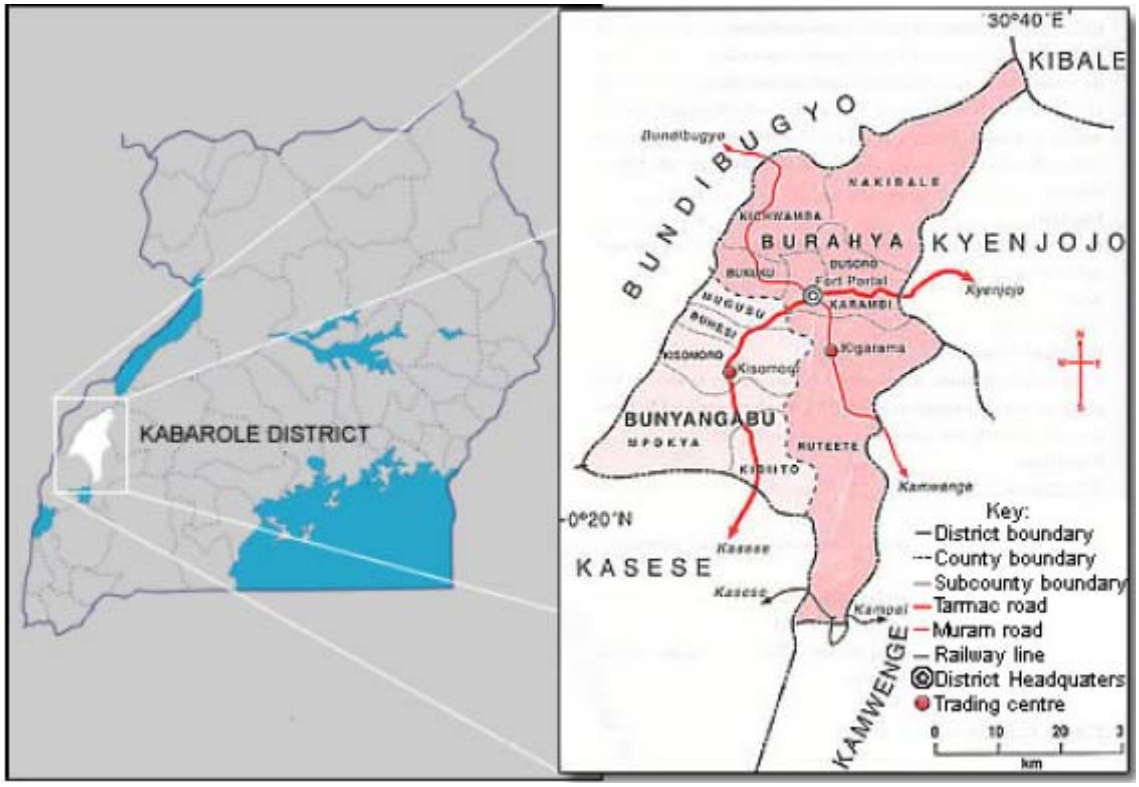
[139] The civil war started in Northern Uganda in the beginning of the 80s. The conflict opposing the Lord's Resistant Army (LRA) and the Allied Democratic Forces (ADF) to the Ugandan government was only resolved in October 2006, when some of the rebels took part in peace negotiations with the government, held in South Sudan. There is now a ceasefire but the region has been strongly affected by the conflict with nearly 400.000 refugees, the majority of whom are still staying in camps.
[140] Influx of refugees in the cities.
[141] AVSI, Misereor, AGEH, the World Food Program (WFP), the European Union (EU) to cite only the main ones.
[142] AVSI (www.avsi.org) is the most important donor of the hospital and an essential technical resource. The organization has set up and takes charge of the management team of SJH.

important than the support of the diocese which, although owner and decision maker, is rather weak in this field.

From 2005 onwards, various agreements have been signed in the context of PEPFAR financing for the set up of a complete HIV-AIDS care programme[143] involving TASO, UPHOLD and CRS. The creation of a new aid fund specific for Northern Uganda (NUMAT) has led to the withdrawal of UPHOLD and should eventually result in the signing of new contracts.

This external support has not prevented SJH from facing growing difficulties. The funds remain insufficient to cover the hospital[144] operating costs and especially the wages[145]. There is also a high staff turnover rate[146] mainly due to the low salaries. The workload increases regularly for the remaining staff and could lead to further turnover[147].

Figure 13. Kabarole District.
(Source: www.coreinitiative.org)



Kabarole Hospital

This hospital is located in West Uganda, in the city of Fort Portal, capital of Kabarole district. The area is politically stable. It is owned by the Anglican diocese (COU) of Ruwenzori and belongs to the UPMB network. Its relationship with the technical authorities of the district is partly formalised. The *District Health Officer* (DHO) restored the annual signing of the contracts

[143] Buddy support and voluntary screening, prevention of mother to child transmission (PMTCT), home-based care, antiretroviral treatment and behaviour changing campaigns (BCC).
[144] The hospital budget has been in deficit since 2006-2007.
[145] Its costs increase by 20% annually since 2001. SJH had to reorganize its staff and give up certain activities while awaiting new sources of revenue.
[146] 17% of the staff left the hospital during 2006-2007.
[147] The usage of services remains high despite the fact that the war refugees gradually leave.

which stipulate the access to the fund of the *Conditional Grant*[148] for all health facilities in the district. Founded in 1903, Kabarole Hospital is one of the oldest hospitals in the country. In 1997, the diocese could no longer fulfil its financial obligations and let the building to a private practitioner. However, the current bishop reintegrated the hospital in the network in 2000. Although battered at the time, the hospital is now slowly rising from the ashes. Kabarole is a modest facility (80 beds) and the smallest of the three hospitals in Fort Portal. The provincial hospital of Buhinga[149] (public) and the Catholic Hospital of Virika are only a few km away from Kabarole.

The structural means of the hospital are mainly confined to user fees and State subsidies[150]. The only external support received comes from the contract signed in 2005 with CRS for the AIDSRelief programme. Its input in the hospital budget (50%) is enormous but the funds can only be used for programme activities. This heavy dependence on one donor is not without risk for such a fragile facility. The budget constraints mean that KH cannot cover the increasing HR costs. The wage bill is a heavy burden for KH's budget and limits its development possibilities.

Results of the interviews and the documentary analysis

CENTRAL LEVEL

We are particularly interested in the way the relationship (or its non-existence) is perceived by the different actors in the absence of an identifiable partnership - and a fortiori a contracting process - on central level between PEPFAR (or its recipients) and the public and faith-based health sector. In general, PEPFAR's interventions (through its recipients) and hence also the contracting activities focus on the district level. This choice explains partly why the visibility of the initiative remains rather limited on central level. It also affects the perception and explains the (limited) awareness of the public and faith-based health actors.

The PEPFAR coordination committee, the activities of which are normally set up directly with the district, allows the MOH to steer the initiative according to the National Health Policy. However, this does not render the day-to-day management of the programmes more transparent. The Health Advisory Committee consists of different technical working groups that would normally favour sharing information. PEPFAR participates in these groups, for example in the Public Private Partnership in Health Group, the Sector Wide Approach Group or SWAP Group, the Policy Advisory Committee and some other partnership fora (Annual Technical Review Board, the Joint Annual Sector Review). It was very difficult to find out what happens in reality as the discourse of public sector actors is often contradictory.

The participants interviewed at MOH level made a relatively negative analysis of the way PEPFAR intervenes in the country. These interviewees included people responsible for planning as well as those in charge of the partnership. The MOH considers transparency to be the main problem. If information is transmitted, it goes mainly to the Director General and the Permanent Secretary for Health at the MOH, and then to the National AIDS Commission (NAC). In general, few people know the reality of the field and those who do know seem to belong mainly to the President's inner circle. The result is that PEPFAR gets a 'political' character.

The available information is mostly limited to the planned resources and the listed recipients but without detailing how these resources are used. This makes it difficult to plan for resources and interventions. However, it seems that some improvement is underway thanks to the efforts of the MOH to obtain additional information (particularly on the availability of resources in the medium term) but also thanks to the presence of a representative at the

[148] This practice, foreseen by the policy of Primary Health Care (PHC) is no longer used by most districts and is in fact a formality.
[149] Buhinga is the provincial referral centre.
[150] In a total budget of 734 million $ in 2007, the contribution of the State amounted to only 80 million of which just 63 million were really received.

American Embassy who is more inclined than his predecessors to collaborate with the Ministry. Identifying possible fields of intervention is the responsibility of PEPFAR: the MOH has no say in the matter, neither in defining the priorities nor in the distribution of allocated funds. Some interventions are identified afterwards through supervision visits to the districts but are confined to very visible initiatives such as those of UPHOLD or NUMAT for example, which the local authorities handle.

Besides the question of transparency, there is also the issue of the intervention manner of PEPFAR: American legislation does not allow direct financing of other governments; the allocated funds are transferred to projects and cannot be included in the MOH budget, although Uganda prefers the latter form of support. The MOH just tries to steer PEPFAR so that it operates in line with national health policy: the definition of intervention priorities, financing matters and the operational level are not overseen. Hence, PEPFAR operates autonomously vis-à-vis the central authorities in these areas, so there is no real partnership.

The MOH recognizes that the initiative is useful and in fact complementary to its own mission but emphasizes also the possible limitations. The efficiency of the interventions is impossible to verify for the MOH and the overriding feeling of some of the participants is that the operating modus of the initiative is more likely to serve the financial interests of the donor than those of the beneficiary country[151]. Finally, if the immediate value of the interventions is admitted, the issue of their sustainability continues to worry the MOH: if there is no joint planning, how can continuity be ensured if PEPFAR were to withdraw?

The Ministry admits nevertheless that it is partly to blame for the current situation: it acknowledges its ineptitude to impose itself as a real 'steward' and full coordinator in the sector. It should demand the information needed, impose its priorities and insist on a complete formalization of the relationship, as this would allow the Ministry to set demands and supervise the interventions. Our interviewees also pointed out the weakness of the local health information system as well as its probable incompatibility with the complexity of the data gathered by PEPFAR through the *Monitoring and Evaluation of Emergency Plan Progress* (MEEP) project. Furthermore, the system of data collection is not made to include information about programmes such as the ones developed by PEPFAR. Hence, the indicators used do only permit to capture these data to some extent.

As is the case for the public sector, no agreement has been signed on central level between PEPFAR or its recipients and the faith-based medical platforms, so there is no formalized relationship. In fact, the question whether a relationship exists is even more justified than in the case of the MOH. Neither UCMB nor UPMB maintain links with PEPFAR and its recipients. The top people involved in the initiative (at the US Embassy and USAID in particular) never approached these bodies. Relations with the faith-based sector at central level developed through IRCU, an institution meant to serve as a contact point for the different religious denominations. Hence, UCMB, UPMB and UMMB, the coordinating bodies of the faith-based medical sector, have been completely bypassed in favour of one single organisation which was originally created to fulfil other tasks. As the different churches expected that other funds (such as those from the Global Fund) would later on also pass through one representative body, the IRCU was designated officially in 2003[152] to play this role of receiver and manager of the allocated funds. It was nevertheless understood that this body would not be responsible for bringing the funds to the peripheral level, in other words maintain contacts with the health facilities themselves.

In the beginning, PEPFAR established a relation with the medical coordination board of a number of Ugandan churches. An example is the Anglican Church of Uganda (CoU) which until recently had direct contact with PEPFAR through USAID. The Church provided them with useful information for identifying possible recipient facilities or programmes and was

[151] Reference is made here to the expatriate staff, the number of foreign recipients and in particular Americans and the price of antiretroviral drugs (limited recourse to generic products).
[152] By the Churches, i.e. for the Catholics by the Episcopal Conference.

responsible for managing the funds allocated to them. However, PEPFAR's wish to limit the number of intermediaries led in 2007 to a review of its individual relationship with the CoU in favour of IRCU. The CoU continues nevertheless to provide information and supervise the financial side as IRCU is unable to identify facilities. The funds themselves are managed by IRCU and paid directly to the beneficiaries without going through the CoU. The medical coordination of CoU finds it increasingly difficult to carry out supervisions as it no longer receives any information about payments. Because UCMB and the Catholic Episcopal conference did not wish to become recipients of the funds, the Catholic authorities decided early on to create an Episcopal body which would manage the funds that their health facilities received from PEPFAR or other global initiatives through IRCU. Thus, GIFMU (*Global Initiatives Funds Managing Unit*) was founded in 2004. However, PEPFAR decided to formalize its relationship with IRCU in order to channel the disbursement of the funds, which amounted to 18 million dollar, to the faith-based sector more efficiently. As one of the clauses of the contract stipulated that IRCU could not bring in a third party for the payment of funds to health facilities, the role of GIFMU became obsolete from July 2007 onwards.

UCMB, UPMB or the medical coordinators of their member churches thus lost control over the programmes set up with PEPFAR funds. The situation was worsened by the communication problems and difficult relation with IRCU: the organization communicates indeed mainly with PEPFAR/USAID which finances its staff. The same problem crops up with other PEPFAR intervention mechanisms and a great number of programmes managed by other main recipients: TASO and UPHOLD - to cite examples specific to the case studies of our research - have no relationship with the Religious Coordinating Bodies (RCB).

