

THE CONTRACTUAL APPROACH AS A TOOL FOR IMPLEMENTING NATIONAL PUBLIC HEALTH POLICIES IN AFRICA

Basic Information and preliminary analysis of GTZ experiences

GTZ/OE 4320

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Introduction

Given the wanton development of the private sector and the failure of the welfare state to provide health care for all, it is most urgent that the role of the state be redefined so as to enable it, together with its partners, to develop a system accessible to all citizens and provide reasonably good quality health care with a satisfactorily high degree of efficiency.

In such a context, the state will focus on its facilitator role and win the support of other partners (both in the public and private sectors) through contractual arrangements for the funding and provision of health care as well as other health-related public utilities (air, water, sanitation, etc.)

The idea of contracting the provision of health care is not new in Africa (especially in English-speaking Africa). Nevertheless, GTZ deems it timely to hold in-depth discussions on the issue in order to clarify its stand with regard to current strategic discussions on the issue initiated by the World Bank and the World Health Organisation.¹

The Health Division of GTZ (OE 4320) believes that the contractual approach is a tool at the service of other existing strategies (sector-wide approach, decentralisation, quality assurance, etc), and a means of redefining the state's/ministry's role in the medium and long term. The Division is aware of the implementation challenges of such an approach at country level. It recommends a systematic evaluation of on-going experiences so as to analyse the impact of the contractual approach on the accessibility and efficiency of services and quality of care as well.

This document presents an analysis of the contractual approach (based essentially on existing publications, especially those of WHO), and provides basic information through a series of questions. Annex I recapitulates some on going experiences under some GTZ-supported health projects in Madagascar, Burkina Faso and Ivory Coast.

Is the contractual approach a new method, or does it meet a specific need in Africa?

Health systems in Africa have over the past three decades undergone profound changes. They are becoming increasingly complex as new actors step in (NGOs, associations, insurance companies, private service providers, etc.), and the separation between the regulatory, funding and service provision roles becomes

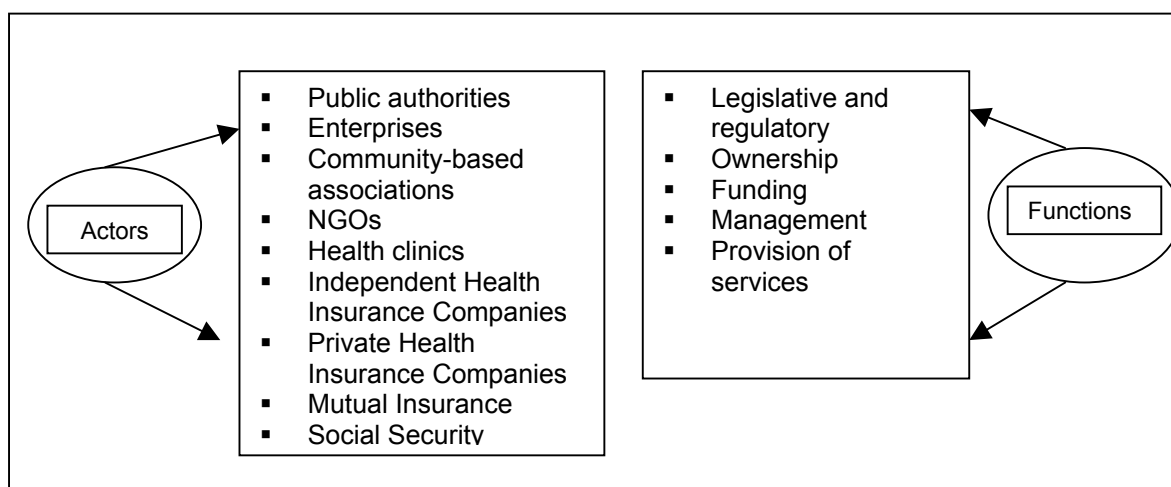
¹ Two international meetings took place with the participation of GTZ –

- « Towards new partnerships for health in developing countries : the contractual approach as a policy tool », Geneva, February 4-6, 1998
- « The contractual approach as a policy tool for implementation of national health policies in African countries, Dakar, October 19-21, 1998

clearer. (See figure 1). Each of these actors may assume more than one function at a time. The legislative and regulatory functions are the prerogative of public authorities. However, decisions on health issues may be taken at various levels in the case of countries with decentralised management systems.

There is the need to codify relationships among these actors, so as to ensure a co-ordinated development of the health care system aimed at more equity, efficiency and quality care. Hence, the justification of the contractual approach based on the contract construed as a social act.

Figure 1: Diversity of actors and functions in present health care systems



Three main periods can be outlined in the development of African health care systems (see figure 2 below):

(i) After independence, most African governments almost had the sole responsibility to for the production, funding, management and provision of services at all levels of the health care pyramid. By the late 70's, economic hardship and structural adjustment policies implemented in these countries put an enormous strain on health budgets, which led to poor performance of health services, especially with regard to the efficiency and quality of health care. Anglo-Saxon economists refer to this situation as 'Government failure'.

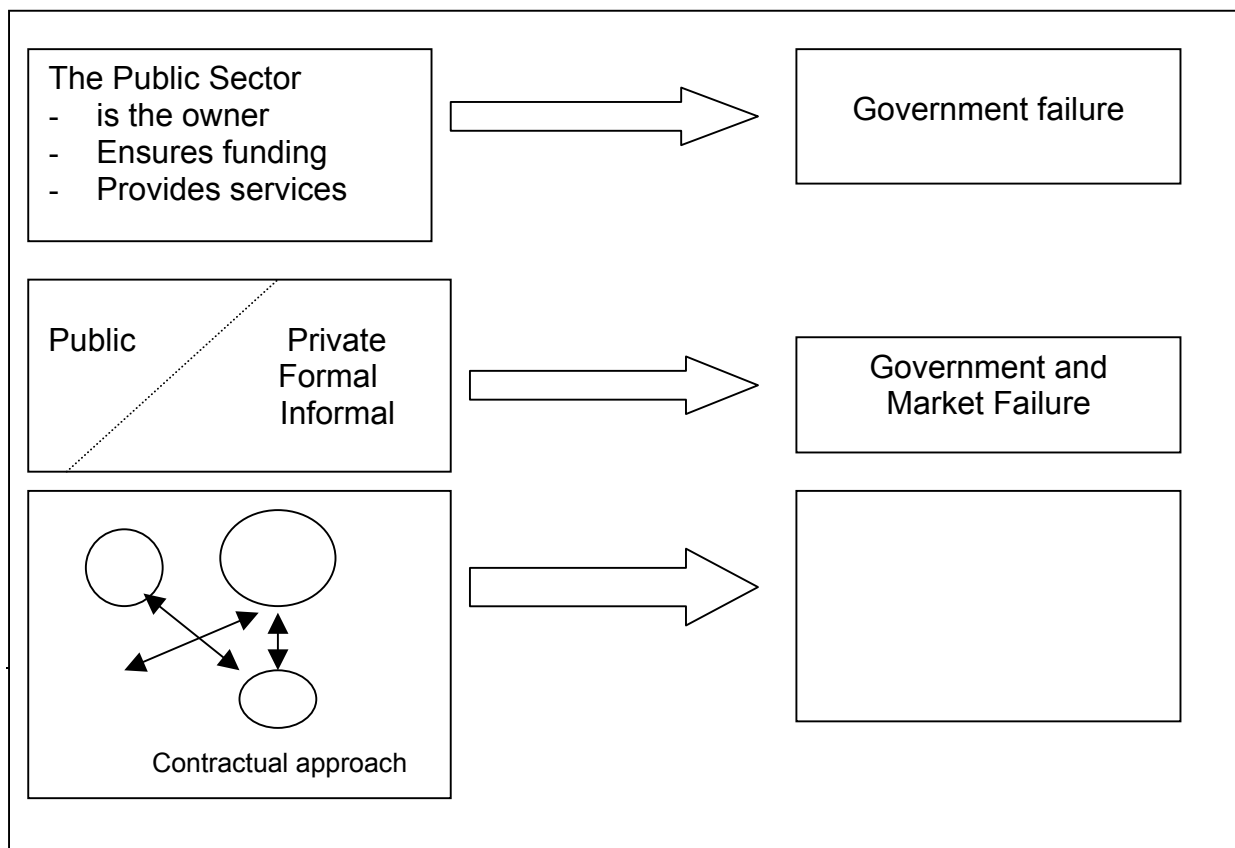
ii) Community participation and cost recovery policies carried out since the early 80s have had little impact; health interventions do not reach the majority of women and children, and the quality of care provided is too poor to make a difference.² Financial

²International Centre for Childhood and the Family-Paris. Eight years of Bamako Initiative implementation. Children in the Tropics. 1997; No 229/230

accessibility and the quality of services offered have hindered the use of health services in the public sector of many countries. This situation has led to the development of formal, but, more especially, informal private services even within public facilities. These services are more often offered in the absence of a well-established regulatory framework, and where such exists, it is poorly enforced. This situation whereby the “market” is central to the development, funding and provision of health care leads to poor quality care with a huge financial barrier. In this case, there is “Market failure», as Anglo-Saxon economists would call it.

