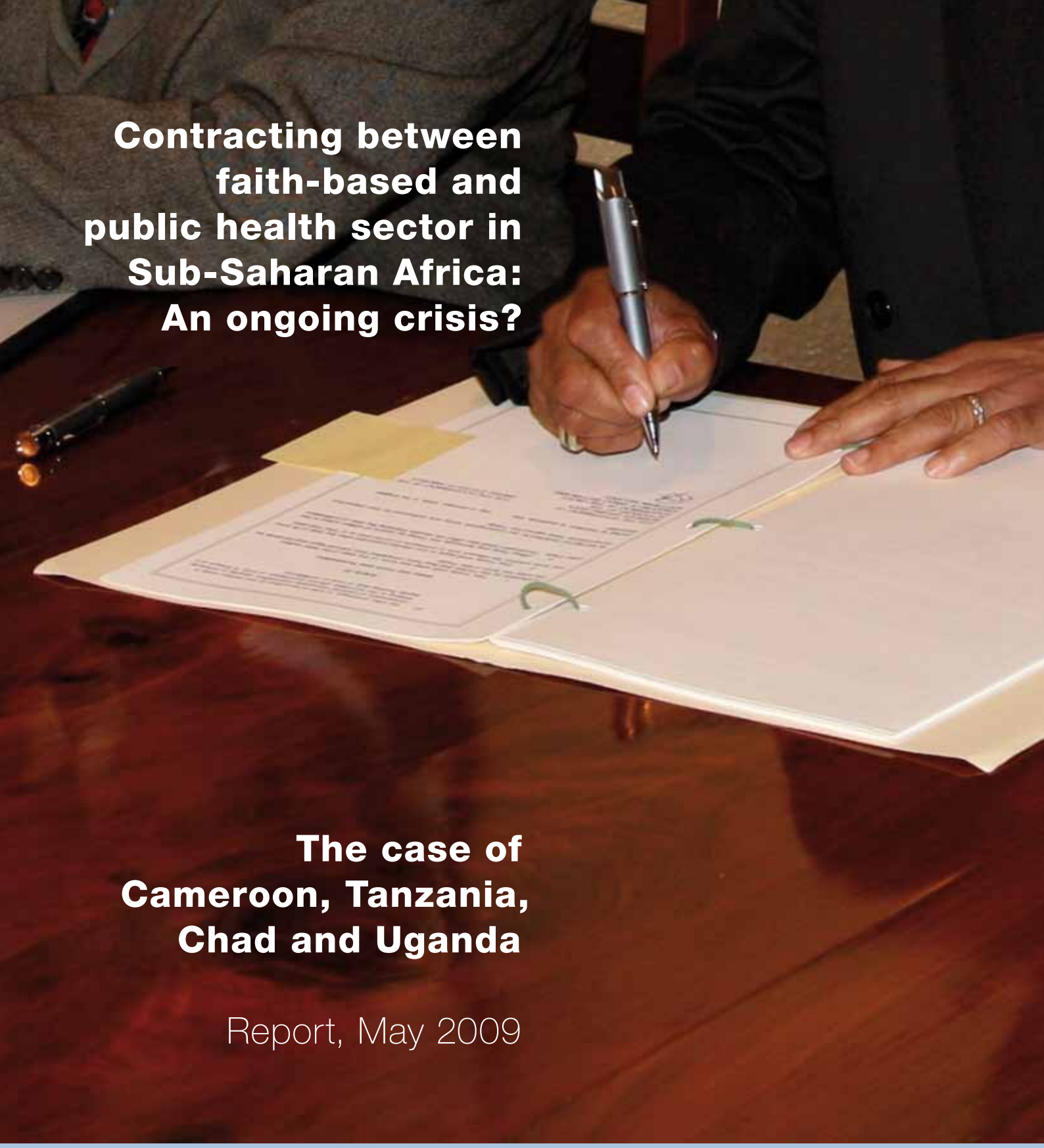

Contracting between faith-based and public health sector in Sub-Saharan Africa: An ongoing crisis?

The case of Cameroon, Tanzania, Chad and Uganda

Report, May 2009

Case study: Tanzania

medicus mundi international network

INSTITUTE OF TROPICAL MEDICINE ANTWERP

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

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Sharing knowhow and joining forces towards Health for All

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List of acronyms

BAKWATA	National Muslim Council of Tanzania
BOG	Board of Governors
CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital
CHMT	Council Health Management Team
CIDR	*Centre International de Développement et de Recherche/* International Centre for Development and Research
CMO	Chief Medical Officer
CSSC	Christian Social Services Committee
CSSC/Z	Christian Social Services Committee/Zonal Coordination Office
DDH	District Designated Hospital
DED	District Executive Director
DMO	District Medical officer
ELCT	Evangelical Lutheran Church of Tanzania
HC	Health Centre
HSSP	Health Sector Strategic Plan
LGO	Local Government
MoH	Ministry of Health
MSD	Medical Stores Department
MSP	Ministère de la Santé Publique
NDDH	Nyakahanga District Designated Hospital
NGO	Non Governmental Organisation
NHP	National Health Policy
NSSF	National Social Security Fund
P4P/ PFP	Pay For Performance
PBF	Performance Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PMORALG	Prime Minister's Office for Regional Administration and Local Government
PNFP	Private Not For Profit
PPP	Public Private Partnership
RMO	Regional medical officer
SWAP	Sector Wide Approach
TCMA	Tanzania Christian Medical Association
TEC	Tanzania Episcopal Conference
TGPSH	Tanzania Germany Program to Support Health
VA	Voluntary Agency
WHO	World Health Organisation

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General introduction

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

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

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

This study looks at the results from three different perspectives:

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

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

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

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

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

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

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

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

Introduction to the country-case report

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

You may therefore wish to refer to the full report to access (1) the Executive Summary, (2) details on research and case-study methodology as well as (3) to the recommandations 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 Basel[1]. Moreover, the MMI website offers the opportunity to access a separate file containing both MMI's foreword as the Executive Summary of the study. The report's annexes are available via the same channel.

