CONTRACTING EXPERIENCES
IN SUB SAHARAN AFRICA

The case of Cameroon, Tanzania, Chad and Uganda
Main findings of a Medicus Mundi International network study¹

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INTRODUCTION

In this paper we present the principal findings of a study conducted on the arrangement of contractual relationships between faith-based (FB) district hospitals in sub-Saharan Africa and public health authorities. Contracting can conveniently be defined as “a voluntary alliance of independent or autonomous partners who enter a commitment with reciprocal obligations and duties, in which each partner expects to obtain benefits from the relationship” (Perrot & de Roodenbeke 2003).

Contracting is a health policy option that frames well in the desire to bridge the gap between public and private healthcare provision. Some situate contracting within the scope of the international and growing trend towards “marketisation” of health care delivery, involving the selective introduction of a range of market mechanisms within the public health system (OECD 1992, World Bank 1993, McPake and Ngalande Banda 1994, Mills 1997). Contracting is also consistent with the emergence of new trends in public sector management, which identify private sector mechanisms as a solution to many of the problems currently experienced by the public sector in many parts of the world (Palmer & Mills 2006).

In parallel, many African countries have adopted partnership- and/or contracting policies and many more implemented formalized agreements, the latter often preceding the first. With respect to their historical involvement in the provision of healthcare, a strong established reputation in quality of care and a still important share (facility and non-facility based organizations) in local healthcare systems, churches often

MEDICUS MUNDI INTERNATIONAL

Medicus Mundi International (MMI) is an international network of 11 private not-for-profit organizations working in the field of international health cooperation and advocacy. MMI aims at enhancing the quality and effectiveness of the work of its members and their partners through sharing know-how and joining forces. The network’s key strategy is to strengthen the health system as a whole. Strengthening the private not-for-profit (PNFP) health sector is an essential aspect in this; it further justifies by the close collaboration of most member with PNFP organisations at district level. In that respect, MMI has shown its interest in contracting for several years and contributed to put the issue of contracting between public authorities and PNFP organisations on the international agenda. Indeed, MMI launched a debate on the repositioning of FB health facilities in national health systems already in the late 90’s. Closer collaboration with local governments soon appeared as one of the options to achieve this goal, with contracting as a key tool and strategic priority for the network. This policy attention from MMI for contracting translated in several milestones: first, the organization of a technical meeting on contracting and PNFP’s in May 1999, which laid the foundations for the 2001 WHA Declaration on the role of contractual arrangements; continuous advocacy amongst higher church authorities (i.e. Catholic bishops) in Episcopal - and Christian Health Associations’ Conferences; and the publication of operational contracting guidelines (2003) for district level health facilities.
have been privileged partners of African Ministries of Health (MoH) in their indisputable efforts to develop collaboration through formal arrangements with the PNFP Health sector. Those have materialized in the emergence of framework agreements at central level and, at district level, devolution of public mission to FB hospitals or organizations. The expected effect of such policies, from the perspective of the public health authorities, was to arrive at an improvement of the public health sector’s coverage and control capacity and application of National Health Policies. The expectation from the PNFP sector, on the other hand, was an explicit recognition of their major contribution \(^8\) to the health sector, and to find a response to the increasing need for collaboration with the public sector as a means to compensate their growing lack of resources.

Today, however, little evidence is available on the impact of ‘classical’, input-based contractual arrangements between the two sectors. Indeed, available data mostly apply to single-country or case evaluations (Palmer & Mills 2006). Contracting today is high on the international (scientific and policy) agenda, but with an obvious shift lately to innovative arrangements – i.e. performance (output) based financing (PBF) \(^*\) contracts – which tend to set the trend for new field experiences \(^10\) in Africa, policy and guidelines’ development, data gathering and analysis and the production of scientific literature. No general analysis of specific contracting experiences linking the public and the FB, PNFP health sector in Africa was conducted so far. The purpose of the MMI study precisely was to contribute to fill those gaps.

The paucity of the available evidence left MMI with a crucial but unanswered question: do the current contracting experiences between FB, PNFP facilities and public health authorities actually work? And if they work, what makes them work? If they are not successful what are the reasons or mechanisms explaining this lack of success? What future stand should MMI take vis-à-vis contracting? Should its involvement in the promotion of contractual arrangements between PNFP and public sector be pursued? If yes, on what terms?

