

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

**The case of
Cameroon, Tanzania,
Chad and Uganda**

Report, May 2009

**Foreword and
Executive Summary**


medicusmundi
international network





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

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Sharing knowhow and joining forces towards Health for All

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Foreword

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

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

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

To make matters worse, there is no general awareness of the crisis, certainly not among the public sector actors.

Unless correcting measures are taken, this almost hidden crisis risks to jeopardize in the medium-term the important contribution which the faith-based health institutions – many of them supported by members of the Medicus Mundi International Network – make to the provision of healthcare in Africa.

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

A rather unexpected issue is provided by the contracts between the US “Presidential Emergency Plan for Aids Relief”(PEPFAR) and the faith-based hospitals in Uganda.

Although the study does not deny the danger of a selective and vertical approach in healthcare provision and the risk of bypassing public and faith-based central government structures in contracting, these contracts obviously offer interesting avenues for improving “classic” contracting relations between the public and faith-based sector. Indeed, these contracts can be considered as benchmarks for contracts characterized by a great extent of specificity and predictability, by the quality and sustainability of the monitoring, steering and evaluation mechanisms, and, last but not least, by the donor’s respect for commitments. The management of the district faith-based hospitals has explicitly voiced its appreciation of these positive aspects.

Now that we know the study’s results and its recommendations – which are shared by ourselves – what are we going to do with them?

Let us be clear: the situations investigated in this study do not question the validity of a support policy to contracting. We believe that contracting remains a most valid option. The study rather emphasizes that the strengthening of such a policy is urgent. The study clearly showed that the different field actors involved in the contracting processes feel the necessity for steady, close and personalized support, adapted to the local context. It is most unlikely that this observation would not hold for other than the countries and cases studied.

The Medicus Mundi International Network intends to play a role here. The experience of our Network’s members - in terms of their support to contracting and knowledge of the faith-based health sector – is an asset to exploit.

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

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

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

We will encourage our member organisations to implement the lessons learnt. As operational actors very much in touch with the field, these organisations are likely to play a

significant support role, in particular with the faith-based bodies and facilities involved in the contracting process.

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

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

We also will have to pay attention to new developments in the field of contracting. The increasing influence of performance contracts (of which the PEPFAR contracts are only one but maybe a rather extreme example) seems an irreversible trend, which will in the short term become much more widespread. It is therefore important to be aware of the lessons which may be drawn from the positive effects of these arrangements, without blindly ignoring their potentially negative aspects. In any case, a status quo, only taking into account the traditional contracting experiences, would be even more dangerous as their analysis shows that there are many shortcomings in their functioning: guiding the field actors efficiently implies being fully in touch with the reality of the current developments.

So let us look back – and then go ahead.



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

Medicus Mundi International is a Network of private not-for-profit organisations working in the field of international health cooperation. The Network members fight global poverty by promoting access to health and health care as a fundamental human right ("Health for All"). The Network aims at enhancing the quality and effectiveness of the work of its members and their partners through sharing know-how and joining forces.

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Executive Summary

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

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

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

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

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

The main results of the study are as follows:

In Cameroon

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

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

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

In Tanzania

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

- The partnership dynamic is still mainly limited to the central level and the partnership policies, their tools and the spirit of cooperation are not circulated enough, which hinders the generalisation of the process. Personal relations and their quality - particularly at peripheral level - remain the key to success for collaboration experiences.

- In general, the decentralisation process of authority remains incomplete and this obstructs the implementation of the contracting process and the development of PPP at district level. Several components need to be improved:
 - o The distribution and acceptance of responsibilities
 - o The knowledge and the understanding of the policies
 - o The communication lines
 - o The different contradictory strata of the regulations (contracts signed on central level in a context of authority that is supposedly the local government's)

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

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

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

In Chad

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

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

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

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

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

In Uganda

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

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

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

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

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

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

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

and operational solutions to the immediate survival needs of the facility. If they can deliver what they promise, this might prove to be the more tempting option.