[1] See contacts on page 2 of the present document

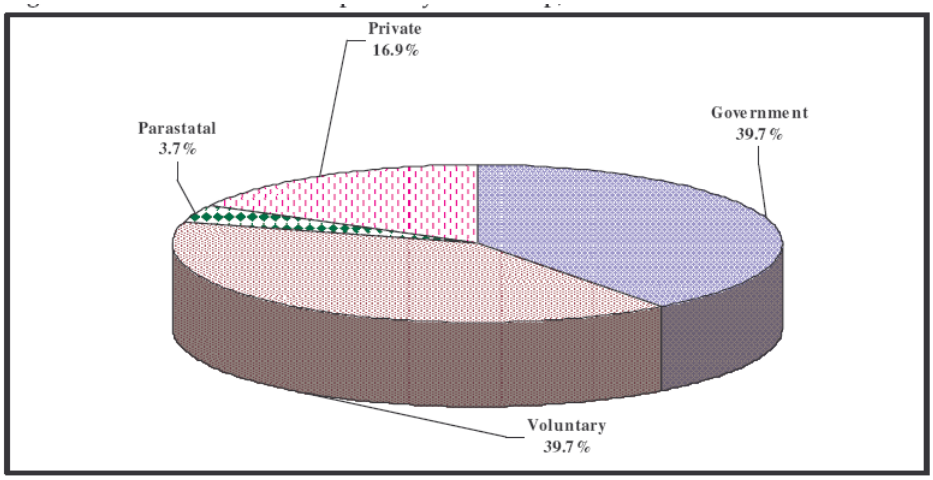
Case-study: Tanzania

General context

PLACE OF THE CHURCH IN THE SUPPLY OF CARE

At the time of independence in 1961, half of the hospitals were run by missionaries. According to most recent statistics, the private not for profit (voluntary) sector - in which the faith-based facilities make up the overwhelming majority - is the second biggest provider of health care in the country. The voluntary sector holds 17,7% of the health infrastructure (against 64,2% for the state), but 39,7% of hospitals, equal to the MOH figure. In total, 41% of hospital beds, according to an official census, belong to faith-based structures. Hence they constitute an indispensable addition to the care provided by the public sector.

Figure 1. Number of hospitals by owner - continental Tanzania 2004-2005 (MOH, ASA 2006)



PARTNERSHIP AND CONTRACTING CONTEXT AT CENTRAL LEVEL[2]

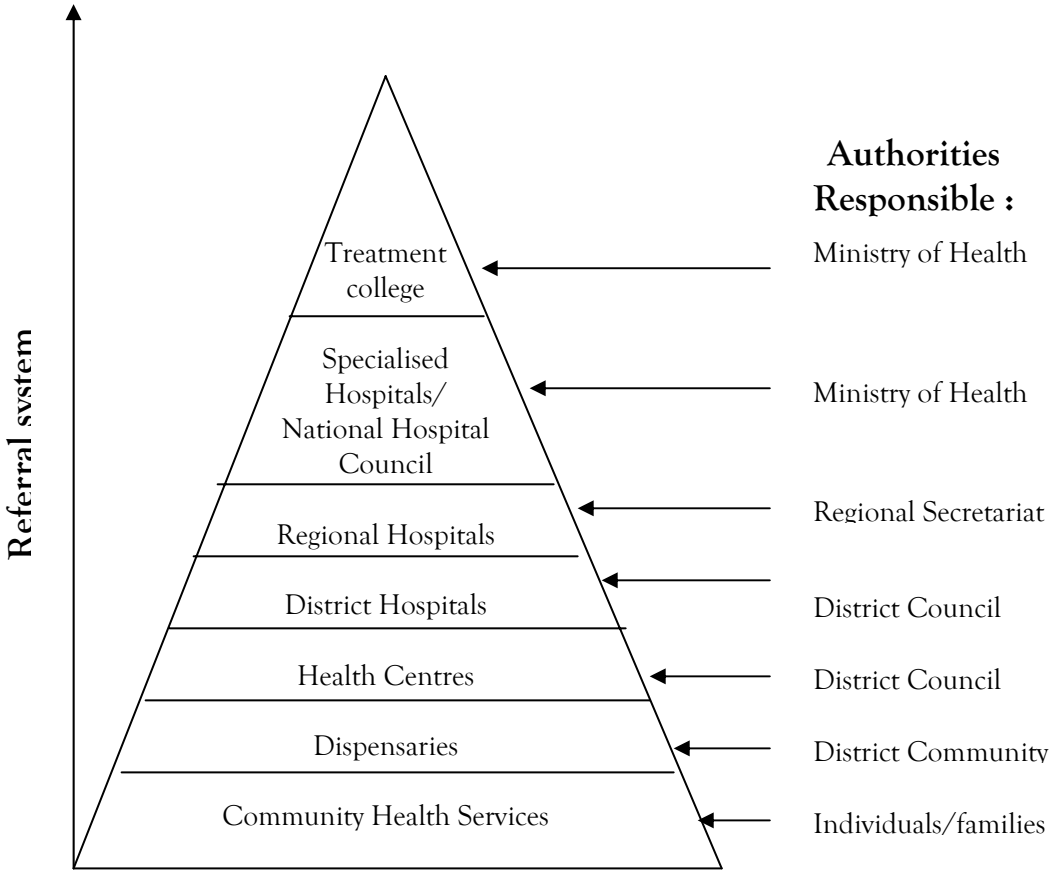
State overtures to the Church started during the colonial period and continued through the active involvement of some of the religious authorities in theorizing on the independence and the recognition of liberation movements. The rapprochement culminated at the time of Independence under Nyerere. The particular interpretation of socialism (Ujamaa) that was typical for Tanzania laid the foundation for a closer relationship while maintaining religious liberties but also reinforcing the control of the state. This system - although creating tensions in the field - marked the origin of the *Tanzanian model* of collaboration between the Church and the State. Today people still have this cooperation model in mind. The validity of this concept is one of the issues treated in the study.

In the health sector the collaboration between the State and the Church rests on a recognition of the crucial role played by the faith-based health facilities (rural, located in enclaves) in covering the territory. This recognition was initially implicit and a result of the adoption of the Principles of primary health care in 1967 by the Arusha Declaration.

[2] Cf. Figure 4.

The process reached a climax in 1972 with the implementation of a decentralized pyramidal health system and a contract model which elevated a number of faith-based hospitals to the rank of District Designated Hospital (DDH).

Figure 2. Organisation of the Tanzanian health system
(Source :MOSW, Tanzania. www.moh.go.tz)



The main objective of the MOH was to compensate for the shortage of public facilities, while at the same time trying to avoid duplication in places where the Church already had hospitals. The Agreement allowed the faith-based facilities to request state funds to cover their current expenditures including the salaries of qualified staff. Only investments and recruitment of staff remained at the owners' expense (diocese, congregation). The first DDHs established a relation with the central authorities (MOH). Sometimes the contract formalizing this relationship was not immediately signed. This was the case for Nyakahanga hospital, described more in detail in this study.

