The difficult relationship between faith-based health care organisations and the public sector in sub-Saharan Africa

The case of contracting experiences in Cameroon, Tanzania, Chad and Uganda

Delphine Boulenger and Bart Criel

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We dedicate this work to the late Professor Dr. Harry Van Balen, former Head of the Public Health Department of the Institute of Tropical Medicine in Antwerp, and former Chairman of the network organisation Medicus Mundi International.

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Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-Retroviral Treatment
AS	Accord de Service/Service Agreement (SA)
AVSI	Associazione Volontari per il Servizio Internazionale
BELACD	Bureau d'Etudes et de Liaison des Activités Caritatives et de Développement
BoG	Board of Governors
C2D	Contrat de Désendettement et de Développement
CAO	Chief Administrative Officer
CBO	Community-Based Organisation
CC	Convention cadre/Framework Agreement
CCT	Christian Council of Tanzania
CD4	Cluster of Differentiation 4
CDH	Council Designated Hospital
CD	Chef de District/District (medical) Chief officer
CDC	Centers for Disease Control
CDZ	Chef de Zone/Area Chief (medical) officer
CEPCA	Conseil des Eglises Protestantes au Cameroun
CET	Conference Episcopale du Tchad/Chad episcopal conference
CHMT	Council Health Management Team
CIDR	Centre International de Développement et de Recherche
CMO	Chief Medical Officer
COGEST	Comité de gestion/Management committee
COSAN	Comité de Santé/Health committee
CoU	(Anglican) Church of Uganda
CP	Contracting Policy
CRS	Catholic Relief Services
CSSC	Christian Social Services Commission
DCOOP	Direction de la Coopération (Cooperation directorate)
DDH	District Designated Hospital
DDHS	District Director of Health Services (former DMO)

DMO	District Medical Officer
DMT	District Management Team
DONG /SPONG	Direction des ONG/NGO directorate
DOSS	Direction des Organisations du Secteur Social/Directorate of social sector organisations
DP(S)	Délégué Provincial (de la santé)/Provincial Health representative
EDF	European Development Fund
EEMET	Eglises et Missions Evangéliques au Tchad/Chad evangelical churches and missions
EGPAF	Elizabeth Glaser Paediatric Foundation
ELCT	Evangelical Lutheran Church of Tanzania
EU	European Union
FALC	Fondation Ad Lucem
FBO	Faith-based Organisation
FCFA	Central African Franc
GIFMU	Global Initiatives Funds Managing Unit
HC	Health Center
HDI	Human Development Index
HIPC	Highly Indebted and Poor Country
HIV	Human Immunodeficiency Virus
HMC	Hospital Management Committee
HPAC	Health Policy Advisory Committee
HTOK	Hôpital de Tokombéré/Tokombéré Hospital)
HR	Human Resources
ICT	Information & Communication Technology
ITM	Institute of Tropical Medicine Antwerp
IRCU	Inter Religious Council of Uganda
JCRC	Joint Clinical Research Centre
KH	Kabarole Hospital
MCD	Médecin Chef de District/District medical chief officer
MDG	Millenium Development Goals
MoH	Ministry of Health
MoU	Memorandum of Understanding
MMI	Medicus Mundi International
MSD	Medical Stores Department

NAC	National AIDS Commission
NDDH	Nyakahanga District Designated Hospital
NGO	Non-Governmental Organisation
NHP	National Health Policy
NRM	National Resistance Movement
NUMAT	Northern Uganda Malaria AIDS and Tuberculosis programme
OCASC	Organisation Catholique de la Santé au Cameroun/ Catholic Health Organisation of Chad
OGAC	US global AIDS coordinator
P4P	Payment for Performance
PA	Protocole d'Agrément/Agreement protocol
PASS	Programme d'Appui au Secteur de la Santé/Health sector support programme
PBC	Performance-Based Contracting
PEPFAR	Presidential Emergency Plan For AIDS Relief
PHC	Primary Health Care
PLHIV	People living with HIV/AIDS
PMORALG	Prime Minister's Office for Regional Administration and Local Government
PNFP	Private Not For Profit
PPHT	Programme de Promotion Humaine de Tokombéré
PPP	Public Private Partnership
PPPH (WG)	Public Private Partnership in Health (Working Group)
RCB	Religious Coordinating Body
RMO	Regional Medical Officer
SA	Service Agreement
SC	Steering Committee
SJH	Saint Joseph Hospital
SLA	Service Level Agreement
SWAP	Sector-Wide Approach
SWOT	Strengths, Weaknesses, Opportunities, Threats
TANU	Tanganyka/Tanzania African Union party
TASO	The AIDS Support Organisation
TEC	Tanzania Episcopal Conference
TCMA	Tanzania Christian Medical Association
TRABEMO	Transfert Béboro-Moïssala

UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UNAD	Union Nationale des Associations Diocésaines
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
UPHOLD	Uganda Programme for Holistic Development
US	United States
USAID	United States Agency for International Development
USD	United States Dollar
VA	Voluntary Agency
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation

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Executive summary

Introduction

In this book we present the principal findings of a study conducted between September 2007 and March 2009 on contractual arrangements between faith-based hospitals and public health authorities in four sub-Saharan African countries (Boulenger, Keugoung & Criel 2009). Contracting can conveniently be defined 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). This book aims at sharing the core findings of the study with a larger audience interested in knowing more about the current interface between faith-based facilities and public health authorities.

In 2007, the network organisation *Medicus Mundi International* (MMI at www.medicusmundi.org) commissioned the Institute of Tropical Medicine (ITM) to conduct a study in order to update its knowledge on the subject of contracting between faith-based hospitals and public health authorities in Africa. MMI is an international network composed of a dozen private not-for-profit organisations working in the field of international health. The MMI network aims at facilitating the work of its members and their partners by sharing know-how and joining forces. The network's key strategic approach is to strengthen the health system as a whole. Strengthening the Private Not-For-Profit (PNFP) health sector obviously is an essential aspect in this endeavor. Moreover, many MMI members have in the past built strong collaborative ties with PNFP organisations at the operational level in African health care delivery systems. There is indeed a strong tradition of collaboration of MMI with the PNFP sector. MMI has consistently shown interest in the subject of contracting and has contributed to put the issue on the international agenda. In the late 90s, MMI launched already a debate on the repositioning of faith-based health facilities in national health systems.

Background

Since the late 1980s, contracts and contracting have become central themes in public sector management reforms taking place in many countries (Palmer 2000). Contracting is a tool that is increasingly being used to enhance the performance of health systems in both developed and developing countries; it takes different forms and cannot be limited to the mere purchase of services. Actors adopt contracting to formalize all kinds of relations established between them. In the health sector, contracting is increasingly seen as a strategy in itself, as a core element of a systemic reform, under which governments expand their attention in the health sector to include not only service delivery but also a range of additional roles. This shift adds the role of health services buyer or purchaser to its traditional role of health care provider (Taylor 2003). According to Carrin *et al.* (1998), the contractual approach needs to be adopted as a powerful policy tool. For instance, contracting can become an instrument to integrate private not-for-profit providers, guided by a public purpose, in national health care delivery systems (Giusti, Criel & de Béthune 1997). Of more recent appearance, and more controversial, are contractual experiences with output-based incentive schemes (Meessen, Kashala & Musango 2007; Eldridge & Palmer 2009). A recent study on Performance-Based Contracting (PBC) in private not-for-profit hospitals in Uganda (Ssengooba 2010) indicated that optimal effectiveness in PBC is difficult to achieve in settings *without* a package of supplementary interventions for improving resource inputs, performance governance and motivating the workforce. This case study from Uganda indicated that financial incentives, as predicted from agency theory, were *not* sufficient for PBC success.

There are thus several types of contractual relations: some are based on the nature of the contract (public or private), others on the parties involved and yet others on the scope of the contract. Perrot (2006) proposed a generic classification of contracts into three categories according to their object: first, delegation of responsibility; second, purchasing of services; and third, cooperation. Contractual relations based on delegation of responsibility are set up so that rather than directly managing health services or undertaking to develop health coverage itself, the state delegates an entity to take over this task. The arrangements that we are studying here - i.e. contracts between

faith-based district hospitals and governments - fall under this category. The rationale behind contractual relations based on an act of purchase is based on a simple principle: rather than providing the service itself, a health actor entrusts a partner with providing it in exchange for payment. Contractual relations based on cooperation involve sharing with a partner the resources needed to work together towards a common goal while respecting one another's identity. 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, however, do not follow this rule; in that case, we refer to 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. Whatever the precise shape and purpose of the contracting arrangements, 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 purpose of the MMI study was precisely to contribute to fill this gap. The paucity of the available evidence left MMI with the question whether the current contracting experiences between faith-based facilities and public health authorities actually work? And if they work, what makes them work? If they are not successful what are the reasons or mechanisms explaining this lack of success?

Methods

The methodological basis for this study is centred around a set of elaborate case study evaluations. The countries and cases were selected in close consultation with MMI. From the start on it was decided 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 thorough documentary analysis and intensive field work for each of the cases. The study took place in four countries: Cameroon and Chad in Francophone Africa and Tanzania and Uganda in Anglophone Africa. For each of the four case-study evaluations, the principal researcher of the study (D. Boulenger) spent four full weeks on the field. The first three cases are examples of rather "conventional" contracting agreements: situations where 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 situations where a faith-based organisation 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, however, is particular and significantly differs from the others because the study focuses on the contracts signed between 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 made because of its obvious important learning potential. We studied the cases of two Ugandan hospitals (St. Joseph-Kitgum and Kabarole Hospital) contracting with PEPFAR.

Each case study is based on a dense and comprehensive description of the observed phenomena, with triangulation of data collected. We drew on the concept of *thick description,* initially developed in the field of ethnography and anthropology and now widely used in the broader field of qualitative research. We also used a historical approach in the study. We attempted to reconstruct, in each of the countries surveyed, the *history* of public-private partnerships and contracting experiences between faith-based organisations and public health authorities. This contributed to clarify the sometimes blurred views on the origins and evolution of contracting experiences and to provide elements explaining their success or failure. They allowed us to put

events in perspective, providing the necessary critical hindsight, in contrast with the often very short time frame in which public health operates.

A considerable number of semi-structured interviews was carried out at the various levels of the health system (central, regional and district) with stakeholders from both public and faith-based sector; and in the case of Uganda, also with representatives from PEPFAR. On the whole, more than 100 semi-structured interviews were held. Furthermore, a considerable number of shorter and more informal interviews were carried out as well. Finally, a detailed documentary analysis was made in each country looking at 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 and allowed us to highlight aspects that appeared to "cross-cut" the different case-studies.

The five case-studies carried out in the four selected countries will be described using an order (Cameroon, Tanzania, Chad and Uganda) reflecting the level of complexity of the experiences, from the more classic to the more atypical examples.

Main findings

1. CAMEROUN

The PNFP sector holds 40 % of the overall national health care provision. It is mainly made up of faith-based providers linked to 3 different organisations (OCASC, CEPCA, FALC)[1]. Contracting processes took off in the early 2000s with isolated pilot cases: faith-based hospitals getting a district referral status, recognition of the churches' role in health care delivery, and focus on (publicly) underserved areas. Gradually, from 2001 on, steps were undertaken towards formalization of *de facto* contracting policies. A major event was the C2D[2] project launched in 2003, which brought in the necessary financial resources to give a real content to the contractual arrangements. Later a partnership strategy was developed (2003-2006) and model documents were established from 2007 on.

[1] *Organisation Catholique de la Santé au Cameroun; Conseil des Eglises Protestantes au Cameroun; Fondation Ad Lucem.*

[2] *Contrat de Développement et de Désendettement* (Programme for Development and Debt Relief).

The setting that was investigated in the MMI study is Tokombéré hospital. It is a Catholic 160 bed hospital (OCASC network), situated in a rural area in the extreme-northern province of the country. The hospital's ownership is in the hands of the Maroua-Mokolo diocese. Tokombéré hospital is characterised by a strong leadership coming from expatriate hospital directors bringing in external resources. The good reputation of Tokombéré hospital, and the health care it delivers, goes well beyond the district boundaries. The hospital de facto plays the role of district hospital since the early 90s, which was formalized by a contract between the diocese and the Ministry of Health (MoH) in 2002. The contract's objectives however 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 character of Tokombéré 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 an obvious 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 the regular requests from the medical director of the hospital. 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 way.

This case points to a role of the faith-based hospital of partial substitution rather than one of complementarity. The hospital functioned mainly on its own resources and the contract basically formalized and prolonged 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, especially at peripheral level. The contracts would have needed revision and up-dating taking into account existing experiences in the country. Finally, there is the issue of sustainability: what will happen after the end of the C2D project…

2. Tanzania

After independence in 1961, Tanzania adopted free health care to be provided by public health services, while the Arusha Declaration (1967) started a health sector reform process 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% of all health services. The Tanzanian faith-based - or *voluntary* - sector is the second biggest health care provider in Tanzania after the government sector. The private-for-profit sector was banned in 1977, but has increased rapidly since the health reforms of the 1990s that also re-introduced user fees. It is worth noting that approximately 87% of all health services in Tanzania are dispensaries, and that hospitals and health centres account for 9% and 4% respectively. Collaboration between the faith-based sector and the government took off under President Nyerere's mandate right after independence. The government's control increased over the faith-based sector, not without some tension, while religious freedom was maintained leading to the 'Tanzanian model' of Public & faith-based collaboration. In the health care sector this led to the recognition of the crucial role played by (rural, isolated) faith-based health facilities in terms of coverage. The government & faith-based collaboration was formalised in 1972 with the adoption of a decentralized, pyramidal health system: a number of faith-based hospitals then acquired the notorious status of District Designated Hospital (DDH), sealed by a formal contract. This enabled the State to compensate to some extent the shortage of public facilities while avoiding duplication. Contracts guaranteed public funding of the DDH's recurrent expenditures. It is worth noting that despite progress in health indicators large inequities remain and that faith-based health services tend to cluster in certain areas.

After Nyerere's death, a Memorandum of Understanding (MoU) was negotiated by the churches pursuing collaboration while offering more protection to the faith-based sector against public absorption (forced nationalizations, as they 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 Catholic Social Services Commission (CSSC) - i.e. a platform that enjoys official recognition - and its five regional coordination bureaus.

The MMI study in Tanzania focused on the case of Nyakahanga DDH (NDDH), a Lutheran hospital located in the north-west of the country in the remote Kagera region. NNDH counts 200 beds and has been the property of Karagwe diocese since 1912. The hospital officially became a DDH in 1992. The NDDH's contract does not differ from the early model and has not been revised to fit the 2005 contracting document. As a consequence, the diocese's public counterpart remains the MoH, whereas DDHs created since 2005 deal with Local Government authorities. This is in obvious contradiction with the current decentralization system. The contract lacks a number of elements that are clearly provided for in the new model: e.g. 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; the backing-up by a solid legal framework, etc.

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 supervision remains erratic. In terms of provision of drugs, the public system faces frequent stock-outs compensated by NDDH on basket-funding and own resources. Available moneys 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. The Church's trust in the contracting relationship is deeply undermined. Withdrawal is used as a thinly veiled threat to enforce improvement.

The Tanzanian contracting model is impressive because of its long-standing character and its large coverage. There is however a need to adapt to the evolving context. There are major problems in information and communication and many important policy documents are simply not

available, especially at the peripheral level 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. This leads to blurred and 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 within itself the seeds of a deterioration of the partnership climate at peripheral level.

3. CHAD

Christian churches in Chad are still young but their facilities cater for about 20% of the national health coverage, half of them being provided by Catholic hospitals and health centres (HCs) under the umbrella of the *Union Nationale des Associations Diocésaines* (UNAD). Faith-based Christian facilities mainly concentrate in the South as a consequence of civil war where they filled the gap left by public authorities. Hospitals and health centres were set on the health map from 1993 onwards, as a result of Primary Health Care (PHC) policy implementation. As for Catholic facilities, their integration was also the result of an active request from the religious authorities. Legalization of church structures and then the signing of first contracts gradually changed the - at first - informal collaboration. Steps towards partnership formalization were taken as soon as 1999, with contracting being one of the National Health Policy's (NHP) strategic orientations. A Contracting Policy (CP) was elaborated from 2001 on. It considers delegation of the public service mission to hospitals as well as delegation of health districts' management to PNFP organisations. In practice most existing contracts were signed with faith-based organisations, mainly for full delegation of district management, inclusive of potentially existing public district hospitals. This ambitious interpretation is barely observed elsewhere.

Contracting experiments are set in the context of health sector decentralization which, however incomplete, forms the background of the CP. The Catholic Church's social sector is itself organized according to a

decentralized model: the UNAD coordinates technical bureaus - the *Bureaux d'Etudes et de Liaison des Activités Caritatives et de Développement* (BELACDs), themselves responsible for coordination at diocesan level. The BELACDs are responsible for management activities in case of delegation of health district administration to the Catholic Church. Public sector organs, policy and operational documents mainly include the MoH directorate of NGOs and the directorate of social sector organisations; the NHP and the CP itself; and operational contracting guidelines. They transpire in framework agreements at central level and operational contracts at peripheral level which are generally the result of active requests from churches' side. The positive reaction of the public sector can be explained by 4 main factors: the battered state of the health system after civil war; the pre-existence of dialogue; the recognition of the role and characteristics of the faith-based health sector. Operational contracts aim at ensuring the commitment of the State towards provision of human resources, infrastructure, tax exemptions and training to PNFP counterparts; but also at the implementation and respect of the NHP by the latter. Participation of both parties in each other's decision making process is not foreseen formally but observed in practice; besides, sensitization activities were conducted and a preparatory training workshop (2004) attended by all key stakeholders. Overall, this results in a quite complete regulatory and operational framework, far more comprehensive than in other case-countries.

A good understanding and mutual perception is found at central level. Open-mindedness of government actors, quality of the partnership and contracting framework, and means of direct and indirect support provided by the contracts are particularly valued by the PNFP sector. However, real weaknesses are clear. Our study looked into the contractual delegation of Moïssala health district's management to the BELACD of Sarh. The district is located some 400 km south-east from N'Djamena, in the Mandoul health prefecture, Southern Chad. 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, 'Transfert Bénoro-Moïssala' (TRABEMO), was followed by 3 main 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

by the preexisting public and faith-based dialogue around the case of Béboro, the consensus on vision, goals and modalities, the weakness of the public health sector's representation and capacity in the South, the proven experience of the Catholics and the willingness of external partners to support the project. There were few real barriers apart from the magnitude of the task and the risks for a Catholic organisation to bear management authority towards other faith-based institutions.

4. UGANDA

The faith-based health sector in Uganda owns about 30% of the country's health facilities, the majority belonging to Catholic and Protestant churches. These networks are represented by the different denominational health platforms: i.e. the "Medical Bureaus". Pressure resulting from the decrease in financial and human resources pushed PNFPs to actively seek a formalized partnership with the public sector after a long period of informal collaboration. Grand principles of public-PNFP collaboration were set in a Memorandum of Understanding 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, be it far below the level of needs. Medical Bureaus collaborate actively in order to unfreeze the process of legal recognition by the public authorities and to promote the development of genuine and meaningful partnership frameworks. An additional source of concern for the Medical Bureaus is the upcoming trend of the Presidential Emergency Plan For AIDS Relief (PEPFAR) funding arrangements to directly contract with individual faith-based facilities.

Uganda became a PEPFAR focus country in 2004. With a budget exceeding 280 million USD in 2008, the American initiative is by far the biggest donor for HIV/AIDS related funding, and more largely in the Ugandan health sector. Recent evidence, however, confirms the weaknesses many observers noted in the way PEPFAR uses and channels its funds. Monies largely remain out of sight and control of the public budget, thereby impairing the planning capacity at the MoH level. The problem is further aggravated by poor leadership at MoH level. The faith-based Medical Bureaus are even less involved. Overall, both the public and the PNFP authorities feel bypassed and lack the information required to adequately steer the process. Sustainability is a matter of concern.

Our field research in Uganda focused on two faith-based hospitals involved in contracting agreements with PEPFAR recipients. The Saint-Joseph's Hospital (SJH) is a facility owned by the Gulu diocese and located in Kitgum, Northern Uganda. Since 2005, contracts have been signed with 3 different Ugandan recipient organisations of PEPFAR funds in order to address HIV/AIDS related needs: Uganda Programme for Holistic Development (UPHOLD), Catholic Relief Services (CRS) and The Aids Support Organisation (TASO). The agreements are constraining: they are extremely detailed, characterised by precise, indicator-bound objectives and activities, rigorous descriptions of respective responsibilities and highly demanding monitoring & evaluation procedures. There is evidence coming from SJH that these PEPFAR contracts lead to some level of distortion in the supply of care and in the allocation of the available human resources in favour of HIV/AIDS related activities. Overall, the involvement of local public health authorities in these contractual arrangements remains limited. On the positive side, however, is the fact that these contracts go together with 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. Last but not least, the contracts are respected by the donor. Overall, contracts with PEPFAR are well appreciated by the local faith-based and government authorities because of their predictability and trustworthiness.

Kabarole Hospital (KH), property of the Anglican Church of Uganda, is the second hospital we investigated in our study. It is a relatively modest facility located in Fort Portal, Western Uganda. The first contract with PEPFAR goes back to 2005 and included prevention, treatment and care activities of HIV/AIDS. It is the only source of external support of KH and represents half of the hospital's annual budget. Many of the observations made with regard to 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 health 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 the incompleteness of information shared. KH critically voices the risk of HIV/AIDS activities developing into a preferential way, thereby skewing the offer of care and unbalancing staff allocation.

Striking in our study is the difference in perception of PEPFAR contracts between central and peripheral level health authorities, both from the point of view of the MoH and the faith-based sector. While the contracts are relatively well appreciated at the peripheral levels of the health system, there exists huge frustration at the central level, where the imperative for a systems approach to address existing inequities between provinces/districts and the need for a strategic perspective obviously appears more urgent. This can also be explained by the lack of involvement of the MoH and the Kampala-based Medical Bureaus of the various faith-based organisations 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 unsatisfactory relationship between public and faith-based sector may well lead the latter to favour policies that contribute to securing their immediate survival, i.e. for faith-based facilities at district level to increasingly opt for the predictable and trustworthy agreements with external organisations like PEPFAR. This may well bode ill for the future of faith-based public partnerships and for the capacity of health systems to ensure health for all and address the social determinants of health.

Cross-cutting issues

Comparative reading and analysis of the case studies allowed us to identify a number of common features among a variety of contracting practices. These constants provide us with an interpretative lens for the assessment of public & faith-based contracting policies in sub-Saharan Africa. First, the contribution by the faith-based sector to health care provision in all countries is significant (20-40%). The faith-based sector is particularly present in the most marginalized rural areas where government services are often limited. Second, the interest to ensure increased integration and to strengthen a systems approach to current health challenges is not new and has been explored since long. The contract acquires within this context a particular significance as a mechanism to enhance a systems approach in order to strengthen not only health care provision, but also to address the social determinants of health at multiple levels.

Current contracting experiments between the public and faith-based health sectors face great difficulties. Awareness of the crisis, particularly among public sector actors is, however, low.

The reasons for this state of affairs are the following. First of all, there is a lack of preparation. Agreements arrive as innovations at the peripheral level of the health systems, they are not built upon lessons learned in previous experiments, and they are seldom accompanied by adequate training or coaching. Second, there are the shortcomings of the contracting documents themselves, marked by incompleteness and poor integration in existing frameworks, further aggravated by the absence of revision mechanisms. This leads to a heterogeneous contracting landscape - sometimes in contradiction with existing policies - where non-harmonized types of agreements co-exist. Third, all country-cases reveal a strong dichotomy between the central and the peripheral level of the health system, further fragmenting the contracting landscape and pointing at the incomplete and immature character of health system decentralization processes. This negatively affects contracting experiences by impairing the follow-up of agreements, the set-up of structural responses to address the difficulties met, and the overall capitalization of experience. Eventually, 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 to a limited extent only. Facilities therefore need to compensate financing gaps on their own or rely on external resources, which are increasingly more limited. Contracts deliver on expectations when backed by sufficient resources, as shown by examples of PEPFAR in Uganda or those of Moïssala district's first agreements in Chad.

Overall, success rather lies in genuine partnership processes at central level and generalization of public-PNFP dialogue than in operational contracting at district level. As far as the more conventional agreements are concerned, the relational character of agreements tends to lead to a static acknowledgement of pre-existing situations (e.g. a faith-based facility in fact playing the role of a district hospital) at the expense of more innovative organisational arrangements.

At best, the current format of contracting experiments seems to offer an inadequate answer to the severe, underlying crisis of the faith-based health sector. It eventually contributes to worsening it as extended responsibilities come with the need for increased mobilization of financial and human resources. These difficulties seriously affect the faith-based health sector and

remain largely underestimated by the public sector. The contracting agreements read - with some nuances - as a recipe for disappointing, imbalanced relationships, benefiting to some extent the public sector while draining the faith-based sector.

This situation reveals a real risk of disintegration of the current partnership dynamic between the public and the faith-based sector in sub-Saharan Africa. Worrying signs already show up, as some faith-based providers are moving away from existing agreements or threatening to do so (Chad, Tanzania). The priority of immediate survival and the search for rapid results stimulate the development of bilateral relations with external donors, at the potential expense of further integration of the health system. Some churches even question the very notion of partnership and their further involvement in the provision of healthcare (Uganda).

Concluding comments

The particular case of PEPFAR contracts in Uganda provides an interesting experience that contrasts with the experience of the more traditional or conventional forms of contracts between public health authorities and faith-based health organisations. The PEPFAR contracts are very much in line with the programme's single–purposed and disease focused character. PEPFAR contracts lack adaptation to the national context, tend to bypass national structures, do not incorporate lessons learned from the past, and are generally characterised by poor transparency for outsiders. On the positive side, however, PEPFAR contracts are appreciated by the operational actors because of their reliability and because of the quality of their monitoring and evaluation mechanisms. This is not always the case in the contracting experiences established with public health authorities.

Our study points to the need to raise awareness among all stakeholders of the crisis in the current contracting landscape and of the need to dramatically improve knowledge and expertise in developing and monitoring contractual arrangements. On the part of the faith-based sector, further professionalization is a mandatory requirement. Adaptation and capacity to deal with the increasing complexity of the health system requires strong administrative, managerial and technical skills. It may also require a larger delegation of managerial authority to facility and diocesan level. Historical agreements need to be revised in order to adapt them to meaningful and

sustainable partnership models. An updated centralised inventory of contracting experiences could contribute to the development of a knowledge base and institutional memory. The latter, essential to enable appropriate capitalization of knowledge and knowledge translation, is currently largely missing. Last but not least, experiences studied in our research show the need for tailored support to address the variety of peculiar situations. Central level policies and models - however complete they may be - do not sufficiently guarantee successful implementation and follow-up. Specific training, technical support and continuous steering are needed to make sure that the arrangements in place are well adapted to the local needs.

Preamble

The present book is based on a study originally commissioned by the Medicus Mundi International (MMI) network. One of the strategic priorities of the MMI 2007-2010 action plan was a repositioning of church-based health facilities within overall health systems in developing countries. Over the years, MMI has developed a special interest in contracting relationships between faith-based health facilities and the public health authorities in sub-Saharan Africa as a means to implement its strategy. The organisation has invested heavily and put considerable energy into promoting contracting in international health policy circles. MMI's advocacy and lobbying efforts at WHO level eventually led to the adoption by the World Health Assembly (WHA) of a resolution on the role of contracting arrangements in improving health systems (Fifty-sixth World Health Assembly 2003). More practically, MMI prepared a two-volume technical guide to assist private (not-for-profit) facilities in the development and implementation of contracting arrangements with the Ministry of Health in the countries in the region (MMI 2003a; 2003b). Contracting was, and is, thus clearly one of MMI's top priorities.

As MMI wished to update its contracting strategy, it asked the Institute of Tropical Medicine (ITM) in Antwerp to carry out a study in sub-Saharan Africa to gain more insight into current contracting policies and operational experiences in the private (not-for-profit) and public sector. This resulted in the publication of a report (Boulenger, Keugoung & Criel 2009). This book aims to provide a revised, more academic version of the report. This revision does not, however, pretend to provide an in-depth update of the basic research material and of the analysis of the original report. Since 2009, contracting processes and contractual experiments have continued to evolve at country level and changes have also occurred with regard to the overall contracting context. One of them consisted in the further development of performance-based contracting experiments and policies, as a result of the gradual adoption by donors of this specific approach.

All contents which formed the basis for analysis, as well as provided references and formulated statements, apply, unless stated otherwise, to 2009, when the original report was published, or the years before.

Introduction

Since the late 1980s, contracts and contracting have become central themes of the transformation in public sector management taking place in many countries (Eldridge & Palmer 2000). Contracting can be defined, as stated by the WHO, 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).

Contracting is a tool that is increasingly being used to enhance the performance of health systems in both developed and developing countries; it takes different forms and cannot be limited to the mere purchase of services. Actors adopt contracting to formalize all kinds of relations established between them. In the health sector, contracting is increasingly seen as a strategy in itself, as a core element of a systemic reform, under which governments expand their involvement in the health sector. Governments take up roles beyond just service delivery. This shift adds the role of health services buyer or purchaser to government's traditional role of health care provider (Taylor 2003). According to Carrin *et al.*, the contractual approach should be used as a powerful policy tool (Carrin, Jancloes & Perrot 1998). For instance, contracting can become an instrument to integrate private not-for-profit health care providers, guided by a public purpose, in national health care delivery systems (Giusti, Criel & De Béthune 1997). More recently contractual experiences are being promoted with output-based incentive schemes for health workers attempting to improve the performance of health systems (Eldridge & Palmer 2009; Meessen, Kashala & Musango 2007; Perrot, Roodenbeke, Musango & Fritsche 2010).

There are thus several types of contractual relations: some are based on the nature of the contract (public or private), others on the parties involved or on the scope of the contract. Perrot proposed a generic classification of contracts into three categories according to their object: first, delegation of responsibility; second, purchasing of services; and third, cooperation (Perrot 2006). Contractual relations based on delegation of responsibility are set up so that rather than directly managing the health services it owns or attempting to assure health coverage itself, the state delegates this task to another entity. The arrangements we are studying here - i.e. contracts

between faith-based district hospitals and governments - fall under this category. The rationale behind contractual relations based on an act of purchase is based on a simple principle: rather than providing the service itself, a health actor entrusts a partner with providing it in exchange for payment. Finally, a contractual relation based on cooperation refers to sharing with a partner the resources needed to work together towards a common goal while respecting each other's identity.