Confronted with the need to assess the validity of its own strategic advocacy, the MMI Network commissioned the Institute of Tropical Medicine, Antwerp (ITM) with a study that would generate more insight on current public-PNFP contracting experiences in the African health sector and feed possible updates of its policy line. It was obvious from the start that the results of the study could and should also be relevant to local policy makers – both from the public and PNFP health sector –, with international stakeholders and the scientific community, as a means to generate knowledge and improve the situation where necessary.

The MMI study was conducted by the ITM between September 2007 and March 2009. Its results were made public by official launching of the end report in Geneva in May 2009. The present article aims at sharing its core findings with stakeholders and organizations familiar with and interested in Doctors with a Africa Cuamm’s activities and concerns, as one of the MMI-network’s oldest and most active members. It also is a stepping stone in MMI’s policy of broader dissemination of the study results within the local and international stakeholders’ community.

**METHODOLOGY** \(^11\)

The methodological basis for this study rested on an analysis of multiple case studies. Five case studies were selected in 4 different countries: Cameroon, Tanzania, Chad and Uganda. The choice of the specific case studies within the countries was conducted with the goal to achieve a selection that would be sufficiently representative of the diversity of current contracting experiences between Ministries of Health and FB facilities at district level.

Cases selected in Cameroon, Tanzania and Chad form a sample of direct, contracting experiences between public health authorities and FB organisations:
- The case of contracting-out district hospital services to a FB facility on a one-to-one (selective) basis: the situation of the Catholic district hospital of Tokombéré, North Cameroon.
- The case of district designated hospitals (DDHs) in Tanzania, illustrated by the example of Nyakahanga Lutheran DDH: a case of contracting of district hospital services to a FB facility within the framework of systemic national policy.
- The example of contracted delegation of district and district Hospital management to a decentralized FB organisation: the situation of Moïssala district to the Catholic BELACD \(^12\) of Sarh (southern Chad).

In Uganda, two cases were selected that deal with service level agreements linking FB hospitals with PEPFAR \(^13\) recipients on the basis of output-based financing. Their inclusion in the overall study was motivated by their high learning potential for public and for FB actors confronted with the upcoming trend of output-based, disease-focused contracting with district-level facilities. A comparison with the more conventional input-financed contracts was moreover likely to provide us with additional insight on the modalities of success or failure of contracting experiments.

The selection process eventually resulted in the following sample:
- Firstly the contractual arrangements linking St Joseph (Catholic) Hospital in Kitgum (Northern Uganda) with 3 major PEPFAR recipients: Catholic Relief Services (CRS, USA), the Uganda Programme for Human and Holistic Development (UPHOLD, USA) and The AIDS Support Organisation (TASO, Uganda).
- Secondly, the Kabarole (Protestant) Hospital in Fort-Portal (Kabarole District), and its sole contract with CRS was chosen.

The general methodological framework of the study is inspired by the realistic evaluation method. The data analysis was conducted in 2 steps: in a first step, the focus was on each case study as an independent entity; the second consisted of a cross-country analysis aiming at identifying constant factors which could feed theoretical reflection on general modalities for success or failure of contracting experiments. The study builds on stringent and detailed observation of field experiences. It is based on the analysis of mainly qualitative data, using largely descriptive and inductive methods. More specifically, the study is based on two pillars. Firstly, an extensive set of interviews, conducted at all levels of the health systems with public and FB sectors. Secondly, a detailed documentary analysis was carried out at country
level of contract and contract follow-up documents, FB and public policy papers, other historical documents. Last but not least, from a methodological perspective, MMI proposed an assessment of the dissemination, use and perceived utility of the contracting guidelines that were drafted and published back in 2003. This part of the study was nested in the overall MMI study and was conducted through a questionnaire addressed at individuals that supposedly constituted the target audience of the guidelines.

RESULTS

COUNTRY CASE-STUDIES

CAMEROON

The private sector holds 40% of the overall national health care provision; the PNFP sector in the country is mainly constituted by FB suppliers linked to 3 different organizations (OCASC, CEPCA, FALC). Contracting processes took off in the early 2000s with isolated pilot cases: FB Hospitals getting a district referral status, recognition of the churches’ role in health care delivery, and focus on (publicly) underserved areas. Gradually, from 2001 on, steps were undertaken towards formalization of de facto contracting policies. A major event was the C2D project launched in 2003, which brought in the necessary financial resources to give a real content to the contractual arrangements. Later a partnership strategy was developed (2003-2006) and model documents were established from 2007 on.

