CHAPTER 4

CONTRACTING BETWEEN FAITH-BASED HEALTH CARE ORGANIZATIONS AND THE PUBLIC SECTOR IN SUB-SAHARAN AFRICA

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Faith-based health providers have historically not been contractually recognised or established within government or public health systems. Medicus Mundi International (MMI) became engaged in an international debate focused on the repositioning of faith-based health facilities in national health systems in the 1990s. Through this, it was recognised that contracting with faith-based health facilities was a critical step towards the development of effective and equitable health care delivery systems, and the ultimate integration of faith-based facilities in public health systems. This paper presents the main findings of a study commissioned by MMI and conducted by the Institute of Tropical Medicine between 2007 and 2009 on contractual arrangements between faith-based hospitals and public health authorities in four sub-Saharan African countries: Cameroon, Tanzania, Chad and Uganda.

INTRODUCTION

In 2007, the network organisation *Medicus Mundi International* (MMI)[25] commissioned the Institute of Tropical Medicine (ITM, based in Antwerp) to conduct a study on the developing trend of contracting between faith-based hospitals and public health authorities in four sub-Saharan African countries.[26] Contracting can be described as "*a voluntary alliance of independent or autonomous partners who enter a commitment with reciprocal obligations and duties, in which each partner expects to obtain benefits from the relationship*" (WHO 1997). Faith-based health providers have historically not been contractually recognised or established within government or public health systems. MMI became engaged in an international debate focused on the repositioning of faith-based health facilities in national health systems in the 1990s. Through this, it was recognised that contracting with faith-based health facilities was a critical step towards the

[25] MMI is an international network composed of a private not-for-profit organizations working in the field of international health. The network's key strategic approach is to strengthen the health system as a whole. Strengthening the Private Not-For-Profit (PNFP) health sector is an essential aspect in this endeavor. For MMI, the contracting of faith-based health facilities is a means to an end – the end being the development of effective and equitable health care delivery systems via the integration of faith-based facilities in public health systems.

[26] This article summarizes findings which are reported more extensively in: *Contracting between the public and the faith-based sector in sub-Saharan Africa: an ongoing crisis? The case of Cameroon, Tanzania, Chad and Uganda* (Boulenger et al 2009)

development of effective and equitable health care delivery systems, and the ultimate integration of faith-based facilities in public health systems.

Since the late 1980s, contracting has become central to health sector reforms (Palmer 2000). Contracting is now a tool that is widely used to enhance the performance of health systems in developed and developing countries: not limited to the purchase of services, but used to formalize all kinds of relations. In the health sector, contracting is now seen as a strategy in and of itself, as a core element of a systemic reform, under which governments expand their attention beyond service delivery to additional roles. Carrin et al (1998), note that the contractual approach is a powerful policy tool. For instance, through contracting, private not for profit (PNFP) providers, guided by a public purpose, can be integrated into national health care delivery systems (Giusti et al 1997). Although, more recently, there have also been some controversial contractual experiences with output-based incentive schemes (Meessen et al 2007, Eldridge and Palmer 2009) that serve as a warning.

There are thus several types of contractual relations: variously based on the scope and nature of the contract (public or private), and the parties involved. Perrot (2006) proposed a generic classification of contracts in three ways: firstly, *delegation of responsibility* (set up so that rather than directly managing the health services it owns or undertaking to develop health coverage itself, the state delegates an entity to take over this task); secondly, *purchasing of services* (a health actor entrusts a partner with providing services in exchange for payment, rather than providing the service itself), and thirdly, *cooperation* (partners share resources needed to work together towards a common goal while respecting one another's identity). The contractual arrangements we are studying here, contracts between faith-based district hospitals and governments, fall under the first category of 'delegation of responsibility'.

The types of contracts and the modalities for establishing contractual arrangements may differ considerably. A central element, however, is the degree of *enforceability* of the contract. Generally speaking, a contract is a binding commitment – 'enforceable' in the legal sense. That means that non-fulfilment of the clauses by one of the parties can lead to penalties, and ultimately the parties can invoke the commitments before the courts. The contract may contain provisions for these penalties and for the means of enforcing them. Some contractual arrangements do not follow this rule; in which case they are referred to as a 'relational contract' (MacNeil 1978). Relational contracts attach great importance to the relationship between the contracting parties, thus waiving a certain degree of detail in favour of the spirit of the agreement reached. They rely primarily on trust and flexibility. We describe below some of the differing contracting relationships that have developed in SSA. However, there is great need for further research into the impact of contractual relationships on the performance of health systems in low- and middle-income countries.

