


**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

**Case study: Cameroon**

  
**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**

By Delphine Boulenger, Basile Keugoung & Bart Criel, Institute of Tropical Medicine, Antwerp

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Medicus Mundi International Network  
Murbacherstrasse 34 · 4013 Basel · Switzerland  
Phone +41 61 383 18 11  
IBAN DE23 3706 0193 1011 1340 13  
office@medicusmundi.org · www.medicusmundi.org  
*Sharing knowhow and joining forces towards Health for All*

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## List of acronyms

ACERAC	<i>Association des Conférences Episcopales de la Région de l'Afrique Centrale/ Association of episcopal conferences for the central african region</i>
AFD	<i>Agence Française de Développement/ French Development Agency</i>
C2D	<i>Contrat de Désendettement et de Développement/ Debt alleviation and development contract</i>
CENC	<i>Conférence Episcopale Nationale du Cameroun/ Cameroon episcopal conference</i>
CEPCA	<i>Conseil des Eglises Protestantes du Cameroun/ Cameroon Council of protestant churches</i>
CIDR	<i>Centre International de Développement et de Recherche/ International Centre for development and research</i>
CVS	<i>Comité Villageois de Santé/ Village health committee</i>
DCOOP	<i>Direction de la Coopération/ Cooperation directorate</i>
EB	Executive Board
FALC	<i>Fondation Ad Lucem au Cameroun/ Ad Lucem Foundation in Cameroon</i>
FBO	Faith Based Organisation
FBH	Faith Based Hospital
HC	Health centre
DH	District Hospital
HTok	Tokombéré Hospital
LGO	Local Government
MOH(SW)	Ministry of Health (and Social Welfare)
NHP	National Health Policy
OCASC	<i>Organisation Catholique de la Santé au Cameroun/ Catholic health organisation in Cameroon</i>
PASS	<i>Programme d'Appui au Secteur de la Santé/ Health Sector Support Program</i>
P4P/ PFP	Pay For Performance
PBF	Performance Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PNFP	Private not for profit
PPP	Public Private Partnership
SSA	Sub-Saharan Africa
SWAP	Sector Wide Approach
WHO	World Health Organisation

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Delphine Boulenger, Basile Keugoung and Bart Criel, ITM Antwerp

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## *Contact*

Address: ITM  
Nationalestraat 155  
B-2000 Antwerp, Belgium

Email: Delphine Boulenger, [contractingstudy@gmail.com](mailto:contractingstudy@gmail.com)  
Dr Basile Keugoung, [keugoung@gmail.com](mailto:keugoung@gmail.com)  
Pr. Bart Criel, [bcriel@itg.be](mailto:bcriel@itg.be)



# General introduction

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

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

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

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

This study looks at the results from three different perspectives:

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

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

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

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

In an annex, this study also tries to answer the question of dissemination, pertinence and use of the Guide to Contracting written by MMI in 2003. The organization wanted an

assessment of the impact of this publication, as significant costs and effort were involved when drafted.

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

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

# Introduction to the country-case report

The present booklet is an excerpt adapted from the full report and intended to provide you with quick and easy access to country-specific data. It presents a complete overview of the country-case's results, their summary and a SWOT analysis in table format. The cross-cutting analysis section (dealing with the results of all 5 case studies) has been kept but recommendations cleared from other countries' specific data.

You may therefore wish to refer to the full report to access (1) the Executive Summary, (2) details on research and case-study methodology as well as (3) to the recommendations and bibliography applying to other countries.

That complete version may be freely uploaded from the MMI website ([www.medicusmundi.org/contracting](http://www.medicusmundi.org/contracting)) or ordered (CD-Rom) from the MMI Executive Secretariat in Basel<sup>1</sup>. Moreover, the MMI website offers the opportunity to access a separate file containing both MMI's foreword as the Executive Summary of the study. The report's annexes are available via the same channel.

