

Public-Private Partnership in Health Service Delivery:

Lessons From Bangladesh

Ferdous Arfina Osman Ph.D

Abstract: Given the limited resources and inefficiencies of both the public and private sectors, partnership can be a straightforward solution to address the growing public health problems in Bangladesh. Partnership is required to exploit the strengths of all the sectors towards fulfilling the health needs of the people, which is always challenging. There exist varieties of models of public private partnerships in health service delivery in Bangladesh. Some of them have produced highly encouraging results and some are challenging. Present study puts forward some lessons from the successful models and the challenging ones. To do so, it analyses the factors contributing to the successes and failures of two selected models of partnership. Findings show that amongst others, firm commitment of all the partners, availability of resources, and clear identification of roles and responsibilities mainly contributed to the success of partnership. On the other hand, the model that couldn't produce the desired results, mainly suffered from the lack of firm commitment of government, poor monitoring and supervision and selection of inappropriate partners.

Introduction

Since 1990s, an ideological growth has been witnessed that public and private sectors should work together. International bodies now advocate 'public-private partnerships' (PPPs) as the policy innovation of recent time and 'actively lobbying to have partnerships be accepted as the way forward' (HAI, 2000). Although the dynamics of public-private partnership arrangements are generic across social sectors, international literature has been persistently emphasizing on country specific study on partnership to gain more insights, to know more about its effectiveness and to mitigate the challenges of partnership.

Government of Bangladesh (GOB) has been pronouncing for public-private partnership in health service delivery since 1980s (GOB,1985). The health care system of Bangladesh is a mix of public and private initiative. In terms of physical infrastructure, public sector is stronger than the private sector although in terms of coverage, the health care system of the country should be termed a privatised one (Osman, 2004). Although public health services aim to make health care accessible and affordable for the poor and marginalized, it has largely failed to do so. On the

other hand, high out of pocket expenditure and unpredictable quality of care by the private sector has limited access to health services for the poor. Non-Government Organizations (NGOs) have emerged as an effective option to make health services accessible to the poor. To improve efficiency in the use of public funds and expand coverage of health services through utilizing the potentials of all the providers available, GOB has opted for public-private partnership. In the health sector, public private partnership has taken a variety of forms producing diverse results. Present study documents the experiences of two programmes, one of which has been successful and the other one is challenging. As a successful programme the Expanded Programme of Immunization (EPI) has been selected while ‘National Nutrition Programme’ has been picked up as a challenging model. Based on the performance of the programmes in terms of coverage and access to services the immunization programme (EPI) has been termed as successful and the nutrition programme as challenging. The paper draws on the findings of a study sponsored by the School of Public Health, BRAC University. Data for the study were collected through documentary survey and interviewing the key government and NGO officials of the respective programmes.

The paper is organized into five sections. Section one presents the conceptual framework of the study. Section two briefly describes the nature of public private partnership in Bangladesh in general while specific discussions are held in two subsequent sections. Section three and four document the experiences of the immunization programme (EPI) and nutrition programme respectively with particular focus on the programme designs, partnership strategies, the strengths and weaknesses of partnership. Section five puts forward some lessons from the findings of the study.

1. Public-Private Partnership: Conceptual Framework

Partnerships refer to public and private sector actors work together on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria, usually through the formation of a new joint entity for implementation (Ahmed, 2000). It is a contract between two partners, where the public sector plays the stewardship and regulatory role and the private sector provides services under certain conditions.

Partnership has significant potentialities for achieving effective and efficient high quality health services. It aims to establish a functional integration and a sustained

operation of a pluralistic health care delivery system by optimising the equitable use of the available resources and investing in comparative advantages of the partners. It ensures the utilization of the potentials of both the public and private sectors. Partnership between public and for-profit private sector is fostered to tap into resources and efficiency in management, while the non-profit private sector for technical expertise or outreach. Thus partnership is increasingly becoming essential as both the public and the private sector recognize their individual inability to address emerging public health issues. Research evidence also indicates that working in isolation can result in duplication of efforts and failure to accomplish health goals, whereas collaboration among health care providers can generate synergy and facilitate the flow of information (Begum 2004).

To discuss public private partnership, defining or clarifying the partners is indispensable. The term 'public' refers to government including both central and local level state institutions. Defining private sector has become complicated due to the emergence of a large number of institutions called NGOs. The distinction between the private sector and NGOs is often blurred due to various sizes, functions and objectives of NGOs. The simplest way to distinguish between these two is: *for-profit private sector* encompassing commercial enterprises of any size and NGOs referring to *not-for-profit private sector*, which provides voluntary services. Thus for a broad and comprehensive analysis of the basic trends of functioning of the institutions in health service delivery, the study has grouped both the for-profit private sector, and non-profit NGOs under the term 'private sector'.

2. Models of Public-Private Partnership in Bangladesh

In Bangladesh less than 40 percent of the population have access to primary health care. To respond to the overwhelming health challenges the government encourages the involvement of NGOs and private sector in health service delivery. More than 4,000 NGOs, including national, international and local organisations are actively operating in the health sector of Bangladesh. A number of partnership models exist between public-private, government-NGOs and also community-based partnerships are there to deliver health services. Since independence, a number of pilot partnership initiatives have been undertaken including private sector and NGO, but most are donor financed and have not been scaled up. Currently 12 major public-private partnership schemes in healthcare are running in Bangladesh (Barakat, 2003). Some

of these models have succeeded to have considerable coverage and outcome while some haven't. Examples include partnerships for family planning, tuberculosis control, immunization, nutrition Essential Service Package (ESP) and urban primary health care project.