When it comes to contracting with the PNFP sector in Africa, public health authorities see it as a powerful opportunity to improve and sustain national health coverage, especially in rural areas. The expectations from the PNFP sector, on the other hand, are to

gain explicit recognition of their contribution to the health sector and to be subsidised accordingly by the public sector. Today, however, little evidence is available on the impact of conventional, input-based contractual arrangements between the two sectors. The paucity of the available evidence left questions as to whether the current contracting experiences between faith-based facilities and public health authorities actually work? And if they work, what makes them work? And if they do not work, what are the reasons for this lack of success?

MAIN FINDINGS: A DIFFICULT RELATIONSHIP

The study described here sought to fill this gap and begin to answer some of these questions. It was framed as a set of case study evaluations carried out in 2007-2009. The study included both Anglophone (Tanzania and Uganda) and Francophone (Cameroon and Chad) countries because of their distinct historical, medical and cultural contexts. Semi-structured interviews (numbering 100) were carried out at different levels (central, regional and district) with stakeholders from both public and faith-based sector. Additional desk review and interviews was also conducted. Cameroon, Chad and Tanzania provided examples of more 'conventional' contracting agreements: where faith-based hospitals have taken on the role of a district hospital or situations where a faith-based organization is entrusted with the management of a health district. However, the Uganda case study was conducted in a slight different fashion, and focused instead on contracts being negotiated between faith-based hospitals and PEPFAR (President's Emergency Plan for Aids Relief) recipients. The intense negotiation around this relationship provided a particular learning potential which warranted this different focus.

Cameroon

In Cameroon, the PNFP sector provides 40 percent of the overall national health care. It is mainly constituted by faith-based providers linked to three different organizations: *Organisation Catholique de la Santé au Cameroun* (OCASC), *Conseil des Eglises Protestantes au Cameroun* (CEPCA), and *Fondation Ad Lucem* (FALC). Contracting developed in the early 2000s with isolated pilot cases: such as faith-based hospitals getting a district referral status, recognition of the churches' role in health care delivery, and a public focus on underserved areas. From 2001, gradual steps were undertaken towards formalization of *de facto* contracting policies. A major event was the *Contrat de Développement et de Désendettement* (C2D) project launched in 2003, which brought in financial resources to give real content to the contractual arrangements. A partnership strategy was developed later (2003-2006) and model documents were established from 2007.

This study investigated the Tokombéré hospital setting – a Catholic 160 bed hospital situated in a rural area in the extreme-northern province of the country. Part of the OCASC network, the hospital is owned by the Maroua-Mokolo Diocese. Tokombéré hospital has been characterised by strong leadership from expatriate hospital directors bringing in external resources. Tokombéré is reported to have a good reputation, extending beyond its district boundaries. Since the early 1990s, the hospital has played the *de facto* role of district hospital, formalized by a contract between the diocese and the

Ministry of Health (MoH) in 2002. However, the contract's objectives have remained vague with a poor definition of the respective obligations and responsibilities. There was, for instance, no specification of the mechanisms of allocation of funds to the hospital, no reference to any authority of the hospital on the public health centres, and no reference to the specific faith-based nature of the hospital. The monitoring and evaluation mechanisms were poorly developed, communication between the stakeholders was not well organised, and there was no structure operating as a functional, problem-solving organ. Moreover, there was a low level of collaboration between the health centre network and the hospital, seriously hampering the functioning of the local district system in a more integrated and systemic way. For example, there was a reported failure of the MoH to respect its commitments in terms of subsidies to be paid, allocation of staff, official recognition of the hospital as district hospital despite regular requests from the hospital's medical director.

This case points to a role of the faith-based hospital of partial substitution rather than one of complementarity. The hospital has functioned mainly on its own resources and the formal contract has basically reiterated the pre-existing situation, without major changes in terms of mutual relationships. It is clear that the level of knowledge on the contracting technicalities and on the institutional mechanisms needed to streamline these arrangements was insufficient. The contracts require revision and up-dating, taking into account other similar experiences in the country. Finally, there is also a major concern about sustainability – in particular about what will occur after the C2D project has ended.

