


**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: Uganda


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

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.

Medicus Mund 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

Table of contents

Table of contents	3
Index of figures and tables.....	3
List of acronyms	4
Acknowledgments by authors.....	5
GENERAL INTRODUCTION	6
INTRODUCTION TO THE COUNTRY-CASE REPORT	8
CASE-STUDY: UGANDA	9
General context.....	10
Place of the Church in the Supply of Care	10
Partnership and Contracting context at Central Level.....	11
<i>The relationship between the public and faith-based sector</i>	11
<i>PEPFAR and the faith-based sector</i>	14
Characteristics of the cases selected	17
Results of the interviews and the documentary analysis	19
Central level	19
Peripheral level: St. Joseph Hospital, Kitgum	22
Peripheral level: Kabarole Hospital, Fort-Portal.....	27
Conclusion	31
ANALYSIS	33
Summary of the results	34
cross cutting findings	34
Specific results: Uganda.....	35
Results of all 5 case studies Cross-cutting analysis.....	39
Recommendations for all 5 case-studies.....	43
Specific recommendations: Uganda.....	44
General conclusion: take-home messages	45
BIBLIOGRAPHY	47

Index of figures and tables

Figure 1. The PNFP health sector structure in Uganda.	10
Figure 2. Distribution of the health facilities between the different coordinating PNFP organisations.....	10
Figure 3. Structure and division of income from financial contributions to the faith-based health sector. (Source: UCMB,UPMB,UMMB, 2007)	12
Figure 4. The contracting process in Uganda	13
Figure 5. Health funding in Uganda.....	14
Figure 6. System for the distribution of PEPFAR funds.	15
Figure 7. Kitgum District.	17
Figure 8. Kabarole District.....	18
Table 2. Synoptic grid of the results	35
Table 3. SWOT Analysis of the case studies	38

List of acronyms

ART	Antiretroviral Therapy
BCC	Behavior Change Communication
BOG	Board of Governors
CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital
CHMT	Council Health Management Team
CIDR	<i>Centre International de Développement et de Recherche</i>
CMO	Chief Medical Officer
CoU	Church of Uganda
CRS	Catholic Relief Services
DED	District Executive Director
DMO/ DHO	District Medical officer/ District Health Officer
EB	Executive Board
FBO	Faith Based Organisation
FBH	Faith Based Hospital
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
HBC	Home Based Care
HC	Health centre
DH	District Hospital
HSSP	Health Sector Strategic Plan
JAHSR	Joint Annual Health Sector Review
KH	Kabarole Hospital
LGO	Local Government
MOH(SW)	Ministry of Health (and Social Welfare)
NHP	National Health Policy
NUMAT Program	Northern Uganda Malaria Aids and Tuberculosis Program
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
RMO	Regional medical officer
SJH	Saint Joseph's Hospital
SWAP	Sector Wide Approach
TASO	The AIDS Support Organization
UCMB	Uganda Catholic Medical Bureau
UPHOLD	Uganda Program for Human and Holistic Development
UPMB	Uganda Protestant Medical Bureau
UMMB	Uganda Muslim Medical Bureau
VCT	Voluntary Counselling & Testing
WHO	World Health Organisation

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.

Delphine Boulenger, Basile Keugoung and Bart Criel, ITM Antwerp

May, 2009

Contact

Address: ITM
Nationalestraat 155
B-2000 Antwerp, Belgium

Email: Delphine Boulenger, contractingstudy@gmail.com
Dr Basile Keugoung, keugoung@gmail.com
Pr. Bart Criel, 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) 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

General context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

Up to 30% of care facilities in Uganda belong to the private not for profit sector: 44 hospitals (42,3% of the total) and 558 health centres, the majority in rural, very remote, areas. There are furthermore 21 health training centres (60% of the training for health officers: nurses and others). The Catholic and Protestant Churches own the majority of the faith-based facilities. They are united in denominational health platforms, respectively UCMB and UPMB² (see below). The presence of Muslims in the sector grows steadily, but is still rather marginal.

Figure 1. The PNFP health sector structure in Uganda.
(Source: UPMB Annual Report 2004/05)

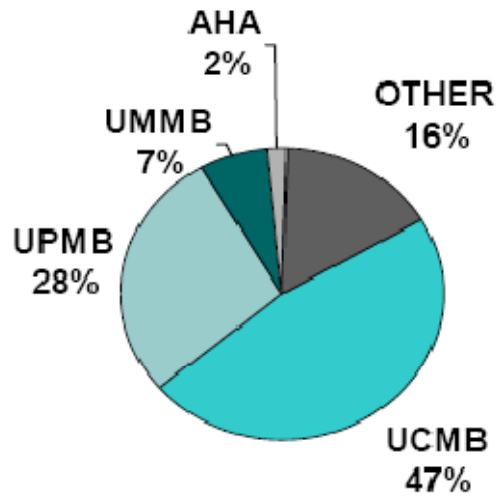
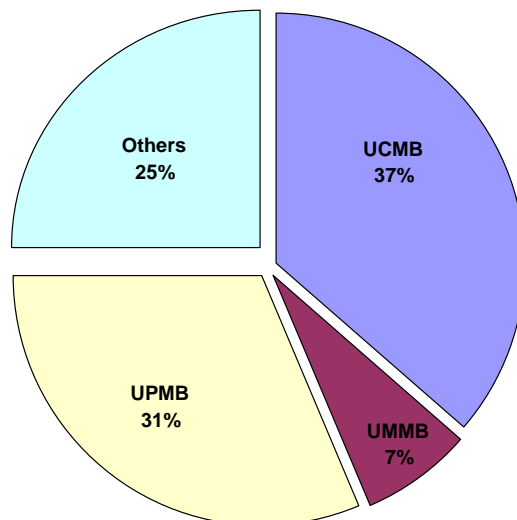


Figure 2. Distribution of the health facilities between the different coordinating PNFP organisations
(Source: UPMB Annual report 2004-05)



² Uganda Catholic Medical Bureau (UCMB); Uganda Protestant Medical Bureau (UPMB).

The relationship between the public and faith-based sector

The relationship between the faith-based network and the MOH goes back to pre-colonial times but remained rather minimal until the end of the nineties. The collaboration was not formalized and consisted mainly of State subsidies³ to the health organisations of the Church⁴. There was however a progressive evolution towards a more structural partnership⁵. The financial difficulties of the faith-based sector, as a result of the gradual decline in funding from traditional donors and a substantial decrease in revenue, induced UCMB and UPMB to openly ask structural help from the State in order to keep up its services.

This led in 1997-1998 to a Memorandum of Understanding (MoU) at central level, which broadly defined the collaboration between the MOH and the Church and the objectives of the support. This document was a first effort to formalize the relationship between the Churches and their public partner and led to a considerable increase in the financial support from the State⁶ to the Voluntary Agencies and the signing of a number of operational contracts⁷ between the religious health structures and the MOH. Joint action of UCMB and UPMB led them, in 2003, to submit to the state an outline of a partnership policy, with the intention of establishing a long lasting relationship and a legal framework.

This partnership and contracting process could not be continued in spite of continued lobbying by the Church authorities with the government. The 2003 document never acquired official approval and thus all further contracting experiments were halted at peripheral level. Since three years this has been a source of intense frustration for the faith-based sector which furthermore suffered heavily from the freeze in state subsidies and a serious crisis in human resources⁸. Today, the financial support of the State to the hospitals represents only 15% on average of the total revenue of the Church (*cf.* Figure 8).

UCMB and UPMB were founded in 1957⁹ to act as a liaison between the Ugandan government, the donors and the hospitals of the network, to channel the State grants and ensure the development of training for nurses. Today, the organizations have committed themselves to supporting health facilities of their respective networks¹⁰ and representing the network in discussions with the Church and State authorities.

UPMB and UCMB¹¹ collaborate intensively to meet the challenges faced by the faith-based health sector today. Their strategy is aimed at obtaining official¹² and formalized recognition of the role the Church plays in the health sector. This would lead to a real integration of the religious health facilities in the national health system and force the State to look for a structural solution for the threats that endanger their survival:

- The financial crisis which results from the gradual reduction in the support of the traditional donors, the fact that the State contributions have remained 'frozen'¹³, a decrease

³ "Grants in Aid" voted by the Frazier Commission in the 50s. This system was retained during the post colonial period; only during the economic crisis in the middle of the 70s this was not the case.

⁴ Voluntary Organisations.

⁵ Report of the Health Services Review Commission (middle of the 80s); "White Paper" (1991).

⁶ The funds allocated increased from 800 million to 17 billion of shillings between 1999 and 2004.

⁷ Service Level Agreements (SLA).

⁸ A substantial revaluation of the public salaries in 2005 only contributed to worsening the situation.

⁹ Government Notice N° 672.

¹⁰ The UCMB network has 72 hospitals and 234 HC; the UPMB network has 15 hospitals and 241 HC belonging to 7 different denominations of which the Anglican Church of Uganda (CoU) is one.

¹¹ And more recently the Uganda Muslim Medical Bureau (UMMB).

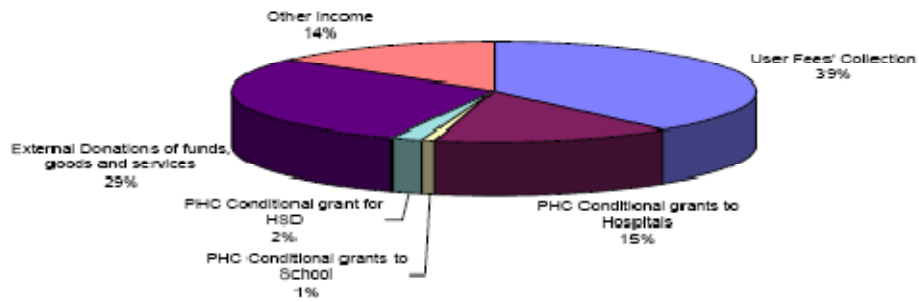
¹² Through the approval of the Draft Partnership Policy of 2003.

¹³ Their share in financing the health activities of the faith-based sector has dropped from 36 to 32% between 2002-2003 and 2005-2006.

in the user fees¹⁴ charged to patients and an increase in the fixed costs of the facilities and particularly in human resources¹⁵;

- The crisis in human resources is mainly a consequence of the low attractiveness of the salaries in the faith-based sector and the massive recruitment campaign of the MOH.

