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**South Asia Human Development Sector**

**Bangladesh**

# NGO Contracting Evaluation for the HNP Sector in Bangladesh

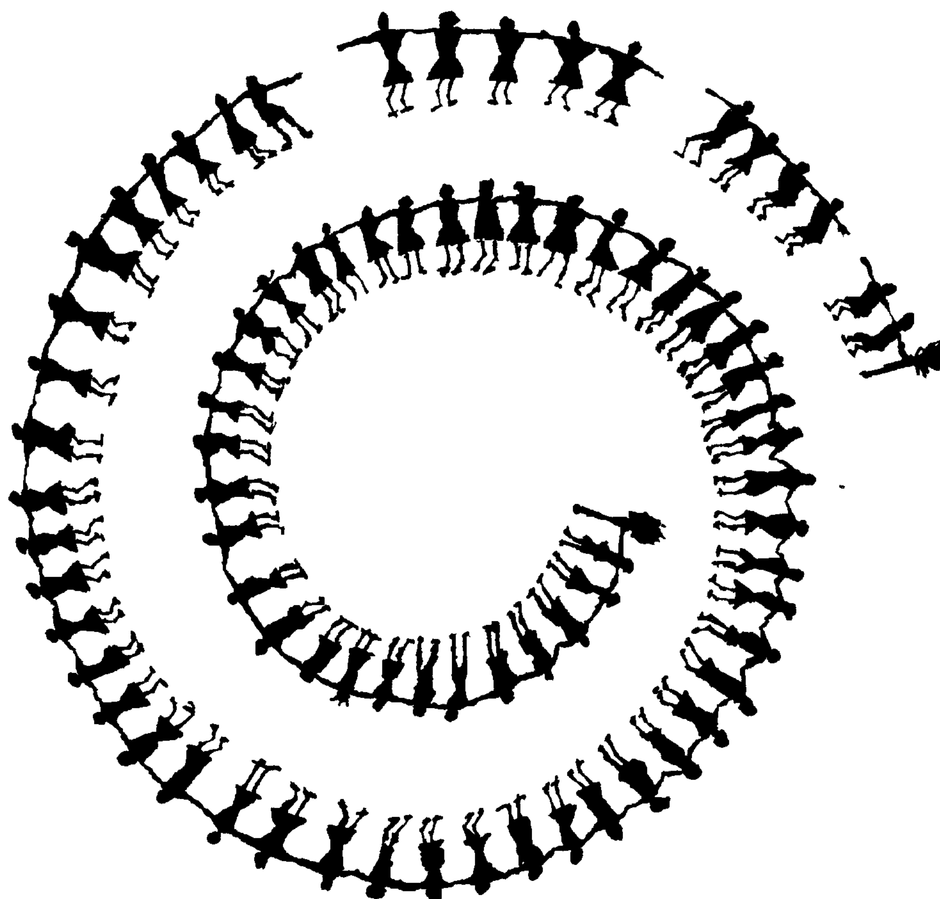
## Evidence and Policy Options

Rafael Cortez

May, 2005

The World Bank

Public Disclosure Authorized



**Discussion Paper Series**

# Bangladesh

# NGO Contracting Evaluation for the HNP Sector in Bangladesh

## Evidence and Policy Options

**Rafael Cortez**

Human Development Unit
South Asia Region

**May 2005**

THE WORLD BANK

## DISCLAIMER

The findings, interpretations and conclusions expressed in the paper are entirely those of the author(s), and do not represent views of the World Bank, its Executive Directors, or the countries they represent.

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*It is not possible to fully ensure health services for a large number of people of the country by the lone efforts of the government with limited resources. The government in its national plan [HNPSP] has put stress on the initiative and massive role of private sector individuals and initiatives, private development organizations, and voluntary institutions, alongside the government efforts to overcome the shortcomings.*[1]

**H.E. Begum Khaleda Zia**
**Prime Minister**
**Government of the People's Republic of Bangladesh**

[1] Private Sector Participation in the Health Sector, *The Independent*, July 11, 2004, pp. 14-16.

# ACRONYMS

| | |
|---|---|
| ADB | Asian Development Bank |
| AIDS | Acquired Immune Deficiency Syndrome |
| BOD | Burden of Disease |
| BINP | Bangladesh Integrated Nutrition Project |
| BMA | Bangladesh Medical Association |
| BPHC | Bangladesh Population & Health Consortium |
| BRAC | Bangladesh Rural Advancement Committee |
| CBO | Community Based Organization |
| CC | Community Clinic |
| CCIPC | Community Clinic Program Implementation Committee |
| CCMG | Community Clinic Management Group |
| CEO | Chief Executive Office |
| CMSD | Central Medical Stores Department |
| CNP | Community Nutrition Promoter |
| DFID | Department for International Development (UK government) |
| DP | Development Partners |
| DOT | Directly Observed Treatment |
| EOI | Expression of Interest |
| DSP | Diversification of Service Provision |
| ESP | Essential Services Package |
| GFATM | Global Fund for AIDS, TB and Malaria |
| GOB | Government of Bangladesh |
| GTZ | German Technical Cooperation Organization |
| HAPP | The HIV/AIDS Prevention Project |
| HAIF | HIV/AIDS Innovation Fund |
| HD | Human Development |
| HIV | Human Immunodeficiency Virus |
| HLSP | Health and Life Science Partnership |
| HNP | Health, Nutrition & Population |
| HNPSP | Health, Nutrition and Population Sector Program |
| HPSO | Health Program Support Office |
| HPSP | Health & Population Sector Program |
| IDA | International Development Association |
| JICA | Japan International Cooperation Agency |
| M&E | Monitoring & Evaluation |
| MDG | Millennium Development Goals |
| MIS | Management Information System |
| MOE | Ministry of Establishment |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| MOHFW | Ministry of Health and Family Welfare |
| MOLGRD&C | Ministry of Local Government, Rural Development and Cooperatives |
| MOP | Ministry of Planning |
| MOU | Memorandum of Understanding |
| MSA | Management Support Agency |
| NAAH | National Accreditation Agency for HNP |
| NAB | NGO Affairs Bureau |
| NDF | Nordic Development Fund |
| NGO | Non-Government Organization |
| NHA | National Health Accounts |
| NICARE | Northern Ireland Health and Social Services |
| NIPHP | National Integrated Population and |