In public-private partnership in health, GO-NGO partnership has been more prominent and conventional. It is often said that Bangladesh is “front-runner in and an excellent case of society, government-NGO partnership” (MOHFW, 1999). Innovativeness, flexibility, donor fund and community approach are the key to GO-NGO collaboration in Bangladesh. Several mechanisms and frameworks are tried to establish partnership ranging from “formal collaborative and contracting arrangements to informal gentlemen's agreements” (World Bank, 2006). The commonest form of partnership is contracting and in general, Government of Bangladesh (GOB) defines partnership as such (Zafarullah et.al 2006). Under this mechanism government assigns NGOs to undertake a specific task on its behalf. Government in this case assumes core responsibility of the joint initiative and take charge of the weaker partners. The subsequent sections deal with two GO-NGO partnerships, one of which has produced impressive results and the other one is facing difficulty to do so.

3. Expanded Programme of Immunization: A Successful Model of Partnership

Immunization is one of the greatest public health achievements of the government of Bangladesh. The Expanded Programme of Immunization (EPI) including vaccination against six diseases: neonatal tetanus, polio, diphtheria, measles, tuberculosis and pertussis, was globally launched in 1974 and was formally launched in Bangladesh on April 7, 1979. But the program could make a little headway until 1985 when it got a new direction. In 1985, GOB began a phase-wise process of EPI intensification from 1985-1990 through partnership with NGOs. The intensified immunization programme was expanded in the country in phases, and near universal coverage was achieved by the end of 1989 (Talukdar, et.al. 1991).

3.1 Partnership Strategy of EPI: Who Does What?

The government made a strong commitment to improving its national EPI programme with the technical and financial assistance of international donors (Perry, 2005). The international partners of the programme include the World Health Organization (WHO), UNICEF, USAID, the Japan International Cooperation Agency (JICA), Rotary International, the Swedish International Development Agency and GAVI (Global Alliance for Vaccine and Immunization). At present, 42 percent of the National EPI programme expenses are paid for by the Government, and the remainder is provided by the external donors (Perry, 2005).

The EPI programme operates throughout the country in collaboration with numerous (20-25) NGOs. During the mid-1980s government sought cooperation from NGOs including BRAC, CARE (Cooperation for American Relief Everywhere), Proshika, Rangpur Dinajpur Rural Services (RDRS), ICDDR,B, Rotary International and many smaller NGOs. Shortage of government manpower to provide immunization services led to the GO-NGO collaboration in EPI. “To deliver EPI services, nearly about 600,000 staff is needed while GOB has only 60,000-70,000,” disclosed a government official during interview. NGOs have strengthened the immunization program throughout the country through providing training for vaccinators, managers and communicators, providing immunization services in areas where government services cannot easily reach, providing many of the communication materials and activities which have supported program expansion, and mobilizing local talent and resources for the program. Three NGOs namely, BRAC, CARE and RDRS provided extensive support to the EPI, each taking responsibility for certain selected upazilas (subdistricts)¹. GOB purchases EPI vaccines with its own currency and supply the vaccines and other logistics e.g. AD syringes, safety boxes, refrigerators, record report forms to all concerned NGOs free of cost. Thus government provides vaccine, human resources, infrastructure, logistics and cold chain.

Private for profit sector participation in the programme was another uniqueness of EPI partnership. Private sector was not involved in service delivery but played an active role in awareness creation through using media resources such as stickers, posters,

¹ For administrative purpose, Bangladesh is divided into 6 divisions, 64 districts and 460 subdistricts/upazilas

pamphlets/brochures, and village theatre. Table 1 presents the nature of sharing of tasks and responsibilities among different partners in EPI

Table 1: Sharing of tasks and responsibilities in EPI

Government	NGO	Private Providers	Community
<i>Central:</i> Policy Guideline Financing Vaccination service Vaccines, cold chain, logistics Human Resources Facility Training Monitoring and supervision Communication Materials Quality Assurance Dissemination <i>Local:</i> Planning, Programming Human Resources Training Monitoring and supervision Coordination	Vaccination service Human resources Facility Training Monitoring and Supervision Quality Assurance Communication materials Community Mobilization	Dissemination Community mobilization	Community mobilization Facility

Table 1 shows that government is the key player in EPI partnership. Other than providing policy guidelines by the central government, local government plays an important role in designing the need-based local level plans and programs, and in coordinating all the partners at the local level which is the key strength of the program. The second important partners are NGOs who play important role in providing training to the vaccinators and community mobilization. During intensification period (1985-90), private providers played a supportive role by disseminating information and community mobilization. On the other hand, the religious leaders, locally known as imams, also played an active role in mobilizing the community.

Figure 1 presents EPI partnership schematically in terms of interactions among the partners. Rectangular boxes denote the main partners. Additional partners are represented through ovals linked to the partner to whom they are responsible. Arrows are used to indicate the flow from the provider of a service component to the user of that service.

