Public Private Partnership in the Cameroonian Health System:

A Case Study of Staff Secondment into the Maroua–Mokolo Diocese

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Declaration

I B. JACOB KUH (KHXBAN001) hereby declare that this is my original work and has not been presented before for the award of a Masters' Degree in Public Health.

Date……..

Signature……..

Abstract

Lower to middle-income countries are often unable to provide comprehensive health care to their citizens, and weak health systems have increasingly been identified as a key factor in this failure. Many interventions are being implemented to strengthen the health systems of lower to middle-income countries. Public-private partnership (PPP) in health care has been identified as one such key strategy and solution. Although the specific rewards of-or obstacles to PPP have not yet been strongly evidenced, PPP interventions are being advised and adopted in many countries as a key health systems intervention. It is therefore important to assess and understand the effects of such PPP efforts.

This study focuses on a particular PPP arrangement in Cameroon – between non-profit faith-based providers and the Cameroonian Ministry of Health. This partnership is based primarily on the secondment of government-employed health workers into the faith-based health system. This case study focuses in particular on this arrangement as it is experienced in the Catholic Maroua-Mokolo Diocese in the Far North Region of Cameroon.

This study finds that although PPP is considered to be helpful in strengthening the national health systems functioning – in this case, all of the focus has been on the secondment mechanism and visible resourcing. Not enough attention has been given to the less visible aspects of partnership such as clashes between workers' aspirations or organisation cultures. This study demonstrates the problems inherent in an applied systems intervention that disrupts existing modes of operation, and does not answer to individuals' aspirations. It is demonstrated that such an intervention mainly results in various forms of resistance rather than immediately strengthened partnership.

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Contents

Appendices

Acronyms list

CC:	Catholic Church
CHA:	Christian Health Association
CORDAID:	Catholic Organisation for Relief and Development
C2D:	Contrat de Développement et de Désendettement
CHS:	Catholic Health Service
DRDC:	Debt Reduction-Development Contract
HIPCI:	Heavily Indebted Poor Countries Initiative
HPSR:	Health Policy and Systems Research
HRH:	Human Resources for Health
HWs:	Healthcare Workers
IMF:	International Monetary Fund
LMICs:	Low and Middle Income Countries
MMD:	Maroua-Mokolo Diocese
MoH:	Ministry of Health
MOU:	Memorandum of Understanding
PHC:	Primary Health Care
PPP:	Public-Private Partnership
PNFP:	Private not for Profit
PFP:	Private for Profit
SAP:	Structural Adjustment Program
TCH:	Tokombere Catholic Hospital
UNFPA:	United Nations Population Fund
UNOCHA:	United Nations Office for the Coordination of Humanitarian Affairs
WHO:	World Health Organisation
WB:	World Bank

PART A: STUDY PROTOCOL

Public Private Partnership in the Cameroonian Health System: A Case Study of Staff Secondment into the Maroua-Mokolo Diocese

Introduction

Public private partnerships (PPPs) are now seen as a vital tool for countries' development. They are "increasingly heralded as an innovative policy tool for remedying the lack of dynamism in traditional public service delivery" (Jamali, 2004: 418). It has been suggested that an effective and efficient partnership between governments and private health sectors may improve access to health care (Raman and Bjorkman, 2000; Ahn et al, 2000; Widdus, 2001). Partnerships are particularly important in the face of economic and health crises.

In Africa, the effects of the economic crises of the eighties are still visible. The Bretton Woods Institutions proposed Structural Adjustment Programs (SAPs) to African indebted nations as one solution to Africa's financial crises (Loxley, 1990; Easterly, 2005). The designers of SAPs believed that African nations were spending too much on social services such as education and health care – and therefore one of the aspects of SAPs was to push African states into reducing such spending (Loxley, 1990; Rodrik, 1990). However, despite such large-scale efforts, Africa's financial crisis has deepened. Several commentators have noted that SAPs rarely aided African states in resolving their financial crisis (Loxley, 1990; Carmody, 1998; Heidhues and Gobure, 2011; Stewart, 1994) – apart from some "relative success" in countries such as Ghana (Loxley, 1990: 8). Some African states are now even more indebted and are today classified as heavily indebted poor countries.

The Heavily Indebted Poor Countries Initiative (HIPCI) is an intervention to assist countries "depending highly on concessional financing from the concession lending arm of the World Bank, (WB), the International Monetary Fund (IMF) and international development

associations" (Isar, 2012: 109). Two HIPCI initiatives have been initiated to date (Isar, 2012). HIPCI Two began in 1999 and differs from HIPCI One by the fact that it "seeks to reduce poverty rates by freeing up resources and promoting social spending to reduce cash debt-service payment" (Isar, 2012: 109).

Cameroon qualified as a heavily indebted poor country in 2000 (IMF, 2006) – meaning that Cameroon qualified for HIPCI Two, which has a particular emphasis on social spending. It is within the framework of HIPCI Two that the French and the Cameroonian governments entered into a debt relief agreement. The agreement gave birth to the Debt Reduction-Development Contract (known in French as *le Contrat de Développment et de Désendettement* or C2D). The on-going C2D agreement has a focus on forest management, environmental protection and four socio-economic areas aimed at improving Cameroonians' living conditions: education, agriculture, rural development, and health (Gain, 2012). One of the key C2D activities in the health sector is to improve partnership between the Cameroonian government and private health providers – in particular partnership with the significant number of private non-profit faith-based health providers who operate in Cameroon.[1]

The C2D in the health sector also supports improved human resources for health (HRH), in particular, the recruitment of health personnel by the Cameroonian government[2]. It is important to note that since the country accepted SAPs, health personnel recruitment was effectively "frozen for fifteen years" from 1985 to 2000 (Amani, 2010: 4). This meant that during this period, less than one hundred medical doctors were recruited into the public health sector per annum upon graduation from the medical faculty of the University of Yaoundé one (Amani, 2010) - then the country's unique medical training facility. Even more

[1] 'Faith-based health providers' (FBHPs) – are also sometimes called 'mission' or 'Church' hospitals. In Cameroon, FBHPs are clustered in three main groups: the Catholic Church, the Adlucem Foundation and the Council of Protestant Churches of Cameroon (a federation of eleven protestant Churches in Cameroon). These FBHPs are distinctive in the way they view the provision of health care as a divine mission.

[2]The Ministry of Health is responsible of governmental activities related to health. In this study, government and Ministry of Health have the same meaning.

problematic was the resulting freeze in recruitment of all other health workers (nurses and the like) from 1985 until the C2D agreement in early 2000. Given an acknowledged HRH crisis in Cameroon (as in Africa more broadly), a strong focus of the C2D agreement was on improved partnership for human resources – and the main strategy for this improved partnership was the secondment of government health workers into the private-not-for-profit health sector (PNFP).[3] In Cameroon, this PNFP sector is dominated by three clusters of faith-based providers, namely, the Catholic Church, the Adlucem Medical Foundation and the Council of Protestant Churches of Cameroon.

Similar strategies have been tried in other African countries (see discussion below) – however the results and implementation of such a health systems intervention have never been properly assessed. In Cameroon, while the secondment of government health care workers into the faith-based health providers' systems was assumed to be a welcome relief, the effects of this intervention on the Cameroonian health system and more importantly on the faith-based providers has not been considered.

Like other such policies and health systems interventions (and as demonstrated strongly in this study), the staff secondment policy is potentially influenced by contextual and systemic factors such as poor collaboration between the Cameroonian government and faith-based providers' authorities, or individual factors such as whether seconded health workers integrate into the new systems in which they are placed. However, such considerations have not been adequately researched.

[3]'Seconded staff' as described in this thesis, are health workers posted in the faith-based health facilities by the Cameroon government (public health sector), but remaining on the government payroll.

Background

In Africa, access to health care remains a dream to many citizens. Although efforts are being made, the road to universal health coverage is still long. Africa has 11 per cent of the world's population but bears 24 per cent of the global burdens of disease (Lange et al, 2008). The continent suffers from severe HRH shortages, with less than 1 per cent of the global health force to be found in Africa (Lange et al, 2008; Anyangwe and Mtonya, 2007).

Developing countries' governments are being challenged to improve or upgrade access to health services. However, in many countries, the public health system is weak, and private or non-state providers play an important role in filling the gap – making it necessary to consider them more carefully in relation to improved universal access (Basu et al, 2012).

In Cameroon, the private health sector currently provides around 40 per cent of health care (Médard, 2001). Although the Cameroonian government is the major health care services provider, it is bolstered by the private-for-profit (PFP) and the private-not-for-profit (PNFP) providers. There is also a 'sub' health sector made up of traditional healers and alternate providers, although these are not commonly recognised as part of the formal health sector (Fkunang et al, 2002). Kamgnia (2006) found that 35 per cent of the population use public health services in Cameroon. Mba and Ongolo-Zogo (2011) reported that 55.6 per cent of urban inhabitants in Cameroon use private health services and 94 per cent of those who participated in that study said they were satisfied with the services they received in private health institutions made up of the PFP and PNFP sub-groups.

This study will focus on the PNFP providers, which in Cameroon are mainly made up of faith-based providers (also known as 'mission-based providers'). In Cameroon, it has been estimated that the Catholic Church alone provides about 40 per cent of the health services in the private sector (Médard, 2001). The common perception of the Catholic Church as a health provider in Cameroon is that it is providing essential health care to rural and marginalised

populations where government facilities are mainly absent, and that Catholic health workers are characterised by dedication, quality service and good governance (Elat and Mayer, 2011). However, although these perceptions are strongly present, there is limited hard evidence of these characteristics and strengths in the available literature.

As governments strive to strengthen their health systems, the Cameroonian government has acknowledged the vital role played by private health providers in general and the Catholic Church in particular (Boulenger and Criel, 2012). *La Stratégie Partenariale du Secteur Santé au Cameroun* (The Health Sector Strategic Partnership in Cameroon) adopted in 2007 and *L'Appui à la Contractualisation des Relations Public-Privés dans le Secteur de la Santé au Cameroun* (The Support for Public Private Relations in the Health Sector in Cameroon) are two key policy documents between the Cameroonian government's Ministry of Health (MoH) and private health providers. These policies are used to materialise and improve PPP in Cameroon, and are aimed at bringing the public and private health providers to the same table. One of the main mechanisms in these policies for improved PPP is the secondment of government health workers into the PNFP sector. For the Catholic Church, this means that the main connection or point of collaboration between the Ministry of Health and the Catholic Health Service (CHS)[4] is this secondment mechanism.

The health system in Cameroon faces a significant human resource crisis as do most African health systems (Anyangwe and Mtonya, 2007). The secondment of medical staff by the government into the PNFP sector generally, and the CHS in particular is seen as a government strategy to strengthen the national health system. In practice, this means that health workers employed through the Ministry of Health are posted into the CHS – remaining as state employees and paid through the government bureaucratic system.

[4] The Catholic Health Service (CHS) – is the translated name used in this study for the loosely connected network or system of Catholic health institutions. In Cameroon, unlike some other African countries, the CHS is not tightly governed from a central point, but is instead mainly governed at a diocese level.

However, the effect of staff secondment on the health system in general and the CHS in particular is not known. Indeed in other African countries (such as Ghana and Malawi), this particular policy intervention has been fraught with difficulties, and in many places has since been adapted or abandoned (see Schmid et al, 2008).[5]

African health systems are plagued with diverse challenges (WHO, 2007). The Cameroonian health system is facing challenges ranging from health worker shortages and lack of motivation, to poor governance and lack of infrastructures (Amani, 2010). In the current environment where strengthening health systems has been recognised as key to providing better health care to populations (Willis-Shattuck et al, 2008), this particular policy issue - the secondment of government staff into Catholic medical institutions - is a useful tracer for broader health systems concerns. The lessons from this policy implementation provide important clues about the state of PPP and policy relations more broadly, critical human resources for health management and systems governance concerns.

The collaboration between public and private providers as a health system strengthening strategy in Africa and Cameroon is recent. In Cameroon, collaboration between the government and the private sector began in the nineties (Greunais, 2001) but was given a substantial boost by the targeted financial support brought by the DRDC program. Considering the newness of PPP in the health sector in Cameroon, it is important to understand what is happening in this partnership. This research will explore the state of PPP in the health sector in Cameroon with a focus on the Maroua-Mokolo Diocese[6] - a diocese in the Far North Region of Cameroon. In Cameroon, the Catholic health services are governed mainly at the diocese level (rather than at a national level), which makes it the appropriate level to consider PPP in this context.

[5] Although Schmid et al (2008) did not focus on secondment – this study remains one of the few that mentions the secondment of public staff into faith based medical facilities.

[6] A 'diocese' is an ecclesiastical district under the jurisdiction of a bishop – usually encompassing more than one health district (as delineated by the government).

This research will explore the question of how the secondment of government staff into Catholic health institutions in this Diocese has affected the management and organisational culture and practices of these institutions, and what the implications might be for the broader Cameroonian health system.

The Cameroon health system: a history of weak governance and limited partnership

The Cameroonian government took over the control of the health system after the country's independence from colonial rule in 1960.[7] Some progress in improving access to health care was observed during the years that followed independence (Berche, 1985). As in many African countries, this progress shrank with the economic crisis of the eighties followed by the devaluation of the country's currency in 1994 (Ntangsi, 1998). Maternal and infant mortality in Cameroon has risen (Kamgnia, 2006). The ratio between health workers and population is estimated at one medical doctor for 11,000 inhabitants and one nurse for 2,081 inhabitants (Médard, 2001). This is far behind the World Health Organisation (WHO) ratio-target of one medical doctor for 1000 patients (Mwenda, 2012) and 500 patients for a nurse (Joubert, 2009).

One hospital in Cameroon serves 45,000 inhabitants and one health centre serves 12,000 inhabitants (Médard, 2001). The ratio is better compared to some other African countries (Médard, 2001). However, in Cameroon, public health infrastructure is often not well maintained - and it is estimated that only 20 to 25 per cent of the infrastructure is being used effectively, with about 30 per cent of the population accessing health care at hospital or tertiary care level (Médard, 2001). Corruption and poor utilisation of financial resources have been highlighted as key governance concerns in the Cameroonian health sector (Médard, 2001). Halajko (2007) found that less than one third of the financial package allocated to

[7]Different regions of what is now Cameroon were governed by Germany, France and Britain at different times in the colonial history – each area had a different governance and public health approach.

health institutions is used for their intended or allocated purpose. Although the financial crisis is cited as the major cause of the breakdown observed in the public administration in general and the public health system in particular, other underlying causes have been noted – with poor governance playing a significant role (Mba and Ongolo-Zogo, 2011).

The effects of poor governance and health systems design can be traced from the years that followed independence. For example, after independence, medical infrastructure was mainly centred in urban areas (Baye et al, 2013). As a result, today, the country's referral or reference hospitals are found in Douala and Yaoundé, the country's two major urban centres, are primarily used by the urban rich (Baye et al, 2013). The unequal distribution of health infrastructure and a weak primary health care system means that much of the rural population is left with unmet health needs and limited access (USAID, 2005).

Public private partnership (PPP) has been described as: "a risk-sharing relationship based on a shared aspiration between the public sector and one or more partners from the private and or voluntary sectors to deliver a publicly agreed outcome and or service" (Dhaene, 2008: 6). Consensus on the benefits of PPP has not yet been reached (Palmer et al, 2002; Basu et al, 2012). Supporters of PPP such as Nishar (2004) push the concept forward by highlighting the assumed benefits it may have. Ramiah and Reich (2006) warned that extensive planning and learning should be done before PPP is implemented, and based on a study in Botswana, noted that PPP is not easy to implement. They wrote about the African Comprehensive HIV/AIDS Partnerships that brought the government of Botswana, the Bill and Melinda Gates foundation and Merck and Co together. The project apparently suffered four years of poor coordination between government officials and the project team. Ramiah and Reich (2006) explained that the lack of comprehension between parties was rooted in the fact that the parties involved had different interpretations of what 'partnership' entailed (Ramiah and Reich, 2006: 550).

Although Ramiah and Reich's (2006) focus is slightly different from the current study, it demonstrates that the implementation of PPP is never easy. Das (2007) wrote about the lack of managerial and technical ability of the Indian government in assisting private health providers. He gave the example of more than two hundred ambulances the Indian government had given to private providers (without consultation on the operational costs) – which were subsequently turned into taxis (Das, 2007). In another partnership between the Indian government and private health providers, Das (2007) reported partnership failure when the government did not release funds on time, or when fewer funds were provided than to similar government hospitals.

There have been a few recent studies considering the emerging partnership agreements between African governments and the faith-based health providers that are still prominent in many countries. Dimmock et al (2012) found that among sixteen African countries, eight had a memorandum of agreement (MOU) between the government and the local consortia of faith-based health providers (the Christian Health Associations, or CHAs). The other eight did not have any kind of contractual agreement in place.

Although PPP is being encouraged, some countries and private health providers remain unconvinced of the value of such partnership. This may be explained by fears of hidden agendas each party believes the other might have – and in some places a historical lack of trust between public and private faith-based providers (see Boulenger and Criel, 2012; Haddad et al, 2008). Partnership between faith-based providers and their respective governments is varied in Africa. For example, in countries where there is a substantial sector of faith-based providers (such as Uganda or Ghana), there is usually an MOU in place which spells out how resources will be shared – mainly with a focus on HRH (Dimmock et al, 2012). In countries with a smaller presence of faith-based providers (such as Mali), there is rarely any contractual relationship in place (Schmid et al, 2008).

In Cameroon, *La Stratégie Partenariale du Secteur Santé au Cameroun* as mentioned above, has the target of achieving a level of "80 per cent collaboration" among all health providers by 2010 (Minister de la Santé, 2006)– although exactly how a percentage of collaboration should be measured is not clear. However, three years after the targeted endpoint of 2010, a strong partnership between the government and faith-based providers is not yet evident. In a key study of this contracting relationship, Boulenger and Criel (2012) noted the distrust that is evident in Cameroon at this time, and that both parties tend to accuse the other of failure to deliver on the terms of this partnership.