Tanzania

After independence in 1961, Tanzania adopted an approach of free health care provision by public health services, and the Arusha Declaration (1967) began a health sector reform aiming at ensuring social and health services to the marginalized populations in the rural areas. The Tanzanian government is the main provider of health services and owns approximately 64 percent of all health services. The Tanzanian faith-based (or voluntary) sector is the second largest health care provider in Tanzania after the government. The private-for-profit (PFP) sector was banned in 1977, but has since re-emerged after the health reforms in the 1990s which also re-introduced user fees. It is worth noting that approximately 87 percent of all health services in Tanzania are dispensaries, and that hospitals and health centres account for 9 percent and 4 percent respectively. Collaboration between the faith-based sector and the government developed rapidly after independence, under President Nyerere's mandate. The government's control has increased over the faith sector, not without tension, although religious freedom has been maintained. In the health care sector this translated in the public recognition of the crucial role played by (rural, isolated) faith-based health facilities in terms of coverage. The collaboration between government and faith-based sectors was formalised in 1972 with the adoption of a decentralized, pyramidal health system: a number of faith-based hospitals then acquired the status of District Designated Hospital (DDH), sealed by a formal contract. This enabled the government to compensate for the shortage of public facilities while avoiding duplication. Contracts also guaranteed public funding of the DDH's recurrent expenditures.

After Nyerere's death, a Memorandum of Understanding (MOU) was negotiated by the churches. This enabled collaboration to continue, while offering more protection to the faith-based sector against public absorption (or forced nationalizations, as sometimes occurred under Nyerere's rule) and enabling access to external financing sources. Further steps gradually led to the adoption of a Public Private Partnership (PPP) as an official policy, still referred to in key documents and embodied by several governing organs. Moreover, old DDH contract models were revised in 2005 in accordance with the decentralization policy and a new type of operational contract was created in 2007 for private (Voluntary Agencies) and public facilities, excluding hospitals. The Christian faith-based health sector today is well represented in the public health arena by the Christian Social Services Commission (CSSC) – an umbrella network which enjoys official recognition - and by its five regional coordination bureaus.

This field research part of this study focused on Nyakahanga DDH (NDDH): a Lutheran hospital in the remote Kagera region in the north west. NNDH currently provides 200 beds and has been the property of Karagwe diocese since 1912. The hospital officially became a DDH in 1992, and the accompanying contract is of the earlier model and has not been revised to fit the 2005 revisions. Consequently, the diocese's public counterpart remains the MoH, whereas DDHs created since 2005 have been decentralized to deal with Local Government authorities. The contract also lacks a number of elements that are provided for in the newer model, such as: a proper definition of the terminology and concepts referred to in the contract; the principle agreement of a monitoring and evaluation system to follow-up contracting policies; the replacement of the old Board of Governors (BoG) by the Hospital Committee as a facility's representative body; or the backing up by a solid legal framework. The current management of NDDH's contracting relationship with the MoH takes place under the auspices of the BoG, but this body does not function in an optimal way. Monitoring of the contractual relationship is not properly done and supervisions remain erratic. In terms of provision of drugs, the public system faces frequent stock-outs, for which NDDH compensates through basket-funding and its own resources. Any available funds are almost completely absorbed by the provision of care at the expense of capital investments. These and other problems have led to a negative perception of the contractual relationship from the perspective of both the hospital and the diocese. Their trust in the contracting relationship has been deeply undermined, and threatened withdrawal has been considered in order to enforce improvement.

The Tanzanian contracting model is impressive because of its long-standing character and its extensive coverage. There is however a need to adapt to the evolving context. There are major problems of information and communication and many important policy documents are simply not available, especially at the decentralised levels of the health system. Moreover, the current contracts established with DDHs are in contradiction with the decentralization of the health system, resulting in impaired management and lack of problem resolution capacity. Decentralization itself remains partial and incomplete, with unclear distribution of responsibilities – leading to dysfunctional communication lines. Tanzanian faith-based facilities face growing difficulties resulting from the decrease in external financial and technical support in a context of increasing demands placed on

health services by the HIV epidemic and a shortage of human resources due to migration and lack of retention policies. The limited capacity of current contracting arrangements to adequately compensate for this situation carries the seed for a deterioration of the partnership climate at facility levels.

