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Strengthening church and government partnerships for primary health care delivery in Papua New Guinea: Lessons from the international experience

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Strengthening church and government partnerships for primary health care delivery in Papua New Guinea: Lessons from the international experience

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SUMMARY

Church health service providers play a prominent role in primary health care service delivery in Papua New Guinea. They are responsible for up to 50% of rural and remote health facilities and also for a number of training facilities for nurses and community health workers. Primary health care facilities are also the predominant point of access to the health system in rural and remote areas of Papua New Guinea where approximately 87% of the population lives.

Stewardship of a mixed health system presents a number of challenges not unique to Papua New Guinea. The evidence suggests that many governments are not performing their stewardship function well. In Papua New Guinea studies suggest that health service provision could be more efficient and effective if there was a greater focus on strengthening the partnership between national and sub-national governments and church health service providers.

There has not yet been any systematic attempt to draw lessons from low and middle income countries that could contribute to a strengthened partnership between church and government health service providers in Papua New Guinea. We undertook an empirical study based on a literature review of international published peer-reviewed and grey literature to answer the questions:

- What makes primary health care service provision by church based organisations different to government health service provision? and
- What are the characteristics of existing arrangements for governments to engage non-government, non-profit providers of primary health care services?

We then explored the possible implications of these findings for Papua New Guinea.

Factors which emerged that may enhance the partnership in Papua New Guinea include: relational contracts which clearly define the respective roles and responsibilities of each party while valuing the distinctive motivations; enabling remote service providers to respond to local contexts within the framework of national policies; assured funding commitments from government coupled with improved transparency from the church in financial reporting; involvement in policy development, planning and implementation of agreed standards; improved human resource management through utilising the strengths of the church sector in training of health workers; acknowledging and managing the differences in culture and style between church and government; and accessing support from other development partners or church health networks to enhance the partnership.

Papua New Guinea has in place a clear framework to enhance the partnership through the National Health Plan 2011-2020. Structures and systems can be strengthened to overcome existing constraints and forestall some of the obstacles that have characterised relationships between the faith-based sector and the government globally.

INTRODUCTION

In most health systems, services are provided by a mix of government and non-government agencies. The nature of non-government providers (for profit or not for profit, secular or non-secular) varies, as do their respective roles (disease specific, comprehensive, health promotion, primary or tertiary care) (Loevinsohn and Harding 2004; Hauck, Mandie-Filer et al 2005; Palmer, Strong et al 2006; Sachs 2007; Schmid, Thomas et al 2008; Rasheed and Karpf 2010). In Papua New Guinea churches play a prominent role in the formal health system, particularly in primary health care (PHC) and health worker training (Hauck, Mandie-Filer et al 2005).

In a recent report on health partnerships in Papua New Guinea to the National Department of Health (NDoH) and the World Health Organization (WHO), Matheson, Elovainio et al (2009) describe the relationship between church health service providers and the national government as weak. This finding reaffirms views in a 2003 review of church health services (Health Sector Monitoring and Review Group 2003) and the 2007 review of a Papua New Guinea and Australian church partnership program (Kelly, Cousins et al 2007). These reviews called for the government and church to work more closely together, arguing that health services could be more effective and efficient if greater effort were made to strengthen the partnership between national and sub-national governments and church health service providers.

The stewardship challenges of managing a mixed public and private health system are not unique to Papua New Guinea and have been discussed globally for more than a decade. De Ferranti (in Lagomarsino, Nachuk et al 2009) argued that effective stewardship of non-government services is crucial to achieving health objectives, but many governments are not performing their stewardship function well.

With this in mind, the authors believed it would be valuable to review the literature from Papua New Guinea and other low- and middle-income countries, to gain a clearer understanding of the value churches can bring to primary health care and to understand the characteristics of effective relationships between government and non-government not-for- profit health service providers. Examining strategies for strengthening service delivery is also timely in the light of the recent release of the Papua New Guinea National Health Plan 2011-2020, which includes strengthening partnerships and coordination as key to revitalising the PHC system.

This working paper outlines the current operational relationship between the government and church providers of primary health care in Papua New Guinea and presents findings from a review of published and grey international literature to answer the questions:

1. What makes primary health care service provision by church-based organisations different from government provision?
2. What are the characteristics of existing arrangements for governments to engage non-government non-profit providers of primary health care services?

The discussion focuses on the relevance of the findings from the literature for government and churches in Papua New Guinea.

BACKGROUND

Primary Health Care Delivery in Papua New Guinea

For the 6.4 million people living in Papua New Guinea, primary health care services are crucial. PHC facilities are the predominant point of access to the health system in rural and remote areas, where approximately 87 per cent of the population live (WHO 2010). However, the provision of these services faces many geographic, cultural, financial and systemic challenges (Newbrander and Thomason 1989; Toikilik, Tuges et al 2010). Many villages can be reached only by air or foot, and 97 per cent of the roads are unpaved (WHO 2009).

The health system is decentralised and tiered, facilities ranging from aid posts through to provincial and national hospitals. PHC services are mostly delivered through health centres, sub-centres and aid posts. Staff at health centres and sub-centres are more highly trained than those at aid posts, and include nursing

officers with midwifery training and health extension officers with training at a level between a nursing officer and medical doctor. Referral and supervision networks exist between the different levels of PHC facilities (and hospitals). District and provincial hospitals often provide basic outpatient services, which could be provided by lower level facilities.

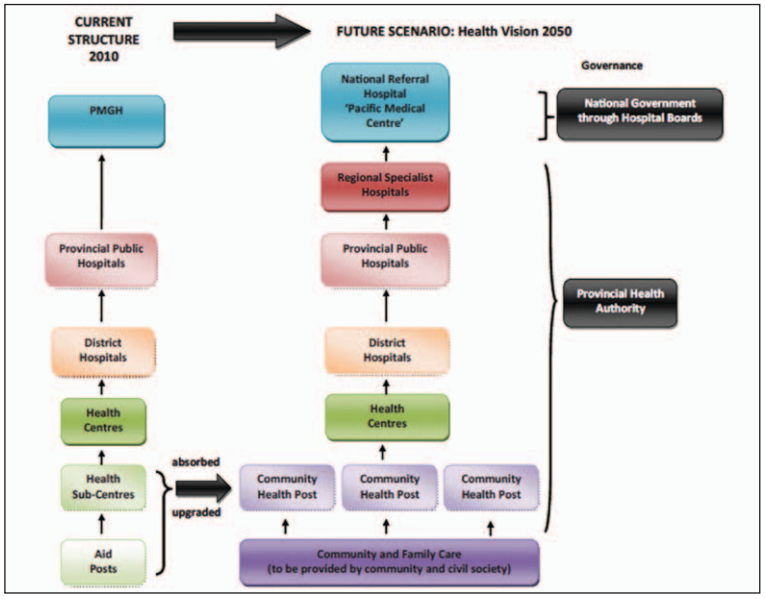
By law, primary health care is the responsibility of provincial governments (*Organic Law on Provincial Governments and Local Level Governments 1995; National Health Administration Act 1997*), while hospitals are statutory corporations governed by boards under the Public Hospitals Act. Church and government providers dominate services delivery, although a small proportion are provided by corporations and private practitioners in urban areas (Janovsky and Travis 2007).

It is has been argued that PHC services have deteriorated since decentralisation (Janovsky and Travis 2007). It is estimated that up to 40 per cent of aid posts have closed over the last 20 years. Supervised deliveries are estimated to have fallen from 52 per cent in 1991 to 39 per cent in 2004, and ambulatory contacts from 2.39 per capita to 1.5 since 2002 (Janovsky and Travis 2007).