The setting that was investigated in the MMI study is Tokombéré hospital. It is a Catholic 160 bed hospital (OCASC network), situated in a rural areas in the extreme-northern province of the country. The hospital’s ownership is in the hands of the Maroua-Mokolo diocese. Tokombéré hospital is characterised by a strong leadership coming from expatriate hospital directors bringing in external resources. The good reputation of Tokombéré hospital, and the health care it delivers, goes well beyond the district boundaries. The hospital de facto plays the role of district hospital since the early 90s, which was formalized by a contract between the diocese and the MoH in 2002.

The contract’s objectives however remained vague with a poor definition of the respective obligations and responsibilities. There was, for instance, no specification of the mechanisms of allocation of funds to the hospital, no reference to any authority of the hospital on the public health centres, and no reference to the specific FB character of Tokombéré hospital. The M&E mechanisms were poorly developed, communication between the stakeholders was not well organised, and there was no structure operating as a functional, problem-solving organ.

Moreover, there was an obvious failure of the MoH to respect its commitments in terms of subsidies to be paid, allocation of staff, official recognition of the hospital as district hospital despite the regular requests from the medical director of the hospital. There was a low level of collaboration between the health centre network and the hospital, seriously hampering the functioning of the local district system in an integrated mode.

This case points to a role of the FB hospital of partial substitution rather than one of complementarities. The hospital functioned mainly on its own resources and the formal contract basically re-conducted the pre-existing situation, without major changes in terms of mutual relationships. It is clear that the level of knowledge on the contracting technicalities and on the institutional mechanisms needed to streamline these arrangements was insufficient, especially at peripheral level. The contracts would have needed revision and up-dating taking into account existing experiences in the country. Finally, there is the issue of sustainability: what will happen after the end of the C2D project?

TANZANIA

The Tanzanian FB – or voluntary – sector is the second biggest health care provider in Tanzania after the government sector. Collaboration between the FB sector and the government took off under President Nyerere’s mandate right after independence. The government’s control increased over the FB sector, which was not without creating tensions, while religious freedom was maintained leading to the ‘Tanzanian model’ of Public-FB collaboration. In the health care sector this translated in the recognition of the crucial role played by (rural, isolated) FB health facilities in terms of coverage. The government-FB collaboration was formalised in 1972 with the adoption of a decentralized, pyramidal health system: a number of FB hospitals then acquired the status of DDH, sealed by a formal contract. This enabled the State to compensate the shortage of public facilities while avoiding duplication. Contracts guaranteed public funding of the DDH’s recurrent expenditures.

After Nyerere’s death, a Memorandum of Understanding (MoU) was negotiated by the churches and pursued the collaboration while offering more protection to the FB-sector against public absorption (forced nationalizations, as they sometimes occurred under Nyerere’s rule) and enabling access to external financing sources. Further steps gradually led to the adoption of a Public Private Partnership (PPP) as an official policy, still referred to in key documents and embodied by several governing organs. Moreover, old DDH contract models were revised in 2005 in accordance with the decentralization policy and a new type of operational contract was created in 2007 for private (Voluntary Agencies) and public facilities, excluding hospitals. The Christian FB health sector today is well represented in the public health arena by the Catholic Social Services Commission (CSSC) – i.e. a platform that enjoys official recognition of the State – and its 5 regional coordination bureaus.

The MMI study in Tanzania focused on the case of Nyakahanga DDH (NNDH), a Lutheran hospital located in the north west of the country in the remote Kagera region. NNDH counts 200 beds and has been the property of Karagwe diocese since 1912. The hospital officially became a DDH in 1992. The NNDH’s contract does not differ from the early model and has
Moreover, the current contracts established with DDHs especially at the peripheral level of the health system. Many important policy documents are simply not available, however a strong need to adapt to the evolving context. There its long-standing character and its large coverage. There is a deterioration of the partnership climate at peripheral level. A good understanding and mutual perception is found at central level. Open-mindedness of government actors, quality of the partnership- and contracting framework, and means of direct and indirect support provided by the contracts are particularly valued by the PNFP sector.

Steps towards partnership formalization were taken as soon as 1999, with contracting being of NHP’s strategic orientations. A contracting policy (CP) was elaborated from 2001 on. It considers delegation of public service mission to hospitals as well as delegation of health districts’ management to PNFP organizations. In practice most existing contracts were signed with FB organizations, mainly for full delegation of district management, inclusive of potentially existing public district hospitals. This ambitious interpretation is barely to be observed elsewhere.