CRS is the only exception we came across that does not bypass the RCB. At first, it operated in the same manner i.e. through a direct relationship with the operational actors in the district. Little by little though, CRS adjusted its position and it now maintains links with UCMB and UPMB. UCMB organizes regular meetings with CRS to consolidate the relationship and progressively get access to the information needed. UPMB was approached to help CRS identify the structures to be included in the programme and joint field visits were organized. Nevertheless the extent of partnership needs to be put in perspective, since UPMB has for example not been informed on the contracts CRS drew up in the field (for instance with Kabarole hospital).

One of the first concerns pertains to the inexperience of the hospitals with contracting partnership matters. There are several known cases in which the contracts do not respect the required legal rules. The dioceses, legal owners of the hospitals, do in fact not systematically sign the documents; the technical managers sometimes sign on their behalf without official delegation of this task. These agreements are thus strictly speaking legally invalid but still implicate an array of obligations and constraints which they barely grasp. Most PEPFAR contracts are in fact based on complex standardized blueprints, drafted according to American legislation and to a great extent not negotiable.

The second major worry lies in the potential distortions caused by contracts which involve a lot of money and strongly target facilities with activities other than only HIV-AIDS prevention. According to UCMB in particular, the effects of projects and their requirements are not really compatible with settings suffering from a serious lack of HR and facing limited infrastructures. Unfortunately most of their hospitals operate in this kind of context. The fear is that the objectives put forward cannot be achieved without other activities suffering in the process.

Finally our interviewees also expressed a fear that HIV-AIDS care will be carried out separately, going against the principle of integration of these activities in the health system.

PERIPHERAL LEVEL: ST. JOSEPH HOSPITAL, KITGUM

St Joseph's Hospital: the HIV clinic and the voluntary counseling & testing centre

Contracting process and analysis of the contracts

CRS

We identified three PEPFAR contracts in SJH: the first one, signed with UPHOLD in 2005, ended in 2007 when the organisation withdrew from the region; the second contract, signed with TASO in 2005 is still in force and aims to boost HIV-AIDS prevention and improve and provide care; the third contract, signed with CRS in 2005, organizes ART treatment and voluntary screening. Before PEPFAR, SJH had no direct link with global initiatives. The Global Fund and the *Multi-country HIV-AIDS Program* (MAP) passed mainly through public institutions; hence the benefit was indirect and came in the form of donations of medicines and reagents by the MOH.

When PEPFAR arrived through CRS (2004), the district health team carried out an evaluation mission in the region in order to select a certain number of facilities likely to benefit from the support of the AIDSRelief Consortium. After a thorough inquiry they decided to include SJH in the programme. The government's priority was to treat patients in public structures, but as no other organisation before CRS had offered the hospital the means to carry out ART treatment, SJH seized the opportunity. However, originally this was a donor initiative, of which the district health authorities took control during the sub-recipients identification stage. The hospital management team was sent on a visit to Lacore Hospital in Gulu, already a beneficiary, in order to assess the programme implications. The team was then invited to submit a proposal for support and this was accepted. The first contract was signed in 2005, between CRS and the hospital. The diocese was ignored: its signature was not on the document.

The first CRS contract was signed in 2005. The signatories were, on the one hand the national representative of CRS, and on the other hand the Chief Medical Officer of St. Joseph hospital. In other words, the kind of situation generally denounced at central level by the faith-based platforms. CRS justifies the situation by saying that it needs to establish a contract with the operational partner while SJH invokes the issue of technical skills. The diocese is a moral authority, not very familiar with the ins and outs of this type of relationship.

The contract was signed for one year and is dependent on the funds allocated to CRS by Washington when the budget is voted. Its renewal is also dependent on the level of performance of the structure (achievement of objectives), its respect of the terms of the contract, its capacity and the mutual wish of the parties to continue their collaboration. In practice, each year the contract has been systematically renewed, since 2005: the standard document is reproduced at each occasion and just mentions the changes made. This document applies to all contracts signed by CRS in the context of the AIDS Relief programme. It emphasizes moreover the strictly autonomous character of the signatory organizations: we are here in the framework of a service agreement, there is no intention of a legal partnership.

The obligations of both parties are only mentioned by referring to the description of the programme provided in annex. It provides a brief description of the resources or services potentially allocated by the donor and limited to support in kind (drugs and laboratory equipment for example). It foresees the conditions under which the funds are paid as well as those for paying back funds by the beneficiary. Article 15 is about the conditions for monitoring and evaluation, specified on the one hand for the objectives set out (monitoring and evaluation of the performance, SEP) and on the other hand for the financial data (SEF).

Annual independent audits are planned for cumulated funds beyond 500.000 USD or 250.000 USD on a yearly basis. More structurally, supervision visits (evaluation of the capacity and monitoring) and the inspection of the financial administration have to be carried out by the donor on the basis of a calendar established by both parties. Some categories of expenses need prior agreement of the donor: these include in particular expenses for expensive capital equipment, improvements to infrastructure and investments.

Finally, a last part includes the particular terms and conditions: it links notably the payment of salaries and remunerations to the systematic submission of attendance sheets/activities; the obligation by the beneficiary to second or recruit the best possible staff for setting up the programme; the need to inform on all contact with the media on the programme or its activities; the law applicable to the contract (Uganda) and the precedence of American law when conflicts need to be resolved.

In the case of SJH there was no real negotiation on this contract: the model was submitted for approval and was then signed.

UPHOLD

In the case of UPHOLD, the selection of beneficiary districts was carried out beforehand, through an agreement between the Ugandan government and USAID. UPHOLD received a list of 20 districts in which it was supposed to set up resource allocation mechanisms and help identify likely candidates in the civil society for inclusion in the programme: Kitgum was part of these. In all cases, the terms, selection criteria and rules that apply to the contracts are specific to UPHOLD but to a large extent controlled by PEPFAR via USAID. PEPFAR stipulates in advance clear targets and defines the services to be set up. On the basis of all these criteria, UPHOLD carried out the selection of sub-recipients in Kitgum District who had put in their candidacy.

The UPHOLD contract is largely comparable to the CRS contract in its formalization level and standardization. This is definitely the case for the general rules applying to the contract i.e. reference to legal texts from the donor and the allocated funds, general conditions governing the payments made, conditions of monitoring and evaluation (financial and technical reports), authorized expenses, conditions applicable to accounting, the audit and the financial administration, the rules applicable to the payments of advances and reimbursements, conditions for termination, suspension and amendments of the contract and the resolution of conflicts. However, the UPHOLD contract is more flexible than the CRS contract: the contracting process implies drafting a detailed proposal by the beneficiary, which is then discussed with the donor. The priorities are thus jointly defined.

The SJH contract defines two important objectives: the provision of decentralized services for voluntary screening and advice to a specified number of adults from 4 sub-counties and the county of Kitgum-city; the provision on the other hand of care and accompaniment of a specified number of people living with HIV in the same zones. Each of these objectives is described in detail with the activities that have to be carried out, and all of them are accompanied by quantitative objectives. As for CRS, the UPHOLD contract was signed by the chief medical officer of the hospital and - again - not by the diocese.

For both UPHOLD and TASO, the signed contracts include detailed obligations and require an important commitment on the part of the beneficiary in terms of skills and time. Besides the activities that need to be undertaken, reporting duties are an essential and detailed part of the documents. If these reporting obligations offer the guarantee, at least theoretically, of excellent monitoring conditions, the constraints which result, weigh particularly heavy on SJH. The hospital had to manage simultaneously three distinct monitoring and evaluation systems, until UPHOLD's withdrawal. The details of the TASO obligations are unknown to us but we found out through the interviews that they put even more strain on SJH, bearing in mind that the funds allocated remain rather modest in comparison to those of CRS.

TASO

TASO Gulu identified possible recipients, focusing on a limited number of structures (governmental or faith-based) that have a public service orientation. A field mission was carried out in the districts and the hospitals of the region to identify possible gaps in existing programmes and analyse the needs (based on statistics). The District of Kitgum was first selected, and then SJH was chosen (within this district). This is obviously a very participatory context, far removed from the principles implemented for AIDS Relief. The final contract is the result of negotiations held specifically with the hospital, operational partner of TASO for the implementation of its programme.

The TASO contract is in fact a simple Memorandum of Understanding (MoU). Of the three documents studied, it is the least precise one. The way it is formulated and its particular characteristics are similar to the contracts we have analysed for the three other case studies of this research. But unlike these, it is, on paper, the one that details most completely the involvement of the different categories of actors of the area: in fact, the MoU officially links TASO to the Kitgum District but with SJH as principal actor of the agreement. This means that the three entities are signatories of the agreement. Two representatives of the district authorities (Chief Administrative Officer (CAO) and the Director of Health Services) and a representative of the hospital (the Chief Medical Officer) signed. These three representatives are regrouped under the label "Local government of Kitgum District". For TASO, the Executive Director (Central Level) and the regional manager for Northern Uganda signed. As in the case of CRS, the diocese as a legal entity was ignored by the agreement. If the district is the entity officially designated by the MoU, the real partner is the hospital.

Contracting instruments/partnerships (monitoring, evaluation)

Because of their level of precision and detail, the contracting documents are the first instrument for managing the relationship: they are real and complex sources of information and serve as a reference for the facility for monitoring the obligations and regulations governing the relationship. The second instrument is the monitoring offered by the donors. Supervision visits are often organized by CRS staff to check the technical aspects of the contract. They are seen as an essential part of the relationship and allow SJH to benefit from direct support in managing, monitoring and evaluating of the activities planned in the contract. Annually, an in-depth financial inspection is also carried out. Finally (and especially during the start-up phase), other members of the AIDSRelief Consortium came and still come to supervise the activities.

Besides the contact with the main representatives of the donors, the hospital benefits from the proximity of the regional offices of TASO and UPHOLD in Gulu and the CRS office in Kitgum. CRS furthermore organises a *local partners forum* in Kampala every three months which is attended by all the facilities involved in the AIDSRelief programme in Uganda; this allows the different hospitals to exchange their respective experiences and thus contributes to capacity building of the people in charge.

Finally, regular training of the actors in the programme enables the facility to acquire the skills needed for achieving the set targets and for following up on the donor's specific procedures.

The reporting and data collection obligations, typical of each contract[153], ensure that the facility remains critical of itself and holds a regular self-evaluation of the programme activities.
Overall, the ability to identify relevant data, analyse and anticipate activities, all of them skills acquired in the context of PEPFAR contracts, have a positive effect on the level of monitoring and evaluation of the hospital's core activities. The skills thus acquired can be exploited in more ways than just for the specific activities of the contracting agreements.

Perception of the relationship and implications

The public sector

In general the public sector has a positive impression about the contracts signed by SJH; it is clear however that the knowledge of public actors of these contracts is rather limited.
CRS, in particular, that visited the region in the identification phase of beneficiary structures, has no longer any contact with the district (AIDS focal point). The same is true for TASO even though there is a joint agreement, contacts are limited to SJH, visits to the district are rare and the donor submits no annual report to the district health authorities. The situation is better for programmes such as UPHOLD (and more recently NUMAT): they have direct contact with the district, and keep it informed about their activities.

The district is also a recipient of funds. However, the money SJH received from UPHOLD was transferred directly, without going through the district. NUMAT has since taken over and all funds are now channelled through the district.

Nevertheless, different instruments offer possibilities for exchange: SJH (unlike, it seems, other faith-based facilities) regularly supplies copies of its reports to the district. This information is however not always exploited. Another exchange opportunity lies in the representative and decision-making bodies, in which both public and religious actors participate. The district management team also has to carry out regular supervisions of the hospital; joint three monthly supervisions (by the technical and the political committee for the fight against HIV-AIDS) are scheduled. In reality, they are not very frequent though, and there is no formal feedback to SJH.

The local government also provides financial and material support to the hospital: although these contributions amount to only 30% of the budget (far lower than the 52% obtained from external donations), they nevertheless allow the hospital to pay part of its expenses.
Finally, sometimes SJH, the district and the district hospital collaborate informally: SJH's skills in the fight against HIV-AIDS are regularly called upon; the facility is invited to delegate some of its specialized staff to train their counterparts of the public sector. There are regular exchanges and interactions in fields not specifically related to HIV-AIDS: exchanges of specialists, equipment, even occasional assistance in the supply of drugs.

Generally speaking, the patients themselves prefer to go to SJH rather than to the public health centres nearby or to the district hospital. The quality of care, skills, reception and quality of the management are mentioned as main reasons for this, on top of the shortage of

[153] See copy of the contract in annex, Vol. II, 5.

district resources in comparison to SJH (drugs, laboratory facilities). This resource gap creates some tension and the emergence of double standards of care.

However, nothing seems to indicate that both parties are really in competition with each another, not even for access to resources. What is deplored is the absence of a three party agreement which would allow the local government to fully exercise its coordination and supervision tasks.

The faith-based sector

The feeling of SJH about its relationship with PEPFAR differs greatly from the perceptions at central level. This indicates first and foremost that hospitals are not really equal in these types of contracts: the difficulties encountered by some facilities of the Catholic network are not necessarily experienced in the same way by other catholic facilities.

The first category of benefits identified by the hospital concerns the set up of the activities: the resources and means proposed by the PEPFAR recipients fill needs such as treatment for PLHIV[154]. The public provision of this treatment is considered unreliable, incomplete and thus not an acceptable alternative for SJH. PEPFAR's support through AIDSRelief/CRS includes ART drugs and treatment of opportunistic infections, equipment (including a CD4 meter) and laboratory reagents. This support, related to the number of patients in the programme, has allowed SJH to come up with a complete package of care, this in addition to the community activities, voluntary screening, counselling and accompaniment which were already on offer thanks to grants from other programmes. The PEPFAR support thus constitutes an essential improvement in terms of access to care.