Chad

Christian churches and health providers in Chad are relatively young, but their facilities now cater for about 20 percent of the national health coverage; half of them being provided by Catholic hospitals and health centres under the umbrella of the *Union Nationale des Associations Diocésaines* (UNAD). Faith-based Christian facilities mainly concentrate in the South after they filled a gap left by public authorities as a consequence of civil war. The UNAD hospitals and health centres were integrated in the health map from 1993 onwards, in line with Primary Health Care policies. Catholic facilities were integrated as a result of a request from religious authorities, and legalization of church structures and the signing of first contracts gradually modified the initially informal collaboration. Steps towards partnership formalization were taken as soon as 1999, with contracting being one of Chad's national health policy strategic orientations. A contracting policy was elaborated from 2001, which considers delegation of public service mission to hospitals as well as delegation of health districts' management to PNFP organizations. In practice, most existing contracts were signed with faith-based organizations, mainly for full delegation of district management, inclusive of potentially existing public district hospitals. This ambitious interpretation is rarely observed elsewhere.

Contracting experiments are set in the context of health sector decentralization which, however incomplete, forms the background of the contracting policy. The Catholic Church's social sector is also decentralized, with the UNAD coordinating technical bureaus (*Bureau d'Etudes, de Liaison des Actions Caritatives et de Développement* - BELACDs) which are in turn responsible for coordination at a diocesan level. The BELACDs bear responsibility for management activities in case of delegation of health district administration to the Catholic Church. Framework agreements are established at central level and operational contracts at peripheral level.

This field research considered the contractual delegation of Moïssala health district's management to the BELACD of Sarh. The district is located in Southern Chad, and its capital, Moïssala, is home to the district hospital. The current situation is the result of a process that began in 1992 with the transfer of a Catholic hospital's equipment and human resources to the moribund district hospital of Moïssala. This project (TRABEMO) was followed by different contracts which gradually delegated the management of the health district and district hospital to the BELACD of Sarh. Financial and technical support of external partners sustained this evolution. Those far-reaching agreements were made possible thanks to the preexisting dialogue between public and faith-based sectors, but also because of the limited range of the public sector in covering the South of Chad. The well-recognised experience of the Catholic Church and the willingness of external partners to support the project further facilitated the contractual delegation of management authority to the BELACD.

The generally positive reaction of the public sector can be explained by: the poor state of the health system after civil war; the pre-existence of a dialogue between the two sectors; and the public recognition of the role of the faith-based health providers. Operational contracts aim at ensuring the commitment of the government (towards provision of human resources, infrastructure, tax exemptions and training of PNFP counterparts), and the commitment of PNFPs (to the implementation of the national health policy). Participation of both in decision-making is not formally foreseen, but takes place in practice. In addition, sensitization activities have been conducted and a training workshop was organised in 2004 and was well-attended by all key stakeholders. In total, a comprehensive regulatory and operational framework has been established in Chad, far more so than in the other three countries investigated. A good atmosphere characterised by mutual respect prevails between the two sectors. The open-mindedness of the government actors, the quality of the contracting framework, and the support provided through the contracts are particularly valued by the PNFP sector. However, real weaknesses are still apparent.

Uganda

The faith-based health sector in Uganda owns about 30 percent of the country's health facilities, the majority belonging to Catholic and Protestant churches. These networks are represented by the different denominational health platforms or Medical Bureaus.[27] Pressure resulting from the decrease in financial and human resources pushed PNFPs to seek a formalized partnership with the public sector after a long period of informal collaboration. Grand principles of public-PNFP collaboration were set in an MOU established in 1998, but partnership policy documents drafted by the Medical Bureaus in 2003 still await legal approval. Faith-based hospitals nevertheless receive public subsidies, although these are felt to be well below the level required. Medical Bureaus collaborate actively in order to facilitate legal recognition by the public authorities and to promote the development of a meaningful partnership framework. An additional source of concern for the Medical Bureaus is the emerging trend of the PEPFAR funding arrangements to directly contract with faith-based facilities, bypassing not only the Medical Bureaux but also the government authorities. Uganda became a PEPFAR focus country in 2004. With a budget exceeding 280 million $US in 2008, the US initiative is by far the biggest donor for HIV/AIDS-related funding in Uganda. Recent concerns have been raised about the channels by which PEPFAR steers such funds. Monies largely remain out of sight of the public budget, thereby impairing the planning capacity at the MoH level. The problem is further aggravated by poor leadership at MoH level, and the faith-based Medical Bureaus are even less involved. Overall, both the public and the PNFP authorities feel that they are being bypassed and lack the information required to adequately steer or engage in the process.