Foster, Condon et al (2009) describe the health system as fragmented with a 'disconnect between hospitals and public health programs, between priority programs and basic health services, between government, churches and other non-state providers, and between the centre and different levels of the health care system'. To overcome the problems caused by this fragmentation, some provinces are trialling the establishment of provincial health authorities. Under the *Provincial Health Authorities Act 2007*, these are statutory corporations with administrative and financial responsibility for hospitals and public health (including PHC) services and integrating government and non-government service providers. They access function grants previously directed to provincial governments. It is hoped that they will strengthen capacity and coordination for provincial health service provision.

In 2010, the National Department of Health released the *National Health Plan 2011-2020*, "Back to basics: Strengthened primary health care for all and improved service delivery for the rural majority and urban disadvantaged" (Government of Papua New Guinea 2010). The plan envisages structural revisions aimed at revitalising PHC as part of a long term *Health Vision 2050* (Figure 1). The restructure includes establishing community health posts as the most peripheral facility, staffed with multiple clinical staff including a midwife. There is likely a need to revise the sources, collection mechanisms and amounts of financing in order to fund these structural reforms.

Figure 1. Health Vision 2050



Source: National Health Plan 2011-2020.

Role of Churches in Primary Health Care

Western medical care in Papua New Guinea began with the missions. Christian missionaries arrived in 1848 (Hauck, Mandie-Filer et al 2005), while missionary nurses first arrived in the late 19th and early 20th centuries (Matheson, Elovainio et al 2009). These communities have grown and spread across much of the country (Hauck, Mandie-Filer et al 2005). Today, church-based health service providers play a prominent role in PHC delivery. It has been estimated that they are responsible for the management of up to 50 per cent of rural and remote health facilities. Further, churches are responsible for running six of Papua New Guinea's nine nurse training facilities and 14 training facilities for community health workers (Bolger, Mandie-Filer et al 2005; Hauck, Mandie-Filer et al 2005). Churches are also active in the provision of HIV-AIDS related services (Kelly, Cousins et al 2007).

As a result of this history, in some rural and remote areas church-based health facilities have a stronger presence than government. More recently churches have also taken over the management of a number of health facilities from the government (Hauck, Mandie-Filer et al 2005; Janovsky and Travis 2007).

In 1974, Scholz (in Matheson, Elovainio et al 2009) described some generalised characteristics of church health services across the country. These included a focus on basic grassroots care, particularly for mothers and children, and on services for rural, rather than urban, populations. Scholz also noted a focus on disease-specific services and the ability to establish strong relationships with local people through long-term engagement. It was also suggested that church health workers demonstrated greater dedication to their work than most of their government counterparts. Many of these perceptions, whether founded or not, are still held by many in Papua New Guinea (Hauck, Mandie-Filer et al 2005).

Church and government PHC facilities have points in common in addition to reliance on public funding. Both are expected to follow the same standard treatment guidelines, pre-training requirements are the same for both, and government in-service training can be attended by staff from both churches and government facilities. Both are also required to provide routine data to the government National Health Information System (Health Sector Monitoring and Review Group 2003).

Churches Medical Council

The Churches Medical Council (CMC) is an umbrella organisation established to represent church health service providers. It represents 24 (of 82) registered church agencies from 14 different Christian denominations. Membership is limited to denominations recognised by other member churches. It is a national level body and works directly with the central government, but there are also sub-national chapters that work with provincial counterparts in accordance with the CMC ideals and constitution.

The CMC is a democratic organisation with a form of proportional representation: the number of voting members is governed by the number of 'appropriate health workers' employed. Membership fees are a source of income for the CMC. Income also comes from government and donor agencies.

The purpose and roles of the CMC are set out in a constitution (amended May 2002) that highlights the importance of partnership with the government: 'Encourage and develop the highest level of health—physical, social, psychological and spiritual—for the people of Papua New Guinea, within the framework of national and provincial health policies …' (CMC 2002). Similarly, the mission of the CMC aims at 'Partnership with the Government and non-Government health care providers through Health Promotion, Training, Clinical Care and Evident (sic) Based Research work' (CMC 2010).

Funding for Primary Health Care

The funding of PHC is predominantly public. Health function grants from the national treasury (general taxation revenue) are allocated to provincial governments for running PHC facilities, though salaries for health workers are funded centrally through the Department of Personnel Management.

Church-run facilities are supported by grants from the National Department of Health. These grants are negotiated with the CMC. Each year, member organisations are required to prepare work plans and budgets

for their health facilities. The CMC then uses these submissions to formulate two grant requests to the NDoH on behalf of its members: one for staff salaries and one for other operational expenses, which are divided among the members. The NDoH has not always met the CMC's total funding requests. It is estimated that a further 100 facilities operated by church groups are unrecognised by the NDoH and therefore without access to the formal health function grants (Matheson, Elovainio et al 2009).

Medical and drug supplies for both government and church facilities are financed centrally, although external donors contribute. Papua New Guinea's version of a sector-wide approach, the Health Sector Improvement Program Trust Account, is also intended to fund goods and services for both government and church PHC facilities. Anecdotally, it has been reported that some church-run facilities have had difficulty accessing funding from this source. Provincial governments also contribute financially to PHC, though Trust Account funding is reportedly being used to replace what some argue should be provincial government financial contributions (NEFC 2007; Provincial and Local-level Service Monitoring Authority 2009).

Many church and government facilities also raise revenue through user fees. While PNG's national health accounts are still developing, the WHO estimates that between 2006 and 2009 18 to 21 per cent of total health expenditure came from private sources, with just over 40 per cent of that from out-of-pocket expenses (WHO 2011). Though user fees represent only a small proportion of the total costs of health services (Inder, Spinks et al 2011), recent research suggests that fees are quite common and are an important source of operational funding that should be provided through grants to provincial governments and the CMC (Sweeney and Mulou 2010).

Some churches have access to other sources of funding through their broader ministries and networks, and from AusAID, which funds indirectly through the Australian church partnership program (Kelly, Cousins et al 2007). However, gaining data on this funding has proven difficult, due in part to inadequate records and in some instances a desire not to reveal the extent of non-government funding (Hauck, Mandie-Filer et al 2005; Provincial and Local-level Service Monitoring Authority 2009). The CMC states that government grants make up 70-100 per cent of total funding (Churches Medical Council 2009).

Although the CMC negotiates funding from the NDoH for PHC, agreements between the churches and government are informal. '[N]umerous memoranda of understanding (MoU) and memoranda of agreement (MoA) have been drafted at the national level, [but] none have been signed' (Matheson, Elovainio et al 2009), so the agreement remains informal (Janovsky and Travis 2007). Recently, the *Church Health Services Act* was developed to provide a legal framework for a formal agreement and was part of 'an attempt by the Churches to increase their recognition in the system' (Matheson, Elovainio et al 2009). However, legal shortcomings in drafting resulted in the act having no legal status, as it is yet to be proclaimed (Matheson, Elovainio et al 2009; Janovsky and Travis 2007). '[W]hile the discussion goes on about the need to revise the Act, also [needed is] an emphasis on how to strengthen this partnership through a mutual, formalized agreement' (Matheson, Elovainio et al 2009).

METHODOLOGY

To contribute to debate on the nature of the engagement and opportunities to strengthen the relationship between church health service providers and the government, we undertook an empirical study based on a literature review of international published peer-reviewed and grey literature to answer the research questions:

1. What makes primary health care service provision by church-based organisations different to government provision?
2. What are the characteristics of existing arrangements for governments to engage non-government non-profit providers of primary health care services?

Findings from the literature review were extracted and the relevance and possible implications of these experiences were considered for Papua New Guinea.

The research questions were identified through two working group meetings and through consultation with representatives from other research institutions in Australia and Papua New Guinea and from AusAID and with senior executive staff from the Papua New Guinea National NDoH and the CMC.

