

**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: Chad


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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Study commissioned and published by the Medicus Mundi International Network (MMI)
Basel, May 2009. Available on CD-Rom and on the MMI website (English and French).
A printed version will be eventually published by the ITM Antwerp.

Our gratitude goes to the ITM Antwerp team, to the members of the Medicus Mundi
International Network and to all the people and organisations that supported the realization
of this study.

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Sharing knowhow and joining forces towards Health for All

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List of acronyms

BELACD	<i>Bureau d'Etudes, de Liaison des Actions Caritatives et de Développement</i>
CDZ	<i>Chef de Zone/ Head of the Zone</i>
CET	<i>Conférence Episcopale du Tchad</i>
CHMT	<i>Council Health Management Team</i>
CIDR	<i>Centre International de Développement et de Recherche</i>
COGES	<i>Comité de Gestion (de centre de santé)/ Management Committee (of a health center)</i>
COSAN	<i>Comité de Santé/ Health Committee</i>
DM	<i>District de Moïssala/ Moïssala District</i>
DH	<i>District Hospital</i>
DONG	<i>Direction des ONG / Directorate for NGOs (formerly SPONG)</i>
DOSS	<i>Direction des Organisations du Secteur Social/ Directorate for Social Sector Organisations</i>
DPS	<i>Délégation (délégué) provinciale de la Santé/ Provincial Health Delegation (Delegate)</i>
EB	<i>Executive Board</i>
ECD	<i>Equipe Cadre de District/ District Management Team</i>
EEMET	<i>Eglises et Missions Evangéliques au Tchad/ Evangelical Churches and Missions in Chad</i>
FBO	<i>Faith Based Organisation</i>
FBH	<i>Faith Based Hospital</i>
FED	<i>Fonds Européen de Développement / European development Fund (EDF)</i>
GOC	<i>Guide Opérationel à la Contractualisation/ Operational Guide for Contracting</i>
HC	<i>Health centre</i>
HR	<i>Human resources</i>
LGO	<i>Local Government</i>
MCP	<i>Médecin-Chef de Projet/ Project Chief Medical officer</i>
MDP	<i>Ministère du Plan/ Ministry for Planning</i>
MOH	<i>Ministry of Health</i>
MSF	<i>Médecins Sans frontières/ Doctores without borders</i>
MMN	<i>Medicus Mundi Navarra</i>
NGO	<i>Non governmental organisation</i>
NHP	<i>National Health Policy</i>
PASS	<i>Programme d'Appui au Secteur de la Santé/ Health Sector Support Program</i>
PC	<i>Politique Contractuelle/ Contracting Policy</i>
PEV	<i>Programme Elargi de Vaccination/ Widespread vaccination Programme (WVP)</i>
PNFP	<i>Private not for profit</i>
PNS	<i>Politique nationale de Santé/ National Health Policy</i>
PRA	<i>Pharmacie Régional d'Approvisionnement / Regional medical stores</i>
PPP	<i>Public Private Partnership</i>
SSA	<i>Sub-Saharan Africa</i>
TRABEMO	<i>Transfert Béboro-Moïssala</i>
UNAD	<i>Union Nationale des Associations Diocésaines</i>
WHO	<i>World Health Organisation</i>

Acknowledgments by authors

Our gratitude goes to all the people and organisations who supported us in the course of this study and without whose help the present report would never have been completed.

For their unyielding support and encouragement and their intermediary peer-review of the document:

- Medicus Mundi International's Executive Board
- The study's steering committee at the Institute of Tropical Medicine (ITM), Antwerp: Bruno Marchal, Bruno Meessen, Pr. Guy Kegels, Harrie Van Balen (Pr. Emeritus) and Pr. Wim Van Damme.
- The international experts: Eric de Roodenbeke, Director General of the International Hospital Federation (FIH), Geneva ; Joseph Mbaitoloum, former National Medical Coordinator at UNAD, Chad ; Jean Perrot, responsible for the contracting desk at the WHO Department Health Systems Financing (HSF), World Health Organization (WHO), Geneva ; and Marieke Verhallen, consultant at PHC-Amsterdam.

For the translation and editing:

Kristien Wynants and Kristof Decoster, ITM, Antwerp.