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

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

- In spite of the wide variety of contexts and experiences, the different case studies show that **contracting between the State and faith-based district health sector faces great difficulties**.
- The current situation can be labelled a crisis; to make matters worse, **there is no general awareness of the crisis at central level**, awareness remains largely confined to the faith-based and peripheral sector. Without rapid intervention, the existing experiments might fail in the medium or even short term and could no doubt call into question the efforts put in at central level in most countries.
- The dysfunction of the contracting experiences rests on a number of common elements. Both **public and faith-based actors are badly prepared for the issues at stake in the contracting relationship, as they have no previous experience, received no adequate training, and the information flow is far from timely and continuous**. In general, the contracting experiences develop in a context marked by limitations and information asymmetry. Contracting documents are often incomplete and not well integrated in the existing national framework (partnership and contracting policies). These documents are moreover seldom revised. The State does not always respect its commitments in terms of the allocation of financial and human resources. The problems mentioned all essentially relate to these issues which are fundamental stakes in a general context of limited resources. The contracts that work are contracts that “have resources” as shown by the first contracts for Chad or a fortiori the examples of PEPFAR in Uganda. There is also a systematic absence or disrespect for monitoring and evaluation mechanisms.
- More generally, **the development and implementation of partnership and contracting policies and initiatives do not fully draw the lessons of the past**. No advantage is taken of previous experiences and this leads to a heterogeneous contracting landscape, composed of diverse historical strata that are often contradictory.
- **This balkanisation of the contracting landscape and the dysfunction of the formal partnership experiences at peripheral level expose the imperfection of a decentralization process** that began around the end of 90s, early 2000s. The dichotomy between the central and peripheral level greatly weakens the follow-up opportunities of the arrangements and the set up of structural solutions to address the difficulties met. It also explains the predominant role of interpersonal relations, to the detriment of institutional solutions.
- **This crisis of contracting experiences fits in with the general crisis in the faith-based sector and also contributes to this crisis**. The financial crisis in the faith-based health facilities is accompanied by a crisis in human resources. Although the state admits that these difficulties exist, the current contracting experiments provide at best a very inadequate answer. The size and escalation of the crisis are ignored. In fact, the Church’s health system still has a strong reputation and seems a stable, unchanging feature in the landscape. Unfortunately this does not exactly correspond to the reality of the field.
- **The particular case of Uganda and the analysis of contracts between PEPFAR and the faith-based hospitals provide a valuable and contrary point of reference, that we can contrast with the observed dysfunction of the “classic” contracting experiences between the public and faith-based sector**. The importance of the resources injected in these contracts, their “exogenous” nature and especially their extreme targeting are not without risks for the benefiting structures, and could distort the provision of care. There are however also some positive aspects which are appreciated by the beneficiaries. The analysis of these advantages displays almost the inverse picture of the contracting relationships between the faith-based structures and the State: their degree of specificity

and predictability, the quality of the monitoring, steering and evaluation mechanisms, their efficiency and the donor's respect of the commitments.

- **These aspects might provide interesting avenues for a rereading and improvement of the contracting relations between the Church and the State.** The contracting approach is very different for the two types of relations: the PEPFAR contracts continuously encourage and stimulate the relationship, while in the case of contracting between the faith-based facilities and the Ministry of Health great efforts are only made during the preparation stage for the set-up.
- Rather than creating conditions for the development and strengthening of the relationship on the basis of innovative objectives, **the contracting arrangements between the faith-based sector and the public sector essentially confirm a factual situation:** the arrangements are often static and create the basis for an imbalanced relationship, which mainly benefits the State.
- Overall, **the situation reveals a real risk of disintegration of the partnership between the public and the faith-based sector in health in Sub-Saharan Africa in the future.** The disappointing experiences of district religious actors lead some to prefer bilateral relations with external donors - with direct but often not sustainable results; elsewhere, the breakdown of relations induces certain peripheral facilities and organisations to move away from signed contracts (Chad) or threaten to withdraw (Tanzania); finally some churches already call into question the very notion of partnership or the conditions set by this notion for participating in the health sector (Uganda).

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

1. For international actors: donors and NGOs:

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

In a more distant future, these country resource centres could form the basis of a **Pan African information and exchange network for Public Private Partnerships and contracting**. Before this network can be set up, country databases have to be created on the basis of more or less compatible models and systems.

It remains essential as for now to respond to the specific training needs of the field actors. Contracting workshops could thus be regularly organized upon request. They should have a content adapted to the local situation and the level and role of the participants in the contracting process. The set-up of such workshops could benefit from the input from local faith-based platforms¹. It is also essential that they are organized in consultation with the Ministry of Health and systematically involve public and religious actors: moreover, besides a training opportunity, these events could also become a platform for dialogue and participate in the dissemination of experiences and their perception.