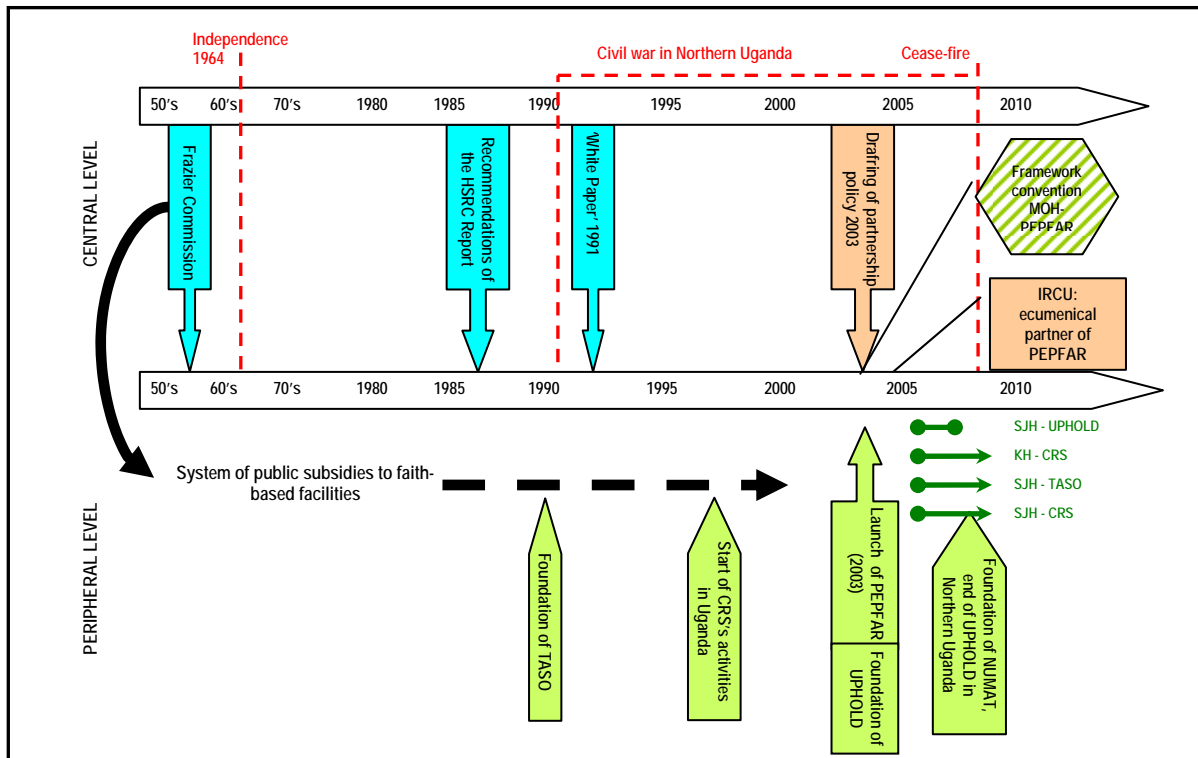
Figure 3. Structure and division of income from financial contributions to the faith-based health sector. (Source: UCMB,UPMB,UMMB, 2007)



¹⁴ This decrease follows a request of the State and is a result of the fact that the faith-based sector applies the National Health Policy.

¹⁵ HR represent on average 44% of the total costs of the facility. The subsidies of the State do not cover the salaries. The Church was forced to increase the salaries as a result of the revaluation of those of the public sector. It is interesting that an analysis of faith-based platforms establishes a direct link between the increase in the share of HR in the operational costs of the health facilities and the growing strength of “global initiatives” (such as PEPFAR) which are not keen on financing the costs of the healthcare system and certainly not the salaries.

Figure 4. The contracting process in Uganda



LEGEND

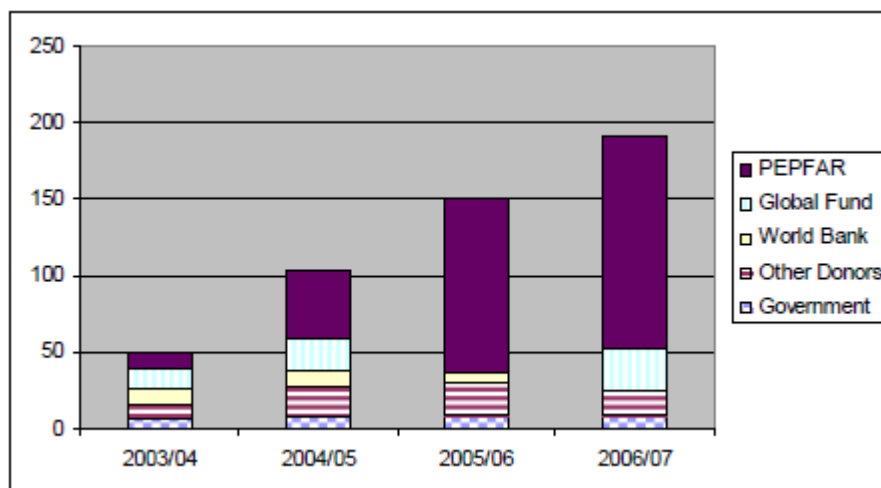
- HSRC Health Sector Review Committee
- MOH Ministry of Health
- PEPFAR President Emergency Plan For Aids Relief
- CRS Catholic Relief Services
- UPHOLD Uganda Program for Human and Holistic Development
- TASO The AIDS Support Organization
- IRCU Inter Religious Council of Uganda
- KH Kabarole Hospital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

- Public sector
- Faith-based sector
- PEPFAR
- End of contracting relationship
- Ongoing contracting relationship

PEPFAR and the faith-based sector

Uganda was one of 15 countries chosen by the President's Emergency Initiative for AIDS Relief (PEPFAR) and has received support for a large number of HIV-AIDS relief, treatment and care projects since 2004. The total amount of PEPFAR funds given to Uganda is officially estimated¹⁶ at 283,6 million dollar (2008). The size of these funds puts PEPFAR in the lead¹⁷ of organizations helping Uganda with the HIV-AIDS pandemic. Moreover, the initiative vaunts the Ugandan "model" of fight against HIV-AIDS and claims it has a significant influence on the development of its strategies.

Figure 1. Health funding in Uganda.
(Source: Oomman N, Bernstein M and Rosenzweig S, 2007)



The government authorities of the partner countries are not very involved in the conceptualization, planning and management of PEPFAR activities. The rules and procedures for managing the funds remain specific to the programme and are governed by criteria dictated by the American Congress. The management and supervision are also taken care of by US representatives¹⁸. Finally the beneficiaries are mostly NGOs, often foreign ones. Although there is a *PEPFAR Board* in Uganda, in which the government and the private sector are represented, it only allows them limited room for manoeuvring.

The PEPFAR policy generally favours a direct link with the peripheral level which partly explains the weak involvement of the central level¹⁹. Recipients and sub-recipients are mainly selected on the basis of their ability to achieve the targets set out and spend the funds allocated as quickly as possible. In general, the PEPFAR system is extremely strict²⁰ and the financial data are not very transparent: thus only the budgets allocated country per country to the recipients are made public²¹. The figures about field programme results are also very difficult to access.

¹⁶ 2008 Country profile, Uganda. Consulted on www.PEPFAR.org

¹⁷ In 2006, 73% of the available funds in the context of the fight against HIV-AIDS in Uganda came from PEPFAR. See also the figures below.

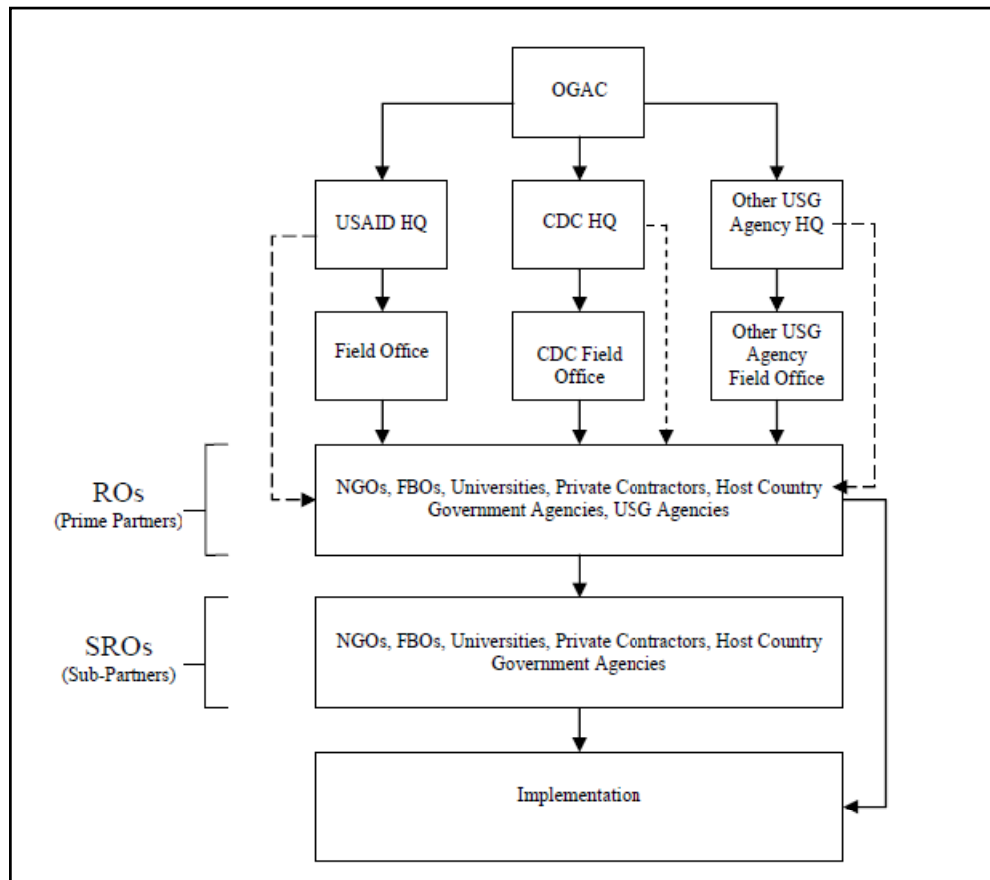
¹⁸ Through the Office of the Global Aids Coordinator (OGAC) in the US, and in the field through Embassies and Agencies such as USAID and CDC.

¹⁹ Capacity strengthening and institutional support are far less important objectives for PEPFAR than for the Global Fund and the World Bank.

²⁰ Earmarking of the funds.

²¹ Financial data on the real payments made are not accessible to the public, the recipient governments or even some of PEPFAR's staff members. The data about the distribution of funds by programme area and the list of funds allocated to the sub-recipients are collected by PEPFAR but are again not accessible for the public.

Figure 2. System for the distribution of PEPFAR funds.
(Source: Oomman N, Bernstein M and Rosenzweig S)



It seemed important to present also three of PEPFAR's main recipients in Uganda: the Catholic Relief Services²², the Uganda Program for Human and Holistic Development (UPHOLD)²³ and The Aids Support Organisation (TASO)²⁴. All three are signatories of contracts which interest us in the context of this study.

CRS is the official relief and development agency of the US Episcopal conference and a member of Caritas. It has been operational in Uganda since 1965. The organisation was put at the head of the consortium responsible for the AIDS Relief programme of PEPFAR and implements most of its activities in Uganda under this label. CRS supports 18 care facilities in 11 districts²⁵.

The UPHOLD programme is very well represented in the field in Uganda²⁶. This programme was launched in 2003 as an initiative of the American organisation *John Snow Incorporated* (JSI). The programme focuses on strengthening community and institutional participation in the development of better quality education and health services, in particular in the context of the fight against HIV/AIDS. From 2005 on, the activities have been placed under PEPFAR, which became the major financing source for the programme. UPHOLD works closely together with the local district governments.

²² www.crs.org

²³ www.uphold.jsi.com

²⁴ www.tasouganda.org

²⁵ According to figures provided by CRS, its activities care for more than 62.400 people, of which 21.000 people are on ART.

²⁶ At the peak of its activities it covered 34 districts. The creation of the Northern Uganda Malaria AIDS & Tuberculosis Program (NUMAT) has led UPHOLD to withdraw from the North of the country, leaving the number of districts supported at 28.

TASO (1987) is the leading Ugandan organisation and one of the most important African organisations involved in the support of people living with HIV-AIDS (PLHIV). It works in close collaboration with the Ugandan government²⁷ and is obviously a major partner for PEPFAR and one of its main recipients. The activities carried out for the PEPFAR programmes in the districts are 'sub-contracted' to competent institutions or facilities²⁸.

The partnership context has to be looked at on two levels in this study: the partnership between PEPFAR and its representatives on the one hand and the State and the Church on the other hand. We were unable to get an interview with the PEPFAR representatives at the US Embassy and USAID, so we have very little information on the links between the state of Uganda and PEPFAR, also because information was scarce at the MOH. We were not able to get hold of a copy of the agreement protocol signed between PEPFAR (Washington) and the Ugandan State for the launch of the programme: we were not able to find a trace of the document and we believe therefore that the document is classified.

There is no convention moreover at central level between PEPFAR and faith-based platforms in spite of the fact that many facilities of the network are involved in the implementation of the programme. The contacts between the Ugandan faith-based sector and PEPFAR happen on central level through an interreligious body: the *Inter-Religious Council of Uganda* (IRCU). This body, chosen by PEPFAR to coordinate most of its interventions with the faith-based sector, had in origin a spiritual mission. It is not very legitimate in the eyes of UCMB and UPMB as they are not represented in this council and IRCU does not bother to communicate with them.