The second category of benefits is without any doubt the most important one: the technical level of support by the donor. The hospital refers here to the obvious benefit it gains from supervisions, initial and continued training, regular contacts as well as reporting requirements. Furthermore, the hospital mentions the technical support for example for managing difficult medical cases (CRS) and the joint search for solutions to the problems met. The quality of the support, the availability of the donor and overall the existence of a true day to day partnership are much appreciated. This is particularly the case for UPHOLD and CRS.

The quality of the data collected gives the facility solid arguments in its negotiations with other donors. The use of programme data is therefore encouraged to fill the identified gaps. Furthermore, the interventions partly alleviate SJH's financial burden.

More negative aspects of the contract are largely downplayed by the staff. They admit that the extra work that came with the programmes was a heavy burden in the initial stages. Staff instability and turnover and SJH's need to cut staff due to a lack of sufficient resources have doubtlessly aggravated the consequences of the mobilization of some staff for specific tasks of the contract.

There is also the issue of staff and their remuneration. The information we obtained was contradictory, as two schools of thought emerged. A first category believed that there is no difference between the salaries inside and outside the programme. SJH has been able to impose its own salary scales to the donors. Others said that some donors - in particular CRS - refuse to deviate from their own procedures. This leads to sometimes important differences in salary for similar jobs.

This leads us to a point of discussion already touched upon in our analysis of public sector perceptions i.e. the flexibility of the donors. We have to distinguish, on the one hand, the elaboration phase of the contracts on the one hand, in which SJH was apparently not actively involved (see the analysis of the contracts), and on the other hand, the monitoring of the activities.

The matter of the flexibility of the programmes concerns mainly one question: that of slots allocated to the hospital by the contracts and which determine the number of people that can

[154] People Living With HIV-AIDS.

be included in the programme (CRS) as objective to be achieved over a specific period: these are difficult to negotiate, because they are dependent on the available budget.

This capacity of the hospital to respond to the need of care of the population depends in an initial stage on the budget effectively awarded to CRS. The slots of SJH have seen a regularly increase since 2005, but in 2007 CRS had to lower its initial subsidy forecasts for the beneficiaries of the region because of a reduction in funds allocated by Washington (and in favour of NUMAT). Although SJH did not have to reduce the number of patients taken on, it had to revise downward the number of additional patients initially foreseen.

This example brings us to the matter of continuity of the programmes. If the donor were to pull out, the state would not be in a position to fill in for the CRS's intervention mode (based on the principle of excellence in the quality of care) in the same manner, because of the cost of a programme (among other reasons).

Overworked staff in facilities swamped with patients tries to convince the patients to turn to the public hospital or other nearby health centres. But generally, the patients boycott these facilities because they have a dodgy reputation.

PERIPHERAL LEVEL: KABAROLE HOSPITAL, FORT-PORTAL

Kabarole Hospital: view of the HIV Clinic and the voluntary counseling & testing centre (Source: www.kabarolehospitalmission.org)

Kabarole was identified thanks to an initiative of CRS. In 2004, a survey by questionnaire was carried out among the care facilities of the Protestant network, with the help of and via UPMB. It was on this base and after some field visits that KH was selected. A first contract was signed in July 2005 between CRS and the Diocese for the set up of an ART treatment programme and the organisation of community activities (voluntary screening and care).

As in the case of Kitgum, the contract follows a standardized model with some slight modifications, sent to the diocese and the state: no real negotiations took place, the contract was pretty much signed in the form it was presented. Only the annex (of the programme description, including the budget) authorizes a few amendments if necessary. The contracting process proceeded rather swiftly and activities could start almost immediately: at the time the patients were already looked after by a support group of the diocese.

Kitgum's only contract is the one signed with CRS for the AIDSRelief programme. We can refer here to the analysis of the CRS contract with SJH, as the documents are very similar. One major difference however is the involvement of the bishop. He is a signatory of the contract and designated by the contract as the authority in charge, respecting in this way the legal status of the hospital. In Kabarole the AIDSRelief programme does not only cover the treatment of the

patients but includes a community prevention component, palliative care (all patients) and voluntary screening (for non TB patients only).

The contracting instruments for KH are the same as those for SJH. They include the contracting document and the different manuals provided by the donor to carry out the activities, the training available, the technical supervisions of the CRS focal points, the financial supervision, the participation every three months in the *Local Partners Forum* in Kampala where representatives of the 18 programme sites get together, the proximity of and access to the local managers at the regional CRS office in Fort Portal, day to day communication by telephone or email and the technical and financial reporting requirements (with the drafting of specific reports).

The situation in Kabarole district is different from the situation in the Kitgum: our analysis shows that there are also discernible differences in the degree of involvement of public actors and their perception of the partnership experiences between the PEPFAR recipients and the faith-based hospitals. There are three hospitals in the town of Fort Portal, capital of the District, two faith-based facilities and one regional hospital (Buhinga). There is no district hospital, so the referral/counter-referral system is based in the regional hospital. Unlike in Kitgum, the public hospital here is an operational facility with a strong reputation; attendance rates are high. The confessional hospitals, for their part, also attract many patients.

The three facilities live together in relative harmony although the functioning of the referral/counter-referral system leaves a lot to be desired. Indeed, somehow many more patients tend to be referred to the regional hospital. The HR crisis in the two confessional facilities (Catholic and Protestant), and acknowledged by the public actors[155] would explain this phenomenon. The fact that PEPFAR settled in the district is important and there are three main organisations involved: JCRC[156], EGPAF[157] and CRS. A large number of public facilities benefit in one way or another from this support. In this sense, the information disseminated by the District on these initiatives seems a lot better than in Kitgum. Finally, the technical managers of the District (DMO, HIV Focal point) display a real willingness to cooperate and coordinate with other actors: substantial efforts are made towards integration of private[158] facilities in the district and information is gathered with inputs from various actors.

As a beneficiary, the public sector is also invited to participate in the meetings organised by the donors. The collaboration conditions are in principle therefore better guaranteed than in Kitgum, even if the ability of the district to boost the partnership remains limited due to lack of resources. In Kabarole, the donors are for example required to present their projects to the district before implementing them on site. An annual action plan (that establishes the priorities for a local intervention) has to be presented and approved by the district authorities. This is after an agreement (MoU) is signed between the donor and the local government. The funds are paid directly to the faith-based facilities without passing through the district.

In general, the district health authorities feel that the PEPFAR activities are set up with their full involvement, in fact they could almost claim that PEPFAR operates in their name. There are some slight nuances however about the degree of synergy reached according to the organisations. An annual district conference forms the occasion to collect the budgets of the different partners. In addition, there are more informal exchange opportunities but according to the district it is really the central level which is the place to discuss issues like for example the respect for the National Health Policy.

The funds allocated to the public sector are managed according to the procedures of the donors, and often go against central government regulations[159]. The active involvement of the

[155] Chief Medical Officer of the regional hospital.
[156] Joint Clinical Research Centre.
[157] Elizabeth Glazer Paediatric Foundation.
[158] The current DMO restored the systematic signing of agreements with health facilities (hospitals, health centres) which benefit from government support.
[159] Each donor requires the opening of a specific account to transfer its funds, while the government pleads in favour of only one account.

district authorities in the implementation stage of the projects leaves a lot to be desired: not only do they play no role in the supervision of the projects but up to now they also did not have the means of exercising this prerogative.

There are also some reservations about the partial involvement of health staff of the programme facilities: this practice leads to unequal treatment of staff in the same institution, to demotivation of staff that is not integrated and might lead in the longer term to a discontinuation of the programmes. The district of Kabarole seems to have obtained that the donors respect the salary scales of the public servants.

Overall, PEPFAR programmes are considered to play a positive role in the district, especially as their funds permit the implantation of activities that the government is unable to set up. One does not make a distinction here between PEPFAR and other initiatives such as those of the Global Fund. This shows that the programmes are so well integrated that the local government does not feel bypassed and that the interventions are seen as complementing those of the public sector; the programmes contribute moreover to the generation of health data which are communicated to the Ministry of Health; they allow to partially compensate for the HR losses of faith-based facilities thanks to secondments and the take over by the donor of some health staff which can then be used more flexibly. The list of priorities that could be improved includes the continuity of the programmes, the implementation of fall-back strategies and more flexibility in the funds awarded[160], furthermore harmonization of procedures and complete and full information.

We observed some interesting differences in the perception of the faith-based sector in Kabarole as compared to Kitgum. Although the recipients' analysis is positive in general, they tend nevertheless to be more critical than their counterparts in Kitgum. It is clear however that the CRS programme in Kabarole is set up in a very different context than the one of SJH. The hospital was only recently taken over by the diocese and is still recovering from some difficult times in which it lost quite some credit with the patients[161]. It has to work next to two other fully operational hospitals in its direct neighbourhood. The hospital has limited means, and these are mainly provided by user fees and state subsidies. Infrastructure is limited and the total capacity (70 beds) is far smaller than in the case of SJH. HR are few and there is a high turnover as a result of the low attractiveness of the salaries in comparison to the public sector.

In spite of the unfavourable conditions and high demands of the programme, KH has been able to obtain each year a renewal of its contract with CRS since 2005 and it saw the funds and slots allocated increase progressively during this same period. The programme staff represents 21% of the total KH staff. The advantages identified are largely similar to those mentioned by Kitgum. They are first of all: the opportunity offered by the programme to take care of the population in the fight against HIV/AIDS in an area where the prevalence rate is about twice as high as the national average[162].

Secondly, the quality of the support in terms of monitoring: the staff working on the programme is trained systematically and training is also offered to hospital departments which have an important support role for the programme[163]. CRS carries out regular (financial and technical) supervisions. Reporting requirements have allowed the staff to develop their analytic skills, to anticipate and manage and the skill to identify and collect data which they can also use for the general activities in the hospital. However, the rather inflexible attitude of the donor leads to the same worries in KH as in SJH but these are voiced more strongly and confront the hospital with the limitations of its bargaining power.

These shortcomings show also the differences in interpretation of some of the problems encountered. CRS does not accept to pay the hospital costs of patients in care; the hospital

[160] There is a conflict between the priorities of the donors and those of the recipients; restrictions imposed on expenses for infrastructures, obligatory use of specific suppliers.
[161] The "private" episode of KH has tarnished its reputation in terms of access and quality of care.
[162] 11,6 against 6,2
[163] CMO and administrator, clinical staff, financial unit, laboratory, pharmacy and warehouse.

considers this an aberration in view of the limited resources of the population. Generally speaking, the rules of the contract are considered as far removed from the realities in the field.
Another issue which cannot be discussed with the donor is the requirement to justify the working time of each employee. If the employee works (far) more than the 40 hours foreseen, it is left to the hospital to decide whether or not it has the means to pay for this supplementary work, as overtime is not paid by the donor.

The question of salary scales remains difficult to resolve. Other participants mention an important salary gap between the salary of hospital and programme staff; this tends to lead to a perception of the HIV clinic as a structure 'segregated' or separate from the hospital. Another issue is the potential development of double quality standards that set the programme activities apart from general activities. The staff fully realizes that there are major differences resulting from the disproportion in available funds. This problem will be gradually resolved as new appointments allow filling the gaps initially created by the secondment of qualified staff to the programme. These new recruitments are however carried out at the expense of the diocese, thus somewhat balancing out the decrease in costs brought about by the payment by CRS of part of the programme staff's salaries.

The share of the allocated funds and the dependence of KH on only one donor raise the question of the continuity of the project. The recent guarantee ensures the theoretical continuation (just like in the case of Kitgum) of the programme for another five years. Besides, CRS makes the hospital a partner in looking for alternative solutions[164]. The level of support provided and the standards applied to the quality of care[165] by the programme reinforce these difficulties and lead to a wide discrepancy with the standards used at national level: the Ugandan state is unable, due to a lack of resources, to adopt the same principles[166].

Generally, the introduction and quality of services have led to an increase in attendance rates as the standing of the facility with the patients improved. Staff numbers have more than doubled. It is however difficult to say what role the programme has played in these trends: the take over of the hospital by the diocese played a positive role as well.
Nevertheless, this positive effect is accompanied by some tensions since the level of activity exceeds the capacity of the infrastructure. The important mobilization of personnel by the programme, the volatility of the staff employed for the general activities and the difficulties in recruitment contribute furthermore to an increase in the workload. It is clear that this situation can in the long term only have a negative influence on the quality of services.

The strict character of the allocated slots and the refusal to provide treatment to some patients who tested positive give the hospital a bad name: a relative drop in attendance of the screening centre seems to confirm this trend. The problem appears more crucial since the number of PLHIV continues to increase in a district that already has a high prevalence rate.

Overall, the medium-term prospects and situation of the hospital seem fragile, unless new financing sources are found. It will become more and more difficult for KH to continue to subsidize user fees in the absence of a substantial improvement in the participation of the state. The recruitment crisis - without solution currently - adds to the vulnerability of the facility. The search for structural solutions appears therefore essential.

[164] In 2008, the programme financed a consultancy mission with the intention to find possible alternatives.
[165] Branded medicines of which the cost was too high for the great majority of patients if they had to pay for these themselves.
[166] The problem is mainly the start-up criteria (viral load) of the treatment for the people living with HIV-AIDS.