This collaboration involved staff from the Health Policy and Health Finance Knowledge Hub at the Nossal Institute for Global Health (University of Melbourne) and staff from the Health Sciences Faculty of the Divine Word University in Madang and the NDoH. In preparation for the research, a week-long training course on literature reviews was developed and conducted by Nossal and DWU researchers for all DWU Health Science Faculty and nominated NDoH staff. Individuals who undertook the training then nominated to become part of the research team.

Description of Literature Search

Preliminary searches indicated that some papers were relevant to both research questions, so the search strategy was broad enough to enable the identification of evidence relevant to either or both questions.

All searches took place between June and December 2010. We searched the PubMed and Medline databases using the terms: 'health care', 'health planning', 'contracting-out', 'not-for-profit', 'church', 'faith-based organisations', 'nongovernment organisations' AND 'primary health care' AND 'developing countries'. Many of these terms were MeSH subheadings, providing a broad search for potentially relevant papers.

Varying combinations of these terms were used in the Google and Google Scholar search engines for additional published and grey literature. We also targeted the following organisational web sites as likely sources of relevant literature: *Lancet*, Eldis, the World Bank, Asian Development Bank, DFID, AusAID, WHO, USAID, UN, Medicus Mundi network, IDD, Papua New Guinea CPP and Christian Connections for International Health. Colleagues were also asked to provide recommendations of relevant reports and web sites, and reference lists of identified articles were subsequently reviewed for additional evidence up to October 2010.

Specific inclusion criteria differed slightly for the two questions. Question one included only studies and documents presenting or discussing evidence of PHC delivered by church or faith-based organisations (FBOs). The inclusions for question two were broadened slightly to take in studies and documents presenting or discussing evidence of not-for-profit non-government providers of PHC in developing countries where the organisations had been contracted to provide services by a government or had an agreement or relationship.

The private for-profit sector of PHC was excluded. We also excluded papers describing or evaluating situations in which non-government organisations [NGOs] were engaged to deliver hospital services because our focus was on engaging NGOs to deliver comprehensive PHC, as happens in PNG.

The search strategy was deliberately inclusive in order to extract the rich knowledge that comes from considering complex issues from a range of disciplinary perspectives. We included all study designs, including controlled studies where available, evaluation documents and descriptive case studies. We also included review documents and those presenting guidelines for partnerships and relationships (including contracting) between government and non-state providers of health services as well as multilateral and bilateral donors.

PubMed, Medline and Google were searched independently by three researchers, and the results were processed to identify relevant articles. Other web sites were searched by one researcher. All potentially relevant evidence was independently assessed by two researchers before inclusion. A third researcher resolved any disputes. Data were extracted independently by two researchers.

Limitations

Readers should be aware that we found very few papers incorporating robust scientific study design. We found predominantly descriptive case studies and program evaluations. Unlike the Cochrane criteria for appraising the quality of randomised controlled studies, there is no consensus on the criteria that could be used to appraise systematically the quality of program evaluations. Studies were selected on the basis of their relevance to the research questions and design, but it was not possible systematically to rate their quality. We included key themes presented in guideline documents although the evidence base underlying some guideline recommendations is difficult to assess.

This paper has focused on primary health care service provision in developing countries and, in relation to question two, the relationship between government and private, not-for-profit health service providers. It is

possible that there are insights relevant to Papua New Guinea which could be gleaned from casting a wider net in terms of contracting examples, although such findings may be less generalisable. While there were some consistent lessons on characteristics for successful relationships observed in multiple settings, as always, context was crucial in the findings of strengths and weaknesses of these relationships.

It is important to note that this paper is an empirical study. The authors do not present a detailed description and critique of each identified paper but rather present the key themes related to our research questions. To varying degrees, the authors had PNG and international experience related to church-based PHC services.

KEY FINDINGS

Differences between Church-Based and Government Provision

There was little in the literature specifically identifying the differences in provision of health services between church-based organisations and government, although a number are demonstrated in discussions of the strengths and weaknesses of faith-based service providers. While these differences are focused on the distinguishing characteristics of church-based organisations, they do not allow us to draw a broader conclusion that church health services are always better or worse than government services in any given situation.

A number of authors referred to the interrelationship between faith and health. We have presented the evidence only in relation to the Christian faith but acknowledge that there may be similarities between these findings and those of other faiths.

We have attempted to present identified differences under the WHO's core health systems 'building blocks' (WHO 2007b) of leadership and governance, financing, workforce and service delivery. Readers should keep in mind the interdependence of these themes and that many reported differences might justifiably have been discussed under two or more of these sub-themes.

Changing Nature of Church Health Services

Churches continue to play an important role in health service delivery, although the distinctions between church and government service providers are increasingly blurred.

Church health services have evolved from their historical roots and form part of a complex array of non-government health care providers, including NGOs and private for-profit providers. Grills (2009) suggests that increasing privatisation in the developing world has largely resulted in 'increased utilization of FBOs because they are frequently the largest provider … In Africa, they are responsible for providing between 30 percent and 70 percent of health care services.' Churches are also described as being 'responsible for a broad spectrum of health care services … with many outreach programmes extending to the most remote communities' (Adjei, Maniple et al (2009). The same authors also highlight the evolving nature of this service provision, initially focusing on curative services located close to churches and missions, extending to dispensaries, health centres and hospitals in rural areas and over time developing 'a more holistic vision supporting community health, rather than merely offering a medical service' (Adjei, Maniple et al 2009). Within the faith-based community there is a consensus that FBOs are providing public goods and services (Adjei, Maniple et al 2009).

The literature also pointed to an increased blurring between private and public domains (UNFPA 2008b). Writing on lessons from a legacy of engaging with FBOs, the United Nations Population Fund perceives both the government and the non-government sector as having a diversity of 'mandates, missions, expertise, services and modality'. Many staff work in both the government and non-government sectors 'or behave within the public sector as if they were offering a private service' (Moran and Batley 2004). The increasing tendency of multilateral organisations to engage with the faith-based sector also contributes to the blurring between state and non-state actors (Grills 2009).

This same blurring between church and government entities has been identified in Papua New Guinea, where the large government subsidisation of church health care results in these services being seen as part of the public sector (Thomason 1993 in Gilson, Sen et al 1994). In Kenya the level of government support for staff and

running costs suggests that over time church health facilities may increasingly come to resemble government institutions (Rasheed 2009a).

The lack of a clear distinction between government and faith-based providers is also apparent among the leadership of the two entities. It is often hard to distinguish between civic and religious leadership, while some FBO leaders also hold senior roles in government and are active in policy making (Sachs 2007; UNFPA 2008b).

Leadership and Governance

There is a risk that FBOs can be isolated from the health system as a whole, with deleterious effects.

In its publication *Everybody's business: Strengthening health systems to improve health outcomes*, the WHO (2007b) describes leadership and governance as 'the most complex but critical building block of any health system'.

The literature suggests that NGOs and FBOs may be isolated from national policy and planning, resulting in a harmful effect on the health system. For example, the WHO (2007a) reported on case studies in Zambia and Lesotho which suggested that FBOs are overlooked by public health decision makers. Others suggest that there has been little participation in national and district planning, a reluctance to adopt national policy in areas such as family planning (Gilson, Sen et al 1994) and a reluctance from some churches to align themselves with government (Green, Shaw et al 2002).

A study of religious entities' contribution to health in Zambia and Uganda (and elsewhere in sub-Saharan Africa) identified a lack of collaboration between church and government health services, resulting in duplication of services, competition for funding and recruitment of staff and volunteers and an inability to access appropriate referral services (Schmid, Thomas et al 2008). Reviewing state capacity and non-state service provision of basic services in fragile and conflict-affected states, Batley and Mcloughlin (2009) also highlighted the potential for parallel systems to increase fragmentation.