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<sup>1</sup> See contacts on page 2 of the present document

# Case-study: Cameroon



## General context

### PLACE OF THE CHURCH IN THE SUPPLY OF CARE

According to figures of the MOH, the private sector represents 40% of the national supply of care. The lion's share is held by three faith-based organizations, in order of importance<sup>2</sup>: *Organisation Catholique de la Santé du Cameroun* (OCASC), the *Conseil des Eglises Protestantes du Cameroun* (CEPCA) and the *Fondation Ad Lucem*<sup>3</sup> (FALC). These facilities are mainly located in rural areas and open to all categories of the population. They complement the public service, or even compensate for the absence of state health facilities. The development of partnerships in the Cameroon health sector is largely explained by the importance of the faith-based sector in the national health supply. OCASC, CEPCA and the FALC are the main partners in this set up and their facilities participate actively in various health policy initiatives (fight against HIV/AIDS, vaccination campaigns, etc).

### PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL<sup>4</sup>

Until recently (2006) no national framework existed for a Public-Private partnership in the health sector. Nevertheless, the formalized partnership between the MOH and a number of faith-based hospitals has its roots in the past<sup>5</sup>.

At the time of the independence, the faith-based organisations largely dominated the sector in numbers and in quality. The situation was redressed as public facilities were progressively set up but faith-based facilities remained superior in terms of distribution<sup>6</sup>, equipment, personnel and reputation. The State's supervision was mainly theoretical at this time. For their part, the faith-based organizations were not really involved in the drafting of health policy and the control of the public sector on these facilities remained very limited.

As in colonial times, the state continued to allot subsidies to faith-based facilities but the system did not function very well anymore<sup>7</sup>. However, this sorry state of affairs did not substantially affect faith-based facilities<sup>8</sup>.

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

The contracting process took off in the health sector in the early 2000s; at the time a national strategic framework was still lacking. Hence, the pilots were isolated cases developed with very limited interaction between the Ministry and the local church authorities. They addressed identified needs and arose because the state was unable (financially) to set up its own facilities there. These contracts recognized the essential role played by the faith-based hospitals<sup>9</sup> - they got the status of district referral hospital - and defined the scope of their collaboration with the MOH.

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

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<sup>2</sup> OCASC is the most important of these with 13 hospitals, 229 health centres; it employs around 3000 people. It is followed closely by CEPCA, which stands out due to the large number of hospitals it manages (31 and 165 health centres). The *Fondation Ad Lucem* - of Christian background but non denominational - runs 10 hospitals and 25 health centres.

<sup>3</sup> Organisation of Christian background but non denominational.

<sup>4</sup> Cf. Figure 1.

<sup>5</sup> 2002 for example in the case of Tokombéré, the hospital that was retained in Cameroon for this study.

<sup>6</sup> Public structures evolved initially mainly in urban areas.

<sup>7</sup> Small amounts and irregular support, in particular since the economic crisis in the 80ies.

<sup>8</sup> Support from the mother congregations and user fees.

<sup>9</sup> i.e.: Tokombéré.

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

#### CHARACTERISTICS OF THE CASE SELECTED

Tokombéré is one of the districts of the Mayo-Sava department in the extreme North province of Cameroon. The hospital chosen is a private Catholic institute affiliated to the OCASC and owned by the Diocese of Maroua-Mokolo. It was founded in 1960 and was for a long time the only health facility of any importance in the region. It adopted a PHC project<sup>10</sup> in 1976 and became a national pilot centre in 1978. This system still exists today and explains in part why Tokombéré hospital (HTok) was able to hold on to its position during the crisis, before the adoption of a reorientation policy of PHC, when other faith-based hospitals were faced with ever growing difficulties. Since 1975, the same expatriate chief medical officer<sup>11</sup>, a man with strong leadership skills, has worked in this hospital and attracted important external support<sup>12</sup>. These factors have contributed to a climate in which the staff is totally committed to the project.