The field research focused on two faith-based hospitals involved in contracting agreements with PEPFAR recipients. Saint-Joseph's Hospital (SJH) is a facility owned

[27] Uganda Protestant Medical Bureau (UPMB), Uganda Catholic Medical Bureau (UCMB), Uganda Muslim Medical Bureau (UMMB)

by the Gulu diocese and located in Kitgum, Northern Uganda. Since 2005, contracts have been signed with three different Ugandan recipient organisations of PEPFAR funds for HIV/AIDS engagement. The agreements are felt to be constraining: they are extremely detailed, characterised by precise, indicator-bound objectives and activities, rigid descriptions of respective responsibilities and highly demanding monitoring and evaluation procedures. There are reports from SJH that PEPFAR contracts have led to some distortion in the supply of care and the allocation of human resources in favour of HIV/AIDS-related activities. Overall, the involvement of local public health authorities in these contractual arrangements remains limited. However, there are also noted positives: these contracts are accompanied by regular training, intense monitoring and evaluation activities, and exchange opportunities with other beneficiary facilities; reporting duties contribute to the development of a reflexive attitude amongst the providers; and contracts are respected by the donor. Overall, contracts with PEPFAR are well appreciated by the local faith-based representatives because of their predictability and trustworthiness.

The other example is Kabarole Hospital (KH), property of the Anglican church of Uganda - a relatively modest facility located in Fort Portal, Western Uganda. The first contract with PEPFAR was set up in 2005 and included prevention, treatment and care activities of HIV/AIDS. It is significant to note that this is the only source of external support which KH receives and it represents half of the hospital's annual budget. Many of the observations made above for SJH also apply to KH. Local health authorities remain largely positive, seeing PEPFAR interventions as a welcome complement to the limited resources currently available, and providing a valuable contribution in terms of data generation. Sources of worry include the issue of sustainability of this support, the absence of fall-back strategies, the rigidity of donors, the lack of harmonization with existing procedures and policies, and limited information sharing. KH critically voices the preferential focus on HIV/AIDS activities skewing the overall offer of care and unbalancing staff allocation.

What was striking was the difference in perceptions of PEPFAR contracts between central and peripheral level health authorities, as well as between MoH and faith-based sector representatives. While the contracts are relatively well appreciated at the peripheral levels of the health system, there is huge frustration at the central level, where there is a strong imperative for a systems approach to address existing inequities between provinces or districts. This frustration is also explained by the lack of involvement of the MoH and the Kampala-based Medical Bureaus in the design and monitoring of the contracts. The PEPFAR programmes tend to develop as autonomous strategies that run in parallel to existing home-grown programmes and health policies. The problems of weak leadership at MoH level, and the incomplete decentralisation process, further compound the situation. The still unsatisfactory relationship between public and faith-based providers may well lead the latter to favour policies and contracts that secure their immediate survival. For example, when faith-based facilities at a district level increasingly opt for the more predictable agreements with external funders such as PEPFAR. This may well bode ill for the future of faith-based engagement in PPP, and for the capacity of the national health system to ensure health for all.

CROSS-CUTTING ISSUES

Although these cases evidence a variety of contracting practices, comparative analysis can identify a number of common features, providing an interpretative lens for the assessment of contracting policies between faith-based and public sectors in sub-Saharan Africa. The contribution of the faith-based sector to health care provision in all four of these countries is significant (20-40 percent of total health care coverage), and the relevance of the sector should not be under-estimated. The faith sector is especially present in marginalized rural areas where government services are rare. In all settings there is a focus on further integrating faith-based health providers in the public health system. Contractual arrangements between faith-based facilities and the Ministry of Health thus acquire a particular significance as a means to promote a systemic and integrated approach in developing national health systems.