The Churches[3] negotiated in 1992 an agreement (Memorandum of Understanding, MoU) with the new Tanzanian government. The document officially recognized the role played by the Churches in the health sector and established the principle of additional financial support through funds from external financing sources. It also offered protection against future

[3] Protestants of the Christian Council of Tanzania, CCT and the Catholics of the Tanzanian Episcopal Conference, TEC.

nationalization attempts[4]. The MoH approved also the creation of a new social Christian platform, the Catholic Social Services Commission (CSSC). At the same time, the public private partnership concept made its official debut in the health sector: the first National Health Policy (PNS, 1990) introduced the cooperation principle with the private sector, which was then consolidated through the 2003 PNS, the health sector strategy (2003-2008) and the gradual creation of specific bodies (national partnership forum, technical PPP working group and the partnership unit at the MOH).

In recent years new contract models were developed together with private partners:[5]

- In 2005, a revision of the DDH contract model in accordance with the decentralization policy (signed at district level);
- In 2007 a new type of operational contract was finally introduced (Service Agreement, SA). It applies in principle to all health facilities, private and public, delivering public services. This new contract concerns mainly the faith-based facilities (Voluntary Agencies, VA) with the exception of the DDH.

CSSC has begun to decentralize 5 coordination areas, setting up a decentralized system of regional partnership fora. The idea is to implement this also on the district level somewhere in the future. Anyhow, until today Tanzania has no specific documents on partnership policy or on contracting policy.

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

All private not for profit health formations that registered with the MOH[6] are in principle marked on the national health map. Within this group, hospitals benefit from direct state support.

We distinguish three different cases:

- *The Voluntary Agencies (VAs) under which category all accredited faith-based hospitals a priori fall. These VAs have only potentially been involved in the contracting process since 2007 and the creation of service agreements (SA). The latter define a series of operating criteria linked to state benefits dependent on achieving fixed objectives (performance indicators). If there are no SAs, the VAs are only entitled to limited support from the Basket Fund managed by the local government.*
- *The DDH are VAs officially designated (by contract) by the MOH as district referral facilities. DDH benefit simultaneously from 1) a Block Grant of the Ministry of Health and 2) a part of the local Basket Fund.*
- *The faith-based network has also two national referral hospitals[7].*

CHARACTERISTICS OF THE CASE SELECTED

The Tanzanian case study mainly focuses on the example of the Nyakahanga District Designated Hospital (NDDH). NDDH hospital belongs to the Evangelical Lutheran Church of Tanzania (ELCT) and is located in the North West of the country (Lake Victoria) in the Kagera region, in the district of Karagwe, near the small town of Kajanga. The Kagera region is special in Tanzania because faith-based health facilities are in the majority there: 10 out of 13 hospitals (2005) belong to the church. This figure covers the total number of referral centres in the district[8]. Only the Kilimanjaro region shows a comparable distribution, although the "domination" of the church is less outspoken there.

Created in 1912 as a simple first aid post, the hospital Nyakahanga is the only hospital in the district and has operated as a referral centre since 1972, at first in an informal way. The

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

[5] CSSC for the faith-based sector.

[6] Registry of Private Hospitals, MOH.

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

[8] See the table below (distribution of hospitals and HC by region and ownership): we note the distribution of hospitals between the government and VAs over the regions of Kagera and Kilimanjaro.

context (the recent wave of nationalisations and the fear of dispossession by the State) explains why the Church leaders did not show much enthusiasm for entering into a contract. Only in 1992 a contract would be signed between the Diocese of Karagwe and the Ministry of Health after a phase of regular meetings between the Church and the State.

A model contract was signed without amendments or revisions. A climate of understanding and relative harmony between the diocese and the MoH characterizes this period. The positive experience of an informal partnership and the exchanges preceding the signing can explain the shift in the church's position. The basics and the modalities of the contracting relationship have not changed, but the climate has: there is a good basis for trust now. It seems that the Church, anxious to ensure the continuity of the status of NDDH as well as the benefits linked to it, understands the advantage which a legalization of the situation brings.

Side-cases

Two other DDHs - Sengerema and Tosamaganga - have also been studied in order to test the representativeness of the NDDH case and extend the framework of the study. It also seems necessary to present their main characteristics although their contracts were only analysed on the basis of one interview.[9]

The Catholic hospital of Sengerema is located in the Sengerema district and the Mwanza region, near Lake Victoria. The hospital is owned by the Diocese of Geita. The hospital was founded in 1959 by two Dutch[10] congregations and became a district hospital (DDH) in 1976, when the Sengerema district was created. The hospital's contract probably dates from this time, although we were unable to get a copy (the original is with the diocese and the hospital did not have a duplicate). The agreement is a result of the excellent relations which the hospital maintained with the public authorities, both on central and local level.

The role of the congregations in the hospital remains important. The Chief Medical Officer belongs to the Congregation of the sister founders. As the Chief Medical officer is an expatriate, the hospital still benefits from direct links with organizations and individuals in Europe and benefits also from a variety of sources of support[11]. Officially, the hospital has 244 beds, but with the opening of a new maternity ward in 2007 this has increased to 281.

[9] With their respective Chief Medical Officers.
[10] Brothers of Mercy of St. Joannes de Deo and the Sisters of Charity of St. Charles Borromeo.
[11] The most important ones are Cordaid (The Netherlands), Danida (Denmark), Blankendaal Foundation, AMREF and more recently CRS in the framework of the AIDS Relief Programme (PEPFAR).

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

Region	Hospitals					Health Centers				
	Gvt	Vol	Par	Pvt	Total	Gvt	Vol	Par	Pvt	Total
Dodoma	5	2	0	0	7	18	2	0	1	21
Manyara	4	2	0	0	6	4	7	0	0	11
Arusha	3	7	1	1	12	16	5	2	6	29
Kilimanjaro	**5**	**9**	**1**	**3**	**18**	**21**	**4**	**1**	**6**	**32**
Tanga	5	4	0	3	12	18	7	0	0	25
Morogoro	5	4	1	2	12	21	5	3	2	31
Coast	5	1	1	0	7	15	1	0	1	17
Dar es Salaam	4	2	2	19	27	5	7	2	9	23
Lindi	5	3	1	0	9	13	1	0	1	15
Mltwara	4	1	0	0	5	12	2	0	0	14
Ruvuma	3	5	0	0	8	8	3	0	0	11
Iringa	5	6	0	4	15	19	14	1	0	34
Singida	3	6	0	0	9	11	2	0	1	14
Mbeya	6	8	0	2	16	20	7	0	1	28
Tabora	4	3	0	0	7	12	2	0	1	15
Rukwa	2	1	0	0	3	20	8	0	0	28
Kigoma	3	2	0	0	5	13	4	1	0	18
Shinyanga	5	1	1	1	8	23	2	0	1	26
Kagera	**2**	**10**	**0**	**1**	**13**	**17**	**11**	**0**	**2**	**30**
Mwanza	6	6	0	1	13	32	3	0	4	39
Mara	3	4	0	0	7	13	4	0	3	20
Total	**87**	**87**	**8**	**37**	**219**	**331**	**101**	**10**	**39**	**481**

The Catholic hospital of Tosamaganga[12] is located in the Iringa district and region. It has 164 beds and is managed by two female mission congregations under the authority of the Iringa Diocese. Until recently, this facility was run as a simple *voluntary agency*.