For the final layout:

Rita Verlinden and Isa Bogaert, secretaries, Department of Public Health, ITM Antwerp.

For their most valuable assistance and the facilitation of field work:

Dr. Robert Basaza (MoH), Br. Dr. Daniele Giusti (UCMB) and Mrs. L Muhirwe (UPMB) in Uganda;

Mrs Grace Mwangonda and Mecklina Isasi-Gambaliko (CSSC) in Tanzania;

The UNAD in Chad.

Last but not least, we are also grateful to the referents met during field work, too many to be mentioned here. We owe them.

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May, 2009

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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) or ordered (CD-Rom) from the MMI Executive Secretariat in Basel¹. 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.

¹ See contacts on page 2 of the present document

Case-study: Chad



Moissala

General Context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

Chad represents a particular case in the context of this study as Christian churches have only recently settled in the country. The Catholic Church in Chad was founded after the Second World War² and counts 7 dioceses³, all located in the South of the country. This young and dynamic church is still largely dependent on other countries, especially at the level of its management structures: the majority of prelates are Europeans⁴. Faith-based care represents about 20% of national health coverage and 10% is provided by facilities of the Catholic network, the *Union Nationale des Associations diocésaines* (UNAD)⁵ (Vridaou 2005): 80 health centres and 3 district hospitals⁶. For the Protestants, the EEMET (i.e. the Association of Evangelical Churches and Missions in Chad) is the most important provider with a network of 84 health centres and 1 hospital. All facilities appear on the health map since the administrative division into districts (district policy 1990-1991).

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

PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL⁷

Chad’s contracting policy in the health sector started early. A contracting policy document (PC)⁸ was elaborated from 2001 on, in line with the National Health Policy of 1999⁹. The Chad legal framework is without any doubt much more advanced¹⁰ than the framework in the other study countries. It is moreover the only example we have come across in this study of a strategy that has been effectively translated into action. The case also allows us to look back, so it makes an evaluation possible. Finally, the type of formalized contracting that exists in Chad is very ambitious: it does not just allow for the delegation of the mission of public service¹¹ to health facilities (hospitals) but potentially also to the districts themselves (the case of Moïssala, Donomanga and Doba). The contracting model can be applied to all potential partners within the not for profit sector: national or international NGOs (faith-based or not), bilateral cooperation and multilateral cooperation agencies. The present contracts include mainly faith-based organisations (belonging to UNAD or EEMET in particular) as well as a certain number of international NGOs (MSF). More recently, pilot experiments have been set up in the drug sector, whereby the management of regional pharmacies (PRA) has been entrusted to private organisations¹².

Generally speaking, central level interviewees display a lot of goodwill in their discourse; moreover, the goodwill is matched by appropriate documentary tools. Even, the contracting policy is based on the decentralisation of authority to intermediate and peripheral levels; the

² Decree of Rome, March 1946.

³ To which the Archdiocese of N’Djamena is added.

⁴ 5 out of 8 bishops.

⁵ i.e. the National Union of Diocesan Associations. This is the Catholic platform and coordination organ of diocesan, social activities of the Church, including healthcare. EEMET (see further below) is its Evangelical counterpart.

⁶ Figures from 2005.

⁷ Cf. Figure 5.

⁸ Volume 1: contracting with the private not for profit sector, MOH, N’Djamena, 2001.

⁹ Contracting is one of the strategic orientations of the NHP of 1999.

¹⁰ The contracting policy document is accompanied by an operating manual and a framework contract model, signed at central level by the different partners. The content of the operational contracts depends on the characteristics of the local situation.

¹¹ Provision of health services and/or administrative tasks.

¹² Pilot Pharmacists without borders in the Regional Supply Pharmacy (PRA) of Abéché, launched in 2007-2008.

prefectural health representatives (DPS) in particular are responsible for setting up operational contracts at their level. The decentralisation process is nevertheless not fully completed at the moment¹³.

The Catholic Church itself is organised according to the decentralised model: for the social sector (health, education, other charity activities, etc.), there is an overarching structure (UNAD¹⁴, created in 1986) responsible for the coordination of the BELACDs¹⁵, at the diocese level. The BELACDs are technical facilities which manage districts on behalf of the dioceses if the State assigned this task to the latter.