Boulenger and Criel (2012) also provide a case example of the Tokombere Catholic Hospital (TCH), which illustrates a lack of respect towards the terms of the PPP MOU by the government. Tokombere Catholic Hospital was transformed into a district hospital after consultation between the government and Catholic authorities in 2003.[8] This transformation was preceded by the closing down of the Tokombere public (district-level) hospital. Boulenger and Criel (2012) noted that in this context, TCH should therefore be receiving the same financial support previously given to the public district hospital. However, they noted that the government was not assuming this responsibility (to be explored more in this study).

Health policy and systems research of Catholic health systems governance

Like other faith-based providers in Africa, although the Catholic Health Service faces significant financial and human resource challenges it has still been broadly suggested that CHS might be providing a high quality of care in Cameroon (Médard, 2001). Médard suggests that this can be explained by CHS's organisational culture characterised by staff discipline, the low level of corruption, good governance and management among others (Médard, 2001). Amani (2010) pointed at the relative advantage faith-based institutions have over public

[8]This is a common strategy in many African countries: a PNFP (usually faith-based) hospital is designated to act as a public district-level hospital – which usually entails a service level agreement between the facility and the district officials, and means that lower level health centers report to that PNFP hospital as though it were a public facility (see Olivier et al, 2014).

hospitals in Cameroon – noting in particular the availability of medical imagery machines that are not found in public hospitals. Elat and Mayer (2011) go so far as to portray the CHS as a model for the public health system in Cameroon to follow. However, just how these issues and perceptions of a superior quality of care and a distinct operational and organisational culture impact on PPP has rarely been researched.

The World Health Organisation (WHO, 2007: 2) defined a health system as "a system that consists of all organisations, people and action whose primary intent is to promote, restore, or maintain health". Although many definitions of a health system are available, the full understanding of what a health system is remains challenging. Health systems are complex as they include many elements - and the interaction between these elements is also the basis of the understanding of a complex health system. Roberts et al (2008) describes a health system as a system made of two groups - a system made up of software and hardware. Previously, health service studies have focused on understanding and improving hardware performance through (mainly) economic analyses (Gilson et al, 2003). The focus has mainly been on mobilising (hardware) resources such as infrastructures, human and financial resources (Gilson et al, 2003). Software in a health system can be understood as the force that drives the structures. An example of a software concern might be HRH motivational factors – however, less attention has been paid to the (invisible) software components of the health system (see Gilson, 2012).

Considering software issues in the Cameroon health system raises many different questions. For example, it has been broadly suggested that health workers in Catholic health facilities might work with high levels of motivation than those in public health facilities (even if in comparable conditions such as working in a rural health centre). One suggestion is that faith-based health workers might be motivated by a specific organisational culture characteristic in faith-based or Catholic health facilities – and that this organisational culture is shaped by a

particular theology, which health workers are encouraged to assume – such as 'assisting the poor as Christ did' (see Olivier, 2014). In this sense, health care workers (Catholic or not) might be brought into this culture through cultural change or organisation learning, "a process of increasing the capacity of effective organisational action through knowledge and understanding" (Carroll and Edmonson, 2002: 52).

Human resource motivation and retention constitutes a major topic in health policy and systems research (HPSR, see Lehman et al, 2008). The importance of organisational culture in health system strengthening has also been documented by Blaauw et al (2003). It would be important to understand whether health workers in Catholic facilities are motivated by different factors, and whether this impacts on quality of care or issues of access. Another related concern would be whether seconding staff from the government into a different (Catholic) organisational culture has implications for care, worker motivation, and on the system more broadly.

While much is being written on PPP in the health sector and the possible benefits it may have in the strengthening of health systems (Bennet et al, 1994), astoundingly little has being written on the particular aspects or mechanisms within PPP, such as staff secondment and its impact on the health system. The closest relevant literature that can be found is studies such as that by Vian et al (2007), which reports on the placement of volunteers from a Pfizer program into medical institutions in development contexts. They assess that successful collaboration resulted from good planning and because volunteers were carefully posted according to the health institutions' needs and volunteers' training (however, here too, the government did not play the role of a financial provider).

In another landscaping study of faith-based health providers in Africa, it was noted that in the staff secondment arrangement in Uganda (between government and the CHA in Uganda), Schmid et al (2008) reported that there was resulting tension between government staff and

faith-based staff at some medical institutions. The salary difference between public and private workers was noted as a main reason for this tension (Schmid et al, 2008). This highlights that partnership tensions often play out at the individual level, and not only at an institutional level – as individuals play an important role in the effectiveness of policy implementation. In particular, health workers (medical staff), can have a strong influence on policy implementation (Walker and Gilson, 2004). In this case, staff perceptions can potentially influence the implementation of the PPP policy (positively or negatively). Therefore, considering the views of front line staff is central to a study such as this.

As argued above, research into PPP implementation– and in particular, its impact on health systems strengthening is urgently needed. However, PPP is characterised by the context in which it is enacted. It is therefore important to explore the policy implementation process of PPP in Cameroon more fully. A closer examination of the interaction between the Catholic health services and the Cameroonian government in one particular Diocese – utilizing the issue of staff secondment as a tracer for broader concerns – should provide useful insight into how health systems components fit together and how policies occur in practice.

Purpose of the study

The purpose of this study is to explore the Cameroonian Ministry of Health's health system intervention of seconding government health workers into Catholic health facilities. In an attempt to explore the effects of secondment into the Catholic Health Services, the following two focus areas will be considered. The first focus area will be an exploration of the Cameroonian policy environment related to PPP in the health sector. The main hypothesis here is that secondment may not achieve its intended aim if clear guidelines on the subsequent management of such seconded staff have not been laid out. An examination of the

broader policy environment should provide insight on issues related specifically to staff secondment.

The second focus area of this study will be the exploration of the integration of the Cameroonian health system. A health system is made up of many elements (WHO, 2007). When these elements do not work together, the health system is less likely to provide better care to populations. An exploration of PPP can be used to explore characteristics of the Cameroonian health system – in particular, how the public and private non-profit health sectors are aligned. This should provide some insight into overall Cameroonian health systems functioning and some recommendations on how to improve systems performance through improved PPP.

Theoretical framing

This research is influenced by several clusters of theory or concepts such as 'organisational culture' or 'public private partnership' (as discussed above, and more below). However it is important to note that this research is deliberately positioned as feeding into the emerging field of 'health policy and systems research' (HPSR) – and as such leans heavily on the related theoretical underpinnings and frameworks of this field of investigation (see Gilson, 2012). In the face of the inherent complexity of health systems (as discussed above), a 'building blocks framework' can assist in understanding health systems. The identified health systems building blocks (as identified by the WHO) are: governance, financing, information system, medical supply, service delivery and human resources (De Savigny and Adam, 2009). It is believed that any intervention aimed at strengthening one of a health system's building blocks will have an impact on one or more of the other building blocks (De Savigny and Adam, 2009).

It is strongly shown that human resource shortage, poor management and lack of motivation hamper health delivery (Mathauer and Imhoff, 2006; Connell, 2007; Willis-Shattuck et al, 2008). Policy-makers have advised on strategies such as staff recruitment, continuous training, performance management, and incentive for retention or remote areas development as an important means to resolve human resources issues within a health system (Mathauer and Imhoff, 2006; Connell, 2007, Willis-Shattuck et al, 2008). However, the interrelated effect of the different building blocks can be seen in relation to strengthening HRH: for example, for human resources to be productive, good governance is needed to guide action.[9] Financing is needed (at least) to pay staff salaries and motivation packages. Medical supplies (drugs, vaccines, and others) are needed, as are information systems which enable management of patient information. Therefore, strengthening all the above mentioned blocks is expected to have a positive impact on the final outcome - the improved delivery of health services.

As mentioned, in addition to being located as a piece of HPSR, other relevant conceptual or theoretical framing will be drawn into this study – in particular the existing work on PPP and organisational culture. Public private partnership in health has been defined as: "any formal collaboration between the public sector at any level (national and local governments, bilateral government donors) and the public sector (commercial, non-profit, traditional healers, midwives or herbalists) in order to jointly regulate, finance or implement the delivery of health services, products, equipment, research, communications or education" (Barnes, 2011:2). As discussed, some scholars are sceptical of the assumed benefits of PPP (Palmer et al, 2002; Basu et al, 2012). Although a climate of uncertainty continues to exist around what partnership actually means in practice, what its benefits might be, and how it should be assessed, PPP continues to be strongly promoted and implemented.

[9] Rules and regulation that guide the provision of health care in a health system

Lasker et al (2001) wrote that most studies of partnerships "lack explanation of the pathway through which partnership functioning influences partnership effectiveness" and that frameworks developed to date "do not identify the mechanism that enables partnerships to accomplish what more than one individual or organisation can accomplish" (182-183). They call the mechanism that enables partnerships to achieve their goals 'synergy', which is "the power, the perspectives, resources of a group of people or organisations" (Lasker et al, 2001:183) – and identify financial resources, skill, connections to other people as key resources needed for a good partnership. They also pointed to characteristics such as the heterogeneity or homogeneity of the group, the presence of trust, effective leadership, governance efficiency as well as external factors such as community characteristics and policies as key elements contributing to the success of partnerships. Lasker et al's (2001) framing of partnership therefore seeks to assess the relationship between policy and partnership functioning and is therefore useful for the current study. However, it should be noted that the Lasker et al (2001) approach is somewhat limited in the way it equates 'partnership' to a mechanism – and therefore does not fully explore many of the relational and contextual challenges of policy implementation.

Walt and Gilson (1994) point out that understanding policy implementation is a difficult task – especially in the health sector – where it is centred on understanding the content, the actors, the context and the implementation process. They also note that policy content, actors and context have been given significantly more consideration than policy implementation processes (Walt and Gilson1994). This study will therefore focus on the policies supporting PPP in Cameroon to better understand staff secondment in the Catholic Health Service system. The study will consider the partnership mechanism factors as outlined by Lasker et al (2001) but will also seek to extend this by focusing on policy implementation in context.

In addition, as discussed above, consideration will be given to the organisational culture, norms, values and aspirations that might influence such policy implementation. Given the intentionally limited scope of this study, this should be considered an exploratory study – as it is not possible to be inclusive of all software issues that might potentially impact on PPP in Cameroon. Instead, a particular focus will be given to 'organisational culture' – which is often raised as an important unique characteristic of faith-based health providers (and which was also a main focus of the larger study in which this one is embedded). An underlying hypothesis is that the organisational culture within Catholic health providers is distinct from that found in public facilities – and that there is therefore a potential 'culture clash' when government-employed staff is seconded into Catholic Health Services without proper processes in place. 'Organisation culture' has been defined differently in various contexts and disciplines (see Scott et al, 2003; Schen, 1990; Davies et al, 2000). According to Scott et al (2003) the definitions of organisational culture ranges from a simple 'this is how we do things here' to much more complex definitions and frameworks. The simpler example is seen widely in literature on faith-based health providers – for example in statements such as 'as Catholics we provide quality services to the poor' (see Schmid et al, 2008).

Vandenberghe (1999) notes that there are not only cultures but also sub-cultures within institutions – and these sub-cultures may not be in harmony with the broader institutional culture. This is important in understanding that there is no single 'Catholic culture' in the Cameroonian CHS – but a series of cultures which are constantly blending and clashing together. Child and Faulker (1998) gave four possible typologies for accommodating cultural diversity within health care organisations. They stated that in a health care institution, when synergy between the different cultures is achieved, no culture dominates; the cultures merge. Segregation is the second base in which no culture dominates. The difference between synergy and segregation is that when segregation takes place, cultures cohabit with each

other without merging. When domination occurs, one culture dominates. Breakdown occurs when one group fails to dominate the other group or groups.

While Child and Faulker's (1998) description captures what happens at the organisational level - O'Reilly et al (1991) focus on the individual level, looking at how a person entering a new organisation 'fits' with the organisational culture, depending on whether it satisfies his or her needs. In this understanding, an organisational culture intervention seeks to achieve an internal integration by establishing a common ground between the different cultures present within the institution. In this study we broadly adopt Schein's definition of culture, as "a pattern of basic assumptions, invented, discovered, or developed by a given group as it learns to adapt with its problem of external adaptation and internal integration that has worked enough to be considered as valid and therefore is to be taught to new members as a correct way to perceive think and feel in relation to these problems" (Schein, 1990: 111). An organisation that adheres to this definition will actively attempt to create an internal cohesion between the different cultures that will be interacting within it (Schein, 1990).

These conceptualisations of organisational culture raise interesting questions in relation to staff secondment in Cameroon. For example, consideration of whether a new staff member entering a health facility adapts to the organisational culture or not. As noted above, Catholic health providers are thought to have a characteristic organisational culture which has been established over many years of operations – and is often actively protected (see Olivier, 2014). Government-employed staff inserted into Catholic health facilities may be resistant to Catholic organisational culture. Such questions are supported by the theoretical frameworks such as those developed by O'Reilly et al (1991), or Child and Faulker (1998). O'Reilly et al (1991) established that when newcomers enter an organisation, they are likely to commit to the organisation if the organisation has values that provide job satisfaction. On the other hand, Child and Faulker's (1998) framework on the four typologies (synergy, segregation,

domination and breakdown) of approaches to managing organisational change in the face of cultural diversity informs us of the possible outcomes when cultures clash. Both perspectives are potentially useful for this study as Child and Faulker (1998) describes what happens at the organisational level meanwhile the O'Reilly framework gives an explanation of what happens at the individual level. To this end, the exploration of the PPP between CHS and the MoH will entail an application of Child and Faulker (1998) framework in an attempt to understand how the Catholic culture and the government culture interact at the institutional level (for example, considering if the observed partnership can be characterised by one of the four above-mentioned typologies). However, human beings and relationships impact on the partnership, and are therefore also important.

Methodology

Study design

This research is designed as an exploratory single-site case study. This research is nested within a broader three country case study funded by Cordaid and conducted by researchers in the University of Cape Town, Health Policy and Systems Division (see project Information Brochure in Appendix B).The Cordaid-funded study focused more broadly on access to sexual and reproductive health services in Catholic Health Services in Ghana, Malawi and Cameroon. The current study draws on the broad study methods and results, but focuses more closely on the organizational culture in the CHS at the Maroua-Mokolo Diocese (MMD), and on the issue of secondment.[10] Baxter and Jack (2006) wrote that a case study can be used when the boundaries are not clear between the phenomenon and the context. It is impossible to explore the effect of staff secondment on the Cameroonian health system without considering the context within which this is taking place. A case study design has also been selected since,

[10] Secondment arose as a secondary finding of the main study, but was not its original focus

according to Neale et al (2006), a case study is appropriate when a unique story has to be told. While medical staff secondment in private health institutions has been briefly documented in Ghana and Malawi (Schmid et al, 2008), this will be the first such study in Cameroon, and the first exploring this policy practice in detail

Characteristics of the study population

The focus of the broader study was on the tensions and complexities of sexual and reproductive health (SRH) service provision through Catholic health systems. The scope of the study was national, but in each country case there was a particular focus on one diocese (which consists of several health centres and hospitals). Participants were considered for the broader study if they had a role to play in the provision of SRH services directly or indirectly. This included health workers at several levels (such as those engaged in maternal health services), health facility managers, and diocese health secretaries, bishops, and some community members. For this sub-study, the perceptions of health workers, facilities managers, and diocese health secretaries were prioritized.[11]

Recruitment and enrolment

A purposive sampling strategy was used in recruiting participants into the main study. The researcher was introduced to medical staff by facility managers or unit managers within targeted medical centres. Participants were given information brochures on the study and their consent was sought after they had read the study information brochure.

Research procedures and data collection methods

Data for the broader study was collected using in-depth interviews, observation and reviewing of policy documents. This study will consist of a second round of thematic analysis of this primary data with a focus on staff secondment with further documentary and policy

[11] A diocese health secretary is a person that coordinates Catholic health services in a particular diocese – and usually acts as an intermediary between the health service managers and the Bishop (as the nominal head of the diocese system) – see Olivier et al, 2014.

analysis. It is important to note that the candidate (Mr J Kuh) was directly engaged in the broader study. He was involved in the tool design and research set-up phase, was involved in the translation of the tools and materials into French, and conducted the primary fieldwork in Cameroon over a one-month period (June-July 2013). This current project therefore constitutes a secondary analysis of this data and extension of the existing project for thesis purposes – but also builds on observations and experiences in the field.

Data collection was scheduled to start in Yaoundé, the Cameroonian capital city. The researcher established contact with those responsible for family planning and maternal and infant health in Cameroon at the Ministry of Health (and appropriate in-country ethical clearance was obtained from regional authorities, see Appendix D). The researcher spent twenty days in the Far North Region of the country (see Appendix F) where the health institutions selected for the study are located. The study was done at three locations: the Mayo-Ouldeme and Maroua-Domayo Catholic medical centres and the Tokombere Catholic Hospital (TCH). Mayo-Ouldeme and Tokombere are two localities situated respectively at about 60 and 50km from Maroua, the regional capital of the far north region.

The researcher spent three full days at the Mayo-Ouldeme Catholic medical centre, during which time seven in-depth interviews were conducted (seven of the eleven staff members). There were expected challenges to the research process, such as electrical black-out periods. The researcher was hosted and housed by the Mayo-Ouldeme Catholic priest, whose house is next to the medical centre. The researcher therefore had considerable access to the medical centre and was able to conduct observation.

For Tokombere Catholic Hospital, the researcher was lodged at the Tokombere hospital guest house and had full access to the hospital. There, eight in-depth interviews were conducted (one with the chief medical doctor of the hospital, six among the eight member staff of the Tokombere hospital maternity and one with a staff at the hospital HIV/AIDS unit).

The researcher also spent ten days in Maroua, where he conducted eleven in-depth interviews at the Maroua-Domayo health centre (three with administrative level staff and eight with health workers).

Apart from the documentary and policy analysis employed, the main data collection tool was in-depth, semi-structured interviews - twenty-three of which were re-analysed for the purpose of this sub-study.