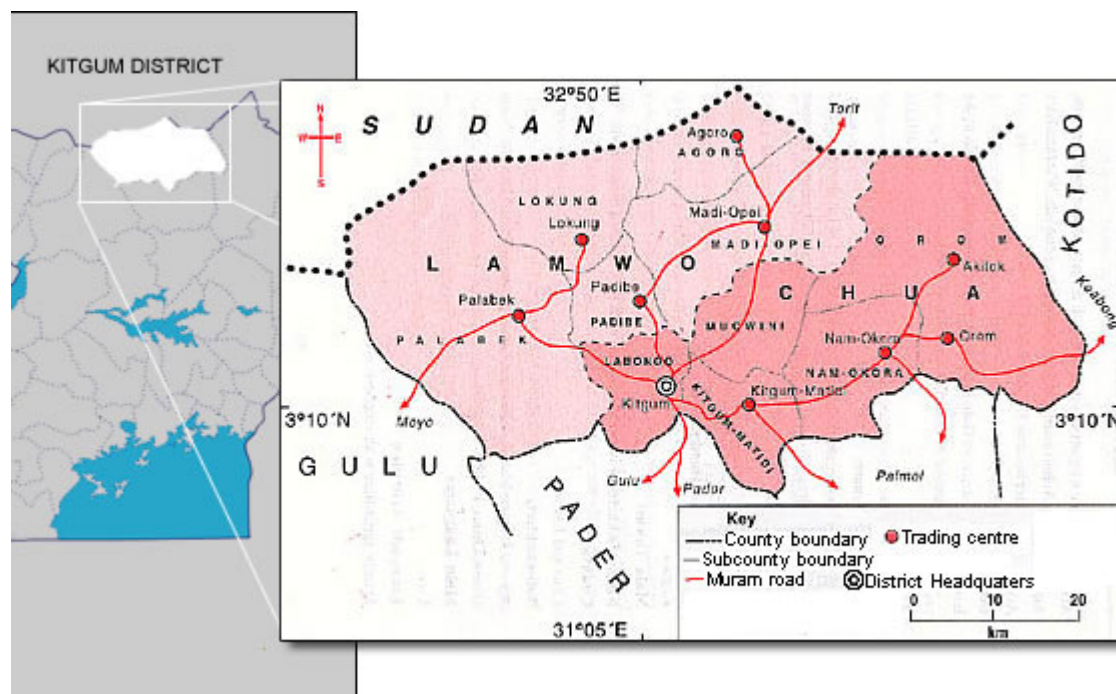
Of the three recipients we studied, CRS is the only one to have a relationship (not formalised) with UCMB and UPMB. TASO and UPHOLD communicate exclusively with IRCU and largely ignore the fundamental role played by the faith-based health platforms. As a result UCMB and UMPB have only scant information about the number of contracts actually signed by "their" hospitals with IRCU or other PEPFAR recipients. This lack of information is aggravated because often the facilities themselves are also reluctant to communicate on the subject. The efforts made by UCMB and UPMB to get a dialogue going with IRCU and obtain answers to their preoccupations have remained largely unheeded up to now.

²⁷ The MOH and the National AIDS Commission (NAC).

²⁸ Sub-recipients such as for example the District of Kitgum or Kabarole Hospital.

Characteristics of the cases selected

Figure 3. Kitgum District.
(Source: www.coreinitiative.org)



St. Joseph's Hospital (SJH)

St. Joseph's Hospital is located in Northern Uganda in the district of Kitgum. The facility was founded in 1942 as a health post by the Italian Sisters of Comboni. It became a hospital and was handed over to the Diocese of Gulu in the beginning of the 70s. Today the facility has 350 beds and operates in a very poor region which suffered badly from twenty years of civil war²⁹. SJH is accredited by UCMB and boasts an excellent reputation.

The hospital is situated nearby a district public hospital (Kitgum Hospital, 200 beds), only two kilometres away. SJH unofficially plays the role of district referral central, attracting not only patients from the district but also from further away. Part of the explanation for this situation lies in the civil war: SJH stayed in business throughout the war and continued to look after an ever increasing number of patients³⁰ to the detriment of the almost moribund district hospital (HD). The years of conflict also explain the large presence of international NGOs and the extensive external support which SJH received at that time³¹. These relationships are or have often been underpinned by contracts (AVSI³², UE, WFP). The hospital benefits furthermore from solid technical support from UCMB. This support seems to be rated as more

²⁹ The civil war started in Northern Uganda in the beginning of the 80s. The conflict opposing the Lord's Resistant Army (LRA) and the Allied Democratic Forces (ADF) to the Ugandan government was only resolved in October 2006, when some of the rebels took part in peace negotiations with the government, held in South Sudan. There is now a ceasefire but the region has been strongly affected by the conflict with nearly 400.000 refugees, the majority of whom are still staying in camps.

³⁰ Influx of refugees in the cities.

³¹ AVSI, Misereor, AGEH, the World Food Program (WFP), the European Union (EU) to cite only the main ones.

³² AVSI (www.avsi.org) is the most important donor of the hospital and an essential technical resource. The organization has set up and takes charge of the management team of SJH.

which stipulate the access to the fund of the *Conditional Grant*³⁸ for all health facilities in the district. Founded in 1903, Kabarole Hospital is one of the oldest hospitals in the country. In 1997, the diocese could no longer fulfil its financial obligations and let the building to a private practitioner. However, the current bishop reintegrated the hospital in the network in 2000. Although battered at the time, the hospital is now slowly rising from the ashes. Kabarole is a modest facility (80 beds) and the smallest of the three hospitals in Fort Portal. The provincial hospital of Buhinga³⁹ (public) and the Catholic Hospital of Virika are only a few km away from Kabarole.

The structural means of the hospital are mainly confined to user fees and State subsidies⁴⁰. The only external support received comes from the contract signed in 2005 with CRS for the AIDSRelief programme. Its input in the hospital budget (50%) is enormous but the funds can only be used for programme activities. This heavy dependence on one donor is not without risk for such a fragile facility. The budget constraints mean that KH cannot cover the increasing HR costs. The wage bill is a heavy burden for KH's budget and limits its development possibilities.

Results of the interviews and the documentary analysis

CENTRAL LEVEL

We are particularly interested in the way the relationship (or its non-existence) is perceived by the different actors in the absence of an identifiable partnership - and a fortiori a contracting process - on central level between PEPFAR (or its recipients) and the public and faith-based health sector. In general, PEPFAR's interventions (through its recipients) and hence also the contracting activities focus on the district level. This choice explains partly why the visibility of the initiative remains rather limited on central level. It also affects the perception and explains the (limited) awareness of the public and faith-based health actors.

The PEPFAR coordination committee, the activities of which are normally set up directly with the district, allows the MOH to steer the initiative according to the National Health Policy. However, this does not render the day-to-day management of the programmes more transparent. The Health Advisory Committee consists of different technical working groups that would normally favour sharing information. PEPFAR participates in these groups, for example in the Public Private Partnership in Health Group, the Sector Wide Approach Group or SWAP Group, the Policy Advisory Committee and some other partnership fora (Annual Technical Review Board, the Joint Annual Sector Review). It was very difficult to find out what happens in reality as the discourse of public sector actors is often contradictory.

The participants interviewed at MOH level made a relatively negative analysis of the way PEPFAR intervenes in the country. These interviewees included people responsible for planning as well as those in charge of the partnership. The MOH considers transparency to be the main problem. If information is transmitted, it goes mainly to the Director General and the Permanent Secretary for Health at the MOH, and then to the National AIDS Commission (NAC). In general, few people know the reality of the field and those who do know seem to belong mainly to the President's inner circle. The result is that PEPFAR gets a 'political' character.

The available information is mostly limited to the planned resources and the listed recipients but without detailing how these resources are used. This makes it difficult to plan for resources and interventions. However, it seems that some improvement is underway thanks to the efforts of the MOH to obtain additional information (particularly on the availability of resources in the medium term) but also thanks to the presence of a representative at the

³⁸ This practice, foreseen by the policy of Primary Health Care (PHC) is no longer used by most districts and is in fact a formality.

³⁹ Buhinga is the provincial referral centre.

⁴⁰ In a total budget of 734 million \$ in 2007, the contribution of the State amounted to only 80 million of which just 63 million were really received.

American Embassy who is more inclined than his predecessors to collaborate with the Ministry. Identifying possible fields of intervention is the responsibility of PEPFAR: the MOH has no say in the matter, neither in defining the priorities nor in the distribution of allocated funds. Some interventions are identified afterwards through supervision visits to the districts but are confined to very visible initiatives such as those of UPHOLD or NUMAT for example, which the local authorities handle.

Besides the question of transparency, there is also the issue of the intervention manner of PEPFAR: American legislation does not allow direct financing of other governments; the allocated funds are transferred to projects and cannot be included in the MOH budget, although Uganda prefers the latter form of support. The MOH just tries to steer PEPFAR so that it operates in line with national health policy: the definition of intervention priorities, financing matters and the operational level are not overseen. Hence, PEPFAR operates autonomously vis-à-vis the central authorities in these areas, so there is no real partnership.

The MOH recognizes that the initiative is useful and in fact complementary to its own mission but emphasizes also the possible limitations. The efficiency of the interventions is impossible to verify for the MOH and the overriding feeling of some of the participants is that the operating modus of the initiative is more likely to serve the financial interests of the donor than those of the beneficiary country⁴¹. Finally, if the immediate value of the interventions is admitted, the issue of their sustainability continues to worry the MOH: if there is no joint planning, how can continuity be ensured if PEPFAR were to withdraw?

The Ministry admits nevertheless that it is partly to blame for the current situation: it acknowledges its ineptitude to impose itself as a real 'steward' and full coordinator in the sector. It should demand the information needed, impose its priorities and insist on a complete formalization of the relationship, as this would allow the Ministry to set demands and supervise the interventions. Our interviewees also pointed out the weakness of the local health information system as well as its probable incompatibility with the complexity of the data gathered by PEPFAR through the *Monitoring and Evaluation of Emergency Plan Progress* (MEEP) project. Furthermore, the system of data collection is not made to include information about programmes such as the ones developed by PEPFAR. Hence, the indicators used do only permit to capture these data to some extent.

As is the case for the public sector, no agreement has been signed on central level between PEPFAR or its recipients and the faith-based medical platforms, so there is no formalized relationship. In fact, the question whether a relationship exists is even more justified than in the case of the MOH. Neither UCMB nor UPMB maintain links with PEPFAR and its recipients. The top people involved in the initiative (at the US Embassy and USAID in particular) never approached these bodies. Relations with the faith-based sector at central level developed through IRCU, an institution meant to serve as a contact point for the different religious denominations. Hence, UCMB, UPMB and UMMB, the coordinating bodies of the faith-based medical sector, have been completely bypassed in favour of one single organisation which was originally created to fulfil other tasks. As the different churches expected that other funds (such as those from the Global Fund) would later on also pass through one representative body, the IRCU was designated officially in 2003⁴² to play this role of receiver and manager of the allocated funds. It was nevertheless understood that this body would not be responsible for bringing the funds to the peripheral level, in other words maintain contacts with the health facilities themselves.

In the beginning, PEPFAR established a relation with the medical coordination board of a number of Ugandan churches. An example is the Anglican Church of Uganda (CoU) which until recently had direct contact with PEPFAR through USAID. The Church provided them with useful information for identifying possible recipient facilities or programmes and was

⁴¹ Reference is made here to the expatriate staff, the number of foreign recipients and in particular Americans and the price of antiretroviral drugs (limited recourse to generic products).