| | |
|---|---|
| | Health Program |
| NNP | National Nutrition Project |
| NPRC | Not-for-Profit Registered Company |
| NSDP | NGO Service Delivery Program |
| OD | Operational District |
| OPD | Out Patient Department |
| PA | Physical Assessment |
| PHC | Primary Health Care |
| PHD | Partners in Health and Development |
| PIU | Project Implementation Unit |
| PKSF | Palli Karma-Sahayak Foundation |
| PM | Prime Minister |
| PMA | Performance Monitoring Agency |
| PME | Performance Monitoring Entity |
| PMU | Project Management Unit |
| PO | Partner Organizations |
| PPP | Public Private Partnership |
| PSO | Program Support Office |
| QA | Quality Assurance |
| SCUSA | Save the Children USA |
| SDF | Social Development Foundation |
| SHAPLA | Strengthening Health and Population for the Less Advantaged |
| SNP | Strengthening Nursing Project |
| TA | Technical Assistance |
| TB | Tuberculosis |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Fund for Population Assistance |
| UNICEF | United Nations Children's Fund |
| UPHCP | Urban Primary Health Care Project |
| USAID | United States Agency for International Development |
| WB | World Bank |
| WHO | World Health Organization |

## Executive Summary

Throughout the world, governments are moving from being exclusively service delivery organizations and toward improving their public health sector management and stewardship capacity. To diversify service provision, the Bangladesh Ministry of Health and Family Welfare (MOHFW) is striving to develop its capability to become active service purchasers in partnership with NGOs and private (for-profit) providers.

Contracting has become a sustainable strategy to diversify health care service provision. Contracting provides greater emphasis on outputs and results, increased autonomy allowing providers to respond quickly to evolving situations, and more flexible working arrangements and incentives for staff and providers to achieve social targets. Since implementation risks exist, it is essential to design policy strategies to overcome those risks.

Potential contracting risks may include: cost overruns in the absence of specific well-defined services; payment mechanisms creating prejudicial reactions of providers who seek to maximize their benefits; and a weakening of capacity to regulate services leading to less desirable quality standards.

This study was designed to assist the MOHFW in its future decision to scale up the commissioning of NGOs and the private sector to deliver HNP services, and to provide guidance to the World Bank in the preparation of the next IDA credit support for the Bangladesh Health, Nutrition and Population Sector Program (HNPSP). A great deal of effort has been made to improve our understanding of the political economy of change related to the diversification of health care provision, and to take into account possible related repercussions, particularly with a focus on the sequencing and timing of the process.

This study has been developed in the context of a sector wide approach for the HNP sector and an overall GOB strategy. It includes targeting mechanisms, private investment promotion in underserved areas, interventions where private sector has comparative advantages to complement public service delivery, more effective management in quality control and response to client needs, and outcome evaluation and regulation.

The report includes an examination of contractual provisions for alternative contracting options that are currently used in the HNP sector to procure NGO services, and also proposes a set of criteria to assess these provisions, taking into consideration equity goals and financial sustainability concerns. An analysis was done to assess the performance of various NGO contracting modalities with regards to the bidding and selection process, flexibility of decision-making, monitoring and supervision, quality assurance, NGOs in the Bangladesh HNP sector are also mapped and classified to indicate the services that NGOs are currently providing.

This review has identified a number of potential areas where improvements might be made, together with suggested actions for future contracting arrangements. For example, there is widespread lack of performance monitoring or incentives for good provider and NGO staff performance. Furthermore, the NGOs have limited understanding about the importance of service provision with regards to professional liability, enhancement of efficiency, financial sustainability and management oversight.

The lesson learnt for contracting HNP services is that key guidelines need to be followed to reduce the likelihood of incurring system losses and to ensure smooth delivery

of services to the poor. The main criteria for contracting include: (a) competitive bidding to select the NGO providers; (b) social accountability through community participation; (c) accreditation systems; (d) performance monitoring/accountability; (e) effective payment mechanisms; (f) retention of user fees; (g) link between performance and payments; (h) staff and provider incentives; (i) training; (j) past performance regarding project/program implementation; (k) the maturity and strength of the management information system (MIS); (l) fiduciary arrangements; (m) methods to improve equity, access and financial sustainability; (n) capacity of the accounting system; (o) measures of cost-effectiveness and efficiency; and (p) overhead and administrative costs and provisions.

By evaluating several NGO contracting modalities, we were able to define some pre-conditions for a successful contracting process in the near future. The findings suggest various legal and institutional issues that can enhance NGOs' performance. The recommendations include the establishment of a private institution, a Management Support Agency (MSA), to manage the contracting, monitoring and financing of non-government and private providers. The MSA would lead the process of contracting, assisted by other accreditation, supervision and consumer rights agencies.