The interviews took place at participants' duty stations. The shortest interviews took one hour while the longest took two hours. Although the researcher was aware of the sensitivity of the questions and therefore took precautions to interview participants away from colleagues, there was a noticeable openness and ease with which participants spoke about these topics (noting that the main study also engaged on issues such as abortion and the use of contraceptive methods in the Catholic context). The researcher understood that data collection is a process during which a researcher enters the field with preconceived ideas, and researcher's reflexivity was carefully considered at all times.

Data analysis

Data collected for the primary study was coded (with each interview given a code known only to the core research team). Recorded interviews and field notes were kept securely by the investigators for further reference and only shared within the team. After transcription and translation, the notes were saved on password protected computers. For this sub-study, the data was hand-coded and analysed using thematic analysis. Thematic analysis is "a search of themes that emerged as being important to the description of the phenomenon studied" (Fereday and Muir-Cochrane, 2006: 82). According to Braun and Clarke (2006), thematic analysis is not ascribed to a particular theoretical perspective. Although thematic analysis cannot be used with all theoretical perspectives, it can assist in a wide range of theoretical analysis. The current study has adopted a critical realist perspective. Braun and Clarke

described a critical realist theoretical perspective as a perspective that "acknowledges the way individuals make meaning of their experiences and in return the way the broad social context impinges on those meaning while retaining focus on the materials and their limits"(2006: 84). The researcher will conduct the analysis using inductive thematic analysis which Braun and Clarke noted is a "process of coding the data without trying to fit the data within the researcher's analytic preconceptions and into a pre-existing coding frame" (2006: 88). It is of course difficult for the researcher to truly free himself from all epistemic and theoretical belief – but it is important to note that the use of an inductive thematic analysis will assist in limiting the researcher influence on the data analysis process by bringing out a valid data analysis (Braun and Clarke, 2006).

The validity of the data collected was strengthened by the usage of more than one data collection method and source. Data from the interviews and policy documents was triangulated to ensure data validity. Data validity was further tested by the sharing of the data to members of the research team who assisted in testing the validity of the data and analysis. The theoretical framing described above was applied to further test the data. A worksheet technique was also used to analyse data. According to Mauthner and Doucet (2003), the worksheet technique requires the researcher to write respondents' words in a column and the researcher interpretation in another column and compare where some of the researcher's opinions and views differ from the respondent point of view. This further assisted in unpacking possible research influence and reflexivity.

Ethical considerations

Description of risks and benefits

The primary study focuses on sexual and reproductive health which is a highly sensitive topic area in the context of Catholic health system. Staff secondment in this context can also be

regarded as potentially sensitive - as workers whose opinions differ from organisational rules or cultures may fear being subject to sanction by management. Facility managers may consider such issues to be an internal management issue, and may fear providing information that could bring the facility into disrepute. Such discomforts were carefully considered and managed. As a qualitative study without clinical intervention, this study would nevertheless be regarded as 'low risk'.

Full ethical consent processes were observed at all times. Considering the sensitivity of the issues investigated, interviews took place in an environment where a third person was not able to listen to what was being discussed during interviews. Each participant was taken through the consent process and assured of their anonymity and confidentiality. Respondents were given information on their rights relating to participating in the study and were assured they could refuse to answer or withdraw if they deemed it necessary.

There were no direct benefits for participants in the study (no financial reimbursement or reward). More broadly, this study aims to strengthen evidence, partnership and systems functioning. The findings may assist systems and facility managers which may have an indirect benefit to participants.

Informed consent process

Prior to the interviews, an information brochure for the broader study was shared with participants (see Appendix B). The researcher came back some time later following the distribution of the brochure. Participants read the information contained in the information brochures and some asked questions. The researcher answered their questions before the start of the interviews. Participants were informed that the study did not have a direct benefit to them (for example that they would not be paid for being part of the study). Their rights to participate or not were explained. They were told that they have to right to ask questions

during or after the interviews, to withdraw from the study at any time, and could conduct the interview in their language of preference.

No children were involved with the study - participants were adult men and women. Taking into consideration their professional status (health care workers and managers), it is possible to assume that they are mentally fit and were able to consent to their participation in the study. The information brochure and consent forms were translated into French giving each participant the ability to read in the language they understand.

Participants were given a code during each interview. In writing up the report or any piece that will come from the data collected for the primary study, participants were assured that their names would not be used in any write-up without express permission. The current study will follow the ethical rules set down for the primary study. During data collection for the primary study, participants' personal details were not requested.

The information was only shared between the research team (all of whom had been briefed on proper ethical procedures). After the production of the study report, the data will be stored securely until a later date when it will be deleted.

There was no financial cost to participants for this study. The interviews were done at their place of work during off-peak hours. The researcher was able to observe that the influx of patients at the hospital and health centres decreased in the afternoon, and therefore interviews were conducted in these times.

At the end of the current study, the results will be shared with key participants and stakeholders, including decision-makers in the Cameroonian health system and international funding partners. A strong attempt will be made to share the findings with all study participants (by emailing the report to the designated health facility manager, and translating key findings), with some time provided in which participants can respond before publication.

It is anticipated that the study will be published in a way to make it more available to a wider audience.

Research planning

The costs of fieldwork and analysis for this research were covered as part of the broader Cordaid-funded research project into which this is embedded. There are no further costs.

Timeline (March 2013-May 2014)

	MAR 2013	**APR 2013**	**MAY 2013**	**JUN 2013**	**JUL 2013**	**AUG 2013**	**SEPT 2013**	**OCT 2013**	**NOV 2013**	**DEC 2013**	**JAN 2014**	**FEB 2014**	**MAR 2014**	**APR 2014**	**MAY 2014**
PREPARATION															
LITERATURE REVIEW															
DATA COLLECTION															
FIELDWORK															
TRANSCRIPTION															
DATA ANALYSIS															
CODING															
ANALYSIS															
WRITING															
WRITING UP															
WRITING UP															
PROJECTION SUBMISSION AND FINDING DISSIMINATION															
SUBMISSION															
DISSEMINATION															

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PART B: STRUCTURED LITERATURE REVIEW

TITLE: The Uptake of a Health Staff Secondment Policy in Cameroon

Introduction

This literature review section provides the broader background to the article that follows. It addresses the question of how the secondment of government staff into Catholic health institutions has affected the management and organisational culture of these institutions and impacted on the Cameroonian health system in general.

The paper that follows is based on a case study of the staff secondment practices designed as a health systems strengthening intervention in Cameroon. Staff secondment addresses the perceived human resources for health shortage –which relates to one of the six health systems building blocks, human resources (WHO, 2007). Staff secondment is a fairly new health systems intervention in Cameroon, and is based on a series of policies whose implementation began in 2007. This strategy entails the posting of government health workers into faith-based health services such as the Catholic Health Service, but with the staff member remaining a government employee. This literature review focuses on literature related to staff secondment in lower to middle-income countries (LMICs), and also provides important background information to the Cameroonian health system. In this literature review, some review methodology is provided, followed by the results of the literature search relating to staff secondment in Cameroon.

Review method

A scoping literature search was conducted utilising databases such as Africa Index Medicus, Ebscohost, Pubmed, Academic One Science and Science Direct. Various combinations of English and French search terms were employed, and they can be clustered into three groups.

Firstly, terms relating to Catholic health services (including: not-for-profit, church, mission, faith-based, as well as French words such as but non-lucratif, église, mission, confessionnelle); terms relating to secondment and partnership (PPP, partnership, collaboration, contracting, secondment, human resources, partenariat public prive, contractualisation, ressources humaines); and finally terms relating to the Cameroon health system in general (Cameroon, health system, public health, health service, LMIC, Cameroun, system de santé, santé public, service de santé, pays en voie de développement).

Given the limited results, no exclusion criteria were initially applied. Three relevant studies on secondment were retrieved (Ntata, 2007; Dryden and Rice, 2008; Hamilton and Wilkie, 2001). However, even these primarily considered staff secondment as a staff capacity building tool rather than a health policy or systems intervention.

Broader Google and Google Scholar searches were then conducted in order to identify more resources and grey literature, and this produced more results. There was in particular, a significant amount of literature relating to PPP, especially relating to PPP in the developed world. Further searches for literature on LMIC countries provided fewer results. If the search was limited to staff secondment, less than four studies dealing with staff secondment could be found. Literature relevant to this study was found in the *Journal of Nursing Management*, grey literature from the Christian Health Associations in Africa (such as reports), conference presentations and some research reports. The lack of studies dealing directly with staff secondment is a sign that this remains a relatively poorly researched area that requires more scholarly attention.

Historical context between the government and Catholic providers

In 1841, the arrival of George Kinghorn Prince and John Clarke missionaries from the Jamaican Baptist Missionary Society marked the beginning of Christianity in Cameroon (Van

Slageren, 1972; Messina and Van Slageren, 2005). They were followed by missionaries from different denominations, among them Catholic missionaries who arrived in 1890 (Etaba, 2007). Upon arrival, missionaries met locals suffering from diseases that also attacked missionaries and colonial staff (Van Slangeren, 1972). The need to fight diseases prompted missionaries (such as Prince), who were often medical doctors to put their skills into practice to assist locals, colonial staff and missionaries alike (Van Slageren, 1972). The early missionary health services, such as those provided by Prince and Good, were ambulatory (Van Slageren, 1972), but medical centres were later constructed, making faith-based providers some of the earliest providers of Western medicine in Cameroon in particular and Africa in general (see Dimmock et al, 2012).

During the colonisation period that followed (in Cameroon from around 1884 to 1960); and on the African continent, faith-based providers were some of the main health providers (Schmid et al, 2008). However, after independence, newly formed African governments adopted a more hands-on approach with some faith-based providers more closely integrated into national systems (such as Tanzania and South Africa - see Leurs et al, 2011). In Cameroon, faith-based providers operated sub health system independently from the national health system until the earlier twenties when the government began a process aimed at integrating private providers into the national health system and reorienting health provision toward primary health care (Okalla and Le Vigoureux, 2001).

Interestingly, the Tokombere Catholic Hospital in the Far North Region of Cameroon has an existing PHC approach to health care provision since the late seventies and is therefore considered a national PHC pilot centre (Boulenger and Criel, 2012). Therefore, it can be said that faith-based providers influenced the shaping of the post-independence health system. This can also be viewed as an early example of collaboration between the government and the hospital. However, Boulenger and Criel (2012) confirmed that such collaboration happened

in a fairly informal way. The informal collaboration between the TCH and the government of Cameroon became a formal partnership in 2002 when TCH became the district designated hospital (Boulenger and Criel, 2012). TCH was then more formally integrated into the national health system through the signing of a service level agreement that stipulated each party's responsibilities. For example, the government had to provide financial subsidies to TCH and the hospital had to adopt national policy and be open to government evaluation (Boulenger and Criel, 2012).

However, it has been noted elsewhere that formal contractual partnerships might limit a key characteristic of faith-based providers, that is, their responsiveness and flexibility (Dimmock et al, 2012). Some policies such as the cost recovery models adopted by the government have not been accepted by some faith-based providers. Indeed, Greunais, 2001) found that in the Maroua-Mokolo Diocese (MMD) where this study is based, the government-specified cost recovery model has not been implemented. He further explained that the cost recovery was not adopted by the Catholic MMD health service because it goes against their ideology of serving the poor. More broadly, many faith-based providers remain fearful of what effects such integration into national health systems might have on their organisational cultures and values (Dimmock et al, 2012).

As mentioned earlier, staff secondment has been attempted in several other African countries such as Uganda, Malawi and Ghana. In Uganda, it was reported by Schmid et al (2008) that there was tension between government staff posted at faith-based health facilities and the local staff. Such tension was mainly caused by salary differences and it was so rife to the extent that the secondment in that form had to be discontinued. In Malawi, the intervention was discontinued because of an apparent lack of understanding between the Malawian government and faith-based providers (Schmid et al, 2008). In Ghana, secondment was also attempted and then stopped as a result of management practice challenges (Olivier, 2014). In

these countries, the secondment implementation was adapted, retaining the spirit of the agreements between the CHAs and their governments, but changing the implementation mechanism so that while the governments financially subsidise the majority of posts (salaries), the recruitment of staff is usually the responsibility of the CHA, and the management of staff the responsibility of each facility manager. In Cameroon, the secondment intervention was proposed under the debt relief programme between the Cameroonian and French governments. One of the debt relief program elements in the health sector is to address the human resources crisis in health by recruiting health workers and posting such recruited workers into faith-based health provider facilities.

The need for an integrated health system

McIntyre et al (2008) advised that an integrated health financing mechanism is the ultimate factor for achieving universal coverage. An integrated health financing mechanism may be better achieved if the different elements in a health system are integrated. The need for an integrated health system is evidence of the fact that a health system has many actors (Bennett et al, 2005). A health system's ability to provide health care may depend on the degree of collaboration between its actors. In other words, a health system whose actors work independently from each other may be less likely satisfy citizens' health needs.

The Cameroonian Ministry of Health seemed to have realised that the fragmentation of its health system is the cause of the health system poor performance. For example, some declarations and policies from the Ministry of Health (MoH) in Cameroon from the early nineties show the MoH desire to transform the national health system through improved integration and partnership. In 1993, the MoH published a declaration that reorganised the nation's health map by dividing the territory into health districts (Okala and Le Vigoureux, 2001). During the same year, a blueprint law on the decentralisation of health care services-

another important aspect of the MoH's desire to transform the national health system was published (Okala and Le Vigoureux, 2001). Médard (2001) pointed to the fact that the decentralisation of health services was done to provide a better response to citizens' health needs as it was believed that the centralisation of decisions at the MoH negatively affected the MoH's decision-making due to bureaucracy. It was therefore believed that the decentralisation of health provision, would improve the national health system response to citizens' health needs (Médard, 2001).

An interesting aspect of the health system reforms in Cameroon is the MoH's (1997) declaration which placed every medical institution (public or private) found within a health district under the supervision of a health district officer, a MoH employee who oversees the activities of the health institutions under his or her supervision (Greunais, 2001). The Cameroonian MoH was attempting in this way to create an integrated (but decentralised) health system. Although the decision-making process was decentralised, placing an employee of the MoH at the head of a health district may be a sign that the MoH wished to provide leadership and coordinate multi-sectoral health provision. It is possibly for this reason that Greunais (2001) explained the MoH's decision to integrate private medical institutions into the national health system as a move aimed at not only winning back its territory, but also the creation of a unified health system.

Although the MoH's desire for an integrated health system should be welcomed because it may enable better health care provision, the government's ability to integrate faith-based providers into the national health system needs to be examined. Greunais (2001) questioned the MoH's ability to implement its declaration considering the fact that the private sector in general and faith-based providers in particular who have been providing health care in Cameroon independently may not accept the integration into the national health system. Faith-based providers seemed to be a barrier to the MoH's intention to strengthen the

national health system. Boulenger and Criel's (2012) findings showed that even the population may be a barrier to the integrated health system project. They established that when the TCH was to be transformed into a district hospital, the local population did not accept the move. The population saw in the move a complete taking over of the hospital by the MoH and believed that such a move may be accompanied by poor service delivery (Medard, 2001; Elat and Mayer, 2011).

Although there is no proof that the MoH's intention was to fully take over control of the private health institutions, it should be noted that the faith-based providers and some of the local population might be resistant to 'integration' at this level (Boulenger and Criel, 2012 and Greunais, 2001). The MoH needed an implementation strategy faith-based providers may accept. It is possibly for this reason that the MoH began negotiating with faith-based providers with the intention to formalise the informal collaboration that existed between them (Boulenger and Criel, 2012). The negotiations were not smooth as Boulenger and Criel (2012) documented in their case study on the TCH. However, faith-based providers and the MoH finally reached an agreement and entered into a partnership.

Staff secondment is one of the ways through which the partnership between the MoH and faith-based providers is being realised in Cameroon. Although the public health system is facing human resources for health shortage (Mba et al, 2011), the MoH has possibly recognised faith-based providers' role in the provision of health care and as such has decided to second staff into faith-based providers' services. The MoH may have accepted the staff secondment intervention (advocated by the French government) because strengthening the public health service alone would not be enough to reach the entire population (and gain universal health coverage). Faith-based providers provide about 40 per cent of the national health coverage (Medard, 2001); strengthening the national health system without considering the private sector may therefore only have a partial outcome. The MoH may have

accepted the staff secondment intervention because it is in line with its national health system strengthening initiative.

Staff secondment a relief for the burdened MMD health service

It is estimated that less than 50 per cent of the current population in Cameroon lives in rural areas (Institut National de la Statistique du Cameroun, 2010). However, considering regional characteristics, in a region such as the Far North Region 76 per cent of its population lives in rural areas (Institut National de la Statistique du Cameroun, 2010). The Far North Region is classified as the second most populated region in Cameroon (Institut National de la Statistique du Cameroun, 2010). Paradoxically, it is the province with less human resources for health besides its density (Institut National de la Statistique du Cameroun, 2010). In contrast, the Littoral Region, the region with the highest human resources for health, the doctor patient ratio stands at 4.4 medical doctors for 10000 inhabitants. In the Far North, it stands at 0.1 medical doctors for 10000 inhabitants. Other interesting facts about the Far North Region are that even when private health workers are taken into consideration, the doctor-patient ratio is still low compared to the ratio in the Littoral Region (UNFPA, 2009), and many public health facilities in that regionare mostly closed because they lack staff (Greunais, 2001).

Public health facilities' closure may mean that faith-based health institutions are the places where inhabitants of the Far North Region are most likely to seek health care. The burden of providing health care rests mainly on the shoulders of the faith-based providers in these areas – so hugely increased demand in the face of a simultaneous human resource shortage. Besides the shortage of health workers, the Far North, North, and Adamoua regions (the three Regions of Northern Cameroon) are constantly affected by epidemics such as cholera and

other concerns such as child malnutrition (UNOCHA, 2013). Malnutrition and cholera are preventable; however, due to shortage of health workers and resources generally, prevention campaigns maybe inadequate - and the limited number of (faith-based) health workers bear the burden of treating these patients.