(iii) The situation in the late 90s is characterised by the multiplicity of actors in the health care sector, making the health care system more complex (public authorities, public and private service providers, enterprises, community-based associations, NGOs, health care funding bodies such as mutual and private health insurance companies, professional associations, etc.). The on-going decentralisation process in many countries has introduced new actors in the health care field: regional and local council authorities have been empowered to provide health care services. Each of these actors may assume several roles at the same time: regulatory, funding, service provision, management, thus making the picture look even more complex. Presently, interaction is very often limited to drawing up joint action plans with little or no success and motivation during the implementation phase.

Figure 2: Changes in African Health Care Systems



Given this context, a contractual arrangement between two or more partners could clarify their respective responsibilities and expectations. Thus, the contract would serve as the instrument formalising the different interactions. The impact of this approach on equity, quality of care and efficiency still has to be proven; the contractual approach must not be considered a panacea.

What is the difference between the Contractual Approach and contracting?

Under the French civil law, (article 1101 of the Civil Code), “The contract is an agreement whereby one or more persons commit themselves to one or several other persons to give something, perform or not to perform an action”.

Thus, a contract shall be defined as

- ⇒ a **voluntary** alliance
- ⇒ between **independent partners** (each with a legal status)
- ⇒ who **mutually commit themselves**, and whereby
- ⇒ each **party expects to derive benefits** from the partnership.

There are three main features that distinguish the contractual approach from contracting proper.

- The contractual approach is a *strategic tool at the service of the development of the health care system, and hence, the national health care policy*, given that it further empowers all the actors of the health care system. The contractual approach gives rise to a social dynamics bringing out the view points, capacities and roles of each entity and leads to the social commitment of the partners. This entails the participation of public authorities (the state, ministry, administrative units, local councils, public or state corporation). For example, a hospital that subcontracts to a security firm is not involved in the contractual approach if the deal simply aims at reducing the cost of that service. On the contrary, we can talk of a contractual approach if this measure is part of a general strategy for the redeployment of the hospital's resources.
- The Contractual Approach seeks to develop a *genuine and sustainable partnership* rather than a relationship between contracting parties. Within the framework of the democratisation process of our communities, the contractual concept has been evolving towards *increasingly negotiable rights*. Governments are now calling on social partners to define contractual relationships. The financing of the health care system in Germany is quite illustrative in this respect. In Germany, compulsory health insurance schemes negotiate budgets with their partners (physicians and hospitals).
- The contractual approach helps to redefine the role of the state in health care systems in Africa. In the long run, it will enable the state to play its role as facilitator and guarantor of an equitable health care system, without having to intervene directly or indirectly in the provision of services.

Is the Contractual Approach aimed at privatising health care systems in Africa?

No. The Contractual approach is not aimed at the outright privatisation of health care systems in Africa. Nevertheless, governments and development agencies must draw lessons from past experiences. The public sector's performance that led to the poor accessibility, efficiency and poor quality of care must be called into question. While it is true that privatisation (formal or informal) may give satisfaction to more patients, it should also be acknowledged that it has often proved very inequitable and of a unsatisfactory quality, especially in a context characterised by lax legal and regulatory supervision over private health care providers and insurance companies.

The contractual approach is not aimed at privatising health care systems. Some private sector management tools could help to upgrade its performance.

The contractual approach seeks to draw the best from the public and private approaches while at the same time avoiding their pitfalls. It aims at placing the state to play its role of regulating the interaction among providers and donors of all sectors (public and private, profit or non-profit) in a bid to guarantee access to reasonably good quality health care. This vision is akin to the concept of "managed competition"³ underlying many on-going reforms in OECD countries⁴.

Among others, the following elements could be considered in the development of a better performing and state-regulated health care system:

- * Flexibility in human resources management
- * Greater empowerment of health care providers with respect to the performance of the health establishments under their control.
- * Demand-based funding of public health establishments as opposed to direct funding through pre-determined budget allocations.
- * A progressive separation of the funding from the provision of health care.
- * Development of appropriate mechanisms for the payment of health care providers.
- * Greater autonomy for district hospitals
- * Greater role played by the civil society in formulating health policies.

What is the current experience with regard to the contractual approach?

Documented, monitored and evaluated experiences of contractual approach are very limited in developing countries. Most documented experience relates to curative health care provision.

³ Broomberg, J. 1994. Health Care Markets for Exports? Lessons for developing countries from European and American Experience. London School of Hygiene and Tropical Medicine. PHP Departmental Publication No . 12

⁴ OECD. 1994. The Reform of Health Care Systems : A review of seventeen OECD countries. Health Policy Studies No. 5

Zambia has embarked on a large-scale management decentralisation process, with district health authorities playing the role of service purchasers⁵. In several African countries (Tanzania, Ghana, Malawi, Zimbabwe, Rwanda, Swaziland, South Africa), the public sector implicitly enters into a contract with state-subsidised private health care providers.

South Africa is one of the few countries having already gathered experience with the contractual approach. In that country, the management of public hospitals is entrusted to private companies. An evaluation of this experience reveals that some contracts are awarded without genuine competition. Contract clauses are drafted with ambiguity, and the performances of the contracting party are not monitored.

Madagascar may be cited where the GTZ-supported Mahajanga project supports several contractual approach experiences. One of these experiences concerns the signing of an approval convention between an interregional health department and a local council on the management of primary care health centres. These are owned by users' association or managed autonomously with community being represented in the management board. This experience addresses the enforcement of legal provisions on decentralisation, and thus significantly contributes to the development of Madagascar's health policy⁶. The experience is still recent and has not yet been evaluated. It does not enable us to assess whether the new institutional arrangements have made it possible to provide better quality health care with greater efficiency and accessibility.

Mali is often cited as an example, given that it has established a framework convention between the State and communities represented by community-based health associations following a principle of sharing of responsibilities and financial commitments. The positive results are noticeable with regard to the extension of first level services and the availability of generic essential drugs.

Concerning contractual approach experiences in prevention and health promotion, social marketing projects implemented by PSI and Futures Group, and community nutrition interventions (SECALINE project- Senegal) can be cited.

Several Latin American middle-income countries (Columbia, Chile, Mexico, etc) are undertaking deep reforms of their health systems, based on contracts between health care purchasers and providers, promoting competition at the primary level by contracting with state-funded private providers. Several Asian countries, the newly independent states of Eastern Europe, including the Russian Federation, are initiating similar policy reforms.

In developed countries, the Health Maintenance Organisation's (HMO)⁷ experience in the United States and the National Health Service (NHS)⁸ reform in England have

⁵ Bennett S, Russel S, Mills A. 1996. Institutional and economic perspectives on government capacity to assume new roles in the health sector: A review of experience. PHP Departmental Publication

⁶ Senant P, Kirsch-Woik, T. 1998. Aspects juridiques de l'approche contractuelle comme outil de mise en oeuvre d'une politique nationale de santé. Projet GTZ de Renforcement du Service de Santé dans la Province de Mahajanga.

⁷ Newhouse, JP. 1993. Free for all ? Lessons from the Rand health Insurance experiment. A Rand Study. Cambridge/Mass ; London

⁸ Robinson, R and LeGrand, J. Evaluating the NHS. Kings Fund Institute, London 1995

made it possible to systematically evaluate contracts between health care purchasers and providers. None of these experiences point to a marked improvement in health care quality, whereas there is evidence of cost reduction. The lack of impact on quality may be accounted for by the payment mechanism used -capitation, which does not foster improvement in the quality of care; rather, it puts a ceiling to health expenditure.