The proposed contracting arrangements include the MOHFW engaging through an international competitive process a Management Support Agency to diversify service provision. The MSA would be responsible for deciding what services to contract out, from whom to purchase HNP and HNP related services, defining the contract payment option, negotiating the terms of the contract with the selected provider, monitoring the performance of the contracted provider, modifying contracts based on performance, and promoting the formation of public and private health networks at the union level. Special financial management and disbursement arrangements will need to be made for this agency, including a special account to administer the funds dedicated to the diversification of service provision.

The main finding from this study is that contracting out HNP services should be adopted when society will benefit. This study explores a number of options to achieve this objective and proposes the establishment of contracting arrangements with features that enhance transparency and improve performance, thus providing a sustainable solution for service provision in the medium as well as the long term.

## Introduction

### Objectives

This study was designed to assist the MOHFW in its decision to scale up the diversification of HNP service provision, and to provide guidance to the World Bank in the preparation of the next IDA credit support to the Bangladesh Health, Nutrition and Population Sector Program (HNPSP). A great deal of effort has been made to improve our understanding of the political economy of change related to the diversification of health care provision, and to take into account possible repercussions, particularly in the sequencing and timing of the process.

The report reviews local and international NGO contracting experiences to examine what works and what does not. NGOs operating in the HNP sector in Bangladesh are mapped and classified to indicate the services they currently provide. In addition, the study examines existing NGO contractual provisions to assess possible contracting arrangements the government can adopt to work effectively with NGOs and the private sector. It also proposes a set of criteria to assess these provisions, taking into consideration equity goals and financial sustainability concerns. Finally, the study's main goal was to recommend strategies for formulating an efficient and sustainable institutional arrangement to contract non-government providers to deliver HNP services to the poor.

### Situation Analysis

The Ministry of Health and Family Welfare's (MOHFW) Strategic Investment Plan (SIP) 2003-2010 includes the policy decision to diversify service provision by means of NGO and private sector services. The MOHFW acknowledges that the diversification of service provision and increasing the stewardship role of the government are complementary to achieving its objectives. The first objective being to strengthen and expand the framework for contracting non-public providers with public funding from the GOB and the pool financiers to increase the provision of HNP services in poor underserved areas. The second objective is to build the MOHFW's stewardship function, which includes improving the quality of care provided by non-public providers directly to protect the interest of users; stimulating competition in the provision of HNP services; and promoting training to improve the functioning of the private sector. In sum, the overall objective of the GOB is to support building national health capacity to deliver HNP services effectively and efficiently to all its citizens, particularly the poor.

The GOB acknowledges that the diversification of service provision through contracting-out non-public providers can yield many important outcomes. First, access to health care services can be extended to a larger share of the poor and populations at risk. Second, coverage provided by public health facilities can be complemented by the comparative advantages of non-public providers. Third, contracting with NGOs can improve service quality and efficiency with particular attention to the needs of the poor, as has been demonstrated in other countries in the region, e.g., Cambodia and Laos,[1] Fourth, private providers can focus their attention on priority public health programs with incentives embodied within a contractual framework.[2] Fifth, diversification can address specific tasks for which the government lacks capacity. Sixth, contracting can provide greater incentives and compensation to health workers to improve their job performance as well as the quality of service delivery to poor and vulnerable users who lack access to care.[3] Finally, private providers focus more on outputs and results.

The public system for health services

provision is grossly inefficient.[4] It breeds low productivity, and a lack of responsiveness and accountability. The 2003 Service Delivery Survey found that only 10 percent of households used the public sector services for treatment (a drop from 13 percent in 1999). The non-public sector (including NGOs) accounted for about 49 percent usage by households. A recent survey of Bangladeshi public health facilities reveals a doctor absenteeism rate of over 42 percent, with the absentee rate of doctors at the rural primary health facilities (i.e., the Upgraded Family Welfare Centers) even higher at 74 percent.[5] User satisfaction with health services is fast emerging as a key issue in the sector as well. Only 54 percent of service users expressed satisfaction with the overall service received from public providers compared to 88 percent of users who are satisfied with the services of private (for-profit) and NGO providers.[6]

The poor are inadequately reached by the public sector. The richest 10 percent of the population are the largest beneficiary group, using 16.4 percent of the public health facilities expenditure, while the poorest 10 percent account for only around 7.8 percent. In comparison, at NGO health facilities the poorest 10 percent of the population use about 14 percent and the richest 10 percent use about 11 percent of the NGO expenditures respectively.[7]

The public sector's insufficient performance along with users' growing dissatisfaction with government health services warrant increased efforts to find alternatives to direct government provisioning. This will require the government to move away from its traditional role as a service provider and to adopt more of a stewardship role for the entire sector. Contracting provides a method for the government to exercise the role of steward, and to purchase services in an orderly and disciplined way.[8] It may also serve as an important tool to harness private sector resources and contracting promotes better planning, resulting in greater efficiency and improved quality. As McCombs and Christianson (1987) observed, contracting is a means for government to introduce market mechanisms---competitive bidding, financial incentives and performance measures---without sacrificing the provision of essential public health services and protecting the needs of the poor and vulnerable. Moreover, contracting allows for greater flexibility and more autonomy for providers to respond to changing conditions faster and to explore innovative methods. Nevertheless, contracting is by no means a panacea. Contracting has inherent challenges associated with accountability, transparency, monitoring and evaluation, as well as the implementation of cost-effective interventions. The diversification of service provision through contracting is a complex process. It requires substantial government and provider capacity and an enabling environment to forge and sustain partnerships between the public and the private sector to improve coverage of quality services for the poor.