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

CHARACTERISTICS OF THE CASE SELECTED

The case study we selected concerns the contracted delegation of the health district of Moïssala to the BELACD of Sarh. It is a peculiar situation since the contracts in this case were made before the contracting policy and its tools were developed. The district of Moïssala is located in the South of the country in the health prefecture of Mandoul. The management is entrusted by contract to the BELACD of Sarh, located at about 200 km from Moïssala, the district capital. The whole situation is the result of a process that began in 1992 when the Catholic¹⁶ hospital of Béboro was transferred (according to the contract) to Moïssala (TRABEMO project). In the beginning the objective was to revitalize the moribund public medical centre of Moïssala, and create a district hospital there. This initial stage was followed by successive contracts through which the BELACD of Sarh was given the management over and the development of the district hospital and then the district itself. All along, the process was accompanied and made possible by the financial and technical support of external partners (Medicus Mundi Navarra¹⁷ and later Misereor).

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

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

¹³ The theoretical replacement (on intermediate level of the administrative pyramid) of the 14 existing health prefectures by 28 departments is not yet implemented.

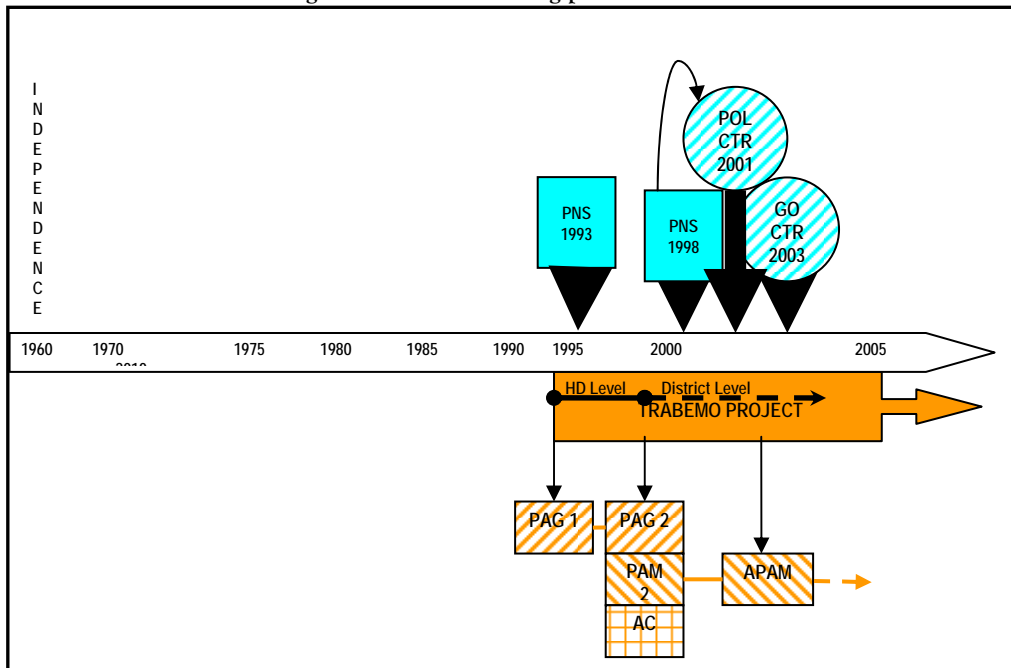
¹⁴ *Union Nationale des Associations Diocésaines.*

¹⁵ *Bureau d'Etudes et de Liaison des Actions Caritatives et de Développement.*

¹⁶ It was in fact a health centre, led by a doctor, which offered health referral services to the population in the district.