The lesson to be drawn for our GTZ projects is the importance to document, monitor and plan for the evaluation of contractual approach experiences. A preliminary inventory of some of the GTZ contractual approach experiences is presented in Annex I.

Is the contractual approach possible despite failing legal systems in many African countries?

There is no doubt that the legal environment will have a bearing on the manner in which the contractual approach is implemented. This tool must be adapted to the development of health care law, courts' performance, the level of corruption and effective decentralisation.

For instance, in the case of inefficient law courts, the contractual approach shall focus on the contract preparation phase in order to bring the partners together and thus avoid all possible pitfalls in the executing phase of the contract. Thus, it would be useful to propose a third party to the contract as an arbitrator for mediation and supervision.

The contractual approach requires a minimum of legal conditions including: freedom of association, the existence of legal personalities for potential partners, the right to seek appeal to neutral authorities, and the possibility for the civil society to get organised in the broadest sense of the word. These conditions are vital to put life into partnership agreements.

Is the contractual approach a substitute for the sector-wide approach advocated by donors like the World Bank?

No! The contractual approach is not an alternative for problems encountered in the implementation of the sector-wide approach. Rather, both approaches are complementary, the sector-wide approach serving as a reference framework for the state's and partners' actions, and the contractual approach enabling all actors to be formally committed to the implementation of the sector program.

What strategy should be adopted in introducing the contractual approach at national level? Are national capacities available to support the contractual approach?

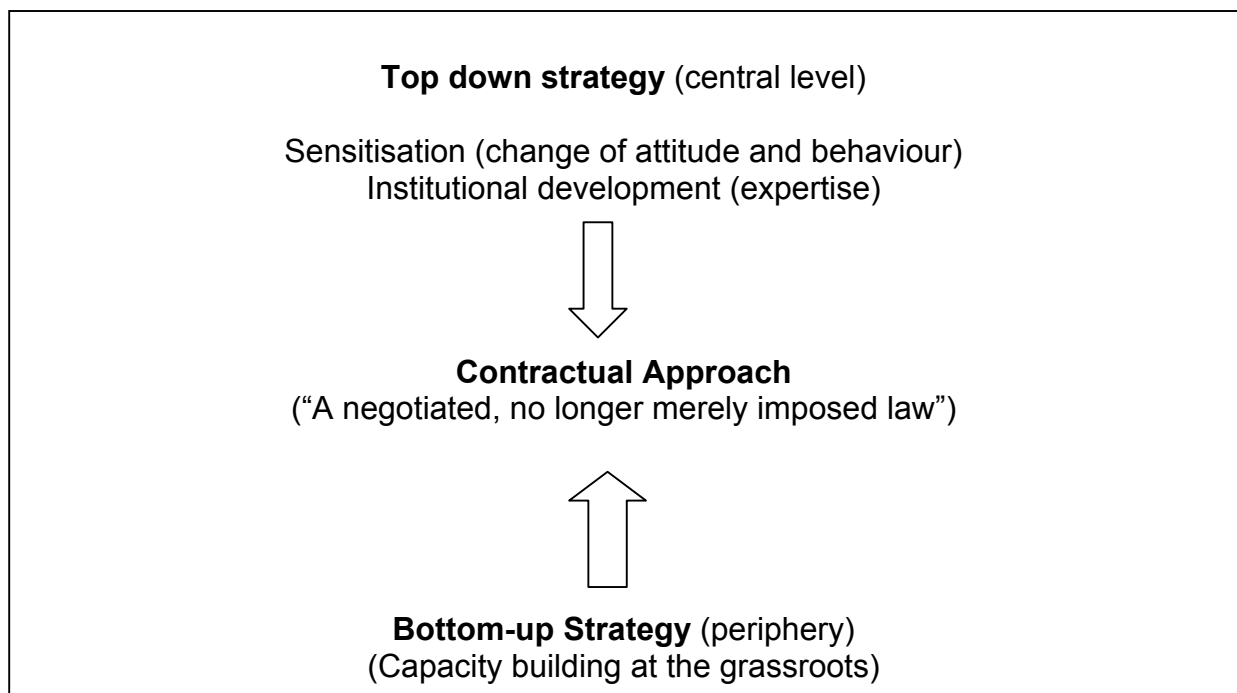
Presently, the capacities of Ministries of health to support the contractual approach are very limited. The same is true – possibly to an even larger extent – for decentralised communities. The experience is minimal, and the state's willingness to get into genuine dialogue with other partners is often questionable. On-going

experiences are very often based on the commitment of some individuals, and do not yet stem from institutional policies, especially in French-speaking Africa.

There is a need to devise a two-pronged strategy for the development of the contractual approach. (See figure 3):

- i) The sensitisation and the development of technical expertise at the central level, and ii) strengthening skills at the grassroots which, through a bottom-up movement, will lead to the emergence of a negotiated, and no longer a merely imposed law

Figure 3: Development strategies of the contractual approach



Above all, this approach demands a change of attitude and behaviour of the decision-makers. The issue is to identify incentives for the authorities to decentralise the decision-making process and control over resources while ensuring, through their regulatory role, solidarity among citizens, quality of care and system efficiency.

The strengthening of state institutions, decentralised communities and the civil society is necessary. Negotiation, legal, marketing, monitoring and evaluation capacities are some of the skills that need to be developed or strengthened.

The existence of a contractual policy should not be a pre-requisite for the implementation of the contractual approach. This policy will gradually emerge from the integration of achievements made at various levels of the health care system.

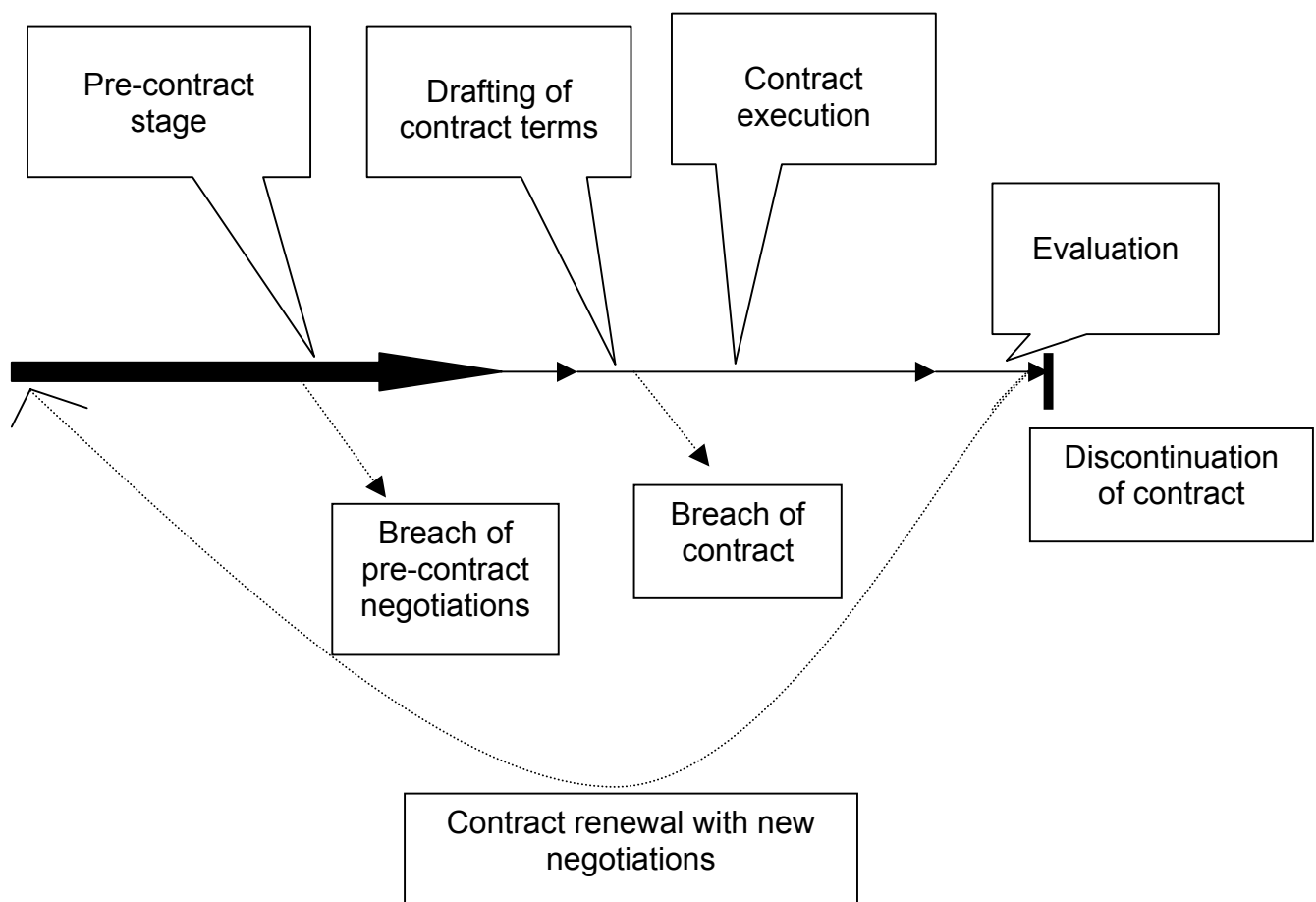
What is the contract cycle and what are the important clauses of a contract?