As a hospital was lacking in the district, the state granted the Catholic hospital the status of *Council Designated Hospital*[13] (CDH) in July 2007, on the basis of the new contract model developed in 2005. This contract was signed with the local government which makes for an interesting comparison with the situation of Nyakahanga.

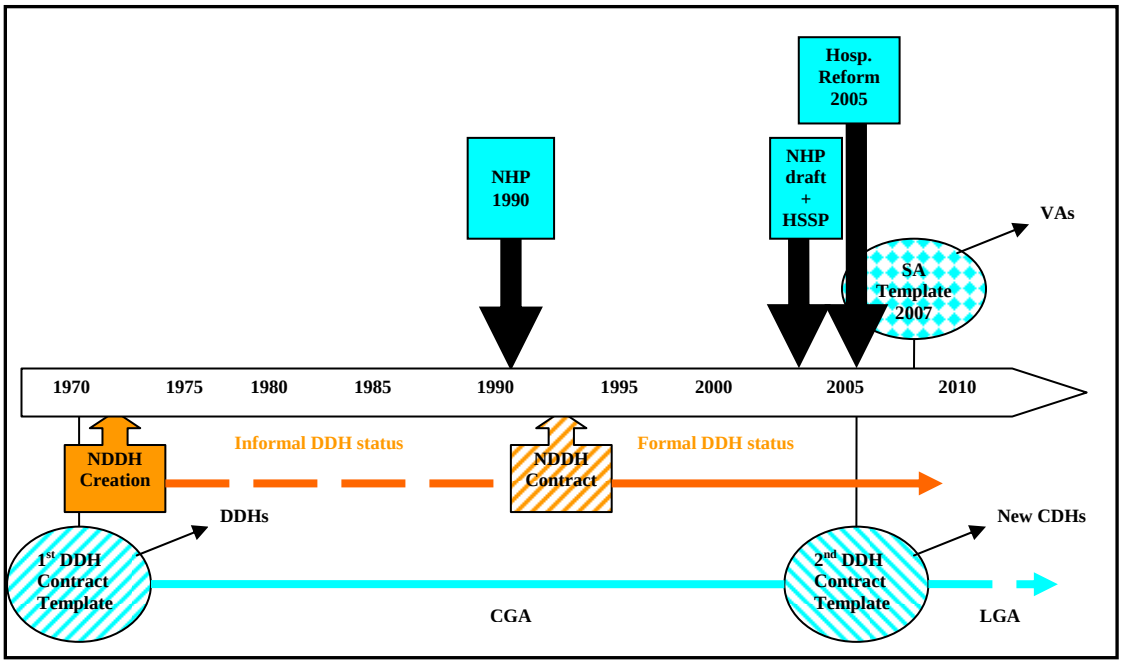
The examples of Tosamaganga and Sengerema show that the context can have an important influence on the destiny of contracting relationships. In Sengerema, the quality of the relations with the district helps to resolve some of the difficulties the NDDH is faced with. The hospital, which benefits from external resources, also takes a more positive stance towards the state. This example shows to which extent the interpersonal relations continue to dominate the debate and determine the chances of success of the relationship that is set up. The contract itself only plays a secondary role in Sengerema. The hospital does not even have a copy of the contract. The situation of Tosamaganga is more difficult to assess, because the relationship is only recent: receiving DDH status is very much appreciated by the facility as before it was just a simple VA, so it only got limited support from the state. We hope to be able to evaluate in more depth the quality of the contracting relationship in time. NDDH is, in spite of the clearly

[12] We do not know when this hospital was founded, but Tosamaganga is an ancient mission post which already existed quite a long time before Independence.

[13] New label replacing that of District Designated Hospital in the context of a revised contract model (2005).

more negative nature of its relations with the public sector, largely representative of the difficulties currently met by a growing number of DDHs. To a large extent these difficulties were expressed in the framework of the meeting of the Tanzania Medical Association in September 2008.

Figure 3. The contracting process in Tanzania



LEGENDE

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

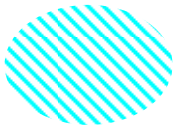
Documents or MOH intervention

Document of the hospital

Contract models

Contracting between the local government and the faith-based facility

Contracting relationship between the MOH and the DDH



Contracting relationship between the local government and the DDH

Ongoing Relationship

Formal Relationship

Informal Relationship

Result of the interviews and the documentary analysis

CENTRAL LEVEL

The main chronological stages of the formalization process of the relationship between the Church and the State have been touched upon in the section outlining the partnership context. The regulatory context does not include any framework document on the contracting policy: the principles are set out in a number of separate and often contradictory documents (PNS, Health Sector Strategy, Decentralization Policy, etc.). The cooperation modalities are mainly defined on an operational level therefore, through three contract models which govern the relations between providers of hospital services and the state.

The DDH contract model (1972?)

We refer here to the analysis of the Nyakahanga hospital contract, because this model holds without any changes for all District Designated Hospitals created before 2005. The exact date of this model is not clear, but goes without any doubt back to 1972; seven years after the first DDHs were created. From this we can infer that the concept and its implementation appeared well before a formal model was drafted. The first experiments were probably developed on the basis of informal relationships and were gentlemen's agreements so to speak.

The CDH contract model (2005)

This new model is the result of the work of the PPP Technical Working Group (PPP-TG) and responds in part to the need to revise the DDH contracts in line with developments in the Health policy and the adoption of new regulatory options. The main change is the adaptation of the model to the health decentralisation context: in this way, the local government authorities are appointed as representatives of the public authorities on behalf of the Ministry of Health. Hence the denomination of the hospitals is changed into *Council Designated Hospitals* (CDH) according to the new administrative set up. A number of significant improvements are made:

- The model includes a definition of the main concepts to which the document refers.
- The principle of monitoring/evaluation is mentioned, without specification of how this monitoring would be carried out and who is responsible for it (reference to the 'current legislation').
- The set up of a management team for the representative bodies (the Hospital Committee in particular, which replaces the former Board of Governors).
- The basis for calculating the salaries taken over by the state is mentioned (framework of 1999, possibly revised).
- The reporting obligations are somewhat specified for the hospital, without any detail however on how this should be done.
- The current legislation and the principles of conflict management are described, but only superficially.