Contracting experiments are set in the context of health sector decentralization which, however incomplete - forms the background of the CP. The Catholic church’s social sector is itself organized according to a decentralized model: the UNAD coordinates technical bureaus – the BELACDs –, themselves responsible for coordination at diocesan level. The BELACDs bear responsibility for management activities in case of delegation of health district administration to the Catholic church.

Public sector organs, policy and operational documents mainly include the 1) MoH directorate of NGOs (DONG) and the directorate of social sector organizations (DOSS); 2) The NHP and the CP itself; and 3) operational contracting guidelines. They translate in framework agreements at central level and operational contracts at peripheral level which are generally the result of active requests from churches’ side.

Public sector can be explained by 4 main factors: the battered state of the health system after civil war; the pre-existence of dialogue; the recognition of the role and characteristics of the FB health sector.

Operational contracts aim at ensuring 1) the commitment of the State towards provision of Human resources, infrastructures, tax exemptions and training to PNFP counterparts; 2) the implementation and respect of the NHP by the latter. Participation of both parties in each other’s decision making process is not foreseen formally but observed in practice; besides, sensitization activities were conducted and a preparatory training workshop (2004) attended by all key stakeholders. In total, a quite complete regulatory and operational framework, far more achieved than in other case-countries.

A good understanding and mutual perception is found at central level. Open-mindedness of government actors, quality of the partnership- and contracting framework, and means of direct and indirect support provided by the contracts are particularly valued by the PNFP sector. Real weaknesses however pop-up.

Our study considered the contractual delegation of Moïssala health district’s management to the BELACD of Sarh. The district is located 200 km away, in the Mandoul health prefecture, Southern Chad. Its capital, Moïssala, is home to the district hospital. The current situation is the result of a process that began in 1992 with the transfer of a Catholic hospital’s equipment and human resources to the moribund district hospital of Moïssala. This project was followed by 3 main contracts which gradually delegated the management of the health district and district hospital to the

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**CHAD**

Christian churches in Chad are still young but their facilities cater for about 20% of the national health coverage, the half being provided by Catholic hospitals and health centres (HCs) under the umbrella of the Union Nationale des Associations Diocésaines (UNAD). FB Christian facilities mainly concentrate in the South as a consequence of civil war where they filled the gap left by public authorities.

Hospitals and HCs were set on the health map from 1993 onwards, as a result of primary health care (PHC) policy implementation. As for Catholic facilities, their integration was also the result of an active request from the religious authorities. Legalization of church structures and then the signing of first contracts gradually changed the – at first – informal collaboration.
BELACD of Sarh. Financial and technical support of external partners sustained this evolution. Those far-reaching agreements were made possible by preexisting public-FB dialogue around the case of Béboro, consensus in view, goals and modalities, the weakness of the public health sector’s representation and capacity in the South, the proven experience of the Catholic’s and the willingness of external partners to support the project. Few real barriers were there but the magnitude of the task and the risks for a Catholic organisation to bear management authority towards other FB institutions.

UGANDA

The FB health sector in Uganda owns about 30% of the country’s health facilities, the majority belonging to Catholic and Protestant churches. These networks are represented by denominational health platforms: the ‘Medical Bureaus’. Pressure resulting from the decrease in financial willingness of external partners and human resources pushed PNFPs to actively seek a formalized partnership with the public sector after a long period of informal collaboration. Grand principles of public-PNFP collaboration were set in a Memorandum of Understanding established in 1998, but partnership policy documents drafted by the medical bureaus in 2003 still await legal approval. FB hospitals nevertheless receive public subsidies, be it far below the level of needs. Medical Bureaus collaborate actively in order to unfreeze the process of legal recognition by the Public authorities and to promote the development of genuine partnership frameworks. An additional source of concern for the Medical Bureaus is the upcoming trend of the Presidential Emergency Plan For AIDS Relief (PEPFAR) funding arrangements to directly contract with FB-facilities. Uganda became a PEPFAR focus country in 2004. With a budget exceeding 280 million $US in 2008, the American initiative is by far the biggest donor for HIV AIDS related funding, and more largely in the Ugandan health sector. Recent evidence (Oomman, Bernstein & Rosenzweig 2007 & 2008) however confirms the weaknesses many observers noted in the way PEPFAR uses and channels its funds. Monies largely remain out of sight and control of the public budget, thereby impairing the planning capacity at the MoH level. The problem is further aggravated by poor leadership at MoH level. The FB Medical Bureaus are even less involved. Overall, both the public and the PEPFAR authorities feel bypassed and lack the information required to adequately steer the process. Our field research in Uganda targeted two FB hospitals involved in contracting agreements with PEPFAR recipients. The Saint-Joseph’s Hospital (SJH) is a facility owned by the Gulu diocese and located in Kitgum, Northern Uganda. Since 2005, contracts have been signed with 3 different Ugandan recipient organisations of PEPFAR funds in order to address HIV-AIDS related needs. The agreements are constraining: they are extremely detailed, characterised by precise, indicator-bound objectives and activities, rigid descriptions of respective responsibilities and highly demanding monitoring & evaluation procedures. There is evidence coming from SJH that these PEPFAR contracts lead to some level of distortion of the supply of care (and in the allocation of the available human resources) in favour of HIV-AIDS related activities. Overall, the involvement of local public health authorities in these contractual arrangements remains limited.