**Method**

Several field instruments were utilized to obtain information from users and personnel, and about facility characteristics. Key NGOs working under four contracting models were selected, and a semi-structured guideline was designed for conducting in depth one-to-one discussion with NGO managers and public officials. To assess the NGO models, the survey team visited 53 health centers of the 16 selected NGOs to gather information from facility personnel about their opinions on service delivery and the NGOs' practices (173 interviews), as well as client opinions (1,224 interviews). See Annex 1 for the exit interview with clients, NGO facility surveys, interviews with NGO facility personnel, and surveys with NGO managers and partners. The survey team held focus group discussions with 93 public officials, health professionals and NGO managers. Household, income, and expenditure surveys

were used to describe results of benefit incidence analysis. To evaluate NGO performance, i.e., perceived quality, technical quality, price, accessibility and cost relative to the public and private sector providers at the *upazila*[9] level, a sample of 50 facilities (public and private providers) were used. Data was collected through the following nine instruments: facility survey (1) exit poll outpatients, (2) exit poll inpatients and direct observation of (3) antenatal care, (4) ARI (5) hypertension, (6) Normal Delivery (7) C-Section, and (8) severe diarrhea for public, and (9) severe diarrhea for private providers. See Annex 3 [10]

**Content of the Study**

This report is divided into four chapters. Chapter 1 is an overview of the current role of NGOs in the Bangladesh health sector and maps the NGOs HNP service provision. Chapter 2 reviews the lessons learnt from the national NGO contracting experiences.

Chapter 3 describes the performance of selected NGO contracting models and draws lessons learnt using specific criteria related to legal framework and governance aspects, bidding and selection process, flexibility of contracts, supervision and regular monitoring and evaluation, service quality, the accessibility of the poor to services, user satisfaction, opinions of NGO facility personnel, etc.

The findings of the comparative advantage analysis are shown for NGOs, public and private providers at the *upazila* level in terms of quality, cost, pricing and accessibility. The primary source of information for this task consists of a sample of 50 facilities.

This chapter also presents policy options for public and private partnerships, specifically with regards to what to do and how to do it to move forward on strengthening the government's stewardship role and on publicly financing the NGO and private sector to promote diversification of HNP service provision.

Finally, Chapter 4 presents the conclusions and recommendations.

# Chapter 1. Role of NGOs in HNP Service Delivery in Bangladesh

*This chapter is an overview and maps the NGOs in the HNP sector in Bangladesh with regard to NGO financing and expenditures, staffing, type of services and quality, as well as the capacity of NGOs to provide services to the poor.*

## 1.1. Mapping NGO Activity in Bangladesh

About 769 NGOs worked in the Bangladesh HNP sector from 2003-2004. The number of NGOs has been increasing at a relatively rapid pace over the past few years. Table 1.1 shows the distribution of NGOs by Bangladeshi Divisions. About 70 percent of all Thanas have NGOs involved in HNP activities.[11]

The contracted manager model, such as the NSDP and the BPHC, operates in a large number of Thanas: the NSDP in 223 and the BPHC in 63 Thanas respectively. Both the National Nutrition Project (NNP) and the Urban Primary Health Care Project (UPHCP) are examples of the direct GOB control model covering 206 Thanas in 2004.[12]

**Table 1.1. Number of Thanas with at Least One NGO Working in the HNP Sector**

| DIVISION COVERAGE | NUMBER OF THANAS | NUMBER OF THANAS WITH NGO ACTIVITIES | PERCENT COVERAGE |
|---|---|---|---|
| Dhaka | 134 | 114 | 85.1 |
| Chittagong | 93 | 59 | 64.4 |
| Rajshahi | 127 | 84 | 66.1 |
| Khulna | 63 | 44 | 69.8 |
| Barisal | 38 | 16 | 42.1 |
| Sylhet | 35 | 33 | 94.3 |
| TOTAL | 490 | 350 | 71.4 |

Source: An Evaluation of NGO contracting in Bangladesh: Contracting NGO for the delivery of health services, AUS Health International in association with ADSL. Report commissioned by the World Bank, November 2004.

## 1.2. NGO Profile in the HNP Sector

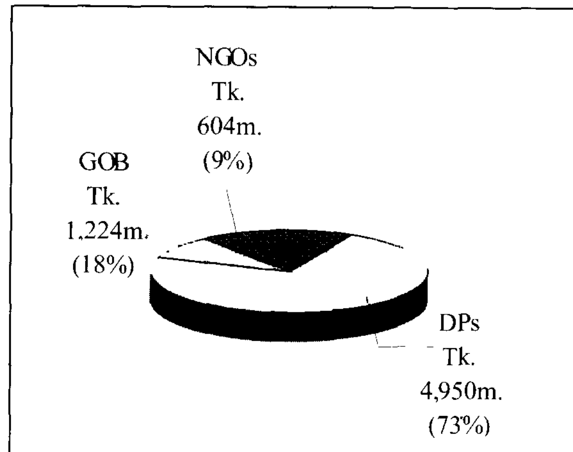
### *1.2.1. NGO Financing and Expenditures*

#### Financing

The increase in NGO service delivery funded by direct DP financial support and public sources has been in response to the need to improve the quality of HNP service delivery, particularly in poor underserved areas.

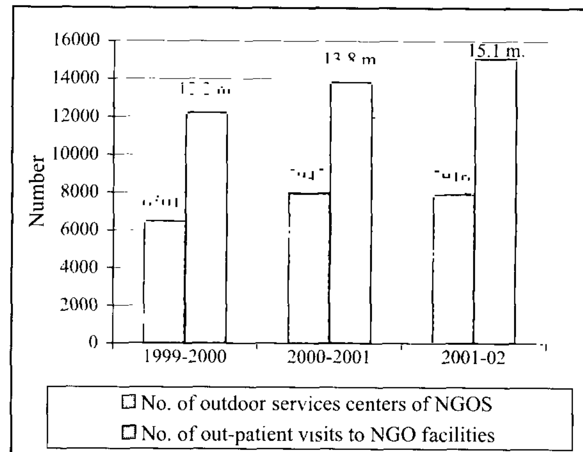
The NGOs average annual expenditure on HNP activities is estimated at US$125 million (equivalent to 8.4% of the total health expenditures), of which DP financed 73%, the GOB 18% and NGOs own resources 9% (Figure 1.1).[13] The current NGO expenditure represents an increase from the 6% of total health expenditures registered by the Bangladesh National Health Account in 1996-1998 (NHA-1).