Figure 1 Partnership in EPI

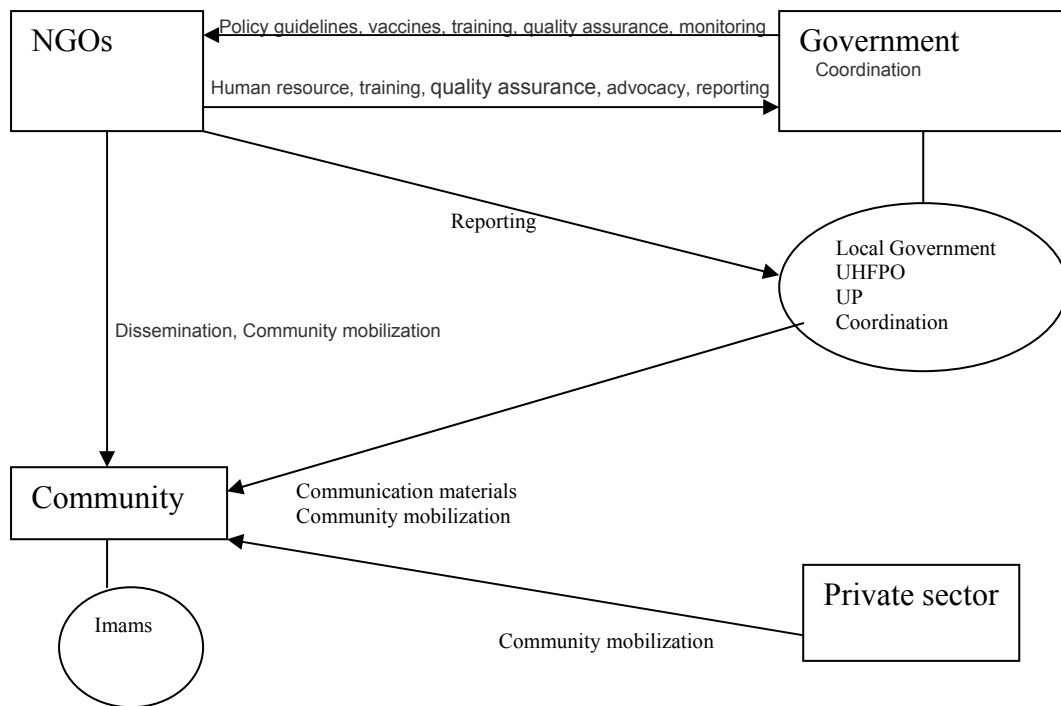


Figure 1 demonstrates that government provides policy guidelines, vaccines, training (training of trainers) to the NGOs at the national as well as at the local level and also monitors and supervises the activities of NGOs. On the other hand, NGOs provide the government with program or planning based on their field experience, human resources, training to the vaccinators, advocacy and reports their performance to the local government. Here, government is the coordinating partner. Government coordinates the activities of NGOs through local government. Quality assurance is done jointly by the government and NGOs. Government through continuous supervision assures quality and NGOs themselves maintain quality of services. NGOs disseminate information and create community awareness. Government (through local government) also mobilizes the community through providing communication materials. Private sector's role is limited to dissemination of information and creating social awareness.

3.2. Evaluation of Performance of EPI

EPI has earned global recognition for its achievements during the past 15 years, and it has been acclaimed as a 'near miracle'. The coverage of children fully immunized

reached 62% countrywide and 80% in Rajshahi division (where BRAC facilitated the programme) by 1991 (Silva et.al. 1991) as opposed to a mere 2% in 1985. In the areas where CARE worked, the coverage expanded remarkably. The evaluations revealed that 100% of the community leaders and 95% of the mothers were familiar with EPI (Choudhury, 1999). To achieve such a result within a five year period, was previously unheard of in the field of public health in this part of the world (Choudhury, 1999). The program faced a set-back in the mid-1990s due to unavailability of donor fund. It started improving again from 1998. Mass awareness has been created through extensive partnership strategy. EPI has become a popular service now. “Currently, 98.25 percent of the parents bring their children for 1st vaccination (BCG)” informed a government official during interview. “The success of EPI has opened an avenue for other programmes. It has become a trendsetter,” opined an NGO official.

Access and Quality

Table 2 presents the growth of coverage of immunization services since partnership began. It shows that in 1985, less than 2 percent of children had obtained the complete series of immunizations, whereas by 1992 that percentage had risen to 65 percent and in 1998 to 70 percent of children from 12 to 23 months of age. At present 82 percent of children aged 12-23 months are fully immunized while it was 73 percent in 2004 (BDHS 2007). Rate of pregnant women receiving tetanus toxoid immunizations also increased dramatically from less than 2 percent before 1985 to 86 percent in 1998.

Table 2: Growth of coverage of immunization services

Year	Coverage in %
1985	2
1992	65
1998	70
2004	73
2007	82

In general, the overall quality of immunization services throughout the country is quite high, and the program has an excellent logistics and cold-chain system. EPI is the most cost effective health intervention for disease prevention, control and elimination. “It is estimated that each year 200,000 child deaths are being prevented through EPI in the country,” informed a government official.

3.3 Strengths/ advantages of partnership

Partnership in EPI was wide-ranging. All the actual as well as the potential actors with their resources became the active partner of this program, which ultimately made the program successful. Following are the key strengths of partnership in EPI that contributed to the miraculous success of the programme.