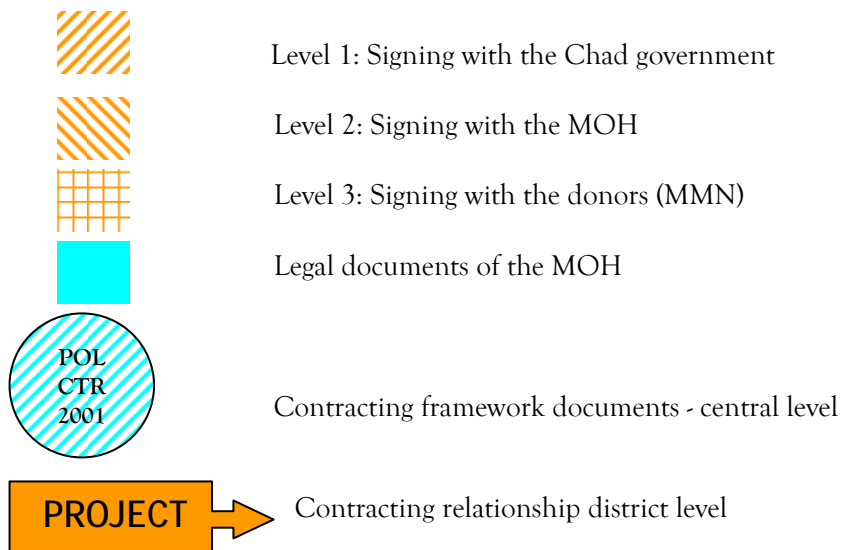
¹⁷ MMN.

Figure 1. The contracting process in Chad



LEGEND

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



Result of the interviews and the documentary analysis

CENTRAL LEVEL

The Chadian contracting process, i.e. the formalization (in mutual consultation) of the relationship between the private not for profit sector and the state, was preceded by more informal collaboration. The collaboration was a direct result of the role the faith-based sector played at the time of the civil war, particularly in the South of the country¹⁸ and during all the conflicts of the post colonial history in Chad. The facilities set up in this era were put on the health map from 1993 onwards when the district policy was implemented (PHC).

Three year activity plans submitted by the BELACD for approval (by the Permanent secretariat of the NGOs (SPONG) to the Ministry of Planning (MDP)¹⁹) triggered the identification of facilities and the start of a dialogue. The integration of the church facilities was the consequence of an active demand from the religious authorities. The State reacted positively, in some cases providing the facilities with infrastructure and personnel. The decade preceding the set up of the contracting policy saw a systematic legalisation of Church structures (UNAD, BELACDs, health facilities) and the signing of the first contracts (Moïssala).

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

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

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

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

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

¹⁸ The faith-based sector ensures 40% of the care in the South of Chad.

¹⁹ This procedure is followed since the mid eighties. Even at that time the health activities planned by the BELACD were submitted for technical advice to the MOH.

For UNAD there is:

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

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

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

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

The Chad legal framework contains nevertheless some weaker points:

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

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

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

- The contracts are submitted to a double reference authority²⁰ which complicates matters when there are problems and there is a need to appeal to the central authorities;
- The lack of resources strongly affects the capacity for monitoring and evaluation of the DONG and the DOSS;

²⁰ DOSS for the Ministry of Health and the DONG for the Ministry of Planning.

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

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

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

The Church for its part stresses:

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

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

- In terms of financial support: the problem of reimbursement of the investments paid in advance by the church; indirect and limited nature of the aid that is provided (exemptions, salary of the civil servants seconded).
- The monitoring and evaluation component (DOSS and DONG): this explains why an assessment of existing experiences has not been carried out so far. Obviously this precludes a thorough assessment of the reality in the field and the formal "success" of existing arrangements.
- The Church points to the difficulties encountered with the representatives of the State²¹ in the districts and with whom the diocese associations have to work on a daily basis. They tend to see the Church as a "donor".
- Due to a lack of correct information, the BELACDs do not always fully benefit from the contracting relationship. They lack the knowledge or are not aware of the opportunities that exist on central level. UNAD is unable to deal with this information gap as they no longer have a medical coordinator.

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

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

²¹ Mainly administrative authorities.

Some issues cause a problem however:

- The lack of capacity (financial, coordination) on State level;
- The absence of an overall and regular assessment of existing experiences: the real extent of operational problems does not seem to be acknowledged, certainly not on ministerial level. Developments are underway which might improve matters: an evaluation workshop planned for end 2008-beginning 2009 on FED²² financing will create a better appreciation of the contracting reality in the health sector.