⁴² By the Churches, i.e. for the Catholics by the Episcopal Conference.

responsible for managing the funds allocated to them. However, PEPFAR's wish to limit the number of intermediaries led in 2007 to a review of its individual relationship with the CoU in favour of IRCU. The CoU continues nevertheless to provide information and supervise the financial side as IRCU is unable to identify facilities. The funds themselves are managed by IRCU and paid directly to the beneficiaries without going through the CoU. The medical coordination of CoU finds it increasingly difficult to carry out supervisions as it no longer receives any information about payments. Because UCMB and the Catholic Episcopal conference did not wish to become recipients of the funds, the Catholic authorities decided early on to create an Episcopal body which would manage the funds that their health facilities received from PEPFAR or other global initiatives through IRCU. Thus, GIFMU (*Global Initiatives Funds Managing Unit*) was founded in 2004. However, PEPFAR decided to formalize its relationship with IRCU in order to channel the disbursement of the funds, which amounted to 18 million dollar, to the faith-based sector more efficiently. As one of the clauses of the contract stipulated that IRCU could not bring in a third party for the payment of funds to health facilities, the role of GIFMU became obsolete from July 2007 onwards.

UCMB, UPMB or the medical coordinators of their member churches thus lost control over the programmes set up with PEPFAR funds. The situation was worsened by the communication problems and difficult relation with IRCU: the organization communicates indeed mainly with PEPFAR/USAID which finances its staff. The same problem crops up with other PEPFAR intervention mechanisms and a great number of programmes managed by other main recipients: TASO and UPHOLD - to cite examples specific to the case studies of our research - have no relationship with the Religious Coordinating Bodies (RCB).

CRS is the only exception we came across that does not bypass the RCB. At first, it operated in the same manner i.e. through a direct relationship with the operational actors in the district. Little by little though, CRS adjusted its position and it now maintains links with UCMB and UPMB. UCMB organizes regular meetings with CRS to consolidate the relationship and progressively get access to the information needed. UPMB was approached to help CRS identify the structures to be included in the programme and joint field visits were organized. Nevertheless the extent of partnership needs to be put in perspective, since UPMB has for example not been informed on the contracts CRS drew up in the field (for instance with Kabarole hospital).

One of the first concerns pertains to the inexperience of the hospitals with contracting partnership matters. There are several known cases in which the contracts do not respect the required legal rules. The dioceses, legal owners of the hospitals, do in fact not systematically sign the documents; the technical managers sometimes sign on their behalf without official delegation of this task. These agreements are thus strictly speaking legally invalid but still implicate an array of obligations and constraints which they barely grasp. Most PEPFAR contracts are in fact based on complex standardized blueprints, drafted according to American legislation and to a great extent not negotiable.

The second major worry lies in the potential distortions caused by contracts which involve a lot of money and strongly target facilities with activities other than only HIV-AIDS prevention. According to UCMB in particular, the effects of projects and their requirements are not really compatible with settings suffering from a serious lack of HR and facing limited infrastructures. Unfortunately most of their hospitals operate in this kind of context. The fear is that the objectives put forward cannot be achieved without other activities suffering in the process.

Finally our interviewees also expressed a fear that HIV-AIDS care will be carried out separately, going against the principle of integration of these activities in the health system.



St Joseph's Hospital: the HIV clinic and the voluntary counseling & testing centre

Contracting process and analysis of the contracts

CRS

We identified three PEPFAR contracts in SJH: the first one, signed with UPHOLD in 2005, ended in 2007 when the organisation withdrew from the region; the second contract, signed with TASO in 2005 is still in force and aims to boost HIV-AIDS prevention and improve and provide care; the third contract, signed with CRS in 2005, organizes ART treatment and voluntary screening. Before PEPFAR, SJH had no direct link with global initiatives. The Global Fund and the *Multi-country HIV-AIDS Program* (MAP) passed mainly through public institutions; hence the benefit was indirect and came in the form of donations of medicines and reagents by the MOH.

When PEPFAR arrived through CRS (2004), the district health team carried out an evaluation mission in the region in order to select a certain number of facilities likely to benefit from the support of the AIDSRelief Consortium. After a thorough inquiry they decided to include SJH in the programme. The government's priority was to treat patients in public structures, but as no other organisation before CRS had offered the hospital the means to carry out ART treatment, SJH seized the opportunity. However, originally this was a donor initiative, of which the district health authorities took control during the sub-recipients identification stage. The hospital management team was sent on a visit to Lacore Hospital in Gulu, already a beneficiary, in order to assess the programme implications. The team was then invited to submit a proposal for support and this was accepted. The first contract was signed in 2005, between CRS and the hospital. The diocese was ignored: its signature was not on the document.

The first CRS contract was signed in 2005. The signatories were, on the one hand the national representative of CRS, and on the other hand the Chief Medical Officer of St. Joseph hospital. In other words, the kind of situation generally denounced at central level by the faith-based platforms. CRS justifies the situation by saying that it needs to establish a contract with the operational partner while SJH invokes the issue of technical skills. The diocese is a moral authority, not very familiar with the ins and outs of this type of relationship.

The contract was signed for one year and is dependent on the funds allocated to CRS by Washington when the budget is voted. Its renewal is also dependent on the level of performance of the structure (achievement of objectives), its respect of the terms of the contract, its capacity and the mutual wish of the parties to continue their collaboration. In practice, each year the contract has been systematically renewed, since 2005: the standard document is reproduced at each occasion and just mentions the changes made. This document applies to all contracts signed by CRS in the context of the AIDS Relief programme. It emphasizes moreover the strictly autonomous character of the signatory organizations: we are here in the framework of a service agreement, there is no intention of a legal partnership.

The obligations of both parties are only mentioned by referring to the description of the programme provided in annex. It provides a brief description of the resources or services potentially allocated by the donor and limited to support in kind (drugs and laboratory equipment for example). It foresees the conditions under which the funds are paid as well as those for paying back funds by the beneficiary. Article 15 is about the conditions for monitoring and evaluation, specified on the one hand for the objectives set out (monitoring and evaluation of the performance, SEP) and on the other hand for the financial data (SEF).

Annual independent audits are planned for cumulated funds beyond 500.000 USD or 250.000 USD on a yearly basis. More structurally, supervision visits (evaluation of the capacity and monitoring) and the inspection of the financial administration have to be carried out by the donor on the basis of a calendar established by both parties. Some categories of expenses need prior agreement of the donor: these include in particular expenses for expensive capital equipment, improvements to infrastructure and investments.

Finally, a last part includes the particular terms and conditions: it links notably the payment of salaries and remunerations to the systematic submission of attendance sheets/activities; the obligation by the beneficiary to second or recruit the best possible staff for setting up the programme; the need to inform on all contact with the media on the programme or its activities; the law applicable to the contract (Uganda) and the precedence of American law when conflicts need to be resolved.

In the case of SJH there was no real negotiation on this contract: the model was submitted for approval and was then signed.

UPHOLD

In the case of UPHOLD, the selection of beneficiary districts was carried out beforehand, through an agreement between the Ugandan government and USAID. UPHOLD received a list of 20 districts in which it was supposed to set up resource allocation mechanisms and help identify likely candidates in the civil society for inclusion in the programme: Kitgum was part of these. In all cases, the terms, selection criteria and rules that apply to the contracts are specific to UPHOLD but to a large extent controlled by PEPFAR via USAID. PEPFAR stipulates in advance clear targets and defines the services to be set up. On the basis of all these criteria, UPHOLD carried out the selection of sub-recipients in Kitgum District who had put in their candidacy.

The UPHOLD contract is largely comparable to the CRS contract in its formalization level and standardization. This is definitely the case for the general rules applying to the contract i.e. reference to legal texts from the donor and the allocated funds, general conditions governing the payments made, conditions of monitoring and evaluation (financial and technical reports), authorized expenses, conditions applicable to accounting, the audit and the financial administration, the rules applicable to the payments of advances and reimbursements, conditions for termination, suspension and amendments of the contract and the resolution of conflicts. However, the UPHOLD contract is more flexible than the CRS contract: the contracting process implies drafting a detailed proposal by the beneficiary, which is then discussed with the donor. The priorities are thus jointly defined.

The SJH contract defines two important objectives: the provision of decentralized services for voluntary screening and advice to a specified number of adults from 4 sub-counties and the county of Kitgum-city; the provision on the other hand of care and accompaniment of a specified number of people living with HIV in the same zones. Each of these objectives is described in detail with the activities that have to be carried out, and all of them are accompanied by quantitative objectives. As for CRS, the UPHOLD contract was signed by the chief medical officer of the hospital and - again - not by the diocese.

For both UPHOLD and TASO, the signed contracts include detailed obligations and require an important commitment on the part of the beneficiary in terms of skills and time. Besides the activities that need to be undertaken, reporting duties are an essential and detailed part of the documents. If these reporting obligations offer the guarantee, at least theoretically, of excellent monitoring conditions, the constraints which result, weigh particularly heavy on SJH. The hospital had to manage simultaneously three distinct monitoring and evaluation systems, until UPHOLD's withdrawal. The details of the TASO obligations are unknown to us but we found out through the interviews that they put even more strain on SJH, bearing in mind that the funds allocated remain rather modest in comparison to those of CRS.

TASO

TASO Gulu identified possible recipients, focusing on a limited number of structures (governmental or faith-based) that have a public service orientation. A field mission was carried out in the districts and the hospitals of the region to identify possible gaps in existing programmes and analyse the needs (based on statistics). The District of Kitgum was first selected, and then SJH was chosen (within this district). This is obviously a very participatory context, far removed from the principles implemented for AIDS Relief. The final contract is the result of negotiations held specifically with the hospital, operational partner of TASO for the implementation of its programme.

The TASO contract is in fact a simple Memorandum of Understanding (MoU). Of the three documents studied, it is the least precise one. The way it is formulated and its particular characteristics are similar to the contracts we have analysed for the three other case studies of this research. But unlike these, it is, on paper, the one that details most completely the involvement of the different categories of actors of the area: in fact, the MoU officially links TASO to the Kitgum District but with SJH as principal actor of the agreement. This means that the three entities are signatories of the agreement. Two representatives of the district authorities (Chief Administrative Officer (CAO) and the Director of Health Services) and a representative of the hospital (the Chief Medical Officer) signed. These three representatives are regrouped under the label "Local government of Kitgum District". For TASO, the Executive Director (Central Level) and the regional manager for Northern Uganda signed. As in the case of CRS, the diocese as a legal entity was ignored by the agreement. If the district is the entity officially designated by the MoU, the real partner is the hospital.

Contracting instruments/partnerships (monitoring, evaluation)

Because of their level of precision and detail, the contracting documents are the first instrument for managing the relationship: they are real and complex sources of information and serve as a reference for the facility for monitoring the obligations and regulations governing the relationship. The second instrument is the monitoring offered by the donors. Supervision visits are often organized by CRS staff to check the technical aspects of the contract. They are seen as an essential part of the relationship and allow SJH to benefit from direct support in managing, monitoring and evaluating of the activities planned in the contract. Annually, an in-depth financial inspection is also carried out. Finally (and especially during the start-up phase), other members of the AIDSRelief Consortium came and still come to supervise the activities.

Besides the contact with the main representatives of the donors, the hospital benefits from the proximity of the regional offices of TASO and UPHOLD in Gulu and the CRS office in Kitgum. CRS furthermore organises a *local partners forum* in Kampala every three months which is attended by all the facilities involved in the AIDSRelief programme in Uganda; this allows the different hospitals to exchange their respective experiences and thus contributes to capacity building of the people in charge.

Finally, regular training of the actors in the programme enables the facility to acquire the skills needed for achieving the set targets and for following up on the donor's specific procedures.

The reporting and data collection obligations, typical of each contract⁴³, ensure that the facility remains critical of itself and holds a regular self-evaluation of the programme activities. Overall, the ability to identify relevant data, analyse and anticipate activities, all of them skills acquired in the context of PEPFAR contracts, have a positive effect on the level of monitoring and evaluation of the hospital's core activities. The skills thus acquired can be exploited in more ways than just for the specific activities of the contracting agreements.