There are four stages in the lifetime of a contract:

- i) A pre-contract stage of contract preparation
- ii) The drafting of terms
- iii) The execution, and
- iv) The evaluation of the contract

Figure 4 below illustrates the cyclical nature of the contract.

Figure 4: The Contractual Cycle



The pre-contract stage

The pre-contract stage is of utmost importance. There is need, in this phase, for a thorough analysis of the initial situation in order to identify problems to be solved and get acquainted with the legal, institutional, economic and social context within which the contract is being prepared. The stakes, aspirations and hidden agendas of the partners must be unveiled, and, where feasible, discussed so as to exactly identify each partner's concerns and intentions. Communication as well as co-operation

among partners will reduce the risk of disputes during the execution of the contract⁹, and will be mutually beneficial to the partners (win-win situation).

For instance, it was at this pre-contract stage stage that the initiator (the Interregional Health Department at Mahajanga-Madagascar) identified the support needed by the partners, more specifically, the need for a third party entrusted, by the initiator, with accompanying the prospective contracting parties with their approval (in Mahajanga, contracting parties were assisted by GTZ, a team of facilitators comprising sociologists and business management experts from the Friedrich Ebert Foundation).

It is worth emphasising the need to agree, at this stage, on criteria for the monitoring and evaluation of the contract. An analysis of contracting experiences shows that this aspect is generally weak. It should be borne in mind that it is not always in the interest of all the partners to monitor and evaluate the contract (for instance, if the contract provides for a minimum vaccination coverage to be attained, the denominator and data collection method should be agreed upon in order to be able to determine it). Monitoring and evaluation responsibilities should be clearly spelled out, and there must be available resources to carry out such monitoring and evaluation.

The drafting of the terms of the contract

It is necessary to draw up contracts that can be easily understood by the future partners. A contract will be clear and accurate in as much as partners were co-operative during the pre-contract stage. The standard clauses of a contract, according to Brousseau¹⁰ are briefly recapitulated in the following table.

Table I. the standard clauses of a contract

CLAUSES	RELEVANCE
Product definition	It is about the common objective of the partners; for example increase the contraceptive prevalence rate
Identification and organisation of resources	Resources used to achieve the set objectives should be specified. They should be identified and their use should be specified.
Co-ordination in time and space	It should be possible to specify who does what and when. The degree of specification will depend on the complexity of the product and the spirit of trust or distrust between the partners.
Safeguarding (guarantee)	The guarantee is a means of exerting pressure on the other partner in case of breach of contract clauses. Under the contractual approach, partners are bound together and would all lose in case of non-execution of contract. The best solution is to

⁹ The Anglo-Saxons distinguish « hard and soft contracts », the first being characterised by a hostile relationship between the contracting partners who often recur to justice for problems encountered

¹⁰ Brousseau E. 1993, L'Economie des contrats: technologies de l'information et coordination interentreprises. PUF, Economie en liberte

	solve problems together.
Mechanisms of supervision/surveillance	It is, as the guarantee, a dissuasive mechanism aimed at making sure that partners abide by the provisions of the contract. Supervision may be done by the legal authorities, or by a jointly appointed supervisor (auditor, ...)
Remuneration of contracting parties	The determination of remuneration often proves very difficult, especially in the absence of previous experiences. The remuneration of service providers must be accurately specified in order to avoid typical pitfalls (insufficient quality in case of capitalization or global assignment, prohibitive costs in case of cash payment for service, etc. Putting much financial risks on one of the partners should be avoided, for this will easily lead to abuse.
Duration	It is important to determine the duration, because it may influence the partners' behaviour and facilitate contract evaluation.

The contract execution stage

This is the time when the contract is implemented, when the parties fulfil their obligations. This stage is generally limited in time. It requires monitoring by the partners, in order to make sure the contract is executed in conformity with the terms drawn up in the pre-contract stage.

The contract may be cancelled by one of the parties or being led to a breach of contract. At this point, the contract may either be renegotiated or discontinued.

The contract evaluation stage

Generally, carrying out evaluations in the social sector is an onerous task. This likely accounts for the fact that many contracts are not systematically evaluated. In the future, contracting parties should address this issue right from the pre-contract stage. It would be advisable to define a set of simple and low-cost evaluation criteria. The purpose of the evaluation, data collection methods as well as cost estimates will have to be determined, depending on the expected benefit from the evaluation exercise.

The total costs of the contract could be evaluated (to verify whether costs are less than those incurred when the service is provided directly by the state); the accessibility to health care and the degree of client satisfaction could also be evaluated. The extent to which the contract can be replicated and sustained should be discussed in order to make sure the chosen strategy is sustainable in the long run. The analytical framework of contracts developed by the Mahajanga GTZ-project (contract description, pre-contract and contract execution stages) at Annex 2 could be of good use to other projects.

What are the costs of a contract?

There is little information available on the costs of the contractual approach. The idea of costing a contract should be viewed in terms of development action and not restricted to the standard contract economy.

Generally, there are three types of financial costs:

⇒ *Contract preparation costs* (identification of partners, funding of contract preparation activities, etc).

⇒ *Costs of the contract* (as specified in the terms of the contract)

⇒ *Contract execution-monitoring costs* (collecting information, carrying out auditing, etc).

Contract preparation and monitoring costs are called transaction costs. It is very important to monitor these transaction costs because they may be high and absorb a substantial part of the efficiency gains derived from contracting (contract management costs may account for more than 20% of the total value in the United States; in the United Kingdom, the costs for preparing calls to tender account for as much as 7.7% of the annual contract costs). It is therefore necessary to find the right match between a perfect contract (which may excessively inflate transaction costs) and a less detailed but consequently less expensive contract.

What are the different types of contract?

A partner can be party to a contract only if it is a legal entity (private individual or corporate body). As a legal entity, the partner is thus directly bound by the contract it is entering into. A legal entity may fall under the public or private law.

Based on these two legal entities (under public or private law), a typology of contractual arrangements likely to bind health actors may be established. Four situations are described below and illustrated in table 2. Annex 3 recapitulates an annotated contract typology.

a) The public authority is solely involved

Most health facilities of the public sector in Africa operate within this framework (*direct or delegated management* to the district medical officer, for instance). Only the public administration is legally answerable. Within the framework of *deconcentration*, (where the central governments hands over certain powers to a subordinate who remains under hierarchical supervision) services may be given some financial autonomy which can go as far as indirect management with an autonomous budget.

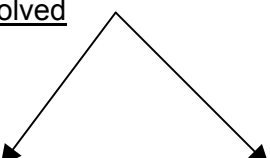

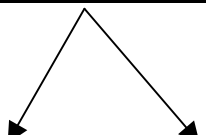
In a situation where the public authority is the only actor involved, mention cannot be made of contractual arrangement, since only one legal entity is involved.

b) The public authority enters into a partnership with another public law legal entity

This is the case of many major hospitals in several African countries that enjoy the status of Public Service Corporation (PSC), or some industrial or commercial state corporations (ICSC) with legal status and financial autonomy. These cases cannot be considered as a contractual approach, since it is a situation where one of the partners is bound by a “compulsory contract” which it cannot terminate. The experience in several countries (Burkina Faso, Mali, Ivory Coast, etc) has shown that these institutions were not necessarily more efficient than health facilities managed directly or by delegation.