The types of contracts and the modalities for establishing contractual arrangements can differ considerably. A key 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 court. The contract may contain provisions for these penalties and for the means of enforcing them. Some contracting arrangements, however, do not follow this rule; in that case, we call the contract 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.

Whatever the form and purpose of contracting arrangements, there is a great need for further research on the impact of contractual relationships on the performance of health systems in low- and middle-income countries.

A recent study on Performance-Based Contracting (PBC) in private not-for-profit hospitals in Uganda (Ssengooba 2010) indicated that optimal effectiveness in PBC is difficult to achieve in settings *without* a package of supplementary interventions for improving resource inputs, performance governance and motivating the workforce. This case study from Uganda indicated that financial incentives alone, as predicted from agency theory, were *not* sufficient for PBC success.

This study looks at the results from three different perspectives. First, an operational perspective: to generate new knowledge which will allow a better understanding of the phenomenon, obviously beneficial for the field actors in sub-Saharan Africa. Second, an institutional and political perspective: to fuel brainstorming and help develop partnership policies, by providing national and local decision makers with an analysis of the contracting context based on some specific experiences of contracting in their country. 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 to focus the research on contracting between the public health authorities and the faith-based facilities or organisations in the district. We did so because most of the health care in Africa is provided by these organisations and for reasons of internal consistency.

The subject was approached by asking a 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, on the other hand, fail, which elements have then contributed to this success or failure? If contracting does not function very well, which obstacles have prevented the harmonious development of contracting relationships between church-based facilities and the public health authorities? Which lessons can be learned from these new insights?

This study 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 experiences will be described in the order mentioned above, i.e. from the more classic to the more atypical examples. Two case studies were conducted in Uganda. Both will also be presented in this section. The final part of the study is dedicated to the analysis of the study results. We will first make a synthesis of the country specific results and then draw some important overall conclusions in a cross-cutting analysis on experiences of contracting between the faith-based district health sector and the State.

Methods

General methodology

METHODOLOGICAL APPROACH

We used a mostly inductive approach where answers and explanations would progressively be generated through a number of selected case studies. The data analysis was done in two steps. Each case study was analysed individually in great depth, including a SWOT analysis, and followed by a cross-cutting analysis of the different case studies.

The study extensively builds on *description*, the cornerstone of qualitative research as stated by Janesick (2000). Indeed, each of the case studies in this research is based on a dense and comprehensive description of the observed phenomena, with triangulation of data collected through documentary analysis and interviews. Our aim was to try and reconstruct the facts to the extent possible and to describe the perception of the different actors on the contractual experiences at stake. Our methodology draws on the concept of *thick description* that was first developed in the field of ethnography and anthropology (Geertz 1973). Since then, the concept has been widely used in the broader field of qualitative research (Denzin 1989; Ponterotto 2006). In line with common practice in thick description, we have tried to provide detailed accounts of the different contexts in our case-studies, to make explicit the intentions and the meanings behind the observed phenomena, and to describe their evolution and development. This approach seemed justified given the complexity of the phenomena under study.

We also used a historical approach in this study. We attempted to reconstruct, in each of the countries surveyed, the *history* of public-private partnerships and contracting experiences between faith-based organisations and public health authorities. This contributed to clarify the sometimes blurred views on the origins and evolution of contracting experiences and to provide elements explaining their success or failure. Historical approaches are increasingly being used in the field of public health (Fee & Brown 1997; Berridge 1999; Perdiguero *et al* 2001; Berridge 2010). They allow to put events in perspective, providing the necessary critical hindsight, in contrast with the often very short time frame in which public health operates.

SELECTION OF CASES

The countries were selected on the basis of three criteria: firstly, the existence of possible solid support/local networks to facilitate the preparation and conducting of the field studies; secondly, their representativeness, in terms of the historical, organisational/institutional and (geo-) political diversity of the African continent[3]; and thirdly, 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 (Democratic Republic of Congo, Benin and Rwanda) were abandoned for reasons of feasibility, in particular 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 their distinctive features and the wealth of information that could be obtained from them through analysis. The questions and the methodology used were adjusted to the specific situation in each of the chosen case studies, and according to the nature of the available sources and the interest expressed by the field actors. Our main initial concern was to remain open to demands: the opinions and needs of local interlocutors were taken into account in the decision making process and determined at least to some extent our research.

In a first stage 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 [4] were excluded from this study in order to guarantee a consistent and well documented base for comparison.

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

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

[4] For example, faith-based hospitals exercising *de facto* or by default the role of public district hospital.

theory on which they are based (Pay for Performance or P4P), or in terms of their application modus - for instance, experiences of delegation of management over the whole district, or specific experiences of P4P applied to a "classic" situation[5].

The cases retained 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 (DDH);

In Chad: we investigated a number of contracts through which the management of the district of Moïssala (Southern Chad) was progressively entrusted to one of the decentralized bureaus[6] of the national Catholic platform.

The particular case of Uganda deserves some explanation. In this case study we opted not for classic contracts, but for an analysis of contracts drawn up between the faith-based hospitals and recipients of the Presidential Emergency Plan For Aids Relief (PEPFAR), one of the leading global initiatives in Africa today. This choice can be justified easily. First, the study of such types of contracts is very interesting in itself and second, Uganda offers obvious opportunities to gain more insight into them. Two hospitals were selected on this basis, with the active support of the medical bureaus. First, the Catholic hospital of St. Joseph, Kitgum (Northern Uganda) with contracts linking it to three PEPFAR primary recipients[7]; second, the Anglican hospital of Fort Portal (Kabarole Hospital) linked by contract to CRS. All contracts investigated in Uganda are connected to HIV/AIDS prevention activities.

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

[6]*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).

[7] Catholic Relief Services (CRS), Uganda Program for Holistic Development (UPHOLD), The AIDS Support Organisation (TASO).

More detailed information concerning the case studies

We collected mostly qualitative field data for the examples in this book. The field work for each case study lasted about 4 weeks on average. We used a mixture of interviews with key actors at the different levels of the health system and for all sectors: faith-based, public and, in the case of Uganda, donors (PEPFAR); and collection and analysis of documents, with similar coverage criteria (levels and sectors of the health system).

The selection of those interviewed followed the same principles; criteria for selection were defined beforehand for all case studies. However, some small changes had to be made for Chad and Uganda. In Chad the delegated district management meant we had to include other categories of actors (health centres, a higher number of district officials) whereas in Uganda, the PEPFAR component obviously had to be taken into account. Selected participants were preferably:

- For the public and the faith-based sector (and PEPFAR): actors of the central and the peripheral level, and the intermediate level if applicable;
- historical witnesses (at the central and the peripheral level), where possible;
- Public sector: officials of the Ministry of Health (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 at central and peripheral levels; hospital staff (chief medical officer, administrator, financial director, chief nursing officer, other clinicians); and, if needed, representatives of the civil servants seconded to the faith-based facility;
- PEPFAR: representatives at the central, intermediate and peripheral levels of the different recipients identified through the contracts. Ideally, also national representatives for PEPFAR, USAID in particular.

The majority of semi-structured interviews were conducted using a standardized questionnaire; in Uganda this questionnaire was slightly adapted to the country's specific situation. The interviews lasted on average

an hour and a half; those with 'historical' witnesses generally lasted longer (up to 3hrs) and were often split up into two sessions.

Occasionally a simplified questionnaire 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 of the individuals and were generally about 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 categorized as follows:

- Contracting documents: primary main and secondary contracts [8], 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[9]; service agreement manuals; the main documents of the health policy.
- Contextual documents for faith-based facilities and organisations, more particularly those relating to the history of the organisations or facilities investigated, or to their structure.
- Routine documents drawn from the Health Information System: annual reports from the hospital, in particular those listing relevant quantitative data.

Overall, more than 100 people were contacted and interviewed, and there were about 30 interviews per case study. The wealth and relevance of material collected, including documentary information gathered from field missions, allowed for triangulation of the data and a thorough cross-cutting analysis.

Interviews per case study are, except for specific cases, about equally divided between the faith-based and the public sector.

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[8] Primary contracts should be understood as first signed/original contracts; amendments to or update of those primary contracts over time may be defined as secondary contracts.

[9] Framework agreements are the overall agreements signed by central level authorities (MoH/faith-based platforms) in which intention and modalities of cooperation/partnership are being defined. The practical application of those framework agreements at peripheral level comes in the form of service agreements signed between public authorities and district level, faith-based health facilities or decentralized representations of faith-based health platforms.

In Cameroon we carried out 17 interviews of which 5 took place at the central level, 4 at the intermediate level and 8 at the peripheral level. We also talked to a village committee in the hospital's catchment area. As this local organ consisted of several participants, the use of the focus group technique was necessary in this particular case. A simplified questionnaire with 9 points was used for this purpose. Five informal interviews at central level completed the information we gathered.

In Tanzania, 18 interviews were conducted of which 10 were at the peripheral level, two of which were short interviews with a simplified questionnaire; 2 at the intermediate level and 6 at the central level. Fourteen informal interviews were also conducted during the annual meeting of the Tanzania Christian Medical Association (TCMA)[10]. We also interviewed the staff of the Christian Social Services Commission (CSSC), the MoH and a number of individuals at the peripheral level.

In Chad we carried out 14 interviews: 4 took place at the central level, 7 at the intermediate and 4 at the peripheral level. We carried out 2 informal interviews with the managers of 5 district health centres in the district of Moïssala as well as interviews with a representative sample of different people of the health district[11].

For Uganda we conducted 15 interviews - similar in scope to the two case studies - at the central level. In addition we had 3 interviews at the intermediate level[12]. Finally for the peripheral level, interviews were equally divided between St Joseph Hospital (8) and Kabarole Hospital (9). A total of 35 interviews were conducted, with an additional 5 informal interviews.

[10]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.

[11]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.

[12]UPHOLD representative and Catholic Bishop of Gulu.

Limitations of the study

Our study has a number of limitations. Firstly there is the interpretation of the research topic by the people we met: although there were some exceptions, in general the interviews clearly revealed that some confusion exists about the difference 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. The mix-up of these types of processes is however also symptomatic of the limited or even faulty comprehension of the concepts. We will shed light on this lack of conceptual insight further in this book. Finally, it also indicates a weakness of the contracting phenomenon in all 4 countries: the generalist notion of a 'partnership' often tends to supplant the specific and well-defined objectives of a functional contract, at least in the minds of the contracting parties.

Secondly, the material collected has its limits. It was not possible to fully exploit the richness of the material gathered under the terms of this study. Therefore, in line with the methodological framework chosen, we focused on the qualitative data, obviously at the expense of the quantitative material - provided among others, by the routine documents of the hospitals. Similarly, the use of qualitative data analysis software (NVivo 8) was limited to the definition of a tree structure for the analysis criteria and encoding of part of the data.

Thirdly there is the quality of the documentary collection. The deficiencies in the filing systems, when they exist at all, are often huge, sometimes even abysmal. This is particularly the case at the peripheral level, especially for data older than 10 years. Difficulties in the collection and identification of the existing documentation are similar. Hence, we often resorted to secondary sources (literature, interviews); this did not eliminate the risk of omissions, however.

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.

Some country-specific limitations need to be mentioned as well:

In Cameroon: the under-representation of the public sector at the peripheral level. Interviews are limited to the Chief District Medical Officer or the District Medical Officer (DMO) as we lacked other operational participants. The DMO was interviewed in Europe where he was staying for studies at the time. He was not really replaced during his absence, which made the field-collection of documents quite difficult.

In Tanzania, a number of documents remained inaccessible to the research team because of the language barrier (Swahili). These mainly included hospital documents (annual reports, reports of the director's committee meeting, etc.) as well as regulatory documents of the Ministry. They were nevertheless collected, so that possible future translations remain an option. This may allow the fine-tuning of our analysis and the correction of probable inaccuracies. The difficulty we had to get in touch with some of the MoH[13] or of the PMORALG[14] staff at central level greatly contrasted with the exceptional level of collaboration and availability of the hospital staff at Nyakahanga. This led to an imbalance in terms of the number of interviews. 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, in spite of the quality of the online information recently made available by the MoH and the PMORALG.

The field mission in Chad was cut short due to suddenly worsening political circumstances. A week of interviews and document collection at the central level was lost as a result. It was not possible to make up for filling the gaps resulting from the shortened field-mission, as we were unable to carry out an extra one. Lack of time also prevented us from deeply looking into the question of health committees and management committees[15] at peripheral level[16]. We opted to address these issues via Hospital Committee interviews instead of administering questionnaires to the Management and

[13] Chief Medical Officer, Director of Planning, etc.

[14] Prime Minister's Office for Regional Administration and Local Government.

[15] COSAN, GOGES.

[16] The creation and functioning of those committees is provided for by the PSSP (*Politique de Soins de Santé Primaires*)

Health Committees as originally planned. Direct contact with the administrative authorities of the district also turned out to be impossible. Overall, the quality and quantity of information gained from the peripheral level was, however, satisfactory.

In Uganda, the main limitations were linked to the difficult access to data on PEPFAR and its local recipients. This problem popped up several times and forced the research team to rely on secondary sources: i.e. other interviews with certain representatives of recipients; secondary literature and documents provided by internet sites of PEPFAR Watch and the US Government Accountability Office [17]. Information on the contracting documents themselves was also sometimes difficult to obtain, especially on financial data. Some of the recipients and beneficiary facilities were reluctant to provide them.

[17] www.PEPFARwatch.org; www.gao.gov

The case of Cameroon

CAMEROON
National capital
Provincial capital
Town, village
Major airport
International boundary
Provincial boundary
Main road
Secondary road
Railroad
© Nations Online Project
Tokombéré District hospital and District headquarters
Catholic Diocese of Maroua-Mokolo and regional Health Delegation
MoH and headquarters of faith-based platforms organisations
NIGERIA
CHAD
CENTRAL AFRICAN REPUBLIC
EQUATORIAL GUINEA
GABON
REPUBLIC OF THE CONGO
Bight of Biafra
Yaoundé
Douala
N'Djamena
Maroua
Garoua
Bafoussam

General context

INTRODUCTION

After two decades of German colonization (1884-1918), followed by the bi-cephalic rule of Great-Britain and France, Cameroon gradually obtained its independence (1960-1961) and entered into a process of country unification. The country eventually became a federal State. Since 1982, Cameroun has been governed by President Paul Biya. It is a democracy with, however, strong autocratic features.

The country enjoyed a sustained growth rate from its independence to the mid-eighties, mainly as a result of the revenues generated by the exploitation of raw materials and more specifically by the development of the national oil industry. The economic growth culminated from 1977 to 1981 with an average growth rate of 13% but remained high until 1985, at around 8% (Mbenda Kombo 2008). In 1986, however, the drastic plummeting of international prices and the 40% depreciation of the USD in comparison with the Central African Franc (CFA) led to a severe economic crisis, which lasted until the implementation of a Structural Adjustment Plan and the devaluation policy of 1994 (Okalla & Le Vigouroux 2001). This economic crisis induced a commensurate crisis in the health sector. Health indicators worsened and allocated budgets decreased. Yet, the crisis seems more qualitative than quantitative (Médard 2001): the network of facilities is relatively well developed and the medical staff and health coverage are quite satisfactory. The same goes for the equipment, at least in terms of quantity. However, equipment is badly maintained and often not operating, and the hospitals' utilization remains low. Generally speaking, taking into account the available means, the productivity of the public health sector appears insufficient. Moreover, the economic crisis resulted in drastic salary cuts for all public officers, the health sector included, which contributed to the demoralization of public health staff. The reputation of human resources in the public health sector is, as a consequence, quite poor: lack of respect towards authority/hierarchy, low morale, low productivity and a high level of corruption. The latter is not only characteristic of the health sector; unfortunately, the problem affects the whole public administration from the higher to the lower levels. One of the main consequences of the situation is

that the largest part of the public health system's costs is supported by the patients.

The Cameroonian health sector has embarked on an almost permanent reform process since the seventies. However, reform often failed or remained insufficiently implemented. The observation applies for instance to the PHC reform. One of the most important policies, launched in 1992, consisted in the reorganisation of the national health system based on the health districts. It was followed by the National Health Development Plan (1998-2008), the introduction of a Minimum Package of Activities for all health facilities and the goal of achieving efficiency and efficacy in the management of resources in 90% of health facilities (Okalla & Le Vigouroux 2001).

The decentralization policy is at the heart of the health system reforms. This policy was introduced by the 1996 constitution and further developed in a health sector strategy document in 1999. Until now, it remains a draft though, possibly as a consequence of resistance by some of the central health authorities to abandon their former prerogatives. The Cameroonian health system has traditionally been characterized by an extreme level of centralization, which led to structural clientelism and related corruption opportunities. The decentralization policy aims at improving the behaviour of health staff through gradual autonomization of health organisations, as human resources are considered to be the main reason behind the crisis of the health sector. As planned by the 1996 constitution, decentralization comes with the delegation of responsibility for the functioning and management of health services to the intermediate and peripheral levels of authority, the central level itself refocusing on more 'noble' activities: the definition of health policies, the follow-up of their implementation, and the definition and control of standards (Médard 2001).

Médard expressed doubts on whether the decentralization policy could ever be achieved considering existing resistance and dysfunctionings. Most of the weaknesses he pointed at in 2001 remain relevant today: an official decentralization policy is still lacking, intermediary and peripheral levels of authority have been put in place but often lack the authority or means to achieve their mission. Moreover, the system is being undermined by a lack of definition and follow-up of responsibilities and insufficient advertising of policy changes at the different levels of authority, resulting in practical confusion. A distinction should therefore be made between the official theory and its informal application or interpretation. On the whole, and

especially for provinces as remote and isolated as the Extreme North province, bypassing of intermediate levels in the best case, clientelism in the worst case still remain necessary to overcome the administrative hassle and dysfunctioning and resolve specific problems.

The decentralization also foresees in the redistribution of resources and reorganisation of allocation authorities, the provincial delegations being responsible for the affectation of staff (also to integrated private not-for-profit facilities) and allocation of budgets. Poor financial management at central level resulting in unsatisfactory allocation of resources, inequity and inefficiency are characteristics of the health sector as mentioned by Médard; unfortunately they have been confirmed in a recent survey conducted by the National Institute for Statistics[18]. This troublesome overall situation also badly affects partnership experiences between the public sector and not-for-profit health facilities, where such partnerships are seen by the State as one of the instruments of the decentralization policy.

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 organisations, in the following order of importance[19]: *Organisation Catholique de la Santé du Cameroun* (OCASC) formerly known as the *Service Catholique de la Santé*, the Conseil *des Eglises Protestantes du Cameroun* (CEPCA) and the Fondation Ad Lucem (FALC). Faith-based facilities are mainly located in rural areas and are open to all levels of society.

Private health facilities have been integrated in the national health system with the health sector reforms. A MoH text dated 1997 specifies that the

[18] *2ème enquête sur le suivi des dépenses publiques et le niveau de satisfaction des bénéficiaires dans les secteurs de l'éducation et de la santé au Cameroun* (PETS 2) - *Rapport principal - Volet santé* - December 2010.

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

State coordinates all health activities in the district, traditional practitioners and private actors included - this is to say, (faith-based) private not-for-profit facilities included. They are therefore meant to enjoy the same rights and respect the same requirements, and are expected to fulfil the same obligations as any other public facility. As such, faith-based facilities complement the public service and even compensate for the absence of State health facilities (Gruénais 2001).

Generally speaking, the productivity of faith-based facilities in Cameroon is considered to be higher, and their quality better than that of the public sector. They doubtlessly often have the preference of patients, as service, accessibility and consideration are experienced as being better than in Public health facilities for equal technical support. Faith-based facilities especially differentiate from public ones in terms of the quality of human resources, a real problem in the public sector. Staffs of faith-based hospitals are considered to practice their profession in a spirit of ministry and to be more disciplined, reliable and dedicated than their public colleagues (Médard 2001; Gruénais 2001).

Faith-based facilities often enjoy external financial support, but in a clearly declining way for most of them. They moreover did not escape the effects of the economic crisis. This growing financial tension is a menace when it comes to keeping up the quality of care and, in the worst case, the accessibility for patients.

The development of partnerships in the Cameroonian health sector is largely explained by both the quantitative and qualitative importance of the faith-based sector in the national health supply. OCASC, CEPCA and the FALC are the main partners in this arrangement and their facilities participate actively in various health policy initiatives like the fight against HIV/AIDS, the organisation of vaccination campaigns, etc.

PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL

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 does have its roots in the past (see Figure 1).

At the time of 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 geographic distribution[20], equipment, personnel and reputation (state supervision being mainly theoretical at this time). For their part, the faith-based organisations were not really involved in the drafting of health policy and oversight by the public sector remained very limited.

As in colonial times, the state continued to allot subsidies to faith-based facilities but the system did not function well[21]; however, this sorry state of affairs did not substantially affect faith-based facilities[22].

The adoption in 1993 of a Primary Health Care Reorientation Policy and the organisation 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. This status, however, was not confirmed officially and had no legal basis.

The contracting process took off in the health sector in the early 2000s, thus preceding the formulation of a national partnership and contracting policy framework by 6 years. Hence, the pilot experiences were isolated cases developed in spite of rather limited interaction between the Ministry of Health and the local Church authorities. They were set up in remote areas where needs had been identified, often because the state proved (financially) unable to ensure coverage by setting up and managing its own facilities. These pilot contracts recognized the essential role played by the faith-based hospitals-which got the status of district referral hospital-, and defined the scope of their collaboration with the MoH.

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

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

[22] Due to support from "mother" congregations and levying of user fees.

It was only from 2000 onwards that the conditions were gradually fulfilled for a formalized contracting policy; more specifically: a collaboration framework (2001); a health sector strategy (2001-2010); and the creation of a sub-directorate for national partnership (2002). Against this backdrop, sector partners gradually agreed - together with the Cooperation Directorate (DCOOP)[23] of the MoH - on the necessity to develop a more comprehensive partnership approach. The process got a boost with the arrival of the 'C2D'project, the French initiative for debt relief of highly indebted countries (see Box 1). The C2D initiative indeed planned to support the PNFP sector and intended to do so by means of contracting. The work of drawing up a partnership strategy was thus started in 2003 and finished in 2006. The models for framework agreements and implementation contracts (see Box 2 for the applicable contracting terminology) were only finalized at the end of 2007. The general C2D contracting process is presented in Figure 2.

[23] DCOOP is an organ of the MoH in charge of formalizing NGO status requests of organisations and of agreeing on their right to cooperate with the State as PNFPs.

Box 1. The French debt relief program in Cameroon : HIPC and C2D

Debt Relief and Development Contracts (C2Ds) stand for France's main bilateral supplement to the HIPC (Highly Indebted and Poor Countries) initiative, which aims at debt relief of low income countries. C2Ds come in addition to the effort made by multilateral donors to relieve HIPC's debt. In the Case of Cameroon, France's contribution accounts for one third of this multilateral effort.

C2Ds are being implemented after completion of the HIPC initiative. C2Ds stand for the refinancing of debts contracted by countries within the framework of public aid for development. Refinancing is ensured by means of donation: countries continue to reimburse their debts but receive a sum from the creditor equal to each completed reimbursement. These donations target the strategic frameworks for poverty relief formulated by the beneficiary countries and are being allocated by common agreement to poverty-relief programs and those contributing to economic growth. The estimated running total of C2Ds for Cameroon is 750 billion FCFA (1, 6 billion USD) for 2005-2020.

Twenty-two - mostly African - countries, amongst which Cameroon, are concerned by this mechanism. For a country like Cameroon, with huge public aid debt to France, several rounds of C2Ds are planned, roughly every three years.

Decisions applying to C2Ds are taken by a joint committee involving the Minister of Finance, the French ambassador, civil society, and potentially members of Parliament. The French Development Agency (AFD) is the organ responsible for C2D implementation in Cameroon, as France assigned the country to its so-called Priority Zone of Solidarity (ZSP).

Funds related to Cameroon's first C2D focus on a restricted number of allocation targets in four major areas; Primary Health Care and disease control (HIV/AIDS) are some of those areas. Allocation targets mainly take the form of sector programs.

A total envelope of 684 million USD had been allocated to Cameroon for the 2006-2010 period, all supported sectors included; 17% of this sum was reserved for the health sector. Specific support to the faith-based health sector accounted for 19,7 million USD, which amounts to 40% of C2D's health sector funding.

Source: French Foreign Office, website of the French Embassy in Cameroun: http://www.ambafrance-cm.org/france_cameroun/spip.php?article697

CHARACTERISTICS OF THE CASE SELECTED

Tokombéré is one of the districts of the Mayo-Sava department in the Extreme North Province [24] of Cameroon, the country's second most populated region [25]. Many inhabitants of this province are of Christian obedience, within a geographical context (the Northern part of the country) where Muslims form the largest part of a mainly rural population. Part of the inhabitants of the extreme North province, living in the mountainous parts of the area and grouped under the appellation of 'Kirdi' [26], were only incidentally converted to the Islam, though traditionally deeply impregnated by religiosity (Aurenche 1996). A part of those groups gradually became Christians after the Second World War, when Christian denominations (first of Protestant-, later [27] of Catholic obedience) started settling in the region. The majority of the area's population however sticks to traditional beliefs (Gruénais 2001).

The bipolarity between Muslim populations on the one hand, and Christian minorities on the other hand, has been strong from Independence until the beginning of the eighties, when the Northern region was considered as a whole and the country was governed by President A.B. Ahidjo, a Fulani originating from the city of Garoua, and of Muslim obedience. This period of time coincided with the segregation (some talk of persecution) of the (Catholic) Kirdis and consistent opposition to the Catholic authorities and their initiatives, more specifically in the domain of health. A good illustration of this situation is given by the example of Tokombéré district, as we will later develop. Difficulties persisted in the first years of Paul Biya's mandate as a president, as Muslim populations of the Northern region remained largely loyal to Ahidjo and continued to hold a great part of local political and administrative mandates. This period of time

[24]The designation 'province' has been replaced with that of 'region' in 2008.

[25] According to the last census report (2010), the population of the Extreme North counted 3 480 414 inhabitants, this is to say 17,5% of the country's total population.

[26]'Kirdi' (Pagan) is a pejorative designation that was given by the Muslim majority to non-Muslim populations, consisting in several ethnic groups differentiated by their languages. Kirdis are concentrated in the mountainous part of the Tokombéré district, whereas Muslim populations (Fulbé and Peuhl ethnic groups) are predominantly to be found in the plains.

[27] Catholic missionaries arrived in 1947 and the first catholic dispensaries were founded around 1960.

saw the partition of the Northern region into three provinces (Amadoua, Extreme North and North) as an attempt by the new president to break the resistance of Ahidjo supporters. Improvement eventually came after 1984 and the definitive eviction of Ahidjo (Gruénais 2001).

The hospital chosen is a private Catholic institution affiliated with the OCASC and owned by the Diocese of Maroua-Mokolo. The facility was founded in 1959 by a Swiss doctor, Dr Maggi, followed in 1960 by the arrival of Simon Mpeke ('Baba Simon'), a Cameroonian priest, originating from the South of the country. The hospital further developed under the impulse of Christian Aurenche, a French expatriate priest and medical doctor, arrived in Tokombéré in 1975. Dr Aurenche has since then assumed the position of chief medical doctor of the hospital, a rather rare case of long-term management stability. Tokombéré hospital was for a long time the only health facility of any importance in the region. It also is part of a larger, original and probably non-reproducible project: the *Projet de Promotion Humaine* (PPHT), i.e. the Project for Human Promotion, launched by the Catholics in Tokombéré, formalized from 1975 into a 'holistic' or global development project covering health, education and agriculture (the latter being the main resource generating activity in this rural area) and strongly involving local populations in their own development and future. The health-related part of the project includes the hospital itself, defined as 'centre for health promotion', a series of itinerary agents responsible for outreach activities, and the villages themselves (defined as 'centres of gravity for health'). The rationale behind the project lies in overcoming the concentration of health activities in curative interventions, by introducing prevention and health promotion activities, all concentrated at village level and requiring the adherence of all villagers (Aurenche 1987).

By adopting this system Tokombéré engaged in a PHC approach as early as 1976[28] and became a national pilot centre in 1978. The project holds recognition at international level[29]and has been the subject of several studies since its creation (Fontaine 1995). At first, the regular outreach activities conducted by the hospital under this PHC project also included visits to

[28] Tokombéré hospital was the first one in Cameroon to implement a PHC policy.
[29] PHC project presented to the 4th session of the Regional African Bureau in 1980; Sasakawa price awarded to Dr Aurenche by the WHO in 1988.

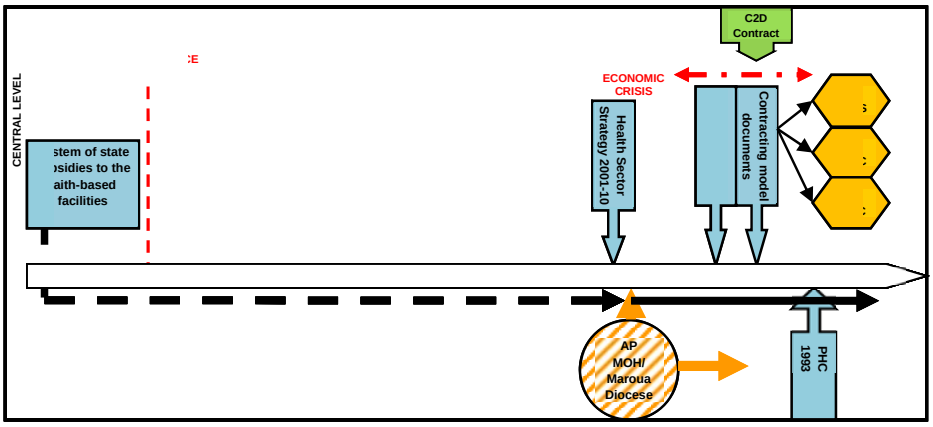
public health centres. This explains in part why Tokombéré hospital (HTok) was able to hold on to its position even during the crisis of the eighties, before the adoption of the PHC reorientation policy, whereas other faith-based hospitals were faced with ever growing difficulties at that time. Part of the explanation lies in the reputation of the hospital and the fact that Dr Aurenche, a man with strong leadership skills, has worked in this hospital ever since 1975, and attracted important outside support[30]. All these factors combine to create a climate in which the staff is totally committed to the project.

As a result HTok enjoys an excellent reputation that ensures the loyalty of the local population: the hospital has a catchment population that goes well beyond the borders of the province (Chad, Nigeria). This reputation owes a lot to the active implementation of the PHC project and the outreach activities that were 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.