- **Firm Commitment of government**

Strong commitment of government as well as of the international donor communities has been the prime factor causing the success of EPI. In mid-1980s EPI was like an all-out movement. GOB adopted EPI as a significant component of maternal and child health intervention in the Primary Health Care (PHC) approach of the Third Five Year Plan (1985-90). There is a consensus among all stakeholders (development partners: NGOs and civil society) to improve the performance of EPI in terms of coverage and quality. Government played an important role in making the program a success. “In fact, partnership began from within the government itself” a government official commented. Ministry of Social Welfare (MOSW), Ministry of Women Affairs (MOWA), Ministry of Home, Ministry of Information, Ministry of Local Government and Rural Development (MOLGRD) all worked together. With regard to the interministerial collaboration, Ministry of education undertook special project on EPI involving the primary schools for social mobilization, Ministry of information gave free broadcast time for EPI and also produced relevant programs to assist the initiative, Ministry of post and telecommunications issued stamps for Universal Child Immunisation (UCI), Ministry of religious affairs participated in sending 200,000 information packages to imams for informing them about EPI, Ministry of social welfare and Ministry of home affairs instructed its staff to get involved in EPI social mobilization activities through its vast network in villages. Active role of local government was another effective strategy to make the program successful. The program effectively used the authority of Deputy Commissioners (DCs), the official head of district administration. DCs were instructed to get directly involved in monitoring and implementation of EPI through the district development coordination committee and to ensure coordination among the social sector agencies of government and NGOs for proper implementation of EPI. Due to the effective role played by the DCs, all the government officials at the local level as well as the Union Parishad (the lowest tier of administration) Chairmen and Ward (the lowest unit of administration) members also got effectively involved in the program. District, and upazila followed

by union level advocacy meetings were held with different government departmental heads, voluntary organizations, professional associations and community leaders to finalize the vaccination sites, organization of logistics, transportation of vaccines, training of volunteers. No other social program has been able to generate so much interest among government officials (Huq, 1991).

- **Availability of resources**

Resource availability is one of the important factors contributing to the success of EPI. The programme was heavily funded and patronized by the international donors and achieved impressive success but faced a temporary setback in late 1990s due to the unavailability of donor fund. Now again, EPI receives funds from the government and donors in sufficient amount without any interruption, which keeps the partners enthusiastic.

- **Social mobilization through multi-partner strategy**

A strong community mobilization is another strength of EPI partnership. Government undertook a multipartner strategy of social mobilization through intersectoral collaboration and taking media, corporate sector and NGOs as its partners. High coverage of immunization in NGO areas was caused due to high degree of social mobilization. NATAB (National Anti Tuberculosis Association of Bangladesh), an NGO, through putting *moni* (a logo saying “Get your child immunized”) tin plates on the back of rickshaws all over the country, stickers and posters on ferries, buses and trains and distributing slides on immunization to many cinema halls (Huq,1991) contributed significantly to create social awareness.

Not only NGOs, private sector also played an active role in awareness creation. At this attempt, Dhaka Match Industries (owned by Swedish Match Company and the Government of Bangladesh) put the *moni logo* on the back of their “Seven Horse” brand, which were sold to the millions of people in the remote parts of the country. This was a unique way of linking the community to the program. Being encouraged by the Match Industries, Bata Company, later donated some space on their signs and shoeboxes; Fisons Bangladesh Limited provided support in the form of counter displays and posters to 20,000 pharmacies carrying their product (Huq, 1991). In later

years, many other business organizations joined the campaign for EPI. Such a high degree of social mobilization has been nonexistent in any other program so far.

- **Strong sense of ownership among the partners**

Frequent communication among the partners grew a strong sense of ownership among them. Each partner (both the service providers and the recipients) was rewarded for his/ her performance. ‘As providers’, NGOs and field workers, and ‘as recipients’ mothers of children who completed the whole vaccination, were given awards for their performance. As a result, a sense of competition grew amongst the partners. The performance award was distributed by the Deputy Commissioner, which again, created an additional enthusiasm to the implementation of the program from all sides. During interview, a Civil Surgeon (a doctor who heads district level health administration) described it in this way:

“Though I was the key person to implement EPI, but performance award was not distributed by me but the Deputy Commissioner. We could realize it well that receiving award from me would not be encouraging for the people rather they would feel honoured by taking award from the Deputy Commissioner. People were so much enthusiastic about the prize distribution programme that it appeared like a festival to them”.

- **Strong Monitoring and Supervision**

EPI had a strong monitoring system. Although initially, supervision and monitoring were weak but gradually, in course of time, it was systematized. Government officials, donor agencies and NGOs all ensured that the program was being supervised regularly. Upazila officials and elected representatives of the union parishads (union councils) used to visit the vaccination sites regularly and take great interest in immunization. The Donor agencies like USAID, WHO, UNICEF have deployed officials at the local level for supervising the program. There also exists an efficient monitoring system. The record of vaccination is maintained on a daily tally sheet at vaccination sessions and compiled in a monthly reporting form. Records are maintained according to ward, union, upazila, and district targets. It is easy to compare the monthly performance with the annual target indicated on the form. Control rooms at the district and upazila always display graphically relevant data to show their progress. BRAC and other NGOs through continuous monitoring reduced wastage of resources and ensured timely arrival of vaccine from the centre.

Thus in 1985 EPI initiated country's most successful partnership model. GO-NGO partnership in EPI has been internationally acclaimed and without partnership the programme couldn't achieve the success that it has attained so far.

4. Nutrition programme: A Challenging Model of Partnership

Nutrition Program of Bangladesh involves two large-scale programs in two phases. In the initial phase it was known as Bangladesh Integrated Nutrition Programme (1995-2002) and the later and present phase is called the National Nutrition Programme (2002-2010). In response to the high rates of low birth weight and malnutrition, government undertook a pilot nutrition intervention supported by the World Bank, the Bangladesh Integrated Nutrition Project (BINP) in 1995. It was the first large-scale multisectoral project on nutrition in Bangladesh, which was implemented through partnership with NGOs and the community. BINP ceased its activities in 2002 and the experiences gained from it are now being used for a much larger National Nutrition Programme (NNP). NNP aims to reduce malnutrition among women, adolescent girls and children. NNP also has encouraged partnership with NGOs and the community as BINP did but the program outcome is not that satisfactory. Despite some positive changes, levels of malnutrition in Bangladesh still remain as one of the highest in the world as approximately, 46% of under-5 children are underweight (BDHS, 2007).