Hafner (2009), writing about the role of African Christian health associations, suggests that with the 'notable exception of Malawi, most CHAs are still not well integrated into national government policies and programs', although he also acknowledges plans 'to promote and share good examples of CHA and government integration'.

This finding of isolation from national planning is not uniform, however. Writing about the relationship between FBOs and government in Africa, particularly since the implementation of health sector reforms, Adjei, Maniple et al (2009) suggest that 'FBOs have become officially recognised partners in the health system within many countries'. This has resulted in the inclusion of FBOs in national health plans and the formalising of contracts for the delivery of health services. There are also examples of the inclusion of private not-for-profit members in decentralised structures such as district health management teams in Uganda, where their involvement is 'critical in the identification of health needs, prioritisation, planning of appropriate response, coordination of service delivery, and monitoring and evaluation of health system performance' (Balabanova, Oliveira-Cruz et al 2008).

While there appears to be some risk of fragmentation or isolation of church health service providers, the WHO has argued that, rather than simply scaling up public services, governments need to make strategic choices among existing providers (WHO SEARO 2009). It is argued that governments need to be pragmatic in trying to reach universal coverage and should explore the potential of using all available resources by integrating non-government contributions into universal coverage efforts (WHO SEARO 2009). It is further argued that 'more private does not mean less government—it implies a strong government presence in a different role that emphasises governance and financing rather than direct provision' (WHO SEARO 2009).

Clear definition of roles and responsibilities helps to create a predictable and transparent environment in which non-government actors can operate. Bennet, Hanson et al (2005) argue that these are important elements of government stewardship. This requires the ongoing collection and analysis of information about non-government providers, including types of services, basic service utilisation and financial data, and their integration into routine health information systems. There is also a need for clear laws and boundaries and clearly defined expectations in return for financial support. The lack of reliable data on the contribution of

faith-based providers and on the scale of religious health facilities has a negative impact on the government's oversight role, suggesting that comprehensive mapping of religious entities is important for appropriate resource allocation (Sikosana, Dlamini et al 1997; Bennett, Hanson et al 2005; Schmid, Thomas et al 2008).

Health System Financing

There is a lack of transparency and consistency in the financing of church health services, resulting in difficulties for both government and non-government providers.

Good health financing encompasses raising 'adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient' (WHO 2007b).

Most facilities are no longer owned, managed and staffed exclusively by missionary organisations, and sources of funding have shifted from external church support to a greater contribution from national governments and indigenous churches, bilateral and multilateral donors and international NGOs as well as from user charges (Green, Shaw et al 2002). This is illustrated in Uganda, where Balabanova, Oliveira-Cruz et al (2008) note:

> [B]y the early 1990's, most charitable support to the mission health facilities had started to dwindle. This coincided with the channeling of a larger proportion of development aid directly to government systems through the Sector-Wide Approach (SWAp) … resulting in loss of revenue for some of the nongovernmental actors, particularly the not-for-profit sector.

However, the move to a SWAp to finance the health sector does not necessarily preclude FBOs accessing donor financing. In Uganda, the introduction of a SWAp in 2000 'engendered the pooling of donor resources, channeling donor funds through the national budget and strengthening Ministry of Health (MOH) leadership for the sector. The SWAp process provided the institutional mechanisms and structures for public-private partnership engagement' (Balabanova, Oliveira-Cruz et al 2008).

Others, (Adjei, Maniple et al 2009), point to the increased reliance on user fees among FBO facilities. In Kenya, for example, user fees were the least significant source of funding historically, but in 2004 provided 71 percent of funding compared to 13 percent from donors, 9 percent from the National Hospital Insurance Fund and 7 percent from others. However, anecdotal evidence also suggests that some FBO facilities apply internal cross-subsidies to exempt the poor from fees.

Some authors have described a lack of transparency in financial matters between church health service providers and governments despite some recognition that 'transparency regarding finances has become an essential element of management of church health services' (Adjei, Maniple et al 2009). Church providers expressed concern about governments knowing the sources and amounts of external financial support churches receive. On the other hand, governments find it difficult to judge the appropriate support to not-for-profit providers when the amount of external contributions is unknown (Sikosana, Dlamini et al 1997; Rasheed 2009a). In Ghana, Rasheed (2009a) notes mistrust by governments due to the unwillingness of churches to disclose accounts, as do Hauck, Mandie-Filer et al (2005), who suggest some reluctance from the churches in Papua New Guinea to share financial data.

The lack of financial transparency also appears to impact sub-nationally. Balabanova, Oliveira-Cruz et al (2008) found that in Uganda support for the partnership between the government and the private not-for-profit sector varied between districts, with some convinced that non-government providers 'are not entitled to a government subsidy because they are able to mobilise adequate resources from user fees and other partners'. In Tanzania, Adjei, Maniple et al (2009) found that local governments were not aware of the funding constraints faced by FBOs and thought that 'FBOs have enough resources'.

Where formal agreements between church and government exist, funding mechanisms vary, but they can provide a framework for financial stability. In a report of experiences with contracts between FBOs and governments in Africa, financing is highlighted as a major challenge alongside human resources (Boulenger, Keugoung et al 2009). Rasheed (2009b) points to the need to manage expectations that a memorandum of

understanding will resolve churches' financial difficulties as well as a requirement for realism about the level of reporting and data required by government if it is to support FBOs in their health mission.

This vulnerable financial base is also impacted by a lack of transparency in procurement, issues with competitive pricing, potential over-reliance on government funding, the cost of subsidies and other resources and a shortfall in realistic knowledge about the costs of services. In some cases access to church financial data has enabled governments to address this latter limitation (Rasheed 2009a).

In 2002 Green, Shaw et al argued that external donor funds are uncertain and that it was becoming harder to raise user-fee income, especially in rural areas, where demand for health services continued to increase, 'reflecting in part the growing needs of long-term conditions such as AIDS and TB'. This poses challenges for church providers. The same authors argue that while churches are likely to continue to have an important role in health care (particularly in Africa), they face challenges including their relationship with government in an uncertain external financing environment.

The churches' focus on services for the poor at a time when donors continue their interest in alleviating poverty may mean donors are a possible source of continued financing. However, there may be limitations to this funding because donors expect to see results in health outcomes, which may be at odds (or at least difficult to demonstrate in the short term) with the church focus on longer term objectives of empowerment and community development (Green, Shaw et al 2002).

A number of governments have also recognised the likely increased costs and impact of failed church health services on the health system as a whole if they are not supported (Rasheed 2009a).

Health Workforce

There are challenges in management of the church health workforce that may impact on services.

A well-performing health workforce works in ways that are responsive, fair and efficient to achieve the best health outcomes, given available resources and circumstances (WHO (2007b). The literature points to strengths and weaknesses of the non-government sector in relation to the workforce and also reports anecdotal evidence about the positive motivations of FBO staff.

Staff management strengths of church health services include effective utilisation to meet the needs of the system, the ability to attract and retain staff and the capacity to respond in emergencies and in conflict areas (Rasheed and Karpf 2010).

Training is also a strength. Rasheed (2009a) writes: '[T]he public sector has also benefited from specialist training, uniquely fashioned to local settings, which are only available in the faith-based sector—the result of years of investment and in-country experimentation'. In Kenya FBOs are responsible for training colleges that educate nurses, midwives and other paramedical staff, as well as providing training for higher level staff and the management of universities (Adjei, Maniple et al 2009). This situation has parallels in Papua New Guinea.