Perception of the relationship and implications

The public sector

In general the public sector has a positive impression about the contracts signed by SJH; it is clear however that the knowledge of public actors of these contracts is rather limited. CRS, in particular, that visited the region in the identification phase of beneficiary structures, has no longer any contact with the district (AIDS focal point). The same is true for TASO even though there is a joint agreement, contacts are limited to SJH, visits to the district are rare and the donor submits no annual report to the district health authorities. The situation is better for programmes such as UPHOLD (and more recently NUMAT): they have direct contact with the district, and keep it informed about their activities.

The district is also a recipient of funds. However, the money SJH received from UPHOLD was transferred directly, without going through the district. NUMAT has since taken over and all funds are now channelled through the district.

Nevertheless, different instruments offer possibilities for exchange: SJH (unlike, it seems, other faith-based facilities) regularly supplies copies of its reports to the district. This information is however not always exploited. Another exchange opportunity lies in the representative and decision-making bodies, in which both public and religious actors participate. The district management team also has to carry out regular supervisions of the hospital; joint three monthly supervisions (by the technical and the political committee for the fight against HIV-AIDS) are scheduled. In reality, they are not very frequent though, and there is no formal feedback to SJH.

The local government also provides financial and material support to the hospital: although these contributions amount to only 30% of the budget (far lower than the 52% obtained from external donations), they nevertheless allow the hospital to pay part of its expenses.

Finally, sometimes SJH, the district and the district hospital collaborate informally: SJH's skills in the fight against HIV-AIDS are regularly called upon; the facility is invited to delegate some of its specialized staff to train their counterparts of the public sector. There are regular exchanges and interactions in fields not specifically related to HIV-AIDS: exchanges of specialists, equipment, even occasional assistance in the supply of drugs.

Generally speaking, the patients themselves prefer to go to SJH rather than to the public health centres nearby or to the district hospital. The quality of care, skills, reception and quality of the management are mentioned as main reasons for this, on top of the shortage of

⁴³ See copy of the contract in annex, Vol. II, 5.

district resources in comparison to SJH (drugs, laboratory facilities). This resource gap creates some tension and the emergence of double standards of care.

However, nothing seems to indicate that both parties are really in competition with each another, not even for access to resources. What is deplored is the absence of a three party agreement which would allow the local government to fully exercise its coordination and supervision tasks.

The faith-based sector

The feeling of SJH about its relationship with PEPFAR differs greatly from the perceptions at central level. This indicates first and foremost that hospitals are not really equal in these types of contracts: the difficulties encountered by some facilities of the Catholic network are not necessarily experienced in the same way by other catholic facilities.

The first category of benefits identified by the hospital concerns the set up of the activities: the resources and means proposed by the PEPFAR recipients fill needs such as treatment for PLHIV⁴⁴. The public provision of this treatment is considered unreliable, incomplete and thus not an acceptable alternative for SJH. PEPFAR's support through AIDSRelief/CRS includes ART drugs and treatment of opportunistic infections, equipment (including a CD4 meter) and laboratory reagents. This support, related to the number of patients in the programme, has allowed SJH to come up with a complete package of care, this in addition to the community activities, voluntary screening, counselling and accompaniment which were already on offer thanks to grants from other programmes. The PEPFAR support thus constitutes an essential improvement in terms of access to care.

The second category of benefits is without any doubt the most important one: the technical level of support by the donor. The hospital refers here to the obvious benefit it gains from supervisions, initial and continued training, regular contacts as well as reporting requirements. Furthermore, the hospital mentions the technical support for example for managing difficult medical cases (CRS) and the joint search for solutions to the problems met. The quality of the support, the availability of the donor and overall the existence of a true day to day partnership are much appreciated. This is particularly the case for UPHOLD and CRS.

The quality of the data collected gives the facility solid arguments in its negotiations with other donors. The use of programme data is therefore encouraged to fill the identified gaps. Furthermore, the interventions partly alleviate SJH's financial burden.

More negative aspects of the contract are largely downplayed by the staff. They admit that the extra work that came with the programmes was a heavy burden in the initial stages. Staff instability and turnover and SJH's need to cut staff due to a lack of sufficient resources have doubtlessly aggravated the consequences of the mobilization of some staff for specific tasks of the contract.

There is also the issue of staff and their remuneration. The information we obtained was contradictory, as two schools of thought emerged. A first category believed that there is no difference between the salaries inside and outside the programme. SJH has been able to impose its own salary scales to the donors. Others said that some donors - in particular CRS - refuse to deviate from their own procedures. This leads to sometimes important differences in salary for similar jobs.

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

The matter of the flexibility of the programmes concerns mainly one question: that of slots allocated to the hospital by the contracts and which determine the number of people that can

⁴⁴ People Living With HIV/AIDS.

be included in the programme (CRS) as objective to be achieved over a specific period: these are difficult to negotiate, because they are dependent on the available budget.

This capacity of the hospital to respond to the need of care of the population depends in an initial stage on the budget effectively awarded to CRS. The slots of SJH have seen a regularly increase since 2005, but in 2007 CRS had to lower its initial subsidy forecasts for the beneficiaries of the region because of a reduction in funds allocated by Washington (and in favour of NUMAT). Although SJH did not have to reduce the number of patients taken on, it had to revise downward the number of additional patients initially foreseen.

This example brings us to the matter of continuity of the programmes. If the donor were to pull out, the state would not be in a position to fill in for the CRS's intervention mode (based on the principle of excellence in the quality of care) in the same manner, because of the cost of a programme (among other reasons).

Overworked staff in facilities swamped with patients tries to convince the patients to turn to the public hospital or other nearby health centres. But generally, the patients boycott these facilities because they have a dodgy reputation.

PERIPHERAL LEVEL: KABAROLE HOSPITAL, FORT-PORTAL



Kabarole Hospital: view of the HIV Clinic and the voluntary counseling & testing centre
(Source: www.kabarolehospitalmission.org)

Kabarole was identified thanks to an initiative of CRS. In 2004, a survey by questionnaire was carried out among the care facilities of the Protestant network, with the help of and via UPMB. It was on this base and after some field visits that KH was selected. A first contract was signed in July 2005 between CRS and the Diocese for the set up of an ART treatment programme and the organisation of community activities (voluntary screening and care).

As in the case of Kitgum, the contract follows a standardized model with some slight modifications, sent to the diocese and the state: no real negotiations took place, the contract was pretty much signed in the form it was presented. Only the annex (of the programme description, including the budget) authorizes a few amendments if necessary. The contracting process proceeded rather swiftly and activities could start almost immediately: at the time the patients were already looked after by a support group of the diocese.

Kitgum's only contract is the one signed with CRS for the AIDSRelief programme. We can refer here to the analysis of the CRS contract with SJH, as the documents are very similar. One major difference however is the involvement of the bishop. He is a signatory of the contract and designated by the contract as the authority in charge, respecting in this way the legal status of the hospital. In Kabarole the AIDSRelief programme does not only cover the treatment of the

patients but includes a community prevention component, palliative care (all patients) and voluntary screening (for non TB patients only).

The contracting instruments for KH are the same as those for SJH. They include the contracting document and the different manuals provided by the donor to carry out the activities, the training available, the technical supervisions of the CRS focal points, the financial supervision, the participation every three months in the *Local Partners Forum* in Kampala where representatives of the 18 programme sites get together, the proximity of and access to the local managers at the regional CRS office in Fort Portal, day to day communication by telephone or email and the technical and financial reporting requirements (with the drafting of specific reports).

The situation in Kabarole district is different from the situation in the Kitgum: our analysis shows that there are also discernible differences in the degree of involvement of public actors and their perception of the partnership experiences between the PEPFAR recipients and the faith-based hospitals. There are three hospitals in the town of Fort Portal, capital of the District, two faith-based facilities and one regional hospital (Buhinga). There is no district hospital, so the referral/counter-referral system is based in the regional hospital. Unlike in Kitgum, the public hospital here is an operational facility with a strong reputation; attendance rates are high. The confessional hospitals, for their part, also attract many patients.

The three facilities live together in relative harmony although the functioning of the referral/counter-referral system leaves a lot to be desired. Indeed, somehow many more patients tend to be referred to the regional hospital. The HR crisis in the two confessional facilities (Catholic and Protestant), and acknowledged by the public actors⁴⁵ would explain this phenomenon. The fact that PEPFAR settled in the district is important and there are three main organisations involved: JCRC⁴⁶, EGPAF⁴⁷ and CRS. A large number of public facilities benefit in one way or another from this support. In this sense, the information disseminated by the District on these initiatives seems a lot better than in Kitgum. Finally, the technical managers of the District (DMO, HIV Focal point) display a real willingness to cooperate and coordinate with other actors: substantial efforts are made towards integration of private⁴⁸ facilities in the district and information is gathered with inputs from various actors.

As a beneficiary, the public sector is also invited to participate in the meetings organised by the donors. The collaboration conditions are in principle therefore better guaranteed than in Kitgum, even if the ability of the district to boost the partnership remains limited due to lack of resources. In Kabarole, the donors are for example required to present their projects to the district before implementing them on site. An annual action plan (that establishes the priorities for a local intervention) has to be presented and approved by the district authorities. This is after an agreement (MoU) is signed between the donor and the local government. The funds are paid directly to the faith-based facilities without passing through the district.

In general, the district health authorities feel that the PEPFAR activities are set up with their full involvement, in fact they could almost claim that PEPFAR operates in their name. There are some slight nuances however about the degree of synergy reached according to the organisations. An annual district conference forms the occasion to collect the budgets of the different partners. In addition, there are more informal exchange opportunities but according to the district it is really the central level which is the place to discuss issues like for example the respect for the National Health Policy.

The funds allocated to the public sector are managed according to the procedures of the donors, and often go against central government regulations⁴⁹. The active involvement of the

⁴⁵ Chief Medical Officer of the regional hospital.

⁴⁶ Joint Clinical Research Centre.

⁴⁷ Elizabeth Glazer Paediatric Foundation.

⁴⁸ The current DMO restored the systematic signing of agreements with health facilities (hospitals, health centres) which benefit from government support.

⁴⁹ Each donor requires the opening of a specific account to transfer its funds, while the government pleads in favour of only one account.

district authorities in the implementation stage of the projects leaves a lot to be desired: not only do they play no role in the supervision of the projects but up to now they also did not have the means of exercising this prerogative.

There are also some reservations about the partial involvement of health staff of the programme facilities: this practice leads to unequal treatment of staff in the same institution, to demotivation of staff that is not integrated and might lead in the longer term to a discontinuation of the programmes. The district of Kabarole seems to have obtained that the donors respect the salary scales of the public servants.

Overall, PEPFAR programmes are considered to play a positive role in the district, especially as their funds permit the implantation of activities that the government is unable to set up. One does not make a distinction here between PEPFAR and other initiatives such as those of the Global Fund. This shows that the programmes are so well integrated that the local government does not feel bypassed and that the interventions are seen as complementing those of the public sector; the programmes contribute moreover to the generation of health data which are communicated to the Ministry of Health; they allow to partially compensate for the HR losses of faith-based facilities thanks to secondments and the take over by the donor of some health staff which can then be used more flexibly. The list of priorities that could be improved includes the continuity of the programmes, the implementation of fall-back strategies and more flexibility in the funds awarded⁵⁰, furthermore harmonization of procedures and complete and full information.

We observed some interesting differences in the perception of the faith-based sector in Kabarole as compared to Kitgum. Although the recipients' analysis is positive in general, they tend nevertheless to be more critical than their counterparts in Kitgum. It is clear however that the CRS programme in Kabarole is set up in a very different context than the one of SJH. The hospital was only recently taken over by the diocese and is still recovering from some difficult times in which it lost quite some credit with the patients⁵¹. It has to work next to two other fully operational hospitals in its direct neighbourhood. The hospital has limited means, and these are mainly provided by user fees and state subsidies. Infrastructure is limited and the total capacity (70 beds) is far smaller than in the case of SJH. HR are few and there is a high turnover as a result of the low attractiveness of the salaries in comparison to the public sector.