Conclusion

The analysis of the contracting relationships that exist in the context of the PEPFAR programmes does not completely confirm the negative a priori perception that surrounds these set ups: the important differences in perception between the central and peripheral level show at the very least that a more nuanced analysis is necessary. The comparison between KH and SJH shows that although there are definitely risks hidden in the existing contracts, their importance largely depends on factors that have no absolute link with the nature of the PEPFAR contracts nor with the approach that characterizes them:

- The "solidity" and importance of the benefiting structure;
- The type of previous experiences; The negotiation ability of the people in charge and their grasp and command of the contracting process;
- The degree and quality of the implication of the legal owner;
- The availability of alternative sources of finance;
- The flexibility of the structure, in particular in terms of infrastructure;
- The capacity of the local government.

The differences in perception, understanding and knowledge of the system are proof of the dysfunction of the communication mechanisms that exist between the central and peripheral level. This can be directly attributed to the decentralised health system. The compartmentalization and fragmentation of the different intervention levels make clear that the decentralization process was never fully implemented. Besides, the different PEPFAR programmes can not all be considered completely equivalent: the system is characterized in fact by multiple intervention mechanisms. The way of operating of programmes such as UPHOLD, CRS and TASO shows important differences:

- in their degree of cooperation with the local authorities;
- in their degree of flexibility;
- in their degree of involvement of beneficiaries in the definition of the objectives;
- in their knowledge and understanding of the local situation.

Furthermore the arrangements proposed include potentially important benefits for the structures that have to implement them:

- The acquisition of general monitoring skills;
- The skills acquired lead to a change in professional culture which could well have a positive influence on the management of the general activities of the facility;
- The quality of the health information system set up is bound to increase the credibility of the structure and provides extra arguments when lobbying with donors for new resources;
- The set up of (new) activities seems to attract more patients and will thus also increase general attendance rates of the hospitals;
- A certain degree of security due to the predictability of the arrangements.

A few risks remain however; they are specifically linked to the nature of the politics governing the programmes, the importance of the programme priorities and the "power" that the sheer amount of the provided funds grants to the donor:

– The weight of PEPFAR's contribution to the prevention of HIV-AIDS in Uganda results in the central authorities allowing the development of autonomous strategies that are largely dominated by the priorities of the donor; this is even more the case for the peripheral level;

- The legal framework of the agreements is decided outside the country they are implemented in, and is not negotiable. It considerably reduces the bargaining power and influence of the field actors;
- The extreme fragmentation of the system, its complexity and lack of transparency of its organs make it difficult to get an overall picture. Both the actors of the faith-based and the public sector testify that their knowledge and understanding of the situation is incomplete;
- The policy of excellence preached and practiced by the programmes leads to the creation of double standards in terms of norms, costs, and quality;
- The low reproducibility of the systems results in the problem of sustainability, all the more crucial as the programme is mostly short and medium term whereas the nature of the activities is often long term.

The fact that the faith-based health platforms are systematically bypassed in these arrangements endangers the quality of the relations which they maintain with the facilities of their respective networks. It diminishes the role they could play in the coordination and guidance of the hospitals, and so prepare them for the signing of such contracts and train them to anticipate the risks inherent in this set up. The reticence of some hospitals to provide their organisation with information on the contracts signed bilaterally with the donors is an indication of a breakdown which should not be ignored.

Finally, the relative success of the contracting arrangements with PEPFAR on peripheral level could well bode ill for the already uncertain future of the partnership between the MOH and the faith-based sector in Uganda. The worsening human and financial resources crises and the absence of a real response from the public sector are likely to undermine the basis for a continued partnership: they could well induce faith-based facilities to progressively shed the partnership project pursued at the central level by UCMB and UPMB, and might lead to a multiplication of direct relations with the donors instead. Indeed, the latter offer instant and operational solutions to the immediate survival needs of the facility. If they can deliver what they promise, this might prove to be the more tempting option.

Analysis

Summary of the results

We made an overview of the different case studies to summarize our observations and prepare a cross-cutting analysis. Two tools were used to make this summary:

- The main characteristics of each case were put next to one another in a synoptic table (*cf.* Table 2) and divided into 3 main categories: i) the results at central level, i.e. specific to the national framework of the contracting relationship investigated; ii) the results at peripheral level and finally; iii) the aspects specific to the scope of the contracting relationship. Within each of these categories, a certain number of large sub-categories have been retained.
- A SWOT (*Strengths, Weaknesses, Opportunities, and Threats*) analysis of the case study was also carried out and its results have also been summarized in a table (*cf.* Table 3).

From these analysis tools emerge a number of constant factors:

- In spite of the large variety of contexts and experiences, the different case studies show the great difficulties with contracting between the public and faith-based sector in the district. This is the case for all denominations and for all the contracts we investigated.
- It is mainly the faith-based sector which mentions these problems, so the malaise is only 'one way'.
- The problems met concern mainly the issue of financial and human resources, fundamental stakes in a setting where internal and external resources are already limited. The contracts that "work" are the « resourceful » contracts, as is proved by the first contracts in Chad or a fortiori the examples of PEPFAR in Uganda.
- The quality of the contracts themselves is systematically questioned, and in particular their incompleteness, the absence of any revision or renewal and the resulting gap with the national health policy, more specifically the partnership and contracting framework at central level.
- It is not always evident to distinguish between the contracting relationship and the effects related to the context: the context of poor governance, institutional weakness and tension created by a lack of resources, that applies to all the different cases, certainly weighs on the success (or failure) of the contracts.

Table 2. Synoptic grid of the results

	CAMEROON	TANZANIA	CHAD	UGANDA
GENERAL CONTEXT (national)				
Context	- The faith-based organisations cannot be overlooked in the provision of care. They have many facilities in mainly rural areas. - The decentralized health policy was only partly implemented and the burden as a result of the centralized policies remains heavy. - The weakness of the MOH at central level (governance, human and financial resources) spreads to that of the religious platforms. Proof is the ignorance about what happens in the field and of which no central database exists.	-The faith-based organisations are very present in the health sector and especially in the rural areas. -It is faced with a serious financial crisis at peripheral level.	- A young, dynamic and minority Church. Operational mainly in the South of the country abandoned by the State during the civil war. The links of the Chad Church with the donors remain important but these resources are decreasing drastically. - A joint will for a partnership marked by a climate of understanding and will by the State to collaborate with the faith-based sector. - A young contracting process but nevertheless preceded by specific experiences in the field (for example in the district of Moïssala).	- The partnership and contracting process between the MOH and the Church is frozen since 2003. - The faith-based sector is faced with a financial and human (resources) crisis. - Difficulties at the Ministry of Health (MOH) and a limitation of the heallth budget. - Large but ever growing PEPFAR financing of activities related to HIV-AIDS prevention since 2004. Limited PEPFAR visibility on central level. - The relations between PEPFAR and the faith-based sector bypass the health platforms.
Contracting Process	- The contracting process developed first bilaterally between the peripheral (PNFP facilities) and central (MOH) level as a result of a reorientation of PHC. - The partnership policy was only set up afterwards in a climate of consensus and encouraged by the donors (C2D). The faith-based sector was completely involved in this development. But currently it is still not operational.	- An older process of which the premises date from post-colonial times. - Initially, the collaboration was informal and then became statutory on the basis of service agreements signed between the health facilities and MOH.	- The partnership developed rapidly at the end of the civil war and in a climate of real collaboration. - The different tools available are the resullt of joint efforts, encouraged by the donors. - The actors are trained and the strategy is widely disseminated. - The current situation had to be evaluated in the country in order to be readjusted.	- Not applicable for PEPFAR: the contracting process happens on peripheral level, relations are set up directly with the operational actors in the district.
Objectives/ Motivations	- The public sector, through a recognition of the social role of the Church, aims for integration of its structures in the health system and its respect of the national health policy. At the same time it is also assured of health coverage - The religious actors see the contracting process mainly as a means of survival of their facilities which are in dire straits and have a growing shortage of HR. They would also like recognition for their important contribution to the Cameroon health sector.	- The start of the DDH happened at the same time as the take over of the area by the State. It marks the willl to integrate the health facilities of the Church out of concern for rationalization and improvement of health coverage. It is also proof of the State's recognition of the social role of the Church. - The faith-based sector wants recognition but mainly access to the ever decreasing means.	-Both parties want to ensure the health coverage in isolated areas where the health system has broken down and the public health facilities are not able to perform. The issue at stake is to recognize and seek recognition for the complementary role of the Church in the health sector and its specific qualities.	- The faith-based sector wants a formalized relationship with the Ministry of Health as a survival strategy. - At PEPFAR level, there is no national partnership as such outside the general agreement signed with other State authorities: the partnership and contracting process is concentrated on operational level (district).

National framework of the relationship	- The framework includes a strategic partnership framework, convention models and service agreements. These do however not include the many previous experiences. Although the partnership framework is likely to include them, the contract models are mostly steered by the specific objectives of the donor (C2D).	- There is no policy or contracting paper. The relationship is based on a series of service agreement models (*District Designated Hospital contracts*, *Council Designated Hospitals*, *Service Agreements*) and the existence at central level of a dynamic forum. - Various document and contracting relationship strata coexist.	- Chad has an almost complete legal framework: contracting policy, framework convention models, operational guide. - This framework came after some of the experiments were set up and thus does not include these.	- The general agreement protocol between PEPFAR and the central public authorities is not accessible and the public actors at MOH level do not know its content. - There is no framework agreement between the MOH or the faith-based sector and PEPFAR or its recipients.
Tools	- The tools comprise the contract models, the framework agreements signed with the faith-based sector and the steering committee of the partnership strategy. This set up is not yet fully operational because the financial means of the C2D are not released. The implementation of the service agreements is delayed and the meeting, reporting and review mechanisms do not yet work.	- There are many tools and opportunities to meet with each other at central level. The partnership process is dynamic and makes progress. This has led to the creation of new contract types which take into account the specific difficulties of some Church facilities (*Voluntary Agencies*), such as not getting State subsidy. - This process remains nevertheless very centralized and should involve the intermediate and peripheral levels of the health pyramid. Due to a shortage of HR in particular, the decentralized facilities of the health platform are not able to fully play this role.	- The relationship between the State and the Church is governed by a framework agreement - The tools for encouraging and monitoring the contracting process do not work properly at the moment because there is no national medical coordinator for the religious platforms	- There are no tools on national level. The PEPFAR Board does not seem to participate in improving the MOH information and the faith-based platforms about the on-going activities.
Perception	- The MOH recognizes the important contribution of the faith-based sector in health and is very much in favour of generalizing contracting as a means to integrate the PNFP facilities in the national health landscape. The faith-based sector is satisfied with its level of involvement in the contracting process but frustrated by the delay in the pay outs of the C2D money, which in turn delays the operationalisation of the framework and contributes to tarnish its reputation even in their own ranks (peripheral level). - The contracts dating from before the set up of the contracting framework escape the attention of the two parties at central level which focus entirely on the new procedures and their specificities.	- The perception of both the religious and public actors at central level is positive and this is a reflection of the dialogue and the collaboration between the sectors. There is insufficient awareness of the problems met at peripheral level through imperfect tools. These problems have to be solved first and foremost by taking into account the limited human resources.	- The goodwilll is mutual and there is a good understanding. The State wants to set up new contracts quickly with organisations or health facilities and certainly recognizes their qualities. - The faith-based sector mentions the MOH's difficulties to monitor the situation. There is a clear distinction between the theory and the contracting reality at peripheral level.	- The MOH and the Church leaders distrust the PEPFAR programme because they feel bypassed. The opaqueness of the system and the lack of communication reinforce this feeling. This situation reduces the management and planning opportunities of the MOH. - With the exception of *Catholic Relief Services* (CRS), the PEPFAR recipients we interviewed do not recognize the role of the faith-based health platforms and talk mainly with the *Inter Religious Coordination Unit* (IRCU). The role of 'IRCU (ecumenical organ) in the PEPFAR programme is questioned by the faith-based platforms. In fact there is no communication between IRCU and these platforms about the activities that are implemented -The religious actors worry about the effects of the programmes on the facilities, more particularly in terms of a distortion of activities.