On the positive side, however, is the fact that these contracts go together with regular trainings, intense M&E activities, and exchange opportunities with other beneficiary facilities. Reporting duties contribute to the development of a reflexive attitude amongst the providers. Last but not least, the contracts are respected by the donor. Overall, contracts with PEPFAR are well appreciated by the local FB and government authorities because of their predictability and trustworthiness.

Kabarole Hospital (KH), property of the Anglican church of Uganda, is the second hospital we investigated in our study. It is a relatively modest facility located in Fort Portal, Western Uganda. The first contract with PEPFAR goes back to 2005 and included prevention, treatment and care activities of HIV/AIDS. It is the only source of external support of KH and represents half of the hospital’s annual budget. Many of the observations made with regards to SJH also apply to KH. Local health authorities remain largely positive, seeing PEPFAR interventions as a welcome complement to the limited resources currently available, and providing a valuable contribution in terms of health data generation. Sources of worry include the issue of sustainability of this support, the presence of fail-back strategies, the rigidity of donors, the lack of harmonization with existing procedures and policies, and the incompleteness of information shared. KH critically voices the risk of HIV-AIDS activities developing into a preferential way, thereby skewing the offer of care and unbalancing staff allocation.

Striking in our study is the difference in perception of PEPFAR contracts between central and peripheral level health authorities, as well from the point of view of the MOH and the FB-sector. There where the contracts are relatively well appreciated at the peripheral levels of the health system, there is huge frustration at the central level. This can be explained by the lack of involvement of the MoH and the Kampala-based Medical Bureaus of the various FB-organisations in the design and monitoring of the contracts. The PEPFAR programmes tend to develop as autonomous strategies that run in parallel to existing programmes designed at central level. The problems of weak leadership at MoH level and the incomplete decentralisation process further compound the situation.

The unsatisfactory relationship between public and FB-sector may well lead the latter to favour policies that contribute to secure their immediate survival, i.e. for FB-facilities at district level to increasingly opt for the predictable and trustworthy agreements with external organisations like PEPFAR. This may well bode ill for the future of FB-public partnerships.

CROSS-CUTTING CONSIDERATIONS

Comparative reading and analysis of the case studies allowed us to identify a number of common features among
a variety of contracting practices. These constants provide us with an interpretive lens for the assessment of public-FBO contracting in SSA. Current contracting experiments between the public and FB health sectors face great difficulties. The ‘crisis’ at stake rests on a number of common elements. First of all, a lack of preparation: agreements come as novelties at peripheral level, do not benefit from capitalization of previous experiments, and are barely accompanied by adequate training. Second, the shortcomings of contracting documents themselves, marked by incompleteness and a poor integration in existing frameworks, further aggravated by the absence of revision mechanisms. The latter translates in a heterogeneous contracting landscape – sometimes in contradiction with policies in vigour – where non-harmonized types of agreements co-exist.

Thirdly, all country-cases reveal a strong dichotomy between central and peripheral level, further fragmenting the contracting landscape and pointing at the imperfection of health system decentralization processes. The latter negatively affects contracting experiences by impairing the follow-up of agreements, the set-up of structural responses to address the difficulties met, and the overall capitalization of experience. In a context of silent dysfunction of peripheral level, contracting arrangements carry the seed for impairment of overall partnership efforts at central level. More specifically, agreements suffer under limited and asymmetrical flows of information and the absence or insufficient functionality of M&E mechanisms. Means of control and constraining appeal modalities are lacking, leaving the partners with little guarantees.

Eventually, the scarcity of financial and human resources is hardly alleviated by the signature of agreements. Governments do not always respect their commitments, or do so to a limited extent only. Facilities therefore need to compensate financing gaps on their own or rely on external resources. Contracts deliver on expectations when backed by sufficient resources, as shown by examples of PEPFAR in Uganda or those of Moissala district’s first agreements in Chad.