Though still relatively small until 5 years ago, the hospital is nowadays a medium sized facility of 160 beds, employing 65 persons with running costs of about 260 million FCFA (570.871 USD) on a yearly basis. It serves a district population of about 100.000 people.

[30] The *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. Contracting process and Tokombéré contracting experiment in the overall context of Cameroon



LEGEND

AP Agreement protocol
C2D Debt relief contract
PHC Primary Health care
FA Framework agreement
MOH Ministry of Health

Public sector
Faith-based sector
Donors
Relation between central and peripheral level
Framework agreement
Service level agreement
Formal relationship
Informal relationship

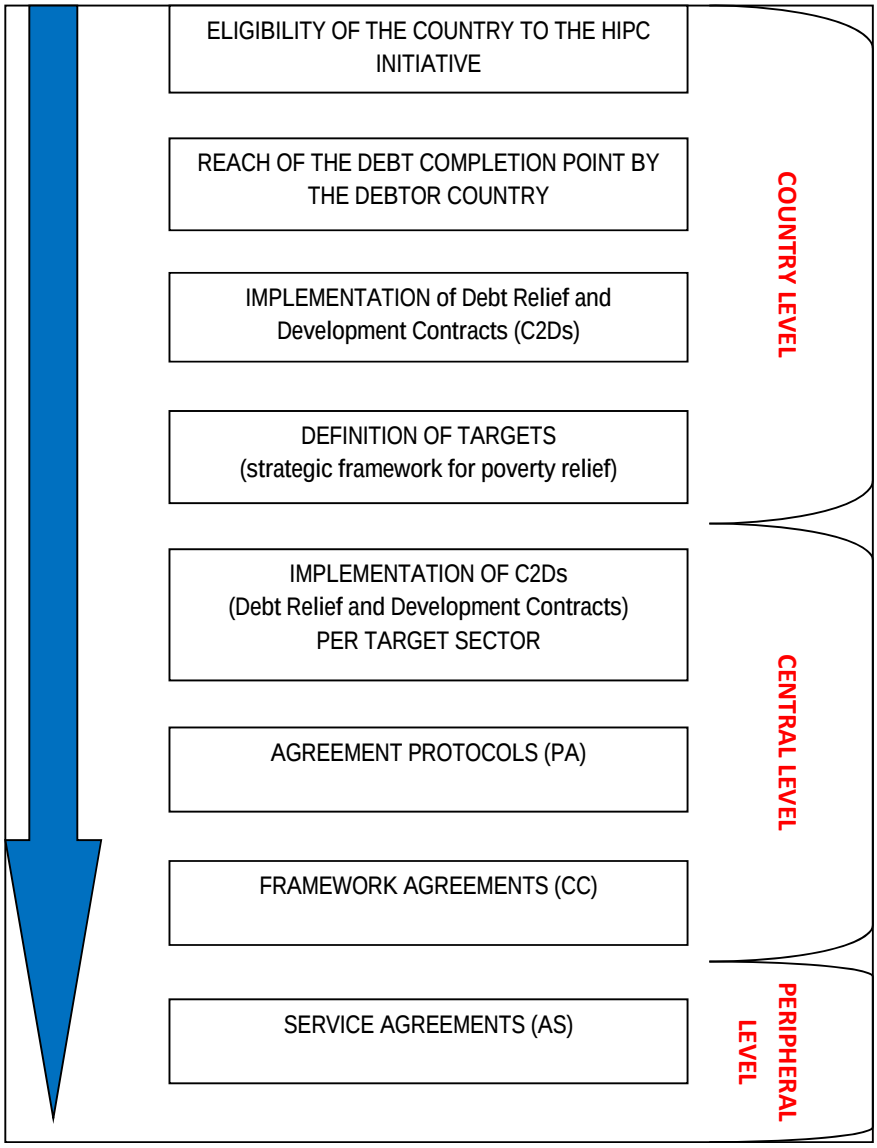
Box 2. C2D Contracting terminology in Cameroon

***Protocole d'Agrément* (PA)/Agreement Protocol :**
Signed protocol whereby public and faith-based authorities at central level declare their intention to collaborate with one another.

***Convention cadre*/Framework agreement (CC):**
Signed agreement (contract) whereby the framework (concepts, modalities, instruments) of partnership is defined between the MoH and a specific not-for-profit organisation at central level.

***Accord de service*/Service agreement (AS):**
Signed agreement (contract) whereby the collaboration between the public health authorities and a specific health facility at peripheral level is defined and detailed.

Figure 2. General C2D contracting process



Results of the interviews and the analysis of documents

CONTRACTING AT CENTRAL LEVEL: FROM DIALOGUE TO FORMALIZATION

Gradually, the Public-PNFP dialogue was formalized; from distant and rather informal collaboration it evolved into a true partnership, including increasing participation of the private (not-for-profit) sector in joint policy organs. Nevertheless, it still took 8 years - from the health sector strategy to the publication of the partnership strategy and framework agreement models - before a legal framework was finalized. If the partnership strategy was the result of sector wide collaboration, the final phase of the process benefited from the specific input of the three main religious PNFP organisations: OCASC, CEPCA and FALC. It also benefited from an essential boost: the setup of the C2D in Cameroon. This provided the necessary financial means and led to strong political commitment to launch the contracting process. A health sector review was conducted by the C2D debt relief project to identify priority areas and beneficiaries. The focus for the first five years was directed to two aspects: the financing of a contracting strategy on the one hand, and on debt relief and structural improvement of faith-based facilities on the other. The relative weight of the three central faith-based networks as health service providers explains why they were chosen as priority beneficiaries.

The C2D initiated - and therefore largely framed - the formalization process of the partnership. This constraint explains why the development of contracting, as a partnership strategy instrument, largely proceeded without referring to the former contracting experiences. The latter came into being between peripheral health facilities and the MoH as soon as2002, in other words, before the launch of the C2D project[31] and the formulation and signature of the first contracting framework documents. The people approached at the central level, from the public as well as the faith-based sector, link the formalization of the contracting process in their discourse to the debt reduction contract, relegating to second place the earlier operational cooperation experiments.

[31] In Cameroon, the HIPC initiative was completed in 2000. Preparatory sector reviews were then conducted by the C2D project, starting in 2003. The whole process culminated in the formulation of a central level contracting framework and the signature of framework agreements by the MoH and the three faith-based networks in 2005-2007.

The most important central level contracting documents are the agreement protocols signed between the MoH's main partners (OCASC, CEPCA, and FALC) and the MoH within the framework of the C2D. In this study we will concentrate on the framework agreement 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 implementation contract.

The tools of contracting are currently being implemented; some are already operational, while others have not yet been put in place. The situation can partly be explained by the delay in the disbursements of C2D. For example, the steering committee foreseen by the partnership strategy, a key instrument for its set-up, has not yet become operational. Its tasks are for the time being carried out by the steering committee of the health sector strategy.

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

These contracts foresee regular follow-up meetings, with the production of written reports by the private partners (e.g. justification of the use of the funds), as well as regular monitoring (every 3 to 6 months) to review and decide on possible adjustments. The MoH has, in this context, the right to evaluate: it has the power to carry out supervisions and follow-up missions in the field. This amounts to an additional administrative instrument next to the contracting tools.

At this stage, it is difficult to assess whether these different tools are efficient and to what extent they can be used since the partnership strategy is still in a very early stage of implementation. The recent payments of the first C2D funds, however, should help speed up the process, but only at a later stage will we be able to assess the situation. Currently all involved emphasize the quality of the relationship, though for the denominational partners this is tempered by worries about the delay in access to the funds promised[32]. Also stressed is the quality of communication. There must be a smooth transfer of information from faith-based facilities to the public sector and a

[32] The payment of the first C2D funds in 2009 may have decreased their worry. During our field trip though, this sentiment prevailed in the faith-based sector.

climate of dialogue, ensuring also that the available information is up to date. We have to point out, however, that in the absence of a specific steering committee, the relations between the public and private sector have tended to develop in a rather "bilateral" fashion, typically through one-on-one, ad hoc exchanges. At the peripheral level, the faith-based sector mostly took the initiative.

At the 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 strong appeal of the faith-based facilities in comparison to their public counterparts in rural settings, due to a reputation of good quality care.

Economic elements:

- The general burden of debt and the reduction of the health budget as a result of the economic crisis of the 80s. Obviously this has affected both the public and the PNFP sector and added to the difficulty of the MoH to ensure financing and adequate coverage of the sector;
- Due to its commitment to economic reform, 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 reduction in support from traditional sources and the effect of the economic crisis, has led to a growing inclination to collaborate with the government;
- A common concern to overcome stalemate situations resulting from a lack of financial resources in faith-based, peripheral hospitals due to competition and old conflicts with the public sector.

External and short-term aspects:

- The pressure and support from donors and international organisations to integrate the private sector in the general offer of care: the WHO was the first organisation to plead in favour of developing a partnership

strategy, already in the initial phase of the inter-sector dialogue. In 2003-2004 the C2D project further built on this idea.
- An undeniable advantage in the 90s was the presence of key MoH people who encouraged the public-private partnership.

Political elements:
- The introduction in 1996 of the decentralization policy [33] that theoretically gave more autonomy to the local entities to manage social issues like health, education, local development. De facto, however, centralization remains a key feature of Cameroon's health administration as the decentralization policy was never fully implemented.

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

Although the contracting strategy implementation has now reached a relatively advanced stage, it was a rather long process, due to a number of factors, which even now continue to play a role:
- The strong de facto centralization of the level of decision making and the heavy bureaucracy in which results depend mainly on the people and not on the legal mechanisms;
- A high level of corruption made even worse by complex financial management procedures. Due to earlier negative experiences, PNFP actors tend to distrust the State, fearing that the government will again fail to keep its commitments;
- The limited financial capacity of the MoH to support the development of the partnership by means of a contracting process. The completion of the HIPC Initiative made it possible to give another boost to the process as the French debt relief programme included a health contracting component;

[33] Constitution of 18 January 1996.

- The extremely slow payments by the C2D programme which in turn led to a slowdown in the implementation of the new legal framework. The signing of the framework agreements between MoH and faith-based networks in October 2007 was prominently covered in the national media; more in particular, the importance of allocated funds was emphasized. Unfortunately, at the time of this study, the funds had not yet been released. Yet, public opinion in Cameroon was not aware of this. The three faith-based networks and their leaders were thus not able to fulfil the promises made when signing the C2D framework agreement; worse, they were even suspected of stealing funds that had failed to materialize[34];
- 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 and tools (and of their use) is mainly limited to the central level. The actors in the district remain largely in the dark.

On the whole, the actors agreed on the good quality of the relationship throughout the process. This can be gathered from 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 PNFP facilities. Mainly the last phase of the process is being criticized, i.e. the implementation phase of C2D. The development of the partnership strategy and contracting document models is, on the other hand, generally seen as a period of intense collaboration and mutual understanding. People complain about the slow process and cumbersome bureaucracy involved in the actual release of C2D funds. More often than not, the agreed payment time frame is not respected.

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

CONTRACTING AT INTERMEDIATE AND PERIPHERAL LEVEL: THE TOKOMBÉRÉ CASE

The contracting process

In 2002, an 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 setup of a district system. This proto-contracting case saw the light when the power in Cameroon was still strongly centralized, both theoretically and de facto. 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 excellent reputation on the other. HTok respects its duty to organize and carry out health service activities - and more specifically the PHC programme - in line with the National Health Policy and in the foreseen administrative constituencies.

But it was actually the implementation of the PHC project at HTok, which served as an example for the development of a national contract model. This decision is thus strong indirect proof of the State's recognition of the role played by the hospital. However, the direct support of the State remains limited (inherited from colonial times) and has never been formalized.

The possibility of a contracting relationship has been discussed since2000 at the initiative of the public authorities. The Provincial Health 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 would benefit both parties. The distrust of the religious authorities, worried that their facilities would be taken over completely by the state, had to be overcome. In the middle of the 80s there had been a temporary setback in the process with the creation of a public health centre almost next door to HTok, with the perspective of this health centre becoming eventually a district hospital. A doctor was appointed to the health centre, which, although not operational, rapidly drained the public funds at the expense of HTok. Furthermore, the District Chief Medical Officer prohibited HTok from doing PHC outreach activities in other public health dispensaries of the District. The hospital had been involved in such activities since 1976, being the only hospital in the

catchment area. As a result, relations between HTok (its Chief Medical Officer) and the local elite became rather tense.

The process ended in 2002 after two years of negotiations. The agreement document, which had been drafted by the DP of the Extreme North, was discussed in detail with the chief medical officer of HTok. Once signed, implementation started rapidly. The slow pace of the contracting process was caused by two issues. At first, the resistance of the religious authorities had to be overcome: they feared losing autonomy and control, but were also suspicious, as the State had gained a rather bad reputation from corruption and bad governance issues. But once the chief medical officer of HTok had been convinced, he actively assisted the DP in persuading the Diocese of the opportunities presented by the arrangement.

There was a need to resolve the conflict between the chief medical officer of HTok and the local elite, who wanted to maintain the public hospital. This local elite had to be convinced; support had to be obtained from the chief medical officers of both HTok and the neighbouring public health centre; and a reclassification solution needed to be found for the latter, as it was no longer intended to be funded, staffed and administered as a District Hospital.

These negative elements were however largely overcome by a substantial number of positive elements:

- Paradoxically, the resistance of the population, alarmed by the possible retreat of HTok staff from public health areas, sparked a multi-sector discussion on the issue of the coexistence of the two hospitals;
- The active involvement of the DP and later the Chief Medical Officer of HTok. The start of the decentralization lent 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;
- Due to its poor financial resources in the aftermath of the economic crisis of the 80s, the State was forced to integrate the faith-based sector in the health map;

- The leading role played by HTok[35] 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. redressing the current 'aberrant situation' in which the facility was not integrated in the district health system; ensuring support for the activities carried out in the hospital; and obtaining legal status and legitimacy;
- The pressure of some donors[36] on HTok to align with the National Health Policy, and be more transparent vis-à-vis the State.

Contract features and mutual obligations

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 (district) hospital, and on issues related to the organisation of the district. Neither of these elements is clearly put forward as the principal objective of the contract; all this has to be decoded through careful reading of the clauses. As the majority of the clauses are about the district hospital, the MoH, the Diocese and HTok tend to consider the formalization of this status as the subject of the contract. The Diocese represents 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 though the content of the document was primarily discussed with him.

The Ministry of Health represents the public side in the contract, which might seem paradoxical, but reflects the persistence of a centralized policy process, in spite of the proclaimed decentralization policy of 1996. Legal references are clearly stipulated[37], although they cannot be considered a guiding, legal contracting framework: they rather consist of fragments of sector policy documents in which the commitment to engage in public-private collaboration is expressed.

[35]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.

[36] More in particular the Belgian Technical Cooperation (BTC).

[37] Framework law n° 96 in the Health sector; Development plan; Health sector strategy.

The obligations of the State are twofold:

- On the one hand, the clauses that relate to the organisation of the health district include the recognition of PNFP health facilities "as centres responsible for the health zones within their area of location. They also cover the appointment of a chief medical officer, the allocation of means to the health facilities - i.e. staff and financial support - and keeping up the dialogue.
- On the other hand, the recognition of HTok as a 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. Nevertheless, the private Catholic health centres are being supervised by HTok, in a tacit manner though. The contract makes no mention of the specific nature of the facility (religious identity) except for a reference made to HTok as a "private hospital of Tokombéré".

The obligations of the Diocese concern the hospital of Tokombéré:

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

The contract foresees the installation of a Steering Committee, involving both PNFP and public sector stakeholders[38], which has to monitor contract implementation in its annual meeting session. However, no functioning mechanisms are foreseen for this steering committee, thus allowing room for interpretation. The contract is for one year with a tacit possible renewal, but there is no clause in the agreement on revision issues. The cases in which termination is possible are modelled on normal legal formulas. The question of resolving possible conflicts is not touched upon.

[38] The CMO and other key staff members of the hospital, the bishop or its delegate, the DP, as well as - theoretically - the Minister of Health or his delegate. In practice, the DP always ends up representing the Minister.

The Steering Committee is thus the only tool mentioned; it is clearly perceived as a management instrument for the contracting relation. This committee is theoretically supposed to meet twice a year, gathering the different levels of the hierarchic pyramid to assess the contracting relation. The difficulties that can arise in the various settings when implementing contracting are discussed, and solutions put forward. The theoretical usefulness of the steering committee is unanimously recognized, but its functioning is hampered in practice, for several reasons:

- The number of times the committee gets together: in practice, only one meeting is held annually, which is clearly seen as insufficient by the members;
- The fact that the operational mechanisms and the respective responsibilities are not clearly defined;
- The central level (MoH) delegates its responsibility systematically to the provincial representatives. The communication between the intermediate and the central level is thus largely dependent on the level of competence and the goodwill of the provincial representative;
- There is no feedback from the MoH on the reports from the DP. Moreover, these reports tend to be produced and distributed with considerable delay. The same (i.e. lack of MoH feedback) is true for the financial and activity reports of the hospital. The resolution of the problems is difficult as the MoH is supposed to remain the ultimate decision maker.

The Bishop and/or the Chief Medical Officer sometimes intervene directly in Yaoundé but they lack knowledge of the mechanisms at work at the central level. Communication is therefore often one-way, from faith-based district level to MoH. The coordination meetings at the district and the provincial levels are considered a useful addition but do not really allow addressing more specific contract questions. They tend to focus on the general implementation of the national health policy and the coordination of scheduled healthcare priorities and service delivery. Overall, these difficulties considerably hamper a smooth relationship[39].

[39] In practice, every year the same difficulties show up, without a concrete solution being found.

Perception of the relationship

The perception of the relationship depends not only on whether the declared objectives of the contract were reached, but also on the respective expectations of the parties involved. On the public side, these expectations are the improvement of health coverage and the care for the population through the integration of the health system. For the faith-based sector, the contract is seen as an instrument to gain 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 the take-over of staff) is only of secondary importance[40]. Of the latter, mainly support in HR is appreciated, doubtlessly because the hospital can put up with relatively limited financial support from the State[41] due to its own external resources. Public authorities and denominational actors acknowledge unanimously that the hospital fulfils its obligations. The only reservation made by the public authorities concerns the poor knowledge of the hospital (or the faith-based authorities) of MoH procedures.

There is also unanimity - both from the public and denominational sector - about the fact that the State does not respect its obligations, which is seen as a major obstacle to the implementation of the contract:

- The subsidies are limited and paid irregularly. In spite of regular complaints there has never been an investment budget allocated to the hospital. 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 considered problematic. Tellingly, 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.). The fact is that the hospital functions despite the fact that it does not, or only partly, access the State's subventions. This lack however is also the main reason why the functioning of the hospital remains very dependent on external funding, whereas a regular flow of public resources, theoretically provided by the law, would help to reduce this dependency or enable further improvements contributing to a better quality of care.

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

[41] State subsidies take up only about 10% of the HTok budget.

- Although the State allocates staff to the hospital, this personnel is generally perceived as being of poor quality. This staff allocation is moreover made without any consultation, and therefore does not always meet the real needs of the hospital. There are complaints, too, 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 rather than under that of the hospital's management.
- Finally, the official recognition of HTok as a district hospital was foreseen by the initial 2002 agreement, but does not figure in any official MoH declaration or document. HTok would like to see it otherwise, obviously, and has repeatedly complained about this omission to the MoH, but so far to no avail.
- In terms of organisation of the district, the collaboration on public health activities between the HCs and the hospital is weak.
- The relationship also suffers from the heavy bureaucracy and opaque State mechanisms. The procedures to get financial support are complex, for example, and often insufficiently grasped by the hospital staff.

Conversely, 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 and better quality of the information provided);

For the denominational side the positive changes are mainly seen in:

- Gaining legitimacy [42] which is an advantage in consultations with possible donors;
- The allocation of financial resources [43], equipment (ad hoc) and subsidized drugs (through vertical programmes), which are much appreciated benefits, in spite of their relative insufficiency. Also, the assignment of State personnel has provided the hospital with a doctor and three extra nurses;
- A better level of collaboration: the hospital has more visibility in the referral/counter-referral system that has been set up. The hospital can take part in meetings organised at the provincial level and in a number of training programmes, and is now integrated in the provincial health system.

  As for the negative aspects, the hospital mentions the counterproductive influence of the introduction of public staff on the behaviour and morale of faith-based staff (both in terms of their professional ethics and a feeling of injustice due to differences in treatment).

Conclusion

The contracting experience in a Cameroon district 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 now) 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 here guarantees mainly a status quo. The fact that the decentralization process was never finished in Cameroon has a negative influence on the contracting experience:

[42] The status of operational unit (UPEC) for the fight against HIV/AIDS is added to the status of district hospital.
[43] 15 million FCFA subsidies, 14 million FCFA credit.

- The decentralization policy initiated in 1996 was never fully implemented: intermediate and local levels of responsibility exist but they 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 towards 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, as well as a difficult and blurred 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 involvement of some people and individual skills continue largely to determine the quality of the contracting relationship and influence its development.
- The further institutionalization and operationalization 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 is essential, notably for questions linked to resources. There is also a need for substantial improvement of the flow of information.
- If the need and the theoretical advantages of contracting are recognized by most actors, its mechanisms and setup still need to be improved.
- The need for training remains evident for the people in charge in the denominational and public sectors and this at all levels of the pyramid. More in particular, this is essential for actors at the peripheral level as they are likely to be directly involved in new contracting arrangements. People at the peripheral level also clearly need to be initiated in 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. There is a need to think about the possibility and ways to integrate these older experiences in the new partnership strategy, notably through their update and adjustment to the more recent contracting document models. If they stay outside the framework, the actors of earlier protocols in the private not-for-profit

sector (like HTok) will probably face ever greater difficulties in finding structural answers to the problems they meet.

- The notion of performance and the definition introduced by the new partnership strategy and the framework agreement models are a great improvement. Earlier protocols could greatly benefit from a revision that would adopt comparable principles.
- The integration of all contracts in the national framework depends on whether they can be traced more easily: at the moment, nobody - neither public nor faith-based actors - seems to have an overview of the existing protocols. The mushrooming of controlling public authorities probably explains this situation.
- Financing of the partnership and contracting strategy currently depends on the C2D project: beyond this five-year time span, there is no guarantee that funding will remain available to ensure the continuity and extension of the contracting process. This may more specifically affect the implementation of contracting arrangements at peripheral level.

The case of Tanzania

Nyakahanga Hospital, ELCT Diocese of Karagwe, and Karagwe District headquarters
Mwanza: CSSC Lake Zone office
Dar es Salaam: MoH & CSSC headquarters
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KENYA
BURUNDI
ZAMBIA
MALAWI
MOZAMBIQUE
DEMOCRATIC REPUBLIC OF THE CONGO
INDIAN OCEAN
Lake Victoria
Lake Tanganyika
Lake Rukwa
Lake Nyasa
SERENGETI NAT. PARK
RUAHA NAT. PARK
TARANGIRE NAT. PARK
MT. KILIMANJARO NAT. PARK
Masai Steppe
KIPENGERE RANGE
Bukoba
Musoma
Mwanza
Geita
Kibondo
Kahama
Nzega
Kasulu
Kigoma
Ujiji
Tobora
Kaliua
Singida
Kondoa
Arusha
Moshi
Same
Mkomazi
Tanga
Wete
Pemba
Pangani
Korogwe
Handeni
Manyoni
Dodoma
Mpwapwa
Morogoro
Sadani
Zanzibar
Kibaha
Dar es Salaam
Mafia I.
Utete
Iringa
Mpanda
Sumbawanga
Mpui
Chunya
Mbeya
Tunduma
Tukuyu
Njombe
Songea
Lindi
Mtwara
Nachingwea
Masasi
Newala
Tunduru
UNITED REPUBLIC OF TANZANIA
National capital
Provincial capital
Town, village
Airport
International boundary
Main road
Secondary road
Railroad
0 100 200 300 km
0 100 200 mi

General context

INTRODUCTION

Tanzania became independent in 1961. The TANU party and more in particular Julius Nyerere seized power. While the first years of Nyerere's government did not challenge the capitalist development model and proceeded with an expansion of basic public services, the Declaration of Arusha in 1967 marked a clear and theorized shift to 'African Socialism' or *Ujamaa* (Gibbon 1995) and the economic and political take-over of all key sectors of activity, including the provision of social services that had remained predominantly governed by private (not-for-profit) providers as a continuation of the situation prevailing during the colonial era.

One of the particularities of the *Ujamaa* model of socialism was that it maintained religious freedom in a context of separation of Church and State. Churches were requested to support the Government policy and contribute to the national objectives: a pragmatic interpretation of Socialism in a context where (Christian) Churches were increasingly influential [44] (Ludwig 1999). This peculiar situation forms the basis of what has often been considered from the outside as a model of harmonious relationship between State and Church.

Although fearing for a Marxist, atheist drift (a fear justified by a large number of nationalizations of Church-owned education and health facilities) most Churches indeed cooperated with the government, by gradually reorienting their social mission in line with public development policies (Leurs *et al.* 2011). In 1972, this climate of dialogue even led to the authorization of functioning of faith-based health facilities - so called 'District Designated Hospitals' - in exchange for increased public control and regulation.

The *Ujamaa* policy remained, however, generally characterized by a high level of centralization. The 1972 act further increased this level of centralization, by removing local governments at the district level. The production of health services was already centrally managed, but the 1972

[44] The number of Tanzanian Christians increased, between 1961 and 1990, from 2 to 8 million (Ludwig 1999).

act also led to the centralization of the management of all public health workers. This situation persisted until the severe economic difficulties[45] in the late seventies and the subsequent crisis of the Governmental social services forced the regime to reconsider its policies. A decentralization phase was initiated in 1982 by the adoption of a series of laws gradually restoring democratic local governments. This decentralization trend deepened in the mid 90's with the Local Government Reform Programme (Munga *et al.* 2009). The health sector was included, as decentralization was seen as one of the main strategies of the health sector reform.

Decentralization in the Tanzanian health sector rests on a solid set of policies and guidelines and is in principle threefold: fiscal, political and administrative. Districts have been empowered with tax raising power and are granted funds to run district community services. Priority setting and resource allocation planning have been delegated from the MoH to the District councils; finally, local government staff (including health workers) administratively fall under the authority of the District Councils.

Whereas those measures have brought obvious theoretical improvements in terms of district level health service planning and delivery, the implementation practice learns that the decentralization experience remains unsatisfactory in many ways (Munga *et al.* 2009; Maluka *et al.* 2010). A number of dysfunctions continue at District level including unclear delineation of powers between the Local Government Authority and health community and boards, power imbalances (the decision-power regarding health issues is concentrated in the hands of the District Medical Officer (DMO) and the Council Health Management Team (CHMT)), power distortions between perceived and theoretical powers and distorted perception of reference authorities, lack of community participation, limited knowledge of political actors (full district Council) on health matters, lack of information sharing (the overwhelming national planning guidelines tend to be only available at the DMO's office, whereas community and private providers remain little knowledgeable), lack of capacity, time and resources. The priority-setting and planning process is often hurried and complicated

[45] This period coincided with the international economic crisis of the late 70's and was further aggravated in Tanzania by the demise of the East African Community (1977) and the economic impact of the war with Uganda (1979-1980).

by insufficient empowerment and involvement of the community and non-public health care (often faith-based) providers: they tend not to be consulted in the priority-setting process; CHMT members often dominate decision-making on the allocation of funds.

The question of funding is one of the main issues when it comes to the power relationship between District and Central Government: a lack of funds affects the priority-setting and planning process by impairing supervision capacity; funds allocated do not, in most studied cases, match planned needs and their provision is often untimely, resulting in disruptions of health care delivery; the district's financial planning and allocation authority is limited by budget ceilings, a high level of conditionality and earmarking that matches local needs. The communication channels from District to central level are indirect, passing through the Regional Medical Officer (RMO) to the MoH via the Prime Minister's Office for Regional Administration and Local Government. This is a potential obstacle for problem solving when combined with unclear perceptions of powers of authority, which often is the case due to a lack of regulation knowledge.

Moreover, as Public Private Partnerships are one of the decentralization strategies, problems affecting the functioning of decentralized fiscal, political and administrative powers can negatively impact partnership dynamics and experiences.

FAITH-BASED HEALTH SECTOR IN TANZANIA

When Tanzania became independent (1961), missionaries ran half of the hospitals. According to recent (2006) statistics, the private not-for-profit sector - in which the faith-based facilities make up the overwhelming majority - is still the second biggest provider of health care in the country. This so-called 'voluntary' sector holds 17,7% of the health infrastructure (against 64,2% for the state), but 39,7% of the hospitals (see Figure 3). According to an official census, 41% of hospital beds belong to faith-based structures. Obviously, care in faith-based facilities complements care provided by the public sector in Tanzania.

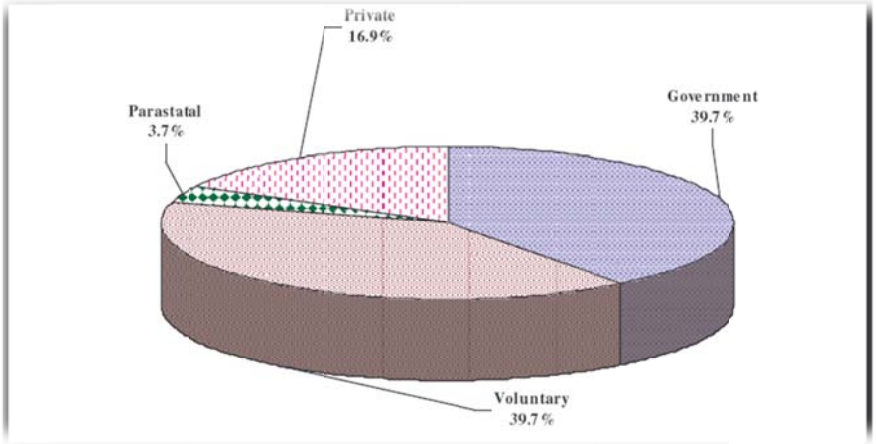
All Christian health and education institutions/facilities are centrally coordinated the Christian Social Services Commission (CSSC). CSSC

functions as an umbrella organisation for the CET and TEC[46] education and health sectors' activities and facilities and operates as the Ecumenical body for co-operation with the Government in the health and education sectors. As for the health sector, CSSC supports, and represents the interests of 89 hospitals, 75 health centres and 680 dispensaries (2011), the majority of which belong to the Catholic Church, followed by the Lutheran (ELCT[47]) Church: in all, about 40% of all health services in Tanzania (Ministry of Health and Social Welfare, 2008). Twenty faith-based hospitals and 120 health centres and dispensaries are run by ELCT, a claimed 15% of the country's health services. CSSC's Muslim counterpart at central level is known as BAKWATA[48], which runs 110 Muslim dispensaries in the country.