S¨PECIFIC CONTEXT (case-studies)					
	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
Context	- The hospital of Tokombéré is the only hospital in an enclave. The expatriate chief medical officer has strong leadership skills and the hospital benefits from regular external support. Its reputation is partly linked to its PHC project which is a model for the national level. It attracts a population from far beyond the district. - The relationship with the district administrative authorities has been difficult. For matters strictly related to health, the hospital has no recourse to the district, as the contract was signed with the central level. The provincial representative who supported the hospital in the start-up phase of the contracting relationship no longer plays the role of intermediary.	- The hospital of Nyakahanga is located in an isolated area, where public referral facilities are absent and where religious actors are dominant. It therefore follows that in 1972, the hospital got the status of DDH. -The hospital operates in a context of a decentralized health system but is not correctly integrated in the district as it has a contract directly with the central level.	- South Chad where the district of Moïssala is located, is an area with very few public facilities as a result of the civil war. - The *Bureau d'Etudes et de Liaison des Activités Caritatives et de Développement* (BELACD), a Catholic organ, filled the void left by the State during the conflict and played an important social role in particular in the health sector.	- SJH is located in an area which has known 20 years of civil war. It is near a public district hospital but fulfils in fact the role of referral facility, attracting patients from the district and beyond. - The area attracted a large number of donors which currently are leaving because of the political stability. - As the area is not very attractive, the quantity and quality of public staff ensues. This is shown by the difficulties of health institutions (district hospital, district management team).	- The hospital is quite old and has known many ups and downs. At the moment it is being renovated. It is the smallest of three facilities (public, Catholic) all situated near one another. - This is a relatively dynamic district
Contracting Process	- The contracting process and its implementation were very much encouraged by the provincial representative. There was initially some opposition from the local elite who were in favour of the set up of a competing public structure. - The mistrust this provoked with the religious leaders has slowed down the implementation of the contract.	- The process goes a long way back but was first informal, probably as a result of the fear by the faith-based actors of a complete take over by the State. - The formalization took 10 years and was based on the positive experience: the Church simply ratified a standard contract model.	- The start of the process happened before the implementation of a national framework. - It took several years and several successive contracts, gradually extending the BELACD's responsibility in matters of managing the district hospital and the district itself. - There was a joint commitment and this was accompanied by continuous support (financial, technical) of BELACD's donors, either directly or via the State.	- The identification of the facilities was an initiative of the donor. The selection was made on the basis of their pre-existing and proven ability; in both cases it rests on the identification of the skills to fulfil the task assigned to them. - The contracting approach varies according to the type of PEPFAR recipient involved, mostly bypasses the district authorities on an operational plan. Nevertheless in the case of Kabarole, the district and public hospital keep up relations with some of the recipients - The contracts are mostly prepared in advance and leave very little room for initiative by the beneficiary facilities: the negotiation phase is as good as non existent. - The diocese, owner of the facilities, is not necessarily involved, not even in the signing of the contracting documents. The target interlocutor is not the legal authority but a skilled operational body	

Objectives Motivations	- The contract confirms the status of Tokombéré as district hospital and includes certain aspects related to the organisation of the district.	-The objective of the DDH contract is the set up of the facility as DH: the religious actors' motivation for signing was the wish for survival and a need to protect the assets obtained	- Contracting is a response to the need to recenter the district around Moïssala and to correct the situation that resulted from the creation of the Béboro HC and the decline of the district hospital; this necessity is fully recognised by the BELACD. - The objective is to develop the district hospital and the district in order to provide health coverage of the area and designate an organisation able to assume the role of the State.	- The common objective for the different contracts is the set up of targeted activities for the fight against HIV-AIDS. The PEPFAR recipients pinpoint the facilities best equipped to carry out the programmes within the timing and with respect of the objectives set out. - The involvement of the faith-based facilities in the contracts stems from a concern for treatment of PLHIV. This response is not provided by the State (or only with poor quality guarantees); there is no alternative for the PEPFAR proposals and their scope. - The objectives of the two parties are therefore well targeted.	
Framework of the relationship	- The HTOK contract was signed between the MOH and the diocese, although according to the decentralization measures, it should have been signed with the district authorities. The result is that its management is complicated. - The contract description remains vague and the obligations are mainly those of the faith-based side.	- The Nyakahanga contract gives the hospital the status of district hospital (DDH). This is a first generation DDH hospital, signed with the central level. - The document has many weaknesses in content and form. - It should be revised and adapted to the more up to date DDH contract (2005) so as to be integrated in the decentralisation framework of the health system.	- The framework of the contracting relationship consists of a series of successive and progressive contracts signed between the BELACD of Sarh and the State; these are accompanied by secondary contracts linking BELACD to its donors and the district civil servants. - The contracts between BELACD and the State are far more complete than those in Cameroon and Tanzania. They are however not integrated in the national framework nor have they been officially renewed after 2006. They escape the decentralisation of the health system management.	- SJH has 3 'PEPFAR' contracts: Two are signed with international partners (CRS, UPHOLD), one with a local organisation (TASO) - In this particular context, the owner (bishop) has not signed the document	- KH has only one contract, with CRS - The bishop has signed the contract.
				- With the exception of the TASO contract, all contracts signed are standard contracts and the only issues that are negotiable are the amounts allocated and the nature of the beneficiary structure. The budget detail and the timeframe of the activities are mentioned in a work plan that is specific to the structure. These contracts, American in origin, are only partly adapted to the specific setting where they are implemented and are difficult to access for these kinds of actors. - An important place is given here to the steering of the relationship and the means for monitoring	

Tools	- The steering committee installled to monitor the relationship gathers not often enough to be efficient. - The responsibility for the main decisions lies on central level as they signed the contract. But the MOH is not directly represented and the office of the district representative does not function properly as a go-between. - The MOH and the DP carry out the routine supervisions but these do not concern the contracting relationship as such.	- The *Board of Governors* is named by the contract as the main tool in the contracting relationship. However, it convenes irregularly (lack of resources) and suffers from the fact that the central authorities are not represented. - Since they are not a signatory of the contract, the district and intermediate levels do not have a decision making role in the relationship. They also do not transmit sufficient information. - The ignorance at central level of the situation in the field results in them avoiding their responsibility in the name of decentralisation.	- The tools used in the context of the relationship are split up in routine elements of the health system and elements specific to the BELACD management. These instruments function. - There are however no structural tools to assess the relationship and in which both the public and faith-based sector also participate. The evaluations carried out are largely made at the request of the donor or as a self-evaluation by BELACD. There is no public-private concertation.	- The tools are provided by a strict framework of preliminary and continued training, audits and external supervisions as well as reporting requirement for the beneficiary structured. - The level of definition of the obligations is very high and their monitoring strictly set out and respected. There is no participation of the district in this and the lessons learnt by all this are not communicated to them.
Perception	- On the whole, the actors are satisfied with the relationship. The faith-based sector mentions the fact that the State does not always respects its commitments and the non formalisation of the status as district hospital. They point to a certain unwillingness to listen from the public sector. - The problems are more clearly ascribed to the health facility than to the contract itself: in the absence of an operational decentralisation which complicates and slows down the decision making. - Overall a certain mistrust continues to underlie the relationships, and especially from the faith-based sector to the public authorities (corruption, inefficiency, etc.)	- The district public sector seems only partly interested in the contracting relationship, in which it is not involved. The relationship is considered positive but only gets little attention from the administrative authorities. - From their side, the faith-based actors are very negative about the many problems encountered and the lack of response from the public authorities at central and peripheral level: information problems (in particular financial), insufficient and irregular financial allowances, and grants in medicines. Furthermore, some activities are considered as being influenced by a political agenda and going against the interests of the hospital (draining of staff notably). There is therefore a real climate of mistrust of the faith-based peripheral sector towards the public sector and its intentions.	- The perception of the relationship is generally good. This has to be qualified however by: i) The weak commitment by the State which means that most of the burden of the relationship and the activities falls on the shoulders of BELACD. ii) The fact that the achievement of the objectives largely depends on the availability of external sources of financing. iii) The existence of threats (HR problems, lack of financial resources and equipment)) to the survival of the facilities if the donor were to withdraw. iv) A marked standstill in the relationship since end 2006 when the last contract ended. v) The existence of other cases (Doba, Laï) where this risk has already been extensively investigated and has led to a breakdown in relations.	- The beneficiary facilities have an overall positive view of the contracting relations with PEPFAR, which are far different from the ones they keep with their overarching platforms. They are not aware that the latter are often excluded from these contracts. and are not in the loop - The potential adverse effects of the contracts, linked to their focalisation and the importance of the resources at stake, are not denied but largely tempered by the benefits that come with these contracts. - The district authorities have a pragmatic approach in this. They tend to approve the initiatives which are beneficial for the district in as far as these contribute to an improvement in the HIV-AIDS care. - It is clear however that the district only has a fragmented knowledge of the programmes that are implemented in non-government settings, and they do actively approach the donors and beneficiaries to remedy this situation. They are not aware that the MOH is not involved at central level.

SCOPE				
Effects, quality	- For the public sector the balance is generally positive: i) Functionality of the district hospital ii) Reduction of the HToK's costs charged to the patients in accordance with the national health policy iii) Improvement in the health information system. iv) The faith-based sector generally respects its commitments except where its catchment area is concerned (it compensates for the PHC activities that are not carried out by the public health centres ; influx of patients from outside the area as a result of the facility's reputation) - For the faith-based sector: i) Obtaining legitimacy ii) Access to financial resources and grants in aid - although not enough. iii) A certain improvement in the technical collaboration and a better visibility of the 2nd line activities. iv) But a lot of nitpicking linked to the weighty administrative procedures from the MOH (in particular where finances are concerned). v) Difficulties linked to the management of civil servants seconded to HTOK and the demoralizing effect their presence has on the religious staff. vi) Insufficient cooperation from the public health centres, especially for the set up of PHC. vii) The set up of the district organisation contributed to the break up of the PHC activities in the public health zones which no longer fell under the responsibility of HTOK. The dysfunction of the public facilities meant that a great number of its referral patients « illegally» visited the hospital.	- Initially, the contract has contributed to the improvement of the collaboration between the Church and the State. This situation was a result of the good relations and the goodwill which united the main actors from both sides. - Today, there is no real monitoring anymore and the feeling that the DDH works in a setting with ever growing problems. Since there is no response from the State, the quality of care suffers more and more due to a lack of human and financial resources. - The gaps in the contracting document and its vagueness play and important part by denying the hospital an efficient support system. - The many problems raised by the faith-based actors are rather structural than directly linked to the contract. They are a result of important differences in the conditions for doing medical work between the two sectors	- The objectives set out are largely achieved: functionality of the district hospital; development of the district (network of health centres, management and community participation system, set up of a cost recovery mechanism and a system of fixed prices for the patients) ; access to care is improved. - All this is mainly the work of BELACD and its technical and financial commitment: the quasi autonomy of the district of Moïssala shows the disengagement of the STATE and does in fact not stimulate change. - The financial burden of the project is becoming heavier for BELACD as the project progresses: the resources are limited and this is being felt in the quality of the services on offer.	- The contracts achieve their targets thanks to the means (monitoring, evaluation, and accompaniment) in force. - They have important side effects which are linked to the amount of funds put in; the package of measures for monitoring and evaluation; the focus of the activities and the strict nature of the contracts; the important input of skilled human resources required to achieve the targets. - The negative effects are: i) the development of double standards in the facility and the district which causes problems for the integration of the hospitals in the local health system but also for the units and staff that care for HIV-AIDS patients within these facilities ; ii) a very substantial financial dependence from external sources ; iii) a mobilisation of qualified hospital staff in a setting with a chronic shortage of skilled HR for the routine activities of the hospital ; iv) the resulting increase in the administrative workload caused by the monitoring and evaluation activities; v) the lack of flexibility in the use of the funds; - The positive effects lie, besides the set up of a system of HIV-AIDS care, especially in the positive general impact of the contracts on the beneficiary structures: i) in terms of training for some members staff ; ii) development of analytical, anticipation and management skills which can also be used for the routine activities of the hospital; iii) appeal for the population ; iv) improvement of credit worthiness of the facilities with other potential donors

Level of awareness and information	- The level of knowledge and information remains insufficient at peripheral level and in particular with HTOK. This is proof that the decentralised authorities do not play their relay role properly. - The hospital entered the relationship unprepared and has to improvise according to the scant data in its possession. This creates more difficulties as the relationship with the central level leads to many problems which are not resolved by the tools of the contract. The insufficient grasp of the MOH mechanisms and the absence of a privileged interlocutor is a disadvantage for the hospital.	- The actors did not get a preliminary training and are far removed from the ongoing partnership process at central level. The hospital studied has only a fragmented knowledge of the national partnership framework and only partly grasps the contract itself, its mechanisms and implications. - The district does not play its role of relay in this.	- Because of a regular assessment of the experiences in the field, the central level (MOH) does not understand the importance of the difficulties met by the peripheral level in the everyday contracting experiences.	- The State (MOH) and the Church are badly informed about PEPFAR and know almost nothing about the contracting relations that exist on peripheral level. - This is explained by 3 factors: i) The specific approach and opaqueness of the PEPFAR system; ii) A lack of leadership at the MOH ; iii) The fragmentation of the contracting experiences (bilateral relations) whereby information is withheld from the beneficiaries even; - The peripheral level only has scant information, mainly focused on its specific experience. There is no participation of the district health authorities in the relationship we investigated.
Future of the contracting relationship	- 'The theory is fine but the practice needs to be improved'	- The religious actors are convinced of the importance of continuing a contracting relationship with the State. This has to be improved considerably however. In fact, the lack of human and financial resources of the Church does not allow a termination of the existing contracts because it would mean that the facilities would have to close. - This improvement has to come through an upgrade of the existing and future contracts and their adaptation to the decentralised health system.	- The local actors, Church and State, would like a continuation of the relationship. This depends for BELACD on the availability of funds which is threatened by the withdrawal (soon) of the present donor. - The State is no viable alternative. The "subjects" of the contracting relationship (district hospital and health centre staff) are worried about BELACD leaving as well ; - In other places (Laï, Doba), the religious authorities have given up, frustrated by the imbalance of the relationship, the lack of involvement (financial and material) by the State, the superficial nature of the management delegation, undermined by the interventions of the administrative powers.	- The beneficiary facilities want the relationship to continue, especially with contracts which cover treatment. They would however prefer greater flexibility. They are aware of the major risk which a breakdown of the contracts would have on the continuation of the ongoing activities. In this context, the MOH is never seen as a viable alternative. At the moment the continuity of the biggest contract is ensured medium term.