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

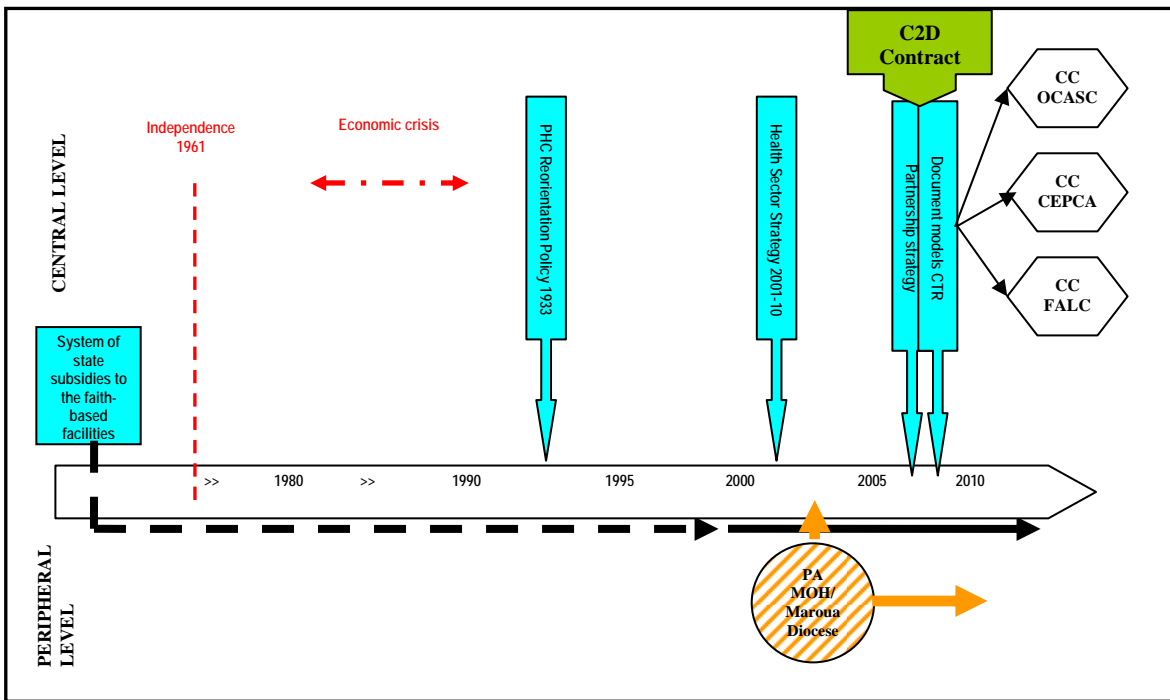
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<sup>10</sup> Project for Human Promotion, in Tokombéré.

<sup>11</sup> Father Christian Aurenche.

<sup>12</sup> *Fondation Christian Aurenche* and the Parish of St Germain-des-Prés in Paris provide the hospital with funds, equipment, expatriate staff, drugs, etc.

Figure 1. The contracting process in Cameroon



**LEGEND**

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

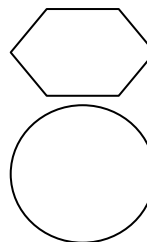
- PA Agreement protocol
- MOH Ministry of Health



Public Sector

Faith-based Sector

Donors



Framework agreement

Service agreement



Formal relationship



Informal



Relation between central and peripheral level relationship

## *Results of the interviews and the documentary analysis*

### CENTRAL LEVEL

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

The C2D priorities frame the formalization process of the partnership. This constraint - also an opportunity because of the money involved - explains why the development of contracting (as a partnership strategy instrument) largely proceeded without referring to former contracting experiences: those that came into being at decentralized level between health facilities and the MOH since 2002, a number of which<sup>13</sup> only precede narrowly the formulation and signing of framework documents. The people approached at central level - from the public as well as the faith-based sector - link this contracting process in their discourse to the debt reduction contract, relegating to second plan the earlier operational cooperation experiments.

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

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

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

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

At this stage, it is difficult to assess whether these different tools are efficient and in how far they are used. The partnership strategy is still in a very early stage of implementation indeed. The recent payments of the first C2D funds should help speed up the process but only after some time we will be able to assess the situation. Currently all actors emphasize the quality of the relationship, although for the denominational partners this is tempered by worries about the delay in access to the funds promised<sup>14</sup>. They also stress the quality of communication: a smooth transfer of information from faith-based facilities to the Public sector; a dialogue

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<sup>13</sup> For example, the agreement protocol signed in November 2007 between the MOH and the private hospital of Petté, managed by the *Fondation Sociale Suisse* in North Cameroon.