INTERMEDIATE AND PERIPHERAL LEVEL

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

The factors that helped set up the project were:

- The existence of an old, although informal, relationship and a consensus of the Catholic Church and the State on the project;
- The need for a functional hospital facility in Moïssala;
- The half-hearted commitment of the State in the south of the country;
- The experience of the Church (Goundi hospital) and the absence of other candidates;
- Béboro is proof of the Church's skills as it provides a good level of health care in the district;
- The commitment and investment of key personnel²³;
- The fact that there existed already a relationship between BELACD and the State through UNAD;
- The immediate availability of an experienced doctor for the post of Chief Medical Officer;
- The support of donors: Medicus Mundi Navarra (MMN) and PASS²⁴.

The obstacles to the project seemed less significant:

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

The contracting arrangements for the TRABEMO project can be divided into two stages²⁵ and include 6 different contracts. In this study we are interested in the 4 basic contracts²⁶ between BELACD and the State of which the last two date from the same time as the national contracting policy. Some general observations can be made here:

²² European Development Fund. Some remaining funds of the 8th FED have been unblocked for organizing a workshop according to the terms of reference to be developed by the DOSS together with its partners.

²³ The provincial health delegate (DPS) of Moyen Chari and the Bishop of Sarh.

²⁴ Support project to the health sector, financing by the World Bank.

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

²⁶ The two others are accompanying contracts: 1) a contract between BELACD and MMN put down the conditions for collaborating between the diocese and the donor in the context of the second stage of project; 2) a second contract signed between MOH staff seconded to the project and the project itself. It details the measures taken by BELACD to give these personnel an advance on their salary.

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

Contract 1: Project TRABEMO

The three year²⁷ contract about the transfer Béboro-Moïssala describes the activities that are planned and stipulates the principle of collaboration between the MOH and BELACD in order to achieve all this. It sums up the respective commitments of BELACD and the State, and also cites a series of specific clauses²⁸.

The commitments of BELACD are:

- Moïssala has to conform to the hospital standards (development of infrastructures, recruitment of staff, implementation of the PMA);
- Supply of means: drugs and medical provisions, logistics²⁹;
- Communication of information (reports, carry out planned evaluations);
- Collaboration with the public authorities (DPS, health committee of the prefecture);
- Development of a cost recovering policy for the district;
- Supervision of health staff in the area.

The latter two clauses anticipate in fact on the second stage of the project. The commitments of the State are mainly indirect:

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

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

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

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

There are two additional components:

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

²⁷ The project has been extended by one year.

²⁸ Duration of the contract, modification procedures, termination, conditions of unilateral termination.

²⁹ The contract includes a list of equipment needed for the project.

The obligations of the State remain the same as well. No additional financial support is foreseen: the partners need to jointly look for external financial support for the final stage of the project.

These two contracts do not contain any clauses on the resolution of conflicts.

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

Contract n° 3 (2001-2005) distinguishes itself from the two previous ones. It benefits from a financial input from PASS³⁰ in the last phase of the project (2002-2006). The objective is to increase the number of HC in line with the development of the district. The document is far more detailed, partly as a result of the requirements of the donor (specific clauses about the administrative aspects of the funds and the justification of expenses, reporting obligations, etc.). The introduction and general layout of the contract give an overview of the previous stages of the project (history, commitments, targets achieved). The specific requirements substantially complement those included in previous contracts:

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

However, the main change lies in the financing mode of this phase: the funds are transferred from BELACD and its own donors to the State through the PASS budget.

This contract³¹ goes a step further than its predecessors but falls nevertheless outside the framework of the PC of 2001 to which it only refers indirectly (side reference at the end of the introduction). Following aspects in particular are missing:

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

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

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

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

- Monthly supervision ('training supervisions') of the HC by the District Chief Medical Officer, CD or the CDZ (Chief Medical Officer of the Area);
- Supervisions of BELACD³².

³⁰ Initial budget of 2 billion CFA increased by an amendment to 50.000.000 CFA over the last year?

³¹ The amendment (contract N°4) repeats the terms of reference of the main contract by adjusting the level of the budget.

³² Administrative supervisions carried out by the director of BELACD; supervision of the HC by the Medical Coordinator of BELACD.