Table 3. SWOT Analysis of the case studies

	CAMEROON	TANZANIA	CHAD	UGANDA
STRENGHTS	- Set up of a framework that is theoretically complete in terms of the partnership policy and contracting tools at central level. - The formalization of the status as district hospital confers a legitimacy to the faith-based facility, especially with the donors. - In spite of its weakness and the difficulties of the cost recovery, the financial support of the State is a 'bonus''. - The signing of the contract has strengthened the collaboration at peripheral level: the hospital is systematically invited to meetings of the district and with the provincial representatives. The staff is invited to training sessions. - In the first stage following the signing, the monitoring of the relationship was carried out.	- There is a strong and dynamic partnership at central level which is stimulated by a motivated interreligious platform. - The contracting experience between the public and faith-based sector goes back a long time and has been systematized nationally.	- The country has a complete and theoretical contracting framework. - The implementation of the contracting strategy was preceded by a major sensitizing campaign for the actors. - The main public and religious actors received an initial training in contracting.	- Dynamic religious and professional platforms - Substantial financial PEPFAR means - The efficiency of the programmes implemented at peripheral level in achieving their objectives - Excellent monitoring and evaluation mechanisms - The ability of the programmes to get their staff interested and committed
WEAKNESSES	- The faith-based platforms are weak and do not fulfil their role as relay between the peripheral and the central level. - There is no central database of the existing contracting experiences and making abstraction of some exceptions, the knowledge of the central level of these matters (MOH and faith-based actors) is extremely fragmented - The whole partnership and contracting process is currently focused on the C2D project and its priorities. - The HTOK contract is not integrated in the new political framework. Its level of specificity is vague and it was never revised. It does not fit in a decentralised setting. - The State insufficiently respects its commitments, particularly in terms of financial means and does not fully play its part in the monitoring and evaluation. - Predominance of the individual contacts in the success and failure of the relations - The positive effects are a result of the legal recognition rather than from the contract.	- Weakness of the MOH partnership unit. - Insufficient decentralisation of the partnership fora. - The contracting experiences at district level are not built on a coherent framework (no partnership nor contracting policy). - Different contract types and generations coexist (DDH, CDH, SA) - Lack of knowledge about the contracting procedures and the specific mechanisms of the contracting relationship.	- The lack of a medical coordinator prevents the Catholic platform from feeding and accompanying the process. - The multiplication of public referral facilities (DOSS- DONG, Ministry of Plan, Ministry of Finances, etc.) - The contracting relationship investigated was not integrated in the national framework: in particular, it does not respect the decentralization principles of the health system. - The financial and operational burden of the contracting relationship rests mainly on the shoulders of the faith-based contracting parties. - The results have not been obtained through collaboration and participation but through forced substitution.	- The absence of a partnership and contracting relationship between the MOH and the Church. - The MOH and the Church at central level are not involved. - The selection of an ecumenical interlocutor at central level who is legitimized by the faith-based platforms. - The information disseminated by the faith-based sector at public level (and in particular through reports) does not reach the central level. It is proof and symptom of the dysfunction of the health decentralization. - The burden the PEPFAR contracts impose on the facilities in terms of workload and input of skilled staff. - The inflexible and largely foreign nature of the contracts. - The development of double standards in the hospitals and more widely in the district health system: means, methods, quality of care.

OPPORTUNITIES	- The implementation of a legal framework is ongoing and the elements that are being developed are likely - if they are fine-tuned to the previous experiences - to improve the monitoring of the relationship. - Available or expected funds - Consensus of the religious actors	- The development of better defined service agreements (SA), which include performance indicators: these contracts, if they work, could lead to the long awaited revision of the DDH contracts. - Awareness of the shortcomings in the relationship between the management team of the hospital and the Church, thanks to the encouragement of individuals. - The will of the central level to decentralise the partnership process	- The possible restoration of the post of health coordinator for the faith-based platform. - The planning of a workshop for evaluating the experiences is ongoing. It should bring together all the actors: there is a real will at central level (public and faith-based) to take stock. Even if this is not sufficient, it would allow drawing attention to the difficulties that exist in order to find solutions to remedy the situation.	- Positive contamination effect of the contracts on the general activities of the hospital: change of the professional culture, development of the skills of the staff; get legitimacy (HIS) with new donors.
THREATS	- The earlier contracting experiences are not integrated in the political framework that was developed recently (in particular the revision of the contracts according to the partnership policy and the contracting tools) and carries the risk of further isolating the facilities involved in it.	- The local public authorities tend to set up various hospitals that compete with the existing DDH. In general the State has a policy of '1 (public) health centre per village', which feeds this type of trend and risks to limit even more the means allocated to the faith-based sector. - Faced with these difficulties, the Churches of Kagera have started to close health centres and intend to threaten to close the DDH in order to be heard.	- Some contracts have (Laï) been or threaten to be (Doba) terminated. - The support of the donors to the faith-based facilities is being drastically reduced at central as well as on peripheral level. - The BELACD of Sarh fulfils the role of district manager for the district of Moïssala, although there is no contracting framework since 2006. - The State's disengagement.	- The risk of a distortion of hospital activities to the detriment of routine tasks. - Tendency of some beneficiary facilities to not communicate with their main platforms about the contracts signed with PEPFAR and other important donors. - The effect of a comparison at peripheral level between the PEPFAR contracts and the difficulties encountered in the relationship with the MOH can worsen the detachment of the hospitals from the partnership and contracting projects of the faith-based platforms.

The contracting experiences between public sector and faith-based facilities all display (or show) substantial difficulties

The research team was shocked by the extent and seriousness of the crisis that affects the contracting process between the State and the faith-based health sector; this sorry state of affairs pertains more or less to all the countries in this study, at least to some extent. This situation is even more paradoxical as it occurs within a general partnership consensus context. The inevitable character of the collaboration, the added value of its formalization are not only admitted but demanded by both sectors and all levels of the hierarchy.
The seriousness of the matter is in part due to its discrete, almost hidden nature: either there is no general awareness on central level (Uganda) or the awareness manifests itself mainly on an operational implementation level (districts). In any case, the awareness remains largely confined to the faith-based sector and is more evidence of a shaky partnership.
The size and escalation of the crisis are worrying: without rapid intervention, the existing experiments might fail in the medium or even short term. Hence, the crisis could no doubt call into question the efforts[167] put in at central level in most countries.

The crisis of the partnership and contracting experiences fits in with the general crisis in the faith-based sector and continues to feed it

The financial crisis is accompanied everywhere by a crisis in human resources. Although the state admits that these difficulties exist, the current contracting experiments provide at best a very inadequate answer. The awareness of this crisis is greater than the awareness of a partnership but nowhere is the crisis dealt with satisfactorily. In fact to the outside world, the Church's health system seems to be a stable feature in the landscape, an asset, a system that works: but this feeling is partly an illusion covering up the real problems.

The State insufficiently respects its partnership commitments

Whatever the development stage of a contracting framework on central level, the service agreements all have this problem, albeit to different degrees. This issue has a particular influence on financial resources and equipment which are so needed by the faith-based facilities in crisis. The support of the State remains structurally insufficient and grapples with a number of difficulties: losses, leakage, delays, weighty procedures, etc. The public sector actors and managers are honest and straightforward about these problems but they do not fully comprehend the scope of the shortcomings. Although they are aware that problems exist, this does not result in (sufficient) remedying actions.

Monitoring mechanisms and their performance leave a lot to be desired

If the crisis in Church-State contracting experiences in health matters is largely ignored (certainly its size), it is because the existing agreements are not or badly followed up. There is a systematic absence of operational monitoring and evaluation mechanisms: specific supervision of the contract and its obligations is missing and contracting tools that might have been planned[168] in this respect do not function properly; at best, difficulties are recognized but no

[167] Definition of specific policies: set up of formalized cooperation frameworks; development of partnership for a.
[168] Steering committees, in particular when they exist.

structural solution is put forward. This situation reflects form problems which mark all service agreements we investigated on peripheral level, but also capacity and resource problems: monitoring and evaluation is a weak area for public facilities, not just with respect to contracting relationships with the private not for profit sector.

Contracting experiences develop in a setting full of limitations and unequal distribution of knowledge

We were surprised to discover the lack of preparation that characterizes the development of most contracting arrangements. Often the public and private actors are very ignorant when starting the formalization of the relations. Specific training, when it is given, generally comes later rather than before the set up of the experiment, it also targets mainly the central level managers.

Generally, the development and implementation of contracting partnership policies and initiatives do not fully draw the lessons of the past

The lessons of the past are not really learnt and are largely ignored when it comes to the development of partnership policies, resulting in all cases in the coexistence of often contradictory models. The contracting landscape is diverse, composed of diverse historical strata which were never synthesised. In addition, the circulation of experiences and knowhow in this area remains very limited. In short, there is no collective, centralized and institutionalized record: the knowledge and the documentation itself of the fragmented and burgeoning experiences[169] remain the work of individuals. The risk is that when the individuals disappear from the scene, the information goes with them.

The balkanization of the contracting landscape and the dysfunction of the formal partnership experiences at peripheral level expose the imperfection of a decentralization process

The difficulties met are a result of the poorly functioning communication and authority lines between central, intermediate and peripheral level. The decentralization policy started in all countries around the the end of the 90s, early 2000s but was undermined by the fact that it was never fully implemented. This poor implementation is reflected by bickering between the various levels of authority, the persistence of relationship mechanisms inherited from the centralization period and the difficult information flow. At worst, the regulatory frameworks and the discourse coming from the central level are just rhetoric, an empty shell, when put next to the real level of knowledge, assimilation and implementation at peripheral level. The contracting experiences at the peripheral level are directly affected by this situation; the dichotomy between central and peripheral level greatly weakens the follow up opportunities of the arrangements and the set up of structural solutions for the difficulties met. It creates confusion about the identity of the legal authorities responsible for managing the relationship for the public part.
This context of institutional weakness explains the predominant role played (in a positive or negative sense) at all levels by individuals. In general, the quality of the partnership, the resolution or (in other cases) aggravation of difficulties all depend on the degree of involvement and leadership of the respective actors of the faith-based and public sector, as well as on their networks. Also the quality of the relations between them is a relevant factor.

[169] In none of the cases researched, there is an exhaustive database which gives access to all the regulations, models and contract documents signed or in force.

The particular case of Uganda and the analysis of contracts between PEPFAR and the faith-based hospitals provide a valuable and contrary point of reference

It is quite important to stress first the negative aspects of these bilateral contracts: the opaqueness of the systems and mechanisms which govern them, their exogenous nature and their targeting on peripheral level are all obstacles to the appropriation of these experiences by the central public and faith-based sectors. This appropriation is also hampered by the power or even impunity of the donors due to the huge amount of resources involved.
The importance of these resources, the fact that these interventions apply strict targeting methods as well as their mobilization of a substantial amount of human and material resources of beneficiaries could certainly distort matters. All this is even more serious because the targeted facilities are weak and jeopardized by the global crisis in the faith-based health sector. Besides, these demanding excellence contracts generate double standards that are likely to have a negative influence on the integration process of beneficiary structures in the national health system.
In spite of all this, faith-based hospitals tend to look favourably upon these contracts: they appreciate their degree of specificity and predictability, the provision and quality of monitoring, steering and evaluation mechanisms and activities which characterize them. Their efficiency and the donors' respect of commitments are other aspects which are highly valued by the beneficiaries. The set up usually leads to local capacity strengthening which (in spite of the focalization of the arrangements) tends to have a positive contaminating effect: all the activities of the facilities are often positively affected over time.

The analysis of the positive aspects of these new types of relationships sheds negative light on the contracting relationships between the faith-based facilities and the state

The aspects which, in the eyes of the beneficiary structures, explain the efficient functioning of the PEPFAR contracts might provide interesting avenues for a rereading and improvement of the contracting relations between the Church and the State in the health sector.
The contracting approach is very different for the two types of relations. In the case of contracts between the public health sector and the faith-based facilities, great efforts are made during the preparation stages of the set up but these seem to stop when the real relationship begins. The PEPFAR contracts on the contrary keep up the logic of the contracting process, and the relationship is continuously encouraged and stimulated: once the contract is signed, the collaboration efforts do not stop but they are continued and strengthened, notably by the day to day monitoring, guidance and critical evaluation of the relationship and the objectives assigned.

The existing arrangements confirm a factual situation rather than creating conditions for development and strengthening of the relationship on the basis of innovative objectives

The formalized relations are often static. For the Church, what matters is basically only the recognition of the role its institutions play in the national health system. The relationship appears imbalanced as the arrangements bring far more relevant benefits for the State (respect of the national health policy, inclusion of faith-based facilities in the national health map and ensuring of coverage in the areas concerned). In more extreme cases, the set up of real development projects (Chad) takes place so that the State benefits while not participating.

The situation displays the real risk of disintegration of the partnership between the public and faith-based sector in health in Sub-Saharan Africa in the future

Due to the difficulties met, none of the parties involved boast about the partnership: the public authorities are aware of their shortcomings and admit that much can be improved. The religious actors tend to become very bitter; the difficulties experienced often lead to a certain degree of mistrust, in certain cases even bitter disillusionment and resignation. These disappointing experiences sometimes make the religious actors in the district prefer bilateral relations with external donors - with direct but sometimes not sustainable results; this preference is accompanied by a trend to distance themselves from the central religious coordination platforms that are involved in the development of partnerships with the state; the breakdown of relations already means that certain peripheral facilities or organizations move away from signed contracts because they do not bring in enough resources to ensure implementation and hence worsen the effects of the crisis in the sector. Certain churches already call into question the very notion of partnership or else the conditions set by the partnership for participating in the health sector: in Uganda, the risk of a break up as a result of the freeze of the partnership process is very real.