The BINP had three components: 1) national nutrition activities including institutional development, IEC, and monitoring and evaluation; 2) Community-Based Nutrition (CBN) and (3) Intersectoral nutrition programme development, supporting schemes such as home gardening and poultry rearing.

The Community-Based Nutrition Component (CBNC) was the core component of the project, which included monthly growth monitoring and promotion (GMP) for children under two years of age and pregnant and lactating women (PLW), supplementary feeding of malnourished PLW and growth-faltered children under 2 years of age and nutrition education for pregnant women, mothers of children under two, and adolescent girls.

The CBNC services were provided by the Community Nutrition Centre (CNC) located at a site donated by an individual in the community. Under the CBNC, a number of Community Nutrition Promoters (CNPs) were recruited. On a quarterly

basis, a community growth chart is prepared which describes the nutritional status of all the children in the community (Perry, 2005). These functions were performed by the CNPs and were supervised by the Community Nutrition Organizers (CNOs). Recruitment of these CNPs and CNOs were proposed or recommended by the union nutrition management committee and approved by the Upazila Nutrition Management Committee. In addition to the CNCs, government Community Clinics (CCs) also provide nutrition services. The components of NNP have remained the same as BINP. Only the CBN has been renamed as Area Based Community Nutrition (ABCN). Like BINP, ABCN is the key focus of NNP, which is being implemented by NGOs. Ten partner NGOs were working with NNP to deliver ABCN services but in August 2006, BRAC, the largest NGO has withdrawn itself from the programme.

4.1 Partnership Strategy: Who Does What?

NNP is being implemented through government and NGO partnership. Planning, financing and logistics are the main responsibilities of government. The chief sources of financial or technical support for the NNP are the Government of Bangladesh (GOB), the World Bank, Canadian CIDA and Netherlands Government, (MOHFW, 2005). Government has established an institutional set-up for the program in the form of Nutrition Management Committee at each of the administrative levels starting from the district down to the community level. It has been realized that behavioral/attitudinal factors play an important role in improving the level of nutrition and NGOs are better equipped to take the programme to the community. Accordingly, NGOs are made responsible for program implementation mainly at the field level. Thus in recognition of the government's capacity limitations and role for community-level service delivery, BINP was implemented largely through the NGOs (World Bank, 2005). As under BINP, NGOs are the major partners with the government in NNP implementation. NGOs are given the responsibility of a number of upazilas. "Partnership with NGOs is one sort of 'contracting' as it is one kind of procurement of service through bidding", said a government official. Government makes contracts with a small number of "lead" NGOs who may, in some upazilas or parts of upazilas, in turn involve a "smaller" partner NGOs to deliver ABCN activities. Under the contract, the tasks, mode of payment, period of time for the work are specified. NGOs recruit only the Upazila Nutrition Manager (head of the nutrition programme) and

field supervisors whose salary is paid by the government. A chain has been established between the CNCs and these implementing NGOs. Although a protocolized referral system is yet to be developed, a significant number of PLWs are referred from CNCs to nearby government and NGO health facilities for growth faltering, severe malnutrition and severe illness. Data shows a very subtle difference in the utilization of Government and NGO facilities. Table 3 presents the nature of sharing of tasks and responsibilities among different partners of nutrition programme.

Table 3: Sharing of tasks and responsibilities in Nutrition program (BINP & NNP)

Government	NGO	Community- CNC
<p>Central: Policy Guideline Financing Facility (Community Clinics) Logistics Human Resources Training Monitoring and supervision Coordination Quality Assurance</p> <p>Local: Nutrition Management Committee Monitoring and supervision Coordination</p>	Provision of ABCN Human resources Training Monitoring and Supervision Community Mobilization Advocacy Coordination	Space for CNC Referral

Table 3 shows that government provides policy guidelines and other large-scale assistances while NGOs are central to the implementation of the program. Government is the coordinating partner of the programme. NNP Project Management Unit (PMU) located at the MOHFW is mainly responsible for coordinating project implementation, formulation of plans and budget for NNP, contracting with NGOs and other line ministries to deliver NNP outputs, monitoring physical and financial performance of partners and taking corrective actions (GOB, 2002). Government also plays a key role in providing training (training of trainers of NGOs) and quality assurance. A core training team, drawn from lead NGOs and relevant national nutrition institutions, conducts the training of trainers. The Government has also designated some agencies to form an Independent Quality Assurance Group for NNP (GOB, 2002). Like the EPI, local government plays a coordinative and managerial role in nutrition.

NGOs are responsible for supervision, monitoring (the growth of newly born babies), training, advocacy and also the provision of ABCN. NGOs submit reports of their activities to the government through local government. Training for field level workers (CNP and CNOs) is the responsibility of the lead NGOs contracted to deliver services at the upazila level. Overall implementation and coordination of the program at the community level is done by the NGOs. Private sector does not have any discrete involvement in the nutrition program.

Community is an important partner as it provides space for CNCs, which act as the referral centres. Community is also involved in the program through village nutrition committees. The committee identifies particular nutrition needs of village.

Figure 2 presents schematically how these different partners interact with each other in the partnership arrangement of nutrition programme.