Assessment reports are produced:

- On a monthly basis by the HC and the hospital: these reports are passed on to the CDZ and from there to the DPS and BELACD;
- The HC also draft half yearly reports, which the CDZ compiles into an annual report (health statistics) and sends to the MOH and the Delegation³³.

Various meetings are organised:

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

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

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

Issues, if they exist, are raised by a minority of public sector staff³⁴ and are mainly about the strict management of human resources issues (flexibility in obtaining holidays; gaining 'credits', etc.). This opposition and discontentment are followed up by the unions and have sometimes caused serious tensions. They led to the 'spontaneous' resignation of one of the Chief Medical Officers of the project and of the HR manager due to the relentless pressure of denigrating letters, and even personal threats. The beginning of the project (Béboro) was disturbed by a number of general strikes as a result of important delays in civil service salaries. The situation was resolved by the signing of a convention giving the public staff employed by the district an automatic advance on their salary, which the state later reimburses to BELACD. These actions of BELACD have helped to establish its authority.

The real difficulties concern:

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

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

³³ The annual report is effectively drafted but is not always passed on to the central level.

³⁴ A number of public agents.

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

Overall the assessment of the HC is positive. Those HC integrated in the project as first line of the district health system have fully accepted the project³⁵ and were informed on it from the very beginning. They are able to define the role played by BELACD³⁶ and to identify clearly the effects of the project, even if their knowledge of the contract remains fundamentally intuitive. Nearly all participants know the role of BELACD. Their vision is clearly influenced by the activities of BELACD which highlighted the implementation of the NHP through the district system and the Primary Health care policy:

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

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

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

In general, the management of BELACD is positively evaluated:

- The system is very beneficial for the population, it guarantees access to care and treatments (fixed price and referral system)³⁷;
- The supervision of BELACD, although strictly technical, preserves the identity of the HC;
- There is generally a climate of good relations with many opportunities for exchanging views; the HC do not function anymore as isolated entities;
- The system is really operational, due to means injected by BELACD;
- The COGES/COSAN system is a guarantee for transparency and a considerable help for those responsible for the HC.

Some reservations are nevertheless formulated:

- The referral system weighs heavily on the HC finances and compensation through the sale of drugs is no longer possible;
- The supply of drugs and medical products is ensured by BELACD but is submitted to specific quotas³⁸ disrupted by the increase in attendance figures at the HC. The health centres have to buy additional supplies and charge these to the population. Understandably, people are not very happy about this; the situation is also a heavy burden on the budget of the HC;
- The staff salary is paid with the limited COGES funds which limits recruitment possibilities and worsens the already bad human resources situation;
- The weak support from the state in terms of equipment particularly;
- The sustainability risk of the system if BELACD were to withdraw and the State had to take over the responsibility for the district.

³⁵ In particular because they were able to keep their identity. Only the religious authorities (non Catholic authorities), owning the HC, have shown a certain resistance: their "conversion" took some effort.

³⁶ Only the HC ignore what it is about (drugs) but this is maybe due to their recent creation.

³⁷ The district attracts a large number of external patients to its area, even from outside the country.

³⁸ Specific quota for each HC.

The state support is appreciated and the state generally keeps its commitments: the secondment of staff increases steadily (33 public staff against 37 BELACD staff in 2008), specific support is supplied (motorbikes), the exemptions are implemented and the import of drugs is permitted. Nevertheless, the state subsidies fall well below the needs they are supposed to cover and this money is difficult to come by because of the deductions on the intermediate levels³⁹. The compensation for the loss of earnings rests entirely on the shoulders of BELACD and contributes to the dependence of the project on external donors and this more and more so, as the area further develops.

In general, BELACD is perceived as assuming well the responsibilities it is attributed. All actors make a positive assessment of the project, as it is seen to bring real results. The viability of the project rests nevertheless nearly entirely on the support of BELACD's donors⁴⁰ because of the feeble financial commitment of the State. Its continuation is currently in danger because the Misereor contract ended at the end of 2008, which forced BELACD to start restructuring its activities. Therefore it is not surprising to see the Church (but also the district management) plead for a greater share out of the financial burden of the district through:

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

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

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

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

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

³⁹ In 2007, only about 6 million could be acquired from a total budget of 22 million FCFA.