Recommendations

For international actors: donors and NGOs

The past should not be overlooked when preparing for the future. **The partnership between the public and faith-based health sector**[170] **should be strengthened through the set up of an institutional collective memory**: this should synthesise the current situation and provide a centralized historical archive of the frameworks, contracting documents and expertise of each country. Such an approach should be planned in the near future to prevent documents and testimonies that are key to the understanding and analysis of earlier experiences[171] from disappearing. Documentation and information centres could be created where all actors from the Public Private Partnerships are represented on a pluralistic and unbiased basis.These centres should have a very broad mandate, associating public and private not for profit actors[172] and giving them the legitimacy needed for "open and exhaustive" access to the relevant data. They should be given a mission of public interest and have a legal status and guarantee of independence against possible interference, all of whom would help to ensure total transparency and access to the collected data for the greater public[173]. In addition, collaboration with local academic institutions[174] could open interesting research possibilities.

In a more distant future, these country resource centres could form the basis of **a Pan-African information and exchange network for PPP and contracting**. They could act for example as an internet forum such as E-Drugs and E-Med[175] in the field of medicines and include and international database. Before this can be set up, country databases have to be created on the basis of more or less compatible models and systems.

It remains essential as for now to respond to the specific training needs of the field actors. Contracting workshops could thus be regularly organized upon request. They should have a content adapted to the local situation and the level and role of the participants in the contracting process. The set-up of such workshops could benefit from the input from local faith-based platforms[176]. It is also essential that they are organized in consultation with the Ministry of Health and systematically involve public and religious actors: moreover, besides a training opportunity, these events could also become a platform for dialogue and participate in the dissemination of experiences and their perception.

For the field: public and religious actors

The streamlining of the contracting landscape should be a priority in all the study countries. The monitoring and evaluation, and eventually the success of existing contracting experiences requires that they be adapted to a coherent and legible framework at all levels of the health system. Besides the integration of all the existing relationships in the national framework developed (contracting policy, framework agreement models and service agreements), this harmonization should be an ongoing process, through regular revisions of the contracting documents. This approach, not pursued at the moment, is one of the means to overcome the

[170] And more extensively, the private not for profit sector.
[171] Tanzania, in the 70s.
[172] At different levels of the hierarchy.
[173] Public and private decision makers, operational actors, national coordination facilities and external support, researchers.
[174] The Schools of Public Health of local public and/or faith-based universities could constitute interesting networks. Makerere School of Public Health in Uganda is such an example.
[175] *cf.* www.essentialdrugs.org
[176] Organizations such as AMCES in Benin, UCMB and UPMB in Uganda, CSSC in Tanzania, UNAD and BELACD in Chad are very experienced in training actors of the faith-based networks (and often also of the public sector). Their links with the field make them indispensable networks for the definition of needs to consider.

gap between the framework of contracting relations and developments in the health policy. In the short term the harmonisation of the experiences would allow to redefine unambiguously the competent levels of authority for the contracts that are rather blurred now as a result of the decentralization process.

Specific recommendations per country

In Cameroon

The first question seems to concern the integration of the contracting experiences outside C2D in the newly developed partnership and contractual framework. This necessitates better tracing of the contracts and their concentration in one place: at the moment, the contracts are to be found in as many different places as their controlling public authorities i.e. a variety of vertical programmes, the Directorate of Cooperation, the minister's cabinet, etc.

As a result, there is not a single body, at the Ministry (DCOOP) nor on the denominational side (OCASC, CEPCA for the hospitals and their respective networks), that seems able to put a figure on the existing protocols. Integrating these contracts - even through revision - in the recently developed plans, would ideally enable drawing up an exact overview and typology and ensure systematic filing.

This step is even more needed since attention has been turned away from these experiments by the implementation of the C2D: outside the framework, the actors of earlier protocols in the private not for profit sector (HTok) run a strong risk of facing ever greater difficulties in finding structural answers to the problems they meet. On top of everything else, they only have a fragmented knowledge of what is going on and therefore only limited means of defending their own case. It is obvious moreover that contracts like the Tokombéré contract merit a review and the integration of proper monitoring and evaluation mechanisms. The notions of performance introduced by the new partnership strategy and the convention models are a great improvement and the earlier protocols could greatly benefit from these.

The reintegration of these experiments in the present process should be advocated with the denominational platforms and the MOH; if not possible, their future integration should be scheduled. Where the process and its implementation remain too concentrated on a national level, decentralisation (partnership on intermediate and peripheral level) would allow the uniform dissemination of information and help the actors of earlier protocols find the means for integration with their controlling authorities.

It is moreover essential to take into account the issue of the government's real support to its faith-based facilities contracting partners. In this respect, Tokombéré is the result of an exceptional situation. It would be dangerous to generalize this case to the rest of the sector: very few facilities benefit from regular external support like in our case study. It is obvious that the financial crisis affecting the faith-based sector (and proved by the debt levels identified through the C2D[177] project) has even more important implications on the Church's ability to operate and maintain the majority of peripheral facilities if the State only partly respects its commitments: **a simplification of financial support mechanisms, their transparency and knowledge by the beneficiary facilities** are important prerequisites for improving the situation. It is moreover **essential that the level of support, its limits and conditions are clearly pointed out in the contracts**. This is only partly the case in the contracting documents signed outside the C2D project.

Also, the harmonisation of the contracting landscape needs to be accompanied by a **clarification of the respective role of the central, intermediate and peripheral levels of the public health authorities.** It is one of the key elements in the operation and improvement of the support mechanisms of the State and certainly dependent on a **continuation of the decentralisation process** initiated in 1996.

[177] FINORG, Definition of the operational conditions of contracting relationships between the actors in the Cameroon health sector - Final report IV, 2004.

In Tanzania

The **development of new DDH contracts and the systematic revision of existing contracts** is planned by the PPP Technical Working Group but cannot be carried out in the short term due to a lack of resources. Therefore we have to wait for a standardization of the present agreements. It seems rather urgent that this project becomes operational in order to adjust all experiments to the regulatory framework (decentralisation, PPP) and ensure proper methods of monitoring and evaluation. This is a prerequisite if real threats to the sustainability of the partnership are to be avoided. According to us, this process should take place parallel with the dissemination of operational contracting experiences that began when the Service Agreements were put in place. Awaiting their impact in a geographic setting as large as Tanzania and keeping in mind the limitations of the available human and financial resources would certainly put off their implementation for many more years.

A review of the conditions for allocating public resources to DDH hospitals ought to accompany the standardization of the agreements: the support for the DDH of the first generation and the Voluntary Agencies is currently often calculated on databases that are often out of date and not reflecting the reality of the field (particularly the number of beds). The viability of the facilities depends in part on such a revision and the opportunity to plan their budget on transparent databases: it is therefore imperative that they get information about the amount and distribution of support committed by the central or the local level.

The government has begun to implement its plan for improving the health services through a programme of primary care (MMAM[178]). The aim is to bring the health services closer to the people: "We intend to reach the rural population as they represent 80% of the residents and they are the ones who do not have access to health services; we hope to achieve access for each village by 2017". (Declaration of the Health Minister, Pr. David Mwakyusa during his inauguration speech at the 71st TCMA assembly). A considerable number of field actors in the faith-based sector fear the emphasis thus put on the development of public health structures at the lower administrative levels scale, as it could eventually endanger the part of the budget reserved for the faith-based facilities.

The capacity of the CSSC to intervene efficiently as a lobby -organisation in the partnership issue is essential here. Strengthening this capacity means that the organisation can improve the level of its assessment of current experiments and obtain concrete data to bolster its case on central level. Without any doubt this will happen through systematic analysis of the present experiments and the acceleration of the decentralization process of CSSC through zonal coordinations: this coordination remains problematic because of the vastness of the territory to be covered and the limitations in terms of human resources - the coordinators are only employed part-time, a situation which should soon be corrected by the appointment of a permanent secretary.

In this sense, the decentralisation of the partnership fora, planned by CSSC through the zonal delegations could contribute to a better understanding of the reality in the field and could on peripheral level advance the climate of cooperation that exists on central level. The fora are also a potential tool for improving the knowledge of the actors. It is striking for example that CSSC is an unknown acronym for the local administrative authorities in the Karagwe district! The (newly created) Afya Mtandao website[179] could in due time become an instrument for collecting data with regard to the contracting experiences, if it is actively consulted and exploited by the field actors. At the very least it is an interesting effort to stimulate exchange between the field actors.

The strengthening of the partnership and the capacity of the faith-based authorities to actively participate in the health policy decisions taken at local level also necessitates better representation of these authorities in the decision taking bodies of the district. This representation and involvement remain for the moment dependent on the type of agreement

[178] Mpango wa Maendeleo ya Yfya ya Msingi (MMAM).
[179] www.afyamtandao.org

signed with the public authority: contracts of the first generation are signed at the central level, but the administrative split up and definition of representative bodies are by now made deficient by the decentralisation policy. The ignorance of the regulatory framework in force induces an underrepresentation of faith-based actors in the existing organs.

We may well wonder finally whether the harmonisation of the situation should not be achieved through the set up of a consistent regulatory framework specific to the central level: the formulation of a Contracting Policy (or Partnership Policy) as such, on the condition of being regularly adjusted to possible changes in the regulatory context, would doubtlessly allow greater visibility for the principle and the facilitation of its acceptance by local authorities. In the current situation, the fragmentation of the principles within the body of documents and declarations is one of the causes of the sustained ignorance of the mechanisms and principles governing the collaboration between the State and the private sector.

In Chad

It is very unlikely that the State on its own is able to resolve the difficulties identified through the existing experiences in the medium term. Hence, the restricted budget and the important national shortage of qualified staff make it indispensable to **integrate the contracts in a long term external aid policy**. The ability of the facilities and organisations to fulfil their part in the contracting arrangements obviously depends on the availability of adequate means. The amount of resources available is currently very much undermined by the operational disengagement of the State and the diminishing influence of traditional sources of support for the Church. At stake here are the sheer existence (and thus survival) of the faith-based health structures as well as the quality of care they provide.

More specifically, the key role played by the *Union Nationale des Associations Diocésaines* (UNAD) in coordinating the BELACDs and representing the interests and advocating for the faith-based sector with the State and international organisations can only be assured if the organisation has a functional and dynamic medical coordinator at its disposal. The restoration of this post, abolished as a result of a lack of human and financial means, is more than urgent as the examples of Doba and Donomanga prove. There is a real risk that the faith-based organisations withdraw from the contracts at local level if there are no additional external means available to them.

It is furthermore essential to harmonize the contracting landscape by systematically **integrating all experiences from before 2001 in a centrally defined contracting framework.** This should be achieved through revision, negotiation and the signing of new agreements. It is also important that primary and secondary contracts (objectives of the public-faith-based relationship on the one hand and provision of external financial and technical means on the other) are clearly distinguished from each other in order to guarantee the sustainability of both the contracting relationship and the joint search for means to continue in spite of the uncertainty of external sources of support.

An **overall assessment of the ongoing experiments in Chad** is needed to be able to judge the representativeness of the conclusions of this report and the possible need to modify the monitoring and evaluation mechanisms of the contracting relationships.

In Uganda

The research team found that in Uganda one of the main difficulties in the contracts between the faith-based health sector and the PEPFAR recipients lies in the actors' ignorance of one another. This can be observed at all levels of the health sector and is also the case between the State, the Church and the donors. This lack of mutual understanding is a result of the opaqueness of the donor's implementation mechanisms, the focus on the operational level of the district, the lack of a sufficiently high degree of professionalism of the facilities and the Church authorities in the district and the fact that the decentralisation process is not yet completed.

It seems thus essential that the faith-based medical platforms continue to **look proactively for a way of getting together, if not with the higher echelons of the PEPFAR representations, then at least with the main recipients effectively involved in the contracting relations with the health facilities of the various Church networks**. It seems clear that quite a number of PEPFAR's principal recipients are not aware of the scope and the real importance of the role played by the different *bureaus* in the health facilities. The benefit of such a rapprochement is shown by the specific case of CRS: the set up of a dialogue with the faith-based platforms has in fact permitted to partly reorient the approach of the donors and show some consideration for the preoccupations of the sector. These closer relationships would no doubt lead to a greater understanding by the faith-based platforms of the real benefits that their facilities can draw from their relationship with PEPFAR. It would allow them to steer these and exploit them in the larger partnership context of the MOH and the Church in health.

But these **platforms also have a preventive role to play with the facilities of the network**, in order to limit the real risk of 'bilateral' contracts signed with PEPFAR: in particular by integrating - with full knowledge of the facts - the aspect of technical support to the hospitals in this type of contract. This support could be translated into specific and regular training in the contracting process and through more specific activities for the development of the facilities' negotiation skills. The example of Virika Catholic Hospital in Fort Portal shows in fact that the hospitals benefit from a certain room for negotiation when such contracts are set up (with CRS in this instance), but only on condition that they can hold solid and well-argued discussions with the donor. The development of specific skills certainly has to be integrated in the policy of capacity strengthening and professionalism of the sector in which UCMB and UPMB are already involved; it also has to involve the Church authorities and encourage the development of professional and functional diocesan coordination bodies, able of efficiently guiding the implementation of possible contracting arrangements in the facilities.

Furthermore, in the specific case of PEPFAR arrangements, it is also imperative that **a successful dialogue between the MOH and the faith-based platforms** be restarted. This should unblock the contracting process. Hence, the public authorities need to become aware very soon of the financial and human resources crisis that the faith-based sector is facing. The research team hopes that this study will make a contribution to this and support the case that the Medical bureaus have been making for several years now. Not only the survival of a sector is at stake here, but also the preservation and further development of the national health coverage.

General conclusion: take-home messages

1. Contracting between faith-based district hospitals and public health authorities in Africa faces a crisis. In spite of the wide variety of contexts and experiences, the different case studies show that contracting between the State and faith-based district health sector has run into great difficulties.