Figure 2 Partnerships in Nutrition

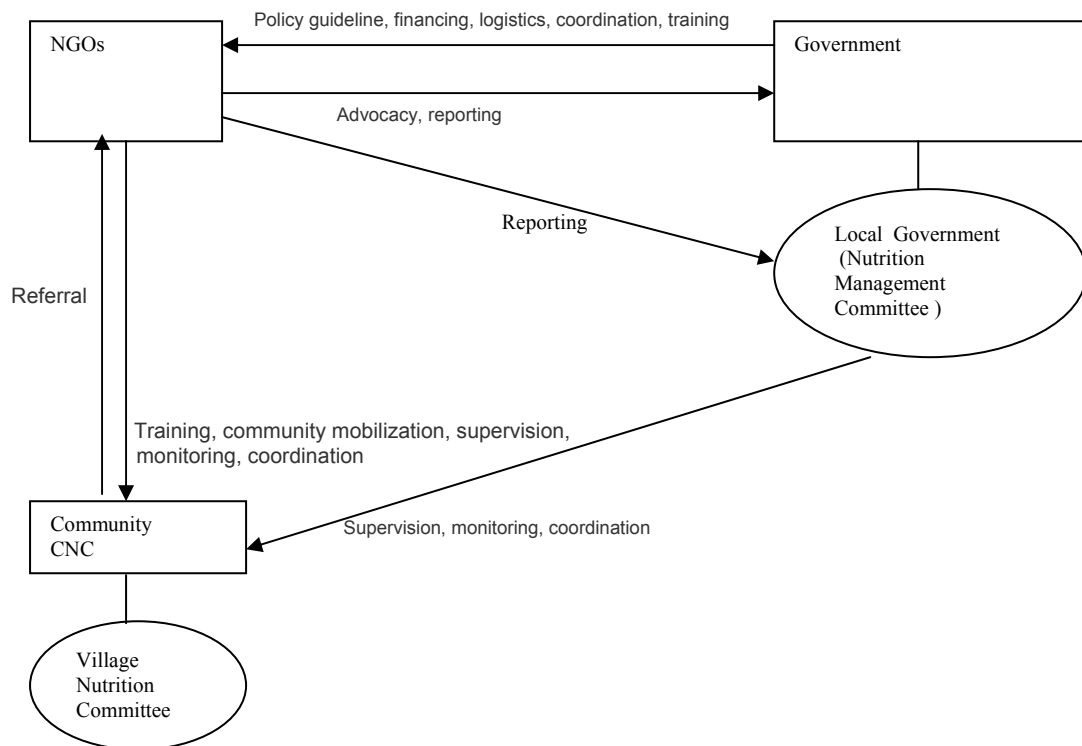


Figure 2 demonstrates that government provides policy guidelines, funding and logistics to the NGOs. NGOs provide advocacy and submit reports of their activities in implementing the ABCN activities to the government through PMU. NGOs also submit a copy of their performance report to the Upazila Nutrition Management Committee. Nutrition Management Committees at the local level coordinates all the

activities of NGOs and the community. At the community level NGOs mobilizes the community. Community is again linked to the local government through CNCs and Village Nutrition Committee. Recruitment of CNPs is initially proposed by the village nutrition committee but is approved by the upazila nutrition management committee. Major problems of CNCs are solved by the District Committees though maximum problems are solved by the union/upazila committee. Local government supervises, monitors and coordinates the activities of CNCs. NGOs provide training, supervise and coordinate the activities of CNCs and mobilizes the community. CNCs, on the other hand, refer the complicated cases (patients) to the NGOs.

4.2 Evaluation of performance of Nutrition Programme:

BINP is one of the largest multicomponent nutrition programs ever implemented in a developing country. It has produced impressive results in its early years particularly in the reduction of severe malnutrition among young children. Compared to the level of nutrition in 1996, the nutritional status of the children under five has improved to a great extent. Table 4 and figure 3 present a slow rate of improvement in nutritional status of children under five since 1996.

Table 4: Slow Improvement in Nutritional Status of Children Under Five since 1996

Indicators	1996-97 (in %)	1999-2000 (in %)	2007 (in %)
Stunting	55	45	36
Wasting	18	10	16
Underweight	56	48	46

Source: BDHS 2004,2007

Figure 3 Slow Improvements in Nutritional Status of Children Under Five since 1996