As for the rest, the document remains to a large extent a copy of the initial contract model. It takes over the latter's structure, the main wording and as a result also the same mistakes. Its revision, although contemplated, has so far not been undertaken. In fact, no DDH agreement signed before 2005 has to our knowledge been revised in accordance with the new contract model.

The Service contract model (Service Agreement, SA) (2007)

This model is also the result of the cooperation between the State, the Church and other government partners in the context of the PPP-TG. This model is operational since 2007.

It represents a fundamental leap in the collaboration process between the State and other health service providers, by bringing up for the first time the issue of formalization of the

relationship between the State and VAs through a service contract. The texts also allow for application of the model in the relationships between public authority and public health facilities.

This marks a considerable improvement in terms of form and completeness of content: this model is very different from the preceding DDH and CDH contracts because it takes into account their main gaps and flaws and corrects them:

- The document refers clearly to the framework documents governing the relationship. There are numerous annexes which allow immediate recourse to this regulatory framework.
- The document has an introduction which states the objectives, user instructions and benefits expected from the agreement.
- The duration of the contract is defined and the conditions for an extension or for breaking the contract are equally mentioned.
- The responsibilities of the different parties are clearly described, especially questions related to the contract management.
- The main text of the agreement is completed by 6 annexes specifying: 1) the details of the services expected from the signing health facilities, 2) the conditions of service creation and their price setting, 3) the level of quality expected and the standards that apply, 4) the detail of how the contract should be managed, 5) financing details (the costs carried by the State and an acknowledgment of other resources that can be used) and 6) payment exemptions for the patients and reimbursement modalities for service providers.

The most important change brought about by the SA lies in the introduction of a system of monitoring and evaluation linked to performance criteria. This marks the passage from a relationship that was mainly founded on mutual confidence to an organized and professionalized system, backed up by a solid legal framework, and to a large extent inspired by the performance contract models. It also includes the take over of the operating expenditure of the VAs concerned. This model is being tested at the moment in a limited number of facilities and excludes the DDH and CDH. So there is a risk of creating a two speed system as no fast harmonization of the current contract models is carried out.

The regulatory framework in Tanzania was progressively strengthened over the last years: this can be derived from the implementation of new CDH contract models and the set up of SAs. These contract models are the principal relationship tools and we have seen their limits. There exists however no specific framework document on the partnership policy or the contracting policy.

The principles of the partnership are summarized in the national policy documents and the sector strategy; there is no framework convention that governs the relationship between the State and the faith-based sector. All efforts put in on central level were concentrated on the development of operational contract models (DDH, CDH and SA). The tools of the partnership dynamic reside therefore in fora that bring together public and religious partners: mainly the Joint Annual Health Sector Review (JAHRS) and the PPP technical working group. It is in this context that the faith-based sector participates in the elaboration of the health policy, that information is shared and a number of key documents are developed[14].

The Church plays an active role in the decision-making process at central level, mainly through the communication and lobbying efforts of the CSSC with the public authorities. This resulted in the resolution of the VA issue[15] through the creation of a SA model. In general, CSSC is invited to participate in all the main meetings about health sector matters. Similarly, the participation of the state in the annual meetings of the Tanzania Christian Medical Association (TCMA) is an excellent opportunity for the VAs, the DDHs and the CDHs to point out their difficulties to the MOH.

[14] The document "Strengthening PPP in Tanzania" (2007) is a recent example; it was published jointly by MOH, CSSC, TGPSH and APHFTA (Association for Private Health Facilities in Tanzania.

[15] These facilities which depend on external and their own funds for their activities are faced with growing financial problems.

The positive evolution, i.e. the fact that consultative structures are getting stronger at central level, is proof that the relationship is on the right track. This positive trend was also confirmed by both public and denominational actors. The input of the church in health matters has long been recognized by the MOH through the State's financial support to the facilities. Moreover, the share of the health budget given to the sector grows faster than many other budget items.

For the faith-based sector (CSSC and the religious authorities, both Catholic and Lutheran), the future clearly lies in a gradual strengthening of the relationship. The efficient performance of the PPP technical working group compensates thus for the shortcomings of the PPP unit of the MOH. The latter is difficult to access and not at all inclined to address the complaints of a sector of which they question the legitimacy. The negative attitude of this unit contrasts with the generally upbeat discourse of MOH.

Overall, difficulties expressed relate mainly to how current problematic situations are dealt with at peripheral level, more particularly the ever growing financial and operational difficulties of faith-based facilities: the problems of staff costs[16] and 'flight' of faith-based staff to the public facilities[17] especially.

INTERMEDIATE AND PERIPHERAL LEVEL

The formalization process in Nyakahanga happened in two main stages. The first stage (1972-1992) occurred when the hospital obtained the status of DDH and, with it, the authorization to act as district hospital. Independent from any contract, it became thus able to enjoy state benefits. The second phase (1992-?) saw the legalization of the status through a contract. In both cases, the State took the initiative but it got the approval of the Church, reluctantly in 1972 but full-heartedly in 1992.

The Nyakahanga contracting document dates from 1992[18] and has never been revised. There are three problems with it:

i) Problems in form and content. There are a number of redundancies in the document and it lacks a logical structure (succession of clauses). In terms of content, the model has quite a lot of flaws:

- The concepts used in the body of the text are not defined;
- There is no clear reference to the political framework that applies;
- The question of conflict resolution is not touched upon, the law governing this issue is not mentioned;
- The responsibilities (people, mechanisms) are badly defined;
- A system of monitoring and evaluation (tools and mechanisms) is not planned; the reporting and information requirements are not mentioned;
- The duration of the contract is not specified and conditions for revising it are not sufficiently made clear;
- The cost of services and the question of who takes care of what (mechanisms, how, etc.) are not properly defined;
- The human resources issue (whose responsibility) is only superficially brought up.

ii) The document is out of date and needs to be revised as a result of a number of developments:

- The faith-based hospitals are losing a growing number of staff to public sector facilities: the issue of HR should be looked into again;

[16] For example, the salary increases approved centrally tend to be implemented a lot later for faith-based staff employed in the DDH. The facilities themselves have to take care of the salary cost in the case of the VAs, except for the few that have signed a service agreement (SA) with the State.