Meanwhile, faith-based providers in Cameroon, like those in other similar contexts, are currently operating under severe financial constraints. Since independence, faith-based providers have seen major changes in their financial and operational contexts – no longer receiving the same support from traditional sources as they used to. As a result, they have had to implement new cost recovery strategies, and have sought closer relationships with their national governments (Dimmock et al, 2012; Olivier, 2014). They have also experienced massive human resource constraints, struggling to support and retain quality staff – so it is little surprise that the faith-based providers in Cameroon would have accepted the proposed staff secondment intervention. In the face of human and financial resources, the insertion of seconded staff into faith-based facilities was perceived as a potential relief to current staff – which ought to improve the quality of care at faith-based health facilities.

Staff secondment overtly benefitting both the Cameroonian government and faith-based providers

The global annual contribution for health went from $5.7 billion to nearly $27 billion between 2000 and 2010 (Sturchio and Goel, 2012). The rise in contribution toward health care can be explained by the involvement of private actors in the health delivery field that was previously dominated by governments and WHO (Sturchio and Goel, 2012). Solutions to health problems are complex and require resources making it difficult for governments to tackle the problems on their own, especially in poorly resourced countries such as Cameroon (Sturchio and Goel, 2012). Widdus wrote that "partnerships appear to be most justified where traditional ways of working independently have a limited impact on a problem" (2001: 718). In other words,

partnerships are avenues to solving problems common to parties when they have used other avenues without success.

In Cameroon for example, providing health care to rural populations is a shared duty of the government and faith-based providers – for the government, it is a constitutional mandate, and for the faith-based providers, a 'divine' and social assignment. Faith-based providers' presence is highly felt in some rural areas in Cameroon, as it is in most African nations; however their activities are often restricted by limited resources (see Gilson et al, 1994; Greunais, 2001; Schmid et al, 2008). On the other hand, in Cameroon, the government has less medical facilities in rural areas, especially in regions such as the Far North region (Greunais, 2001). However, both parties do provide health care to rural populations. Their respective shortcomings (limited resources for faith-based providers and limited coverage for the government) make universal coverage a distant goal.

Universal coverage dominates contemporary discourse in the health care field (Sengupta, 2013). Governments are attempting to ensure that their entire populations have access to health care. A partnership therefore seems to be an ideal solution in Cameroon for faith-based providers and the government to improve access to health services, especially for rural populations. Each party seems to have a strength that balances out the other party's weakness.

It is not clarified in the highly limited literature exactly why the Cameroonian government and the faith-based providers entered into a partnership. It is not clear whether they realised that they might be able to solve each other's limitations, and that by working together they could achieve an efficient service delivery to rural populations. It would be important for future work to more closely consider the evolution and motivations behind the national-scale intervention (noting that this research is more narrowly focused as an exploratory case study of the implementation of the strategy in one region).

Researchers such as Nishtar (2004) advocate for PPP in the health sector because they believe PPP is able to strengthen health systems. A health system may be qualified as strong or weak depending on the number of people accessing the health care – and most African health systems have been qualified as weak because few people have such access (see Harris et al, 2009; Oyibo and Ejughemre, 2013). Based on this level of assessment, if the staff secondment intervention between the MoH and faith-based providers could be seen to improve or increase access to health care for the rural population, the partnership could be seen to be a 'success' and have strengthened the national and Catholic health systems.

This staff secondment intervention has the potential to strengthen both the national and the faith-based providers' health systems. However, Ramiah and Reich (2006) have shown that interventions that are reliant on partnership are difficult to implement. They note that actors' understanding of what partnership means is a major barrier to partnership success (Ramiah and Reich, 2006). In a landscaping study of faith-based health providers in Africa, in the staff secondment arrangement in Uganda (between government and the Christian Health Associations in Uganda), Schmid et al (2008) reported that there was resulting tension between government staff and faith-based staff at some medical institutions. Das (2007) wrote about the lack of managerial and technical ability of the Indian government in assisting private health providers. He gave the example of more than two hundred ambulances the Indian government had given to private providers (without consultation on the operational costs) – which were subsequently turned into taxis (Das, 2007). In another partnership between the Indian government and private health providers, Das (2007) reported partnership failure when the government did not release funds on time, or when less funds were provided to faith-based hospitals in contrast to similar government hospitals which were given more funds.

These studies highlight partnership tensions at the individual level, not only at an institutional level – arguing that individuals play an important role in the effectiveness of policy implementation. In particular, health workers (medical staff), can have a strong influence on policy implementation (Walker and Gilson, 2004). However, they do not unpack in detail the underlying issues that may cause the pitfalls observed at the individual and institutional levels. Put differently, the partnership is usually explored in the available (limited) literature in relation to its visible elements, rather than its underlying causal factors.

In Cameroon the government began adopting declarations aimed at transforming the national health system in the early nineties (Greunais, 2001; Okala and Le Vigoureux, 2001). It was only in the early twenties that the government began attempting to integrate faith-based providers into the national health system (Greunais, 2001). The decade between the policy adoption and implementation may have been caused by the lack of financial resources needed to implement the integration intervention. The intervention was implemented when the French government put the C2D agreement into effect (Boulenger and Criel, 2012). The C2D funds were not only meant to strengthen the partnership between faith-based providers and the government; they were also intended to be used for paying health care workers recruited under the C2D programme (UNFPA, 2009).

Study's contribution to the existing literature

It may be suggested that perhaps both the government and the faith-based providers that signed into this agreement, neglected to properly consider the effects the staff secondment intervention may have on their systems - most likely because finances to pay seconded staff were made available. (Or perhaps, more fairly, if they did have concerns, these were overwhelmed by the potential of the strategy and their existing systems constraints).

It will be argued in the article that follows that it is important to look at the effect of the presence of seconded staff on faith-based health workers and seconded staff's values, beliefs and expectations. Several authors have noted that faith-based providers have a specific working or organisational culture (see Greunais, 2001; Medard, 2001; Elat and Mayer, 2011). According to Elat and Mayer (2011), faith-based providers' organisation culture is characterised by staff dedication and good governance, and others such as Medard (2001) observed that such organisational cultural differences resulted in superior quality of services. Greunais (2004) pointed to the fact some faith-based medical institutions are examples to follow because of their good managerial techniques. He added that the Maroua-Mokolo Diocese (MMD) health service has a good leadership and is an example to emulate.

It is also known that faith-based and Catholic providers might also have comparative weaknesses, for example, it has been suggested that they might have poorer financial controls and reserves (see Schmid et al, 2008). However, what the above literature suggests is that in Cameroon, there are distinctive organisational cultural elements within the faith-based and Catholic institutions, and that such might need to be considered more closely.

Overall there seems to be an acute shortage of studies that examine the staff secondment intervention in Cameroun (or elsewhere in Africa). This review shows that Boulenger and Criel's (2012) study seems one of the few contributions which address faith-based health providers (and the staff secondment intervention) in Cameroon. Literature was drawn from diverse sources for this review. Further research work is highly necessary- and should be useful, not only in Cameroon, but also to other country's contexts in which such intervention is being considered or implemented.

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PART C: ARTICLE MANUSCRIPT

Journal targeted 'HEALTH POLICY AND PLANNING'[1]

Title of article: Public private partnership in the health sector in Cameroon: A case study of staff secondment into the Maroua-Mokolo Diocese

B. JACOB KUH

KEY MESSAGES

- Staff secondment between the public and private non-profit health sectors is being implemented with little knowledge of intervention's implementation success or ability to strengthen the Cameroonian health system.
- Case study research shows that staff secondment creates clashes between organisational cultures and individual norms act as barriers to the successful implementation of the secondment intervention.
- The success of the staff secondment intervention depends more on careful planning of the implementation mechanism, and consideration of how the implementation might affect organisational cultures and individuals norms.

KEY WORDS: Staff secondment; public-private partnership; organisational culture; faith-based providers; non-state providers; Catholic Church; Cameroon; health system.

[1] Instructions for authors in Appendix E - authors' contribution and information are excluded. For the purpose of this thesis, the student is the sole and first author of the work.

Abstract

Background: Public private partnership (PPP) between governments and non-state faith-based health providers has recently been deliberately strengthened in several African countries, including Cameroon. Cameroon is considered to have a weak health system because of limited public service provision and access. In this case, PPP includes the arranged secondment of government-employed health workers into faith-based health facilities. Little is yet known about how this policy impacts on these faith-based systems, or the broader national health system.

Methods: This paper reports on a case study of the staff secondment policy and implementation in Cameroon. It is a sub-study to a three-country case study, which focused on maternal health services by Catholic providers. Data from twenty three [23] semi-structured interviews conducted with health workers and managers at three medical facilities in the Far North Region of Cameroon was considered. Utilising thematic analysis, these three facility sites were compared, also drawing on observation data as well as primary and secondary literature.

Results: It was found that Catholic health managers emphasise a 'participatory' management approach. They saw the seconded staff as a potential threat to this management approach, and to the Catholic organisational culture more broadly. Other issues such as modes of patient reception, health worker motivation strategies and geographic placement of staff were prioritised.

Discussion: In other African countries such as Ghana, similar secondment interventions have been discontinued and adapted because of negative reactions to the secondment mechanism. In Cameroon, staff secondment was perceived as a useful systems strengthening intervention. However, several barriers to the effective implementation of this systems intervention can be

seen, in particular the clash between organisational cultures and management practices as well as a limited implementation mechanisms. Individual health worker's values also needed to be carefully considered.

Conclusion: In lieu of a complete redesign of the secondment strategy, better selection and orientation processes, and a greater level of management control being given to the direct line managers can mitigate some of the implementation barriers.

Introduction

Public private partnership (PPP) is now seen as a vital tool for countries' development (Jamali, 2004), particularly in the face of economic and health crises. Structural Adjustment Programs (SAPs) were proposed to African indebted nations as one solution to the financial crises that continue to delay Africa's development since the nineteen-eighties by the Bretton Wood institutions (Loxley, 1990; Easterly, 2005). Due to SAP's apparent inability to assist African countries to strengthen their economies (Loxley, 1990; Easterly, 2005), in many countries, structural adjustment was replaced by the Heavily Indebted Poor Countries Initiative (HIPCI).

Cameroon qualified as a heavily indebted poor country in 2000 (IMF, 2006). It is within the framework of HIPCI that the French and the Cameroonian governments entered into a debt relief agreement. The agreement gave birth to the Debt Reduction-Development Contract (known in French as *le Contrat de Développment et de Désendettement* or C2D). One of the key C2D activities in the health sector is to strengthen PPP – in particular partnership between the Cameroonian government and private non-profit (PNFP) faith-based health providers who operate in Cameroon.[2] The C2D in the health sector also sought to improve human resources for health (HRH), in particular, the recruitment of health personnel by the Cameroonian government. Within this context, some health workers are recruited under the C2D programme and are then seconded into faith-based non-profit health institutions, a process known as 'staff secondment'. The effects of staff secondment on faith-based health services and the national health system are yet to be established.

[2]'Faith-based health providers' (FBHPs) – are also sometimes called 'mission' or 'Church' hospitals. In Cameroon, FBHPs are clustered in three main groups: the Catholic Church, the Adlucem Foundation and the Council of Protestant Churches of Cameroon (a federation of eleven protestant Churches in Cameroon). These FBHPs are distinctive in the way they view the provision of health care as a divine mission.

Background

The first missionaries arrived in Cameroon in 1841 (Van Slageren, 1972). Upon arrival, they met locals suffering from diseases and this prompted them to put their skills into practice, as they were often also medical doctors (Van Slageren, 1972). In addition, most mainstream religions have an inherent ethos to 'heal the sick', and this often translates into engagement in health provision (Olivier 2014). Missionaries seem to have introduced Western medicine in Cameroon. During the colonisation period that followed from around 1884 to 1960, faith-based providers were some of the main health providers in Cameroon as in colonised Africa in general (Schmid et al, 2008). After independence, faith-based providers usually operated sub-health systems independently from the national health system. In the early twenties, the Cameroonian Ministry of Health (MoH) began a systems restructuring process which intended to integrate private providers into the national health system and reorient health provision more strongly toward primary health care (Okalla and Le Vigoureux, 2001).

The Cameroonian MoH seemed to have realised that its fragmented health system contributed to the national health system weakness. This is possibly why the MoH adopted a declaration placing every medical facility found within a health district under the supervision of a health district office (Greunais, 2001) – presumably to better coordinate health system activities, and as a result of a general push towards decentralization another MoH's action aimed at strengthening the national health system (Médard, 2001).Whether it was their own idea, or as a result of international pressure (as a result of the C2D agreement and a condition of French financing), the MoH also began to seek a closer partnership with local faith-based providers, overtly in order to strengthen HRH and the Cameroonian health system. Another influential factor is likely to have been that in Cameroon, faith-based providers are still usually located in rural areas where government medical facilities are limited (Greunais, 2001). For example, in regions such as the Far North Region, the second most populated region in the country, faith-

based providers service a large number of people where there are few government facilities (Institut National de la Statistique, 2010). Greunais (2001) noted that government medical facilities are closed because they lack staff. This, he argues, is in contrast to Catholic health care centres such as the Mayo-Ouldeme and Maroua-Domayo and The Tokombere Catholic hospital where constant medical assistance is available. As in other African countries, governments have frequently seen closer partnership with faith-based providers as an opportunity to extend the national system in support of goals such as universal health coverage (Olivier, 2014).

Meanwhile, faith-based providers in Cameroon, like those in other similar contexts, are currently operating under severe financial constraints. Since independence, faith-based providers have seen major changes in their financial and operational contexts – no longer receiving the same support from traditional sources as they used to. As a result, they have had to implement new cost recovery strategies, and have sought closer relationships with their national governments (Dimmock et al, 2012; Olivier, 2014). They have also experienced massive human resource constraints, struggling to support and retain quality staff – so it is little surprise that the faith-based providers in Cameroon would have accepted the proposed staff secondment intervention. In the face of human and financial resources, the insertion of seconded staff into faith-based facilities was perceived as a potential relief to current staff – which ought to improve the quality of care at faith-based health facilities.

However, Greunais (2001) suggests that faith-based providers might resist this integration into the national health system. Ramiah and Reich (2006) have shown that such partnership interventions are difficult to implement. Cameroon is not the first nation where staff secondment has been implemented. The intervention faced many challenges in Malawi and Uganda and had to be discontinued (Schmid et al, 2008). Das (2007) wrote about the lack of managerial and technical ability of the Indian government in assisting private health

providers. Das (2007) reported the failure of another partnership in India, arguing the failure can be attributed to the government – as the government did not release funds to hospitals on time, or when too few funds were offered in comparison with public hospitals. These studies highlight partnership tensions not only at an institutional level, but also at the individual level.

It seems from the available literature that there was very little implementation planning or instructions that accompanied the secondment strategy (see Boulenger and Criel, 2012). With a focus on a strategy which on the surface should provide immediate relief to a critical concern (financial support of the human resource crisis), it would appear that very little attention was given to systems 'software' factors such as differing staff values, perceptions and expectations, as well as differing management practices and organisational cultures. Focusing on the implementation of secondment in the Catholic Maroua-Mokolo Diocese[3] (MMD) in the Far North Region of Cameroon, this paper will argue that these neglected systems software issues are key factors behind individuals and organisation's performance, and ultimately behind the success of the secondment partnership intervention. This will be done by addressing the question of how the secondment of government staff into Catholic health institutions has affected the management and organisational culture of these institutions and impacted on the Cameroonian health system more broadly.

Study Approach and Methods

This research is designed as an exploratory single-site case study – with the case being the Maroua-Mokolo Diocese (MMD) in northern Cameroon. Baxter and Jack (2006) wrote that a case study can be used when the boundaries are not clear between the phenomenon and the

[3] A 'diocese' is an ecclesiastical district under the jurisdiction of a bishop – usually encompassing more than one health district (as delineated by the government).

context. It is impossible to explore the effect of staff secondment on the Cameroonian health system without considering the context within which this is taking place.

This case is drawn from a broader three-country study, which focuses on the tensions and complexities of sexual and reproductive health (SRH) service provision within Catholic health systems. Participants were considered for the broader study if they had a role to play in the provision of SRH services directly or indirectly. For this sub-study, the perceptions of health workers, facilities managers, and diocese health secretaries[4] were prioritised. A purposive sampling strategy was used in recruiting participants. This study consisted of a second round of thematic analysis of primary data with a focus on staff secondment with further integration of documentary and policy analysis, as well as observation. The first author of this article gathered the primary data utilised for this analysis at three facility sites and diocese offices in the Far North Region of Cameroon over a one-month period (with the broader study running from January 2013 to June 2014).

The Maroua-Mokolo Diocese (MMD) was selected for the broader study as it demonstrated useful examples of implementation practice within the Catholic Health Service (CHS). It should be noted that in Cameroon, each Catholic Diocese runs a decentralized and autonomous health system – and each Diocese system is loosely networked together into the national Catholic Health Service (CHS). At the Diocese level, the health service is supervised by a Diocesan Health Secretary (reporting to the Bishop of that Diocese), and is made up of all medical institutions within the Diocese geographical boundaries. Each Diocese overlaps the demarcation of several government health districts (see Olivier, 2014). The MMD Catholic Health Service is made of 13 health centres and a large referral hospital. The secondment

[4]A Diocese Health Secretary is a person who coordinates Catholic health services in a particular diocese – and usually acts as an intermediary between the health service managers and the Bishop (as the nominal head of the diocese system) – see Olivier et al, 2014.

intervention is governed in the MMD by a memorandum of understanding between the Cameroonian Ministry of Health and the Maroua-Mokolo Diocese.