<sup>14</sup> The recent payment of the first C2D funds may have decreased their worry. During our field trip though, this sentiment prevailed in the faith-based sector.

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

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

Structural elements:

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

Economic elements:

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

External and short-term aspects:

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

Political elements:

- The introduction of the decentralization policy<sup>15</sup> which gave more autonomy to the local entities to manage social issues such as health, education, local development.

“Emotional” aspects:

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

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

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

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<sup>15</sup> Constitution of 18 January 1996.

- The limited financial capacity of the MOH to support the development of the partnership and contracting process. The HIPC Initiative completion made it possible to boost the process once again as the French debt remission programme (C2D) included a health contracting component;
- The extremely slow payments by the C2D programme which in turn slow down the implementation of the new legal framework. The media hype surrounding the signing of the framework agreements with the three main religious organizations played against the latter, as it made them suspects of pocketing funds which in reality they had not even seen yet<sup>16</sup>;
- The novelty of the concept of contracting and the absence of any preliminary training for the actors involved in its implementation;
- Furthermore, the knowledge of the mechanisms, the tools and their implications is mainly limited to the central level: the actors in the district remain largely in the dark.

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

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

#### INTERMEDIATE AND PERIPHERAL LEVEL

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

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

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

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<sup>16</sup> Even within the faith-based sector itself and in particular on peripheral level.

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

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

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

- The resistance of the population, alarmed by the possible retreat of the HTok staff from the public health areas<sup>17</sup> has paradoxically led to the start of a multi-sector discussion forum on the issue of the coexistence of the two hospitals;
- The active involvement of the DP and later the Chief Medical Officer of HTok. Thus, the start of the decentralization lend support to the initiative of the DP by giving him the authority to submit a proposal to the central authorities for a partnership contract between the MOH and the diocese;
- The state was forced to integrate the faith-based sector in the health map, in the aftermath of the economic crisis of the 80s and due to its poor financial resources;
- The leading role played by HTok<sup>18</sup> in an enclave with no real public equivalent;
- The wish of the religious authorities and the Chief Medical Officer of HTok to get recognition for the role they played, i.e. redress the current 'aberrant situation' in which the facility was not integrated in the district health system, ensure support according to the activities carried out in the hospital and obtain legal status and legitimacy;
- The pressure of the donors<sup>19</sup> to align with the National Health Policy and towards greater transparency vis-à-vis the state.

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

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

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<sup>17</sup> Decision by the District Chief Medical officer, see above.

<sup>18</sup> 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.

<sup>19</sup> Belgian Cooperation.

The obligations of the State are twofold:

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

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

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

The obligations of the diocese concern the hospital of Tokombéré:

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

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

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

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

The bishop and/or the Chief Medical Officer intervene sometimes directly in Yaoundé with all the difficulties that a lack of knowledge of the mechanisms at work and the absence of privileged interlocutors at central level entail. The communication is therefore often one-sided, from the hospital to the intermediate and central levels. The coordination meetings at district and provincial level are considered a useful addition but do not really allow taking up specific contract questions. Overall, these difficulties often considerably hamper the progress of the relationship<sup>20</sup>.

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

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<sup>20</sup> In practice, the same difficulties are repeated every year without a concrete solution being found.

public side, these expectations are the improvement of health coverage, the care for the population through the integration of the health system. For the faith-based sector the contract is seen as an instrument for official recognition by the state of the skills and the role of the Church and more particularly of Tokombéré hospital. The access to state support (exemptions, subsidies, training, and take-over of staff) is only of secondary importance<sup>21</sup>. In this category, it is mainly the support in HR that is appreciated, doubtlessly because the hospital can bear to put up with limited support from the state<sup>22</sup> because of its external resources. Public authorities and denominational actors acknowledge unanimously that the hospital fulfils its obligations. The only reservation made by the public authorities is about the poor knowledge of the hospital (or the faith-based authorities) of MOH procedures.