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

[18] See Part II, annex 5.

- The social protection funds (NSSF, NHIF, PPF, etc.) were created only after the contract was signed: the contract therefore does not tackle the question of equal salary between civil servants and private not for profit staff;
- The development of activities, the expansion of the hospital and its target population call for a revision of the contract's financial terms and the level of state support.

iii) Nyakahanga is a DDH from the first generation and therefore:

- The public signatory of the contract is the MOH. Hence, the mechanisms linking the hospital to the public sector are outdated in the context of decentralization of power and the cause of dysfunctions;
- The DDH contracts made after 2007 (for example the contract of Tosamaganga hospital) were signed by the local governments and therefore better adapted to the present situation;
- Until now, no DDH of the "first generation", including Nyakahanga, has signed a revised contract in line with the 2005 model.

The main tool of the relationship should be the contract itself. However, since the hospital had until recently no copy, the contract could not be used as a reference. We have seen the limitations of this. The Board of Governors (BOG) is therefore the main tool for monitoring the relationship, even if its powers are not those of a contract steering committee. The board convenes in principle four times a year and consists of the management team of the hospital, the religious authorities, the representatives of the local government (DMO), the intermediate level (RMO) and central authorities. Its aim is to ensure respect for both the National Health Policy and the principles governing the faith-based facility. This is the only occasion where those in charge of public and faith-based facilities at different levels can meet and where they can address the actual problems in a structural way. If its efficacy is confirmed by the historical witnesses for the first period of the relationship (1992-2000), today the Board's role seems to have decreased due to following reasons:

- The Board only meets once every year due to lack of funds[19]. This considerably limits its ability to monitor[20].
- The central level representation is systematically delegated to the intermediate level. The contract is under the authority of the MOH and is signed with it. Consequently, the problems sprouting from decisions taken on that level are difficult to resolve. The intermediate (RMO) and peripheral levels refuse to act as a substitute for the MOH and do not always transmit all information to the central authorities[21].
- The problems of the local and intermediate level (mainly questions which do not involve other financial resources than those managed by the district in the context of the Basket Fund) seem to be treated in a straightforward manner though.

The only other monitoring tools are routine supervisions of the central level. These should inspect the execution of the PMA:

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

[19] The cost of paying the participants comes entirely out of the hospital budget.
[20] The latest Council Comprehensive Health Plan (CCHP) decided to allocate part of the Basket Fund to the financing of the meetings.
[21] The communication between the intermediate and central level happens indirectly, through the PMORALG (Prime Minister's Office for Regional Administration and Local Government).

The hospital's management team and the bishop have a rather negative perception of their relationship with the district authorities. The contacts with the technical levels (office of the DMO) are quite good but these contacts lead only to limited concrete results, as the administrative authorities, who tend to have a political agenda, often interfere. In fact, a lot of the authorities' decisions tend to favour the public health sector to the detriment of the DDH, often against the advice of the DMO whose powers are limited. The overriding sentiment in faith-based circles is that they are not heard, especially on the lack of financial and human resources. As these shortcomings are pointed out by the ECD supervisions, the frustrations grow ever deeper. In general, the hospital counts more on the intervention of CSSC at central level to find a structural solution for their difficulties.

The interviews held with the technical and administrative management largely confirm the problems that exist. The discourse of the administrative authorities shows a deep ignorance (faked?) of the hospital's difficulties. The positive analysis they make of the quality of the partnership is also exemplary of the gap that exists between the two sides. The DMO has a far more qualified view of the situation: it recognizes the problems that exist but points out that the district is unable to provide a solution: in the mind of the public side, it is up to the central level to come up with solutions since the contract, governing the NDDH, was signed with the MOH and not with the district.

The religious actors deplore the lack of feedback given by the different levels of public authority, mainly central, on the reports provided. This problem occurs particularly in budget matters. The hospital projects annually its budget; the lack of feedback on this preliminary budget is made worse by the fact that the amount of the subsidies allocated is not communicated; in practice this amount is much lower than the needs expressed and irregularly paid out. The hospital is therefore unable to implement the budget foreseen. The growing financial strain is intensified by the great number of exemptions[22] included in the health legislation for which there is no financial compensation system[23]. About 75% of the NDDH patients are treated free of charge.

The provision of drugs to NDDH should benefit from MOH support but there are frequent stock disruptions in the Central Pharmacy (MSD)[24]. In practice the NDDH is obliged to buy locally at very high prices and to use up the resources provided by the Basket Fund and a large share of the hospital's own resources. The drugs themselves have to be sold to the patients, while the medicines provided by the MSD are free of charge. The situation is not understood by the patients and harms the reputation of the facility.

These different issues are not without consequences:

- The hospital is faced with a situation of growing financial strain (deficits in 2007 and 2008).
- The available financial resources are used for care, which hampers a regular policy of investment. In the long term, this constraint weighs on the quality of care provided (lack of space, beds, outdated equipment, etc.).
- The differences in employment conditions between the public and faith-based sector leads to a growing number of staff resignations in the faith-based sector. Since 2006-2007 the HR problems have been getting worse: more and more staff resign, looking for better conditions in the public sector (retirement policies, training and promotion opportunities). The lack of financial resources in the hospital does not allow the management to offer the staff prospects (promotions in particular) attractive enough to keep them loyal to the facility. This might aggravate the trend in the short term.

[22] HIV-AIDS, Tuberculosis, malaria, chronic diseases, etc. The patients treated for these conditions have to be treated free of charge.
[23] Only the drugs are theoretically paid for.
[24] Medical Stores Department.

- The management team is fully aware of the limits of the current contract, but is not in a position to remediate this, as it is not correctly informed[25].
- The dysfunction of the Board of Governors and the difficulties experienced to solve the problems identified undermine the trust of the church leaders (owners of the hospital) in the future of the contracting relationship. In desperation, the bishop is considering to threaten the public authorities with closure of the hospital in a last-ditch effort to get what he wants. Recently about 16 faith-based dispensaries have closed down for similar reasons in the Kagera region (according to the faith-based authorities) without provoking any reaction from the public bodies. This initiative is therefore not without risks.

[25] The existence of a new contract model was for example not even known until the visit of the research team (sic!).