In spite of the unfavourable conditions and high demands of the programme, KH has been able to obtain each year a renewal of its contract with CRS since 2005 and it saw the funds and slots allocated increase progressively during this same period. The programme staff represents 21% of the total KH staff. The advantages identified are largely similar to those mentioned by Kitgum. They are first of all: the opportunity offered by the programme to take care of the population in the fight against HIV/AIDS in an area where the prevalence rate is about twice as high as the national average⁵².

Secondly, the quality of the support in terms of monitoring: the staff working on the programme is trained systematically and training is also offered to hospital departments which have an important support role for the programme⁵³. CRS carries out regular (financial and technical) supervisions. Reporting requirements have allowed the staff to develop their analytic skills, to anticipate and manage and the skill to identify and collect data which they can also use for the general activities in the hospital. However, the rather inflexible attitude of the donor leads to the same worries in KH as in SJH but these are voiced more strongly and confront the hospital with the limitations of its bargaining power.

These shortcomings show also the differences in interpretation of some of the problems encountered. CRS does not accept to pay the hospital costs of patients in care; the hospital

⁵⁰ There is a conflict between the priorities of the donors and those of the recipients; restrictions imposed on expenses for infrastructures, obligatory use of specific suppliers.

⁵¹ The "private" episode of KH has tarnished its reputation in terms of access and quality of care.

⁵² 11,6 against 6,2

⁵³ CMO and administrator, clinical staff, financial unit, laboratory, pharmacy and warehouse.

considers this an aberration in view of the limited resources of the population. Generally speaking, the rules of the contract are considered as far removed from the realities in the field. Another issue which cannot be discussed with the donor is the requirement to justify the working time of each employee. If the employee works (far) more than the 40 hours foreseen, it is left to the hospital to decide whether or not it has the means to pay for this supplementary work, as overtime is not paid by the donor.

The question of salary scales remains difficult to resolve. Other participants mention an important salary gap between the salary of hospital and programme staff; this tends to lead to a perception of the HIV clinic as a structure 'segregated' or separate from the hospital. Another issue is the potential development of double quality standards that set the programme activities apart from general activities. The staff fully realizes that there are major differences resulting from the disproportion in available funds. This problem will be gradually resolved as new appointments allow filling the gaps initially created by the secondment of qualified staff to the programme. These new recruitments are however carried out at the expense of the diocese, thus somewhat balancing out the decrease in costs brought about by the payment by CRS of part of the programme staff's salaries.

The share of the allocated funds and the dependence of KH on only one donor raise the question of the continuity of the project. The recent guarantee ensures the theoretical continuation (just like in the case of Kitgum) of the programme for another five years. Besides, CRS makes the hospital a partner in looking for alternative solutions⁵⁴. The level of support provided and the standards applied to the quality of care⁵⁵ by the programme reinforce these difficulties and lead to a wide discrepancy with the standards used at national level: the Ugandan state is unable, due to a lack of resources, to adopt the same principles⁵⁶.

Generally, the introduction and quality of services have led to an increase in attendance rates as the standing of the facility with the patients improved. Staff numbers have more than doubled. It is however difficult to say what role the programme has played in these trends: the take over of the hospital by the diocese played a positive role as well. Nevertheless, this positive effect is accompanied by some tensions since the level of activity exceeds the capacity of the infrastructure. The important mobilization of personnel by the programme, the volatility of the staff employed for the general activities and the difficulties in recruitment contribute furthermore to an increase in the workload. It is clear that this situation can in the long term only have a negative influence on the quality of services.

The strict character of the allocated slots and the refusal to provide treatment to some patients who tested positive give the hospital a bad name: a relative drop in attendance of the screening centre seems to confirm this trend. The problem appears more crucial since the number of PLHIV continues to increase in a district that already has a high prevalence rate.

Overall, the medium-term prospects and situation of the hospital seem fragile, unless new financing sources are found. It will become more and more difficult for KH to continue to subsidize user fees in the absence of a substantial improvement in the participation of the state. The recruitment crisis - without solution currently - adds to the vulnerability of the facility. The search for structural solutions appears therefore essential.

⁵⁴ In 2008, the programme financed a consultancy mission with the intention to find possible alternatives.

⁵⁵ Branded medicines of which the cost was too high for the great majority of patients if they had to pay for these themselves.

⁵⁶ The problem is mainly the start-up criteria (viral load) of the treatment for the people living with HIV-AIDS.

Conclusion

The analysis of the contracting relationships that exist in the context of the PEPFAR programmes does not completely confirm the negative a priori perception that surrounds these set ups: the important differences in perception between the central and peripheral level show at the very least that a more nuanced analysis is necessary. The comparison between KH and SJH shows that although there are definitely risks hidden in the existing contracts, their importance largely depends on factors that have no absolute link with the nature of the PEPFAR contracts nor with the approach that characterizes them:

- The “solidity” and importance of the benefiting structure;
- The type of previous experiences; The negotiation ability of the people in charge and their grasp and command of the contracting process;
- The degree and quality of the implication of the legal owner;
- The availability of alternative sources of finance;
- The flexibility of the structure, in particular in terms of infrastructure;
- The capacity of the local government.

The differences in perception, understanding and knowledge of the system are proof of the dysfunction of the communication mechanisms that exist between the central and peripheral level. This can be directly attributed to the decentralised health system. The compartmentalization and fragmentation of the different intervention levels make clear that the decentralization process was never fully implemented. Besides, the different PEPFAR programmes can not all be considered completely equivalent: the system is characterized in fact by multiple intervention mechanisms. The way of operating of programmes such as UPHOLD, CRS and TASO shows important differences:

- in their degree of cooperation with the local authorities;
- in their degree of flexibility;
- in their degree of involvement of beneficiaries in the definition of the objectives;
- in their knowledge and understanding of the local situation.

Furthermore the arrangements proposed include potentially important benefits for the structures that have to implement them:

- The acquisition of general monitoring skills;
- The skills acquired lead to a change in professional culture which could well have a positive influence on the management of the general activities of the facility;
- The quality of the health information system set up is bound to increase the credibility of the structure and provides extra arguments when lobbying with donors for new resources;
- The set up of (new) activities seems to attract more patients and will thus also increase general attendance rates of the hospitals;
- A certain degree of security due to the predictability of the arrangements.

A few risks remain however; they are specifically linked to the nature of the politics governing the programmes, the importance of the programme priorities and the “power” that the sheer amount of the provided funds grants to the donor:

- The weight of PEPFAR’s contribution to the prevention of HIV-AIDS in Uganda results in the central authorities allowing the development of autonomous strategies that are largely dominated by the priorities of the donor; this is even more the case for the peripheral level;

- The legal framework of the agreements is decided outside the country they are implemented in, and is not negotiable. It considerably reduces the bargaining power and influence of the field actors;
- The extreme fragmentation of the system, its complexity and lack of transparency of its organs make it difficult to get an overall picture. Both the actors of the faith-based and the public sector testify that their knowledge and understanding of the situation is incomplete;
- The policy of excellence preached and practiced by the programmes leads to the creation of double standards in terms of norms, costs, and quality;
- The low reproducibility of the systems results in the problem of sustainability, all the more crucial as the programme is mostly short and medium term whereas the nature of the activities is often long term.

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

Finally, the relative success of the contracting arrangements with PEPFAR on peripheral level could well bode ill for the already uncertain future of the partnership between the MOH and the faith-based sector in Uganda. The worsening human and financial resources crises and the absence of a real response from the public sector are likely to undermine the basis for a continued partnership: they could well induce faith-based facilities to progressively shed the partnership project pursued at the central level by UCMB and UPMB, and might lead to a multiplication of direct relations with the donors instead. Indeed, the latter offer instant and operational solutions to the immediate survival needs of the facility. If they can deliver what they promise, this might prove to be the more tempting option.

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: UGANDA

Table 1. Synoptic grid of the results

GENERAL CONTEXT (national)	
Context	<ul style="list-style-type: none"> - The partnership and contracting process between the MOH and the Church is frozen since 2003. - The faith-based sector is faced with a financial and human (resources) crisis. - Difficulties at the Ministry of Health (MOH) and a limitation of the health budget. - Large but ever growing PEPFAR financing of activities related to HIV-AIDS prevention since 2004. Limited PEPFAR visibility on central level. - The relations between PEPFAR and the faith-based sector bypass the health platforms.
Contracting Process	<ul style="list-style-type: none"> - Not applicable for PEPFAR: the contracting process happens on peripheral level, relations are set up directly with the operational actors in the district.
Objectives/ Motivations	<ul style="list-style-type: none"> - The faith-based sector wants a formalized relationship with the Ministry of Health as a survival strategy. - At PEPFAR level, there is no national partnership as such outside the general agreement signed with other State authorities: the partnership and contracting process is concentrated on operational level (district).
National framework of the relationship	<ul style="list-style-type: none"> - The general agreement protocol between PEPFAR and the central public authorities is not accessible and the public actors at MOH level do not know its content. - There is no framework agreement between the MOH or the faith-based sector and PEPFAR or its recipients.
Tools	<ul style="list-style-type: none"> - There are no tools on national level. The PEPFAR Board does not seem to participate in improving the MOH information and the faith-based platforms about the on-going activities.
Perception	<ul style="list-style-type: none"> - The MOH and the Church leaders distrust the PEPFAR programme because they feel bypassed. The opaqueness of the system and the lack of communication reinforce this feeling. This situation reduces the management and planning opportunities of the MOH. - With the exception of <i>Catholic Relief Services</i> (CRS), the PEPFAR recipients we interviewed do not recognize the role of the faith-based health platforms and talk mainly with the <i>Inter Religious Coordination Unit</i> (IRCU). The role of IRCU (ecumenical organ) in the PEPFAR programme is questioned by the faith-based platforms. In fact there is no communication between IRCU and these platforms about the activities that are implemented -The religious actors worry about the effects of the programmes on the facilities, more particularly in terms of a distortion of activities.

SPECIFIC CONTEXT: case-studies		
	St Joseph Hospital (SJH)	Kabarole Hospital (KH)
Context	<ul style="list-style-type: none"> - SJH is located in an area which has known 20 years of civil war. It is near a public district hospital but fulfils in fact the role of referral facility, attracting patients from the district and beyond. - The area attracted a large number of donors which currently are leaving because of the political stability. - As the area is not very attractive, the quantity and quality of public staff ensues. This is shown by the difficulties of health institutions (district hospital, district management team). 	<ul style="list-style-type: none"> - The hospital is quite old and has known many ups and downs. At the moment it is being renovated. It is the smallest of three facilities (public, Catholic) all situated near one another. - This is a relatively dynamic district
Contracting Process	<ul style="list-style-type: none"> - The identification of the facilities was an initiative of the donor. The selection was made on the basis of their pre-existing and proven ability; in both cases it rests on the identification of the skills to fulfil the task assigned to them. - The contracting approach varies according to the type of PEPFAR recipient involved, mostly bypasses the district authorities on an operational plan. Nevertheless in the case of Kabarole, the district and public hospital keep up relations with some of the recipients - The contracts are mostly prepared in advance and leave very little room for initiative by the beneficiary facilities: the negotiation phase is as good as non-existent. - The diocese, owner of the facilities, is not necessarily involved, not even in the signing of the contracting documents. The target interlocutor is not the legal authority but a skilled operational body. 	
Objectives/ Motivations	<ul style="list-style-type: none"> - The common objective for the different contracts is the set up of targeted activities for the fight against HIV-AIDS. The PEPFAR recipients pinpoint the facilities best equipped to carry out the programmes within the timing and with respect of the objectives set out. - The involvement of the faith-based facilities in the contracts stems from a concern for treatment of PLHIV. This response is not provided by the State (or only with poor quality guarantees); there is no alternative for the PEPFAR proposals and their scope. - The objectives of the two parties are therefore well targeted. 	
Framework of the relationship	<ul style="list-style-type: none"> - SJH has 3 'PEPFAR' contracts: Two are signed with international partners (CRS, UPHOLD), one with a local organisation (TASO) - In this particular context, the owner (bishop) has not signed the document 	<ul style="list-style-type: none"> - KH has only one contract, with CRS - The bishop has signed the contract.
	<ul style="list-style-type: none"> - With the exception of the TASO contract, all contracts signed are standard contracts and the only issues that are negotiable are the amounts allocated and the nature of the beneficiary structure. The budget detail and the timeframe of the activities are mentioned in a work plan that is specific to the structure. These contracts, American in origin, are only partly adapted to the specific setting where they are implemented and are difficult to access for these kinds of actors. - An important place is given here to the steering of the relationship and the means for monitoring 	
Tools	<ul style="list-style-type: none"> - The tools are provided by a strict framework of preliminary and continued training, audits and external supervisions as well as reporting requirement for the beneficiary structured. - The level of definition of the obligations is very high and their monitoring strictly set out and respected. There is no participation of the district in this and the lessons learnt by all this are not communicated to them 	