Current contracting experiments between the public and faith-based health sectors face great difficulties. Moreover, awareness of these challenges, particularly among public sector actors, is strikingly low. The sometimes problematic state of the relationship between faith-based and public sectors can be as a result of the following factors, clustered into three main areas. Firstly, there is a lack of preparation and participation. Agreements arrive at the peripheral level of the health system in a top-down manner; rarely incorporate lessons from preceding experiments; and are rarely accompanied by adequate training or coaching. Secondly, the contracting documents have many shortcomings - marked by incompleteness, poor integration in existing frameworks, and further aggravated by the absence of any mechanisms for revision. This leads to a heterogeneous contracting landscape, sometimes in contradiction with existing policies, where various non-harmonized types of agreements co-exist. Thirdly, all these country-cases revealed a strong dichotomy between the central and the peripheral level of the health system, further fragmenting the contracting landscape and pointing to the incomplete and immature character of the decentralization processes. This negatively affects contracting experiences by impairing the follow-up of agreements, the establishment of structural responses to address difficulties, and the capitalization processes of past experiences. The scarcity of financial and human resources is hardly alleviated by the signature of agreements. Governments do not always respect their commitments, or do so only to a limited extent, thereby putting faith-based facilities under great strain as they try to fill financial gaps. Contracts deliver as expected if and when they are effectively backed by sufficient resources, as shown by the examples of PEPFAR in Uganda and the one of Moïssala's first agreement in Chad.

Success of the relationship between faith-based facilities and public health authorities appear to lie more in the quality of the partnership processes at the central level, than in the operational contracts themselves. As far as the more conventional agreements are concerned, the *relational* character of the agreements leads to proper acknowledgment of pre-existing situations (such as a faith-based facility playing the role of a district hospital) rather than leading to innovative organisational arrangements. At best, the current format of contracting experiments seems to offer an inadequate answer to the severe crisis the PNFP and faith-based health providers are facing. These difficulties seriously affect faith-

based providers and remain largely underestimated by the public sector. The contracting agreements read, with some nuances, as a locus for disappointing and imbalanced relationships, benefiting the public sector to some extent while pressurising faith-based providers. This situation reveals a real risk of disintegration of the current partnership dynamic between the public sector and faith-based providers in many sub-Saharan African countries. This is demonstrated by worrying signs, such as was seen in Chad and Tanzania where faith-based providers are threatening to move away from existing agreements. The priority of immediate survival and the search for direct results stimulate the development of bilateral relations with external donors, at the potential expense of further integration in the overall health system. Some churches have begun to question the very notion of 'partnership' and whether their involvement in the provision of healthcare can be maintained in the future at all.

CONCLUSION

The particular case of PEPFAR contracts in Uganda provides an interesting contrast to the more conventional contracting forms between public health authorities and faith-based health providers. The PEPFAR contracts are of course in line with the program's purpose and disease-focused character. Responses in this study suggest that these contracts tend to lack adaptation to the national policy context, problematically bypass national structures, do not incorporate lessons learned from the past, and lack transparency for outsiders (including the MoH). On the positive side, however, PEPFAR contracts are appreciated by the operational actors because of their strong reliability and because of the quality of their monitoring and evaluation mechanisms. These are important assets which are often lacking in the other types of contracting experiences faith-based providers have established with public health authorities.

Our study points to the need to raise awareness among stakeholders on the crisis in the current contracting landscape, and the need to dramatically improve knowledge and expertise in designing, implementing and monitoring contractual arrangements. On the faith-based side, further professionalization of health management is a critical requirement. Adaptation and capacity to deal with increasingly complex health systems requires strong administrative, managerial and technical skills. It may also require a larger delegation of managerial authority at facility and diocesan levels than is currently in place. Historical agreements need to be revisited in order to adapt them to meaningful and sustainable partnership models. Updated national inventories of contracting experiences could contribute to the development of a strong knowledge-base and improved institutional memory. The latter, essential to enable appropriate capitalization of knowledge and knowledge translation, is currently largely absent. Finally, the experiences described briefly here, point to the need for tailored and continuous support to build capacity and address these various situations. Central level policies and models, however complete, do not sufficiently guarantee successful implementation and follow-up. Specific training, technical support and continuous steering at district level are needed so as to ensure that the arrangements in place are well-adapted to local needs.

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