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

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

Public authorities perceive the effects of contracting as largely positive:

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

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<sup>21</sup> The public actors tend to consider on the contrary that these advantages are the principal motivation of the faith-based sector.

<sup>22</sup> The part of the subsidies of the state constitutes only about 10% of the HTok budget.

For the denominational side the changes reside mainly in:

- The acquisition of legitimacy<sup>23</sup> which is an advantage in consultations with possible donors;
- The allocation of financial resources<sup>24</sup>, equipment (ad hoc) and subsidized drugs (vertical programmes) are much appreciated benefits, in spite of their relative insufficiency. The secondment of state personnel has provided the hospital with a doctor and three extra nurses;
- A better level of collaboration: the hospital has a better visibility for the activities of the second line; a referral/counter referral system has been set up; the hospital can take part in meetings organized on provincial level, in a number of training programmes and is generally integrated in the provincial health system.

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

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<sup>23</sup> The status of operational unit (UPEC) for the fight against HIV/AIDS is added to the status of district hospital.

<sup>24</sup> 15 millions FCFA subsidies, 14 millions FCFA credit.

## Conclusion

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

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

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

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

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

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

# Analysis

## Summary of the results

### CROSS CUTTING FINDINGS

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

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

From these analysis tools emerge a number of constant factors:

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

SPECIFIC RESULTS: CAMEROON

**Table 1. Synoptic grid of the results**

GENERAL CONTEXT (national)	
<b>Context</b>	<ul style="list-style-type: none"> <li>- The faith-based organisations cannot be overlooked in the provision of care. They have many facilities in mainly rural areas.</li> <li>- The decentralized health policy was only partly implemented and the burden as a result of the centralized policies remains heavy.</li> <li>- 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.</li> </ul>
<b>Contracting Process</b>	<ul style="list-style-type: none"> <li>- The contracting process developed first bilaterally between the peripheral (PNFP facilities) and central (MOH) level as a result of a reorientation of PHC.</li> <li>- 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.</li> </ul>
<b>Objectives/ Motivations</b>	<ul style="list-style-type: none"> <li>- The public sector, through a recognition of the social role of the Church, aims for integration of its structures in the health system and its respect of the national health policy. At the same time it is also assured of health coverage</li> <li>- 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.</li> </ul>
<b>National framework of the relationship</b>	<ul style="list-style-type: none"> <li>- The framework includes a strategic partnership framework, convention models and service agreements. These do however not include the many previous experiences. Although the partnership framework is likely to include them, the contract models are mostly steered by the specific objectives of the donor (C2D).</li> </ul>
<b>Tools</b>	<ul style="list-style-type: none"> <li>- The tools comprise the contract models, the framework agreements signed with the faith-based sector and the steering committee of the partnership strategy. This set up is not yet fully operational because the financial means of the C2D are not released. The implementation of the service agreements is delayed and the meeting, reporting and review mechanisms do not yet work.</li> </ul>
<b>Perception</b>	<ul style="list-style-type: none"> <li>- The MOH recognizes the important contribution of the faith-based sector in health and is very much in favour of generalizing contracting as a means to integrate the PNFP facilities in the national health landscape. The faith-based sector is satisfied with its level of involvement in the contracting process but frustrated by the delay in the pay outs of the C2D money, which in turn delays the operationalisation of the framework and contributes to tarnish its reputation even in their own ranks (peripheral level).</li> <li>- 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.</li> </ul>