<p>Perception</p>	<ul style="list-style-type: none"> - The beneficiary facilities have an overall positive view of the contracting relations with PEPFAR, which are far different from the ones they keep with their overarching platforms. They are not aware that the latter are often excluded from these contracts. and are not in the loop - The potential adverse effects of the contracts, linked to their focalisation and the importance of the resources at stake, are not denied but largely tempered by the benefits that come with these contracts. - The district authorities have a pragmatic approach in this. They tend to approve the initiatives which are beneficial for the district in as far as these contribute to an improvement in the HIV-AIDS care. - It is clear however that the district only has a fragmented knowledge of the programmes that are implemented in non-government settings, and they do actively approach the donors and beneficiaries to remedy this situation. They are not aware that the MOH is not involved at central level.
<p>SCOPE</p>	
<p>Effects, quality</p>	<ul style="list-style-type: none"> - The contracts achieve their targets thanks to the means (monitoring, evaluation, and accompaniment) in force. - They have important side effects which are linked to the amount of funds put in; the package of measures for monitoring and evaluation; the focus of the activities and the strict nature of the contracts; the important input of skilled human resources required to achieve the targets. - The negative effects are: <ul style="list-style-type: none"> i) the development of double standards in the facility and the district which causes problems for the integration of the hospitals in the local health system but also for the units and staff that care for HIV-AIDS patients within these facilities ; ii) a very substantial financial dependence from external sources ; iii) a mobilisation of qualified hospital staff in a setting with a chronic shortage of skilled HR for the routine activities of the hospital ; iv) the resulting increase in the administrative workload caused by the monitoring and evaluation activities; v) the lack of flexibility in the use of the funds; - The positive effects lie, besides the set up of a system of HIV-AIDS care, especially in the positive general impact of the contracts on the beneficiary structures: <ul style="list-style-type: none"> i) in terms of training for some members staff ; ii) development of analytical, anticipation and management skills which can also be used for the routine activities of the hospital; iii) appeal for the population ; iv) improvement of credit worthiness of the facilities with other potential donors
<p>Level of awareness and information</p>	<ul style="list-style-type: none"> - The State (MOH) and the Church are badly informed about PEPFAR and know almost nothing about the contracting relations that exist on peripheral level. - This is explained by 3 factors: <ul style="list-style-type: none"> i) The specific approach and opaqueness of the PEPFAR system; ii) A lack of leadership at the MOH ; iii) The fragmentation of the contracting experiences (bilateral relations) whereby information is withheld from the beneficiaries even; - The peripheral level only has scant information, mainly focused on its specific experience. There is no participation of the district health authorities in the relationship we investigated.
<p>Future of the contracting relationship</p>	<ul style="list-style-type: none"> - The beneficiary facilities want the relationship to continue, especially with contracts which cover treatment. They would however prefer greater flexibility. They are aware of the major risk which a breakdown of the contracts would have on the continuation of the ongoing activities. In this context, the MOH is never seen as a viable alternative. At the moment the continuity of the biggest contract is ensured medium term.

Table 2. SWOT Analysis of the case studies

STRENGTHS	<ul style="list-style-type: none"> - Dynamic religious and professional platforms - Substantial financial PEPFAR means - The efficiency of the programmes implemented at peripheral level in achieving their objectives - Excellent monitoring and evaluation mechanisms - The ability of the programmes to get their staff interested and committed
WEAKNESSES	<ul style="list-style-type: none"> - The absence of a partnership and contracting relationship between the MOH and the Church. - The MOH and the Church at central level are not involved. - The selection of an ecumenical interlocutor at central level who is legitimized by the faith-based platforms. - The information disseminated by the faith-based sector at public level (and in particular through reports) does not reach the central level. It is proof and symptom of the dysfunction of the health decentralization. - The burden the PEPFAR contracts impose on the facilities in terms of workload and input of skilled staff. - The inflexible and largely foreign nature of the contracts. - The development of double standards in the hospitals and more widely in the district health system: means, methods, quality of care.
OPPORTUNITIES	<ul style="list-style-type: none"> - Positive contamination effect of the contracts on the general activities of the hospital: change of the professional culture, development of the skills of the staff; get legitimacy (HIS) with new donors.
THREATS	<ul style="list-style-type: none"> - The risk of a distortion of hospital activities to the detriment of routine tasks. - Tendency of some beneficiary facilities to not communicate with their main platforms about the contracts signed with PEPFAR and other important donors. - The effect of a comparison at peripheral level between the PEPFAR contracts and the difficulties encountered in the relationship with the MOH can worsen the detachment of the hospitals from the partnership and contracting projects of the faith-based platforms.

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 efforts⁵⁷ 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

⁵⁷ Definition of specific policies: set up of formalized cooperation frameworks; development of partnership for a.

planned⁵⁸ 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 experiences⁵⁹ 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

⁵⁸ Steering committees, in particular when they exist.

⁵⁹ 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 sector⁶⁰ 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 experiences⁶¹ 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 actors⁶² 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 public⁶³. In addition, collaboration with local academic institutions⁶⁴ 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-Med⁶⁵ 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 platforms⁶⁶. 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

⁶⁰ And more extensively, the private not for profit sector.

⁶¹ Tanzania, in the 70s.

⁶² At different levels of the hierarchy.

⁶³ Public and private decision makers, operational actors, national coordination facilities and external support, researchers.

⁶⁴ 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.

⁶⁵ cf. www.essentialdrugs.org

⁶⁶ 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: Uganda

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

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

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

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

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.

Bibliography

GENERAL BIBLIOGRAPHY

Methodology

- Pawson R & Tilley N (1997) Realistic evaluation. Sage Publications.
- Yin RK (2003) Case study research. Design and methods. 3rd edition. *Applied Social Research Methods Series 5*, Sage Publications.
- Ritchie J & Lewis J (2003) Qualitative research practice. A guide for social science students and researchers. Sage Publications.
- Patton MQ (2002) Qualitative research & evaluation methods. 3rd edition. Sage Publications.
- Center for Global Development (2006) When will we ever learn? Improving lives through impact evaluation. Report of the Evaluation Working Group. Washington DC: Center for Global Development.
- Castaño R, Bitran R & Giedion U (2004) Monitoring and Evaluating Hospital. Autonomization and its effects on Priority Health Services. Bethesda, MD: Partners for Health Reformplus project, Abt Associates Inc.
- Hutchinson PL & Lafond AK (2004) Monitoring and evaluation of decentralization reforms in developing country health sectors. Bethesda, MD: Partner for Health Reformplus Project, Abt Associates Inc.
- Liu X, Hotchkiss D, Bose S, Bitran R & Giedion U (2004) Contracting for Primary Health services: Evidence on its effects and framework for evaluation. Bethesda, MD: Partners for health Reformplus Project, Abt Associates Inc.

Contracting, general

- Perrot J (2004) The role of contracting in improving health systems performance, Discussion Paper N° 1, WHO, Geneva, EIP/FER/DP.E.04.1
- Perrot J & de Roodenbeke E (éds), La contractualisation dans les systèmes de santé. Pour une utilisation efficace et appropriée, *Karthala*, Paris, 2005.
- Liu X *et al.* (2006) The impact of contracting-out on health system performance: A conceptual framework. *Health policy* (doi: 10.1016/j.healthpol.2006.09.012).
- ECSA Health Community. Achieving health goals by paying for performance. A brief on Performance Based Financing (PBF). USAID, ECSA, Health Systems 2020.
- Hecht R, Batson A & Brenzel L (2004) Making health care accountable: Why performance-based funding of health services in developing countries is getting more attention. *Finance & Development*, 16-19.
- Perrot J & de Roodenbeke E. Les hôpitaux et la contractualisation (trouvé sur site "la politique hospitalière & le financement de l'hôpital en Afrique" WB, MAE Fr, GDLN, <http://info.worldbank.org/etools/docs/library/233097/Reform%20Hospitaliere/start.htm>)
- McPake B & Ngalanda Banda EE (1994) Contracting out of health services in developing countries. *Health Policy and Planning* 9(1), 25-30.
- Perrot J (2007) Une politique de contractualisation: guide pour son élaboration et son suivi, OMS, HSF, HSS, Discussion paper 2, pp 64.
- World Health Organization (2003) The role of contractual arrangements in improving health systems' performance, WHA56.25, 28 May.
- Kumaranayake L (1998) Economic Aspects of Health Sector Regulation: Strategic Choices for Low and Middle Income Countries, Ed: Departmental Publication N° 29, London: London School of Hygiene and Tropical Medicine.

- Green A, Shaw J, Dimmock F & Conn C (2002). A shared mission? Changing relationships between government and church health services in Africa. *International Journal of Health Planning and Management* 17, 333-53.
- Carrin G, Perrot J & Sergent F (1997) The contractual approach: new partnerships for health in developing countries; technical document, World Health Organization (WHO), Division of Intensified Cooperation with Countries in Greatest Need (ICO), Geneva, pp: 63, Macroeconomics Health and Development Series 24; WHO/ICO/MESD-24.
- Palmer N, Strong L, Wali A & Sondorp E (2006) Contracting out health services in fragile states. *British Medical Journal* 332(7543), 718-721.
- Mills A, Hongoro C & Broomberg J (1997) Improving the efficiency of district hospitals: is contracting an option? *Tropical Medicine and International Health* 2, 116-126.
- Van Balen H (1999) Un contrat pour la santé. Contracting NGOs for health. Report of the MMI technical meeting, during the 52nd World Health Assembly, Geneva, May 1999. Medicus Mundi International, Brussels, 7-10.
- Perrot J, Mathonnat J & Tangcharoensathien V (2006) Round table: Contracting and health services. *Bulletin of the World Health Organisation* 84(11), 910-13.
- Bennett S, Hanson K, Kadama P & Montagu D (2005) Working with the non-state sector to achieve public health goals, World Health Organisation (WHO), Geneva, pp: 18, Making Health Systems Work. Working Papers 2.
- Broomberg J, Masobe P & Mills A (1997) To purchase or to provide? The relative efficiency of contracting out versus direct public provision of hospital services in South Africa. In: Bennett S, McPake B & Mills A [ed.]. Private health providers in developing countries; serving the public interest? London and New Jersey, Zed Books, 214-36.
- Siddiqi S (2005) Regional Consultative Meeting on the Role of Contracting in Improving Health System Performance. Contracting out publicly financed health services, 18-20/04/2005, Cairo (ppt).
- Preker AS, Liu X & Velenyi EV (2007) Public Ends, Private Means: Strategic Purchasing of Health Services, (Dir), *World Bank Publications*, pp 436.
- Contracting and Health Services (2006). Special theme issue. *Bulletin of the World Health Organization* 84(11).
- Heinbuch SE (1996) Achieving effective service-contracting results: the process is the key to success. *International Journal of Health Care Quality Assurance* 9(3), 32-41.
- Vining AR & Globberman S (1999) Contracting-out health care services: a conceptual framework. *Health Policy* 46(2), 77-96.
- Mills A, Hongoro C & Broomberg J (1997). Improving the efficiency of district hospitals: is contracting an option? *Tropical Medicine and International Health* 2(2), 116-26.
- Bodart C & Schmidt-Ehry B (1999) The contractual approach as a tool for the implementation of national public health policy in Africa;GTZ,Eschborn.