The literature also indicates other strengths of church (and NGO) health workers, including strong motivation, a willingness to serve in remote areas, a non-bureaucratic and flexible style, close relationships with the community, an ability to innovate and high quality and low costs in some areas of service provision (Gilson, Sen et al 1994). In Papua New Guinea church health services have more flexibility in hiring and dismissing staff than do government services (Health Sector Monitoring and Review Group 2003). It is argued that this has led to more discipline among their workforce. However, there is evidence that in some church health organisations recruitment and promotion of staff are restricted by religious affiliation, which creates some difficulties for the sector-wide planning of human resources (Rasheed and Karpf 2010).

Case studies from Africa suggest a range of human resource management challenges for church health services (Boulenger, Keugoung et al 2009; Adjei, Maniple et al 2009). For example, in Chad staff salaries were paid with designated funds from the government, which limited recruitment possibilities. In Uganda, churches had difficulties in recruiting staff due to low salaries and a massive recruitment campaign of the MOH. An increase in the fixed costs of facilities (particularly staff) increased the financial vulnerability of the faith-based

sector, where on average human resources represent 44 per cent of the total costs and where the state subsidies did not cover the salaries. Churches in Uganda were forced to increase staff salaries as a result of increases in the public sector.

In Tanzania, when the government improved working conditions in public facilities by increasing salaries and allowances, it resulted in significant personnel losses among FBOs. Similar trends of salary matching are taking place in Papua New Guinea, and lower salaries for church health workers than for their government counterparts have been reported (Health Sector Monitoring and Review Group 2003). Concerns have also been expressed by the government. In Ghana FBOs 'were providing perks to attract staff', which the government felt was not in line with the spirit of an agreement between FBOs and the public sector (Rasheed 2009a).

In an attempt to address personnel losses from the faith-based sector, the Christian Social Services Commission in Tanzania looked at designing an incentives package for health workers in FBO facilities. It found that 'a mix of financial and non-financial incentives was perceived to be the most effective strategy for improved retention of health workers ' (Schwerzel 2006 in Adjei, Maniple et al 2009). Among the proposed non-financial incentives were allowances for remotely based staff, improved social security arrangements, professional development opportunities and a rural health workers savings and credit scheme.

The urgency of addressing human resource issues in the faith-based sector led to the formation of the African Christian Health Associations technical working group on human resources with support from the Capacity Project, funded by USAID. The Capacity Project worked to strengthen FBO networks' human resources and documented the breadth of pre-service and in-service trainings offered by FBOs, with a focus on nursing and midwifery pre-service training in Malawi, Kenya, Tanzania, Uganda and Zambia. As a result there has been progress in human resource matters, for example in contributions to planning and budgeting, cost sharing with governments on health worker salaries, health insurance schemes, retention strategies and the identification of areas for further collaboration (USAID 2006).

Health Service Delivery

Church and government health services may be similar in structure and function but have differing cultures and management styles.

We identified no major differences in the types of services or structure of service delivery between church and government providers, although there is evidence that church health services have a stronger presence in rural and remote areas in some settings (Green, Shaw et al 2002; Hauck, Mandie-Filer and Bolger 2005). There is also an evolution of church services towards more holistic community health (Adjei, Everd et al 2009).

A key strength of government health services is their undisputed location as part of the public health system and the status of staff as government employees, with other resources of the state such as central medical stores, legal and audit services also being available (Green, Shaw et al 2002). Weaknesses in government services are described as those that may characterise all state services, including a shortage of funds and material resources, lack of management support and training and a sense of isolation (Green, Shaw et al 2002).

Even where church and government health services appear to be similar in structure and function, the culture and management styles can be very different. Green, Shaw et al (2002) describe government services as ruled by a strong sense of hierarchy and procedure, while church health services tend to have a distinctive culture derived from their religious affiliation. Government health services are provided as part of the social welfare responsibility of the state, while churches vary in their prime objective from welfare, often with an emphasis on the poor or marginalised, to evangelism (Green, Shaw et al 2002).

Sachs (2007) documented the contribution of FBOs to Family Health International's HIV programs in more than 70 countries and explored the degree to which the strengths of FBOs have been maximised. He suggests that a hallmark of services by FBOs is the attention paid to the personal dimensions of care.

The reputation of faith-based entities in providing care efficiently is acknowledged, but there is limited data to support this observation (Sikosana, Dlamini et al 1997). In Uganda, where the private not-for-profit sector

provides about 40 percent of all health services and 34 percent of the facilities (86 percent in rural areas) Balabanova, Oliveira-Cruz et al (2008) suggest they provide good value for money, given that their share of the health budget is just 5 percent.

Church health services may also lack adherence to national policy objectives. In sub-Saharan Africa, Banda, Ombaka et al (2006) noted a lack of adherence by FBOs to the rational use of medicines policy and to good storage and distribution systems and drug donation practices.

Faith and Health

There is a complex relationship between faith and health in some settings, and resultant influences on health-seeking behaviour and health services.

A pilot study in Zambia and Lesotho suggests that public health decision makers fail to recognise the significance of the interrelationship between religion, health and well-being. '[R]eligion is so overwhelmingly significant in the African search for wellbeing … and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives' (WHO 2007a).

Urging greater dialogue between different faith organisations as well as the public and private sector, the authors of the WHO (2007a) study emphasise both the tangible (clinical) support and intangible (spiritual) support provided by FBOs. This finding accords with that of Hauck, Mandie-Filer et al (2005) in Papua New Guinea. Sachs (2007) also suggests that outside of the Western world, 'faith often does not exist as a privatized and distinct realm set apart from social, political, and scientific matters'. This complex reality of health and faith, particularly in Africa, is described by Schmid, Thomas et al (2008) through the notion of plural health worlds in which people's conceptions of health are framed by inherited and socialised knowledge.

The FBO holistic conception of health and health care as encompassing the individual's medical, physical, mental, social and spiritual well-being can impact on services. Some authors suggest that in caring for the 'wholeness of people and communities' (Sachs 2007), churches offer a wide range of services (Sachs 2007; Bandy, Crouch et al 2008). A faith dimension to health care can also lead to additional emphasis on services for the poor or marginalised (Grills 2008).

In describing the Comprehensive Rural Health Project in Jamkhed, India, Chand and Patterson (2007) suggest that a values-based attitude has resulted in improved maternal and child health by promoting a comprehensive approach, introducing participatory community decision making, empowering women through transferring health knowledge, working to eliminate discrimination based on caste or gender and mobilising the community to emphasise beneficial traditional practices and eliminate harmful ones.

Some authors also describe the complexity and apparent contradictions that can exist between faith and health care. FBOs are often the sole providers in remote areas and have unique insights particular to a location from their pastoral work (Rasheed and Karpf 2010). FBOs also have the potential to share information and gain support through dispelling myths about health care (Rasheed and Karpf 2010). However, the authors also acknowledge that faith can preclude the delivery of information or services and contribute to delays in seeking care. Judgmental or hostile attitudes may also deter some community members from seeking assistance, and services can be sabotaged by conservative health groups.

Faith-based providers can lack a consensus on policy issues such as the provision of condoms and family planning (Green, Shaw et al 2002). There are also negative examples of the impact of faith on health care in Ghana in areas such as specialist care, mental health practices and sexual health (Rasheed 2009a). However, FBOs can also assist to legitimise and promote information and services that might otherwise escape public notice and may be in a unique position to shape social values, increasing public knowledge and influencing opinion (Sachs 2007; UNFPA 2008a). Even where a faith effect has been found to influence providers of services, Grills (2008) suggests that this can be moderated by the external environment.

Schmid, Thomas et al (2008) cite anecdotal evidence that the religious commitment of health workers can

impact positively on their work ethic and the quality of care. However, there is a need for further research to verify the claims about better care by FBOs, particularly since some faith-based health services work under severe constraints on the size of their workforce and the large service outputs required of them. Exploring the FBO response to HIV in India, Grills (2008) concludes that faith substantively affects FBO programs and directs the focus of care towards 'caring for the poor, the marginalized and geographically isolated'.