The memorandum of understanding has 10 articles. Article 1 states the MoU objective: the strengthening of the partnership between the Ministry of Health and the MMD aimed at the development of the Tokombere health district. Article 3 outlines the Ministry of health's responsibilities. They entail: recognising the Tokombere private hospital as the district hospital of the Tokombere health district and private health centres as centres responsible for the provision of health care where they are located; ensure that the health centres have the necessary resources (financial and human) necessary for their functioning; appoints the health district representative; ensure that decisions are taken after consultation with the MMD-CHS. Article 4 outlines the MMD-CHS responsibilities. They entail: the adherence to MoH health provision guidelines within the district; the forwarding of quarterly and annually activities report to the regional delegation of health; a transparent management of allocated resources and the integration of human resources posted in agreement with the MoH; the collaboration with monitoring and evaluation delegation from the MoH or the regional delegation of health. It should be noted that this document is not widely available (none of the CHS staff or facility managers interviewed had a copy at the time of this research); however it is the main policy that governs this partnership in this location.

Apart from the documentary and policy analysis employed, the main data collection tool was in-depth, semi-structured interviews - twenty-three (23) of which were assessed as relevant for this sub-study[5]. The interviews took place at participants' duty stations, in French, the participants' language of choice. For this sub-study, the data was hand-coded and analysed using thematic analysis. An analytical framing was conceived to guide data analysis. The

[5] This is a secondary study, the data analyzed for this study was pulled from the data collected from the primary study and was re-analyzed. Because this is a sub-study, a different data collection approach was not conceived. However the topic investigated in this study strongly emerged in the data collected for the primary study.

analytical framing was done by combining Child and Faulker's (1998) and O'Reilly (1991) frameworks. Child and Faulker's framework presents four typologies that are likely to occur when two organisational cultures meet in an organisation. O'Reilly et al's framework explains what may happen in such interactions at both individual and organisational levels.

All proper ethical protocols were employed in this low risk study. Confidentiality was provided and maintained for all participants (and as such, specific facility and individual's names are not provided in this article). Prior to commencing data collection, ethical clearance was received from the University of Cape Town's Ethics Committee as well as from appropriateCameroonian authorities.

In the following section, key findings are outlined, and additional secondary literature is also provided to unpack some of these findings – an approach that is necessary given the exploratory and qualitative nature of this study. This is followed by further discussion and conclusions

Findings

Catholic managers' perceptions of poor communication

The managers of the Catholic facilities that were interviewed unanimously agreed that in their opinion the staff secondment intervention is having limited success in strengthening the Catholic Health Service (CHS). They attributed what they perceived as the intervention's 'failure' primarily to the lack of communication between the Ministry of Health (as represented in their view by the regional delegate of health) and the Catholic Health Services. They felt that when seconded health workers (HWs) are posted, their profiles do not correspond with facilities' human resources needs. The regional delegate of health seconds staff without consulting the CHS management. One of the facility managers stated that, "It does

not help to have people who are just a double, a triple or quadruple of what we have already. We need qualified workers but when we continue to receive auxiliary nurses meanwhile we have many here, it is not helpful" [Catholic Facility Manager. Maroua, 2013].

Facility managers emphasised that seconded health workers were seldom present on duty. They believed that in general, seconded staff tended to assume duty and leave after a couple of weeks. During fieldwork, it was observed that former Catholic health workers[6] that were then recruited by the government and posted at the same health centre where they had previously served as Catholic health workers tended to remain on duty. (Former Catholic health workers may be considered as seconded health workers when they are employed through the government and posted back into Catholic facilities). One seconded staff member, who has not worked before for the Catholic Church was on duty during fieldwork at the Tokombere Hospital maternity. One of her managers noted: "She was recently posted here; we do not know for how long she will stay" [Catholic Unit Manager. Tokombere, 2013].

According to the MOU between the Diocese and the MoH, the MoH has to "provide the human resources necessary for the good functioning of Catholic medical facilities; this includes posting and salaries payment among others after consultation with the Catholic leadership to establish HRH need and availability." Another MOU clause attributes to the MoH the responsibility to make decisions. However, decisions should be made in consultation with faith-based providers' representatives (MOU, 2002: Article 3)

It is entirely possible that the Cameroonian MoH simply did not have the requested specified human resources available to be able to second them. However, the Catholic managers

[6]Note that 'Catholic staff' in this article means staff employed through the Catholic system – not that the staff are necessarily Catholic in religious belief (in Cameroon, staff are not employed based on religious profile, and most staff in the Catholic facilities are in fact not necessarily Catholic). Three categories of staff can be found at a Catholic facility; staff employed through the Catholic system, former Catholic staff recruited by the government and seconded staff that did not work for the Catholic Church previously.

signalled a significant communication gap, noting this intended consultation was totally absent. They felt they had little control over the secondment process, or power to negotiate which health workers were seconded into their facilities. When health care workers who have not previously worked for the Catholic Church were seconded, facilities managers considered them to be 'wanderers' or visitors who would inevitably leave after a short period.

Different staff management approaches

According to the Catholic staff and managers, the MMD-CHS has intentionally adopted a supportive management approach that is participatory and cordial in style. More in-depth research is required to understand how extensively this approach is practiced – and how it is balanced against more traditionally reported Catholic authoritative or paternal approaches (see Olivier, 2014). However, during this fieldwork, this supportive management approach was observed consistently as staff and facility managers interacted in a number of different ways. In the case facilities, the managerial positions are held by younger staff – who addressed staff older than them by calling them 'mom' or 'dad' (in French). This form of casual address was also observed when managers addressed staff in their age range as 'chief' (or '*chef*' in French). These forms of casual address are small indicators of a broadly appreciative managerial approach that the health workers stressed was an important aspect of their organisational culture that was distinct from what they had observed or experienced in government facilities. A health care worker at the Mayo-Ouldeme health centre stated that: "We share information on our patients, with the chief of the centre, for example, I talk a lot about cases that happen in the hospital, I am more experienced than him and he has studied more than me so we sit together to seek solutions for issues that arise at the centre" [Catholic Staff. Mayo-Ouldeme, 2013].

However, this supportive and appreciative managerial approach does not prevent the managers from practicing discipline or enforcing regulation around quality of care or human

resource practice. For example, in relation to an issue in which it was expected that firm regulation was practiced – such as the provision and promotion of contraceptives in the Catholic facilities – it was widely observed and noted that health workers felt free to discuss such issues openly with colleagues and managers. However, there were still clear rules in terms of practice that were enforced. As one health worker noted, "A seminar was held in which we asked the leaders why we do not administer modern contraceptives. At the end of the seminar, we were told that the Church position remains the same, we can speak about modern contraceptives, but we are not allowed to administer them or sell them at our health care centres" [Catholic staff. Mayo-Ouldeme, 2013]. The participant's statement gives an example of both the more supportive and participatory style – and the regulation, as managers have the final decision on how health care is administered. This example also shows the way particular regulations flow down a line of governance from the Bishop of the Diocese, through the MMD-CHS, to the managers and into practice (see Olivier, 2014).

Management literature describes how managers can choose between top-down (authoritative) and bottom-up (supportive or participatory) approaches to staff management. For example, in a comparative study of performing hospitals, Mannion et al (2006) observed that hospitals in which a top-down approach was used, performed better than hospitals where different approaches to staff management were used. In contrast, Pimbert and Pretty (1995) reported that in an environment where people are given consideration, they are much more likely to be involved in any activity being carried out, and that staff should be given room to participate in the day to day activities of the organisation. Tellis-Nayak (2001) point out that managers have the responsibility to create an environment that encourages staff's participation - an environment they can create by listening to staff, acknowledging their efforts and considering how decisions they take as managers will affect staff's life. Dieleman et al (2003) found that consideration by managers is a motivator for rural health workers in

North Vietnam. While this article cannot delve too deeply into these different management approaches, it is important to note that the Catholic management culture observed during this research was overtly 'participatory' and 'cordial' – although rules and regulations were still clearly in effect for certain disciplinary matters.

The partnership contract between the Diocese and the government does not specify the Diocese's or CHS management's role in relation to seconded staff management. In practice, this has resulted in a situation where the Catholic management team cannot discipline seconded staff (who are in effect governed by the district health officer, although not in any practical way). This is a situation Hamilton and Wilkie called "the lack of role definition for the individual and organisation" (2001: 315), which in their view is a serious barrier to staff secondment.

In the MMD-CHS, Diocese leadership noted that the lack of role definition was not only an obstacle in the implementation of staff secondment, but it also in some cases had resulted in the Diocese leadership or facility management requesting some seconded health workers (who did not respect Catholic rules) to leave. As one participant put it: "Among government workers, there are some who do not respect the rules. When it becomes a regular situation, we call the health worker and tell him or her that the decision to join us was done willingly, if they do not want to work again with us, they are welcome to leave" [Diocesan Health Committee Member. Maroua, 2013].

Poor staff collaboration between regular Catholic and seconded staff

The majority of CHS staff that were interviewed and observed did not welcome the seconded staff into their work environment (except for those seconded staff who were in fact previously Catholic staff now employed on the government payroll). The majority of the regular Catholic staff emphasised the need for seconded staff to respect CHS rules - and some were strongly

against the presence of seconded staff for the reason that they disrupted the way health care was provided (the quality of care).

In 2000, a *British Medical Journal* editorial focused on the collaboration between health care professionals. The editorial stressed that the most important thing about collaboration is not what healthcare professionals have in common, but how well their differences can be used to achieving organisation goals. Dieleman et al (2003) and Willis-Shattuck et al (2008) found that for most health workers, their colleagues' appreciation and recognition are important motivators.

A strong sense of collaboration and solidarity was observed and noted between regular Catholic staff. Those that were interviewed reported that they perceive themselves to be working as a 'family' – and this was a strong motivator for their work at that facility. As one of the Catholic staff interviewed said: "We work as a family, when I see something I cannot handle I call my colleagues we sit and decide on what to do" [Catholic Staff. Mayo-Ouldeme, 2013]. In contrast, appreciation between the regular Catholic and seconded staff appeared to be very limited – and in most cases collaboration was absent.

The values and perceptions people hold determine their course of action and reflect their agency (Giddens, 1979). However, because these values and perceptions are not overtly visible, they are not often given consideration. This suggests that even if the seconded staff were well managed, the perceptions of the regular Catholic staff might still inhibit their interaction and collaboration.

The secondment intervention has created two distinct groups inside the Catholic institutions – with the regular and seconded staff standing on either side of a distinct line in the organisational sand. Given the other experiences of secondment in Africa this cohabitation is not likely to improve, even given more time, if it continues in the same way (see Schmid et al,

2008) – or if some way is not found to harness differences towards organisational goals. Paying Catholic and government staff at the same rate may be one of the ways to mitigate the differences. Although regular Catholic staff requested that seconded staff should respect their work ethics, government health workers are better paid than private health workers in Cameroon (UNFPA, 2009). Salary differences' may cause further division between seconded staff and regular Catholic staff (although this concern did not emerge very clearly in this particular analysis). It is likely that the lack of collaboration between staff weakens the quality of care in the facilities – and ultimately the health system. While the inability of Catholic managers to discipline seconded staff can be seen as an institutional level barrier (perhaps a 'hardware' issue), the staff perceptions might be more of an individual-level and systems 'software' related barrier. Consideration needs to be given to staff's perceptions, values and norms as they may contribute to weaken the implementation of the policy and overarching strategy.

Seconded staff motivation and retention

The primary data revealed that an important non-financial retention strategy utilized by the MMD-CHS is to post staff close to their home or village of origin. At all three case sites, the majority of the regular Catholic health workers were from the surrounding local areas. For example, at the Mayo-Ouldeme health centre, only one staff member was not from Mayo-Ouldeme; the health workers interviewed at the Tokombere hospital maternity were all from Tokombere; and at the Domayo-Maroua health centre, health workers who were not immediately from Maroua originated in the neighbouring villages. As one health worker from the Domayo-Maroua health centre said (having moved from the south of the country): "I am happy to work here because my family lives here, I am here with my parents and I was born here" [Catholic Staff. Maroua, 2013].

Most staff at the Mayo-Ouldeme hospital (and especially those who reported being schooled by the Catholic Church and employed by the Church after graduation), reported being happy when they joined the health institutions where they are currently working. According to them, working at a Catholic health facility was also a way to serve their local communities. A staff member at the Mayo-Ouldeme health centre said that he was very happy to be serving his people especially because of the response he received from the community for the service he provides. He described an incident at the local market as follows: "My wife and I went to shop, many people came around to greet me and some bought items for us; my wife was surprised." [Catholic Staff. Mayo-Ouldeme, 2013]. A staff member at the Tokombere hospital described the assistance he got from the youth of a community where he went for an outreach program. They brought back his motorcycle that developed a mechanical fault during his visit at the village. He said: "They brought back my motorcycle without requesting anything, I was so amazed by the assistance they gave; it is in recognition of my work" [Catholic Staff. Tokombere, 2013].

It should be noted that the availability of staff willing to work in rural areas such as Tokombere and Mayo-Ouldeme is a major concern and constitutes a barrier to the provision of care to the rural population (Dieleman et al, 2003). Although Maroua is an urban area, health care workers from the south of Cameroon are less likely to want to work in Maroua because it is far from their place of origin – meaning that strategies to employ and retain local health workers is particularly important.

As mentioned earlier, the MMD-CHS recruits health workers from the localities where the health centres are located. Although this strategy has some challenges (for example, whether there are enough local qualified staff to fill those positions), the managers and Diocese staff believed that this strategy is currently helping to retain health care workers.

Mba et al (2011) observe that health workers usually leave their posts because they are unable to provide basic needs for themselves and their families. Israr et al (2000) established that some health care workers engage in agricultural activities to cope with the financial crisis in Cameroon. However, the MOU between the MMD and the government states that the MoH will provide the required health workers to the MMD-CHS after evaluating the need and availability of health workers. This statement suggests that the posting of seconded staff is done after accessing the numerical needs of Catholic health institutions (in this research we were not able to verify the extent to which this actually happened, although enquiry was made).

Managers and Diocese staff noted that this approach did not take key motivation and retention factors into consideration. The managers' view is supported by Mba et al's (2011) finding which states that the MoH does not have a concrete staff management policy. This stands in contrast to the UNFPA (2009) report which notes that the mobility of MoH' staff is geographically related and tends to satisfy staff requests when possible. Seconded staff from the south of the country could be posted into the MMD Catholic facilities. It is interesting that Greunais (2001) found that most government health centres in the Tokombere and Mokolo health districts had been recently closed down because they lacked health care workers. This is reportedly because of this problem of retaining staff from the south in the north (although not clearly evidenced). In any case, the current strategy clearly did not take such issues of retention or motivation strongly into account. Seconded health care workers have needs and values that needed to be taken in consideration before their posting – and are less likely to stay if such are not met – otherwise undermining the core intentions that underpin the secondment strategy.

'People-centred' health care provision

Nearly all of the management and regular Catholic staff cited the ethos of 'reception' as a culture particular to the Catholic health service compared to the public health service. 'Reception' in this sense might also be described as the 'welcome' or 'compassionate care' – which is often stated in the secondary literature to be a strong organisational ethos or aim of Catholic health service, and is rooted in the theological basis which emphasizes care for others, and being in service to others, and potentially resulting in a higher quality of care (see Olivier, 2014).

According to the participants, 'reception' is understood as the distinctive Catholic institutional approach to receiving and treating a patient with respect and dignity. Participants noted that they are always focused on patients' satisfaction. Regular Catholic staff were unanimous in their understanding that the way a patient is received by a health care worker contributes greatly to the patient's satisfaction and recovery. A participant noted: "reception contributes 50 per cent to the patient recovery, medications contribute 50 per cent" [Catholic worker. Mayo-Ouldeme, 2013]. This difference was perceived as a key point of pride in the Catholic service, as a health worker noted: "We receive people from as far as Nigeria because of the way we treat our patients" [Catholic staff. Tokombere, 2013].

For example, an observation that supports this claim came from the Mayo-Ouldeme health centre, where during a consultation the patient could not communicate with the health worker because they did not speak the same language. The language spoken by the patient was identified and the health care worker who spoke the language was called, even though she was not actually on duty at the time. This effort and dedication was emphasized throughout the study as part of the organisational culture – being willing to go the extra mile. This was articulated in the Catholic institutions in the language of 'service'. (Note that in this study such organisational cultural themes such as 'reception' and 'service' were not overtly religious in nature – although it could clearly be argued that such emerge from religious theological

underpinnings – however, we do not explore this here in too much detail, being focused on the secondment implementation, see Olivier, 2014).

McIntyre et al's (2009) framework on access to health care emphasises access in relation to affordability, availability and acceptability. It highlights acceptability as an important but often neglected aspect of access to health care. Acceptability or patient responses to the service they receive determine patients' health seeking attitudes as do availability and affordability. Writing on the doctor-patient interaction, an aspect that often impacts strongly on acceptability, Gafni et al (1998) stated that patients are likely to revisit a doctor who treated them with dignity.

The focus of the Catholic management and organisational culture which values staff that are willing to go an extra mile supports what could be termed a patient-centred approach supported by the MMD-CHS. According to all reports, and observation in this research, regular Catholic health workers seemed to have taken this on board, and were on call and available to assist their colleagues on demand.

In contrast, most respondents felt that seconded staff did not adhere to this organisational culture or value – and did not provide the same reception or dedication in terms of willingness to work longer hours or be available on demand. At one of the sites, regular Catholic staff are given one day off per week, while the seconded staff are off-duty all weekend (suggesting another reason for resentment from the regular staff). Even so, a seconded staff noted that: "Working here is demanding and challenging" [Seconded Staff. Maroua, 2013]. A facility manager reported that seconded staff requested additional payment when they were asked to work longer hours. There was concern that if such demands were granted, Catholic staff may also then expect money for working long hours and the carefully cultivated organisational culture, which promotes 'reception' and dedication, may then disappear.