CSSC represents the interests of its member Churches in various health-related platforms at central level and furthermore actively contributes in policy formulation at central level. It is as such deeply involved in the Tanzanian PPP dynamic, as a member of the PPP Technical Working Group of the MoH. CSSC also is an important player in disseminating the PPP strategy at lower level, by organizing for instance regional PPP meetings that bring together public and private stakeholders. The recent decentralization process initiated by CSSC is sustaining the process as 5 CSSC Zonal Policy Fora[49], responsible for implementing CSSCs Head Office policies at a decentralized level, act as regional partnership platform responsible for promoting PPPs and fostering partnerships. The idea is to implement this also at the district level sometime in the future. Karagwe District in the Kagera Region falls under the Lake Zonal Policy Forum.

[46] The Christian Council of Tanzania (CCT) is the central governing body of protestant Churches, and the Tanzanian Episcopal Conference that of the Catholic Church.
[47] Evangelical Lutheran Church of Tanzania.
[48] National Muslim Council of Tanzania.
[49] Eastern Zone, Western Zone, Northern Zone, Southern Zone and Lake Zone.

Figure 3. Number of hospitals by owner - continental Tanzania 2004-2005



Source : MoH, ASA 2006

PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL

(See Figure 6 for an overview of the Tanzanian contracting landscape in context, showing the case of Nyakahanga DDH)

State overtures to the Church started during the colonial period and continued as a consequence of the active involvement of some of the religious authorities in theorizing on the independence and the recognition of liberation movements. The rapprochement culminated after Independence under Nyerere. The particular interpretation of socialism (*Ujamaa*) that was typical for Tanzania, laid the foundation for a closer relationship that not only maintained religious freedom in general but at the same time reinforced the control of the State. This system - although creating tension in the field - marked the origin of the *Tanzanian model* of collaboration between the Church and the State. People today still act with this cooperation model in mind. The validity of this model is one of the issues that will be treated in the study.

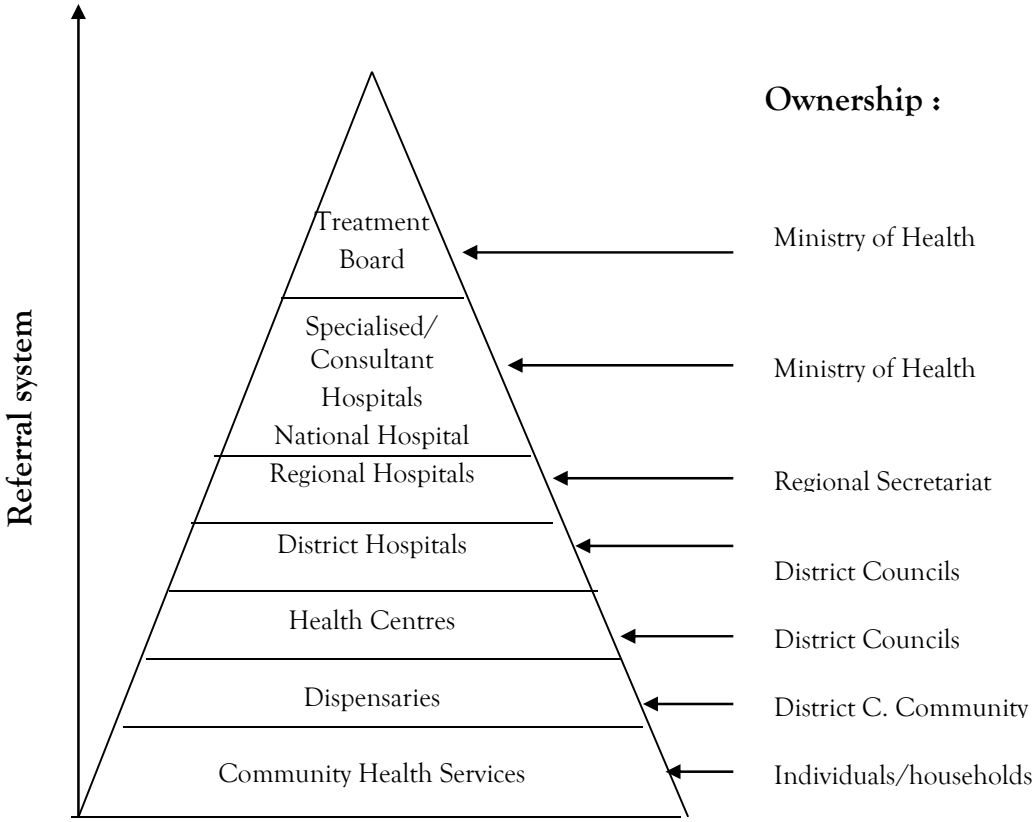
In the health sector the collaboration between the State and the Church rests on recognition of the crucial role played by faith-based health facilities in covering the territory. This recognition - however informal - came as a

logical consequence of the Arusha Declaration (1967), which, in setting the framework of the *Ujamaa*, also included the adoption of the principles of primary health care.

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 current 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 (NHP, Health Sector Strategy, Decentralization Policy, etc.). The cooperation modalities are therefore mainly defined at the operational level, through three contract models, which govern the relations between providers of hospital services and the State.

The cooperation reached a climax in 1972 with the implementation of a decentralized pyramidal health system and a contract model that elevated a number of faith-based hospitals to the rank of District Designated Hospital (DDH). The overall pyramid of health services in Tanzania is presented in Figure 4.

Figure 4. Organisation of the Tanzanian health system



Source : MoHSW, 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. DDH Agreements allowed the concerned faith-based facilities to request State funds to cover their current expenditures including the salaries of qualified staff. The owners (Diocese, Congregation) only had to fund investments and recruitment of staff. 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.

In 1992 the CET and TEC Churches negotiated 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 the Government declared its willingness to support the Churches by sharing with them possible external grants. It also offered protection against future nationalization attempts[50]. The MoH also approved in 1992 the creation of the Christian Social Services Commission (CSSC), which became the Christian body for co-operation with the Government in the health and education sectors. At the same time, the public- private partnership concept made its official debut in the health sector. The first National Health Policy (1990) introduced the cooperation principle with the private sector. This was then consolidated through the 2003 NHP, followed by the health sector strategy (2003-2008). In addition, specific bodies were gradually created to facilitate cooperation: the national partnership forum, the technical PPP working group and lastly the partnership unit at the MoH.

In recent years new contract models have been developed together with private partners:[51]

- In 2005, a revision of the DDH contract model took place in line with the decentralization policy (signed at the district level);
- Finally, in 2007 a new type of operational contract was introduced (Service Agreement, SA). It applies, in principle, to all health facilities, private and public, who deliver public services. In practice, this new contract applies mainly to faith-based facilities (so-called 'Voluntary Agencies' or VA), with the exception of the DDHs (see Box 3 for further details on DDHs and VAs).

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

[51] CSSC for the faith-based sector.

At the time this study ended however, Tanzania had no specific partnership policy or contracting policy documents embedding the principles and modalities of cooperation in the health sector.

Box 3. Faith-based hospitals in Tanzania : Voluntary Agencies (VAs) and District Designated Hospitals (DDH)

All private (not-for-profit) health facilities that registered with the MoH[52] 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 been involved in the contracting process since 2007 and the creation of service agreements (SA): only a small part of them have since then signed such an agreement, the major part of them functioning on the mere basis of their accreditation. The Service Agreements define a series of operating criteria: achieving set objectives (performance indicators) determines access to State benefits. If there are no SAs, the VAs are only entitled to limited support from the Basket Fund[53] managed by the local government. In contrast, VAs that signed SAs also receive block grants.
- The DDHs are faith-based hospitals officially designated (by contract) by the MoH as district referral facilities. DDHs benefit simultaneously from a Block Grant of the Ministry of Health and part of the local Basket Fund.
- The faith-based network also has two national referral hospitals[54], also benefiting from State support.

[52] Registry of Private Hospitals, MoH.

[53] The Health Basket is a funding mechanism that has been established in 2000. It is funded by a group of Government and Development Agencies that pool un-earmarked resources to support the Health Sector Reform's implementation through the Health Sector Strategic Plan III. This plan has been defined jointly by all Health Sector Stakeholders within the Sector Wide Approach.

Those basket funds come in addition to the so-called 'block grants', which form the recurrent funding of health at local level. These grants are awarded to each Local Government Authority (LGA) on the basis of four allocation factors: population, poverty count, district medical vehicle route and under-five mortality (2004).

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

CHARACTERISTICS OF THE CASE SELECTED

The Tanzanian case study focuses mainly on the example of the Nyakahanga District Designated Hospital (NDDH). NDDHospital belongs to the Evangelical Lutheran Church of Tanzania (ELCT) and is located in the North-West of the country (Lake Victoria), more specifically in the Kagera region, in the district of Karagwe, near the small town of Kajanga (see Figure 5 for a map of Karagwe district showing health facilities). The ELCT Diocese of Karagwe is the owner of the hospital, as it is of 3 more dispensaries. The majority of health centres and dispensaries in the district belongs to the Karagwe District Council (public health sector), a few others to the Rulenge Diocese (Catholic Church). The Kagera region is special in Tanzania because faith-based hospitals are in the majority there: 10 out of 13 (2005) belong to the church (see Table 1). Only the Kilimanjaro region shows a somewhat comparable distribution, but there the "domination" of the church is less pronounced.

Created in 1912 as a simple first aid post, the hospital in Nyakahanga is the only hospital in the district, and has operated as a referral centre since 1972, at first only informally. The wave of nationalisations which started in 1967, affecting all key-sectors of the Tanzanian economy and services[55], and the fear of dispossession by the State, explain why Church leaders did not show much enthusiasm for entering into a contract at first. Only in 1992 was a contract signed between the Diocese of Karagwe and the Ministry of Health after a period of regular meetings between the Church and the State.

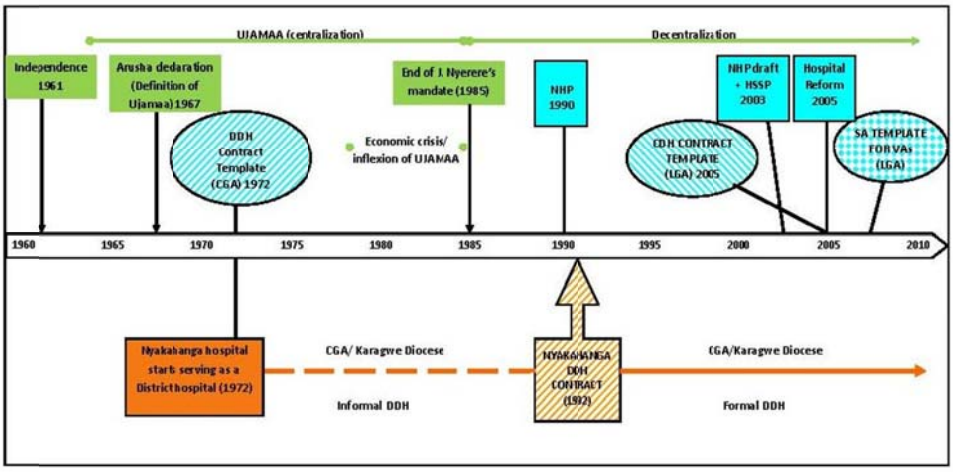
The contract was signed without amendments or changes to the original contract model. A climate of understanding and relative harmony characterised this early period. The positive experience of the informal partnership and the regular and apparently fruitful meetings preceding the signing can explain the shift in the Church's position. The basics and the modalities of the contracting relationship have not changed since 1992 as the original contract was neither amended nor revised after 1992. A good basis for trust, which earlier was lacking, now exists. The Church, anxious to

[55]Nationalizations started in all sectors with the Arusha Declaration of 1967, establishing the *Ujamaa* and the shift from the capitalist model to so-called 'African Socialism'. This trend ended in the late 70's where a severe economic crisis forced Julius Nyerere's regime to reconsider its policy.

ensure the continuity of the status of NDDH as well as the benefits linked to it, understands the advantage brought by the legalization of the situation. This generally positive appreciation of the relationship with the public health authorities is, however, getting undermined by the persistence of recurring problems the hospital is facing, in particular with regard to financial and human resources allocation.

Figure 5. Karagwe district and health facilities

Figure 6. Contracting process and Nyakahanga DDH contracting experiment in the overall context of Tanzania



LEGEND

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

MOH policy documents or intervention

Nyakahanga hospital events/ documents

General political/ policy environment

Formal partnership

Informal partnership

Contract template

Contracting agreement

MOH/DDH levels

LGA/CDH levels

LGA/VA levels

A few other cases

Two other DDHs (Sengerema and Tosamaganga) have also been studied in order to test the representativeness of the NDDH case. It seems necessary to present their main characteristics although their contracts were only analysed on the basis of one interview with their respective Chief Medical Officers.

The Catholic hospital of Sengerema is located in the Sengerema district in the Mwanza region, near Lake Victoria. The hospital is owned by the Diocese of Geita. The hospital was founded in 1959 by two Dutch [56] congregations and became a district hospital (DDH) in 1976, when the Sengerema district was created. The hospital's contract with the MoH probably dates from this time, though we were unable to get a copy as the original is with the Diocese and the hospital did not have a duplicate. The agreement is a result of the excellent relations of the hospital with the public authorities, both at the central and local levels.

The role of the female congregation 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 organisations and individuals in Europe. The hospital can also draw on a variety of sources of external support[57]. Officially, the hospital has 281 beds.

The Catholic hospital of Tosamaganga[58] 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*, this is to say with public accreditation but limited financial support from the State.

As a hospital was lacking in the district, the State granted the Catholic hospital the status of *Council Designated Hospital* (CDH) in July 2007, on the basis of the new contract model developed in 2005, which since then replaces the label of District Designated Hospital for newly accredited

[56]Brothers of Mercy of St. *Joannes de Deo and the Sisters* of Charity of St. Charles Borromeo.
[57]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).
[58]We do not know exactly when this hospital was founded, but Tosamaganga is an ancient mission post that already existed quite a long time before Independence.

hospitals. The term Council (instead of District) reflects the denomination changes resulting from the administrative reorganisation and further decentralization of the health system. In accordance with this reorganisation, Tosamaganga's contract was signed with the local government, which makes for an interesting comparison with the situation of Nyakahanga, where the contract was signed with the central level instead.

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

Region	Hospitals					Health Centres				
	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**

Source : MoH, Annual health statistical tables and figures - Tanzania's Mainland, 2008

The examples of Tosamaganga and Sengerema show that the context can have an important influence on the fate of contracting relationships. In Sengerema, the quality of the relations with the district helps to resolve some of the difficulties the NDDH faces. The hospital, which benefits from external resources, also takes a more positive stance towards the State. This example shows to which extent interpersonal relations continue to play a role 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 relatively recent. Receiving CDH status was very much appreciated by the facility as previously it was simply a VA, with limited support from the State. For lack of hindsight we cannot yet evaluate the quality of this contracting relationship in more detail. In spite of its relatively positive appreciation of the relationship with the public health authority since the signature of the contract, NDDH is largely representative of the difficulties currently met by a growing number of DDHs. Many of these difficulties were expressed by the DDHs in a meeting of the Tanzania Medical Association in September 2008.

Result of the interviews and the analysis of documents

CENTRAL LEVEL

The regulatory framework in Tanzania has been progressively strengthened over the last few years due to the implementation of new contract models for private not-for-profit District/Council reference facilities and the setting up of Service Agreements for other private not-for-profit hospitals. These contract models, which are the principal relationship tools, however, have their limits. Unfortunately there exists no specific framework document on the partnership, or an encompassing contracting policy.

The principles of the partnership are summarized in national policy documents and in the sector strategy, and there is no framework agreement that governs the relationship between the State and the faith-based sector. All the efforts at the central level focused on the development of operational contract models (DDH, CDH and SA).

The DDH contract model (1972)

We refer here to the analysis of the Nyakahanga hospital contract, because this model was applied without any changes to all District Designated Hospitals created before 2005. It is not clear when the model was adopted for the first time, but it certainly goes back to the year 1972, seven years after the first DDHs were created. From this we can infer that the concept of District Designated Hospital (and its practical implementation) preceded the drafting and application of the formal DDH model agreement. The first experiences probably developed on the basis of informal relationships and were, so to speak, gentlemen's agreements.

The DDH contract model typically includes:

The mention of parties signing the agreement - the Ministry of Health (Government) on the one hand, and the Diocese (owner of the hospital) on the other - as well as the number of beds (size) of the hospital.

A first section detailing the elements agreed upon by both parties:

- ✓ The share of costs between the Diocese and Government: capital expenditure, development projects and staff housing on the one hand, and recurrent expenditure and 'other related services' on the other.
- ✓ The mention of a 'Board of Governors' (BOG) as the governing body of the hospital and its duty to act in accordance with 'the medical ethics and policies of the Government' as well as with the 'principle of the faith' fostered by the relevant religious body.
- ✓ The composition of the BOG (a mix between diocese and government appointed members), the terms of its mandate, its function and duties and its meeting frequency. BOG authority delegation for day-to-day running of the hospital is foreseen.
- ✓ The appointment, appointment authority and functions of the Medical Officer in charge of the hospital.
- ✓ The creation of a Hospital Management Committee to assist the Medical Officer in the day-to-day running of the hospital, and the creation of an Advisory Committee whose function it is to advise

the Management Committee. Both committees' composition is detailed.

- ✓ The duty of the hospital to deliver health services, fulfill all medical functions and be staffed as any other, government-managed district hospital.
- ✓ A series of provisions related to hospital staffing: formerly employed staff remains employed by the Diocese; the diocese is responsible for staffing the hospital and the Government may attach additional staff upon request. The salary and other financial rights of employees is to be the same as for civil servants.
- ✓ A series of provisions related to the funding of the hospital: the Government is responsible for funding running costs and approved services upon approval of estimates provided by the BOG for each financial year. Funding is paid quarterly and in advance. Charging fees from patients is allowed if in accordance with the applicable ministerial directives; tax-exemption for hospital supplies is provided as for Government hospitals. Additional funding of recurrent expenditures, possibly resulting from an extension or improvement of the hospital, are subject to prior approval of the Government.
- ✓ Auditing of accounts of expenditure is required yearly and to be performed by Government-approved auditors.
- ✓ Amendments to the agreement are mentioned as a possibility, subject to joint approval by both parties (Diocese/Government).

A second section titled 'Maintenance of discipline', defining a list of 'disciplinary offence or offences', responsible disciplinary authorities, and the way to handle penalties.

The CDH contract model (2005)

This new model is the result of the work of the PPP Technical Working Group (PPP-TWG)[59] 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 regulations. The main change is the adaptation of the model to the decentralisation context, in which 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 first includes a definition of the main terms used further in the document[60] .
- The principle of monitoring/evaluation is mentioned, without specification, though, of how this monitoring would be carried out and who is responsible for it (reference to the 'current legislation').
- The former Board of Governors is replaced by a Hospital Governing Committee. Day-to-day running of the hospital may be delegated to a Hospital Management Committee (HMC) instead of to the sole Medical Officer in charge of the hospital. The HMC is chaired by the Medical Officer and further includes ten members, representative of the different functions, sections and services of the hospital, and - if applicable - one representative of a training institution attached to the hospital.
- The reference document for determining staff salaries paid by the Government is clearly mentioned (1999 Staffing levels for facilities/institutions, or later amendments).

[59] The PPP TWG is one of the 9 Technical Committees - SWAp working groups of the Tanzanian MoHSW. It answers to 3 strategic objectives: 1) Ensuring a conducive and legal environment to facilitate PPP; 2) Ensuring effective operationalisation of PPP (through national, regional and council level workshops, forums, meetings); 3) Enhancing PPP in the provision of health and nutrition/social welfare services (Tanzania Joint Annual Health Sector Review 2010). The technical WG is composed of key stakeholders of the health sector including public (MoHSW and PMORALG), private (APHTA), private not-for-profit (CSSC) and donor community representatives.

[60] E.g.: Church, Diocese, Government, District, Council, etc.

- The reporting obligations for the hospital are suggested, but without any detail 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 took over the latter's structure and, as a result, also the same mistakes. Further improvement by revision is therefore being contemplated. Furthermore none of the DDH agreements signed before 2005 has to our knowledge been revised in accordance with the new contract model: CDH contracts so far only apply to faith-based hospitals newly awarded the status of Council (formerly District) hospital.

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 has been operational since 2007, and 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 authorities and government health facilities.

This is a considerable improvement in terms of form and completeness of content. The new model is very different from the preceding DDH and CDH contracts; it takes into account their main gaps and flaws and tries to correct them:

- The document refers clearly to the framework documents governing the relationship. Numerous annexes refer specifically to this regulatory framework.
- The document has an introduction that states the principal objective and the benefits (delivering 'affordable, cost-effective and quality health services'), 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.

- In addition to the main text of the agreement, there are 6 annexes specifying: 1) the details of the services expected from the signing health facilities; 2) the expected service output and cost; 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 performance contract models. It also includes the payment by the Government of the recurrent costs of the VAs concerned.

This SA model was being tested in a limited number of facilities at the time of the study, and excluded the DDHs and CDHs. The plan is to scale it up to about 27 facilities after the pilot stage. It strictly applies to faith-based hospitals (VAs) not acting as district reference facilities and which, as such, did not benefit from equal Government support. There is a risk, however, of creating a two-speed system as DDH and CDH contract models do not yet reach the same level of precision and therefore, of predictability. No harmonization of the different contract models had been carried out at the time the study was ended.

The partnership dynamic resides mainly in platforms that bring together the public and religious partners (mainly the Joint Annual Health Sector Review - JAHRS - and the PPP Technical Working Group). It is in these settings that the faith-based sector participates in the elaboration of the health policy, that information is shared and that a number of key documents are developed[61].

The Church plays an active role in the decision-making process at the central level, mainly through the communication and lobbying efforts of the

[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).

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.

This positive evolution, i.e. the fact that consultative structures are getting stronger at central level, shows that the relationship is on the right track. In interviews, the positive trend was confirmed by both public and denominational participants. 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 dedicated Public Private Partnership Technical Working Group (PPP TWG) is a vital tool in this. In fact, the efficient performance of the PPP TWG compensates for the shortcomings of the dedicated PPP unit of the MoH[63]. The latter is difficult to access and is 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, the difficulties expressed relate mainly to how current problematic situations are dealt with at the peripheral level, and more particularly the ever growing financial and operational difficulties of faith-based facilities: especially the problems of staff costs[64] and 'flight' of faith-based staff to the public facilities[65].

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

[63]The PPP Unit is responsible for tackling the PPP strategy within the MoH.

[64] 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.

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

The formalization of the Nyakahanga contracting experience 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. Although there was no formal contract, it became thus able to enjoy State benefits. The second phase (1992-today) saw the legalization of this status through a contract. In both cases, the State took the initiative. In 1972 the Church reluctantly approved; in 1992 however, the Church fully endorsed the agreement.

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

First, there are problems with form and content. There are a number of redundancies in the document and it lacks a clear, logical structure with a succession of clauses. In terms of content, the model has a number 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 and the law governing this issue is not mentioned;
- The responsibilities are badly defined;
- A system of monitoring and evaluation 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 are not properly defined;
- The human resources issue is only superficially brought up.

Second, 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;

- The contract does not set the principle of equal salary or benefits[66] 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.

Third, there is the fact that 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 out-dated 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 are 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 no copy until recently, 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 body 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 health representatives of the local district government (DMO), the intermediate, regional level (RMO) and the central authorities (MoH). Its aim is to ensure respect for both the National Health Policy and the principles governing the faith-based facility, as laid out by the religious owners. This is the only setting 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. Although the historical

[66]Social benefits of civil servants include retirement allowances and, more recently, social health insurance. Social protection funds (National Social Security Fund/NSSF, National Health Insurance Fund/NHIF, Parastatal Pension Fund/PPF,...) were created only after Nyakahanga signed its contract agreement with the MoH. By lack of later revisions, the inclusion of social protection mechanisms for faith-based staff has never been negotiated. Differences in social benefits for faith-based staff compared to civil servants, are, overall, a major source of frustration and attrition in DDHs.

witnesses confirm its efficacy for the first period of the relationship (1992-2000), today, the Board's role seems to have decreased for the following reasons:

- In practice, the Board only meets once a year due to a lack of funds[67]. This considerably limits its ability to monitor.
- The central level representation is systematically delegated to the intermediate level. The contract is still under the authority of the MoH and was signed with it. Consequently, problems arising from decisions taken at 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 for which resolution depends on the local and intermediate levels (mainly questions strictly involving financial resources 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 implementation of the National Essential Health Package:

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

The hospital's management team and the Bishop have a rather negative perception of their relationship with the district authorities. 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

[67] The cost of paying the participants comes entirely out of the hospital budget. 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 is indirect, through the PMORALG (Prime Minister's Office for Regional Administration and Local Government).

tend to have a political agenda, often interfere. In fact, a lot of the authorities' decisions tend to favour the public health sector at the expense of the DDH, often against the advice of the DMO whose powers are limited. The overriding feeling in faith-based circles is that they are not heard, especially with regard to the lack of financial and human resources. As these shortcomings are pointed out by the District Management Team supervisions, the frustrations grow ever deeper. In general, the hospital counts more on the intervention of CSSC at the central level to find a structural solution for their difficulties.

The interviews held with 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. In spite of the obvious gap between the two sides, they assess the quality of the partnership as rather good, for example. The DMO has a far more qualified view of the situation. He recognizes the problems that exist but points out that the district is unable to provide a solution. As from the DMO's point of view, 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 authorities deplore the lack of feedback on reports by the different levels of public authority. Mainly the silence at central level is regretted. This problem occurs particularly in budget matters. The hospital projects its budget annually, but 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 typically much lower than the needs expressed and is, moreover, paid out irregularly. The hospital is therefore unable to implement the budget as foreseen. Furthermore, the growing financial strain is made worse by the great number of exemptions[69] foreseen in the health legislation for which there is no financial compensation system[70]. About 75% of the NDDH patients are treated free of charge.

[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.

The provision of drugs to NDDH should be a benefit of MoH support, but there are frequent stock-outs in the Central Pharmacy (MSD)[71]. In practice the NDDH is forced to buy locally at very high prices using up the resources provided by the Basket Fund and a large share of the hospital's own resources. As a consequence, patients have to pay for drugs bought by the hospital under those conditions (cost-recovery), while available medicines provided by the MSD remain 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 necessary investment. In the long term, this constraint weighs on the quality of the care provided (lack of space, beds, out-dated equipment, etc.).
- The difference 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 with more and more staff resigning and looking for better conditions in the public sector (retirement policies, training and promotion opportunities). Due to the lack of financial resources in the hospital, the management cannot offer the staff sufficient incentives (promotions in particular) to ensure their loyalty to the facility. This might aggravate the trend in the short term.
- The management team is fully aware of the limits of the current contract, but is not in a position to redress the situation, as it is not correctly informed of recent developments[72].
- The dysfunction of the Board of Governors and the difficulties experienced to resolve the problems identified, undermine the trust of the Church leaders (owners of the hospital) in any future contracting

[71] Medical Stores Department.
[72] The existence of a new contract model, for example, was not even known until the visit of the research team.

relationship. A desperate Bishop is even considering threatening the public authorities with closure of the hospital as a last-ditch effort to get what he wants. Recently in the Kagera region, however, about 16 faith-based dispensaries have closed down for similar reasons (according to the faith-based authorities) without provoking any reaction from the public bodies. Such an initiative is therefore not without risks.

Conclusion

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

First, the partnership dynamic is still mainly limited to the central level. The partnership policies and tools are not circulated enough, and the spirit of cooperation does not trickle down to the lower levels. This 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, and the harmonization contract reference authorities, in line with the decentralization policy. Contracts originally signed at central level have not been revised in accordance with a context of authority that is now supposedly with the local government.

Second, the contracting tools are being improved but their implementation remains incomplete.

The operational performance contracts (SAs) are a real improvement (in form and content) but do not apply to the DDHs. The application of the new CDH 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 at 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 difficulties 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 from the relationship. 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 currently face.

The case of Chad

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EGYPT
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Aozou
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BORKOU - ENNEDI - TIBESTI
NIGER
Faya-Largeau
Fada
Koro Toro
KANEM
Nokou
Nguigmi
Mao
Salal
Bol
Ngouri
Moussoro
BATHA
Djédaa
Ati
Oum Hadjer
OUADDAÏ
Abéché
Farchana
Am Zoer
Biltine
Guéréda
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WADI FIRA
Iriba
Tiné
Bahia
SUDAN
CHAD
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HADJER-LAMIS
Am Dam
Mangalmé
Goz Beïda
NIGERIA
N'Djamena
CHARI-BAGUIRMI
Bokoro
Mongo
Massenya
Abou Deïa
Melfi
GUERA
Am Timan
SALAMAT
Bongor
TANDJILE
Kélo
Lai
MOYEN-CHARI
Kyabé
Koumra
Sarh
Moundou
Doba
Goré
CAMEROON
CENTRAL AFRI
CHAD
National capital
Région capital
Town, village
Airport
International boundary
Région boundary
Main road
Road or trail
0 100 200 300 km
0 50 100 150 200 mi
N'DJAMENA
Capital city and
Site of the
MoH & UNAD
BEBORO
Site of
Béboro
faith-based
HC
SARH
Site of
the
BELACD
MOÏSSALA
Site of the district
hospital
KOUMRA
Site of thePref.health
delegation

General Context

INTRODUCTION

The fifth largest country of the African continent, Chad, is a landlocked Sahel country with one of the lowest HDIs in the world[73]. After gaining independence in 1960, the country became the theatre of recurrent conflicts in a context of tense and often murky political developments rooted in ethno-clannish allegiances, successive alliance reversals and sub-regional tensions (Klein 1996). While the current central government has been regularly challenged recently by the rebel opposition in Eastern Chad, the unstable situation of that part of the country is largely a result of sub-regional conflicts in the Darfur area, as Chad shares its eastern border with Sudan and the Central African Republic. Large population movements have affected the country since the beginning of the Darfur crisis, due to the in-flow of Sudanese refugees and the internal displacement of Eastern Chadian populations fleeing local insecurity in violence-peak periods. The refugees issue is an additional burden for the country's already weak human and financial resources.