Conclusion

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

The partnership dynamic is still mainly limited to the central level:

- The partnership policies, their tools and the spirit of cooperation are not circulated enough, which hinders the generalisation of the process. The personal relations and their quality - particularly on peripheral level - remain the key to success for collaboration experiences.
- In general, the decentralisation process of authority remains incomplete and this obstructs the implementation of the contracting process and the development of PPP on district level. Several components need to be improved:
  - The distribution and acceptance of responsibilities
  - The knowledge and the understanding of the policies
  - The communication lines
  - The different contradictory strata of the regulations (contracts signed on central level in a context of authority that is supposedly the local government's)

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

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

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

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: TANZANIA

Table 2. Synoptic grid of the results

General CONTEXT (national)	
Context	-The faith-based organisations are very present in the health sector and especially in the rural areas. -It is faced with a serious financial crisis at peripheral level.
Contracting Process	- An older process of which the premises date from post-colonial times. - Initially, the collaboration was informal and then became statutory on the basis of service agreements signed between the health facilities and MOH.
Objectives/ Motivations	- The start of the DDH happened at the same time as the take over of the area by the State. It marks the willl to integrate the health facilities of the Church out of concern for rationalization and improvement of health coverage. It is also proof of the State's recognition of the social role of the Church. - The faith-based sector wants recognition but mainly access to the ever decreasing means.
National framework of the relationship	- There is no policy or contracting paper. The relationship is based on a series of service agreement models (*District Designated Hospital contracts*, *Council Designated Hospitals*, *Service Agreements*) and the existence at central level of a dynamic forum. - Various document and contracting relationship strata coexist.
Tools	- There are many tools and opportunities to meet with each other at central level. The partnership process is dynamic and makes progress. This has led to the creation of new contract types which take into account the specific difficulties of some Church facilities (*Voluntary Agencies*), such as not getting State subsidy. - This process remains nevertheless very centralized and should involve the intermediate and peripheral levels of the health pyramid. Due to a shortage of HR in particular, the decentralized facilities of the health platform are not able to fully play this role.
Perception	- The perception of both the religious and public actors at central level is positive and this is a reflection of the dialogue and the collaboration between the sectors. There is insufficient awareness of the problems met at peripheral level through imperfect tools. These problems have to be solved first and foremost by taking into account the limited human resources.

SPECIFIC CONTEXT (Nyakahanga Hospital (NH))	
Context	- The hospital of Nyakahanga is located in an isolated area, where public referral facilities are absent and where religious actors are dominant. It therefore follows that in 1972, the hospital got the status of DDH. -The hospital operates in a context of a decentralized health system but is not correctly integrated in the district as it has a contract directly with the central level.
Contracting Process	- The process goes a long way back but was first informal, probably as a result of the fear by the faith-based actors of a complete take over by the State. - The formalization took 10 years and was based on the positive experience: the Church simply ratified a standard contract model.
Objectives/ Motivations	-The objective of the DDH contract is the set up of the facility as DH: the religious actors' motivation for signing was the wish for survival and a need to protect the assets obtained
Framework of the relationship	- The Nyakahanga contract gives the hospital the status of district hospital (DDH). This is a first generation DDH hospital, signed with the central level. - The document has many weaknesses in content and form. - It should be revised and adapted to the more up to date DDH contract (2005) so as to be integrated in the decentralisation framework of the health system.
Tools	- The *Board of Governors* is named by the contract as the main tool in the contracting relationship. However, it convenes irregularly (lack of resources) and suffers from the fact that the central authorities are not represented. - Since they are not a signatory of the contract, the district and intermediate levels do not have a decision making role in the relationship. They also do not transmit sufficient information. - The ignorance at central level of the situation in the field results in them avoiding their responsibility in the name of decentralisation.
Perception	- The district public sector seems only partly interested in the contracting relationship, in which it is not involved. The relationship is considered positive but only gets little attention from the administrative authorities. - From their side, the faith-based actors are very negative about the many problems encountered and the lack of response from the public authorities at central and peripheral level: information problems (in particular financial), insufficient and irregular financial allowances, and grants in medicines. Furthermore, some activities are considered as being influenced by a political agenda and going against the interests of the hospital (draining of staff notably). There is therefore a real climate of mistrust of the faith-based peripheral sector towards the public sector and its intentions.

SCOPE	
Effects, quality	- Initially, the contract has contributed to the improvement of the collaboration between the Church and the State. This situation was a result of the good relations and the goodwill which united the main actors from both sides. - Today, there is no real monitoring anymore and the feeling that the DDH works in a setting with ever growing problems. Since there is no response from the State, the quality of care suffers more and more due to a lack of human and financial resources. - The gaps in the contracting document and its vagueness play and important part by denying the hospital an efficient support system. - The many problems raised by the faith-based actors are rather structural than directly linked to the contract. They are a result of important differences in the conditions for doing medical work between the two sectors
Level of awareness and information	- The actors did not get a preliminary training and are far removed from the ongoing partnership process at central level. The hospital studied has only a fragmented knowledge of the national partnership framework and only partly grasps the contract itself, its mechanisms and implications. - The district does not play its role of relay in this.
Future of the contracting relationship	- The religious actors are convinced of the importance of continuing a contracting relationship with the State. This has to be improved considerably however. In fact, the lack of human and financial resources of the Church does not allow a termination of the existing contracts because it would mean that the facilities would have to close. - This improvement has to come through an upgrade of the existing and future contracts and their adaptation to the decentralised health system.

Table 3. SWOT Analysis of the case

STRENGHTS	- There is a strong and dynamic partnership at central level which is stimulated by a motivated interreligious platform. - The contracting experience between the public and faith-based sector goes back a long time and has been systematized nationally.
WEAKNESSES	- Weakness of the MOH partnership unit. - Insufficient decentralisation of the partnership fora. - The contracting experiences at district level are not built on a coherent framework (no partnership nor contracting policy). - Different contract types and generations coexist (DDH, CDH, SA) - Lack of knowledge about the contracting procedures and the specific mechanisms of the contracting relationship.
OPPORTUNITIES	- The development of better defined service agreements (SA), which include performance indicators: these contracts, if they work, could lead to the long awaited revision of the DDH contracts. - Awareness of the shortcomings in the relationship between the management team of the hospital and the Church, thanks to the encouragement of individuals. - The will of the central level to decentralise the partnership process
THREATS	- The local public authorities tend to set up various hospitals that compete with the existing DDH. In general the State has a policy of '1 (public) health centre per village', which feeds this type of trend and risks to limit even more the means allocated to the faith-based sector. - Faced with these difficulties, the Churches of Kagera have started to close health centres and intend to threaten to close the DDH in order to be heard.