Besides these statutory ties, the public authority can make specific contractual arrangements, for instance, *remunerated indirect management* (the management of a public department is entrusted to a legal entity remunerated by the community), *public service concession* (the public authority entrusts a legal entity with the provision of a public service. The legal entity deducts its remuneration from user fees), a *performance contract* (which specifies performances to be attained by the independent legal entity within a specified time frame; for example, the performance contract by the “Pharmacie Populaire du Mali” specifying the financial performances and reforms to be achieved within a specified number of years).

Table 2: “Contract” typology

<u>The public authority is solely involved</u> 		The public authority enters into partnership with another public law legal entity 	<u>The public authority enters into partnership with a private legal entity</u> 	
Delegation	Devolution	“Compulsory contract” (predetermined contractual arrangement)	Sub-contracting	Co-operation
<ul style="list-style-type: none"> • Direct management • Management by delegation 	<ul style="list-style-type: none"> • Direct state control • Indirect state control 	<ul style="list-style-type: none"> • Remunerated indirect management • Public service concession • Performance contract 	<ul style="list-style-type: none"> • Remunerated indirect management • Public Service concession • Accreditation 	<ul style="list-style-type: none"> • Joint subsidiaries. • Franchise
Primary care health units		Hospitals (PSC and ICSC)	Public hospital entrusted to churches	

Source: WHO. The contractual approach. Macroeconomics series. No. 24, modified.

c) The public authority enters into partnership with a private legal entity

Under such a contractual arrangement, there are two possibilities: either (i) sub-contracting proper (the government becomes a passive once the contract is signed) or (ii) a co-operative contractual arrangement whereby the public authority continues to play an active role after the signature of the contract. For each of these two cases, there is a specific form of contract.

With regard to sub-contracting, there may be a “*concession contract*” (the public authority entrusts the provision of a public service to a private legal entity which deducts its remuneration from fees collected from service users)/ a *remunerated public concession* (whereby the management of a public service is entrusted to a private legal entity which is remunerated by public funds), or specific types of contracts (*authorisation or accreditation*). Hospitals entrusted to churches fall under such specific arrangements.

Wherever the public authority continues to play an active role in the execution of the contract, it may be within the scope of jointly established subsidiaries (joint ventures) or network contracting (franchise).

The network contract (franchise) is interesting insofar as it gives room for the public authority to assign some responsibilities to the franchisee while at the same time it continues to monitor the latter’s performance, provide the franchisee with know-how and pursue the facilitation of the network. (Mac Donald’s is a well-known example!).

Mention should be made of the experience of some African countries where the state signs a contract with a delegate private contracting authority such as Faso Bara in Burkina Faso. That private contracting authority manages contracts on the state’s behalf, and resorts to the private sector for the provision of services (such as nutrition and literacy programmes in Senegal).

d) The public authority is not part of the contractual arrangement

This type of arrangement is irrelevant, since it involves two private partners. The public authority shall play its role in accordance with existing local laws and regulations.

How are contracts awarded?

The award of contracts is delicate, especially in countries where the award of public markets is tainted by intransparent practices. In order to avoid indelicacies as much as possible, it is of utmost importance that the process be transparent and conducted according to established rules. Generally, contracts may be awarded through open competition or negotiation. These are two different strategies leading to a different behaviour of the respective actors.

The determination of the method for the contract award will strongly depend on prevailing local conditions. Ideally, prospective contractors should be given the opportunity to compete through a *public invitation to tender*. This procedure is not feasible in the absence of competition in the region (which is often the case in Africa),

and does not always guarantee the selection of the contractor offering satisfying quality. Often enough, past experiences with partners are the best means to judge the quality of work to be done in future. The costs for preparing and conducting public invitations to tender are often considerable.

Competition based on a short-list allows the pre-selection of potentially suitable and qualified candidates for the provision of the services. This type of competition often results in more expensive contracts than those in the case of public invitation to tender; however there are greater guarantees for the execution of the contract. Frequently, the selection of candidates for the short-list harbours the risk of a compromise.

The award of contracts based on *mutual agreement* is often the only alternative, given the absence of competition. In such a case, the terms of the contract are negotiated with the identified partner. The best results are achieved when partners enter into negotiations with a spirit of mutual trust and respect. This, however is rarely the case as the state is seen more often than not as an untrustworthy partner. Given this, negotiations would not yield optimum results.

At what levels is GTZ concerned with the contractual approach?

First of all, GTZ should take a stand with regard to the contractual approach, which it is doing in this paper. The paper can be used to sensitise GTZ field actors (AMAs), and all concerned persons at the headquarters in Eschborn. It gives a clear mandate to GTZ field actors to participate in national and international meetings on the subject, to attempt jointly formulated and agreed experiences with our country partners, and document such experiences so that they may be useful to others, and influence future international discussions on the contractual approach.

The contractual approach as a universal/horizontal topic once more highlights the need to establish links between the different organisational units within GTZ in order to capitalise the expertise of colleagues outside the health unit: legal, commercial, marketing, non refundable co-operation, decentralisation, state reform expertise, etc. The analysis of GTZ experiences on other continents (Asia, Latin America, and Europe) should be used in discussions on the introduction of the contractual approach in Africa.

GTZ, as the German agency for the implementation of bilateral co-operation, has always felt itself obliged to consider public authorities as a preferred partner. It is thus important, within the framework of the contractual approach, that GTZ sector-wide assistance in future are targeted on other actors, especially local government authorities (local communities), and potential civil society partners (civil society-based associations, NGOs). It is through reinforcing the capacities of these alternative partners that they will be in a position to negotiate reforms with the state.

The GTZ should be prepared, based on country demands, to provide the required expertise (legal, negotiation skills, institutional development, monitoring, evaluation, etc.) to strengthen the capacities of ministries and other partners to contribute to the development of the contractual approach.

Where can I obtain additional documentation?

- Articles

Carrin, G. Jancloes, M. Perrot, J. 1998. Towards new partnerships for health development in developing countries: the contractual approach as a policy tool. Tropical Medicine and International Health. Volume 3 No. 6 pp 512-514.

- Other Documents

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Brousseau E. 1993. L'Economie des contrats: technologies de l'information et coordination interentreprises. PUF, Economie en liberté.

OECD. 1994. The Reform of Health Care Systems: A review of seventeen OECD countries. Health Policy Studies No. 5

Bennet S, Russel S, and Mills A. 1996. Institutional and economic perspectives on government capacity to assume new roles in the health sector: A review of experience. PHP Departmental Publication No. 22. London: Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.

Senant, P. et Kirsch-Woik, T 1998. Aspects juridiques de l'approche comme outil de mise en oeuvre d'une politique nationale de santé. Projet GTZ de Renforcement du Service de Santé dans la Province de Mahajanga.

Broomberg, J. 1994. Health care markets for exports? Lessons for developing countries from European and American Experience. London School of Hygiene and Tropical Medicine. PHP Departmental Publication No.12

Broomberg, J.1998 Experiences of contracting: an overview of the literature. Presented at the WHO/Geneva meeting 4-6 February on « Towards new partnerships for health development in developing countries: the contractual approach as a policy tool »

Perrot, J. 1998. L'approche contractuelle comme outil de mise en oeuvre de la politique nationale de santé. OMS Division ICO.

Case Studies presented during Geneva (Feb 4-6th, 1998) and Dakar (Oct 19-21th, 1998) meetings available at WHO, Division ICO on: Mali, Papua New Guinea, Tanzania, Madagascar, Zambia, Comores, Bolivia, Lebanon, Senegal, Gabon, India, Haiti, Nepal, Bangladesh, Ivory Coast, Cambodia.