**Figure 1.1. NGO Funding of HNP Expenditures by Source, average for 1999-00 and 2001-02**




Source: Bangladesh National Health Accounts 1999-2001, HEU, MOHFW, 2003.

**Figure 1.2. No. of NGO Outdoor Service Centers and No. of Out-Patient Visits to NGO Facilities**




Source: Bangladesh National Health Accounts 1999-2001, HEU, MOHFW, 2003

## Expenditures

The number of out-patient visits to NGOs increased from 12.2 million in 1999-2000 to 15.1 million in 2001-02, while the number of NGO outdoor service centers increased from 6,501 to 7,947 over the same period (Figure 1.2). The bulk of the NGO's clients are women and children.[14] Out-patient services account for on average 41 percent of the HNP expenditures of NGOs. On average about 90 percent of the outdoor services are provided by small and medium NGOs.

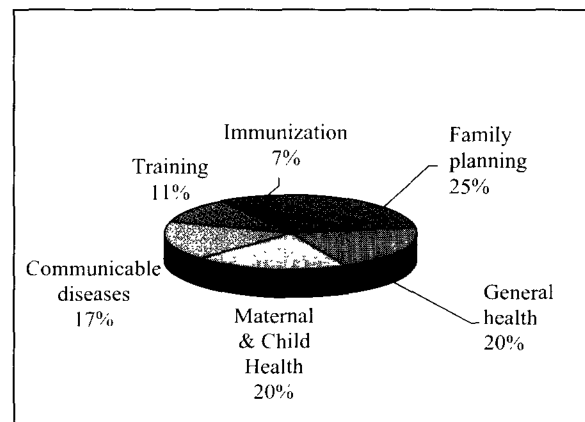
## Fees

The facility questionnaire[15] includes health center managers' reporting on the percent of clients exempted from fee payment. Family planning (permanent method) and child immunization show the highest degree of exemptions. More than 80% of individuals receiving permanent family planning method are exempted from payment. NGOs also exempt a significant number of clients for general consultation services. Both the UPHCP and NSDP-BPHC NGOs reported exempting about 50% of clients from payment for general consultation and about 20% for specialized consultation. The exemption rates are lowest for normal and c-section deliveries, with NGOs charging between Tk.275 to more than Tk.2,000 for a normal delivery and Tk.4,000 to Tk.6,000 for a c-section.

### *1.2.2. Type of Services and Mode of Delivery:*

From 1999 to 2001, NGOs concentrated their expenses in a few key areas of healthcare. Family planning had the largest share of expenditures with 25%, followed by general health (20%), maternal and child health (20%), communicable diseases (17%), training (11%) and immunization (7%) (See figure 1.3). However, NHA-2 estimated that the very large NGOs provided 59% of the NGOs activities.[16]

**Figure 1.3. Average HNP Expenditure of NGOs by Area of Healthcare, for 1999-00 and 2001-02**




Source: Bangladesh National Health Accounts 1999-2001, HEU, MOHFW, 2003.

NHA-2 also describes the major modes of NGO

service delivery. Their services are distributed as follows: 45% community-based public health service delivery, 41% outpatient services. Inpatient services and training account for only 3% and 11% respectively.[17]

### *1.2.3. Equipment and Drug Availability*

The 2004 NGO facility survey, carried out for this study, found that about a third of all health centers reported having all the basic equipments and supplies. Another 60% had almost all the essential items listed in the questionnaire. Almost all health centers reported having needles and syringes, functional sterilizer and fridge. About a third of the health centers reported that they did not have vaccines in stock.

**Table 1.2. Percent of NGO Health Centers Reporting Availability of Various Equipment, Drugs and Supplies in the Center**

| Availability category | Basic equipment and supplies | Vaccines available | Oral drugs (out of 13) | Injectable drugs (6) |
|---|---|---|---|---|
| None | 0 | 28.1 | 0 | 18.7 |
| Less than half | 9.4 | 9,4 | 0.0 | 15.6 |
| More than half | 59.4 | 0.0 | 81.3 | 40.6 |
| Have all items | 31.2 | 62.5 | 18.7 | 25.0 |

Source: NGO Facility Survey 2004 (AUS Health International with ADSL Bangladesh).

About 19% of health centers reported having all 13 basic drugs; 80% had almost all the drugs. Among the health centers surveyed, only 25% reported having all the injectable drugs, and 19% did not have any of the drugs listed in the survey questionnaire (see Table 1.2). The availability of various equipment, supplies, drugs and vaccines is positively associated with the facility size. The average availability score for drugs (percent of drugs in stock) increases with the number of services delivered from the health center.

### *1.2.4. Quality of Health Care Services*

Excluding the specialized health and nutrition centers, the number of clients interviewed for the survey was 817, of which 77% were female. Most of the male clients visiting the health centers were children. In the exit interview, 57% of the clients were from urban areas (excluding the exit interviews conducted in NNP nutrition centers). Of the clients interviewed, 64% were married and 32% were never married, again indicating the emphasis the health centers place on mothers' and children's health.