Contracting, public & faith-based sectors

- Verhallen M & Criel B (2000) Experiences of Sub-Saharan African Countries with Contracting between Government and Private, Not for Profit, Health Care Providers; Contribution to the CAPUBPRIV Study steered by the School of public Health of the Free University of Brussels (ULB), Belgium, Institute of Tropical Medicine, Antwerp, Belgium.
- Gruénais ME (2004) Les qualités de l'offre de soins confessionnelle en Afrique subsaharienne. *Autrepart* 29, 29-46.
- Palmer N (2000) The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries. *Bulletin of the WHO* 78(6).
- CERAO, CEB, AMCES, MMI, Conférence de Cotonou: Le Ministère de la Guérison à l'aube du 3ème millénaire: défis et opportunités, Bénin, 31-05 au 2-06-2005. *Recueil de textes préparatoires* (version provisoire), pp 39, 2005/CERAO, CEB, AMCES, MMI, Pastoral Health Care at the Dawn of the 3rd Millennium. Challenges and Opportunities, Cotonou, Benin, May 31 to June 2, 2005, *Proceedings and Results*, 2005, pp 40.
- Christian Health Association's Conference, Dar es Salaam/Bagamoyo 16th to 18th January 2007: Christian Health Associations at Crossroad towards Achieving Health Millennium Development Goals (MDGs).
- Schulpen TWJ (1976) Integration of church and government services in Tanzania; effects at district levels. *African Medical and Research Foundation*, Nairobi.
- Preker A & Harding AS (2003) Private participation in health services. World Bank, Washington.
- Mills A & Broomberg J (1998) Experiences of contracting: an overview of the literature. World Health Organization (WHO), Division of Intensified Cooperation with Countries and Peoples in Greatest Need (ICO), Geneva.
- Traore LF (2004) Problematic partnership between the public and the private health sectors at district level in Bamako - Mali., Prince Leopold Institute of Tropical Medicine Antwerpen.
- Lönnroth K, Uplekar M & Blanc L (2006) Hard gains through soft contracts: productive engagement of private providers in tuberculosis control. *Bulletin of the World Health Organisation* 84(11), 876-83.
- Bennett S, Hanson K, Kadama P & Montagu D (2005) Working with the non-state sector to achieve public health goals. World Health Organization, Geneva, pp. 18. Making Health Systems Work Working Papers 2.
- Peters DH, Mirchandani GG & Hansen PM (2004) Strategies for engaging the private sector in sexual and reproductive health: how effective are they? *Health Policy and Planning* 19(Suppl.1), i5-i21.
- Mills A, Bennett S & Russell S (2001) Government purchase of private services. The challenge of health sector reform; what must governments do? Palgrave, Basingstoke, 118-142, Palgrave, Basingstoke. The Role of Government in Adjusting Economies.
- Gilson L, Adusei J, Arhin D, Hongoro C, Mujinja P, Sagoe K, Bennett S, McPake B & Mills A (1997) Should African governments contract out clinical health services to church providers? Private health providers in developing countries; serving the public interest? Zed Books, London. pp 276-302.
- Giusti D (2000) Consequences of the new roles of government for the NGO providers from the perspective of a national coordinating body. *MMI Newsletters* 65, 5-14.
- Giusti D, Criel B & de Béthune X (1997) Viewpoint: Public versus private health care delivery: beyond the slogans. *Health Policy and Planning* 12(3), 193-8.
- England R (2004) Experiences of contracting with the private sector: a selective review, Roger England. London: DFID Health Systems Resource Centre.

- Bhushan I, Keller S & Schwartz B (2002) Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia. Medium-term study on the effects of contracting NGOs and private suppliers to provide primary health care services in Cambodia. Asian Development Bank (ADB).
- WHO (2005) Working with the Private Sector to Achieve Public Health Goals at the Country Level. Draft, 31 March 2005.
http://www.hsnet.org/pubs/6MontreuxPrivatesectortemplate_31Mar2005.pdf
- The "Montreux Challenge": Making Health Systems Work. Glion sur Montreux, Switzerland, 4-6, April 2005.
- Green A, Shaw, J, Dimmock F & Cath Conn (2002) A shared mission? Changing relationships between government and church health services in Africa. *The International Journal of Health Planning and Management* 17 (4), 333-53.

Contracting, Africa

- Palmer N & Mills A (2005) Contracts in the real world: Case studies from Southern Africa. *Social Science and Medicine* 60, 2505-14.
- Gilson L, Adusei J, Arhin D, Hongoro C, Mujinja P, Sagoe K, Bennett S, McPake B & Mills A (1997) Should African governments contract out clinical health services to church providers? Private health providers in developing countries; serving the public interest? Zed Books, London. pp 276-302.
- Bodart C & Schmidt Ehry B (1999) L'approche contractuelle comme outil de mise en oeuvre des politiques nationales de santé en Afrique; information de base et analyse préliminaire de l'expérience GTZ., Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Eschborn.
- Sossou Y, Kousseimou AK & Fanou J (2003) Etude sur l'approche contractuelle dans la gestion du système de santé de zone sanitaire; résumé du rapport. *Medicus Mundi International Newsletter* 70, 4-9.

Contracting, GHI

- http://www.theglobalfund.org/en/files/publications/civilsociety/05_AnEvolvingPartnership_fr.pdf
- USAID (2006). Insight for implementers. Improving Health System Performance through Monitoring and Evaluation, pp 12, PHRplus.

PPP

- Public-private partnerships for public health Results of a workshop examining questions of PPPs in international public health. Authors: M.R. Reich. Publisher: Harvard Center for Population and Development Studies, 2002.

Health systems, Africa, general

- André J, Burke J, Vuylsteke J, Van Balen H, Janssens PG & Kivits M (1997) Evolution of health services [ed.]. Health in Central Africa since 1885; past, present and future. King Baudouin Foundation, Brussels 1, 89-158.
- Amonoo Lartson R, Ebrahim GJ, Lovel HJ & Ranken GJ (1984) District health care; challenges for planning, organisation and evaluation in developing countries, Macmillan, London.
- Bennett S & Ngalande Banda E (1997) Public and private roles in health; a review and analysis of experience in sub-Saharan Africa, World Health Organization (WHO), Division of Analysis, Research and Assessment (ARA), Geneva.
- Mills A, Palmer N, Gilson L, McIntyre D, Schneider H, Sinanovic E, & Wadee H (2004) The performance of different models of primary care provision in Southern Africa. *Social Science and Medicine* 59, 931-43.

- Hamel J & Janssen PW (1988). On an average: the rural hospital in sub-Saharan Africa. *Tropical Doctor* 18, 139-42.
- English M, Lanata CF, Ngugi I & Smith PC (2006) The District Hospital. Disease Control Priorities in Developing Countries (2nd Edition), ed. 1.211-1.228. New York: Oxford University Press. DOI: 10.1596/978-0-821-36179-5/Chpt-65.

Faith-based health sector

- Banda M, Ombaka E, Logez S & Everard M (2006) Multi-country study of medicine supply and distribution activities of faith-based organizations in sub-Saharan African countries. World Health Organization (WHO), Geneva; Ecumenical Pharmaceutical Network, Nairobi.
- Mills A, Brugha R, Hanson K & McPake B (2002) What can be done about the private health sector in low-income countries? *Bulletin of the World Health Organisation* 80, 325-30.
- Hanson K & Berman P (1998) Private Health care provision in developing countries: a preliminary analysis of levels and composition. *Health Policy and Planning* 13(3), 195-211.
- Institute for Health Sector Development. 2004. Private sector participation in health, Report to KfW, Frankfurt am Main. http://www.kfw-entwicklungsbank.de/DE_Home/Fachthemen/Kooperatio17/Privatsekt98/PSP_im_Bereich_Gesundheit.pdf
- Bennet S, McPake B & Mills A (1997) Private health providers in developing countries. London and New Jersey. Zed Books.

CORDAID

- Cordaid Procurement agency, Guide d'application et de vérification de l'approche contractuelle, 2004.

PEPFAR

Thomsen, S K (2007), Responding to PEPFAR - How NGOs navigate aid conditionalities

SPECIFIC BIBLIOGRAPHY

Uganda

- Ssenooba F & Alii (2007) Tracking HIV/AIDS Funding in Uganda. Draft Report, Makerere University School of Public Health.
- Verhallen M (2003) The contractual approach: ways forward for Uganda. Review of memoranda of understanding and service level agreements between Public health authorities and private not for profit facilities, UCMB.
- Fenenga C, de Jager A (2007) Cordaid-IICD Health Programme Uganda; Health Management Information Systems as a tool for organizational development, IICD.
- UCMB, UPMB, UMMB, Facts and figures of the PNFs: knowing and understanding the facility-based PNFP health sub-sector in Uganda. August 2007.
- http://www.interchurch.org/resources/uploads/files/289UCMB-UPMB_UMMB_Profile.doc
- Giusti DG (1995) L'hôpital confessionnel: obstacle ou atout à l'intégration dans le système de santé de district? Le cas de l'hôpital de Matany en Ouganda, Institut de Médecine Tropicale Prince Léopold Antwerpen.

- Meessen B, Van Damme W, Kirunga Tashobya C & Tibouti A (2006) Poverty and user fees for public health care in low-income countries; lessons from Uganda and Cambodia [viewpoint]. *Lancet* 368(9554), 2253-57.
- Barr A & Fafchamps M (2006) A client-community assessment of the NGO sector in Uganda. *The Journal of Development Studies, Taylor and Francis Journals* 42(4), 611-39.
- Mutyaba S (2001) Religious Medical Bureaux in Uganda. *Uganda Health Bulletin* 7(3).
- Religion and Politics in East Africa: The Period since Independence, and: Development and the Church of Uganda: Mission, Myths, and Metaphors, and: African Christianity: Its Public Role (review) *Mediterranean Quarterly* 13(1), 117-22.
- Hansen & Holger B (1984) Mission, Church and State in a Colonial Setting: Uganda 1890-1925. London: Heinemann/New York: St. Martin's Press.
- Jeppsson A (2004) Decentralization And National Health Policy Implementation in Uganda - a Problematic Process. Department of Community Medicine, Malmö University Hospital, Lund University, Sweden.
- Following the Funding for HIV/AIDS
- Oomman N, Bernstein M & Rosenzweig S (2007) A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund and World Bank MAP in Mozambique, Uganda and Zambia. *HIV AIDS Monitor - Centre for Global Development*.
- Adupa RL & Mugerwa CG (2005) Review of the Performance and Contribution of Development Assistance and Major Funding Mechanisms of the National AIDS Response. Kampala, Uganda AIDS Commission, Republic of Uganda.
- Magumba, G, Kironde S *et al.* (2006). UPHOLD CSO-CSO Partnerships: What Makes Them Work? August 2006. Kampala, Uganda UPHOLD, USAID.
- Magumba, G, Kironde S *et al.* (2006) UPHOLD CSO Follow-Up Capacity Report, June 2006. Kampala, Uganda UPHOLD, USAID.
- Adupa RL (2006) Review of development assistance and major funding mechanisms of the National AIDS response. Ppt presentation
www.aidsuganda.org/aids/FUNDING%20MECHANISM%20%20JANUARY%2031%20PRESENTATION.ppt
- Ploem R (2006) AIDS controversies in Uganda further analyzed. Report of the mission to Uganda from 5 until 16 December 2005. KIT, Share-Net, Wemos.
- Omaswa F (2004) GHIs and partnerships. Harmonization for the achievement of health related MDGs. Experience from Uganda. Ppt presentation.