<b>SPECIFIC CONTEXT (Tokombéré Hospital (HTok))</b>	
<b>Context</b>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- The relationship with the district administrative authorities has been difficult. For matters strictly related to health, the hospital has no recourse to the district, as the contract was signed with the central level. The provincial representative who supported the hospital in the start-up phase of the contracting relationship no longer plays the role of intermediary.</li> </ul>
<b>Contracting Process</b>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- The mistrust this provoked with the religious leaders has slowed down the implementation of the contract.</li> </ul>
<b>Objectives/ Motivations</b>	<ul style="list-style-type: none"> <li>- The contract confirms the status of Tokombéré as district hospital and includes certain aspects related to the organisation of the district.</li> </ul>
<b>Framework of the relationship</b>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- The contract description remains vague and the obligations are mainly those of the faith-based side.</li> </ul>
<b>Tools</b>	<ul style="list-style-type: none"> <li>- The steering committee installed to monitor the relationship gathers not often enough to be efficient.</li> <li>- The responsibility for the main decisions lies on central level as they signed the contract. But the MOH is not directly represented and the office of the district representative does not function properly as a go-between.</li> <li>- The MOH and the DP carry out the routine supervisions but these do not concern the contracting relationship as such.</li> </ul>
<b>Perception</b>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> <li>- Overall a certain mistrust continues to underlie the relationships, and especially from the faith-based sector to the public authorities (corruption, inefficiency, etc.)</li> </ul>

SCOPE

<p><b>Effects, quality</b></p>	<ul style="list-style-type: none"> <li>- For the public sector the balance is generally positive:</li> <li>i) Functionality of the district hospital</li> <li>ii) Reduction of the HToK's costs charged to the patients in accordance with the national health policy</li> <li>iii) Improvement in the health information system.</li> <li>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)</li> <li>- For the faith-based sector:</li> <li>i) Obtaining legitimacy</li> <li>ii) Access to financial resources and grants in aid - although not enough.</li> <li>iii) A certain improvement in the technical collaboration and a better visibility of the 2<sup>nd</sup> line activities.</li> <li>iv) But a lot of nitpicking linked to the weighty administrative procedures from the MOH (in particular where finances are concerned).</li> <li>v) Difficulties linked to the management of civil servants seconded to HTOK and the demoralizing effect their presence has on the religious staff.</li> <li>vi) Insufficient cooperation from the public health centres, especially for the set up of PHC.</li> <li>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.</li> </ul> <p>The dysfunction of the public facilities meant that a great number of its referral patients « illegally » visited the hospital.</p>
<p><b>Level of awareness and information</b></p>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> </ul>
<p><b>Future of the contracting relationship</b></p>	<ul style="list-style-type: none"> <li>- 'The theory is fine but the practice needs to be improved'</li> </ul>

Table 2. SWOT Analysis of the case

<p><b>STRENGTHS</b></p>	<ul style="list-style-type: none"> <li>- Set up of a framework that is theoretically complete in terms of the partnership policy and contracting tools at central level.</li> <li>- The formalization of the status as district hospital confers a legitimacy to the faith-based facility, especially with the donors.</li> <li>- In spite of its weakness and the difficulties of the cost recovery, the financial support of the State is a 'bonus'.</li> <li>- 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.</li> <li>- In the first stage following the signing, the monitoring of the relationship was carried out.</li> </ul>
<p><b>WEAKNESSES</b></p>	<ul style="list-style-type: none"> <li>- The faith-based platforms are weak and do not fulfil their role as relay between the peripheral and the central level.</li> <li>- 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</li> <li>- The whole partnership and contracting process is currently focused on the C2D project and its priorities.</li> <li>- 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.</li> <li>- The State insufficiently respects its commitments, particularly in terms of financial means and does not fully play its part in the monitoring and evaluation.</li> <li>- Predominance of the individual contacts in the success and failure of the relations</li> <li>- The positive effects are a result of the legal recognition rather than from the contract.</li> </ul>
<p><b>OPPORTUNITIES</b></p>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- Available or expected funds</li> <li>- Consensus of the religious actors</li> </ul>
<p><b>THREATS</b></p>	<ul style="list-style-type: none"> <li>- 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.</li> </ul>

## *Results of all 5 case studies*

### *Cross-cutting analysis*

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

The research team was shocked by the extent and seriousness of the crisis that affects the contracting process between the State and the faith-based health sector; this sorry state of affairs pertains more or less to all the countries in this study, at least to some extent. This situation is even more paradoxical as it occurs within a general partnership consensus context. The inevitable character of the collaboration, the added value of its formalization are not only admitted but demanded by both sectors and all levels of the hierarchy.