Table 1.3 reports the type of service the interviewed clients received on the day of the 2004 NGO facility survey. The most important type of service provided by the health centers, in both rural and urban areas, was adult health services. In rural areas, adult health services are relatively more important than in urban areas. Maternal care and women's health are the second most important category of services delivered. Child health related services are not as important as expected in rural areas. Only about 16% of services are child health related; whereas in urban areas it is about 23% of the total. In both rural and urban areas, family planning services accounted for about 10% of all services used by the clients in NGO health centers.

**Table 1.3. Distribution of NGO Services Received on the Day of Interview as Reported by Clients**

| Type of service | Rural health centers | | Urban health centers | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Family planning | 37 | 10.6 | 50 | 10.7 |
| Maternal care | 91 | 26.0 | 120 | 25.7 |
| Women's health | 21 | 6.0 | 43 | 9.2 |
| Curative Child Health | 43 | 12.3 | 45 | |
| Preventive child health | 14 | 4.0 | 65 | 13.9 |
| Other adult health | 141 | 40.3 | 139 | 29.7 |
| Accident | 2 | 0.6 | 5 | 11 |
| Others | 1 | 0.29 | 0 | 0 |
| Total | 350 | 100 | 467 | 100 |

Source: NGO Facility Survey 2004 (AUS Health International with ADSL Bangladesh).

In general, users' satisfaction is at a relatively acceptable level; few users show a low level of satisfaction with NGO services (Table 1.4).[18]

In rural health centers, about 77% of patients received a prescription, while in urban areas the

proportion was about 81% (Table 1.5). The patients interviewed were also asked to rate the quality of service received from the health center on the day of the visit, and the results are very positive. The exit interviews show that the NGO facilities tend to specialize in maternal and women's health and child illnesses, the priority services for NGO primary health care delivery system. Most of the users reported that they were happy with the types of services provided, and the services they received met their health care needs.

Most of the NGOs charge some fee for the provision of services. In our sample of clients from rural areas, 30% said that they did not pay any money for the services they received. In urban areas, the proportion receiving free services was much lower, only about 18%. Availability of drugs in the health center is often considered an important factor affecting utilization of health centers. Fifty-four percent of rural and 29% of urban clients reported obtaining the drugs from the health centers they visited. It appears that not all NGO health centers have available the primary health care related drugs.

**Table 1.4. Exit Interview Related to Service Quality in NGO Facilities**

| Service related quality indicators | Best | | Medium | | Low | | Lowest | |
|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | Rural | Urban | Rural | Urban | Rural | Urban |
| Did you get all the services you expected? (%) | 46.6 | 50.1 | 49.4 | 45.0 | 3.1 | 4.5 | 0.86 | 0.43 |
| How satisfied are you with the service? (%) | 59.4 | 51.8 | 27.8 | 44.8 | 3.4 | 3.2 | 0.00 | 0.21 |
| How much of your needs were satisfied? (%) | 39.0 | 60.0 | 52.9 | 32.1 | 8.3 | 7.7 | 0.00 | 0.21 |

Source: Exit interview with clients, 2004 (AUS Health International with ADSL Bangladesh).

**Table 1.5. Provider Related Quality Measures as Reported by the Clients in NGO Facilities**

| Provider related questions | Rural area health centers | Urban area health centers |
|---|---|---|
| Provider spent enough time (%) | 93.1 | 97.0 |
| Provider asked questions (%) | 95.7 | 93.4 |
| Physical checkup done (%) | 76.3 | 51.4 |
| A prescription was given in writing (%) | 77.1 | 81.5 |
| Will recommend the health center | 96.8 | 96.2 |

Source: NGO Facility Survey 2004 (AUS Health International with ADSL Bangladesh).

### *1.2.5. NGO Staffing*

The total number of NGO staff is estimated at 21,000, which includes both part-time and full-time staff.[19] Labor incentives still seem to be a challenge. According to the interviews with facility personnel survey commissioned as part of this study (see Annex 2),[20] about half of the NGOs' personnel reported unhappiness with their salary and benefit levels, 40% questioned the level of workload, and surprisingly, only 26% of the staff interviewed said that their salaries are paid regularly on time. Another problem affecting labor performance is the limited capacity of NGOs to offer their staff a sustainable and attractive long-term career path. About a third of all personnel interviewed said that the growth potential within the organization was not good enough, and 26% said that the future potential was very bad. Despite these problems, most personnel scored the quality of the health facility very well, particularly in terms of equipment quality, facility cleanliness, treatment quality received by patients, and punctuality of personnel. On a scale of 0 to 10, the average score for equipment quality was 8.0, and cleanliness was 8.0. Most other aspects of quality, e.g., treatment quality, punctuality of personnel etc., received a score of 9.0. Overall the quality score does not vary significantly among various NGO facilities.[21]

All personnel mentioned that they work about 8.0 hours a day, six days a week. Service

providers in facilities operated by large NGOs reported working 70 hours per week, compared to about 46 to 47 hours per week for health care providers working for other NGOs. Senior staff members of large NGOs also work longer hours. Despite the higher workload of personnel working in facilities operated by large NGOs, the expected monthly salary levels reported were relatively lower for those personnel than other types of NGOs. On average, the medical doctors earn Tk.13,500 per month and the medical assistants and paramedics about Tk.8,200 and Tk.6,300 per month respectively. However, salary is not the only source of income for NGO health center personnel; about 46% reported that they receive additional payments from the NGO for their work. Few NGO personnel reported receiving any tips or gifts from patients.