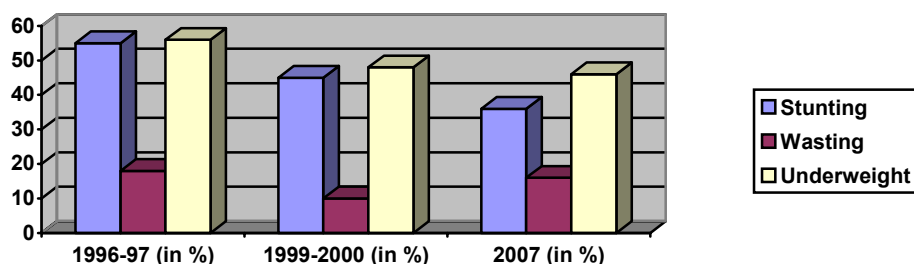


Table 4 shows that in 1996-97 the rate of stunted children under five was 55 percent, which was reduced considerably to 45 percent in 1999-2000 but in 2004 the rate of decline (43%) was rather slow. In the same way, in 1996-97 the rate of wasted children under five was 18 percent, which was significantly reduced to 10 percent in 1999-2000, but in 2004 it was slightly reduced to 13 percent. More interestingly, the number of underweight children was reduced to 48 percent in 1999-2000 from 56 percent in 1996-97 though in 2004 the rate remained the same. Thus it is seen that BINP in its early years of operation performed well but it could not be sustained in the following years. As a result, the ultimate impact of the program over the nutrition status cannot be termed as a satisfactory one. Another reason for terming BINP as a less successful program is that there is a big gap between its targets and achievements. BINP aimed to reduce underweight and stunting rates by 50 percent over a period of five years. Now BINP has ceased to exist and NNP has started its operation but still about 36 percent of children under five are stunted and 16 percent are wasted and 46 percent are underweight (BDHS 2007). Thus BINP, (a US\$ 60 million project) and NNP (a \$US 92 million project) couldn't succeed to produce a satisfactory impact on the level of nutrition of the people of Bangladesh. Moreover, the programme has reached only in 105 of 464 upazilas.

The central thrust of the project design was to change nutritional behaviour of mothers. The OED, World Bank (2005) report suggests that although the project has had success in promoting nutritional information, a considerable knowledge-practice gap remains: that is, women do not put into practice the 'good behaviours'. Another study (ICDDR,B 2005) shows that in BINP areas only 25 percent of pregnant women took more food and 55 percent of women took rest. The project did not have any impact in reducing the gap. Moreover, although NNP targets the rural population,

urban children in Bangladesh enjoy a much better nutritional status compared to the rural children. In 2000, the proportion of moderately stunted children was 47 percent in rural areas and 35 percent in urban areas. Again, the proportion of underweight children was 49 percent in rural areas and 40 percent in urban areas (NIPORT, 2001).

5.2 Weaknesses of the Partnership

Partnership in nutrition program couldn't produce a significant output. Some programmatic weaknesses as well as inefficiencies of the partners influenced the poor outcome of partnership. They are the following:

- **Irregularities of the Programme causing discontinuity of the flow of fund**
Irregularities of the programme are one of the key factors that contributed to the poor outcome of partnership. The programme failed to keep timing since its inception. Although in paper, BINP started in 1995 but the programme started its operation in the field in the middle of 1996 (due to the delay in fund release and administrative complexities). NNP was supposed to start from 2002 but it commenced effectively in the field in 2004 though BINP ceased to its activities in 2002. Due to these irregularities, program performance was disrupted in many ways. The glaring instance is that due to the irregularity of the program, ministry could not form the Management Support Agency (MSA) in due time. Although a Management Support Agency (MSA) was supposed to be established by the development partners and government officials in order to ensure proper selection/procurement of NGOs but it couldn't be functional. As a result, old NGOs were to continue their work.

Discontinuity of the program also caused the loss of its momentum and affected the flow of fund. This led to the dissatisfaction of the community partners. "Assurance of salary of CNP was hindered as programme did never run smoothly. Due to this, officials felt discouraged to go to the field, as they could not answer the queries of CNPs about their remuneration" informed a government official during interview.

- **Frequent Changes of Programme Direction**

Change of program direction has caused uneasiness of partner NGOs. With the termination of BINP, the program turned into a project with its unspent money. .BINP had two important components like nutrition gardening and poultry

nutrition. Under the suggestion of the World Bank these two components were removed from the newly undertaken project. The World Bank study report on nutrition gardening was not positive², which discouraged the Bank to pilot the program further. Another essential component of nutrition is poultry rearing which exists in NNP. Under this programme poor women are provided with training on poultry rearing and are supplied with necessary inputs and micro credit (at present TK 1200), which is a revolving fund and “the recovery is cent percent”, informed an official. About 98 percent households are getting additional income from poultry rearing and children in more than 99 percent households have been consuming at least two eggs in a week by this time (MOHFW, 2006). But the World Bank has suggested for redesigning the poultry-rearing programme while almost hundred percent selected beneficiaries were already trained on poultry rearing. Due to these sorts of changes partner NGOs as well as the community can't remain committed to the programme goals.

Since 2006, NNP has been operating as a part of the larger sectoral programme called the Health, Nutrition and Population Sector Programme (HNPSPP). As a result, payment system to NGOs has also been changed. Procurement of fund has become very complicated. These changes in programme direction heavily discomfort the partner NGOs.

- **Complicated/lengthy procedure of renewing contracts with NGOs**

Contact renewing takes time due to a lengthy procedure in the ministry and the World Bank. This affects the morale and commitment of the implementing NGOs. More importantly, it makes the salary of community nutrition workers (CNPs) uncertain.

- **Inefficiency of Government**

From the government side, lack of managerial efficiency at both the central and local level is one of the key barriers to the success of the partnership. The government officials interviewed opined that this mismanagement was due to the discontinuity of donor fund. Frequent discontinuity of fund and changes in the programme direction affect the managerial capacity at the central level. At the local level also, programme lacks a strong management and monitoring capacity.

² due to faulty sampling, informed an official of NNP.

In BINP, upazila services were provided inadequately by the Upazila Family Planning Officers (UFPOs) with other responsibilities and little organizational incentive to devote time to contracts, payments, and monitoring responsibilities in nutrition (World Bank, 2000). “Upazila Health and Family Planning Officers (UHFPOs) have a tendency of noncooperation for NNP terming it as NGO program”, alleged a government official during interview.