The key geographical distinction in Chad, however, is the one between the Sahel Northern and Sudanese Southern part of Chad. One third of the country's population is concentrated in the North, which played a major role in the political and military history of the country. Ethnically speaking, the North consists of predominantly 'Arabic' Muslim populations. The South is predominantly Christian and has limited political power, in spite of its playing an important economic role (cotton). Moreover, the two parts of the country have a different rural tradition: nomadic cattle breeders in the North contrast with sedentary farmers in the South.

Tensions between the North and the South have culminated after the first civil war (1965-1979), during which Northern opposition movements challenged the François Tombalbaye regime; at the time the regime was perceived as a symbol of Southern political domination.

The power reversal resulted in the posting of Muslim administrative and military public servants in the South, the start of a period of successive

[73]Chad's rank on the Human Development Index is 163 out of 169 countries (UNDP 2010).

rebellions and repressions and multiple conflicts between Muslim cattle breeders or small traders and local Christian or animist farmers. After the second civil war (1979-1982) the State's presence declined a bit, with administrative and legal powers increasingly acting along the lines of a North-South antagonism in a context where human capital and infrastructures had been badly affected by the conflict (Magrin 2001). It is particularly from this period on that Christian Churches in the South developed their influence at grassroots level through the expansion of faith-based social services.

Since 1990, the country has been led by President Idriss Deby. He runs a strong regime and faces a relatively weak democratic opposition. Unfortunately, the regime is characterized by fragile State Governance, the absence of a real democratic process and recurring corruption problems. The long period of civil wars and recurring conflicts has left the country's economy in a battered state. The rural sector still dominates the country's economy; it is, however, affected by a severe crisis, especially due to the crisis of the cotton-growing sector (MoH 2010).

The economic crisis peaked in the 1990s and has only been partially alleviated by the recent exploitation of the country's oil resources in the region of Doba, from 2003 onwards. In this context, the country remains hugely dependent on external aid, even if the negotiated distribution of oil-exploitation revenues has brought some relief in the social and poverty-alleviation sector[74].

This still fragile situation is well illustrated in the health sector. National health services suffer from a structural weakness as evidenced by some of the poorest health indicators in Sub-Saharan Africa. If some improvements have been reached in terms of access to healthcare infrastructure[75] in the last

[74] 65% of the oil revenues are currently allocated to the social sector, including the health sector. This theoretical improvement is, however, undermined in practice by the low performance of budget execution (WHO 2008).

[75] Access to health still remains very poor, especially due to the vastness of the country, the underserving of rural areas and the generally scarce functioning facilities: 30% of the population has effective access to health services (Kurowski *et al.* 2003).

decade, key health indicators[76] have hardly improved since 2001 and remain alarming. Moreover, Chad suffers from a severe crisis of human resources (Wyss *et al.* 2001; Kurowski *et al.* 2003; MoH 2010): a shortage of health workers (4936 in 2009), low level of qualification (50% of human resources in health are unqualified; there are 0,37 physicians for 10.000 people and an average of 0,3 qualified health workers - physicians, nurses and midwifes - for 1000 people), low salaries, a relatively high number of support and management staff, and a high expatriation rate of qualified health workers. The geographical distribution of health workers and health facilities shows great imbalances, with half of the health workforce being concentrated in the capital city and rural regions being structurally underserved. In comparison, the situation in the Southern part of the country appears somewhat better in terms of health coverage, mainly due to the role of the private not-for-profit (generally faith-based) health sector.

The response of the Government to the general health sector crisis remains extremely weak. Figures of 1999 showed a public health expenditure per capita of 0,5 USD per year; general government health expenditure as a percentage of total health expenditures was 39,9%, with a large part of this expenditure funded by external aid (2003). Total health expenditure as percentage of GDP amounted to 7% in 2009[77]. Moreover, the part of the MoH budget in the general budget of the State declined in the past few years [78] ; hence, the effective budget allocation remained insufficient. Although public health expenditure and staff expenditure significantly increased in 2007, the health sector still predominantly relies on external aid which - unfortunately - tends to decrease. Add to this worrisome situation weak institutional (management) capacity, a poor implementation of national policies and a waste of public resources and the picture is clear. The revision of the National Policy (2007), largely inspired by the MDGs, aims to correct the weakness of the health system, especially with regard to the

[76] Average life expectancy at birth of 49 years (1993), infant mortality rate of 102/1000 with an under-five mortality of 209/1000 (2009), Maternal mortality of 1100/100.000 live births (2001).
[77] WHO World health observatory 2009.
[78]From 8,4% in 2003 to 5,3% in 2007 (MoH 2010).

human resources issue. It focuses on the strengthening of management policies and strategies, capacity improvement and staff motivation.

Chad adopted a decentralized administration model in 1996 with decentralization and deconcentration of (political) administration powers to intermediary and peripheral levels. Decentralization has reached a new momentum with the constitutional revision of 2005. A dedicated Ministry has been created to manage the conception, coordination, follow-up and implementation of the decentralization policy. Following the recent revision (2008) of the decentralization system, the country is now divided into 22 regions, 61 departments and 238 sub-prefectures. The health sector administration is equally decentralized but only partially modeled on the political administration units: it encompasses an intermediary level of 22 health delegations, 79 health districts at peripheral level and 1051 so-called 'zones of responsibility' at community level (MoH 2010).

However, this decentralized administrative division is largely contradicted by the high level of centralization of public services, including decision-making bodies and social/health infrastructure. Moreover, the practical implementation of decentralized administration remains poor, as evidenced for instance by the non-functional character of many administrative health bodies: only 54 of the districts and 725 of the zones are effectively functioning.

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

Chad represents a particular case in this study as Christian churches have only recently settled in the country. The Catholic Church in Chad was founded after the Second World War[79] and counts 7 Dioceses[80], all of which are located in the South of the country. This relatively young and dynamic Church is still largely dependent on other countries, especially when it comes to funding and management. The majority of the prelates still come from Europe[81], for example. Faith-based care represents about 20% of national health coverage. Half of faith-based care is provided by facilities of the Catholic network (Vridaou 2004) with 80 health centres and 3 district

[79] Decree of Rome, March 1946.
[80] To which the Archdiocese of N'Djamena is added.
[81] Five out of eight Bishops.

hospitals [82]. For the Protestants, the EEMET (i.e. the Association of Evangelical Churches and Missions in Chad) is the most important representative organisation, with a network of 84 health centres and 1 hospital. All faith-based facilities appear on the national health map since the introduction of the health district system (1990-1991).

The role of the Churches in the health sector was limited at first, but grew 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, the faith-based sector stepped in with health centres and hospitals. Even today the faith-based health centres and hospitals are still largely concentrated in this region.

All social activities of the Catholic Church are coordinated by a central platform, the *Union Nationale des Associations Diocésaines* (UNAD)[83], located in the capital city, N'Djamena. The UNAD was launched (1986) by agreement by the *Conférence Episcopale du Tchad* (CET)[84], the central and highest authority of the Catholic Church. The UNAD is the charity and social coordinating organ of the so-called BELACDs (*Bureaux d'Etudes et de Liaison des Actions Caritatives et de Développement*), themselves holding the role of coordinator of health facilities of each of the Chadian dioceses. Nowadays, there are 6 BELACDs, active in each of the 6 dioceses of the Country[85] (see Figure 7 showing the overall organisation of the Catholic health network in Chad). Their creation was more or less contemporary of the creation of these dioceses, some preceding and others following the creation of the UNAD.

The UNAD as well as the BELACD are legally registered as not-for-profit humanitarian organisations. This registration is depending on the Chadian Ministry of Plan and Economy (CMPE) and provided on the basis of a validation and approval given by the CMPE Directorate of NGOs (DONG).

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[82] Figures from 2005.

[83] 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.

[84] The CET is the permanent council of the country's bishops, presided by the Archbishop of N'Djamena. It has a sovereign, final authority on all aspects of pastoral and non-pastoral activities of the Church.

[85] Doba, Goré, Laï, Moundou, Pala and Sarh.

DONG evaluates all (international and national) NGO projects in Chad on the basis of a detailed project document. Validation is theoretically provided for three years, depending on the project's compliance with the Chadian government policies, its technical feasibility and its viability. Validation conditions the obtaining of tax exemptions and, if relevant, of possible authorization to independently import 'sensitive' goods (drugs and medical supplies as far as the health-related activities of the UNAD are concerned). The DONG is also responsible for approval extension. Specific follow-up, aiming at verifying the continued fulfilment of above mentioned criteria is therefore theoretically conducted by the DONG. This follow-up is independent of that of the health sector authorities and therefore induces additional administrative constraints for the UNAD in terms of reporting. At the time the study was conducted, the DONG was more or less non-functioning due to lack of human resources as well as basic equipment. Repeated sacking and plundering [86] of the Directorate's premises had aggravated the situation, resulting in the loss, for instance, of administrative archives[87].

Health-related activities of the UNAD should theoretically be governed by a medical coordinator. Such a coordinator was in function until the person moved to another project, coinciding with the expiry (2008) of the funding agreement with Misereor, which so far carried the salary costs for the position. By lack of a new funding agreement, the position remained vacant and still was at the time the present study was carried out. UNAD's medical coordinator is in principle responsible for contacts and negotiations with (inter)national partners in the health sector and relevant suppliers (drugs). Above all UNAD ensures the guidance, training, coordination and evaluation of the different BELACDs (staff), the distribution of funds amongst them as well as the centralization of needs in terms of medicines and medical supplies[88]. The current vacancy of the function is a real problem

[86]Recurring (eastern) rebels' marches on the capital are often associated with plundering, also affecting some of the premises of public institutions.

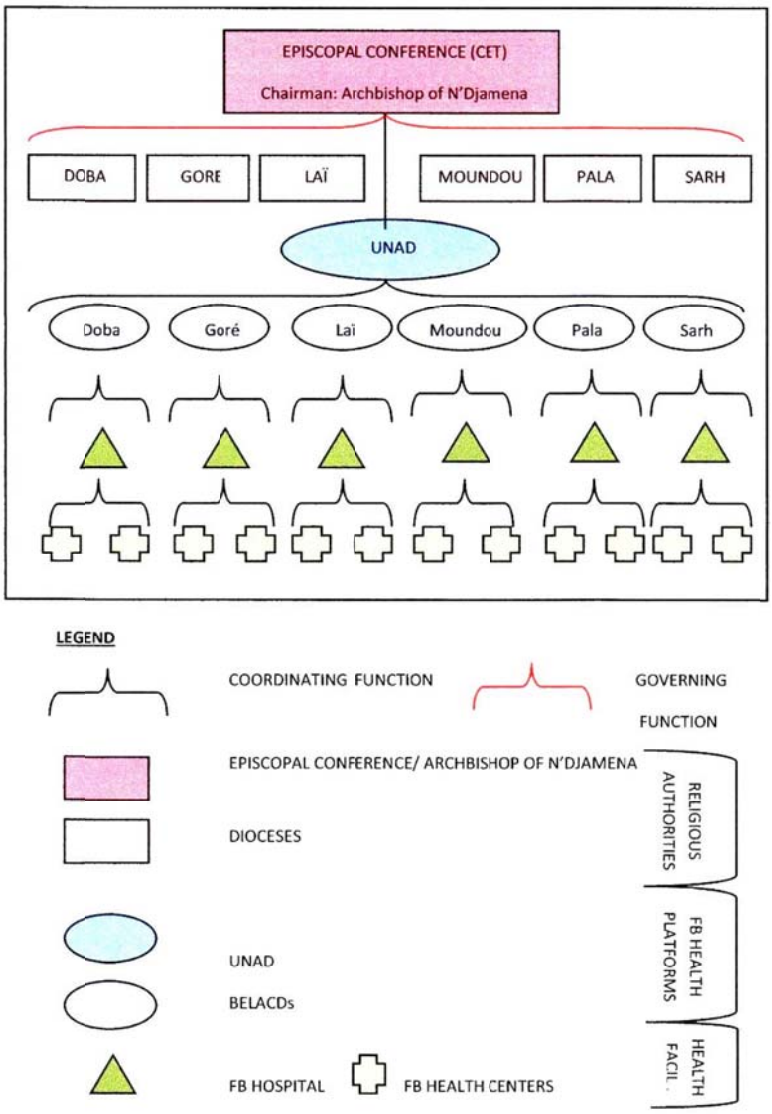
[87] Copies of NGO authorization documents and evaluation reports were unavailable at the time of our field mission. It was not clear how and if follow-up was still ensured.

[88] Including : evaluation of needs based on consumption forecasts per diocese/BELACD; launch of a yearly competitive tender for the procurement of medicines and medical supplies;

considering the specificity of the position and its heavy responsibilities: the UNAD is obviously not capable to follow these matters up, as lack of financial resources made it impossible to replace the medical coordinator after his resignation. His replacement is subject to the availability of new, dedicated external resources.

evaluation of offers and placement of orders; follow-up and reception of orders; dispatching to the BELACDs and management of possible complaints.

Figure 7. Overall organisation of the Catholic health network in Chad



PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL

Chad's contracting policy in the health sector started early in comparison with the other countries in the study (see Figure 8 for an overview of the Chadian contracting landscape in context, showing the case of Moïssala district). A contracting policy document (CP)[89] was elaborated in 2001 in line with the National Health Policy of 1999[90]. The Chad legal framework is without any doubt much more advanced[91] than the framework in the other study countries. Moreover, it is the only example we have come across in this study of a strategy that has been effectively translated into action. The case allows us to look back; in other words, an evaluation is 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 to health facilities (hospitals), but also potentially to the districts themselves (the cases 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 - as well as bilateral and multilateral cooperation agencies. Currently contracting is mainly with faith-based organisations (linked to UNAD or EEMET in particular) as well as with a number of international NGOs like MSF.

More recently, pilots have been set up in the drug sector, whereby the management of regional pharmacies (*Pharmacies Régionales d'Approvisionnement*) has been entrusted to private organisations[92].

Generally speaking, the Government central level interviewees display a lot of goodwill. The policy documents show the goodwill of the central level, even if at the same time the contracting policy takes into account the decentralisation of authority to intermediate and peripheral levels; prefectural health representatives (*Direction Régionale de la Santé*) in particular

[89] Volume 1: contracting with the private not-for-profit sector, MoH, N'Djamena, 2001.
[90] Contracting is one of the strategic orientations of the NHP of 1999.
[91] The contracting policy document includes 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.
[92] Pilot project of Pharmacists Without Borders in the Regional Supply Pharmacy (PRA) of Abéché, launched in 2007-2008.

are responsible for setting up operational contracts at their level. The decentralisation process is nevertheless not fully completed at the moment[93].

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

The Church structures were short of means at the time of the study due to a substantial decrease in external support and the difficulty of mobilizing new resources. For three years UNAD got no external financial support and, as a consequence, was no longer able to maintain the post of Health Coordinator, as noted earlier.

CHARACTERISTICS OF THE CASE SELECTED

The case study we selected concerns the delegation by the MoH of the health district of Moïssala to the BELACD of Sarh. The situation is rather peculiar since the contracts were made before the national contracting policy and its tools were developed. The health district of Moïssala is located in the South of the country and is administratively part of the Mandoul Region. It falls under the coordinating authority of the Health prefecture delegation of Mandoul, located in Koumra[94]. The management of the district is entrusted by contract to the BELACD of Sarh, located about 200 km from Moïssala,

[93] The theoretical replacement at the intermediate level of the administrative pyramid of the 14 existing health prefectures by 28 departments is not yet implemented.

[94] The current Chadian health map still reflects the old administrative zoning. The correspondence between health and administrative maps ended with the revision of the country's administrative zoning. Sarh used to be the capital of the former Moyen Chari prefecture. The new administrative zoning (2008) has divided the former Moyen Chari prefecture into 3 regions. The Mandoul region is home of the Barh-Sara department, headed by the city of Moïssala. The capital of the region is Koumra. Sarh now belongs to and heads the Moyen Chari Region and the Bar-Koh sub-division (Department). Administratively Sarh and Moïssala therefore now belong to different administrative divisions. Koumra and Sarh are distant from each other, which does not facilitate communication and visits from and to Sarh, head of the health district to Moïssala district or to the prefectural health delegation (Koumra) and vice-versa. The situation is further complicated by the fact that the BELACD of Sarh, head of the Moïssala district is already quite remote from the district city and hospital.

the district capital. The current situation is the result of a process that began in 1992 when the Catholic[95] hospital of Béboro was contractually transferred to Moïssala[96] (TRABEMO project). In the beginning the objective was to revitalize the moribund public medical centre of Moïssala, and create a district hospital. This initial stage was followed by successive contracts through which the BELACD of Sarh was given management responsibility over (the development of) the district hospital and then over the health district itself. All along, the process was facilitated by the financial and technical support of external partners: Medicus Mundi Navarra (MMN) and later Misereor.

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

First, the case of the district of Donomanga, entrusted through a contract to BELACD/Diocese of Laï. The district is located in the Southwest 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 provision of equipment for the district hospital (St Michel Catholic hospital).

Second, the case of Doba in the Eastern Logone, entrusted to BELACD/Diocese of Doba. The management of the district was taken up by BELACD in 2003 but this arrangement was never formalized. In

[95] The facility, led by a doctor, was in fact a health centre that offered hospital-like health referral services to the population in the district.

[96] This process, referred to as the TRABEMO (**'Tra**nsfert **Bé**boro **Mo**ïssala') project aimed in the longer term at the restoration of Moïssala in its role as a Health District center, by first enabling the local health facility to regain its role as a district hospital. During the civil war, this Southern public hospital had more or less been abandoned as a consequence of the public authorities' withdrawal. Its role had gradually been taken over by the small, Catholic facility of Béboro, where at the time of the transfer (faith-based) qualified hospital-level human resources, material means and activities were concentrated. TRABEMO was launched as a result of a common concern of public and Catholic authorities to bring the situation in line with the national administrative health zoning policy, taking into account the fact that Béboro is a fairly remote location. The project included a voluntary transfer of qualified human resources, material means and activities from Béboro to Moïssala, restoring Béboro as a faith-based health center, and Moïssala as a public hospital, but managed by the Catholics through the BELACD of Sarh. This delegated management was a way to compensate for the lack of human and financial resources at the public level in this part of the country.

this case there is a public hospital for a district (Doba), which does not function properly. In practice, the Catholic Hospital of St. Joseph, Bébédja, carries out its tasks.

Result of the interviews and the analysis of documents

CENTRAL LEVEL

The Chadian contracting process, i.e. the formalization 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[97], and during all the conflicts of the post-colonial history in Chad. The faith-based facilities set up in this era were put on the health map in 1993 when the district policy was implemented.

Three year activity plans submitted by the BELACD for approval to the Ministry of Planning (MDP)[98] through the permanent secretariat of NGOs (SPONG [99]) triggered the identification of facilities and the start of a dialogue. The integration of the Church facilities was the consequence of a request by the religious authorities. The State reacted positively and, in some cases, provided the facilities with infrastructure and personnel. In the decade before the contracting policy was set up, Church structures (UNAD, BELACDs, and health facilities) were systematically legalized and the first contracts (like in Moïssala) were signed.

Formalisation of contracting experiences started in 1998 when Chad began revising the National Health Policy paper (NHP). At that time, an inter-sector round table was established in which the Church participated.

The resulting document set out the principle of a partnership between the public and the private sector and contracting appeared as one of the favoured strategies. A number of factors gave a boost to the process:

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

[98] This procedure has been followed since the mid-eighties. Even at that time the health activities planned by the BELACD were already submitted for technical advice to the MoH.

[99] SPONG is an intermediate executive public organ created in 1985, depending on the Ministry of Planning and responsible for the accreditation and coordination of NGOs. Its denomination changed in 2002, when SPONG replaced the former acronym of DONG (*Direction des ONG*, i.e. NGO Directorate).

- The battered state of the health system at the end of the war (lack of human resources, infrastructure and funds);
- The fact that a dialogue existed already;
- The recognition of the complementary role of the Church in the sector and its specific characteristics, including the supply and quality of services, managerial and organisational skills and transparency;
- The active support of international organisations: the World Bank gave part of the PASS[100] 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 sync with the elaboration of the National Health Policy and involved all partners. The national contracting policy, drafted with the help of the WHO, was approved in 2001 after negotiations with the health sector partners and a series of amendments.

This process was furthermore accompanied by active sensitization efforts:

- By the MoH, first towards its own officers and then towards health sector partners;
- By UNAD towards bishops, the different BELACDs and health facilities;
- The publication of an operational manual completed the process, and was intended as guidance to help actors start up, develop and further maintain contracting relationships. This document is the practical translation of the contracting policy document.
- Also, an effort was made to provide appropriate training. UNAD organized a training session for UNAD, BELACD and MoH officers in 2004, with the collaboration and support of Cordaid and CIDR. This session was largely based on contracting guidelines published by MMI in 2003.

Chad offers a complete arsenal of operational and regulatory frameworks, which are the result of a sector-wide consensus: the framework agreements

[100] The PASS (*Projet d'Appui au Secteur de la Santé*) is a World Bank funded project (2000-2006) principally aiming at increasing and enhancing basic health services delivery through the implementation of the National Health Policy and the institutional strengthening of the MoH. USD 41,5 Million were allocated to the project.

signed at the central level between the MoH and the partners shape the service agreements signed at district level.

In the case of UNAD there exists:
- A signed agreement (1986) with the Episcopal Conference of Chad (CET)[101]: this agreement ratified the creation of the UNAD and defined its overall mission as a coordination platform for the Church's charity activities. The same year saw the creation of the BELACD in the Diocese and city of Sarh, as a technical implementing representation of the 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;
- An agreement 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 formulation of these documents, but on the basis of proposals first made by the Church. The obligations of the State towards UNAD include:
- Support with human resources, infrastructure and exemptions;
- Access for private sector staff to training given by the public sector.

In return the Church commits itself to the implementation of the National Health Policy in its facilities and in all management delegation contracts that 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 (pertaining to the drug sector), still needs further work;
- 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;

[101] The *Conférence Episcopale du Tchad* (CET) is the general Catholic Church authority.

- As of 2008, the decentralisation policy developed by the Prime Minister's office, which aims to replace the health prefectures by departments, more modest in size, was still not in place. This means that there is an important *de facto* distance between the district centres and the prefecture authorities, who sign the public part of the operational contracts implemented after 2001.

The National Health Policy, the Contracting Policy and the Operational Guide to Contracting (GOC) are the basic tools that shape 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 of contracting documents. Other more operational tools were also worked out when the PC was drafted but have now disappeared, more specifically: a monitoring committee for the contracting policy (for dealing with technical questions and managed by the DOSS) and a steering committee for validating framework documents and the orientation of the contracting policy. The PNFP sector participates actively in the development of partnerships at central level. State cadres are equally involved in some of the meetings organised by the private faith-based sector.

The different partners in the relationship believe in the system. Nevertheless, there are some weaknesses:

- The contracts are submitted to a double reference authority[102] 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;
- At first, the Church was very much involved in sector meetings, but when the job of medical coordinator for UNAD was abolished, this changed. In practice, the Church is no longer represented in the ministerial meetings, except on questions about HIV/AIDS.

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

The assessment of the partnership by the actors at central level is very positive: willingness, commitment and 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, and 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 the faith-based sector's 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 granted by the central level and the permission to import medical products;
- That the central level commits itself very quickly when invited to become involved in the partnership reality (operational contracts make up the obvious place for the further development of a contracting policy).

However, the positive tone of the discourse needs to be tempered when it comes to the practical reality of things: the theory is good and partnership experiences arise in many places, but in practice there are real weaknesses. These mostly concern the State's respect of its commitments:

- In terms of financial support: the problem of reimbursement of investments paid in advance by the Church; the 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): those are more or less considered partial duplications, were the DOSS (MoH) monitoring and evaluation should (in the eyes of the faith-based sector) suffice for all central level follow-up needs. But the weakness (financial means as well as human resources) of the central public authorities above all is reflected in low monitoring and evaluation capacity, translating in low technical support to the districts. This may for instance explain why an assessment of existing experiences has not, thus far, been carried out.

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 representatives of the State in the districts and with whom the Diocesan 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 that exists at the central level. UNAD is unable to deal with this information gap as they no longer have a medical coordinator.

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

- A full and operational regulatory framework, which stimulates the conclusion of new service agreements at the 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 in which the Church appears as an active partner. In the case of new operational projects, it even often demands and initiates the collaboration.

Some issues, however, remain a problem:

- The lack of institutional capacity at the State level;
- The absence of an overall and regular assessment of existing experiences. The real extent of the operational problems does not seem to be acknowledged, certainly not at ministerial level. An evaluation workshop had been planned for end 2008 - beginning 2009 on FED[103] financing, which may have helped improving the situation by allowing a better appreciation of the contracting reality in the health sector. It is, however, not known to the research team whether this workshop, still a project at the time of the field-mission, actually took place or brought the needed improvements.

[103] *Fonds Européen de Développement* (FED) or European Development Fund. Some remaining funds of the 8th FED had been released for organizing a workshop according to the terms of reference to be developed by the DOSS together with its partners.

INTERMEDIATE AND PERIPHERAL LEVELS

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 provided staff to the dispensary. Gradually it was authorized 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 based health-system (NHP 1993) corrected this situation and led to a reorientation of hospital activities back towards the public hospital and established Moïssala as the capital of the district.

The factors that helped establish 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 recognized experience of the Church[104] and the absence of other relevant candidates;
- Béboro was proof of the Church's skills as it provided a good level of health care in the district;
- The commitment and investment of key personnel[105];
- The fact that there existed already a relationship between BELACD and the State through UNAD as both were recognized and approved in 1986;
- The immediate availability of an experienced doctor for the post of Chief Medical Officer;
- The support of donors: Medicus Mundi Navarra (MMN) and PASS[106].

In comparison, the obstacles to the project seemed less significant:

- The opposition of the beneficiary population in the Béboro area, much more behind the scenes than openly expressed;

[104] This recognition was largely based on the example of the faith-based hospital of Goundi, also located in the Moyen-Chari Province. This hospital, created in 1974 and considered a model in terms of availability of integrated quality health services, already co-operated with the State on the basis of an agreement signed in 1986.

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

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

- The potential risk for the Church to take over a district that is not entirely Catholic and thus provoking suspicion or opposition from other religious groups in the area (fear of religious domination).

The contracting arrangements for the TRABEMO project can be divided into two stages[107] and include 6 different contracts. In this study we are interested in the 4 basic contracts[108] 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:

- The public signatories of the contracts varied considerably, for example: the Ministry of Planning, Finance, the MoH (co-signatory of all contracts, as is the SPONG) and the Ministry of Development and Economic Promotion all signed at least one contract. This carries the risk of disintegration of authority.
- The two last contracts (much later than the PC) still included the central level of public authority as a contracting party rather than the Provincial Delegation as foreseen in the national legal framework. This specificity is a consequence of the fact that TRABEMO preceded the elaboration of a national contracting policy and is an indication of the fact that the project, even if considered part of contracting experiences falling under the new policy framework, was not fully adapted to comply with this set of regulations, especially not with regard to the shift of public governing authority from central to decentralized level.

[107]Firstly, the actual transfer of Béboro hospital to Moïssala (1992-1996) and secondly the development of the Moïssala health district (1996-2006).

[108]The two others are accompanying contracts: a first contract between BELACD and Medicus Mundi Navarra (MMN) set the conditions for collaborating between the diocese and the donor in the context of the second stage of the project; a second contract signed between MoH staff seconded to the project and the project itself. It details the measures taken by BELACD to give this personnel an advance on their salary.

Contract 1: Project TRABEMO (1993)

The three-year[109] contract arranging the transfer of Béboro to Moïssala describes the activities that are planned and stipulates the principle of collaboration between the MoH and BELACD in order to achieve the aims. It sums up the respective commitments of BELACD and the State, and also cites a series of specific clauses like duration of contracts, modification of procedures, conditions of termination, etc.

The commitments of BELACD are:

- Moïssala has to conform to the hospital standards (development of infrastructure, recruitment of staff, and implementation of the PMA[110]);
- Supply of means: drugs and medical provisions, logistics[111];
- Communication of information (reports, carrying 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 in fact anticipate the second stage of the project. The commitments of the State are mainly indirect:

- Handing over of the health facilities in the area;
- Payment of salaries and replacement of public staff already there;
- Support for the activities carried out in the context of specific programmes (for example the Enlarged Programme of Immunisation - EPI);
- Tax exemption when buying drugs as well as the authorisation to import pharmaceuticals.

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

[109] The project has been extended by one year.
[110] The *Paquet Minimum d'Activités*/Minimum Package of Activities.
[111] The contract includes a list of equipment needed for the project.

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:

- The contract foresees in the active participation of the (prefectural) health delegation in the activities of the district;
- The contract provides for the appointment of a Chief Medical Officer for the Project (MCP) and a head of the district's Human Resources Department.

The obligations of the State remain the same as well; no additional financial support is foreseen. However, both partners are required to 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) is distinct from the two previous ones. It benefits from a financial input from PASS[112] in the last phase of the project (2002-2006). The objective is to increase the number of HCs in line with the development of the district. The document is far more detailed than the others, 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 the requirements included in previous contracts, notably:

[112] Initial budget of 2 billion CFA (4,397,559.39 USD) increased by an amendment of 50.000.000 CFA (109,936.43 USD) over the last year.

- 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 (organisation chart of the district, management tools for the two categories of staff, etc.);
- Learning from past experiences (coordinated sharing 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.