The seriousness of the matter is in part due to its discrete, almost hidden nature: either there is no general awareness on central level (Uganda) or the awareness manifests itself mainly on an operational implementation level (districts). In any case, the awareness remains largely confined to the faith-based sector and is more evidence of a shaky partnership.

The size and escalation of the crisis are worrying: without rapid intervention, the existing experiments might fail in the medium or even short term. Hence, the crisis could no doubt call into question the efforts<sup>25</sup> put in at central level in most countries.

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

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

#### **The State insufficiently respects its partnership commitments**

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

#### **Monitoring mechanisms and their performance leave a lot to be desired**

If the crisis in Church-State contracting experiences in health matters is largely ignored (certainly its size), it is because the existing agreements are not or badly followed up. There is a systematic absence of operational monitoring and evaluation mechanisms: specific supervision of the contract and its obligations is missing and contracting tools that might have been

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<sup>25</sup> Definition of specific policies: set up of formalized cooperation frameworks; development of partnership for a.

planned<sup>26</sup> in this respect do not function properly; at best, difficulties are recognized but no structural solution is put forward. This situation reflects form problems which mark all service agreements we investigated on peripheral level, but also capacity and resource problems: monitoring and evaluation is a weak area for public facilities, not just with respect to contracting relationships with the private not for profit sector.

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

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

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

The lessons of the past are not really learnt and are largely ignored when it comes to the development of partnership policies, resulting in all cases in the coexistence of often contradictory models. The contracting landscape is diverse, composed of diverse historical strata which were never synthesised. In addition, the circulation of experiences and knowhow in this area remains very limited. In short, there is no collective, centralized and institutionalized record: the knowledge and the documentation itself of the fragmented and burgeoning experiences<sup>27</sup> remain the work of individuals. The risk is that when the individuals disappear from the scene, the information goes with them.

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

The difficulties met are a result of the poorly functioning communication and authority lines between central, intermediate and peripheral level. The decentralization policy started in all countries around the end of the 90s, early 2000s but was undermined by the fact that it was never fully implemented. This poor implementation is reflected by bickering between the various levels of authority, the persistence of relationship mechanisms inherited from the centralization period and the difficult information flow. At worst, the regulatory frameworks and the discourse coming from the central level are just rhetoric, an empty shell, when put next to the real level of knowledge, assimilation and implementation at peripheral level. The contracting experiences at the peripheral level are directly affected by this situation; the dichotomy between central and peripheral level greatly weakens the follow up opportunities of the arrangements and the set up of structural solutions for the difficulties met. It creates confusion about the identity of the legal authorities responsible for managing the relationship for the public part.

This context of institutional weakness explains the predominant role played (in a positive or negative sense) at all levels by individuals. In general, the quality of the partnership, the resolution or (in other cases) aggravation of difficulties all depend on the degree of involvement

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<sup>26</sup> Steering committees, in particular when they exist.

<sup>27</sup> In none of the cases researched, there is an exhaustive database which gives access to all the regulations, models and contract documents signed or in force.

and leadership of the respective actors of the faith-based and public sector, as well as on their networks. Also the quality of the relations between them is a relevant factor.

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

It is quite important to stress first the negative aspects of these bilateral contracts: the opaqueness of the systems and mechanisms which govern them, their exogenous nature and their targeting on peripheral level are all obstacles to the appropriation of these experiences by the central public and faith-based sectors. This appropriation is also hampered by the power or even impunity of the donors due to the huge amount of resources involved.

The importance of these resources, the fact that these interventions apply strict targeting methods as well as their mobilization of a substantial amount of human and material resources of beneficiaries could certainly distort matters. All this is even more serious because the targeted facilities are weak and jeopardized by the global crisis in the faith-based health sector. Besides, these demanding excellence contracts generate double standards that are likely to have a negative influence on the integration process of beneficiary structures in the national health system.