- **Ineffective monitoring and supervision of NGO performance**

Nutrition programme does not have any effective system of monitoring and supervision. Government officials from the centre monitor and supervise the performance of NGOs in the field without any specific criteria or principle. While supervising, government officials have to depend entirely on the NGO officials as they are the field level implementers. “Usually the NGOs become the hosts of government officials during their field visits. They offer them sumptuous dinner and sometimes accommodation. As a result, the officials have to be satisfied with the performance report of NGOs as presented to them,” informed a government official. Through this kind of supervision, in most of the cases, the GOB officials fail to obtain the real picture of the performance of the programme.

- **Faulty Selection of NGOs**

Selection of NGOs, the key implementers at the field level, was faulty. The selection was allegedly biased by personal choices or connections of the politicians at the central level. In most cases these NGOs lacked the required manpower and expertise to carry out their training and social mobilization responsibilities. “One NGO called ‘Proshika’ was withdrawn from the programme due to political reason though it was doing well,” commented an NGO official. Due to the inexperienced NGOs involved, the program suffered many setbacks. For instance, in 2003, the NNP started and served one-year contracts to the partnering NGOs. The program was started in October and all the preparations including training of field level implementers were supposed to be finished within six months. But the preparatory stage continued to exist till June and the contract with NGOs was to be terminated in October. In the remaining four months a major portion of the fund was left unspent. As a result, two months extension was made. Afterwards, the contract was extended for another six

months. Thus the program (both BINP and NNP) runs in a piecemeal basis. Due to these sorts of mismanagement, in many times the programme runs with the unspent money. This produces (or produced during BINP) uncertainty, affecting dedication and commitment of the partners. The underlying cause of this problem has/had been indecision / irregularities in appointing / selecting NGOs. Some NGOs didn't have any prior experience in implementing nutrition program. Inefficiency and inexperience of the implementing NGOs largely contributed to the poor performance of BINP. "In some cases, due to inexperience, NGOs finished 21 day training in 14 days and in the end, produced fabricated evaluation report", informed a government official during interview. There was also a lack of commitment among the small NGOs. "These NGOs were more interested for personal gains than serving the community" alleged the official.

- **Government is over dominant**

True partnership approach does not exist in nutrition program. Wide-ranging control of government over the implementing NGOs affected the program performance. NGOs had some flexibility while working under BINP but under NNP, NGOs have to work under the strict control of government. As a result, the NGOs face problems in their operations. For instance, "BRAC wanted to provide Ante Natal Care (ANC) under nutrition program as it is very much related to it but government didn't agree. Due to such lack of flexibility, BRAC believes it couldn't produce a satisfactory performance in nutrition," informed a BRAC official during interview.

- **Clumsy Partnership**

Partnership arrangement was rather clumsy. As multi parties were involved in the local level nutrition management committees, the problems couldn't be resolved immediately. For instance, dropouts of CNPs couldn't be replaced by the implementing NGOs. The government and NGOs did recruitment of CNO and CNP jointly through the nutrition management committees. Recruitment of CNO, CNP was a complicated procedure. For recruiting CNO/CNP village nutrition management committee has to put forward recommendation, which has to be scrutinized by the union committee and then to be approved by the upazila level committee.

All these factors have made partnership in nutrition challenging. Despite very slow progress in improving the level of nutrition, the programme has a success in community mobilization and participation in the programme.

5. Lessons Learnt

It's a continuing challenge for the health sector to find optimal means for harnessing the strengths of all the sectors in ways, which will best address priority needs. Learning lessons from the existing partnerships is the simple and straightforward means of identifying the best opportunities and avoiding the weaknesses. Present study offers two sets of learning: factors that contribute to the success of partnership and factors that contribute to make partnerships difficult and challenging.

Partnership in EPI produced outstanding achievements. By virtue of partnership, the country has achieved near universal coverage in immunization. In mid eighties EPI turned into a social movement where all the relevant actors extended all-out cooperation and support to the program. The root of all these efforts was strong commitment of government and effective partnership among all the relevant actors. In EPI, partners had a sense of ownership; all partners were equally respected and valued. As a result all tried to produce the best result. NGOs particularly BRAC contributed a lot to the success of the program. Strong commitment of government and donors and its associated impact on resource availability and managerial efficiency was the underlying reason for the overall success. Strong commitment of government involved all the partners meaningfully and systematically into the program. From this model of partnership following lessons can be learnt:

- Partnership with all the relevant actors: government (all the relevant ministries), NGOs, private sector, and the community is crucial to the success.
- Strong commitment at all levels of government can make a program successful.
- Smooth flow of resources is a prerequisite to the success of partnership.
- Active involvement of local government can play an effective role in community mobilization and in ensuring efficient service delivery.

- Training, strong supervision and monitoring by all the partners is a key to the success of partnership.
- Communication among the partners leading to a strong sense of ownership, mutual trust and respect are significant concerns for the success of partnership.
- Role of each partner was clearly laid out which prevented from raising any confusion.

Partnership in nutrition couldn't produce a satisfactory result. In this partnership, government has failed to provide a well-defined program outline due to the excessive compliance to donor' prescriptions. Frequent changes in program direction and the associated irregularities in fund disbursements made the partners less committed and less directed to attain the program goals. Moreover, many inefficient NGOs were made the partners. NGOs were also not comfortable enough with the partnership due to excessive control of government.

From the challenging model of partnership in nutrition the following lessons can be learnt

- Lack of commitment of government as well as the implementing NGOs affects the success of partnership.
- Frequent changes in the program direction and irregularities of the programme coupled with discontinuity of the flow of fund are detrimental to the success of partnership.
- Faulty selection of partner NGOs leads to inefficiency in program implementation.
- Excessive control of government over the partners is detrimental to the core philosophy of partnership.

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