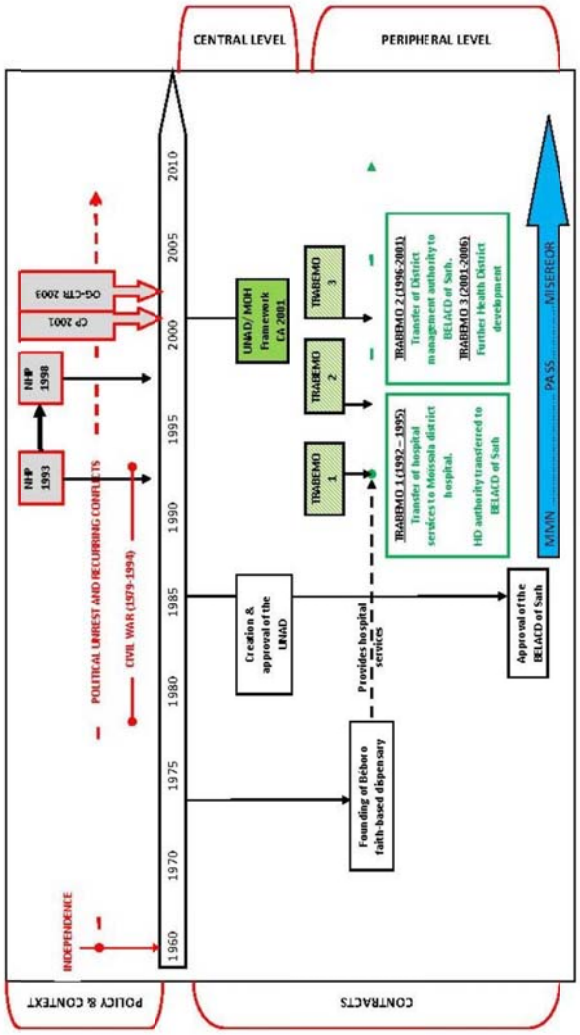
This fourth contract [113] (amendment n°1) goes a step further than its predecessors but is nevertheless not conceived in line with the PC of 2001, to which it only refers indirectly (brief reference at the end of the introduction). The following aspects, in particular, are missing:

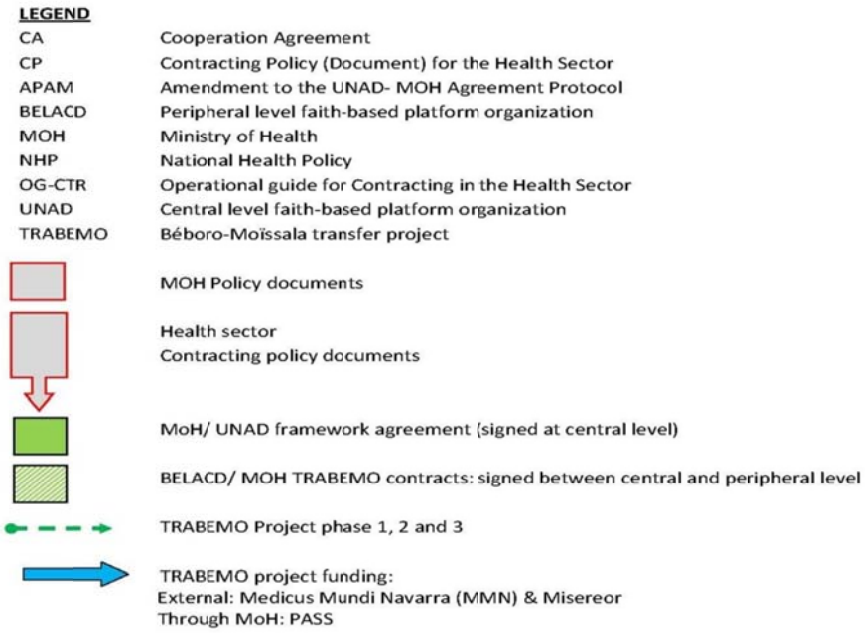
- The terms of reference and a timetable;
- The indicators for monitoring and evaluation;
- The identification of monitoring mechanisms;
- The conditions for making amendments or for renewal of the contract (this is in fact a provisional project which depends on PASS financing);
- The specific mandate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

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

[113] The amendment (contract n°4) repeats the terms of reference of the main contract by adjusting the level of the budget.

Figure 8. Contracting process and Moïssala contracting experiment in the overall context of Chad





Tools for managing the district exist and are implemented in line with the NHP. They also apply to the project and all contribute to the verification of whether the objectives of the contracts are achieved and the obligations respected.

The different tiers of the public authority carry out supervisions, but their frequency is lower than foreseen due to a lack of resources. This supervision targets health centres that have reported problems such as shortage of drugs, referral and/or financial difficulties and consists of monthly supervisions ('training supervisions') of the HCs by the District Chief Medical Officer,

CD or the CDZ (Chief Medical Officer of the Area). In addition, the BELACD, as responsible faith-based authority also conducts supervisions[114].

Assessment reports are produced:
- On a monthly basis by the HCs and the hospital: these reports are passed on to the CDZ and from there to the DPS and BELACD;
- The HCs also draft half yearly reports, which the CDZ compiles into an annual report (health statistics) and sends to the MoH and the Prefectural Health Delegation[115].

Various meetings are organised:
- A quarterly meeting of all actors, gathering everyone who is responsible for the HCs and discussing whether the objectives were reached;
- A half yearly meeting of the Director's committee where a review and synthesis of the activities is scheduled.

In addition to this, BELACD can be called upon whenever needed. It remains the first party to be informed in all circumstances. These tools are in general considered efficient and satisfactory. The relationship between BELACD, the other actors, authorities and representatives of the public sector is generally positively evaluated in Moïssala. This is demonstrated 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 the public sector staff and are mainly about the strict HR management style (flexibility in obtaining holidays; gaining 'credits', etc.). Labour unions have also sometimes caused serious tension. Their opposition led to the resignation of one of the Chief Medical Officers of the project and of the HR manager. Relentless pressure by hate mail, and personal threats played a role. The beginning of the project (Béboro) was interrupted by a number of general strikes as a result of delays

[114] Administrative supervisions carried out by the director of BELACD; supervision of the HC by the Medical Coordinator of BELACD.
[115] The annual report is effectively drafted but is not always passed on to the central level.

in the payment of civil service salaries. The situation was resolved by the signing of an agreement giving the public staff, employed by the district, an automatic advance on their salary (which the state later reimbursed to BELACD). These actions of BELACD have helped to establish its authority.

The real difficulties concern:

- The issue of the absence of cost recovery which puts a strain on the financial balance of the hospital and indirectly on the balance of the HCs;
- 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 a limited supply on the Chad market and the low attractiveness of Moïssala (lack of loyalty of the temporary staff assigned by the State);
- The problem of hospital equipment: the hospital still functions with outdated material from Béboro;
- The hospital being geographically far away from BELACD, as well as from the prefectural health delegation, the latter are difficult to reach for the District Management Team (DMT) and recourse is therefore limited.

The religious authorities consider contracting as a protective measure (guarantees), and as a means to access benefits. The relations with the district technical management are considered excellent. But the relations with the administrative authorities are cooler: there is a certain mistrust of "politics" and a tendency of some individuals belonging to the administrative authorities to protect their own interests, particularly financial interests.

The BELACD 'culture' has imposed itself; the division between public and BELACD staff is not very clear anymore. Even in the interviews there is a characteristic unity of purpose. Moreover, BELACD people are present in 6 public health centres, and their presence is not considered a problem.

Overall the assessment of the HCs is positive. The HCs integrated in the project as a first line of the district health system have fully accepted the

project[116]. They have been informed of it from the very beginning. They are able to see the positive role played by BELACD 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 stressed the implementation of the national health policy through the district system and the Primary Health Care policy. This is exemplified through:

- The creation of the Management Committees (COGEST) and Health Committees (COSAN)[117];
- 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 delegation of management responsibilities is expressed through:

- The system of cost recovery, based on payment per sickness episode. This contrasts with the system of *'paiement à la molécule'* (payment per drug) that is still very common in Chad;
- The BELACD supervisions;
- The management modus of the referral system: the costs for outpatient care are included in the fee paid by the patient at the HCs. Once this fee paid, the patient will not have to disburse any additional money at referral level. The costs made at hospital level for a referred patient (consultation, treatment) are invoiced by the hospital to the HCs which are due to reimburse them.

[116] In particular because they were able to keep their identity. Only the religious authorities (non-Catholic authorities), owners of the HCs, have shown a certain resistance: their "conversion" took some effort.

[117] COGEST and COSAN are community participation tools foreseen by the NHP at peripheral level, in each of the health zones. Each district is divided in health zones, each of them supposedly housing a health centre. Each health centre is supposed to be managed by a community management committee (COGEST), whereas the COSAN is the voice of the community for health issues at peripheral level.

In general, the management of BELACD is positively evaluated:

- The system is very beneficial for the population as it guarantees access to care and treatment (fixed price and referral system)[118];
- The supervision of BELACD, although strictly technical, preserves the identity of the HCs;
- The climate is generally good with many opportunities for exchanging views; the HCs do not function anymore as isolated entities;
- The system is really operational, due to means injected by BELACD;
- The COGEST/COSAN system is a guarantee for transparency and a considerable help for those in charge of the HCs.

Some reservations are nevertheless formulated:

- The referral system weighs heavily on the HCs finances, and compensation through the sale of drugs is no longer possible;
- The supply of drugs and medical products is ensured by BELACD but there are quotas specified for each HC. Due to the increased attendance at the HCs, the health centres have to buy additional supplies and then pass these costs on to the patients. Understandably, people are not very happy about this and the situation has become a heavy burden on the HC budgets;
- The staff salary is paid with the limited COGEST funds which diminishes recruitment possibilities and worsens the already bad human resources situation;
- The weak support from the State, in terms of equipment particularly;
- The sustainability risk if BELACD were to withdraw and the State had to take over the responsibility for the district.

The State support is well appreciated. The State generally keeps its commitments: there is a steady increase of temporary staff (33 public staff against 37 BELACD staff in 2008); specific support is provided (motorbikes); exemptions are implemented, and the import of drugs is permitted. Nevertheless, the State subsidies fall well below the needs they are supposed to cover because the money needed is lacking due to deductions at the

[118] The district attracts a large number of external patients, even from outside the country (Chad has a border with the Central African Republic in the South).

intermediate levels[119]. The compensation for the loss of earnings rests entirely on the shoulders of BELACD and contributes to the dependence of the project on outside donors. This problem is expected to only get worse.
In general, BELACD shoulders well the responsibilities it is given. All actors make positive assessments of the project, as it brings tangible results. The viability of the project rests nevertheless almost entirely on the support of BELACD's donors[120] because of the weak financial commitment of the State. Its continuation is presently in danger because the Misereor contract, which ended in the later part of 2008, forced BELACD to start restructuring its activities. Therefore, it is not surprising to see the Church (and the district management) plead for a greater share of the State in the financial burden of the district through:

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

Generally speaking the assessment of this experience is positive. It needs however, 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 in line with the PC of 2001:

[119] In 2007, only about 6 million could be acquired from a total budget of 22 million FCFA (13.284 out of 48.708USD). Sums budgeted at central level do not reach the district directly but transit through intermediary levels of the administrative pyramid, each deducting part of the money. Corruption, even if not clearly mentioned, is a well-known problem in a country like Chad where public officers are poorly remunerated: it may therefore partly explain the situation. At central level also, disbursement capacity remains low, as a manifestation of poor financial management capacity.

[120] Medicus Mundi Navarra, then the PASS through the State and currently Misereor. MMN financed the first phase of the TRABEMO project. The Chadian MoH took over from 2001 to 2006 on PASS funding. Misereor furthered the project's financing, theoretically until the end of 2008.

- 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 health district happens on an informal basis. There is no contract that formalizes the situation, although the BELACD carries the health district management and related costs under the authority of the local bishop. Here the Church is also considering abandoning its responsibilities.

In these two cases, it comes as no surprise that the bad relations with the local (administrative) authorities are singled out for criticism:

- Local authorities tend to deal with matters among themselves and systematically 'forget' to involve BELACD/Diocese, although the latter are in principle '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.

Conclusion

Unlike other countries studied, Chad has a complete and functional regulatory framework. However, this framework is only partially implemented: the contracting agreements made before 2001 at peripheral level have not necessarily been revised. Moreover, informal, sometimes far-reaching partnership relationships have developed in the field (for example in the district of Doba) which are not backed by specific contracting (service) agreements.

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 that delegates district management responsibility to BELACD has achieved the objectives that were formulated initially. In an institutionally very fragile country, this system of delegation to experienced organisations emerges as a realistic way forward to realize the development of health districts and improve geographical and financial access of the population to good quality health care.

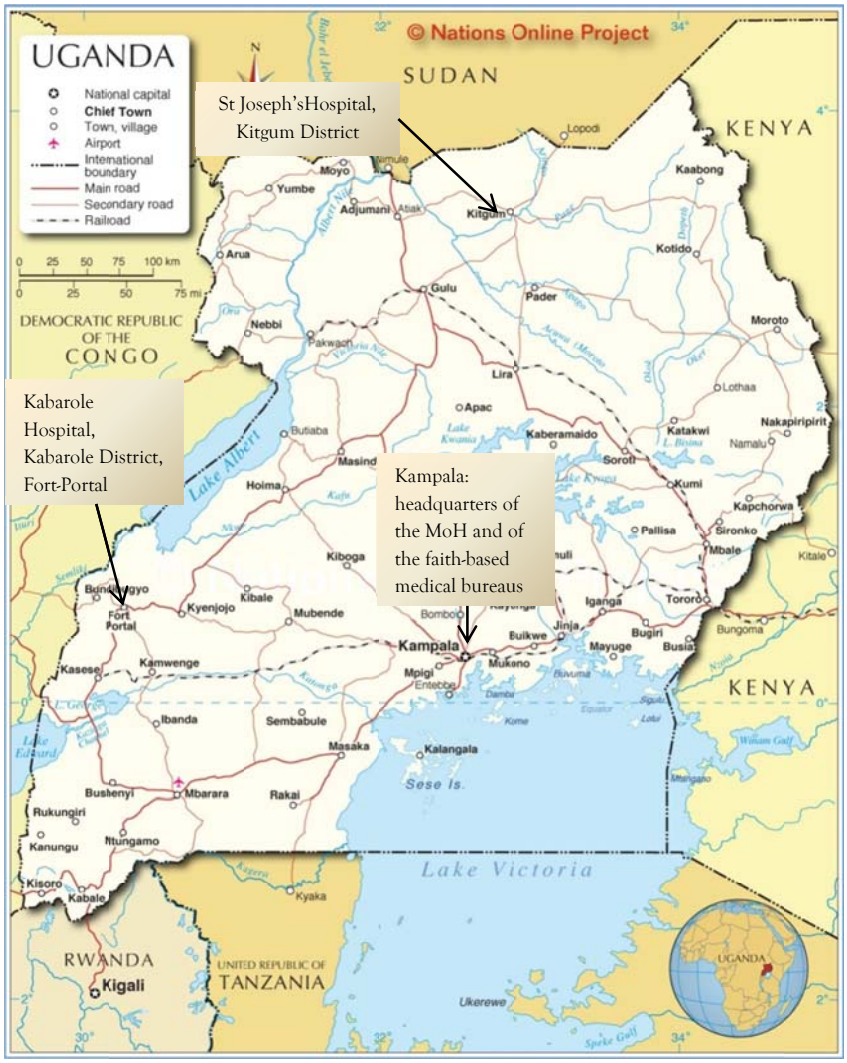
However, this experience falls outside the framework developed in 2001: the relationship between BELACD and the central State authorities seems to work better than more recent contracting experiences (Doba, Laï) which involve the local government. In the latter cases, the shaky collaboration with the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

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 financial involvement of the State 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 much relief. Although the texts exist, in general the central level seems not very inclined (or able) to seek pro-actively concrete solutions to the problems brought up by contracting NGOs.

Overall, a centralized reassessment of the implementation of the contractual policy adopted in 2001 would need to be considered. A first evaluation conducted in 2004 by the MoH concluded on the significant increase of contracts signed as a result of the policy's launch, but recognized the need to revitalize the process as many of the policy's initiators had left the health system since then. This reservation remained valid at the time the study was conducted, as no action had been taken in between to familiarize newcomers and actual decision makers and partners involved in the process with the principles and rules of the policy and its operational guidelines. The great instability affecting positions within the national health system is a major hinder in those matters. But it also seems vital to examine existing contractual experiences and their functioning as a means to evaluate the policy's actual effects on health system strengthening and consider an improvement of existing sustaining mechanisms.

The case of Uganda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UGANDA
National capital
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Airport
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SUDAN
KENYA
DEMOCRATIC REPUBLIC OF THE CONGO
RWANDA
UNITED REPUBLIC OF TANZANIA
Lake Victoria
Lake Albert
Lake Edward
Sese Is.
Kampala
Kigali
St Joseph'sHospital, Kitgum District
Kabarole Hospital, Kabarole District, Fort-Portal
Kampala: headquarters of the MoH and of the faith-based medical bureaus

General context

INTRODUCTION

Uganda became independent in 1962. After a short period of relative peace, marked by strong local governments' power and weakness of central authority, a phase of severe political turmoil, civil wars and major human rights violations started in 1966. The dark period would last for 20 years, until the National Resistance Movement (NRM) seized power under current President Yoweri Museveni. The new regime put an end to human rights abuses and a process of democratization was launched including political liberalization and restoration of press freedom. The Government also started broad economic and public sector reforms.

The stability of the regime has been seriously challenged only by the recurrence of the rebel opposition of armed resistance groups[121] in the North-Eastern part of the country ('Acholiland'). Recently a cease-fire was signed. The region, centred around the city of Kitgum, has, however, been badly affected by the conflict, leaving it largely outside of the implementation trend of public reforms and subsequent improvements. Social, human and economic resources and infrastructure of the region have, moreover, come out of the conflict in a battered state. For instance, Kitgum district ranks lowest (9%) in terms of percentage of the population having access to a health facility within 5 km walking distance.

As part of broader strategy aiming at restoring the country's credibility and sustaining the democratization process, first steps toward decentralization were taken by the new regime in the late 1980's, with the creation of local councils. Those were empowered with political and economic jurisdictional powers with the aim of improving service delivery and accountability. Political stability, democratization and economic growth allowed for thorough public sector reform and the effective implementation of the decentralization programme in the mid-1990s, resting on the Local Government Statute of 1993, confirmed and strengthened by the 1995 national Constitution, and operationalized through the 1997 Local Government Act. The process resulted in the devolution of political,

[121] Mainly the Uganda's People Democratic Army, The Holy Spirit Movement and the Lord's Resistance Army.

administrative and fiscal powers to local Governments. By now, Uganda's decentralization policy is considered to be the most far-reaching and complete one of the African continent (Jepsson 2004), encompassing a well-defined legal framework, well defined and operational local Government structures, a functional administrative system and a steady progress in fiscal decentralization: 38% of the national budget is spent at the local level (Ukidi & Guloba 2006).

Uganda's decentralized system is based on districts and knows no intermediary level of authority. The Central Government is responsible for regulation, policy and advice, the elaboration of standards and overall supervision. Planning, administration and financial management authority are devolved to local Government Councils heading each of the districts and assisted by a Chief Administrative Officer (CAO). The central government authority is represented at district level by a Resident District Commissioner (RDC). Districts (of which the number dramatically increased from 39 in 1991 and 45 in 1997 to 83 in 2006), are further divided in counties, sub-counties, parishes and villages.

Decentralization of the health system is modelled on the political and administrative decentralization structures, with the MoH holding power in terms of policy setting, definition of standards, quality assurance, training, supervision, response to epidemics and other disasters, as well as in terms of monitoring and evaluation. The responsibility of service provision is delegated to national and regional (referral) hospitals while at local level, district authorities and hospital management boards are responsible for health services implementation and service delivery; they also have staffing and staff management authority. The district health authority is in the hands of District Health Teams headed by a District Director of Health Services (DDHS, former District Medical Officer or DMO). Sub-districts built around a hospital or upgraded health centre (HC IV) form a sub-level that does not exist in the overall decentralized system of Government (Bashaasha *et al.* 2011).

The Ugandan decentralization system's positive results on service delivery - especially in terms of access, utilization and quality, are unanimously recognized. As for healthcare delivery, the abolition of user fees in the public sector (2011) has led to greater financial access, while service coverage and delivery were increased by the construction or rehabilitation of facilities (Ukidi and Guloba 2006). The Ugandan decentralization process and system

has been the object of numerous studies which, however, pointed at a number of weaknesses. First of all, decentralization in terms of benefits did not result in an overall improvement of health indicators (Jepsson & Okuanzi 2000). Several challenges are mentioned including the tension between local and national interests, the tension between the SWAP and the local government focused approach, and the low planning and implementation capacity and accountability of local governments with regard to programmes funded by the government or external donors (Onyach-Olaa 2003). Lack of (planning and management) skills and capacity, and weak institutional capacity at local government level is also a major source of concern and results in low accountability and problems of coordination between central and local level (Ukidi & Guloba 2006, Steiner 2006).

A specific point of discussion is the level of fiscal decentralization. Districts are highly dependent on the government budget as the latter accounts for 95% of their revenue. The capacity of local governments to raise taxes and generate revenue is limited. Spending flexibility of local governments is moreover compromised by the high level of government funding conditionality, as conditional grants are the largest source of government funding (85% in 1999/2000). National priorities stipulated in those grants do not always meet the local agenda and needs (Steiner 2006).

In the public health sector, the situation is worsened by the overall budget ceiling on health expenditures imposed by the Ministry of Finance (MOF) on the basis of macroeconomic concerns, expressing the low level of priority of health in the public agenda as a factor of economic growth. In spite of ongoing MoH efforts to advocate for increased budget allocation, budget allocation remains low and impairs the implementation of the Health Sector Strategic Plan (HSSP). In general, resources allocated to the health sector on national budget remain inadequate; a high level of dependency on external aid is thus unavoidable.

Although decentralization is unanimously supported by donors, the introduction of the health SWAp in the late 1990's has led to a process of relative recentralization whereby the MoH regained much of its influence, moving from a promotional and facilitating role to a prescriptive one. Districts have little influence on the SWAp while they are expected to implement and deliver according to its priorities, as set in the National Health Policy of 1999. The MoH has full control over funds allocated within the SWAp and has the authority of approval or veto on district support

provided by donors within the framework of SWAp. Policy making is heavily influenced by donors, especially within a context of weak MoH leadership and governance (Jepsson 2004).

Place of the Church in the Supply of Care

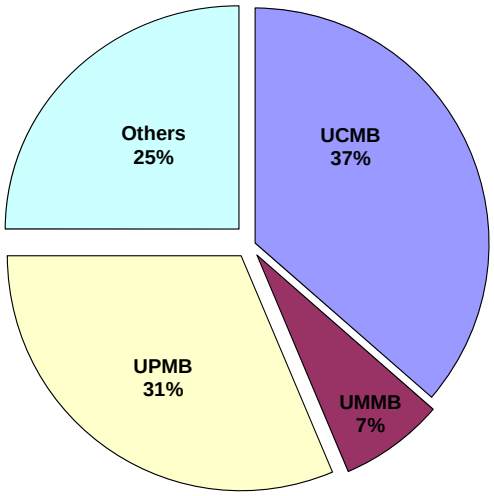
Up to 40% of healthcare facilities in Uganda belong to the private (not-for-profit) sector: 44 hospitals (42,3% of the total) and 558 health centres, the majority in rural, and very remote, areas. There are, furthermore, 21 health-training centres: 60% of these for the training of health staff. In comparison, the Government of Uganda runs a total of 1.694 health units (2008).

Faith-based PNFP facilities have been described as offering better services than non-faith based facilities (Jeppsson & Okuonzi 2000). The Catholic and Protestant Churches own the majority of the faith-based facilities (see Figure 9). They are united in denominational health platforms, respectively the Uganda Catholic Medical Bureau (UCMB) and the Uganda Protestant Medical Bureau (UPMB). The Muslim presence in the sector, represented by the Uganda Muslim Medical Bureau (UMMB), is growing steadily, but is still rather marginal. All facilities included, the three bureaus contribute for 75% of the PNFP health sector. Recently, an Orthodox medical platform, known as UOMB, has been created.

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

The UCMB network has 72 hospitals and 234 HC and falls under the governance of the Uganda (Catholic) Episcopal Conference, as one of its commissions. In addition, HIV/AIDS issues are separately managed by the HIV/AIDS focal point commission.

Figure 9. Distribution of the health facilities between the different coordinating PNFP organisations



Source : UPMB Annual Report 2004/05

The UPMB network officially belongs to Anglican Church of Uganda (CoU) but its 17member hospitals and 261 member HCs are affiliated to 7 different denominations of which CoU is the most important one (UPMB data for 2010). It moreover runs 10 training institutions. Each of the network members contributes to the financing of the network through an annual member fee. However, most of UPMB's financial resources issue from external donors[122].

The UMMB belongs to the Uganda Muslim Supreme Council and coordinates a network of 8 facilities: 5 health centres, one nursing home, a clinic and a medical centre[123]. It was founded in 1978 but has only be functional since 1999.

[122] Donors contributed for 74%, local partners for 7%, and internally generated revenues for 19% of UPMB's total income in 2010.
[123] Data as from Uganda's Medical and Dental Practitioners Council (UMDPC).

UOMB seems to have been a very marginal player until now and is not, so far, actively involved in the faith-based medical bureaus' joint activities.

UCMB, UPMB and UMMB, show a remarkable level of co-operation with each other, translating at policy level in common identification and voicing of concerns, and common drafting of statements. This has particularly been the case since 2001 with regard to identified risks and experienced threats affecting the PNFP healthcare delivery sector and compromising its sustainability. In general, UCMB, UPMB and UMMB collaborate in order to share data and, for instance, elaborate sound PNFP health sector statistics. Common training sessions are regularly organized for health facility managers. The medical bureaus moreover play an important role at national level, being the organs representing the interest of the faith-based PNFP health sector in national level consultations or reviews and participating in policy drafting (e.g. National Health Policy).

PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL

Public-Private Partnership in Health (PPPH) in Uganda

The relationship between the faith-based network and the MoH goes back to pre-colonial times but remained rather limited until the end of the nineties. The collaboration was not formalized, and consisted mainly of State subsidies[124] to the health facilities of the Churches[125]. There was, however, a progressive evolution towards a more structural partnership: a Uganda health policy review (1986)[126] recommended the revival of cooperation, a recommendation reiterated by the MoH in 1993[127]. 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 for structural help from the State in order to keep

(http://www.umdpc.com/uploads/UMMBhospitals.pdf, consulted July, 2011).

[124] "Grants in Aid" were voted by the colonial government's Frazer Committee on Medical and Health Policy in 1954, which recommended that public subsidies were introduced to fund the faith-based (so-called 'voluntary') health sector. This system was retained during the postcolonial period; due to the economic crisis, it was stopped in the middle of the 70s, until its revival in 1986.

[125] In the country terminology faith-based facilities are called 'voluntary' organisations/ agencies.

[126] Report of the Health Services Review Commission (1986).

[127] Cabinet "White Paper".

up their services: this was voiced in memorandum, submitted to the MoH in 1996.

In response, the MoH established a taskforce (1996); its recommendations resulted in 1997-1998 in a Memorandum of Understanding (MoU) at the central level, which broadly defined the collaboration between the MoH and the Churches and the objectives of the support. This document was a first effort to formalize the relationship between the Churches and their public partner. It led in practice to the vote of subsidies, opening the way to a considerable increase in financial support from the State [128] to the Voluntary Agencies. A limited number of operational contracts (Service Level Agreements or SLAs) between the religious health facilities and the MoH were also signed. In 2001, the MoH requested the Public Private Partnership in Health Working Group (PPPH-WG) to draft a PPP policy. In 2003, UCMB and UPMB jointly submitted an outline to the State, with the intention of establishing a long lasting relationship and a legal framework.

In spite of continued lobbying by the Church authorities with the government, the 2003 document never acquired official approval. The partnership process therefore got stuck, preventing the development of contractual arrangements at peripheral level. This has since then 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[129]. Today, the financial support of the State to the hospitals represents, on average, only 15% of the total revenue of the Church health sector (see Figure 10).

UPMB and UCMB, and more recently also the UMMB, intensively collaborate to address the challenges faced by the faith-based health sector

[128] The funds allocated increased from 800 million to 17 billion of shillings (313.100 to 6,6 million USD) between 1997 and 2004.

[129] Under the pressure of the Health workers' union wages of civil servants in the health sector were substantially increased in 2004. At the same time, macroeconomic constraints led the Ministry of Finance to freeze the health budget. As very little room was left for non-wage expenses, PNFP health sector support (falling under that non-wage category) started stagnating (if not decreasing in absolute value). The incapacity of the PNFP sector to increase workforce remuneration to the level civil servants wages had been increased to resulted in massive exodus of PNFP workers to the public sector (Giusti 2008).

today. Their strategy is aimed at obtaining official and formalized recognition of the role the Churches play in the health sector through the approval of the Draft Partnership Policy of 2003. 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:

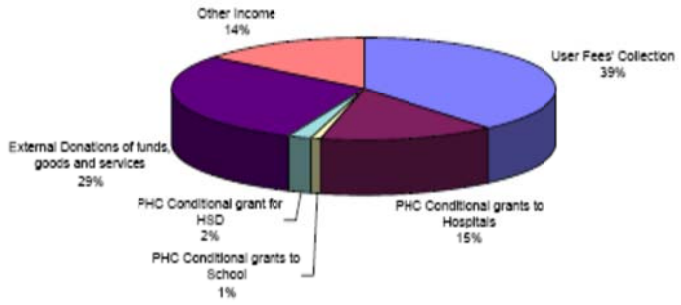
- The financial crisis is due to the gradual reduction in support from traditional donors, the fact that the State contributions have remained 'frozen'[130], a decrease in user fees[131] charged to patients, and an increase in the fixed costs of the facilities and particularly in human resources[132];
- 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.

[130] Their share in financing the health activities of the faith-based sector has dropped from 36 to 32% between 2002-2003 and 2005-2006.

[131] 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. User fees were abolished in 2001 in the public sector but resource constraints prevented the faith-based PNFP sector to follow suit. This point has been reported by several MoH representatives as a source of concern or even reason for mistrust.

[132] 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. Interestingly, an analysis of faith-based platforms found 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 10. Structure and division of income from financial contributions to the faith-based health sector.



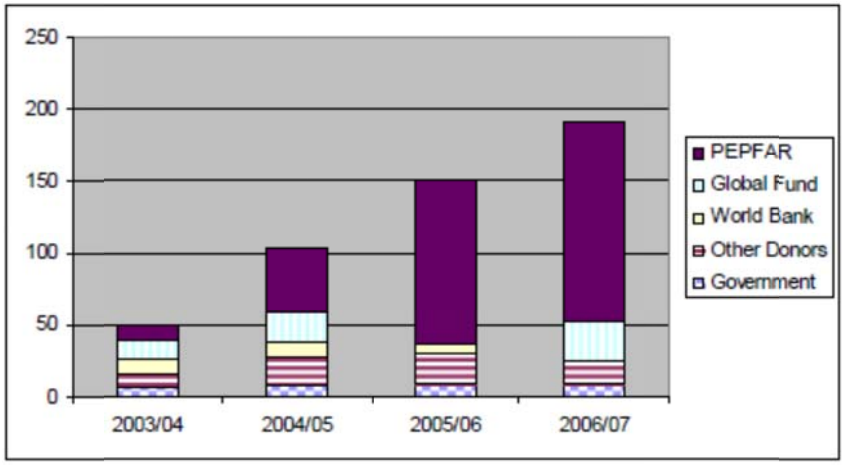
Source : UCMB, UPMB, UMMB, 2007

PEPFAR and the faith-based sector

Uganda was one of 15 countries chosen by the US 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 was officially estimated[133] at USD 283,6 million (as of 2008). The size of these funds puts PEPFAR in the lead[134] of organisations and initiatives helping Uganda with the HIV/AIDS pandemic (see Figure 11 showing the importance of PEPFAR in the overall health funding in Uganda). 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.