Discussion

This article can only brush across several broad areas of conflict that arise as a result of the secondment strategy. On the whole, the staff secondment intervention is not seen to be strengthening the MMD-CHS, and there are several main reasons for this. Firstly, seconded staff are seen to be absent from their posts or only there short-term before moving on. There is a perceived major communication gap between the MoH and the CHS – and in particular the MoH does not seem to be able to match staff to the HR needs in the MMD-CHS facilities. There are no implementation guidelines for the secondment arrangement, which means that Catholic managers are unable to supervise seconded staff effectively, or hold them accountable to CHS regulations. There appear to be major divisions between seconded and regular Catholic staff that hampers staff collaboration for effective teamwork and quality of care. The posting of seconded staff does not take the particular CHS retention or motivation strategies into account. Without these motivation and retention strategies, seconded staff tend to demand financial compensation for extra work, which threatens the ethos and management style intentionally adopted by the MMD-CHS. Finally, seconded staff do not appear to become enculturated in the Catholic organisational culture which values 'reception' or welcome, compassionate care and dedication 'beyond the call of duty'.

These barriers to staff secondment success are located at both institutional and individual levels. In Child and Faulker's (1998) framework that looked at the interaction of two or more organisational cultures within an organisation, they observed that in such cases breakdown of one culture is likely to occur. Similar effects can be seen here, where the cultural clash that is occurring as a result of this particular secondment strategy is seen to be threatening the existing Catholic organisational culture. For example, looking at the difference in staff management approaches, seconded staff are asked to leave the MMD-CHS when they are not willing to adhere to established rules. This is not only for infractions of overt health facility

regulations (poor quality of care), but also when tacit Catholic organisational rules are broken (such as poor dedication or absenteeism). Child and Faulker (1998) would explain this case as the inability of either the Catholic or the government organisational culture to dominate, segregate or merge. Domination occurs, when one of the organisational cultures disappear or subsumed by the other. Segregation occurs when both cultures coexist independently. Synergy occurs when both cultures merge. None of the three typologies cited above fit the description of the interaction between the Catholic and government organisational cultures. It appears that 'breakdown', the fourth typology of Child and Faulker's (1998) framework can better describe the interaction between the Catholic and government organisational cultures. A breakdown occurs when an organisational culture tries to dominate but does not succeed. Catholic managers expected seconded health workers' adherence to the Catholic organisational culture (even without any actual management control), in effect overcoming the public system's organisational culture. However, if the main result is that seconded staff simply leave the facility through rapid turn-over, then neither culture can be said to have dominated or won-over these staff.

Considering the Catholic organisational culture aspect which can be described as 'patient-centred care', it has been demonstrated in the above description that a key assumption of the Catholic CHS is that their staff need to be individually dedicated to provide quality care and satisfy patients. So far, the only successful example of enculturation is in seconded staff that were formerly trained or employed in the CHS (and then applied for the post through the government system), and obviously this is the case because they were previously enculturated while they were trained or groomed as Catholic health workers previously. This study could not go in-depth enough to unpack what it would take to enculturate a regular seconded staff member enough for them to adopt appropriately CHS attitudes as required by the MMD health service. However, the fact that managers do not have management control over such staff

would suggest that such a process would be fairly intense and lengthy – and perhaps from the manager's perspective not even worth trying considering that seconded staff tend to cycle rapidly out of the system. For all these reasons, from the managers' and MMD-CHS perspective, the secondment strategy did not bring relief to their human resource needs.

Child and Faulker's (1998) framework can assist in explaining the interaction between the government and the Catholic organisation cultures. However, there are many other potentially useful frameworks that could be usefully applied to this situation to understand how these organisational cultures interact and impact on health services. For example, Vandenberghe (1999) observes that many cultures co-exist in an organisation, so it is important to consider that even the Catholic organisational culture is made up of many sub-cultures. Vandenberghe (1999) observation can be sustained by Olivier et al's (2014) study which found that Catholic sexual and reproductive rules were individually interpreted by Catholic workers, who blended different theological and public health regulations and interpretations on a case by case basis. It might be useful to consider in later research whether this interpretative practice was different between seconded and Catholic staff.

The observation about the variety of cultures is important – as the secondary literature tends to generalise in broad sweeps about the 'comparative advantages' and 'disadvantages' of faith-based health providers and Catholic institutions (Olivier, 2014). It has been argued that such generalisations do significant damage to our understanding of the complexity of faith-based health providers, and there is some risk of presenting these modern institutions in an overly romantic and nostalgic way that emphasises their missionary history and their inherent ethos of compassionate care or dedication, without really understanding whether this is still possible in modern facilities, and how this impacts on quality of care (Olivier, 2014).

Therefore, while this article does stress some of the strongest elements that are most overt (or have the most power) in the Catholic organisational culture, and which are strongly supported

by both Catholic doctrine and managerial style – we recognise that there are multiple cultural elements acting in such facilities. More work is necessary to unpack these and understand in detail how they impact on aspects such as systems functioning and quality of care.

Culture can also be considered more closely at the individual level. For example, O'Reilly et al (1991) provide a framework that states that individuals may be motivated to work for an organisation if the organisation meets their needs. As noted above, MMD-CHS managers perceive that they are not able to meet the needs of the seconded staff (such as being paid for overtime), without damaging their own managerial and cultural system. As a result, seconded health workers are often absent or cycle rapidly out of the system when these needs are not met. Also on the individual level, there appears to be a generally negative (and ironically enough 'unwelcoming' and 'unreceptive') attitude towards seconded staff – from management and regular Catholic staff alike. While this could not unpack this in any more detail here, it seems from the interviews and observation that regular Catholic staff are well aware of their managers' negative attitudes towards the seconded staff and the secondment arrangement, and this has in turn enabled their open vocalisation of their negative attitudes towards seconded staff. We can only speculate, but perhaps if the managers had intentionally put up a more positive front, stressing the positive and helpful resource seconded staff are supposed to be to the facility and system, then perhaps regular staff would have been more welcoming and collegial, and perhaps seconded staff would not be cycling out as rapidly as they are.

Conclusions

By integrating and triangulating multiple data sources, and applying a combination of Child and Faulker (1998) and O'Reilly et al (1991) frameworks, this case study has shown that the staff secondment intervention in Cameroon had the potential to be a health system

strengthening intervention. The study reveals that the likelihood for 'breakdown' to occur between opposing organisational cultures is very high. The breakdown between the Catholic and the public sector organisational cultures is most evident when seconded staff leave or are asked to leave as a result of the various elements discussed above. At this time, the MMD-CHS Diocese and facility management usually view their departure as a relief – mainly because they felt the presence of the seconded staff, without any management control, threatened the core elements of the Catholic organisational culture, that they put a lot of emphasis on preserving.

Human resources are critical to every health system. In the present HRH crisis in Cameroon and Africa, suitable solutions are important for health provision and the health system. This study suggests that the public health system in Cameroon does not have an effective HRH management strategy in place – at least so far as that the motivation and retention of seconded (public) staff does not seem to be adequately considered. Public health workers rapidly leave their duty posts in search for better working and living conditions. A better retention and motivation strategy could mitigate this problem – in particular one that took the integration (and movement of staff) between the public and private health sectors into account. There is some suggestion that the faith-based sector has stronger health systems 'governance' than the public sector in Cameroon – in particular relating to staff retention and motivation (see Amani, 2010; Médard, 2001; Greunais, 2004). While this has not been strongly proven, it does suggest that cross-sector learning (in effect PPP) in relation to such issues would be useful.

This study has also highlighted that Catholic organisation culture may be a major barrier to this particular staff secondment strategy. The distinctive Catholic culture (rooted in theology) is highly protected within these facilities, and is supported by the Diocese (as the facilities 'owners'), as well as management practice. One question that remains unanswered is how far

systems 'integration' can be expected with such stark cultural differences between the public and Catholic systems (see Olivier, 2014). Does PPP or 'integration' of non-state actors into the Cameroonian system mean that these distinctive characteristics of Catholic organisational culture must be removed? (This is a major concern of many faith-based providers across Africa, see Dimmock et al, 2012). More in-depth health systems analysis is required here, however, it can be suggested that PPP which intentionally focuses on commonalities between public and faith-based providers (such as an orientation towards universal health coverage) might enable partnership and integration that still allows for characteristic differences (see Olivier, 2014).

It is important to consider that the sustainable provision of quality health care to the poor remains a burden and concern for faith-based providers, especially in rural areas such as the Far North region of Cameroon. Their ability to continue to do so with limited resources is a concern – and at the same time, the government may not be able to satisfy rural population health needs because it has a limited presence in such areas. Given such mutual constraints, it is imperative that cooperative solutions are found. In relation to secondment, there are both grand-scale and mid-range recommendations. A grand-scale recommendation might be to completely overhaul the secondment strategy, for example as they have done in other African countries, where instead of secondment, the government now financially subsidizes faith-based human resources, but does not have any involvement in the selection, allocation or management of these staff (see Schmid et al, 2008).

Mid-range recommendations might suggest the 'tweaking' of the current secondment strategy to improve its chances of implementation success. The suggestions that follow are in this vein, and suggest possible solutions to better staff secondment. This study suggests that to benefit from staff secondment, an implementation addendum may be added to the current MOU (which gives only general clauses about staff secondment without implementation details).

The MOU might benefit from clauses that compel the MoH to regularly communicate with MMD-CHS on staff secondment selection and posting. It may be a reality that the MoH simply does not have requested staff available, but because selection and posting processes are done without consultation, MMD-CHS staff and managers feel slighted. The establishment of a forum or independent body that might adjudicate such communication and negotiation may assist in the implementation and enable or encourage the communication between the government and faith-based providers. (Noting that such a forum would need to have decentralised offices located at district or regional office level, since the system is highly decentralised in Cameroon, and national level collaboration is of limited value here, especially in relation to faith-based providers, see Olivier, 2014).

This study also highlights that the historical relationship between the MoH and faith-based providers prior to the implementation of the partnership and staff secondment intervention was not properly considered. Greunais (2001) noted that the Catholic Church was not implementing the Cost Recovery strategy as recommended by the MoH – mainly because the Catholic Church is a state within a state. This is a reminder that although there are national representatives and authorities, the Catholic Church also sees itself as being broader than national borders, which has an impact on how strongly national guidelines are adhered to. This might also have an effect on the success of policy implementation – such as in this case of secondment - and needs to be more fully considered in terms of research and implementation practice.

Furthermore, in order to make the intervention successful and useful to both faith-based providers and the MoH, further study should be undertaken, as this research only skims the surface of this complex issue in one region. For example, a study of different actors' perceptions towards secondment – including more individuals from inside the MoH system should prove enlightening. Such research might be able to highlight more barriers at the

individual and systems levels. Furthermore, this research was designed as an exploratory study – but more intensive explanatory and intervention-style research should prove effective. This research was also intentionally focused at the Diocese level given the decentralised nature of the Catholic system – however, a national level study would highlight a different array of relational issues and barriers to the implementation of such partnership strategies.

This study aimed at exploring the implementation of the staff secondment intervention as a health system strengthening strategy in the Maroua-Mokolo Diocese in the Far North Region of Cameroon. This study has shown that this health system strengthening intervention or strategy is currently having limited effects due to both software and hardware issues – such as organisational culture differences and limited consideration of management control. The study provides an important example for a system strengthening strategy that is being implemented or considered in several other lower to middle-income countries. For such contexts, the main lesson is that careful consideration needs to be taken when systemic interventions are undertaken that hinge on individual and institutional values, behaviours and cultures. However, the reasons that caused both parties to accept the staff secondment intervention are yet to be strongly evidenced. The recommendations made by this study can be useful if the reasons for which the parties entered into the partnership are strong enough to compel them into working toward the intervention's success.

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Appendix A: Informed Consent Form Utilised in Research – English and French

AMELIORER L'ACCES AUX SERVICES DE SANTE SEXUELLE ET REPRODUCTIVE AU GHANA, MALAWI ET CAMEROUN: LES INFLUENCES DE LA STRATEGIE DU PERSONNEL MEDICAL/SOIGNANT CATHOLIQUE ET SON IMPLEMENTATION.

Nous menons une étude de cas dans trois pays portant sur l'accès aux services de santé sexuelle et reproductive au sein des organisations confessionnelles.

Le but de cette étude est de chercher à mieux comprendre comment l'accès aux services de santé sexuelle et reproductrice peut être amélioré et si des interventions comme 'la prise des décisions informée' peuvent améliorer l'accès particulièrement chez les prestataires catholiques qui font face à des difficultés particulières et répondent avec des innovations particulières dans la prestation de ces services.

Les personnes ressources clés seront invitées à participer dans cette étude – y compris des représentants des services de santé catholique et d'autres confessions et des partenaires nationaux de santé.

Il vous sera fourni une brochure qui vous donne des informations générales de l'étude de sorte que vous pourriez connaitre assez sur l'étude de manière à accepter de participer.

AVANTAGES LIES A VOTRE PARTICIPATION OU LA PARTICIPATION DES AUTRES :

- Vous ne seriez pas payé pour participer à cette étude et il n'y aura aucun avantage direct pour vous comme participant.
- Les résultants de cette étude recommandés par un bailleur de fond international de la santé et du développement, pourront être utilisés pour identifier les domaines d'investissements qui pourront accélérer et soutenir un accès efficace aux soins de santé, encourager l'élaboration des politiques et le développement des ressources dans les pays africains, donner un aperçu des méthodes pour améliorer les pratiques, apporter des preuves aux décideurs et universitaires engagés dans le domaine.

PARTICIPATION VOLONTAIRE ET DROIT DE RETRAIT.

- Votre participation à cette étude est entièrement volontaire.
- Les réponses complètes sont les plus utiles pour la recherche mais si vous décidez de participer, vous pouvez refuser de répondre à des questions et vous avez le droit d'arrêter votre participation quand vous voulez.
- Vous pouvez poser des questions avant, pendant et après l'interview.
- Nous anticipons que l'interview durera environ une heure.
- Les données recueillies pour cette étude seront gardées dans la confidentialité.
- Vos réponses à nos questions ne serviront qu'à des fins de cette recherche.

- Cette étude a été examinée et approuvée par le comité d'éthique à la recherche humaine de la faculté de science de la santé de l'université de Cape Town (et des informations envoyées aux autorités locales compétentes).

Si vous acceptez de participer, s'il vous plait signer le formulaire de consentement ci-joint.

QUI MÈNE CETTE ÉTUDE ? Des chercheurs de l'Ecole de Santé Publique et la Médecine Familiale de L'université de Cape Town liés au International Religious Health Assets Programme (IRHAP)

Dr. Jill Olivier est la directrice de cette étude. Si vous avez des questions concernant cette étude vous pouvez la contacter en utilisant les coordonnées suivantes:

Téléphone : +274066489 Courriel : jill.olivier@uct.ac.za.

Si vous avez des points d'ombre sur les informations qui vous ont été présentées ou vous voulez en savoir plus, veillez demander le chercheur avant de signer.

FORMULAIRE DE CONSENTEMENT : INTERVIEW D'UNE PERSONNE RESSOURCE.

AMELIORER L'ACCES AUX SERVICES DE SANTE SEXUELLE ET REPRODUCTIVE AU GHANA, MALAWI ET AU CAMEROUN.

ETUDE MENE PAR IRHAP POUR LE COMPTE DE L'OCSAID.

En signant ci-dessous, je confirme que j'ai été informé(e) sur l'étude de l'accès aux services de santé sexuelle et reproductive et je consens (parafez le block qui vous convient)

De participer à l'interview	
Avoir le processus enregistré électroniquement	

Signature du Participant : _____

Nom du Participant : _____

Signature du Chercheur : _____

Nom du Chercheur : _____

Votre participation à cette étude est très appréciée et nous serons respectueux des informations que vous fournissez.

IMPROVING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN GHANA, MALAWI AND CAMEROON: THE POLICY INFLUENCES AND IMPLEMENTATION OF CATHOLIC HEALTH PROVIDERS

Informed Consent for Stakeholder Interview

We are conducting a three-country case study of faith-base organisations in providing access to sexual and reproductive health services. The purpose of the study is to understand better how access to sexual and reproductive health services can be improved, and whether interventions such as «Informed Decision Making » can improve access, especially with Catholic health partners who face particular challenges and respond with particular innovative practices in relation to providing these services.

Key stakeholders will be asked to participate in this study-including representatives of Catholic health services and denominations and broader national health service partners.

You will have been provided with an information brochure that describes the broader study, so that you might know enough about the study so as to agree to participate.

What are the expected benefits to you or to others for participating in this research study?

- You will not be paid for participating in the study and there will be no direct benefits to you as a participant.
- The results of this research, commissioned by an international health and development funder, could be used to identify areas for investment that would accelerate and sustain access to effective health services; encourage policy and resources development among African countries; provide insight into methods for improved practice; and contribute evidence to policy-makers and academics engaged in this field.

Your rights to participate, not participate, or withdraw from this study.

- Your participation into this study is entirely voluntary
- Complete answers are most helpful for the research, but if you decide to participate, you may refuse to answer any question and you are free to stop any time.
- You have the right to ask questions at any point before or after the interview.
- We expect that completing the interview will take about 1 hour.
- All information collected for the study will be kept confidential
- Your responses to our question will only be used for research purposes.

This study has been reviewed and approved by the Human Research Ethic Committee of the Faculty of Health Sciences at the University of Cape Town (andinformation sent to appropriate local authority).

<u>If you agree to participate, please sign the attached consent form,</u>

<u>Should you not agree to participate, we thank you for letting us tell you about the research.</u>

Who is carrying out this study? Researchers from the University of Cape Town School of Public Health and Family Medicine- linked to the International Religious Health Assets Program (IRHAP)

The principal Investigator for this study is Dr Jill Olivier. If you have any questions about this study contact her at: telephone +274066489email: jill.oliovier@uct.ac.za.

INFORMED CONSENT FORM: STAKEHOLDER INTERVIEWED

Improving access to health services in Ghana, Malawi and Cameroon.

Study conducted by IRHAP on behalf of CORDAID.

By signing below, I confirm that I have been informed about the research on access to sexual and reproductive health services and that I agree (initial the appropriate blocks you agree to)

To participate in the interview	
To have the process electronically recoded	

If there is any part of the subject information sheet that you did not understand or you want to know more about, you should ask the researcher before signing.