2. For the field: public and religious actors:

The streamlining of the contracting landscape should be a priority in all the study countries. The monitoring and evaluation, and eventually the success of existing contracting experiences requires that they be adapted to a coherent and legible framework at all levels of the health system. Besides the

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

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

Specific recommendations per country

In Cameroon

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

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

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

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

It is moreover essential to take into account the issue of the government's real support to its faith-based facilities contracting partners. In this respect, Tokombéré is the result of an exceptional situation. It would be dangerous to generalize this case to the rest of the sector. Very few facilities benefit from regular external support like in our case study. It is obvious that the financial crisis affecting the faith-based sector (and proved by the debt levels identified through the C2D² project) has even more important implications on the Church's ability to operate and maintain the majority of peripheral facilities if the State only partly respects its commitments: **a simplification of financial support mechanisms, their transparency and knowledge by the beneficiary facilities** are important prerequisites for improving the situation. It is moreover **essential that the level of support, its limits and conditions are clearly pointed out in the contracts**. This is only partly the case in the contracting documents signed outside the C2D project.

² FINORG, Definition of the operational conditions of contracting relationships between the actors in the Cameroon health sector - Final report IV, 2004.

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

In Tanzania

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

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

The government has begun to implement its plan for improving the health services through a programme of primary care (MMAM³). The aim is to bring the health services closer to the people: “We intend to reach the rural population as they represent 80% of the residents and they are the ones who do not have access to health services; we hope to achieve access for each village by 2017”. (Declaration of the Health Minister, Pr. David Mwakyusa during his inauguration speech at the 71st TCMA assembly). A considerable number of field actors in the faith-based sector fear the emphasis thus put on the development of public health structures at the lower administrative levels scale, as it could eventually endanger the part of the budget reserved for the faith-based facilities.

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

In this sense, the **decentralisation of the partnership fora**, planned by CSSC through the zonal delegations could contribute to a better understanding of the reality in the field and could on peripheral level advance the climate of cooperation that exists on central level. The fora are also a potential tool for improving the knowledge of the actors. It is striking for example that CSSC is an unknown acronym for the local administrative authorities in the Karagwe district! The (newly created) Afya Mtandao website⁴ could in due time become an instrument for collecting data with regard to the contracting experiences, if it is actively consulted and exploited by the field actors. At the very least it is an interesting effort to stimulate exchange between the field actors.

³ Mpango wa Maendeleo ya Yfya ya Msingi (MMAM).

⁴ www.afyamtandao.org

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

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

In Chad

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

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

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

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

In Uganda

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

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

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

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

Take-home messages

1. Contracting between faith-based district hospitals and public health authorities in Africa faces a crisis. In spite of the wide variety of contexts and experiences, the different case studies show that contracting between the State and faith-based district health sector has run into great difficulties. To make matters worse, there is no general awareness of the crisis, certainly not among the public sector actors. Unless correcting measures are taken, this almost hidden crisis risks to jeopardize in the medium-term the important contribution which the faith-based facilities make to the provision of care in Africa.
2. The dysfunction of the contracting experiences can be explained by a number of factors: the lack of information and inadequate preparation of the actors, the almost systematic absence of support mechanisms adapted to the reality and needs of the field, the lack of monitoring and evaluation systems for the contracting experiences and the fact that a management culture, that would integrate the lessons of the past in matters of contracting in current policies and tools, is lacking. Finally, the State does not always respect its commitments.
3. The contracts between the Presidential Emergency Plan for Aids Relief (PEPFAR) and the faith-based hospitals in Uganda provide a valuable and contrary point of reference. Although we do not underestimate the risk of a selective and vertical approach in contracting, nor do we intend to hide the fact that public and faith-based central government structures in health are mostly bypassed by PEPFAR, these contracts offer interesting avenues for improving “classic” contracting relations between the public and faith-based sector. Indeed, these contracts are characterized by a great extent of specificity and predictability, by the quality and sustainability of the monitoring, steering and evaluation mechanisms, and, last but not least, by the donor’s respect for commitments. The management of the district faith-based hospitals appreciates these positive aspects.
4. The results of this study should be presented in each country (Cameroon, Tanzania, Chad, Uganda) if we want to achieve relevant and sustainable changes in the field. This dissemination process should be well prepared and steered and has to involve actors from all sectors and levels: the public and religious health authorities at central and peripheral level, the care providers and the community representatives.
5. Generally the field actors involved in the contracting processes feel the necessity for steady, close and personalized support, adapted to the local context. Without any doubt, this observation can also be made in other than the countries and cases studied. Consequently, the elaboration of technical manuals, such as the one developed by Medicus Mundi International (MMI) in 2003, is not very useful.