[133] 2008 Country profile, Uganda. Consulted on www.PEPFAR.org.
[134] In 2006, 73% of the available funds in the context of the fight against HIV/AIDS in Uganda came from PEPFAR.

Figure 11. Health funding in Uganda.



Source : Oomman, Bernstein and Rosenzweig, 2007

The government authorities of the partner countries are usually not very involved in the conceptualisation, 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, with the management and supervision also taken care of by US representatives[135]. The primary beneficiaries - i.e. the recipients - 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 dealing directly with the peripheral level which partly explains the weak involvement of the central level[136]. Recipients are mainly selected on the basis of their ability to achieve the targets set out and spend the allocated funds as quickly as possible. In general, the PEPFAR system is extremely strict (earmarking of funds)

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

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

although the financial data are not very transparent: only the budgets allocated country per country to the recipient countries are made public[137]. The figures about field programme results are also very difficult to access.

It is important to present here also three of PEPFAR's main recipients in Uganda: the Catholic Relief Services[138], the Uganda Program for Human and Holistic Development (UPHOLD) [139] and The AIDS Support Organisation (TASO)[140].All three are signatories of contracts that 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 PEPFAR AIDS Relief programme and implements most of its activities in Uganda under this label. CRS supports 18 care facilities in 11 districts[141].

The UPHOLD programme[142] is very well represented in the field in Uganda[143] through regional offices. This programme was launched in 2003 as an initiative of the American organisation *John Snow Incorporated* (JSI). The programme strategically focuses on strengthening community and institutional participation in the development of better 'utilization, quality, support and sustainability of services' in the three technical domains of education, health, and HIV/AIDS. From 2005 on, the activities have been placed under PEPFAR, which became the major financing source for the

[137] Financial data on the real payments made are not accessible to the public, the recipient governments and 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.

[138] www.crs.org

[139] www.uphold.jsi.com

[140] www.tasouganda.org

[141] According to figures provided by CRS, its activities cater for more than 62.400 people, of which 21.000 people are on ART.

[142] The description of UPHOLD is based on the information provided by UPHOLD's website at www.uphold.jsi.com

[143] At the peak of its activities in 2006, it covered 34 districts. After the creation of the Northern Uganda Malaria AIDS & Tuberculosis Program (NUMAT), UPHOLD withdrew from the North of the country, leaving the number of districts supported at 28.

programme. UPHOLD's intervention is described as designed to support the Ugandan Government's social priorities and policies as well as USAID's performance framework strategic objective on 'management and organisational excellency for high quality workforce, supported by modern and secure infrastructure and operational capacities'[144].

UPHOLD intervenes using an integrated approach [145] . Health interventions include child, adolescent and integrated reproductive health, HIV/AIDS prevention and care, and communicable disease control. Cross-cutting technical interventions focus on performance improvement, quality assurance, private sector support, behaviour change and community ownership and development. UPHOLD focuses on the district and sub-district levels, working closely with the local district governments.

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: it provides care to more than 100.000 people on a yearly basis, for a total of 200,000 registered clients since 1987, 40,000 ART-enrolled patients since 2004. It also provides support to 5000 orphans. Eleven service centres at district level - further decentralised at local level into so-called 'mini TASOs' and Community-based Organisations (CBOs) - cover a large part of the country. TASO works in close collaboration with the Ugandan government 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 (sub-recipients, as for example the District of Kitgum or Kabarole Hospital).

The organisation offers programme-based services including HIV/AIDS counselling, medical care (home-based care, outreach clinics, day care centres), social support, nutritional support, advocacy and networking activities, training, and research activities. TASO adopted a decentralized and regional approach, delegating part of the management authority to 6 regional offices, covering 4 regions (North, Centre, East and West). This

[144] Strategic goal 8 (see http://www.usaid.gov/policy/par05).

[145] The three broad technical domains are augmented with interface technical domains of intervention: Education/health, Education/HIV/AIDS, Health/HIV/AIDS and Education/health/HIV/AIDS.

decentralized system aims at providing support and monitoring to service centres, CBOs and mini TASOs.

The partnership context at central level was looked at from two perspectives: the partnership between PEPFAR (its country representatives and its primary recipients) and the State on the one hand, and with the Church and its representative bodies on the other hand. We were unable to get an interview with PEPFAR representatives at the US Embassy and USAID, so we have very little information on the connection 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 and suspect, therefore, that the document is classified.

No agreement exists, moreover, at the central level between PEPFAR and faith-based platforms in spite of the fact that many facilities of the networks are involved in the implementation of the programme. The contacts between the Ugandan faith-based sector and PEPFAR happen at the 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 keep in touch with them.

Of the three recipients we studied, CRS is the only one with 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 UPMB 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 the facilities themselves are often also reluctant to speak on the subject. The efforts made by UCMB and UPMB to get a real dialogue going with IRCU and obtain answers to their concerns have remained largely unheeded up to now.

Characteristics of the cases selected

St. Joseph's Hospital (SJH)

St. Joseph's Hospital is located in Northern Uganda in the district of Kitgum (see Figure 12). It was founded in 1942 by the Italian Sisters of Comboni as a health post. It became a hospital and was handed over to the Diocese of Guluat in the beginning of the 70s. Today the facility has 350 beds and operates in a very poor region that suffered badly from twenty years of civil war[146]. SJH is accredited by UCMB and boasts an excellent reputation.

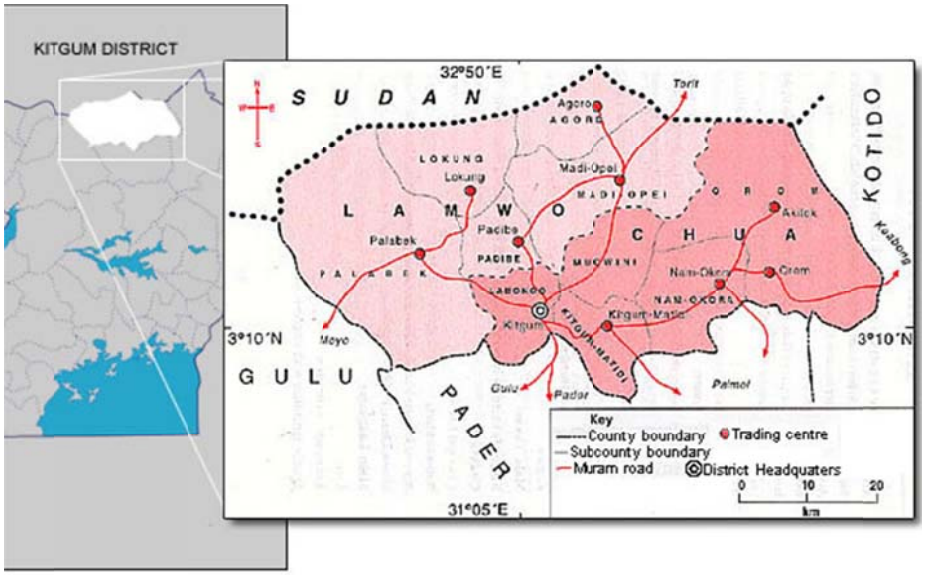
The hospital is situated near a district public hospital (Kitgum Hospital, 200 beds), only two kilometres away. SJH unofficially plays the role of district referral centre, attracting not only patients from the district but also from further away. Part of the explanation for this situation lies in the fact that SJH stayed in business throughout the civil war and continued to look after an ever increasing number of patients (influx of refugees) at the expense of the almost moribund district hospital. The years of conflict also explain the large presence of international NGOs and the extensive external support SJH received at that time[147]. These relationships are, or have often been, underpinned by contracts (AVSI[148], EU, WFP). The hospital benefits furthermore from solid technical support from UCMB. This support seems to be rated as more important than the support of the Diocese. The latter is, although owner and decision maker, indeed rather weak in this field.

[146] The civil war started in Northern Uganda in the early 80s. The conflict opposing the Lord's Resistance 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.

[147] AVSI, Misereor, AGEH, the World Food Program (WFP), the European Union (EU) to cite only the main ones.

[148] AVSI (www.avsi.org) is the most important donor of the hospital and a vital technical resource. The organisation has put into place and takes charge of the management team of SJH.

Figure 12. Kitgum District



Source : www.coreinitiative.org

Since 2005, various agreements have been signed (in the context of PEPFAR financing) for setting up a complete HIV/AIDS care programme[149] involving TASO, UPHOLD and CRS. The creation of a new USAID/PEPFAR funded project specific for Northern Uganda (NUMAT) has led to the withdrawal of UPHOLD and was, at the time the study was carried out, about to result in the signing of new contracts.

This abundant external support has not prevented SJH from facing growing difficulties. The funds remain insufficient to cover the hospital operating costs and especially the wages. There is also a high staff turnover

[149] Buddy support and voluntary screening, Prevention of Mother to Child Transmission (PMTCT), home-based care, antiretroviral treatment and Behaviour Changing Campaigns (BCC).

rate[150]due mainly to the low salaries. The workload increases regularly for the remaining staff, which could lead to further increased turnover.

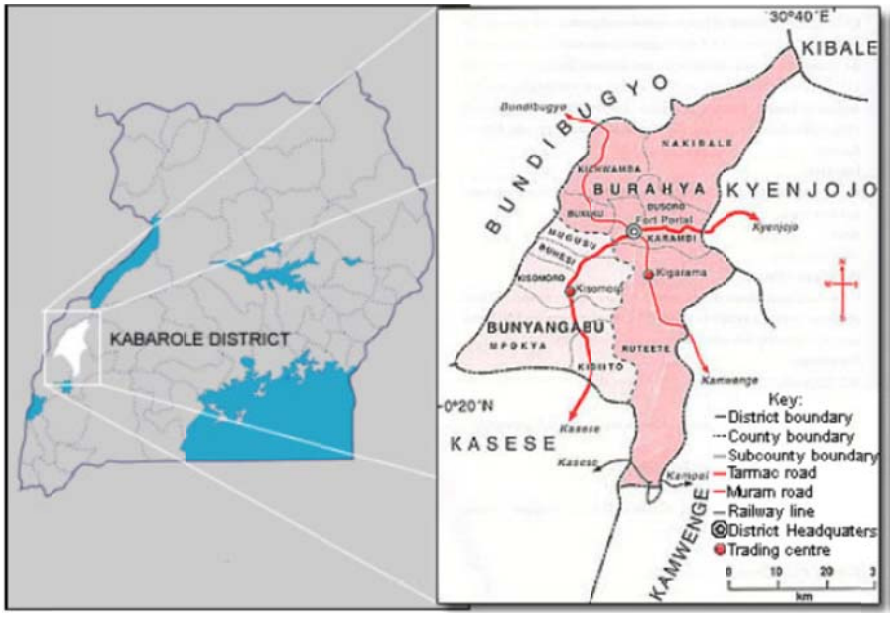
Kabarole Hospital

This hospital is located in West Uganda, in the city of Fort Portal, capital of Kabarole district (see Figure 13). The area is politically stable. The facility 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 that stipulate access to the fund of the *Conditional Grant*[151] 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 to the hospital and leased the building to a private practitioner. In 2000, the premises were reintegrated into the network by the Bishop. Although battered at the time, the hospital is now slowly rising from its ashes. Kabarole is a modest facility (80 beds) and the smallest of the three hospitals in Fort Portal. The provincial public hospital of Buhinga and the Catholic hospital of Virika are only a few kilometers away from Kabarole.

[150] 17% of the staff left the hospital in the period 2006-2007.

[151] This practice, foreseen by the policy of Primary Health Care (PHC) is no longer used by most districts and is in fact a formality. Conditional grants in these districts are not conditioned by the signature of a contract.

Figure 13. Kabarole District



Source : www.coreinitiative.org

Structural financing of the hospital is mainly confined to user fees and State subsidies[152]. The only external support comes from the contract signed in 2005 with CRS for the AIDS Relief programme. Its contribution in the hospital's 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 imply that KH cannot cover the increasing HR costs. Wages are a heavy burden for KH's budget and limit its development possibilities.

[152] In a total budget of 734 million Ugandan Shillings in 2007, the contribution of the State amounted to only 80 million of which just 63 million were really received.

Results of the interviews and the analysis of documents

CENTRAL LEVEL

(See Figure 14 for an overview of the Ugandan contracting landscape in context, showing the cases of St Joseph and Kabarole Hospital).

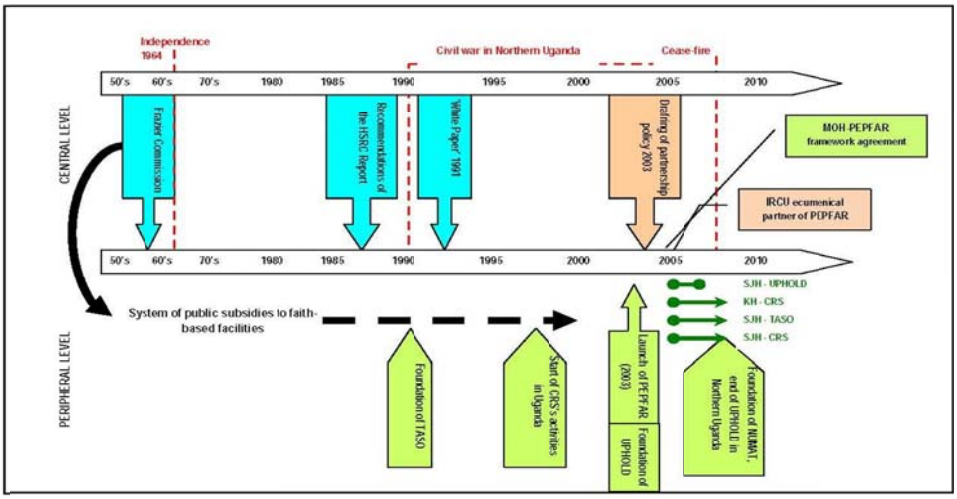
In the absence of an identifiable partnership, at central level, between PEPFAR (or its recipients) and the public and faith-based sector, we are particularly interested in the way the relationship (or rather its non-existence) is perceived and, *a fortiori*, how the contracting process is evaluated. In general, PEPFAR's interventions (through its recipients and the contracting activities) focus on the district level. This strategic choice partly explains why the visibility of the initiative remains rather limited at the central level (with the alleged but non-verifiable exception of the President's office). Central public and faith-based health actors are only vaguely aware of PEPFAR activities in districts.

The MoH steers the initiative through a coordination committee (the activities of which normally deal directly with the district) allowing it, in principle, to ensure appropriateness of PEPFAR interventions with the National Health Policy. However, this does not make day-to-day management of the programmes more transparent. In its turn, USAID/PEPFAR participates in the technical working groups[153] of the MoH-based Health Policy Advisory Committee (HPAC)[154]. All this should in principle allow for effective collaboration between the MoH and USAID/PEPFAR. It was, however, very difficult to find out what happens in reality, as the discourse of public sector actors was often contradictory.

[153] The Sector Budget Working Group (WG), the Public Private Partnership for Health WG; the Basic Package WG; the Medicines Working Group; the Human Resources for Health WG; the Supervision, M&E, Research WG; The Health infrastructure WG; and the Hospitals & Health centres IV WG (Compact between the Government of Uganda and Partners for implementation of the Health Sector Strategic and Investment Plan 2010-2015).

[154] The HPAC is the health sector's SWAp oversight and steering (coordination and management) body. It comes second in importance in the Ugandan Health Sector's oversight structure, is governed by the HPAC Secretariat and further consists of the above-mentioned technical working groups.

Figure 14. Contracting process and Kitgum and Kabarole contracting experiments in the overall context of Uganda



LEGEND

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

Public sector

Faith-based sector

PEPFAR

ended contracting relationship

ongoing contracting relationship

The participants interviewed at the MoH level assessed the way PEPFAR intervenes in the country as rather negative. These MoH interviewees included people responsible for planning as well as those in charge of the partnership. The MoH considers transparency the main problem. If information is transmitted, it goes to the Director General and the Permanent Secretary for Health at the MoH, and then to the National AIDS Commission (NAC), but does not circulate through the policy and planning unit. In general, few people know what happens in the field, and those who would know, at least in general terms, are claimed to belong mostly to the President's inner circle, a level difficultly accessible for most MoH officers. The result is that PEPFAR has acquired a 'political' character.

The available information is mostly limited to planned resources and listed recipients without detailing how these resources will be used. This makes it difficult to prepare for the resources and interventions. It seems, however, 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. Also the presence of a new representative at the American Embassy who seems more inclined than his predecessors to collaborate with the Ministry, is playing a positive role. 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 of PEPFAR's interventions may be identified afterwards by the MoH through supervision visits to the districts, but are confined, for example, to very visible initiatives such as those of UPHOLD or NUMAT which the local authorities handle.

From USAID's perspective, however, cooperation with the MoH exists on PEPFAR activities. The Ugandan Ministry of Health is, for instance, responsible for providing USAID Uganda and the PEPFAR country team with population-based surveys, as a basis for behaviour change measurement. In general, USAID/PEPFAR relies on the Ministry's willingness and capacity to report on clinical and surveillance data on a regular basis. These data seem to be missing, pursuant to the MoH's own recognition of its weak supervision and reporting capacity. The last USAID Uganda audit report (2010) on prevention-related PEPFAR activities mentions that such a survey was conducted for the last time in 2005. It is not unthinkable that having the opportunity to meet with USAID/PEPFAR, and NAC representatives could have provided the research team with a different appreciation of the

effective level of cooperation of PEPFAR with the Ugandan government, especially with the MoH. We can at least conclude that, from the perspective of the Policy & Planning unit of the MoH, this cooperation was lacking at the time our study was carried out and transparency was far to seek.

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. Allocated funds are thus transferred to projects and cannot be included in the MoH budget, although Uganda prefers the latter form of support. The MoH merely tries to steer PEPFAR so that it operates in line with national health policy. But the MoH has no real say in the definition of intervention priorities, financing matters or operational issues. 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 targets and financial interests of the donor than those of the beneficiary country[155]. Finally, if the short-term 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. The MoH acknowledges that it has been unable to impose itself as a real 'steward' and coordinator in the health sector. It should normally insist on getting the information needed and impose its priorities. Also, it should normally push for a 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 and its probable incompatibility with the complex data gathered by PEPFAR through the *Monitoring and Evaluation of Emergency Plan Progress* (MEEP) project. Furthermore, the system of data collection is not

[155] Reference is made here to the expatriate staff, the number of foreign recipients and in particular American organisations and the price of antiretroviral drugs (limited recourse to generic products).

conceived to include information about programmes such as the ones developed by PEPFAR. Hence, the indicators used only permit to capture this data to some extent.

As is the case for the public sector, no agreement has been signed at the 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 the central level developed through IRCU, an institution intended as a platform where the different religious denominations can meet. Hence, UCMB, UPMB and UMMB, the respective coordinating bodies of the faith-based medical sector, have been completely bypassed in favour of an organisation that was originally created to fulfil other tasks. As the different churches expected that other funds (such as those from the Global Fund) would later also pass through one representative body, in 2003 the IRCU was designated officially[156] to play this focal role of receiver and manager of allocated funds. It was nevertheless understood that this body would not be responsible for bringing the funds to the peripheral level; in other words, for maintaining contacts with the health facilities themselves.

In the beginning, PEPFAR established a relation with some of the medical coordination boards or medical boards/departments[157], where existing, of a number of Ugandan churches. The Anglican Church of Uganda (CoU) is an example: until recently it had direct contact with PEPFAR through USAID. The Church provided them with useful information for identifying possible recipient facilities or programmes and was responsible for managing the funds allocated to them. However, PEPFAR's wish to limit the number of intermediary interlocutors led in 2007 to a review of its individual relationship with the CoU in favour of

[156] By the Churches, i.e. for the Catholics by the Episcopal Conference.

[157] In the Catholic Church of Uganda, this board identifies with the UCMB. But specific medical boards/departments may exists in member Churches of the UPMB network, which contains a large number of different denominations whose specific policies may slightly differ from the general orientations of UPMB.

IRCU. The CoU continues nevertheless to provide information and supervise the financial side, as IRCU is unable to identify facilities. The reality is, however, that the funds themselves are managed by IRCU and paid directly to the beneficiaries without going through the CoU and therefore drastically limiting CoU's financial supervision capacity. The medical coordination board 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 were to receive from PEPFAR or other global initiatives through IRCU. Thus, GIFMU (the *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 USD 18 million, 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 in July 2007.

UCMB, UPMB or the medical coordinators of their member churches thus quickly lost control over the programmes set up with PEPFAR funds. The situation was worsened by communication problems and a strained relation with IRCU, which communicates mainly with PEPFAR/USAID who finances its staff. The same problem crops up with other PEPFAR intervention mechanisms. A great number of programmes managed by other main recipients (TASO and UPHOLD) than IRCU cite examples for the case studies of our research in which they bypass the Religious Coordinating Bodies (RCB).

CRS is the only recipient that does not bypass the RCB, it appears. At first, it operated in the same manner as the others, 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 facilities to be included in the programme and joint field visits were organized. Nevertheless the extent of the collaboration needs to be put in perspective, since UPMB has not, for

example, been informed on the contracts that CRS drew up with Kabarole hospital.

One of the first concerns pertains to the inexperience of the hospitals with contracting and partnership matters. There are several known cases in which the contracts do not respect the required legal rules. For instance, the Dioceses, legal owners of the hospitals, do not systematically sign the documents. Technical managers sometimes sign on their behalf without official delegation of this task. These agreements are thus strictly speaking legally invalid but still involve an array of obligations and constraints, which the facilities often 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 that typically involve a lot of money and strongly target facilities with activities other than only HIV/AIDS prevention. According to UCMB in particular, the requirements of programmes are not really compatible with settings already suffering from a serious lack of HR and limited infrastructure. Unfortunately, most of the network's 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, which would go against the principle of integration of these activities in the health system.

PERIPHERAL LEVEL: ST.JOSEPH HOSPITAL, KITGUM

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 the start of PEPFAR in Uganda, SJH had no direct link with global initiatives. The benefit coming from other major global health initiatives (The Global Fund and the *Multi-country HIV/AIDS*

Program (MAP)) was indirect because channelled through the MoH; it 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 that could benefit from the support of the AIDS Relief 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. Originally this was a donor initiative, but 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 the national representative of CRS, and the Chief Medical Officer of St. Joseph hospital. In other words, it was the kind of situation generally denounced at the 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 being a moral authority is 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 performance of the facility (achievement of objectives); its respect of the terms of the contract; its capacity; and the mutual wish of the parties to continue their collaboration. Since 2005 the contract has been systematically renewed, and the standard document produced simply mentions any changes made. This model 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 organisations, and merely represents a kind of service agreement, where there is no intention of a legal partnership.

The obligations of both parties are mentioned only 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 reimbursement by the beneficiary. Article 15 is about the conditions for monitoring and evaluation.

Annual independent audits are planned. Supervision visits and inspection of the financial administration have to be carried out by the donor on the basis of a schedule established by both parties. Some categories of expenses need prior approval of the donor. These include, in particular, expenses for costly 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; and 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 simply 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 then help identify likely candidates in the civil society (of which faith-based facilities) 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 largely 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 forward their request.

The UPHOLD contract is largely comparable to the CRS contract as far as formalization and standardisation of the contract are concerned. 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 the accounting, audit and financial administration; the rules applicable to the payments of advances and reimbursements; conditions for termination, suspension and amendments of the contract; and finally the resolution of conflicts. However, the UPHOLD contract is more flexible than the CRS contract. It foresees the drafting of 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 decentralised services for voluntary screening and counselling 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 areas. 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. The UPHOLD contract was signed by the chief medical officer of the hospital and once 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. Although these reporting obligations offer the guarantee, at least theoretically, of excellent monitoring conditions, the resulting constraints weigh particularly heavily 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

Focusing on a limited number of facilities (governmental or faith-based) that have a public service orientation, TASO Gulu (one of TASO's regional offices) identified a few possible recipients. A field mission was carried out in the districts and hospitals of the region to identify possible gaps in existing programmes and analyse perceived needs (based on statistics). Within this district Kitgum was selected first, and then SJH. This is obviously a very

participatory process, far removed from the principles implemented for AIDS Relief. The final contract is the result of negotiations held specifically with the hospital that is the 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. 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 in the area. The MoU officially links TASO to the Kitgum District with SJH as principal agent of the agreement. This means that the three entities (District, hospital and TASO) 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 the agreement. These three representatives are regrouped under the label "Local government of Kitgum District". Representing 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. Although 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 genuine 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 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 AIDS Relief 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. Furthermore, every three months CRS organises a *local partners' forum* in Kampala that is attended by all the facilities involved in the AIDS Relief 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 enables the facility to acquire the skills needed for achieving the targets and for following up on the donor's specific procedures.

A regular self-evaluation of the programme activities and the collection and reporting of data, typical of each contract, ensures that the facility remains critical of itself. Overall, the ability to identify and analyse relevant data and to anticipate activities (all 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 public agents' knowledge of the of these contracts is rather limited.

CRS, that visited the region in the identification phase of beneficiary facilities, 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 directly transferred without going through the district. NUMAT has now taken over and all funds are now channelled through the district.

Nevertheless, different instruments offer possibilities for exchange. SJH (unlike other faith-based facilities) regularly supplies copies of its reports to the district, Although this information is not always exploited. Another exchange opportunity lies in the representative and decision-making bodies,

in which both the public and religious actors participate. The district management team organises quarterly supervisions, carried out by the technical and the political committee for the fight against HIV/AIDS. In reality, though, these visits are not very frequent, 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.

Sometimes SJH, the District and the District Hospital do collaborate informally. SJH's skills in the fight against HIV/AIDS are regularly called upon and the facility is invited to delegate some of its specialized staff to train their counterparts of the public sector. There are also regular exchanges and interactions in fields that are not specifically related to HIV/AIDS; for example, the exchanges of specialists, equipment, and occasional assistance in the supply of drugs.

Generally speaking, the patients prefer to go to SJH rather than to the public health centres nearby or to the District Hospital. In addition to the quality of the management, the quality of the care, the skills and the reception are the main reasons for this preference, on top of the shortage of district resources in comparison to SJH (drugs, laboratory facilities). This resource gap creates some tension and the emergence of double standards of care.

Nothing, however, 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 that 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 the central level. This indicates, first and foremost, that hospitals are not really equal in this type 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 relates to the initiation of certain activities, for instance the resources and means proposed by the PEPFAR recipients to address certain needs such as treatment for

People Living with HIV/AIDS (PLHIV). The public provision of this treatment is considered unreliable, incomplete and thus not an acceptable alternative for SJH. PEPFAR's support is channelled through *AIDS Relief*/CRS and includes ART drugs and the 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, in addition to the community activities, voluntary screening, counselling and accompaniment which were already offered 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 support by the donor. The hospital refers here to the obvious benefit it gains from regular contacts, supervisions, initial and continued training and reporting requirements. Furthermore, the hospital mentions the technical support for managing difficult medical cases (CRS) and the joint search for solutions to any problems. The quality of the support, the availability of the donor and the overall 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 in the identified gaps. Furthermore, the interventions partly alleviate SJH's financial burden.

The 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, initially. Staff instability and turnover, and SJH's need to cut back on staff due to a lack of 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 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, particularly CRS, refuse to deviate from their own procedures. This leads sometimes to important differences in salary for similar jobs.

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

The lack of flexibility of the programmes is mainly mentioned with regards to the *slots* allocated to the hospital by the contracts. These slots define an objective in terms of the number of people to include in the programme (CRS) within a specific period of time. As the number of people effectively needing inclusion may exceed the allocated slots (which happens rather systematically), room for renegotiation is desired by the hospital but is very difficult to achieve: the initial allocation of slots by CRS indeed depends on the available budget.

The capacity of the hospital to respond to the need for care of its catchment population thus depends on the budget effectively awarded to CRS by PEPFAR's governing body in the US. Slots allocated to SJH had seen a regular increase up till 2005, but in 2007 CRS had to lower its initial subsidy forecasts for its beneficiaries in the region because of a reduction in funds allocated by Washington (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 donors were to pull out, the State would not be in a position to fill in for the CRS in the same manner, because of the cost of the programme (among other reasons).

Overworked staff (in facilities swamped with patients) try to convince the patients to go to the public hospital or other nearby health centres. Generally, however, the patients boycott these facilities because they have a shoddy reputation.

Peripheral level: Kabarole Hospital, Fort-Portal

Kabarole was identified thanks to an initiative of CRS. In 2004, a survey was carried out among the care facilities of the Protestant network, with the help of and via UPMB. It was on this basis and after some field visits, that KH was selected. The first contract was signed in July 2005 between CRS and the Diocese for the launch 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, which were sent to the Diocese and the State. No real negotiations were necessary and the contract was pretty much signed in the form it was presented. The annex of the programme description, including the budget does authorize, however, a few amendments if necessary. The contracting process proceeded rather swiftly with activities starting almost immediately. At the time the patients were already being looked after by a support group of the Diocese.

Kabarole's only contract is the one signed with CRS for the AIDS Relief programme. As the contract document is a model used by CRS for all AIDS Relief related contracts, and thus more or less the same for SJH and for KH, the analysis of CRS' contract with SJH also applies to KH. 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 AIDS Relief programme does not only cover the treatment of the patients but also includes a community prevention component: palliative care (for 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, namely: the training available; the technical supervisions of the CRS focal points; the financial supervision; the quarterly participation 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; and the fulfilment of the technical and financial reporting requirements (with the drafting of specific reports).

The situation in the Kabarole district is different from the situation in Kitgum in terms of involvement of local public authorities and of 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 at the regional hospital. Unlike in Kitgum, the public hospital here is an operational facility with a strong reputation and high attendance rates. The confessional hospitals, for their part, also attract many patients.

The three facilities exist in relative harmony although the functioning of the referral/counter-referral system leaves a lot to be desired - somehow many more patients tend to be referred to the regional hospital. The HR crisis in the two confessional facilities, acknowledged by the public actors, would explain this phenomenon. PEPFAR's settlement in the district is important and essentially involves three primary recipient organisations: the Joint Clinical Research Centre (JCRC), the Elizabeth Glazer Paediatric Foundation (EGPAF) and CRS, with a large number of public facilities benefiting from their 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 the integration of the private 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 required, for example, 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, 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 opportunities for exchanging opinions though the central level remains the place to discuss issues like, for example, the respect for the National Health Policy.