For rural NGO health centers, the health care providers spend about 27 minutes traveling to the facility. For large NGOs, more than 80% of providers live within five miles of the health center but for other rural NGOs, about 57% reported living within a five-mile radius. Seventy percent of service providers in large NGO facilities reported that their families live with them in the local area. Among service providers in other NGO categories, 75% reported living with their family in the local area.

This study has not focused on how NGO and private sector staff are managed differently from those in the public sector, but it does provide relevant data on salaries, and opinions of staff from public and private providers in Annex 3.

**Table 1.6. Utilization of Curative Health Care Services by Provider Type**

| Type of facilities | Household categories by quintile of household per capita income | | | | | Total |
|---|---|---|---|---|---|---|
| | 1<br>Poorest | 2 | 3 | 4 | 5<br>Richest | |
| NGO (Codes 2,8) | 1.7 | 25.0 | 28.3 | 16.7 | 28.3 | 100 |
| Private clinic/ hospitals (Codes 7,9) | 14.5 | 17.0 | 19.0 | 22.2 | 27.4 | 100 |
| Public clinic/ hospitals (Codes 1,6) | 18.3 | 16.6 | 20.2 | 25.2 | 19.6 | 100 |
| Other sources (Codes 3,4,5,10,11) | 23.7 | 22.5 | 22.0 | 19.8 | 12.0 | 100 |
| Total | 19.20 | 19.7 | 20.6 | 21.30 | 19.2 | 100 |

Notes: Type of Facilities: 1 = Govt. Health Worker; 2 = NGO Health Worker; 3 = Homeopath; 4 = Ayurved/Kabiraji/Hekim; 5 = Other Traditional/Spiritual/Faith Healer; 6 = Govt. Doctor (Govt. Facility); 7 = Govt Doctor (Private Facility); 8 = Doctor from NGO Facility; 9 = Doctor from NGO Facility; 10 = Salesman of Pharmacy/Dispensary; 11 = Others.

Source: HIES 2000: Question 8 of Section 4 (Part A).

### *1.2.6. Equity*

Table 1.6 shows the utilization of curative services in Bangladesh based on the results of the household income and expenditure survey (national survey). Among the NGO service users, about 30% were from the poorest two income quintiles.

Of those using NGO facilities for medical care, about a third obtained medicines from the facility itself, whereas users of the public and private hospitals and clinics obtained their medicines from the facility at a rate of 22% and 2% respectively. A high proportion of users of NGO healthcare services did not pay for their drugs, compared to users of other providers' services. However, this exemption is not fully in favor of the poor.

Among the NGO facility users, only 30% of those who obtained free drugs belonged to the poorest 40% group. This proportion was lowest among the private facility users (19%) and highest among users of "other" types of medical care (59%). Average payments for those who paid for services were: Tk.416 for NGO, Tk.546 for private clinics, Tk.761 for

public clinics and hospitals and Tk.370 for others sources, with the lowest variation among users from public facilities.[22]

### *1.2.7. Monitoring and Supervision*

All the health centers reported to be open for six days a week and about eight hours a day, but vaccination services were available for only three days per week. One third of the centers provided child vaccination services every day. On average, the health centers were supervised quite intensively (at least 16 times in six months). Most of the visits were from the contracting agencies. However most of the NGO health centers' personnel mentioned that the number of visits was inadequate for proper functioning of the health centers. On average, the NGO health centers achieved more than 75% of their targets measured in terms of number of visits, while for adult health services, the target was exceeded by more than 80% (see Table 1.7).

Considering the health centers that reported the targets and actual delivery, the average achievement rate is almost 100% or more for all types of services.

**Table 1.7. NGO Performance: Average Target per Month, Actual Delivery in May 2000 and Target Achievement Rate in May 2004**

| Types of services | Target/Month | Actual/ Month | Achievement rate (%) |
|---|---|---|---|
| Child Immunization | 391 | 347 | 88.7 |
| Maternal Care | 520 | 396 | 76.2 |
| Family Planning | 783 | 599 | 76.5 |
| Curative Child Health | 384 | 307 | 79.9 |
| Adult Health services | 409 | 740 | 180.9 |

Source: NGO Facility Survey 2004 (AUS Health International with ADSL Bangladesh).

# Chapter 2. NGO Contracting Evaluation in the HNP Sector in Bangladesh

*This chapter is divided into three major sections. The first section reviews the lessons learnt from the national NGO contracting experiences and assesses several NGO experiences in ten broad areas. In the second section, four NGO modalities are assessed based on the findings of client exit interview and NGO facility survey, highlighting the strengths and weaknesses of those contracting models employed in Bangladesh. These modalities are compared in terms of facility characteristics, staff opinions, users' satisfaction and opinions, contract characteristics, and supervision and evaluation capacity. The third section provides new evidence on the comparative advantages of NGOs and public and private for profit providers. The results suggest that there could be potential benefits in contracting-out specific health interventions.*

## 2.1 Contracting Models in the HNP Sector of Bangladesh

### *2.1.1. The Options*

A review of contracting models used in recent years to involve NGOs in the delivery of the Essential Services Package (ESP) in Bangladesh has resulted in a list of at least nine related experiences. The first model is the basic government procurement approach and related procedures and guidelines for implementation, as defined by the GOB's Public Procurement Regulations (2003). The MOHFW and other ministries, including the MOF, follow these regulations when contracting with any entity to procure goods and services. Second, USAID has used contracting in many of its projects. USAID has used contracting to provide assistance directly to the public, especially the poor, using NGO service providers in the health sector and in many other social and development sectors. In the health sector, the consortium group NSDP has implemented the contracting process. Third, the World Bank is supporting the GOB's National Nutrition Project (NNP). The MOHFW is conducting the tendering process for this project. The contracting process took some time to be refined and necessitated additional capacity building within the MOHFW. Recent allegations of irregularities in the use of funds may however result in a reexamination of the actual capacity level of the GOB.