ENGAGEMENT OF NON-GOVERNMENT, NON-PROFIT PROVIDERS OF PRIMARY HEALTH CARE

Challenges have been identified in efforts to strengthen the collaboration between church and state providers (Bennett, Hanson et al 2005). Effective strategies that may assist non-government providers to contribute to public health goals include improving the information governments have about the nature and number of non-government providers, developing public sector management capacity and promoting organisational capacity of non-government providers (Bennett, Hanson et al 2005).

Among the interventions to improve coverage and promote collaboration is contracting. Much of the literature comes from the experience of contracting not-for-profit NGOs rather than churches or FBOs specifically. This evidence was included in the original search strategy because it was believed these lessons might be relevant to engagement between churches and government.

Health networks and a variety of other mechanisms can also strengthen the relationship between non-government, not-for-profit health service providers and the government.

Contracting

Contracting allows greater specificity in defining the roles, responsibilities and objectives of government and non-government actors. In the complex health care arena of developing countries, relational contracts that focus on the importance of the relationship over time may be the most appropriate.

A spectrum of contractual relationships has resulted in the development of a classification of contracts: classical, neoclassical and relational. Classical contracts govern a discrete transaction while neoclassical contracts govern transactions that allow a level of flexibility (MacNeil 1978 in Palmer 2000). Relational contracting is increasingly attracting attention and exists when 'the reference point of the relationship ceases to be the contract itself…' and instead becomes 'the entire relation as it has developed through time' (MacNeil 1974 in Palmer 2000).

In relational contracts, the focus is on preserving relationships and harmony rather than stipulating terms. They allow a response to the increasing duration and complexity of service delivery and are suitable when a high degree of dependency exists between the contracting partners (Palmer 2000). While suggesting that vague specification in relational contracts may be optimal, some authors caution that, in the absence of a cooperative relationship, they can constitute 'a simple neglect of basic requirements to be clear on what government funds were purchasing' (Mills and Broomberg 1998).

In describing the context in which incomplete relational contracts might be appropriate, Palmer (2000) highlights the challenges and suggests that they might be most efficient in low- and middle-income settings where 'costs of writing, managing and monitoring complete contracts would pose a great burden on under-resourced health departments' and where there may also be a limited choice of service providers. Palmer also suggests that 'the trust that develops in a longer term contractual relationship may act as a more efficient alternative to costly monitoring', resulting in a positive effect on the relationship between government and non-government service providers (Palmer 2000).

The more usual approach to contracting of FBOs has been through the provision of licences and block grants or through subsidies for staffing of church health services, with little or no specification of the services to be provided (Moran and Batley 2004). The same authors argue that while there is a fine balance between trust and abuse of freedom, relational contracts are justified by faith-based commitment and motivation.

England (2004) argues that to improve access to services, contractual arrangements need specifically to encourage providers to serve the poor and to include subsidies to reduce out-of-pocket payments by consumers. He also suggests a range of additional factors that should be considered when introducing contracting in poorer countries, such as the need for public sector reform to address the separation of purchaser and provider, along with a significant reduction in public sector staff. There is a need for a knowledgeable purchasing organisation with information about services and costs and the ability to fulfil its obligations.

Contract design should clearly specify outputs and payment mechanisms, which provide incentives for the provider while addressing non-performance. There should be clear agreement on the contractual relationships, with carefully planned monitoring and evaluation. However, in a systematic review of contracting in developing countries, Lagarde and Palmer (2009) suggest caution in defining the target indicators by which the provider will be assessed because this may distract attention 'from unmeasured to measured outcomes'. On the other hand, incomplete contract specifications make monitoring difficult.

Batley and McLoughlin (2009) also argue that, regardless of the type of contracting, a thorough assessment of the need for not-for profit engagement should be undertaken, with a focus on effective service delivery, prior to entering a contract. Where national approaches are envisaged, it may be appropriate to trial mixed regional or district approaches to allow learning (Batley and McLoughlin 2009).

Limited capacity of the contracting agency was commonly cited as a barrier to successful contracting—for example, when there is limited ability to specify clearly the services to be provided and inadequate resources for monitoring (Mills and Broomberg 1998; England, 2004; Loevinsohn and Harding 2005; Loevinsohn 2007; Lagarde and Palmer 2009; Batley and Mcloughlin 2009). Capacity shortcomings can also exist on the non-government side. Some of the capacity weaknesses of government can be explained by a lack of quality information on service delivery and costs. Even where there were issues of the capacity of governments to manage contracts, Loevinsohn and Harding (2004) suggest that there can be successful programs.

Conditions Conducive to Contracting

There appear to be a range of conditions conducive to successful contracting in developing countries as well as a number of challenges.

Boulenger, Keugoung et al (2009) examined the experience of contracting faith-based service providers in Cameroon, Chad, Tanzania and Uganda. They examined three classical contracting agreements in which providers took on the managing of a district hospital or health district and the contract in Uganda between a faith-based hospital and the US Presidential Emergency Plan for Aids Relief. In the latter case the authors suggested that there were valuable lessons for classical contracting relations despite the problems with vertical approaches to health care and the risks involved in bypassing central government. These included a focus on specificity and predictability, quality monitoring, steering and evaluation mechanisms and donor respect for commitments. The management of the district faith-based hospitals explicitly voiced its appreciation of these aspects (Boulenger, Keugoung et al 2009).

Despite positive examples, Boulenger, Keugoung et al (2009) conclude that 'contracting between private not-for-profit institutions and public health authorities in Africa faces a crisis'. They suggest that the important contribution which the faith-based institutions make could be jeopardised by a lack of information sharing, lack of support mechanisms, lack of monitoring and evaluation and failures to keep commitments between faith-based and public sector actors. The authors see streamlining of contracting as a priority.

Among the issues impacting on country contracting, Boulenger, Keugoung et al (2009) highlight the experience from Cameroon, where they suggest that incomplete decentralisation has affected implementation. While intermediate and local responsibility exists, they 'operate in a strong climate of centralization which complicates the management of the relationship', while the MOH 'becomes more and more a distant partner in the contracting relation'. The authors conclude: '[F]urther institutionalization and operationalisation of the decentralization process appears to be a necessary condition for improving and optimizing the implementation

of the contracting relationship'. The same authors also found that dysfunctional communication between national and peripheral governments contributed to the incomplete implementation of contracts in Tanzania and Chad, as did the perceived 'authority' of the donor.

A number of identified institutional weaknesses also restricted the effectiveness of contracting. These included a weak non-government sector with little competition for contracts, a history of mistrust between the government and non-government actors, corruption and non-transparent tendering and centralised, bureaucratic systems that limit the freedom of managers (Moran and Batley 2004). Broader social and political factors also impact. For example, contracting is more successful where corruption is discouraged, where contractors are compliant and where there is an effective legal system to ensure that sanctions for non-compliance are meaningful (Mills and Broomberg 1998).

Loevinsohn and Harding (2004 and 2005) suggest that contract management may be improved by limiting the number of contracts with non-government providers and/or the number of payments per contract to increase transparency. Others suggest a role for civil society or consumers in monitoring and also note that contracting can be implemented at national and/or district level (Mills and Broomberg 1998).

In developing contracting guidelines for policy makers, Abramson (2004) notes the need to consider carefully the national legal framework and political environment as well as the capacity of the public sector to manage contracting. She suggests: '[T]he decision to contract is not the inevitable result of a straightforward process … Rather, contracting responds to a country's particular needs at a particular time. ' Other conditions she suggests include the capability to utilise programmatic, administrative and financial data, functioning information systems, an analysis of the unit costs by the public sector and the availability of private providers.