The funds allocated to the public sector as a PEPFAR beneficiary are managed according to the procedures of the donors, and often go against

central government regulations[158]. The active involvement of the District authorities in the implementation stage of the projects leaves a lot to be desired: they play no role in the supervision of the projects, and also miss the means of exercising this prerogative.

There are also some reservations about the fact that only part of the health staff in beneficiary facilities are involved in the programme, leading to an unequal treatment of the hospital staff in terms of salary and the demotivation of the staff that are not integrated. The district of Kabarole, however, seems to have seen to it that the donors respect the salary scales of the civil servants.

Overall, PEPFAR programmes are considered to play a positive role in the district, especially since their funds permit to carry out 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 left out and that 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 also allow partial compensation for the HR losses of faith-based facilities (thanks to the temporary assignment of staff), and for the use of present health staff for programme activities. The list of issues that could be improved includes: the continuity of the programmes; the implementation of fall-back strategies and more flexibility in the use of allocated funds[159], with the harmonization of procedures and completeness of 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 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

[158] Each donor usually requires the opening of a specific account to transfer its funds, while the government pleads in favour of only one account.

[159] 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.

from some difficult times in which it lost quite some credit with the patients[160]. It has to work near two other fully operational hospitals. The hospital has limited resources, 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. HRs are few and there is a high turnover as a result of the low attractiveness of the salaries compared to the public sector.

In spite of the unfavourable conditions and high demands of the programme, KH has been able to obtain, for each year since 2005, a renewal of its contract with CRS, seeing its funding and allocated slots increase progressively during this same period. The programme staff represents 21% of the total KH staff. The chief advantage identified is largely similar to that mentioned by Kitgum, namely: 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.

Another advantage is the quality of the support in terms of monitoring: the staff working on the programme is trained systematically. Training is also offered to hospital departments that have an important support role for the programme. CRS carries out regular (financial and technical) supervisions. Reporting requirements have allowed the staff to develop their skills, to anticipate, manage, identify and collect data which they can use for the general activities in the hospital. The rather inflexible attitude of the donor, however, leads to the same worries in KH as in SJH and confronts 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 paying the hospital costs of patients in its care. The hospital considers this an aberration in view of the limited resources of the population. Generally speaking, the rules of the contract are considered far removed from the realities in the field.

Another issue that 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 since the overtime is not paid by the donor.

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[160] The "private" episode of KH has tarnished its reputation in terms of access and quality of care.

The question of the salary scales remains difficult to resolve. Some informants mention a gap between the salaries of the hospital and its programme staff. This tends to lead to a perception of the HIV clinic as a sub-facility, '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 major differences result from the disproportion of available funds. Quality-level imbalances, however, tend to be corrected by the appointment of new staff, filling the gaps created with the shifting of qualified staff to the programme. The recruitments, however, need to be 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 has made the hospital a partner in looking for alternative solutions[161]. There is a wide discrepancy with the quality standards used at the national level. Due to a lack of resources, the Ugandan State is unable to adopt the same principles.

Generally, the quality of services has led to an increase in patients, and staff numbers have more than doubled. It is difficult to say what role the programme has played in these trends although it is noted that the takeover 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. These tensions are, to name a few: the important mobilization of personnel by the programme; the volatility of the staff employed for the general activities; and the difficulties in recruiting which lead 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 nature of the allocated slots and the consequent 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

[161] In 2008, the programme financed a consultancy mission with the intention to find possible alternatives.

confirm this trend). The problem is all the 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 adds to the vulnerability of the facility and the search for structural solutions appears, therefore, essential.

Conclusion

The analysis of the contracting relationships that exist in the context of the PEPFAR programmes in Uganda does not completely confirm the negative *a priori* perception one might have: 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, they tend not to be related to the nature of the PEPFAR contracts or with the PEPFAR approach as such, but rather to depend on the following factors:

- The "solidity" and importance of the recipient facility;
- 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 involvement of the legal owner;
- The availability of alternative sources of finance;
- The flexibility of the facility, in particular in terms of infrastructure;
- The capacity of the local government.

The differences in perception, understanding and knowledge of the system show a dysfunction of the communication mechanisms that exist between the central and peripheral level. Interventions remain fragmented and geographically confined. The decentralization policy and its effective implementation at intermediary and peripheral levels of authority does not translate, in practice, in effective communication sharing. The low capacity of central and local government authorities in capturing information on PEPFAR programmes, their implementation and results may also contribute to limited leadership and stewardship. 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 facilities 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 facility and provides extra arguments when lobbying with donors for new resources;
- The setup 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 have to do with the nature of the politics governing the programmes, the importance of the programme priorities and the "power" that the sheer amount of the funds provides to the donor:

– Because of the weight of PEPFAR's contribution to the prevention of HIV/AIDS in Uganda, the central authorities allow 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. This considerably reduces the bargaining power and influence of the field actors;
- The extreme fragmentation of the system, its complexity and opacity 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 implemented HIV/AIDS programmes results in a problem of sustainability, all the more crucial as these programmes are mostly short and medium term whereas the nature of

the needs of people living with HIV/AIDS (especially ART treatment) obviously requires long term action.

The fact that the faith-based health platforms are systematically bypassed in these arrangements jeopardizes the quality of their relations with the facilities of their respective networks. It diminishes the role they could play in the coordination and guidance of the hospitals, in preparing them for the signing of such contracts and in helping them to anticipate the risks inherent in this setup. The reticence of some hospitals to provide their umbrella 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 at 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 relief 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.

Summary of the results

We made an overview of the different case studies to summarize our observations and prepared 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 comparative synoptic table (see Table 2), and a SWOT (*Strengths, Weaknesses, Opportunities, and Threats*) analysis of each case study was also carried out and its results summarized in a table (see Table 3).

From these analytic tools emerge a number of constant factors:

- All case studies point to the huge difficulties the faith-based sector experiences in the contracting process. 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-sided'.
- The problems relate mainly to 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 demonstrated by the first contracts in Chad or *a fortiori* the examples of PEPFAR in Uganda.
- The quality of the contracts is systematically questioned, and in particular their incompleteness - the absence of any revision or renewal and the resulting gap with the national health policy, or more specifically, the partnership and contracting framework at the central level.
- It is not always evident to distinguish between the contracting relationship and the effects related to the context. Poor governance, institutional weakness and the tension created by a lack of resources, apply to all the different cases and certainly weigh on the success (or failure) of the contracts.

Table 2. Synoptic grid of the results

	CAMEROON	TANZANIA	CHAD	UGANDA
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 dramatically decreasing. - 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 health budget. - Large but ever growing PEPFAR financing of activities related to HIV/AIDS prevention since 2004. Limited PEPFAR visibility at central level. - The relations between PEPFAR and the faith-based sector bypass the health platforms.

	CAMEROON	TANZANIA	CHAD	UGANDA
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 old process that started already in early 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 result 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 at peripheral level, relations are set up directly with the operational actors in the district.

	CAMEROON	TANZANIA	CHAD	UGANDA
Objectives/ Motivations	- The public sector, through a recognition of the social role of the Church, aims for integration of the latter's 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 takeover of the area by the State. It marks the will 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 desperately needs access to resources.	-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 at operational level (district).

	CAMEROON	TANZANIA	CHAD	UGANDA
National framework of the relationship	- The framework includes a strategic partnership framework, models for conventions 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.	- Chad has an almost complete legal framework including an explicit contracting policy and operational guidelines. - 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.

	CAMEROON	TANZANIA	CHAD	UGANDA
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 setup 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*), for example, 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.

	CAMEROON	TANZANIA	CHAD	UGANDA
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 tarnishing 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 goodwill 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.

	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 cannot contact 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 is compromised. 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

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
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 takeover 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, but most often bypasses the district authorities. 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: there was almost no negotiation. - 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.	

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
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.	

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
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 facility. The budget detail and the timeframe of the activities are mentioned in a work plan that is specific to the facility. 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	

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
Tools	- The steering committee installed to monitor the relationship gathers not often enough to be efficient. - The responsibility for the main decisions lies at 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 are no public-private meetings.	- 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 facilities. - Obligations are strictly defined 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.	

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
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 .	- 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.	

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
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.	- 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	- 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	- 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 facilities: i) in terms of training for some members' staff; ii) development of analytical, anticipation and	

	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.	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	on offer.	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

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
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 at 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.	

	Tokombéré Hospital (HTok)	Nyakahanga Hospital (NH)	District of Moïssala (DM)	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
Future of the contracting relation-ship	- '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. The relationship 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

	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. - Contracting 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

	CAMEROON	TANZANIA	CHAD	UGANDA
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 platforms. - 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. - Absence of an ecumenical interlocutor at central level legitimized by the faith-based platforms. - The information disseminated by the faith-based sector at public level (and in particular through does not reach the central level. It is proof and symptomatic 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.

	CAMEROON	TANZANIA	CHAD	UGANDA
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 at 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 at the expense 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.

Cross-cutting analysis and discussion

The public -faith-based contracting experiences all display 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 was more or less the case in all the countries in this study. This crisis situation is all the more paradoxical as it occurs within a general partnership consensus context. The inevitable character of the collaboration and the added value of its formalization are not only admitted but also demanded by both sectors and all levels of the hierarchy.

The seriousness of the crisis is partly due to its discrete, almost hidden nature. Either there is no general awareness at the central level (Uganda), or it manifests itself mainly at an operational implementation level (districts). In any case, the awareness of the crisis remains largely confined to the faith-based sector: yet more evidence of a shaky partnership.

The size and scale of the crisis is worrying and without rapid intervention, the existing experiences might fail in the short or medium term.

The crisis of the partnership and contracting experiences fits in well 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 experiences provide at best a very inadequate answer. Although a proclaimed partnership is a fact in all countries, questioned actors tend to emphasize the negative aspects of the relationship and more generally the crisis affecting the relationship and current contracting arrangements. So far, the least one can say is that the crisis has not been properly addressed. Worse, the outside world still considers the Church's health system a beacon of stability in the landscape and an asset. However, this assessment is more and more an illusion and tends to cover up the real problems.

The State insufficiently respects its partnership commitments

Whatever the development stage of a contracting framework at the 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 vital to the faith-based facilities in crisis. The support of the State remains structurally insufficient and grapples with a number of difficulties, including: losses, leakage, delays, weighty procedures, etc. The public sector agents and managers are honest and straightforward about these problems but 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 existing agreements are not, or poorly, followed up. There is a systematic absence of operational monitoring and evaluation mechanisms. Specific supervision of the contract and its obligations is missing, as are contracting tools that might have been planned but are often dysfunctional to some extent. At best, the difficulties are recognized but no structural solution has been put forward. This situation reflects not only problems of form, which mark all the service agreements we investigated at the peripheral level, but also problems of capacity and resources. Monitoring and evaluation remains a weak area for the public sector at district level, not just with respect to possible contracting relationships with the private not-for-profit sector. All-round monitoring tasks are also affected; irregularity and relative superficiality characterize them all too often.

Contracting experiences develop in a general climate of unpreparedness and knowledge gaps.

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 after the initiation of the experience, and targets mainly the central level managers.

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

Lessons from the past have not really been learned and are largely ignored when it comes to the development of partnership policies. This often leads to the coexistence of contradictory models. The contracting landscape is varied and usually consists of arrangements concluded at different periods in time, answering to various forms and models and therefore referring to sometimes contradicting policy frameworks and administrative references: in none of the countries studied was there a real attempt to harmonize the situation, through revision of older contracting documents.

In addition, the circulation of relevant experiences and know-how in this area remains very limited. In short, there is no collective, centralized and institutionalized record. The knowledge and the documentation of the fragmented and burgeoning experiences remain largely the work of individuals. In none of the cases investigated there is an exhaustive database which gives access to all the regulations, models and contract documents signed or in force. 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 the peripheral level expose the imperfection of a decentralization process

Many difficulties are the result of the poorly functioning communication lines between the central, intermediate and peripheral levels. The decentralization policy started in all countries around the end of the 90s or early 2000s but was never fully implemented. This poor implementation and difficult information flow is reflected by the bickering between the various levels of authority, and the persistence of relationship mechanisms inherited from the centralization period. At worst, the regulatory frameworks and the discourse coming from the central level are just rhetoric, if compared with the field knowledge and implementation practice at the peripheral level. The contracting experiences at the peripheral level are directly affected by this situation. The dichotomy between the central and peripheral levels, and the lack of a relay level greatly weaken the follow-up opportunities of the arrangements and structural solutions needed to address arising difficulties. There is often great confusion about the identity of the legal authorities responsible for managing the relationship.

This context of institutional weakness explains the predominant role still played (in a positive or negative sense) at all levels by individuals. In general, the quality of the relationship of the partnership, the resolution or (in some cases) aggravation of the difficulties all depend on the degree of involvement and leadership of the respective players of the faith-based and public sector, as well as on their networks.

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

It is important to first stress the negative aspects of these bilateral contracts: the opaqueness of the systems and mechanisms which govern them; their exogenous nature; and their targeting of the peripheral level. These are all obstacles for the central public and faith-based sectors to develop at least some kind of shared ownership of these experiences. This control is further hampered by the sheer power of the donors and huge amount of resources involved. In this region, donors have a lot of leverage and clout.

The importance of these resources (these interventions apply strict targeting methods and mobilize a substantial amount of human and material resources of their beneficiaries) could certainly distort matters. All this is even more serious because the targeted facilities are weak and affected by the general crisis in the faith-based health sector. In addition, these contracts generate double standards that are likely to have a negative influence on the integration process of recipient facilities 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, and the steering and evaluation mechanisms and activities which characterize them. Their efficiency and the donors' respect of commitments are other aspects that are highly valued by the beneficiaries. The set-up usually leads to local capacity strengthening which tends to have a positive spill-over effect. In fact, 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 a negative light on the contracting relationships between the faith-based facilities and the state

The aspects that, in the eyes of the recipient facilities, explain the efficient functioning of the PEPFAR contracts might provide interesting avenues for the 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 faith-based facilities, great collaboration efforts are made during the preparation stages of the set-up; they seem to stop, however, 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 are continued and strengthened, notably through tools such as 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 and first of all the recognition of the role its institutions and facilities play in the national health system. The relationship appears imbalanced as the current 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 coverage in the areas concerned). In more extreme cases (Chad), the setting up of real, contracted development projects takes place with little financial and administrative involvement of the State, and rests essentially on the shoulders of faith-based organisations while obviously also benefiting the public sector.

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

Due to the difficulties met, none of the parties involved boast about the partnership, though the public authorities are aware of their shortcomings and admit that much can be improved. The religious actors are getting

increasingly bitter. The difficulties experienced often lead to a certain degree of mistrust or, in certain cases, even utter disillusionment and resignation. These disappointing experiences sometimes make the religious actors in the district prefer bilateral relations with external donors, with immediate but sometimes unsustainable results. This preference goes with 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 means that certain peripheral facilities or organisations move away from signed contracts because they do not come with enough resources to ensure implementation. This worsens 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 disintegration of the partnership is very real.

Conclusions

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 should be strengthened through the establishment 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 scheduled for 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 in which every actor from the Public Private Partnerships is represented on a pluralistic and unbiased basis. These centres should have a broad mandate, associating public and private (not-for-profit) actors 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 the guarantee of independence against possible interference, all of which would help to ensure total transparency and access to the collected data for the greater public. In addition, collaboration with local academic institutions 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[162] in the field of medicines) and include an international database. Before this can happen, country databases would have to be created of more or less compatible models and systems.

It remains essential for now to respond to the specific training needs of the field actors. Contracting workshops could be regularly organized and should have a content adapted to the local situation and the administrative level and role of the participants in the contracting process. Such workshops

[162] *cf.* www.essentialdrugs.org

could also benefit from the input from local faith-based platforms. Organisations 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. It is essential that such workshops be organized in consultation with the Ministry of Health and systematically involve public and church related actors. Moreover, besides a training opportunity, these events could also become a platform for dialogue thus allowing participation in the dissemination of experiences and their perception.

For the field: public and church related 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. The integration of all the existing relationships in the developed national framework is of course essential: it involves the adaptation of contracting policy, framework agreement models as well as service agreements. This harmonization should, however, be an on-going 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 for the redefinition, unambiguously, of the competent levels of authority for the contracts that are now rather blurred 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. For the moment, the contracts are to be found in as many different places as their supervising 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 that seems able to put a figure on the existing protocols: neither at the Ministry, where one could perhaps expect it from DCOOP, nor on the denominational side, through OCASC and CEPCA for the hospitals and their respective networks. Integrating these contracts - possibly through revision - in the recently developed framework would ideally enable to draw up an exact overview and typology, and ensure systematic filing.

This is even more needed since attention has been turned away from these experiences 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 encounter. On top of everything else, they only have a fragmented knowledge of what is going on and are thus not well equipped to defend their own case. It is obvious moreover that contracts like the Tokombéré contract require a review and the integration of proper monitoring and evaluation mechanisms. The notion of performance introduced by the new partnership strategy and the framework agreement models are a great improvement and earlier protocols could greatly benefit from these.

The reintegration of these experiences in the present process should be advocated with the denominational platforms and the MoH; if impossible, then their future integration should be scheduled. Where the process and its implementation remain too concentrated at the national level, real decentralisation (partnership at the intermediate and peripheral level) would allow for the uniform dissemination of information and help the actors of earlier protocols find the means for integration with their respective overseeing authorities.

It is moreover essential to take into account the issue of the real level of government support to faith-based contracting partners. Tokombéré, it has to be stressed, is the result of an exceptional situation. It would be dangerous to generalize this experience 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 project) will have even more important repercussions on the Church's ability to operate and maintain peripheral

facilities if the State only partly respects its commitments. A simplification of financial support mechanisms, their transparency and knowledge by the recipient facilities are important prerequisites for improving the situation. It is moreover essential that the level of support, its limits and conditions be 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 roles 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. In order to achieve this, the decentralisation process initiated in 1996 has to be continued and implemented.

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 experiences to the regulatory framework (decentralisation, PPP) and ensure proper methods of monitoring and evaluating. This is absolutely vital to avoid jeopardizing the sustainability of the partnership. We believe this process should take place in parallel to the dissemination of operational contracting experiences that began when the Service Agreements were put in place. Considering the vastness of the country, and keeping in mind the limitations of the available human and financial resources, keeping close track of the functioning and real outcomes of concluded contracting arrangements would certainly help avoid unnecessary pitfalls in their implementation.

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 for the Voluntary Agencies is currently calculated on databases that are often outdated 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 budgets on transparent information. It is therefore

imperative that they get the correct 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 (Mpango wa Maendeleo wa Afya ua Msingi or MMAM). 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"[163]. A considerable number of actors in the faith-based sector thus fear the emphasis put on the development of public health structures at the lower administrative levels, as it could eventually jeopardise 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 relation is essential. This includes strengthened capacity to foster the generation of good data from peripheral level facilities, and capacity to collect this data to bolster their case at the central level. Clear indicators and results would further enhance the organisation's capacity to assess on-going experiences better.

Systematic review and analysis of the current experiences would certainly generate a first and essential layer of usable information. The successful acceleration of the decentralization process of CSSC will without any doubt be instrumental in facilitating such a wide-ranging data collection process: the organisation is currently reinforcing its presence at decentralized level through so called 'zonal coordination units' which ideally would function as intermediaries between peripheral facilities and the centre. This coordination remains problematic because of the vastness of the territory that needs to be covered and the limitations in terms of human resources, especially as coordinators are only employed part-time. This situation should be immediately corrected by the appointment of a permanent secretary.

In this sense, the decentralisation of the partnership forums - planned by CSSC through the zonal delegations - could contribute to a better understanding of the reality in the field. Consequently, the climate of cooperation that exists at the central level could then also trickle down to the

[163]Declaration of the Health Minister, Pr. David Mwakyusa during his inauguration speech at the 71st TCMA assembly.

peripheral level. But it is obvious that a lot remains to be done. It is striking, for example, that CSSC was an unknown acronym to the local administrative authorities in the Karagwe district at the time of study!

The website[164] recently launched by CSSC, which functions as a network platform focusing on ICT for health, could, in due time, become an instrument for collecting data with regard to the contracting experiences, but only if it is actively consulted and used by the field actors. At the very least it is meant to be 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 the local level also requires better representation of these authorities in the decision making 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 were signed at the central level and therefore refer to administrative zones and representative bodies that have become obsolete with the implementation of the Tanzanian decentralization policy. Ignorance of the regulatory framework in force led *de facto* to an underrepresentation of faith-based actors in the district level public decision and administrative bodies.

The question is whether harmonisation of the situation should not be achieved through the setting up of a consistent regulatory framework at the central level. The formulation of a Contracting Policy (or Partnership Policy) and related contracting tools would doubtlessly allow greater visibility for contracting rules and sharing of responsibilities, and facilitate their acceptance by local authorities, at least if they are regularly adjusted to possible changes in the larger regulatory context (e.g. National Health Policy, decentralization policy, etc.). The fragmentation of the contracting policy principles in numerous documents and declarations currently contributes to sustained widespread ignorance of the mechanisms and rules governing the collaboration between the State and the private sector.

[164]Afya Mtandao: www.afyamtandao.org

In Chad

It is unlikely that the State on its own will be able to resolve the difficulties affecting contracts signed with the PNFP sector in the medium term. Due to the restricted budget and the important national shortage of qualified staff, the integration of the contracts in a long term external aid policy is essential. The ability of the facilities and organisations to fulfil their obligations in the contracting arrangements obviously depends on the availability of adequate means. The amount of resources available is currently limited due to the operational withdrawal of the State and the diminishing influence of traditional sources of support for the Churches. It is no exaggeration to state that the sheer existence (and thus survival) of the faith-based health structures is at stake here as well as the quality of care they provide.

More specifically, the key role played by UNAD (*Union Nationale des Associations Diocésaines*/UNAD) in coordinating its diocesan delegation units BELACDs and representing the interests of the faith-based sector in negotiations with the State and international organisations, can only be assured if the organisation has a functional and dynamic medical coordinator. The reintroduction of this post, abolished as a result of a lack of human and financial resources, is more than urgent as the examples of Doba and Donomanga prove. There is a real risk that the faith-based organisations will withdraw from the contracts at the local level if there are no additional external resources made 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 are clearly distinguished from each other. This is key to guaranteeing the sustainability - in spite of the uncertainty of external funding - of both the contracting relationship and the joint search for means to continue.

An overall assessment of the on-going experiences in Chad is needed in order to assess the validity 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 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. A substantial number of PEPFAR's principal recipients are not aware of the vital role played by the different *bureaus* in the health facilities. The potential advantages of such a rapprochement are obvious from the specific case of CRS. In the latter case, starting a real dialogue with the faith-based platforms allowed the latter to modify the approach of the donors; there was some consideration for the concerns of the sector. 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. In addition, this sort of dialogue would restore their steering capacity and provide them with comparison material and a wealth of useful experience to help streamline the partnership between MoH and the churches in the health sector.

These platforms can also play a preventive role towards the network's facilities, in order to limit the risk inherent in 'bilateral' contracts signed with PEPFAR, by providing the hospitals with specific technical support (i.e. by means of a training) introducing them to this type of contract. This support could take the form of specific and regular training in the contracting process; also, more specific activities to boost the facilities' negotiation skills can be considered. The example of Virika Catholic Hospital in Fort Portal shows that that there is sometimes room for negotiation when contracts are set up (with CRS in this instance), but then the facilities need to have the skills to argue their case forcefully with the donor. Hence, the development of specific skills has to be part of the policy

of capacity and professionalism strengthening of the sector in which UCMB and UPMB are already involved. Church authorities also need to be involved. The development of professional and functional Diocesan coordination bodies should be encouraged. Their role would be to efficiently guide 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. It is essential that the public authorities become aware 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 end and supports 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.

Strategic considerations for the future: what are the options?

Faith-based health facilities play an important role in African health systems, especially in rural areas. They have been doing so for many decades and still continue to do so. The health centres and hospitals that belong to the faith-based sector make up an important part of the pluralistic health systems that African countries have today. These diversified health care delivery systems are composed of publicly-owned government facilities, private not-for-profit facilities of which the faith-based structures are part, private for-profit facilities, both in the formal and informal sector, and finally traditional medicine. The faith-based health care delivery sector constitutes up to 30-40% of the supply of hospital care in rural areas, with variations from country to country. In the most remote areas, the faith-based sector is even often the only (hospital) provider. The sector is characterized by a high level of resilience; it has 'survived' many periods of crisis and political turmoil. Public opinion respects the sector and associates it with good quality care. The general perception is one of committed and empathetic health workers. The PNFP sector in general, and the faith-based health sector in particular, are much appreciated - also by government officials - because of their

professionalism and the continuous attempts to provide accessible person-centred care of good quality. In many instances, the activities of the faith-based sector stretch beyond the mere provision of individual patient care and encompass public health activities in the community for the populations for which they have taken responsibility.

As amply illustrated in this study, it is clear that the faith-based sector is currently under great strain. The sector experiences a major resource crisis as (financial) support from the Northern Churches is decreasing. The secularization of European society in the last decades of the 20th century affected the ability of Northern sister Churches to help financing the health care delivery in the faith-based sector in sub-Saharan Africa. The flow of funding has not dried up, but is by no means what it used to be a couple of decades ago. In addition, there also is a crisis in terms of human resources. The faith-based sector does not escape the human resource crisis that also hits the public sector. The increasing mobility and brain drain of qualified health workers, internally in the country and externally to OECD countries, also influences the faith-based sector.

In this situation of crisis, what are the possible ways out? The worst case scenario would be one where the faith-based sector moves out of the health sector because of the lack of resources to function properly. This seems a rather extreme scenario but it is one that is increasingly mentioned, in informal conversations with managers and interlocutors of institutions in charge of the faith-based sector. At the same time, the people in charge of the sector emphasize that such a choice would be a choice by default. However, the very fact that such an exit option crosses people's minds is significant in itself. It points to the fact that the resilience of the faith-based health sector may have reached its limits. The government sector needs to be aware of this crisis situation and realize that the creativity, networking and resilience of the faith-based sector are not inexhaustible.

Most if not all faith-based health centres and hospitals heavily rely upon income generated by user fees. They have no choice but to charge patients for the care that is offered because this income is crucial in complementing the other sources of financial income. If user fees continue to increase, though, the policy can be at odds with the fundamental mission of faith-based facilities aiming to reach the poorest and the most vulnerable in society. This vocation of the faith-based health care delivery sector could thus become diluted and jeopardized by the practice of charging patients at the

time and point of health services' utilization - a scenario whereby the private not-for-profit sector, by default, gradually mutates into a private for-profit sector. This scenario is increasingly taking place in a variety of settings. The alternative is that the sector decides to close down its facilities altogether, if the institutions and people in charge of the faith-based sector believe that the mission/vision has become unrecognizable after too many compromises.

The issue of universal coverage is high on the international agenda today. The WHO World Health Report (2008) has given due importance to this policy objective for low and middle income countries, but also for high income countries. If African countries are to make progress in that respect, it is not only crucial that the faith-based sector is kept 'on board', but also that the sector is genuinely integrated in national health policies, in a way that is respectful and compliant of national priorities and planning. Faith-based hospitals should not only continue treating individual patients, but also take up responsibility vis-à-vis the network of primary health centres located in the community. This is only possible if substantial amounts of public funds - including donor funding allocated to Ministries of Health through budget support - are directed to the faith-based facilities in a fair way, i.e. according to allocation criteria that take the public role of these facilities properly into account. Today, this is not sufficiently the case. There must be no room for positive discrimination, but there should be none for negative discrimination either. The contracting tool has its place in that enterprise: it is a vehicle to finance the faith-based sector in a way that 'strings are attached' to the funding. Indeed, conditions in terms of systems integration of faith-based facilities may be - should be - explicitly incorporated in the contractual arrangements that are established between the two protagonists.

The different scenarios outlined above are thus as follows. First, there is the (ideal) option of a fair and sustainable share of public funding and human resource allocation to the faith-based health care facilities, with a commitment of the latter to respect national choices and priorities, enforced via appropriate mutually beneficial contracting arrangements that aim to strengthen the integration - not the assimilation - of a sector with a specific identity in overall national health policies. Second, there is the option of the faith-based sector having to adopt - by default - a profit-making rationale. The concern to recover costs would then become essential, at the expense of the accessibility and quality of the health care. The very specificity and strengths of the sector would be progressively undermined, perhaps even disappear. To

some extent, this scenario is materializing today. The third scenario is even less appealing: faith-based facilities would simply decide to close down and the Church would progressively withdraw from the health care delivery sector. Public authorities have always assumed that the resilience of the faith-based sector makes such a scenario unlikely, even in situations of great (financial) pressure and strain. But, as indicated by some of the persons interviewed in our study, the cracks begin to show in the alleged unconditional commitment of the faith-based sector, of its authorities and workforce, to remain active in the health sector at any cost.

Our study has pointed to a fourth scenario. The Uganda case illustrates the case where donors simply circumvent governments and establish direct contracts with faith-based facilities. In Uganda, PEPFAR is a case in point. Our study did not carry out a detailed investigation into PEPFAR's reasons for doing so, but it allows us nevertheless to come up with plausible and not mutually exclusive explanations. Perhaps PEPFAR considers channelling of the funding via national public institutions as inefficient, unreliable and untrustworthy; and/or PEPFAR may simply not be interested in service outputs other than in the domain of HIV/AIDS care. The 'damage' done in the medium and long term can be substantial: governments and Ministries of Health are increasingly being bypassed and thereby losing grip on the policies of international donors on their territory; there is also an increasing imbalance in the nature of the health care provided in the faith-based facilities with which highly specific and detailed contracts are established for a specific (and selective) package of care. In the case of PEPFAR, the bias is clearly in favour of HIV/AIDS related activities. An important finding of the Uganda case study is that the staff at the (faith-based) hospital level actually appreciates the trustworthiness of PEPFAR in terms of commitments made. Eventually, however, there will be many losers and losses in the process. The government's credibility will be further undermined, the structural funding problems of the faith-based health sector are not solved, and the supply of care at peripheral level will be increasingly fragmented and selective - which is at odds with the tradition of offering comprehensive care in the faith-based sector.

In the short term, the strategic top priority is to engage into a multi-stakeholder dialogue whereby the study findings are shared, that assesses the likelihood of different future scenarios - with their respective pros and cons -

and where the basis is laid for a shared action plan. The involvement of the international donor community in that endeavour will be essential.

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