In spite of all this, faith-based hospitals tend to look favourably upon these contracts: they appreciate their degree of specificity and predictability, the provision and quality of monitoring, steering and evaluation mechanisms and activities which characterize them. Their efficiency and the donors' respect of commitments are other aspects which are highly valued by the beneficiaries. The set up usually leads to local capacity strengthening which (in spite of the focalization of the arrangements) tends to have a positive contaminating effect: all the activities of the facilities are often positively affected over time.

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

The aspects which, in the eyes of the beneficiary structures, explain the efficient functioning of the PEPFAR contracts might provide interesting avenues for a rereading and improvement of the contracting relations between the Church and the State in the health sector.

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

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

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

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

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

## Recommendations for all 5 case-studies

*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<sup>28</sup> should be strengthened through the set up of an institutional collective memory:** this should synthesise the current situation and provide a centralized historical archive of the frameworks, contracting documents and expertise of each country. Such an approach should be planned in the near future to prevent documents and testimonies that are key to the understanding and analysis of earlier experiences<sup>29</sup> from disappearing. Documentation and information centres could be created where all actors from the Public Private Partnerships are represented on a pluralistic and unbiased basis. These centres should have a very broad mandate, associating public and private not for profit actors<sup>30</sup> and giving them the legitimacy needed for “open and exhaustive” access to the relevant data. They should be given a mission of public interest and have a legal status and guarantee of independence against possible interference, all of whom would help to ensure total transparency and access to the collected data for the greater public<sup>31</sup>. In addition, collaboration with local academic institutions<sup>32</sup> 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<sup>33</sup> in the field of medicines and include an international database. Before this can be set up, country databases have to be created on the basis of more or less compatible models and systems.

**It remains essential as for now to respond to the specific training needs of the field actors.** Contracting workshops could thus be regularly organized upon request. They should have a content adapted to the local situation and the level and role of the participants in the contracting process. The set-up of such workshops could benefit from the input from local faith-based platforms<sup>34</sup>. It is also essential that they are organized in consultation with the Ministry of Health and systematically involve public and religious actors: moreover, besides a training opportunity, these events could also become a platform for dialogue and participate in the dissemination of experiences and their perception.

*For the field: public and religious actors*

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

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<sup>28</sup> And more extensively, the private not for profit sector.

<sup>29</sup> Tanzania, in the 70s.

<sup>30</sup> At different levels of the hierarchy.

<sup>31</sup> Public and private decision makers, operational actors, national coordination facilities and external support, researchers.

<sup>32</sup> The Schools of Public Health of local public and/or faith-based universities could constitute interesting networks. Makerere School of Public Health in Uganda is such an example.

<sup>33</sup> cf. [www.essentialdrugs.org](http://www.essentialdrugs.org)

<sup>34</sup> Organizations such as AMCES in Benin, UCMB and UPMB in Uganda, CSSC in Tanzania, UNAD and BELACD in Chad are very experienced in training actors of the faith-based networks (and often also of the public sector). Their links with the field make them indispensable networks for the definition of needs to consider.

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

### *Specific recommendations: Cameroon*

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

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

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

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

It is moreover essential to take into account the issue of the government's real support to its faith-based facilities contracting partners. In this respect, Tokombéré is the result of an exceptional situation. It would be dangerous to generalize this case to the rest of the sector: very few facilities benefit from regular external support like in our case study. It is obvious that the financial crisis affecting the faith-based sector (and proved by the debt levels identified through the C2D<sup>35</sup> project) has even more important implications on the Church's ability to operate and maintain the majority of peripheral facilities if the State only partly respects its commitments: **a simplification of financial support mechanisms, their transparency and knowledge by the beneficiary facilities** are important prerequisites for improving the situation. It is moreover **essential that the level of support, its limits and conditions are clearly pointed out in the contracts**. This is only partly the case in the contracting documents signed outside the C2D project.

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

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<sup>35</sup> FINORG, Definition of the operational conditions of contracting relationships between the actors in the Cameroon health sector - Final report IV, 2004.

## *General conclusion: take-home messages*

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

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

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

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

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

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

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

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

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

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