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Annex 1: Preliminary inventory of GTZ Contractual approach experiences.**Example 1: Contract within the framework of the decentralisation of health services/MADAGASCAR.**

GTZ Project No.	93.2077.1-01.100	
Project title	Support of Primary Health Care	
Status as at	18 January 1999	
Who are the partners?	Partners involved	Legal status
	1. Interregional Health Development Department DIRDS 2. Local council	1. Legal entity governed by Public law. 2. Legal entity governed by Public law
What is the major problem the contract seeks to solve?	Cause of the contract: Decentralisation is under way and a new health policy is being implemented; however, there is a lack of technical and/or institutional guidelines.	
Is it an explicit or implicit contract? What is the title of the contract?	<div> <div>Explicit</div> <div>Implicit</div> </div> <p>Title of contract: Agreement for the opening and running of the. health centre in ...</p>	
What are the main objectives of the contract?	Purpose of the contract: Management of the health centre and the pharmacy.	
What are the activities / commitments expected of the partners?	<p>Partner 1: The DIRDS, represented by the district health services, appoints staff, is the technical supervisory authority and provides technical support to basic health workers: supervision, training and marking of health workers.</p> <p>Provides public credits, buildings and equipment.</p> <p>Partner 2: The local council is the administrative and financial supervisory authority of the Centre. Administratively, it marks workers and monitors the administrative and financial activities on a quarterly basis, authorises an annual external audit. Provides council credits buildings and equipment.</p>	

What are the systemic improvements expected?	<p>Expected contract results: Transfer of skills and resources to the council for the management of the health centre.</p> <p>Expected improvement: better management of the centre, supervision of health personnel, improvement in the quality of care.</p>
What is the duration of the contract? (from... to ...)	One year
How was the contract awarded?	<ul style="list-style-type: none"> • Competition (open invitation to tender) • Competition on a short list • <u>Mutual agreement</u>: in compliance with existing laws on decentralisation • Others
Does the contract provide for monitoring?	<ul style="list-style-type: none"> • Yes <u>No</u> • Specified monitoring indicators. Yes <u>No</u> • Visit/supervision: <u>Yes</u> No • Report: <u>Yes</u> No (Annual audit) • Other types of monitoring: The project runs a supporting/ consulting entity (UDAC) which monitors the activities of the centre and supports the partners.
Does the contract provide for evaluation? If yes, how shall the contract be evaluated?	<ul style="list-style-type: none"> • <u>Yes</u> No • Type of evaluation: Annual audit initiated by the local council, carried out by an external organisation (UDAC?); indicators are not precisely defined.
What has been the role of the GTZ-supported project during the different contract stages?	<ul style="list-style-type: none"> • Preparation: The project has initiated the use of the contractual approach. It has identified and co-ordinated support-counsel needed by the parties involved. • Drafting: the project intervened as interface through UDAC. The project proposed standard contracts that were discussed. • Execution: the project provided technical and institutional support.

	<ul style="list-style-type: none"> • Evaluation: the role of the project is about to be defined, formulation of evaluation guidelines. 	
What type of technical support did public authorities grant during the various stages of the contract?	<ul style="list-style-type: none"> • Preparation: advice to health workers and district health services. • Drafting: None • Execution: None • Evaluation: None 	
What type of external support (source and form) did partners benefit from during the formulation and execution of the contract?	<p>Source: Friedrich Ebert Foundation</p> <p>Form: Information and training workshops on decentralisation and the role of local councils.</p>	<p>Source: UDAC</p> <p>Form: Management training workshop</p>
What are the conditions for dissemination of the contract on a larger scale?	<p>Conditions</p> <p>Improve on methodology of the contractual approach after an analysis of the evaluation.</p> <p>Support the setting-up of a committee for the development of the contractual approach at national level.</p> <p>Support the health sector reform process (update the institutional framework).</p>	
What are the strengths of this contract? (Or of the contractual approach?)	<p>Implementation of laws on decentralisation.</p> <ul style="list-style-type: none"> - Communities are learning their future role. Peripheral structures are involved in the decentralisation process. - This is the starting point of a negotiated law. 	
What are the weaknesses of this contract? (Or of the contractual approach?)	<p>Poor sensitisation, information and involvement of the central authorities at the beginning. All contractual approach objectives were not well stated at the beginning (due to lack of experience).</p> <p>Still to be evaluated.</p>	
Do you have any	A dozen of similar contracts were established between	

comments?	late 97 and late 98, using a contractual approach methodology that has evolved with experience on the field. The standard contract has remained unchanged, with the exception of new technical data on cost recovery available in ministries.
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Example 2: Contract for the development of partnerships with a private enterprise/MADAGASCAR.

GTZ Project No.	93.2077.1-01.100	
Project title	Support of Primary Health Care	
Status as at	19 January 1999	
Who are the partners?	Partners involved	Legal status
	1. AQUALMA 2. District health service 3. Management committee	1. Legal entity governed by Private law. 2. 2. Legal entity governed by Public law 3. No legal status
What is the major problem the contract seeks to solve?	Cause of the contract: map gaps in the geographical coverage of the area with health services	
Is it an explicit or implicit contract? What is the title of the contract?	<div style="display: flex; justify-content: space-between;"> <u>Explicit</u> Implicit </div> <p>Title of contract: Opening of a health centre in Besekoa</p>	
What are the main objectives of the contract?	Purpose of the contract: to open and run a primary care health centre with the participation of a private enterprise and a user's association.	
What are the activities / commitments expected of the partners?	<p>Partner 1: District Health Service</p> <p>Technical supervision and support: supervision and training of health workers</p> <p>Partner 2: AQUALMA</p> <p>Provision of human and material resources, equipment and facilities</p> <p>Control of the management committee</p> <p>Partner 3: Management Committee</p> <p>Runs the centre</p> <p>Is accountable to AQUALMA</p>	
What are the systemic improvements expected?	Sound management, good financial accessibility of the centre	

	Quality of care Effective supervision of health personnel	
What is the duration of the contract? (from... to ...)	Unlimited duration	
How was the contract awarded?	<ul style="list-style-type: none"> • Competition (open invitation to tender) • Competition on a short list • <u>Mutual agreement</u>: the only existing enterprise in an inaccessible area • Others 	
Does the contract provide for monitoring?	<ul style="list-style-type: none"> • Yes <u>No</u> • Specified monitoring indicators. Yes <u>No</u> • Visit/supervision: <u>Yes</u> No • Report: <u>Yes</u> No • Other types of monitoring: 	
Does the contract provide for evaluation? If yes, how shall the contract be evaluated?	<ul style="list-style-type: none"> • Yes <u>No</u> • Type of evaluation: 	
What has been the role of the GTZ-supported project during the different contract stages?	<ul style="list-style-type: none"> • Preparation: Interface between and advice to parties involved • Drafting: idem • Execution: support and advice to partners • Evaluation: none. 	
What type of technical support did public authorities grant during the various stages of the contract?	<ul style="list-style-type: none"> • Preparation: DIRDS gave technical support to the district health service • Drafting: Idem • Execution: None • Evaluation: None 	
What type of external support (source and form)	Source: UDAC	Source:

did partners benefit from during the formulation and execution of the contract?	Form: Support and advice of the user's association and the management committee	Form:
What are the conditions for dissemination of the contract on a larger scale?	<p>Conditions</p> <p>Public services committed to partnership with the private sector</p> <p>Define criteria for selection of companies</p> <p>Accurately define conditions for partnership</p> <p>Support a partnership development organisation serving as interface between future partners</p>	
What are the strengths of this contract? (Or of the contractual approach?)	<p>Good accessibility and quality of services offered.</p> <p>User rates much higher than usual in other public health centres.</p>	
What are the weaknesses of this contract? (Or of the contractual approach?)	<p>Withdrawal of district health service</p> <p>No genuine communication forum between the district health service and other partners.</p>	
Do you have any comments?	<p>The contract should have been signed with the user's association (corporate body governed by private law) as a third partner instead of the management committee. There was an unnoticed drafting mistake, the president of the association being also the chairman of the management committee.</p> <p>At the amendment, in order to respect the standards, the objective of the contractual approach should be to more involve the district health system in the running of the health centre and to better prepare the monitoring/evaluation procedures.</p>	

Example 3: Contract with a non-profit organisation/MADAGASCAR

GTZ Project No.	93.2077.1-01.100	
Project title	Support of Primary Health Care	
Status as at	19 January 1999	
Who are the partners?	Partners involved	Legal status
	1. GTZ 2. Mahajanga Intercorporation Health Service (OSIEM)	1. Corporate body governed by private law. 2. Corporate body governed by private law (Non-profit organisation)
What is the major problem the contract seeks to solve?	Cause of the contract: To reach a target population outside of the primary care health centres	
Is it an explicit or implicit contract? What is the title of the contract?	<div> <div><u>Explicit</u></div> <div>Implicit</div> </div> Title of contract: Programme for the provision of community-based (factories) family planning services (OSIEM, Mahajanga)	
What are the main objectives of the contract?	Purpose of the contract: Family planning and reproductive health services offered by non medical personnel (SBCU)	
What are the activities / commitments expected of the partners?	Partner 1: GTZ Technical and financial support Partner 2: OSIEM Provide human resources and infrastructure To implement SBCU programme To report to the health project	
What are the systemic improvements expected?	The provision of a new service	
What is the duration of the contract?	From June 25, 1998 (unlimited duration)	
How was the contract awarded?	<ul style="list-style-type: none"> • Competition (open invitation to tender) • Competition on a short list 	