Overall, success rather lies in the partnership processes at central level and the generalization of a public-PNFP dialogue than in operational contracting at district level. As far as classical agreements are concerned, the relational character of agreements tends to lead to static acknowledgement of pre-existing situations (e.g. a FB facility factually playing the role of a district hospital) rather than creating innovating organisational arrangements.

At best, the current format of contracting experiments thus seems to offer an inadequate answer to the stringent, underlying crisis of the FB health sector. It eventually contributes to worsen it as extended responsibilities come with the need for increased mobilization of financial and human resources. These difficulties seriously affect the FB health sector and remain largely underestimated by the public sector. The contracting agreements read – with some nuances – as a locus for disappointing, imbalanced relationships, benefiting to some extent the public sector while draining the FB sector.

This situation reveals a real risk of disintegration of the current partnership dynamic between the public and the FB sector in sub-Saharan Africa. Worrying signs already show up, some FB providers moving away from existing agreements or threatening to do so (Chad, Tanzania). The priority of immediate survival and the search for direct results stimulate the development of bilateral relations with external donors, at the potential expense of further integration of the health system. Some churches go further and call into question the very notion of partnership and the pursuit of facility-based involvement in the provision of healthcare (Uganda).

**CONCLUSIONS & RECOMMENDATIONS**

The particular case of PEPFAR contracts in Uganda provides a valuable and contrary point of reference, although not without risks. The latter are largely a consequence of the programme’s disease focused character, its lack of adaptation to national context, and its limited flexibility and overall opacity. On the positive side, the PEPFAR contracts’ degree of specificity and predictability, the quality of the monitoring, steering and evaluation mechanisms, and the donor’s respect of the commitments are elements that are lacking in too many other contracting experiences. These aspects might provide avenues for a rereading and improvement of the contractual relations between churches and governments in sub-Saharan Africa.

Overall, raising awareness about the relative failure of current contract appears as a priority as it will condition collaborative research of adequate solutions. This would respond to a felt need in the field. Such response would definitely involve the donor community, as an improvement of the situation will obviously require complementary funding. Indeed, the paucity of resources at government level and the priority thus often given to public sector facilities and staff in funding clearly intervenes as a weakening factor in public-FB contracting. Targeted, sustainable international support to contracting processes and follow-up and managing organizations (public and FB) are both needed. At the FB side, further professionalization appears as a mandatory requirement for future development. Adaptation and capacity to deal with the changing and increasingly complexity of the health system requires strong administrative, managerial and technical skills. It may also require a larger delegation of managerial authority to facility and diocesan level.

Overcoming the current balkanization of the contracting landscape will need to go through continuous and systematic optimization of existing agreements. This implies a revision of historical agreements in order to adapt them to partnership models. It is a mandatory step on the road to institutional embedding and further integration of the health system. A centralized, continuous account of contracting experiences should contribute to the development of an institutional memory. The latter, essential to enable appropriate capitalization of knowledge, is currently largely missing.

Last but not least, experiences studied in the MMI research show the need for tailored support to address the variety
of peculiar situations. Central level policies and models – however appropriate and complete they may be – do not guarantee successful implementation and follow-up. The same applies to theoretical contracting guidelines, as those developed by MMill. Specific training, technical support and continuous steering are by far the tools mentioned as best adapted to the needs. Their benefits are further acknowledged by the case of PEPFAR contracts in Uganda and the effect of built-in, functional M&E mechanisms.

One question remains: whether output-based contracting models (as PEPFAR agreements are) could and should be systematized in the case of direct public-FB collaboration at district level. Our study did not explore this specific question. Neither did our research capitalize on quantitative data; we focused on qualitative findings. Nor was our goal to conduct systemic research on the impact of specific contracts on specific facilities. This important research agenda has still to be completed.
none of the older DDHs contracts had yet been revised to fit this model. Being too recent to allow appreciation of possible improvements. Moreover, starting to be applied to new facilities (e.g. Tosamaganga), the experience by the end of our study, adapted CDH contract documents were just

Service Agreement (SA).

working-group, MoH Partnership Unit.

Health Sector Strategy, National Partnership Forum, Technical PPP

protestantes au Cameroun; Fondation Ad Lucem.

For Uganda, PEPFAR- and PEPFAR recipient stakeholders were also interviewed.

www.medicusmundi.org/contracting


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