Signature of participant: _____

Printed Name: _____

Signature of Researcher: _____

Printed Name: _____

Date: _____

We greatly appreciate your participation in this study and will be respectful of the information you provided.

Appendix B: Information Brochure for Interview Participants – English and French

RENFORCEMENT DES STRATÉGIES ET SYSTEMS POUR L'ACCES AMELIORE AUX SERVICES DE SANTE SEXUELLE ET REPRODUCTIVE.

RESEARCH COLLABORATIVE EN COURS: 2013-2014.

AMELIORER L'ACCES AUX SERVICES DE SANTE SEXUELLE ET REPRODUCTIVE AU GHANA, AU MALAWI ET AU CAMEROUN : LES INFLUENCES DE LA STRATEGIE DU PERSONNEL MEDICAL/SOIGNANT CATHOLIQUE ET SON IMPLEMENTATION

CONTEXTE

Le personnel de santé catholique en Afrique opère dans le contexte de systèmes de santé complexes influencé par toute une gamme de stratégies provenant du gouvernement, des dénominations et de bailleurs de fonds tout aussi bien que de structures internes de gouvernance organisationnelle. Les interprétations que font les gérants et les soignants/le personnel médical de cet environnement de politique complexe ont un impact sur leurs décisions et leurs actions, et ultérieurement sur l'accès aux soins médicaux.

Une des questions les plus sensibles touche la prestation de services de santé sexuelle et reproductive (SSR) par le personnel médical catholique. Au niveau de la politique internationale et dans les media publics, une vaste polémique et beaucoup de déclarations généralisées au sujet de la prestation des services de santé provenant 'des catholiques' ont lieu.

Cependant, il y a très peu de données précises qui permettent d'analyser comment les services de SSR sont livrés au sein des dispensaires/établissements catholiques, et ce que cela représente par rapport à l'accès aux soins en général. Récemment, il y a eu quelques recherches qui ont suggéré que toutes les généralisations sur « les catholiques et la planification familiale » ou « les catholiques et les capotes » sont problématiques, parce ce qu'elles ne reflètent pas la réalité de la véritable livraison des services.

Il y a donc un besoin importante comprendre comment le personnel médical catholique opère – au sein du contexte de leur système de santé particulier— et combien les stratégies et les perceptions influencent la livraison des services et l'accès en général.

Il est important de remarquer, cependant, que c'est un domaine très sensible pour la recherche et pour l'engagement/la mobilisation. Le partage de l'information est un défi –aussi bien entre patient et soignant, entre administrateurs de services de santé et dénominations en place, entre les services privés et les partenaires publics, ou services privés et leurs bailleurs de fonds internationaux, et bien sûr, entre chercheurs et médecins.

OBJECTIFS DE L'ETUDE

Nous proposons donc un processus de recherche consultative tout au long de l'année 2013, qui sera organisée autour des objectifs suivants :

- Construire un corps d'évidence de référence sur les soignants/le personnel médical religieux des organisations à but non-lucratif dans le contexte de leurs services de santé spécifique (au Ghana, au Malawi et au Cameroun), avec une concentration particulière touchant l'accès aux services SSR

- Mieux comprendre les influences multiples, au niveau des stratégies, sur les infrastructures de santé reproductives et sexuelles catholiques (en comprenant la théologie catholique en tant "qu'influence en politique de santé")
- Mieux comprendre comment la politique de PDI de l'OCSAiD est saisie et mise en place dans ces trois pays, tout en identifiant les obstacles et les opportunités pour un accès aux services de SSR amélioré
- Comprendre comment "la confiance" impacte le partage de l'information dans un nombre de niveaux différents au sein de ces contextes.

STRATEGIE DE RESEARCH

Une étude de cas exploratoire avec une conception flexible et des participations seramenée pendant une periode de 12 mois, conçue dans le cadre des systems de santé et politique de recherche.

Outils des Methods Mixtes: Etude documentaire systematique de la littérature pertinente, analyse documentaire et politique, et recherche sur le terrain comparant les trois sites retenus comme cas de l'étude (y compris des entretiens en profondeurs, des groupes focaux, des observations, quelque sondages des clients, atelier participatif).

Les Intervenants Clés: inclurait une gamme de gestionnaires politiques et membre des programmes (des sites catholiques ainsi que des partenaires générales; nationaux, districts et locaux) le personnel de santé et des clients.

Analyse: Trianguler les données multiples. Entreprendre l'analysethématique du materiel qualitatif. Inclure la consultation et l'analyse participative pour incorporer l'aperçu des conseillers dans les résultats.

Phase 1: Aperçu: (Janv- Mar 2013) Revue des données secondaires, de rapports et d'études; analyses de stratégies et évaluation de systèmes de santé de trois pays.

Phase 2: Visites initiales dans les pays concernés et consultation (Avr- Mai 2013) Consultation avec les personnes ressources clés dans les trois pays.

Phase 3a: Recherche basée dans un centre médical/projet:(Juin-Juil 2013) Etudes des cas dans les sites médicaux sélectionnés comme cas.

Phase 3b: Questionnaire: (Juin-Juil 2013). Un bref questionnaire sera développé et circulé plus largement parmi l'ensemble des partenaires de l'OCSAID (et dans d'autres pays). Ceci a pour but d'obtenir des données additionnelles.

Phase 4: Analyse de la recherche et interprétation: (Août 2013). Analyse initiale et consultation des conseillers.

Phase 5: Visites des pays et consultation: (Sept-Oct 2013). Retourner l'analyse préliminaire aux personnes ressources des pays concernés pour vérification et recherche de suivi où il sera nécessaire.

Phase 6: Analyse et rédaction (Nov-Dec 2013) Analyse finale, intégration des données, comparaison de cas, rédaction

Phase 7: Achèvement (Javi-Fev 2013) Fin du projet, délibérations avec les acteurs-clés, rédaction du rapport final et soumission.

PARTENAIRES DE LA RESEARCH

Institution Financière : L'Organisation Catholique pour le Secours et l'Aide au Développement (www.cordaid.nl).

Gestion de la Recherche : International Religious Health Assets Programme (IRHAP) (www.irhap.uct.ac.za) L'Ecole de Sante Publique de et de la Médecine Familiale de L'Université de Cape Town (www.uct.ac.za) avec d'autres intervenants clés intervenant comme conseillers.

INTERETS DES PARTENAIRES

L'Organisation Catholique pour le Secours et l'Aide au Développement (OCSAID) a récemment adapté sa politique de planification familiale, se tournant vers un modèle de « prise de décision informée» (PDI) qui tient à confronter et mitiger certaines des polémiques et sensibilités qui entourent la livraison de services de santé sexuelle et reproductive catholique (SSR), dans un effort pour réduire la mortalité maternelle et pour améliorer l'accès aux services de SSR.

À l'intérieur de la communauté catholique en général, il y a des opinions très variées par rapport à la SSR et quant à l'acceptation de la planification familiale en particulier. Une orientation de la politique vers la PDI encourage une information totale et correcte sur la planification familiale à travers toute la gamme des services de SSR ou, au moins, la promotion d'un partage de l'information qui concerne l'orientation vers d'autres services de santé.

L'OCSAID voit l'intervention de cette politique de PDI comme une opportunité pour mieux comprendre le fonctionnement des services de santé catholiques plus amplement afin de construire un partenariat et un dialogue interne entre les partenaires de l'OCSAID, et pour comprendre la pertinence de cette politique de PDI ainsi que ses potentiels et les obstacles à son implémentation.

Les intérêts du chercheur:

Les partenaires de recherche engagés dans ce projet (dirigé depuis la Division des Systèmes et Politiques de Santé de l'Université de Cape Town) sont déterminés à construire un corps d'évidence factuelle sur la nature du fonctionnement des établissements de santé catholiques au sein de contextes de systèmes de santé complexes.

C'est-à-dire que le projet proposé n'a pas l'intention d'alimenter les polémiques au sujet « des catholiques et la planification familiale ». Au contraire, nous le considérons en tant qu'opportunité pour construire des preuves réelles sur la façon dont les établissements religieux à but non-lucratif fournissent un accès aux services de SSR; et comment les perceptions influencent les comportements, à l'intérieur des systèmes de santé tout ce qui mènera à des décisions mieux informées et fondées sur des preuves et à des systèmes de santé plus solides.

Les intérêts des partenaires de l'institution catholique:

Nous sommes conscients que la recherche peut être une charge par rapport à des ressources et des capacités déjà presque épuisées. Nous sommes convaincus que cette recherche alimente un corps d'évidence critique par rapport au domaine des systèmes de santé en général; et elle fournit un support pour renforcer les systèmes de santé, les pratiques en SSR, et les relations collaboratives; ainsi qu'il permet un espace utile pour une pratique réflective pour améliorer la gouvernance des systèmes de santé.

IMPROVING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN GHANA, MALAWI AND CAMEROON: THE POLICY INFLUENCES AND IMPLEMENTATION OF CATHOLIC HEALTH PROVIDERS

Background

Catholic health providers in Africa operate in complex health systems context – influenced by an array of policies from government, denominations, funders, as well as internal organizational governance structures. Managers' and health workers' interpretations of this complex policy environment impact on their decisions and actions, and ultimately on access to health care.

One of the most sensitive public issues is provision of sexual and reproductive health (SRH) services by Catholic providers. At an international policy level and in the public media, there is much controversy, and many generalized statements about 'the Catholics' provision of health services. However, there is very little real evidence which provides insight into how SRH services are provided in Catholic facilities, and what this means for access more broadly. Recently, there has been some research which has suggested that any generalized statements about 'Catholics and family planning' or 'Catholics and condoms' are problematic, as they do not adequately reflect the reality of actual service provision.

There is therefore a significant need to understand how Catholic health providers operate – within the context of their particular health system – and how different policies and perceptions influence service provision and access more broadly.

It is important, however, to note that this is a sensitive area for research and engagement. Information sharing is a challenge – whether between patient and provider, between health managers and denominational governing bodies, between private providers and public partners, between private providers and their international funders, and of course, between researchers and practitioners. We believe that underlying questions about building evidence of SRH services and implementation/interpretation of particular policies, lies broader questions about trust and information-sharing within particular health systems, which have a strong influence on access and governance.

CORDAID's Interests: The Catholic Organisation for Relief and Development Aid (Cordaid) has recently adapted its policy towards family planning, shifting to a model of 'Informed Decision Making' (IDM) which seeks to confront and mitigate some of the controversy and sensitivity around Catholic provision of sexual and reproductive health (SRH) services in an effort to reduce maternal mortality and to improve access to SRH services. Within the Catholic community at large, there are many different views on SRH and the acceptance of FP in particular. A policy orientation towards IDM encourages full and accurate information on FP across the range of SRH services, or at least promoting accurate sharing of information on referral to other providers. CORDAID sees this IDM policy intervention as an opportunity to better understand the operation of the Catholic providers more broadly, to build partnership and internal dialogue between CORDAID partners, and to understand the relevance of the IDM policy and potentials and barriers to implementation.

Researcher's Interests: The research partners engaged in this work (managed out the Health Policy and Systems Division, University of Cape Town) – are keen to build evidence on the nature of Catholic facilities' operations within complex health systems contexts. That is, there are no intentions for this proposed work to feed into controversial statements about

'Catholics and Family Planning'. Instead, we see this as an opportunity to build real evidence on *how* faith-based non-profit facilities provide access to SRH services; and on how perceptions influence action within health systems – all leading towards better evidence-informed decision-making and stronger health systems.

Catholic Facility Partner Interests: We understand that research can be a drain on already-stretched human resources and capacity. We are determined that this research feeds important evidence into the broader health systems arena; provides support for strengthening health systems, SRH practices, and collaborative relationships; and also provides a useful space for reflective practice to improve health systems governance.

Proposed Research: We therefore propose a consultative research process during 2013 which will have the following objectives:

1. To build base-line evidence on faith-based non-profit providers in their particular health systems context (in Ghana, Malawi and Cameroon), with a particular focus on access to SRH services
2. To better understand the multiple policy-level influences on sexual and reproductive health services in Catholic facilities (with Catholic theology being understood as a significant 'policy influence')
3. To better understand how the CORDAID IDM policy is understood and implemented in these three countries, identifying barriers and opportunities for improved access to SRH services
4. To understand how 'trust' impacts on information-sharing at a number of different levels within these contexts

Study Outline: The research will be of a flexible design over a 12-month period, with participatory elements, mainly utilizing qualitative tools, and framed in the context of health systems and policy research.

Phase 1: Overview: Desk review of secondary data, reports and studies; policy analysis and health systems assessment of three case study countries	**Jan-Feb 2013**
Phase 2: Initial country visits and stakeholder consultation: Research (including visits) in Cameroon, Ghana and Malawi – including collection of documentary materials, interviews with key informants at global, country, network, and sample institution levels (including religious leaders, public health officials); and focus groups of stakeholders at selected representative sites.	**Mar-Apr 2013**
Phase 3a: Facility/project-based research: Health facility/project sites will be selected as 'cases' for more in-depth research with select facility staff.	**May-Jul 2013**
Phase 3b: Questionnaire: Based on findings from initial in-country visit, a brief questionnaire will be designed and circulated among CORDAID partners more broadly (and in other countries). This aims to gain additional input in other contexts.	**May-Jul 2013**

Phase 4: Research analysis and interpretation: by primary investigator and research team, including input from advisory group	**Aug 2013**
Phase 5: Country visits and consultation: Preliminary analysis and results are brought back to country stakeholders and participants for checking and further consultation. Follow-up interviews where necessary.	**Sept-Oct 2013**
Phase 6:Final analysis, integration of data, case comparison, write-up	**Nov-Dec 2013**
Phase 7:Project end, consultation with stakeholders, final report writing and submission	**Jan-Feb 2013**

For more information:

CORDAID Project Lead: Geertje van Mensvoort gen@cordaid.nl

Research Lead: Dr. Jill Olivier (International Religious Health Assets Program, Health Policy and Systems Division, School of Public Health and Family Medicine, University of Cape Town jill.olivier@uct.ac.za)

Appendix C: Interview Guide for Semi-structured Interviews

INTRODUCTION

Introduce yourself, the study (guided by the brochure information) and walk the participant through the consent form. *Some key issues to address*:

- Who you are (ensuring they have your contact information)
- That this is a *three country study* being run from the University of Cape Town in South Africa – running during 2013 and some of 2014
- It is affiliated with the International Religious Health Assets Programme (previous the African Religious Health Assets Programme) which has been working on issues of faith and public health for over a decade now – seeking to strengthen evidence and health systems integration
- That this study is funded by CORDAID, a Catholic partner, who wants to understand the health systems context to improve their collaborative relationship
- That this is the very first exploratory visit to understand the Cameroon context better
- That this study *does not* seek to make sensational claims about 'Catholics and condoms' but rather understand the complex health systems context in which they operate
- Do not raise the issue of Informed Decision Making in the introduction unless the interviewee does, and if so, describe it as a small part of this research, with CORDAID trying to understand whether it has traction or relevance for the Cameroon context (it is not desirable for the entire interview to be focused on preconceived ideas of IDM – if introduced early on, try to table it for later discussion)
- Please reassure the participant that we are very serious about ethics, and that the ethical consent forms are there to protect the participant
    - "All these interviews are confidential. Although we will use your interview in developing our broader understanding, we won't be telling other people what you said specifically and we won't link anything you have said to your name in our reports"
    - "I would like to try and ensure that I have a good record of the interview, gathering your views as accurately as possible. So may I tape-record this interview? May I ask you to sign this confidentiality form to confirm your agreement to talk to me. I will leave you with the information brochure and the first page of this form."
- That we will ensure that all information we gain comes back to participants for review and confirmation (please ensure you have email addresses and contact details where appropriate)
- *Depending on the discussion, you may want to reiterate:* that there are no direct funding consequences of this interview (either reimbursement, or funding decisions)

RESPONDENT CHARACTERISTICS

Before you begin assign a code to the interview, and only use the assigned code in subsequent notes about the interview. Also make notes of:

- the person's position (type of staff); gender; age (roughly); length of appointment in the facility; date and place of the interview (as per consent form)

1. CONTEXTUAL QUESTIONS

These questions are contextual, and work as an ice-breaker to relax the participant. The questions need to be shaped to the institutional context – for example, if you are interviewing someone at a national level, ask them about the national system and their role, if it is a facility level about the facility and their role. Please always be careful of asking a person's religious affiliation, and only ask this if it does not come up in conversation.

- **Please tell me about this organisation** (facility/clinic/network/unit)
    - Probe: what services are provided, how many staff, what level of staff?
    - Probe: How is it structured, how it is funded, who are the managers, who 'owns' it, what community does it serve, how is it linked to other organisations/facilities
    - Probe: is there an organisational chart?
    - Probe: we are trying to understand the history of the Cameroon health system – what can you tell us about its history or development? What were the key events in the development of the health system?

- Please tell me about your role in this organisation
    - Probe: What do you do on a daily basis, how long have you done this, what is your training/background, what is your religious affiliation

- What *policies* influence how this institutions operates, and your work (noting that by policy we include all government, district, funding and theological 'policies')
    - Probe: When an example is provided, ask how important this policy is, or what element of the policy is most relevant.
    - Probe: If no response, give examples such as HIV/AIDS policies, family planning policies, theological statements from the Catholic Bishops Conference, or MOUs with government or funding partners
    - Probe: what policies guide human resource issues? (MOU with government, with the Christian Health Association etc)
- Do any policies conflict with each other?

- Probe: we find in this context that faith-based providers often have many different policies and guidelines influencing them, often saying different things at the same time – is that the case here?
- Probe: e.g. between the theological guidelines and the family planning policies, if so, how are these tensions understood/handled?

2. ORGANISATIONAL CULTURE

Keep an eye open for the difference between explicit and tacit rules.