⁴⁰ MMN, then the PASS through the State and currently Misereor.

Conclusion

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

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

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

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

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

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: CHAD

Table 1 - Synoptic grid of the results

GENERAL CONTEXT (National level)	
Context	<ul style="list-style-type: none"> - A young, dynamic and minority Church. Operational mainly in the South of the country abandoned by the State during the civil war. The links of the Chad Church with the donors remain important but these resources are decreasing drastically. - A joint will for a partnership marked by a climate of understanding and will by the State to collaborate with the faith-based sector. - A young contracting process but nevertheless preceded by specific experiences in the field (for example in the district of Moissala).
Contracting Process	<ul style="list-style-type: none"> - The partnership developed rapidly at the end of the civil war and in a climate of real collaboration. - The different tools available are the result of joint efforts, encouraged by the donors. - The actors are trained and the strategy is widely disseminated. - The current situation had to be evaluated in the country in order to be readjusted.
Objectives/ Motivations	- Both parties want to ensure the health coverage in isolated areas where the health system has broken down and the public health facilities are not able to perform. The issue at stake is to recognize and seek recognition for the complementary role of the Church in the health sector and its specific qualities.
National framework of the relationship	<ul style="list-style-type: none"> - Chad has an almost complete legal framework: contracting policy, framework convention models, operational guide. - This framework came after some of the experiments were set up and thus does not include these.
Tools	<ul style="list-style-type: none"> - The relationship between the State and the Church is governed by a framework agreement - The tools for encouraging and monitoring the contracting process do not work properly at the moment because there is no national medical coordinator for the religious platforms
Perception	<ul style="list-style-type: none"> - The goodwill is mutual and there is a good understanding. The State wants to set up new contracts quickly with organisations or health facilities and certainly recognizes their qualities. - The faith-based sector mentions the MOH's difficulties to monitor the situation. There is a clear distinction between the theory and the contracting reality at peripheral level.
SPECIFIC CONTEXT (District of Moissala (DM))	
Context	<ul style="list-style-type: none"> - South Chad where the district of Moissala is located, is an area with very few public facilities as a result of the civil war. - The <i>Bureau d'Etudes et de Liaison des Activités Caritatives et de Développement</i> (BELACD), a Catholic organ, filled the void left by the State during the conflict and played an important social role in particular in the health sector.
Contracting Process	<ul style="list-style-type: none"> - The start of the process happened before the implementation of a national framework. - It took several years and several successive contracts, gradually extending the BELACD's responsibility in matters of managing the district hospital and the district itself. - There was a joint commitment and this was accompanied by continuous support (financial, technical) of BELACD's donors, either directly or via the State.

Objectives Motivations	<ul style="list-style-type: none"> - Contracting is a response to the need to recenter the district around Moissala and to correct the situation that resulted from the creation of the Béboro HC and the decline of the district hospital; this necessity is fully recognised by the BELACD. - The objective is to develop the district hospital and the district in order to provide health coverage of the area and designate an organisation able to assume the role of the State.
Framework of the relationship	<ul style="list-style-type: none"> - The framework of the contracting relationship consists of a series of successive and progressive contracts signed between the BELACD of Sarh and the State; these are accompanied by secondary contracts linking BELACD to its donors and the district civil servants. - The contracts between BELACD and the State are far more complete than those in Cameroon and Tanzania. They are however not integrated in the national framework nor have they been officially renewed after 2006. They escape the decentralisation of the health system management.
Tools	<ul style="list-style-type: none"> - The tools used in the context of the relationship are split up in routine elements of the health system and elements specific to the BELACD management. These instruments function. - There are however no structural tools to assess the relationship and in which both the public and faith-based sector also participate. The evaluations carried out are largely made at the request of the donor or as a self-evaluation by BELACD. There is no public-private concertation.
Perception	<ul style="list-style-type: none"> - The perception of the relationship is generally good. This has to be qualified however by: <ul style="list-style-type: none"> i) The weak commitment by the State which means that most of the burden of the relationship and the activities falls on the shoulders of BELACD. ii) The fact that the achievement of the objectives largely depends on the availability of external sources of financing. iii) The existence of threats (HR problems, lack of financial resources and equipment)) to the survival of the facilities if the donor were to withdraw. iv) A marked standstill in the relationship since end 2006 when the last contract ended. v) The existence of other cases (Doba, Lai) where this risk has already been extensively investigated and has led to a breakdown in relations.
SCOPE	
Effects, quality	<ul style="list-style-type: none"> - The objectives set out are largely achieved: functionality of the district hospital; development of the district (network of health centres, management and community participation system, set up of a cost recovery mechanism and a system of fixed prices for the patients) ; access to care is improved. - All this is mainly the work of BELACD and its technical and financial commitment: the quasi autonomy of the district of Moissala shows the disengagement of the STATE and does in fact not stimulate change. - The financial burden of the project is becoming heavier for BELACD as the project progresses: the resources are limited and this is being felt in the quality of the services on offer.
Level of awareness and information	<ul style="list-style-type: none"> - Because of a regular assessment of the experiences in the field, the central level (MOH) does not understand the importance of the difficulties met by the peripheral level in the everyday contracting experiences.