	<ul style="list-style-type: none"> • <u>Mutual agreement</u>: Employed women being the target group, OSIEM is the only existing company • Others 	
Does the contract provide for monitoring?	<ul style="list-style-type: none"> • Yes <u>No</u> • Specified monitoring indicators. Yes <u>No</u> • Visit/supervision: <u>Yes</u> No • Report: <u>Yes</u> No • Other types of monitoring: 	
Does the contract provide for evaluation? If yes, how shall the contract be evaluated?	<ul style="list-style-type: none"> • <u>Yes</u> No • Type of evaluation: to be specified 	
What has been the role of the GTZ-supported project during the different contract stages?	<ul style="list-style-type: none"> • Preparation: Initiator • Drafting: negotiator • Execution: party of contract • Evaluation: 	
What type of technical support did public authorities grant during the various stages of the contract?	<ul style="list-style-type: none"> • Preparation: Support/advice for OSIEM • Drafting: Interface between OSIEM and GTZ • Execution: participates in monitoring of contract • Evaluation: not specified 	
What type of external support (source and form) did partners benefit from during the formulation and execution of the contract?	<p>Source: USAID /MSH/APPRPOP/PF</p> <p>Form: technical support two both parties</p>	<p>Source: Company executives</p> <p>Form: provision of service providers and premises</p>
What are the conditions for dissemination of the contract on a larger scale?	<p>Conditions</p> <p>Public services committed to enter into partnership with private sector</p> <p>Improve monitoring procedures</p>	

What are the strengths of this contract? (Or of the contractual approach?)	Development of partnership Use of latent potentials.
What are the weaknesses of this contract? (Or of the contractual approach?)	The contract was not signed between the right partners, this was due to financial management procedures, DIRDS (and not GTZ) should have signed the contract with OSIEM. Rather a case of contracting than contractual approach
Do you have any comments?	The contract can be analysed as a partnership between a bi-lateral co-operation agency and an NGO, but in the first place, GTZ stood in for DIRDS only for financial reasons.

Example 4: Agreement between a GTZ-supported project and health district/BURKINA FASO

GTZ Project No.	95-2051.1-001.00	
Project title	Rural Health project (PSMR) Burkina Faso	
Date	Project phase: 10/1998 – 09/2000	
Who are the partners?	Partners involved	Legal status
	1. GTZ (German contribution to PSMR) 2. Regional Health Department (DRS) intermediary level 3. The Health District	1. Corporate body governed by private law. 2. Corporate body governed by public law 3. Corporate body governed by public law
What is the major problem the contract seeks to solve?	Cause of the contract: Difficulties to distribute, control and justify funds for health districts within the framework of the project. Insufficient ownership of the districts for the project action plan.	
Is it an explicit or implicit contract? What is the title of the contract?	<u>Explicit</u> Implicit Title of contract: Agreement on local subsidies- funds for the running of health districts	
What are the main objectives of the contract?	Purpose of the contract: provide a “legal framework” for GTZ funding for health districts.	
What are the activities / commitments expected of the partners?	Partner 1: GTZ Disburse funds to DRS (once per year) Partner 2: DRS - quarterly disbursement of funds according to established criteria (= planned activities fall into framework of project) - ensure that activities are carried out - control district accounts	

	<ul style="list-style-type: none"> - present quarterly summary report to GTZ <p>Partner 3: Health District</p> <ul style="list-style-type: none"> - At the beginning of the quarter: request for funds with details of proposed activities - carry out planned activities - at the end of the quarter: present a financial balance-sheet and a progress report
What are the systemic improvements expected?	<ul style="list-style-type: none"> - Empowerment for the district executive team - Empowerment of DRS (disbursement of funds and financial control) - Improved functional relationships between DRS and health districts
What is the duration of the contract?	10.01.1999 – 31.12.1999
How was the contract awarded?	<ul style="list-style-type: none"> • Competition (open invitation to tender) • Competition on a short list • <u>Mutual agreement</u>: the health districts being the only health care providers in the provinces • Others
Does the contract provide for monitoring?	<ul style="list-style-type: none"> • <u>Yes</u> No • Specified monitoring indicators. Yes No • Visit/supervision: <u>Yes</u> No <p>Assumption: Health districts are supervised by DRS</p> <ul style="list-style-type: none"> • Report: <u>Yes</u> No <p>Quarterly report from districts to DRS. Quarterly summary report from DRS to GTZ.</p> <ul style="list-style-type: none"> • Other types of monitoring:
Does the contract provide for evaluation? If yes, how shall the contract be evaluated?	<ul style="list-style-type: none"> • Yes No • Type of evaluation: DRS commit itself to verify that district activities are in accordance and to control finances regularly. GTZ country office regularly initiates

	external audits of DRS.	
What has been the role of the GTZ-supported project during the different contract stages?	<ul style="list-style-type: none"> • Preparation: Discussions with concerned parties (DRS and Districts) • Drafting: drafting in close Cupertino with DRS (GTZ country office to approve contract prior to signature) • Execution: support DRS to enable it to support districts • Evaluation: support DRS for control of districts 	
What type of technical support did public authorities grant during the various stages of the contract?	<p>In all stages, no support of MOH, discussions were held with DRS and districts, only.</p> <ul style="list-style-type: none"> • Preparation: • Drafting: • Execution: • Evaluation: 	
What type of external support (source and form) did partners benefit from during the formulation and execution of the contract?	<p>Source: none</p> <p>Form:</p>	<p>Source:</p> <p>Form:</p>
What are the conditions for dissemination of the contract on a larger scale?	<p>Conditions</p> <p>Existence of a donor; commitment of both the donor and the district to adopt the contractual approach.</p>	
What are the strengths of this contract?	<p>Relationships among GTZ-DRS-District regarding funding are clarified.</p> <p>Enhances transparency in the use of funds.</p>	
What are the weaknesses of this contract?	<p>The contract does not mention the technical support of DRS to the districts.</p> <p>The technical support of the project for DRS and the districts is not mentioned, although provided for.</p> <p>Increase in bureaucratic procedures on district level (quarterly planning)</p> <p>The execution of the contract does not necessarily improve the quality of health care or coverage, since these objectives have not been specified in the contract...</p>	

	<p>Frequently, lack of administrative capacities on district level to draft funding requests and vouchers. Consequently, there are delays in the disbursement and justification of funds.</p>
<p>Do you have any comments?</p>	<p>This case is particular inasmuch it is executed in the framework of an existing GTZ supported project. As other donors in Burkina Faso (World Bank, GTZ) having the same approach, there is the opportunity to adopt a "sector-wide approach" on district level, provided that the donors are willing to sign a single agreement with the district. There is a need for an improved consultation between donors.</p>

Example 5. Partnership agreements for the provision of health care between the Ministry of Public Health and the CDSS/COTE D'IVOIRE.