While some authors wrote of the importance of government capacity, others highlighted the parallel importance of appropriate capacity and a willingness to partner by non-state actors (Batley and Mcloughlin 2009).

Health Networks and Improving Engagement of Churches

Health networks can play a role in improving engagement of churches in the health system and reducing the transaction costs for government, although the nature of the engagement may require adjustment over time.

Health networks or national coordinating bodies, more usually known as Christian hospital or health associations, first developed in Africa during the 1960s as the result of an initiative from the Christian Medical Council, which was established as part of the World Council of Churches. Many of these networks continue and 'the development of relationships between Government and church health services … has been assisted by the establishment of such coordinating bodies' (Green, Shaw et al (2002). In Papua New Guinea the Churches Medical Council provides this coordination.

There are examples of effective partnerships between government and Christian health associations in countries such as Zambia, where contracts have been negotiated with the government to provide health care in some districts where the association's members provide the only facilities (Bandy, Crouch et al 2008). Green, Shaw et al (2002) also describe the emerging role of coordinating bodies in policy dialogue and funding negotiations, which has allowed for countrywide agreements covering government subsidies in a number of African countries.

Schmid, Thomas et al (2008) argue that faith-based networks can be important in integrating church health services into the health system. Where health networks are effective, they have reduced the administrative and management load on government in working with individual church entities, while at the same time managing to increase their 'authority' with respect to their members (Rasheed 2009a). Networks can also facilitate learning by the government. In Ghana the government learned from the financial data of faith-based service providers the real cost of health care, resulting in revisions to its funding models (Rasheed 2009a).

However, health networks do not always create a better operational relationship between government and non-government health service providers. Rasheed (2009a) warns that in Ghana, where the Christian Health Association provides a range of services on behalf of its members, the government felt that the association

itself did not support national health objectives. Rasheed (2009a) also observes that such health networks can lack the authority to ensure that all members submit their plans and budgets for government scrutiny and that networks may need to improve their capacity to coordinate church health services.

Health networks also have to manage tensions among members. Citing the example of Ghana, Rasheed (2009a) describes differences in opinion over disclosure of finances to the government, some members suggesting that the government should be able to examine only the accounts specifically related to their funding.

Others, reflecting on the changing environment for both government and church services, call into question the role of national church health coordinating bodies, suggesting that the trend to devolution of health services to districts means that such bodies 'may no longer have a quasi-managerial role in passing on policy directives and distributing money from central government' (Green, Shaw et al 2002). However, the same authors also reflect on the possibility of new opportunities for church health networks, particularly where they are seen as serving members by providing specialist advice and support in areas such as financial management. Even in a decentralised environment, it is likely that advantages will remain in joint purchasing and procurement, central negotiation of tax exemptions and advocacy of policy. There is also a role for networks in sharing best practice with government (Green, Shaw et al 2002).

Other Approaches to Strengthening Partnership

A number of other approaches can be considered to strengthen the partnership between faith-based providers, government and donors.

Chand and Patterson (2007) describing the roles of FBOs in improving maternal and newborn health in Uganda and Tanzania, recommend a range of ways to strengthen partnerships among FBOs, policy makers and donors (Table 1).

There is a range of implications for the partnership between church and state health services (Green, Shaw et al 2002). Ministries of health need to change attitudes to the NGO sector, to allow it greater engagement in developing policies and plans and to apply consistent standards. The same authors suggest a range of mechanisms to strengthen the relationship mirroring those described in Table 1, with an emphasis on partnership rather than on a 'narrow public service focus'. They also urge church health agencies to enter into dialogue with government about their roles and relationships but also to recognise that this will inevitably mean 'compromising the independence of such agencies and opening up their often closed decision and budget processes'. Greater collaboration between Christian denominations to present a unified policy front to government is also urged (Green, Shaw et al 2002).

High-level political support from within the MOH appears to be a vital factor in determining positive relationships between churches and the state (Green, Shaw et al 2002), along with a willingness by church health service providers to support fully national health plans and policies. This will require new partnerships and collaboration and a willingness to shape future relationships proactively (Green, Shaw et al 2002).

DISCUSSION

Much of the evidence from this literature review comes from countries in Africa where churches play a significant role in primary health care, as they do in Papua New Guinea. While we recognise the distinctive culture and history of Papua New Guinea, the genesis of health service provision has some parallels with the missionary history in Africa as well as with broader health sector developments including decentralisation, the utilisation of SWAps, the increasing use of contracts, some uncertainty in external funding, difficulties in raising user-fee income and the demands of long-term conditions such as AIDS and TB. African settings also show an evolution in the role of church health services, from providers of free care based on external support to organisations largely funded by government mechanisms—a trajectory similar to that under way in PNG.

While there are positive examples of collaboration, there are also strains on church health services in Africa, particularly related to the health workforce and financing in a climate of reduced external support. While we do not suggest that these same challenges are necessarily present in Papua New Guinea, strengthening existing structures and systems and addressing any concerns in the relationship between the government and churches may avoid some of the pitfalls already apparent in some African countries.

Table 1. Recommendations for Strengthening Partnerships among FBOs, Policy Makers and Donors

For FBOs	For Policy Makers	For Donors
Documenting and disseminating information through mapping services, monitoring and evaluation, and publishing; Participating actively in national and global policy development and mechanisms for resource allocation and decision-making; Strengthening capacity in management, leadership development and financial stewardship; Strengthening values of justice, equity, medical ethics, care and compassion in the FBO health care system and integrating them within the country's health care system.	Examining the potential of FBOs through health system assessments and planning at the country, regional, district or local level, especially the role of national FBO health networks; Engaging FBOs through participatory decision making processes in policy development, identification and distribution of resources, co-management of health districts and the development of health implementation plans; Promoting the development of a national strategic plan that utilises the reach, holistic services, compassionate care, trust and sustainability of FBO providers; Endorsing a joint decision making process that strengthens public and FBO pre-service educational facilities to incorporate evidence base in their curricula; Developing a national HR plan that implements human resource reforms that do not undermine the FBO networks but strengthens the entire system.	Supporting MoHs to build capacity of national FBO networks; Supporting training, recruitment and retention of health care professionals equally for government and for FBOs; Supporting MoH and FBO health networks to promote and deliver the holistic and integrated programs that are their strength

Source: Chand and Patterson 2007.

Papua New Guinea has in place a number of the strategies, policies, structures and systems that the evidence suggests are useful in strengthening the partnership between churches and government. The strategic focus of the new *National Health Plan 2011-2020* (Government of PNG 2010) provides an important opportunity to strengthen the alignment of church and government health services through a common commitment to a national framework. Other positive factors include the presence of the CMC and the long history of churches and government working together.

The literature points to the evolving nature of many government-church partnerships and suggests the need to re-examine the relationship so that church health services are 'defined, recognised and promoted as not-for-profit public sector partners' of the government, rather than as private sector competitors (Chand and Patterson 2007). The National Health Plan explicitly recognises the need to review the partnership 'in line with the new challenges faced by the sector'.

The value placed on the partnership in Papua New Guinea is demonstrated through the wide participation in the development of the National Health Plan and the inclusion of a specific strategy to engage community-based organisations in both planning and delivery of services. This suggests that difficulties arising from the isolation of churches from the health system, and from national planning and policy development in particular, which were identified in the literature, may not apply to the same extent in Papua New Guinea. However, there remains a perception among some church providers that their role is not well recognised by government, suggesting that even though some progress has been made, there remains room for improvement (Matheson, Howse et al 2009).

The incorporation of information about churches and other non-government service providers into the routine health information system also assists in integration (Bennett, Hanson et al 2005). In Papua New Guinea a 'National Health Information System within a single operating policy' is defined in the National Health Plan, providing the opportunity to strengthen this integration. However, it has been suggested that moves by the churches to appoint an information officer and build their own information system may run counter to this integration and may need further discussion (D. Matheson, personal correspondence with authors, 2011).