To make matters worse, there is no general awareness of the crisis, certainly not among the public sector actors. Unless correcting measures are taken, this almost hidden crisis risks to jeopardize in the medium-term the important contribution which the faith-based facilities make to the provision of care in Africa.

2. The dysfunction of the contracting experiences can be explained by a number of factors: the lack of information and inadequate preparation of the actors, the almost systematic absence of support mechanisms adapted to the reality and needs of the field, the lack of monitoring and evaluation systems for the contracting experiences and the fact that a management culture, that would integrate the lessons of the past in matters of contracting in current policies and tools, is lacking. Finally, the State does not always respect its commitments.

3. The contracts between the Presidential Emergency Plan for Aids Relief (PEPFAR) and the faith-based hospitals in Uganda provide a valuable and contrary point of reference. Although we do not underestimate the risk of a selective and vertical approach in contracting, nor do we intend to hide the fact that public and faith-based central government structures in health are mostly bypassed by PEPFAR, these contracts offer interesting avenues for improving "classic" contracting relations between the public and faith-based sector. Indeed, these contracts are characterized by a great extent of specificity and predictability, by the quality and sustainability of the monitoring, steering and evaluation mechanisms, and, last but not least, by the donor's respect for commitments. The management of the district faith-based hospitals appreciates these positive aspects.

4. The results of this study should be presented in each country (Cameroon, Tanzania, Chad, Uganda) if we want to achieve relevant and sustainable changes in the field. This dissemination process should be well prepared and steered and has to involve actors from all sectors and levels: the public and religious health authorities at central and peripheral level, the care providers and the community representatives.

5. Generally the field actors involved in the contracting processes feel the necessity for steady, close and personalized support, adapted to the local context. Without any doubt, this observation can also be made in other than the countries and cases studied. Consequently, the elaboration of technical manuals, such as the one developed by Medicus Mundi International (MMI) in 2003, is not very useful.

This report is based on a complete but non exhaustive analysis of collected information. The scope of these data largely exceeded the expectations of the research team. It quickly became obvious that it was impossible to analyse all data within the deadline set for the report unless we limited the number of hypotheses to be tested and the methodology applied. The recourse to specific software for qualitative analysis, which was initially foreseen, also had to be postponed.

We are faced with a wealth of promising data. It would be regrettable if this corpus was cast aside after this report. Hence, we plan to further exploit this information in the months and years to come. Several avenues are open to us: either more systematic data collection for one of the study countries (monograph), or adding other experiences likely to shed new light on the

case studies, or also processing the data with other methods, etc. These research lines and the feasibility of the project will be explored in 2009.

Annex: questionnaire survey

Knowledge, distribution and use of the MMI contracting guidelines (2003)

At the request of MMI, and in parallel with the general research, we conducted a survey to advise the organisation about the future of the Methodological Guide to Contracting published in 2003[180]. We capitalized on the field visits to interview a limited number of key participants about their knowledge, the dissemination and the use(fulness) of the MMI guide. We also wanted to assess the guide's impact and whether it was worth all the efforts which MMI and CIDR had put into this. If not, some complementary actions (re-dissemination, revision, etc.) would be considered. As the subject is rather loosely linked to the general subject of the study, we decided to treat the issue separately.

METHODOLOGY

The survey was carried out in the form of a structured questionnaire, based on a standardized grid[181] with 16 questions. These were classified according to 4 priority axes (dissemination, knowledge, use and usefulness) and 2 sections: i) a first section addressed participants who knew the MMI guide and were likely to have used it ; ii) a second section addressed the users of the guide and the « naïve" participants.

Therefore the first series of questions dealt exclusively with the guide itself, while the second set of questions addressed other forms of support which the participants had benefited from as a result of the contracting process: the aim was to isolate possible shortcomings of the MMI guide and provide guidelines for a possible modification of the support policy as implemented by MMI up to now.

The participants have mainly been selected in 2 of the 4 study countries: the workload for the main research subject (due to the conduction of interviews and the collection of documents) only allowed us to conduct the survey in countries where the main researcher could get the help of an extra interviewer. This was the case in Uganda where the help of the *Uganda Catholic Medical Bureau* has allowed us to recruit a local assistant to carry out the survey[182] and in Cameroon, where the field work was carried out together with Dr Basile Keugoung, former District Chief Medical Officer (MCD) in Méri (Extreme North Province) and PhD student at the Institute of Tropical Medicine in Antwerp. Two extra participants have furthermore been interviewed in Chad.

The organizations and people in this research were selected because of their involvement or experience in matters of Public-Private health contracting. The private sector is represented by not for profit organizations only, in accordance with the target public of the manual. We also tried to get in touch with a staff member of the local WHO representation in each country for two reasons: i) The link that MMI maintains with this organisation and ii) the role of information carrier that WHO representations are supposed to play at local level. The participants represent the central level (faith-based platforms, NGOs, MOH staff, WHO), the intermediate level (diocesan health coordinators, church leaders) and local actors (faith-based hospitals, local district health authorities). In total, 25 questionnaires were collected.

[180] MMI-CIDR. Guide for implementing contracting in a district health facility in the context of a partnership between the MOH and a NGO - 2 parts, 2003.
[181] Cf. Tome II, Annex 1.
[182] Mr. Andrew Adrian Mukiibi.

In Uganda

Mr. A. Mukiibi conducted the surveys by questionnaire after preliminary training by (and in direct collaboration with) the main researcher. In this context, the target audience came from the central and peripheral level of the health pyramid. For the central level this included the faith-based medical platforms, a certain number of representatives of the MOH, the national representatives of various international and local NGOs and the local WHO representation. At peripheral level the Chief Medical officers of the various Catholic and Protestant hospitals were contacted.

The results of the Uganda survey largely directed the selection of the Cameroon participants and more in particular led to a clearer targeting of the central level, theoretically the primary focus of information dissemination.

In Cameroon

The survey was carried out by the main researcher and Dr. Keugoung. The central, intermediate and peripheral level has been involved but the main emphasis was put on the central level. The specificity of the Cameroon context has been respected through the selection of participants from the three main (faith-based) government partners: OCASC, CEPCA and FALC, which are closely involved in the contracting policy initiated by the C2D project. CNLS has also been selected for the survey, as vertical programmes are linked by contract to a substantial number of health facilities, notably in the fight against HIV-AIDS.

On peripheral level, for the sake of convenience only Tokombéré hospital was selected. The route taken by the research team to Yaoundé and then Tokombéré allowed us to diversify peripheral level representation: the health coordinators of three dioceses in the Extreme North of Cameroon (Maroua, Garoua and N'gaoundéré) were also included.

The Muslims were not interviewed because of lack of time and their limited involvement in the operational side of the health sector. Taking into account the results obtained at the (non faith-based) NGOs in Uganda, the research team decided not to include these in the Cameroon study.

In Chad

The absence of an extra survey assistant and the short duration of the field mission only allowed us to conduct two questionnaire surveys, both of them on intermediate level, with 2 *Bureaux d'Etude et de Liaison des Activités Caritatives et de développement* (BELACD) in the South of the country. The collected questionnaires both revealed that the guide is well known: this is mainly due to the organisation by UNAD in 2004 of a training workshop on contracting; the workshop was based on the MMI guidelines and aimed at faith-based actors. We therefore decided to include them in our analysis in spite of the non-representativeness of the sample: the analysis of the details collected would allow us - more so than in the case of Cameroon and Uganda - to analyse the strengths and weaknesses of the guide.

The analysis of the results has been carried out on the basis of a synoptic grid which classifies the responses per country and intervention level for each axis of the survey. It combines quantitative (frequency of some aspects, in particular the reported knowledge, use and usefulness of the Methodological guide of MMI) as well as qualitative aspects (strengths and weaknesses of the guide and other forms of contracting used or wished by the participants).

RESULTS

Although the survey has been carried out on a limited sample of countries and participants, the univocal nature of the collected results makes representativeness nevertheless likely: only 17% of the interrogated people know the MMI guide.

The analysis of the questionnaires for Cameroon and Uganda reveals clearly the limitations of the 2003 manual. The two main questions mainly got a negative answer: the manual is not generally known and a fortiori not used. For participants at peripheral level, the people

theoretically targeted by the document, the figure (of negative answers) is about 100%. The few people that knew and used the manual were directly involved with MMI. It is interesting that the workshop organized by AMCES in Benin in May 2008 did not use the manual, although it had been handed out to the participants. None of the people of the WHO-AFRO representations had heard of the guide.

This assessment may be tempered by the results obtained in Chad. The guide was used there for a national training workshop[183]. Chad was the only country in the study where (some) participants at intermediate/peripheral level stated that they knew this tool.

Making abstraction of this country, it is difficult to assess the real usefulness of the MMI Contracting guidelines: based on the experiences of the interviewees, this question could not be decisively answered.

Notwithstanding, we have been able to formulate three general conclusions:

– The guide is not known and remains therefore unused
– Knowledge and use are generally restricted to the central level;
– The first line people responsible for dissemination do not distribute the information.

Asked about the guideline's quality, the interviewees distinguished two main categories of positive aspects: i) The concern for exhaustiveness (completeness) and ii) the illustration provided by the case studies in Volume II of the document. These observations are mainly made by participants at central level. Nobody was able to be more specific about the document's content.

The criticism mainly concerned the ease of use:

i) The document is addressed to well-informed readers able to grasp the technical and legal language; as a result, the document's accessibility and comprehension are questionable, in particular for potential users on peripheral level.

ii) The size of the document is considered an obstacle to its use: time constraints and difficulty in understanding make it unlikely that an individual will use it, certainly not on the peripheral level.

Whether it concerns observations made by the interviewees who know the guide or hypotheses formulated in general on the usefulness of a guide as a support tool to contracting: i) the actors recognize that the « principle is good » but ii) emphasize that providing a guide does not suffice, even more so if the tool is not accompanied by a structured introduction (training workshop).

When encouraged to formulate suggestions for improving the manual and to state their opinion about the use and usefulness of other support tools, the people questioned agreed on three main issues:

i) A Guide such as the MMI's Contracting Guidelines is only worthwhile if it is properly introduced, through a training workshop for example.

ii) Most of the participants only have limited experience and knowledge of contracting. Training is considered the most efficient and useful form of support. Reference is mainly made to basic training which equips the partnership actors according to their intervention level.

iii) The more informal role of exchanges of experience is emphasized. However these exchanges are rare outside the central level: informal meetings, conferences, etc.

[183] *Atelier sur la contractualisation des associations de l'UNAD avec le Ministère de la Santé Publique au Tchad*. UNAD-CIDR, N'Djaména, November 2004.

Furthermore, two additional comments can be made:

i) The manual, published in 2003, is out of date. Contracting is a dynamic process which evolves rapidly; a number of "new" elements are not sufficiently taken into account in the current document:

- The dominant contracting method tends to follow the Performance Contract model[184] which the manual does not deal with as such. Public-private faith-based contracting, although strictly speaking still not following the principles of this model, is in some countries well on its way to adopt them (Tanzania, Cameroon);
- The new types of contracting partnerships developed through bilateral relations between the hospitals and "global" financing initiatives (in particular PEPFAR[185]) raise a substantial number of questions which need a specific approach. These types of initiatives, developed mostly after 2003, are not included in the guide;
- The case studies mentioned are old: their content has probably evolved; experiences that occurred after 2003 might considerably enrich the text;
- The private not for profit sector is not included in the document although it clearly is a part of the strategies presently developed by the public sector in the countries of the study.

ii) Second, we can question the validity of a document that has a wide scope:

- The situation of the faith-based sector has to be considered separately from the situation of other non profit organizations (NGOs), notably international ones;
- In fact, NGOs and other international organisations tend to implement their own rules in contracting matters and more generally in Public Private Partnerships (PPP). It is unlikely that these organizations use or disseminate the guide to their local partners;
- It is difficult to start from a general theory and then apply it to all the specific situations: the field no longer lacks experiences: even if unorganized, they exist and have to be taken into account. A tailor-made approach adapted to the situation in each country is advisable but requires a profound knowledge of this local situation;
- An exhaustive document is mainly interesting for a certain type of users: policy makers.

RECOMMENDATIONS TO MMI

It is important that MMI re-evaluates the 2003 manual as follows:

- The tool can only become functional if 1) it includes an introduction-training and 2) if this training is regularly repeated: frequent changes in the organization chart (alternating Ministries in particular) carry the risk of loss of information. The constraints of these alternations and the unequal distribution of skills make the transmission of knowledge unlikely when people change jobs.
- The present guide cannot be a dynamic policy document or worthy of dissemination unless it is substantially revised. Indeed, a regular revision should be scheduled in order to keep it up to date (new types of contracts and related problems, update of the case studies, etc.).

The workload and cost of this approach seem not justified in view of the expected use, so we have to think of an alternative plan:

- The development of a more accessible manual to be used by the health facilities and their owners (non specialists) and focusing on the main principles, the risks and pitfalls of contracting.
- The organization of annual training workshops and "updates", taking into account the local situation. This form of support could be carried out jointly with specialist organizations (such as CIDR[186]) and rely on the local structures (religious platforms and their decentralized representations, in particular also the MOH and the local government).

[184] PBF: Performance Based Contracting; P4P: Pay for Performance.
[185] President's Emergency Initiative for AIDS Relief.
[186] Centre International de Développement et de Recherche, www.cidr.org.

- The usefulness of such an approach requires the involvement of the different levels according to their level of competence and specific role.

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