GTZ Project No.	96.9102.3 (GTZ financed measure)	
Project title		
Date	29 December 1998	
Who are the partners involved status?	Partners involved	Legal status
	1. Social and Health Development Committee (CDSS) of Vridi. 2. Ministry of Public Health	1. Corporate body governed by Private Law 2. Corporate body governed by Public Law
What is the major problem the contract seeks to solve?	No problem (since the CDSS is new); rather, an objective: the CDSS will accomplish, through contracting, the role of public health care provider.	
Is it an explicit or implicit contract? What is the title of the contract?	<div>Explicit</div> <div>Implicit</div> <p>Contract title: Improvement of living conditions in a neighbourhood of Abidjan (Agreement for the provision of health care between the Ministry of Public Health and the CDSS)</p>	
What are the main objectives of the contract?	Specify the terms of the association in view of the provision of public health care.	
What are the activities/commitments expected of the partners?	<p>Partner 1: The CDSS</p> <ul style="list-style-type: none"> - Deliver PHC in the Port-Bouet Est (Abidjan) neighbourhood. - Promote health through health education. - Facilitate the provision, by the health centre, of curative and preventive health care. - Recruit skilled staff for the centre and keep diplomas at disposal of MOH - Propose tarification with draft budget for the approval by MOH. - serve as training centre 	

	<ul style="list-style-type: none"> - can be requisitioned in case of an epidemic or disaster, and vaccination campaigns - Support the enforcement of Ivorian social security regulations, and take out an insurance policy for civil liability. - Can forward medical files in case of referral - provide annually the MPH with: a statistical report , an inventory of equipment, buildings and personnel, financial and accounting reports, a provisional budget, minutes of the General Assembly - reporting in compliance with the HMIS - Undertakes to open its accounts with the services of the Ministry of Public Health. <p>Partner 2: The MOH, through the Regional Department of Health for the South.</p> <ul style="list-style-type: none"> - Is represented de jure at meetings of the Board of Governors and General Assemblies. - accepts CDSS staff for training in public health centres - helps CDSS to benefit from tax and customs exemption in case of importation of equipment or donations - Will provide reports on the information system in force at the Ministry of Public Health. - grants authorisation to open an account at the MOH pharmacy for the supply of drugs - ensures supervision of the centre
What are the systemic improvements expected?	<ul style="list-style-type: none"> - assurance that the health centre will fulfil its role of public health care provider - Technical supervision by the MOH to ensure quality of care and sound management. - supply and sale of essential drugs ensured
What is the duration of the contract duration?	Three (3) years, from 15 December 1998 to 15 December 2000.

	Termination after a 6 month notice.	
How was the contract awarded?	<ul style="list-style-type: none"> • Competition (open invitation to tender) • Competition on a short list • Mutual Agreement • Others 	
Does the contract provide for monitoring?	<ul style="list-style-type: none"> • <u>Yes</u> No • Monitoring indicators specified: Yes <u>No</u> • Visit/Supervision: <u>Yes</u> No • Report: <u>Yes</u> No • Other forms of monitoring: 	
Does the contract provide for evaluation? If yes, how shall the contract be evaluated?	<ul style="list-style-type: none"> • Yes <u>No</u> • Type of evaluation 	
What has been the role of the GTZ-supported project during the different contract stages?	<ul style="list-style-type: none"> • Preparation: The project funded this phase; however, the NGO being the initiator of the activity assumed the leading role. (But the NGO used exactly the procedures described and adopted by French co-operation-funded FSUCOM). • Drafting: NGO (idem) • Execution: should start by late December 98 • Evaluation: not yet applicable 	
What is the type of technical support granted by public authorities during the different contract stages?	<ul style="list-style-type: none"> • Preparation: no direct support, but the NGO frequently consulted with the Abidjan Health Directorate that has experience in this field (being supported by of French co-operation). • Drafting: idem • Execution: should start by late December 1998 • Evaluation: Yes, evaluation of compliance with by-laws. 	
What type of external support (source and form)	Source: None	Source:

did involved partners benefit from during the formulation and execution of the contract?	Form:	Form:
What are the conditions for the dissemination of this contract on a larger scale?	<p>Requisite Conditions:</p> <ul style="list-style-type: none"> - study problems of the legal framework raised by FSUCOMs during a workshop in January 99 and find a solution - Adapt and test this contractual approach with public health centres, and set up a working group on these alternative approaches at central level. 	
What are the strengths of this contract?	<p>- stimulates discussions on the autonomous management of health centres and the development of “alternative health care provision”</p>	
What are the weaknesses of this contract?	<ul style="list-style-type: none"> - Lack of a national legal framework for this type of contract. - Neither monitoring nor evaluation of the contract. 	
Do you have any comments?	<ul style="list-style-type: none"> - This contract is identical for the 10 or 12 Abidjan FOSUCOMs - The MOH's intention to create 22 additional FSUCOM centres in Abidjan in 1999 should lead to the organisation of a workshop on problems raised by this type of contract. - It is also hoped that a working group on: “alternatives in health care provision /contractual approach” with an operational research action plan between the MOH and other partners (French co-operation, World Bank, European Union, GTZ, Canada) will be set up. 	

Annex 2. Framework for the analysis of contracts established by the GTZ project of Mahajanga in Madagascar

Contract description

Descriptive items of the contract		Definition	Contractual implications
Parties	1		
	2		
Purpose			
Cause			
Classification			
Effects			
Penalties/litigation			
Attached contracts			

Pre-contract stage

Actors		Their commitment	Their objectives	Activities/Strategies
Internal Parties	1			
	2			
External Parties	1			
	2			

Contractual Phase

Actors		Commitments	Activity	Contract execution	
				Strengths	Weaknesses
Internal parties	1				
	2				
External Parties	1				
	2				

Annex 3: Contract typology

Parties involved	Government authorities (1)		The authorities + self-governing bodies governed by public law (2)	The authorities + corporate bodies governed by private law (3)			Individuals governed by private law
Type of organisation	Administration (8)		Predetermined legal framework (4)	Contractual agreements (5)			Autonomy (6)
Characteristics of relationships with the authorities	Delegation (7)	Decentralisation (9)	Autonomy defined and limited by authority (10)	Co-operation (11)		Autonomy of execution (12)	No direct link with authorities (13)
Involvement of the authorities	Direct or delegated management (14)	Hierarchical structure (15)	Subject to authorisation (16)	Joint management (17)	Network (18)	Subcontracting (19)	Laws and regulations (20)
Standard contracts		Direct or indirect state control (21)	- authorisation, annual plan (22)	Subsidiaries , private interest groups, joint ventures (23)	Franchise, concession on a commercial basis (24)	Public service concession accreditation (25)	

Source: OMS 1997. L'approche contractuelle: de nouveaux partenariats pour la santé dans les pays en développement. Série macro-économique, No 24, p.30, modified

1. Authorities ruled by executive power in sensu strictu. Executive powers may be the government on national or regional level with their executive bodies on provincial, district or local level. In the following authorities are referred to authorities in sensu strictu.
2. Self-governing bodies are authorities in a broad sense. They are legally independent administrative units of indirect public authority (e.g. public sick funds).
3. Corporate bodies governed by private law being subject to rights and duties: individuals (e.g. a physician, a pharmacist) or a legal entity (e.g. a hospital).
4. Public authorities define the legal framework for self-governing corporate bodies; This framework is not ...
5. Public authorities sign contracts with corporate bodies governed by private law to fulfil their duties. Public duties are laid down by law and serve as framework for the terms of contract.
6. Typically, no legal framework exists for the terms of contract. Application of private law.
7. The delegate administrative unit acts on behalf of the delegating authority.
8. As the respective administrative units are not legal entities, no contracts exist. The superior towards the inferior administrative unit usually establishes the link through instructions.
9. Subnational administrative units which are funded and staffed by the superior authority but fulfil their tasks independently.
10. Autonomy of self-governing corporate bodies within the established legal framework.
11. The authority acts as regulator/controller within the execution of the contract.
12. Both parties fulfil their tasks independently. No regulatory or controlling interference by public authority.
13. Application of the general rules of corporate law.
14. The health service is delivered and managed by the public authority.
15. The public authority is not involved directly in the management of the health service but remains present indirectly through hierarchical links.
16. The potential self-governing body applies for the registration as self-governing body in order to fulfil certain public duties.
17. Joint use of funds and staff by both parties

18. The public authority defines the rules: for quality and cost control, to ensure the equal access to services by the insured etc
19. The service to be delivered is defined by one party (as a rule the public authority).
20. Relevant law to be applied: Corporate, contract, cartel etc. General rules can be those governing the professional orders (e.g. physicians).
21. Once a partner has been chosen the negotiations begin. The contract may be either drafted entirely or simply adapted from a standard contract.
22. Public concession is granted to a self-governing body managed by a public manager who is paid according to the results he/she achieves. A public authority granted a concession enjoys financial and administrative autonomy. An annual workplan defines the framework of the results to be achieved. Inside this framework the service providers are free to act.
23. The subsidiary represents a separate legal entity. Few applications so far, possibly with public hospitals.
24. The franchisee is being granted a limited licence by the franchise-holder for a single or regular fee; he is thus entitled to exclusively commercialise a product in conformity with the concept given by the franchise-holder in a pre-defined area; The franchisee in turn has relative autonomy in the way he commercialises the product (see car dealers).
25. see note 22