Among the assets of the churches are an extensive network of health facilities and training institutions and a strong management and supervisory capacity and culture (D. Matheson, personal correspondence with authors, 2011). Improving the levels and mix of skills in the health workforce is an important strategy articulated in the National Health Plan, and churches are expected to continue to be critical to further skill building. The literature suggests that the public sector can benefit from specialist training designed for local settings and offered by the churches (Rasheed 2009a). However, the capacity to deliver these services may rely on ongoing government support. This highlights the interdependence of churches and government and the importance of clarity in funding. The WHO (2007a) recommends that FBOs and government agencies look at a range of options for improving understanding, including formal courses, joint training and shared materials as well as respectful engagement, to bring about collaboration in policy making.

The literature highlighted the role of contracting as a mechanism to engage non-government, not-for-profit primary health care providers. It also suggests the need for a balance between inputs, outputs and intermediate and long-term outcomes in contracting and for appropriate monitoring. This is particularly important to encourage services for the poor and to allow greater equity and an appropriate mix of incentives for both church and government providers.

A relational contract may be more appropriate in low- or middle-income settings such as Papua New Guinea, particularly for services in more rural and remote settings. These findings seem largely consistent with the recommendations offered by Matheson, Howse et al (2009) in their review of health partnerships in Papua New Guinea. They recommended a more explicit understanding of contracted roles and expectations and greater information sharing between the government and the CMC.

At present the CMC negotiates annual grant funding based upon budgeted resource inputs. Output-based contracting may allow more flexibility for the contracted party to determine the resource mix that will deliver the agreed outputs. This is consistent with the literature findings that there is value in maintaining some level of autonomy for contracted service providers. This flexibility already exists to some extent in Papua New Guinea, but there may be value in more clearly articulating the range of authority.

The National Department of Health is responsible for negotiating contracts and funding with the CMC. However, primary health care is the responsibility of the provincial government or provincial health authority, and day-to-day operations can often be monitored by district governments. As a result, there is potential for a misalignment of priorities and policies between levels of government that may impact on services and which could result in the National Department of Health becoming a more distant partner.

Matheson, Howse et al (2009) argue that the establishment of provincial health authorities may provide an excellent opportunity for strengthening partnerships between government and non-government bodies. There is also the possibility that, if provincial health authorities succeed in reducing fragmentation of hospital and public health services and improve coordination of government and non-government service providers under their authority (an important goal in itself), there is a risk that the current role of the CMC may become outdated. 'The CMC needs to respond to this environmental change, or it will be left talking to central Government when the real action is in the Provinces'(D. Matheson, personal correspondence with authors, 2011). While these potential changes will impact on relationships between national and provincial governments and the CMC, they provide an opportunity to strengthen provincial relationships through local service agreements within an overarching national agreement.

The experience in Africa suggests that there are both advantages and challenges in health networks such as the CMC, but that they can play a crucial role in: representing their constituents in national policy and planning; information collection; supporting alignment with government standards; monitoring outputs and outcomes; negotiating agreements; joint purchasing and procurement; and advocacy. Optimising the CMC role in the context of decentralisation has the potential to reduce the transaction costs for government and allow stronger coordination and greater consensus among churches. This may require changes to its current constitution, representation and ways of operating.

A range of multilateral and bilateral donors globally have recognised the importance of facilitating partnership between religious entities and governments. Strategic partnership agreements such as those between UNAIDS and FBOs may be useful for articulating partnership principles in revisions to current agreements in Papua New Guinea, particularly because the focus of these partnerships is consistent with transparency and harmonisation efforts and with 'supporting national ownership, country-led approaches and accountability' and alignment with country priorities (UNAIDS 2009). The inclusion of faith-based entities in country coordinating mechanisms of the Global Fund could also be further explored to gain greater input from FBOs in health policy development.

The literature suggests that effective laws and clear boundaries are important in clarifying expectations of both purchasers and providers, particularly in return for financial support (Bennett, Hanson et al 2005). Again, a clear framework for any improvements in this area in Papua New Guinea is provided through strategies in the National Health Plan aimed at ensuring compliance with relevant acts, policies and standards and a requirement for annual reporting, including on expenditure.

There is some evidence of reluctance by the churches in Papua New Guinea to share financial data (Hauck, Mandie-Filer et al 2005). Greater transparency and sharing of this data can benefit the whole sector by increasing trust between government and the churches, making the real costs of services clearer and allowing government to allocate sufficient resources to the non-state sector.

In Papua New Guinea, where bilateral partners provide important support for the health sector, there may also be opportunities for them to facilitate a strengthened partnership between the churches and government. The Papua New Guinea Church Partnerships Program links church health and education providers with similar NGOs in Australia (Kelly, Cousins et al 2007). The program has realised some improvements in the capacities of Papua New Guinea church service providers and is an example of a meaningful bilateral contribution. However, it is important that such partnerships do not undermine government-led mechanisms such as SWAps and alignment with key policies such as those of the National Health Plan.

In Africa, it appears that in many countries there is not a clear picture of the scale and scope of faith-based providers. Standard approaches to data collection, management, use and dissemination are needed to quantify the value added by FBOs in health services (WHO 2010). The Centre for Interfaith Action on global policy and the WHO have been working with a range of partners to develop a geographic mapping tool to collect data on health infrastructure and services to address this knowledge deficit and enable service monitoring (WHO 2010). In Papua New Guinea the NDoH has developed a facilities audit that has been applied in five provinces, and the Asian Development Bank is working with the University of Papua New Guinea to develop a geo-mapping tool to present comprehensive information about health activity, workforce and infrastructure (D. Matheson, personal correspondence with authors, 2011). This data will improve service provision and monitoring and quantify the scope of church health services.

CONCLUSION

The literature identified a number of ways in which primary health care by church-based organisations may differ from that offered by government. It also suggests that experience from settings where church health services are a major contributor, rather than from the broader experience of contracting of health services, may provide relevant lessons for Papua New Guinea. A strong, trusting partnership in which the strengths of each are utilised for the benefit of the overall system, combined with an environment that enables the partnership to flourish, appears to offer an effective way to address the considerable challenges in the health sector in settings similar to Papua New Guinea.

Factors that emerged from the literature that may enhance the partnership include: relational contracts that clearly define the roles and responsibilities of each party while valuing the distinctive motivations; enabling remote service providers to respond to local contexts within the framework of national policies; assured funding from government coupled with improved transparency from churches in financial reporting; involvement of church health service providers in policy development, planning and implementation of agreed standards; improved human resource management through utilising the strengths of the churches in training health

workers; acknowledging and managing the differences in culture and style between churches and government; and support from other development partners or church health networks.

Papua New Guinea has a clear framework to enhance the health sector partnership between churches and the government through the National Health Plan 2011-2020 and the longer term Health Vision 2050. Structures and systems can be further strengthened to overcome existing constraints and forestall some of the obstacles that have characterised relationships between the faith-based sector and government in countries in Africa and elsewhere.

In searching for evidence about relations between government and church health service providers in Papua New Guinea, we found a lack of clarity in both the documented and practical relationship. Understanding how agreements between differing levels of government and church health service providers are implemented may assist in overcoming potential strains in relationships and aid implementation of government policy. National and sub-national case studies of how partnerships works in practice would be valuable in taking this further.

This review suggests a number of important limitations in the global evidence. These include the differences in the provision of health services between faith-based and government providers in specific contexts; the relationship between faith and health; the role of FBOs in achieving better health outcomes; and the role of contracting on health outcomes and the equity and quality dimensions of health services. Improved understanding of these dynamics may also contribute to a strengthened partnership.

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