SECTION INTRO: We are interested in what it means to be a Catholic institution – or as we say, its 'organisational culture'

- **What makes this a Catholic institution?**
  - (*this question is only for interviews with Catholic institutions, for others, ask similar 'what makes a Catholic institution different?')*
  - Probe: What is different about a Catholic institution?
  - Probe: What values are important in a Catholic health institution?
  - Probe: e.g. quality of care, kinds of services provided, kinds of people served
  - Probe: expect answers such as 'compassionate care', or 'we serve the poor' – probe for more detail, and in particular for HS functions, e.g. what makes the care compassionate?
  - Probe: check if staff are being seconded from government, and what that means in relation to organisational culture
  - Probe: check on ownership and management of the institution if this has not already been raised, probe on what this means in practice (management, funding etc)
  - Probe: how many of the people working here are Catholic? (what percentage) Do you have people of other faiths working here? (Adventists? Muslims?) How do they fit in with the Catholic organisational culture?

- What makes the care in a Catholic institution different from that in a government institution?
  - Probe: e.g. patient to doctor ratio, working hours (health workers come in earlier), medical supplies
  - Probe: on issues of health-worker motivation, how they keep health workers motivated to work in rural areas
  - Probe: on issues of user fees (e.g. if response is we serve the poor, ask about specific financing mechanisms that make this possible)

- Probe: would you say you trust Catholic health facilities more or less than government health facilities (why/why not?) – is this about how they are managed as a whole? What influences your level of trust in these facilities? (e.g. role of health workers, how they are managed such as disciplinary or promotion systems, training or skills, level and form of payments)
- Probe: does this trust or distrust influence how people experience care, access, or satisfaction with services?

· How are staff recruited to this institution *(adapt question for interview level)*
  - Probe: is the post openly advertised or are people placed?
  - Probe: Is the administrator/manager hired because of their religious or public-health/medical knowledge/experience?
  - Probe: do they seek someone with particular values?
  - Probe: if an equally qualified Catholic and a non-Catholic are looking to be hired, will the Catholic get preferential hiring option?

· When a new, non-Catholic worker joins this organisation, how do they learn about the rules and nature of the organisation?
  - Probe: we are interested in what we call 'organisational culture' – about what makes this organisation different
  - Probe: what was your experience joining this organisation?
  - Probe: Is there orientation? Who conducts it? What is the content of this orientation? What materials are provided?
  - Probe: Is there material on family planning/reproductive health services/medical ethics in this orientation?
  - Probe: is there a mission statement? (look at walls)
  - Probe: do health workers get fed into your system from Catholic training colleges (e.g. nurses training colleges)

· What happens when someone breaks the rules, for example around family planning?
  - Probe: How often does this happen? Is there a disciplinary process? Are people fired (e.g. for providing artificial contraception? Does the church get involved (e.g. what managers are involved, is the bishop informed?)
  - Probe: ask for examples
  - Probe: is there different management needed for Catholic and non-Catholic staff?

3. INFORMATION-SHARING

It is very important to make notes of what information is mentioned here, and be sure to ask at the end of the interview whether you might be able to have that information (when appropriate).

Note, we are interested in trust and information flow, but do not ask directly 'whether people trust each other enough to share full information' – it is up to the interviewer to probe on this issue indirectly.

SECTION INTRO: we are interested in how information is shared, and what information you have available for your work.

What information about your work do you share with others?

- Probe: What information flows 'up', what information do you send to your manager, what information gets sent where? How often? What quality? Electronic or hard copies?
- Probe: what information flows 'down' to you?
- Probe: what information flows 'back' to you (e.g. if you send data to the government, does it come back after being synthesized? Do you get information about other facilities/the district/the national picture)
- *If useful, draw an information flow on a piece of paper, showing loops*
- Probe: what information flows e.g. to their manager, M&E data to government, to the district, to the bishop, to the diocese, to health managers, to the community, to funders, to patients
- Probe: what kind of information flows e.g. M&E data, evaluation reports, articles, newspaper reports, letters (i.e. not only data, but all forms of communication)
- Probe: is there information that cannot be shared (e.g. not only private patient records, but monitoring/funding data to government etc)

· What information do you get from others that assist you with your work?

- Probe: *this is an extension of the above – space to ask again about specific information sources, and also to identify information gaps*
- Probe: e.g. if you are speaking to a bishop who is making theological decisions about family planning, what information does he get from the Vatican/elsewhere?
- Probe: e.g. if you are speaking to a hospital administrator, what information do they get about district health services, specific issues or indicators that need attention, referral options etc

· Can you describe the referral system here? *(adapted to interview level)*

- Probe: What referral options are there here? How do you know where to refer to? Does referral happen (and on what specific issues?) Does referral happen mainly within the Catholic system, or with other providers?
- Probe: Do you have a map?
- Probe: how would a new staff member know where to refer to?

Appendix D: Ethics Clearance forms (UCT and Cameroon)

REPUBLIQUE DU CAMEROUN
Paix - Travail - Patrie
****
MINISTERE DE LA SANTE PUBLIQUE
****
SECRETARIAT GENERAL
****
DELEGATION REGIONALE DE
L'EXTREME-NORD
****

Tél : 2229 10 67
Fax: 2 229 28 04
E-mail :
delsante_en@yahoo.fr

REPUBLIC OF CAMEROON
Peace – Work - Fatherland
****
MINISTRY OF PUBLIC HEALTH
****
SECRETARY GENERAL
****
REGIONAL DELEGATION
FOR FAR NORTH
****

N° 516 **/L/13/MINSANTE/SG/DRSPEN/hm.**

Maroua, june 24, 2013

THE REGIONAL DELEGATE OF PUBLIC HEALTH FOR FAR NORTH

TO

Dr. Jill Olivier
UNIVERSITY OF CAPE TOWN
SCHOOL OF PUBLIC HEALTH AND FAMILY MEDICINE

Object : ***Research agreement***

I confirm the receipt of your letter written on June 19, 2013 relative to a **request for approval of qualitative case study on Catholic health providers in Cameroon**. The data collection for this activity will be conducted by Mr Jacob kuh, a MPH student you supervise at the University of Cape Town upon the thesis "Improving access to sexual and reproductive health services in Maroua Diocese, Cameroon".

Then, by the present correspondence, I mention my approval to conduct this research and hope this will be conducted with respect of ethical, non-extractive and participatory research practices. I will also be happy to be provided with any final research product for the benefit of the Far North population.

Warm regards,

THE REGIONAL DELEGATE OF PUBLIC HEALTH FOR FAR NORTH

Dr DJAO REBECCA

UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Faculty of Health Sciences Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
e-mail: sumayah.ariefdien@uct.ac.za

12 December 2012

HREC REF: 626/2012

Dr J Olivier
School of Public Health & Family Medicine
Anatomy Building
FHS

Dear Dr Olivier

PROJECT TITLE: INFORMED DECISION MAKING WITH CATHOLIC HEALTH PROVIDERS FOR IMPROVED ACCESS IN AFRICA

Thank you for addressing the issues raised by the Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

Approval is granted for one year till the 15 December 2013.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form, if the study is completed within the approval period.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

sAriefdien

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

sAriefdien

Appendix E: Journal Instructions to Authors

This is an abbreviated version of the author instructions for the journal 'Health Policy and Planning' (Oxford University Press). The full instructions can be seen at http://www.oxfordjournals.org/our_journals/heapol/for_authors/index.html

Oxford Journals | Medicine | Health Policy and Planning | Information for Authors

Health Policy and Planning's aim is to improve the design and implementation of health systems and policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. HPP is published six times a year.

HPP has a double-blinded peer-review policy. All papers, in each of the categories described below, are peer reviewed.

Specific objectives are to:

- Attract high quality research papers, reviews and debates on topics relevant to health systems and policies in low- and middle-income countries;
- Ensure wide geographical coverage of papers including coverage of the poorest countries and those in transition;
- Encourage and support researchers from low- and middle-income countries to publish in *HPP*;
- Ensure papers reflect a broad range of disciplines, methodologies and topics;
- Ensure that papers are clearly explained and accessible to readers from the range of disciplines used to analyse health systems and policies; and
- Provide a fair, supportive and high quality peer review process.

Health Policy and Planning welcomes submissions of the following types: original articles, review papers, methodological musings, research in practice, commentaries, and papers in our series 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

Authors should pay close attention to the factors that will increase likelihood of acceptance. As well as the high overall quality required for publication in an international journal, authors should address HPP's readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health systems and policy issues and debates in low- and middle income countries. Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected or returned to the authors for redrafting prior to being reviewed. In addition, economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.

Public health specialists writing about a specific health, policy, challenge or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made.

Manuscripts must be submitted online. Once you have prepared your manuscript according to the instructions below please visit the online submission website. Instructions on submitting your manuscript online can be viewed here.

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by *HPP. HPP* discourages the submission of more than one article dealing with related aspects of the same study.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office athpp.editorialoffice@oup.com

During the online submission procedure, authors are asked to provide: a) information on prior or duplicate publication or submission elsewhere of any part of the work; b) a statement of financial or other relationships that might lead to a conflict of interest or statement that the authors do not have any conflict of interest; c) a statement that the manuscript has been read and approved by all authors (see also section on authorship below); d) the name, address, telephone and fax number of the corresponding author who is responsible for negotiations concerning the manuscript. The manuscript must be accompanied by copies of any permission (see heading Permissions below) to reproduce already published material, or to use illustrations or report sensitive personal information about identifiable persons.

All papers submitted to HPP are checked by the editorial office for conformance to author and other instructions all specified below. Non-conforming manuscripts will be returned to authors.

AUTHORSHIP

All persons designated as authors should qualify for authorship. The order of authorship should be a joint decision of the co-authors. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should be based on substantial contribution to conception and design, execution, or analysis and interpretation of data. All authors should be involved in drafting the article or revising it critically for important intellectual content, must have read and approved the final version of the manuscript and approve of its submission to this journal. An email confirming submission of a manuscript is sent to all authors. Any change in authorship following initial submission would have to be agreed by all authors as would any change in the order of authors.

LANGUAGE EDITING

All publications in the journal will be in English. Authors whose 'first' language is not English should arrange for their manuscripts to be written in idiomatic English before submission. If English is not your first language, before submitting your manuscript you may wish to have it edited for language. This is not a mandatory step, but may help to ensure that the academic content of your paper is fully understood by journal editors and reviewers. Please note that language editing does not guarantee that your manuscript will be accepted for publication. For further information on language editing services, please click here. Several specialist language editing companies offer similar services and you can also use any of these. Authors are liable for all costs associated with such services.

MANUSCRIPT TYPES AND PREPARATION

Original research

Manuscripts should preferably be a maximum of 6000 words, excluding tables, figures/diagrams and references.

The **title page** should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter; Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the **acknowledgements**, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All **measures** should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Statistics:

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.

- Report simple analyses first, then only more sophisticated results.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (E.g., do not say "beta" or "regression coefficient", but "mean change inY per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as N (%), not just %.
- Report p values with 2 digits after the decimal, 3 if <0.01 or near 0.05. E.g., 0.54, 0.03, 0.007, <0.001, 0.048. Do not report p values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc)."

MANUSCRIPT FORMAT AND STYLE

Only articles in English are considered for publication

Prepare your manuscript, including tables, using a word processing program and save it as a .doc, .rtf or .ps file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.

Manuscript Preparation:

- Page 1: Title Page - please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;
- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

Page 2: Abstract

Abstract should be prepared in one paragraph, with a limit of 300 words. No headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds.

Page 3: Introduction

The Introduction should state the purpose of the investigation and give a short review of the pertinent literature, and be followed by:

Materials and methods. The Materials and methods section should follow the Introduction and should provide enough information to permit repetition of the experimental work. For particular chemicals or equipment, the name and location of the supplier should be given in parentheses.

Results. The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

Discussion. The Discussion should be an interpretation of the results and their significance with reference to work by other authors.

Abbreviations. Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All **measures** should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

References:

References must follow the Harvard system and must be cited as follows:

Baker and Watts (1993) found...

In an earlier study (Baker and Watts 1993), it...

Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:

Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics **Volume number in bold:** page numbers.

Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). Book title in italics.2nd edn. Place of publication: Publisher's name, page numbers.

Up to five authors should be cited. If there are more, cite the first three authors and follow with 'et al.', e.g.:

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For more details, please consult the journal's mini style checklist.

Tables: All tables should be on separate pages and accompanied by a title - and footnotes where necessary. The tables should be numbered consecutively using Arabic numerals. Units in which results are expressed should be given in parentheses at the top of each column and not repeated in each line of the table. Ditto signs are not used. Avoid overcrowding the tables and the excessive use of words. The format of tables should be in keeping with that normally used by the journal; in particular, vertical lines, coloured text and shading should not be used. Please be certain that the data given in tables are correct

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FUNDING: The following rules should be followed:

The sentence should begin: 'This work was supported by …'

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'National Institutes of Health' not 'NCI' (one of the 27 sub institutions) or 'NCI at NIH' - see the full RIN-approved list of UK funding agencies for details

Grant numbers should be complete and accurate and provided in brackets as follows: '[grant number ABX CDXXXXXX]'

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An example is given here: 'This work was supported by the National Institutes of Health [P50 CA098252 and CA118790 to **R.B.S.R.]**and the Alcohol & Education Research Council [HFY GR667789].

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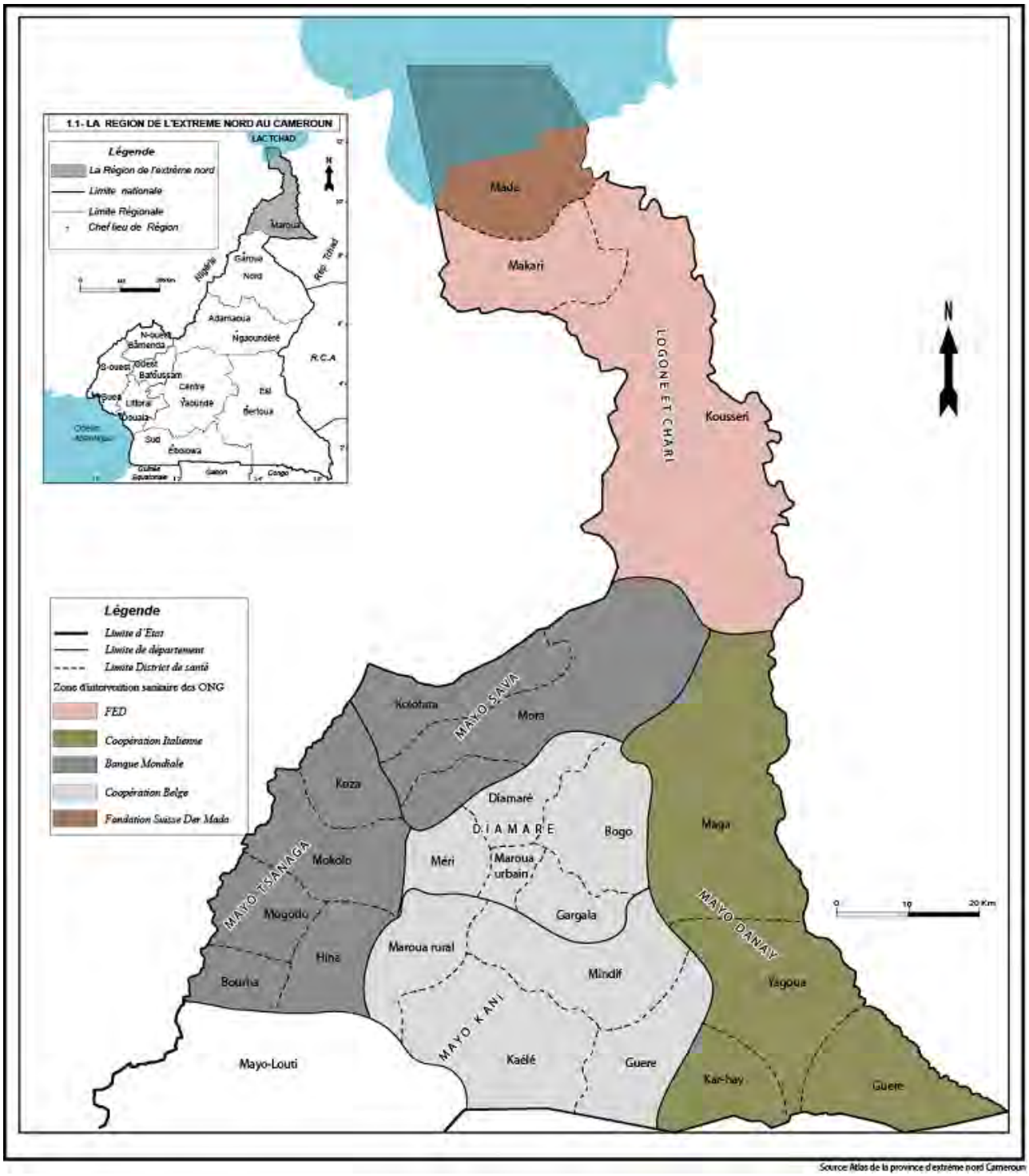
Appendix F: Geographical Location of the Maroua-Mokolo Diocese



Source Atlas de la province d'extrême nord Cameroun

Appendix G: Themes emerging from thematic analysis relating to staff secondment

The staff secondment intervention does not strengthen the Catholic health service.	Catholic managers cannot discipline seconded staff.	The lack of communication between Catholic managers and MoH.	Seconded staff belief that the work load is heavy.
Seconded staff are constantly absent and do not adhere to Catholic organisational culture.	*No disciplinary provision for seconded staff was made.*	*Staff seconded do not match Catholic HRH needs.*	*Seconded staff request additional pay to work longer hours*
Catholic staff are posted at health centres in the neighbourhood of their place of birth.	Regular Catholic staff considered seconded staff as threat to the Catholic working culture.	Two different staff management approaches	There is no retention and motivation strategy for seconded staff
Retention and motivation strategies used by Catholic managers	*Regular Catholic staff did not collaborate with seconded staff.*	*Seconded staff have difficulties adjusting into Catholic management style.*	*Seconded staff are posted without consulting them.*