Results of all 5 case studies
Cross-cutting analysis

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

The research team was shocked by the extent and seriousness of the crisis that affects the contracting process between the State and the faith-based health sector; this sorry state of affairs pertains more or less to all the countries in this study, at least to some extent. This situation is even more paradoxical as it occurs within a general partnership consensus context. The inevitable character of the collaboration, the added value of its formalization are not only admitted but demanded by both sectors and all levels of the hierarchy.
The seriousness of the matter is in part due to its discrete, almost hidden nature: either there is no general awareness on central level (Uganda) or the awareness manifests itself mainly on an operational implementation level (districts). In any case, the awareness remains largely confined to the faith-based sector and is more evidence of a shaky partnership.
The size and escalation of the crisis are worrying: without rapid intervention, the existing experiments might fail in the medium or even short term. Hence, the crisis could no doubt call into question the efforts[26] 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

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

planned[27] in this respect do not function properly; at best, difficulties are recognized but no structural solution is put forward. This situation reflects form problems which mark all service agreements we investigated on peripheral level, but also capacity and resource problems: monitoring and evaluation is a weak area for public facilities, not just with respect to contracting relationships with the private not for profit sector.

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

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

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

The lessons of the past are not really learnt and are largely ignored when it comes to the development of partnership policies, resulting in all cases in the coexistence of often contradictory models. The contracting landscape is diverse, composed of diverse historical strata which were never synthesised. In addition, the circulation of experiences and knowhow in this area remains very limited. In short, there is no collective, centralized and institutionalized record: the knowledge and the documentation itself of the fragmented and burgeoning experiences[28] 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

[27] Steering committees, in particular when they exist.
[28] In none of the cases researched, there is an exhaustive database which gives access to all the regulations, models and contract documents signed or in force.

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

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

It is quite important to stress first the negative aspects of these bilateral contracts: the opaqueness of the systems and mechanisms which govern them, their exogenous nature and their targeting on peripheral level are all obstacles to the appropriation of these experiences by the central public and faith-based sectors. This appropriation is also hampered by the power or even impunity of the donors due to the huge amount of resources involved.
The importance of these resources, the fact that these interventions apply strict targeting methods as well as their mobilization of a substantial amount of human and material resources of beneficiaries could certainly distort matters. All this is even more serious because the targeted facilities are weak and jeopardized by the global crisis in the faith-based health sector. Besides, these demanding excellence contracts generate double standards that are likely to have a negative influence on the integration process of beneficiary structures in the national health system.
In spite of all this, faith-based hospitals tend to look favourably upon these contracts: they appreciate their degree of specificity and predictability, the provision and quality of monitoring, steering and evaluation mechanisms and activities which characterize them. Their efficiency and the donors' respect of commitments are other aspects which are highly valued by the beneficiaries. The set up usually leads to local capacity strengthening which (in spite of the focalization of the arrangements) tends to have a positive contaminating effect: all the activities of the facilities are often positively affected over time.

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

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

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

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

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

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

Recommendations for all 5 case-studies

For international actors: donors and NGOs

The past should not be overlooked when preparing for the future. **The partnership between the public and faith-based health sector[29] should be strengthened through the set up of an institutional collective memory**: this should synthesise the current situation and provide a centralized historical archive of the frameworks, contracting documents and expertise of each country. Such an approach should be planned in the near future to prevent documents and testimonies that are key to the understanding and analysis of earlier experiences[30] from disappearing. Documentation and information centres could be created where all actors from the Public Private Partnerships are represented on a pluralistic and unbiased basis. These centres should have a very broad mandate, associating public and private not for profit actors[31] and giving them the legitimacy needed for "open and exhaustive" access to the relevant data. They should be given a mission of public interest and have a legal status and guarantee of independence against possible interference, all of whom would help to ensure total transparency and access to the collected data for the greater public[32]. In addition, collaboration with local academic institutions[33] could open interesting research possibilities.

In a more distant future, these country resource centres could form the basis of **a Pan-African information and exchange network for PPP and contracting**. They could act for example as an internet forum such as E-Drugs and E-Med[34] in the field of medicines and include and international database. Before this can be set up, country databases have to be created on the basis of more or less compatible models and systems.

It remains essential as for now to respond to the specific training needs of the field actors. Contracting workshops could thus be regularly organized upon request. They should have a content adapted to the local situation and the level and role of the participants in the contracting process. The set-up of such workshops could benefit from the input from local faith-based platforms[35]. 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

[29] And more extensively, the private not for profit sector.
[30] Tanzania, in the 70s.
[31] At different levels of the hierarchy.
[32] Public and private decision makers, operational actors, national coordination facilities and external support, researchers.
[33] 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.
[34] *cf.* www.essentialdrugs.org
[35] 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: Tanzania

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

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

The government has begun to implement its plan for improving the health services through a programme of primary care (MMAM[36]). The aim is to bring the health services closer to the people: "We intend to reach the rural population as they represent 80% of the residents and they are the ones who do not have access to health services; we hope to achieve access for each village by 2017". (Declaration of the Health Minister, Pr. David Mwakyusa during his inauguration speech at the 71st TCMA assembly). A considerable number of field actors in the faith-based sector fear the emphasis thus put on the development of public health structures at the lower administrative levels scale, as it could eventually endanger the part of the budget reserved for the faith-based facilities.

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

In this sense, the decentralisation of the partnership fora, planned by CSSC through the zonal delegations could contribute to a better understanding of the reality in the field and could on peripheral level advance the climate of cooperation that exists on central level. The fora are also a potential tool for improving the knowledge of the actors. It is striking for example that CSSC is an unknown acronym for the local administrative authorities in the Karagwe district! The (newly created) Afya Mtandao website[37] could in due time become an

[36] Mpango wa Maendeleo ya Yfya ya Msingi (MMAM).
[37] www.afyamtandao.org

instrument for collecting data with regard to the contracting experiences, if it is actively consulted and exploited by the field actors. At the very least it is an interesting effort to stimulate exchange between the field actors.

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

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

General conclusion: take-home messages

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

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

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

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

4. The results of this study should be presented in each country (Cameroon, Tanzania, Chad, Uganda) if we want to achieve relevant and sustainable changes in the field. This dissemination

process should be well prepared and steered and has to involve actors from all sectors and levels: the public and religious health authorities at central and peripheral level, the care providers and the community representatives.

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

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

We are faced with a wealth of promising data. It would be regrettable if this corpus was cast aside after this report. Hence, we plan to further exploit this information in the months and years to come. Several avenues are open to us: either more systematic data collection for one of the study countries (monograph), or adding other experiences likely to shed new light on the case studies, or also processing the data with other methods, etc. These research lines and the feasibility of the project will be explored in 2009.

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