Future of the contracting relationship	<ul style="list-style-type: none"> - The local actors, Church and State, would like a continuation of the relationship. This depends for BELACD on the availability of funds which is threatened by the withdrawal (soon) of the present donor. - The State is no viable alternative. The "subjects" of the contracting relationship (district hospital and health centre staff) are worried about BELACD leaving as well ; - In other places (Lai, Doba), the religious authorities have given up, frustrated by the imbalance of the relationship, the lack of involvement (financial and material) by the State, the superficial nature of the management delegation, undermined by the interventions of the administrative powers.
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Table 2 - SWOT Analysis of the case

STRENGTHS	<ul style="list-style-type: none"> - The country has a complete and theoretical contracting framework. - The implementation of the contracting strategy was preceded by a major sensitizing campaign for the actors. - The main public and religious actors received an initial training in contracting.
WEAKNESSES	<ul style="list-style-type: none"> - The lack of a medical coordinator prevents the Catholic platform from feeding and accompanying the process. - The multiplication of public referral facilities (DOSS- DONG, Ministry of Plan, Ministry of Finances, etc.) - The contracting relationship investigated was not integrated in the national framework: in particular, it does not respect the decentralization principles of the health system. - The financial and operational burden of the contracting relationship rests mainly on the shoulders of the faith-based contracting parties. - The results have not been obtained through collaboration and participation but through forced substitution.
OPPORTUNITIES	<p>The possible restoration of the post of health coordinator for the faith-based platform.</p> <ul style="list-style-type: none"> - The planning of a workshop for evaluating the experiences is ongoing. It should bring together all the actors: there is a real will at central level (public and faith-based) to take stock. Even if this is not sufficient, it would allow drawing attention to the difficulties that exist in order to find solutions to remedy the situation.
THREATS	<p>Some contracts have (Lai) been or threaten to be (Doba) terminated.</p> <ul style="list-style-type: none"> - The support of the donors to the faith-based facilities is being drastically reduced at central as well as on peripheral level. - The BELACD of Sarh fulfils the role of district manager for the district of Moissala, although there is no contracting framework since 2006. - The State's disengagement.

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 efforts⁴¹ 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

⁴¹ Definition of specific policies: set up of formalized cooperation frameworks; development of partnership for a.

planned⁴² 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 experiences⁴³ 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

⁴² Steering committees, in particular when they exist.

⁴³ 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 sector⁴⁴ 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 experiences⁴⁵ 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 actors⁴⁶ 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 public⁴⁷. In addition, collaboration with local academic institutions⁴⁸ 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-Med⁴⁹ 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 platforms⁵⁰. 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

⁴⁴ And more extensively, the private not for profit sector.

⁴⁵ Tanzania, in the 70s.

⁴⁶ At different levels of the hierarchy.

⁴⁷ Public and private decision makers, operational actors, national coordination facilities and external support, researchers.

⁴⁸ 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.

⁴⁹ cf. www.essentialdrugs.org

⁵⁰ 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: 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.

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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