The fourth option recently has been developed to resolve the contracting problem faced by the World Bank financed HIV/AIDS Prevention Project (HAPP). Over fifteen months after credit signing, there was very little project implementation. The Bank therefore requested the GOB to contract with UNICEF to implement the project's NGO contracting component. With the assistance of PHD, UNICEF has screened over 554 expressions of interest (EOIs) for short-listing purposes, and has identified 90 NGO organizations. Those were reviewed at UNICEF's head office site using a physical assessment (PA) tool. The actual proposal assessment is currently ongoing, and contract negotiations were scheduled for completion in September/October 2004.

A fifth option includes the ADB contracts used since 1998 to implement its Urban Primary Health Care Project (UPHCP). This model represents some significant differences compared to other models currently in place. This project recently has been evaluated by RDP Medi Vision International.[23] The ADB is planning to follow this project with a second project known as UPHCP-2. The design process for that project is currently underway.

Sixth, the Global Fund has contracted with the international NGO Save the Children USA (SCUSA) to work with the NGO Bangladesh community to implement the large grant-funded HIV project. SCUSA had expected to sign contracts with NGOs by September 2004. Seventh, BRAC has implemented many NGO delivered services by collaborating with DP as a "break bulk" operation, combined with a monitoring and evaluation function. In addition, as a partner with smaller NGOs, BRAC often has managed service delivery in health and other human development (HD) sectors.

Eighth, PKSF has performed a contracting function in the micro-credit sector, and now believes it could perform a similar function in the health and social sector fields. It increasingly has played the role of a financial intermediary for DP in the micro-credit field, especially since 2002 when it began implementing the poverty alleviation project supported by the IDA credit. PKSF follows very strict guidelines when preparing a short list of NGOs with whom it plans to work. These criteria include: (a) the basic characteristics of the NGO organization; (b) information regarding the organizer or founder of the NGO; (c) characteristics regarding the management processes and the Chief Executive Officer (CEO); (d) the personnel, including their technical and organizational skills; (e) the state of the physical plant and space (working area); (f) the NGO's field activities to mobilize the community's resources; (g) a review of past performance regarding project/program implementation; (h) the maturity and strength of the management information system (MIS); and (i) the capacity of the accounting system. Some or all of these characteristics are employed by one or more of the possible models to determine whether an NGO would be able to perform its contracted obligations. The most unique feature of this set of guidelines is the incorporation of an assessment of the past performance criterion.

Finally, DFID has worked with NGOs through at least three modalities during the HPSP period. These options were: (a) Partners for Health and Development (PHD) (formerly known as BPHC); (b) HLSP through the SHAPLA project; and (c) NICARE through the implementation of the public private partnership (PPP) project. They all used DFID contracting guidelines for crafting the agreements with the NGOs with whom they worked during the implementation of the HPSP period, from 1998 to 2003. NICARE has obtained a no-contract extension to further implement a unique NGO arrangement with local community groups in the delivery of the ESP.

This study identifies ten broad areas that are essential for assessing the performance of NGO contracts. Within these ten categories, forty-eight specific criteria have been identified. The ten areas of assessment include: (a) payment mechanisms, (b) fiduciary arrangements, (c) performance monitoring/accountability, (d) financial management reporting and accountability requirements, (e) dispute resolution procedures/processes, (f) management of facility staff, (g) performance incentive specifics clearly articulated, (h) equity in access to services and financial sustainability, (i) measures of cost-effectiveness and efficiency, and (j) overhead and administrative costs and provisions. To highlight the strengths and weaknesses of current contracting models employed in Bangladesh, these ten categories were used. A summary of the assessment of the nine contracting options previously defined and discussed is presented in Table 2.1.

**Table 2.1. Assessment of Various Contracting Models Used in the Bangladesh HNP Sector, 2004**

| | Contract Assessment Criteria | POTENTIAL CONTRACTING OPTIONS USED IN BANGLADESH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1. GOB/MOH FW/ MOF | 2. USAID | 3. WB/NNP/M OHFW/ MOWCA/ BRAC | 4. WB/HAPP/ UNICEF | 5. ADB/ UPHCP/MO LGRD&C | 6. GLOBAL FUND/ Save The Children USA | 7. PKSF | 8. BRAC | 9. DFID/SHAP LA/ NICARE |
| I. | Payment Basis and Mechanisms | | | | | | Note 19 | Note 17 | | |
| | 1. Fee for Service System (FFS) | no | allows | no | No | allows | no | NA | no | not stated |
| | 2. Prepay Capitation | no | no | no | No | no | no | NA | no | no |
| | 3. Fixed Amount | generally | yes | yes | yes | yes | generally | NA | yes | yes |
| | 4. Combination | no | yes | no | No | no | no | NA | no | no |
| | 5. Bonuses Paid for Meeting Performance Targets | not generally | yes | no | No | yes | ? | NA | no | possible |
| | 6. Payment Frequency | per schedule. | generally qtrly | per schedule | qtrly | qtrly | mthly/qtrly | per schedule | mthly | qtrly |
| | 7. Payment Linked to Performance Reporting? | not generally | no/financial reporting | no | No | yes | no | NA | can be | yes |
| | | | | | | | | | | |
| II. | Fiduciary Arrangements and Accountability | | | | | | | | | |
| | 1. Board Functions & Responsibilities | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria |
| | 2. Meeting Frequency | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria |
| | 3. Representation | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria |
| | 4. Number of Members | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria | in contract | SL Criteria | SL Criteria | SL Criteria |
| | 5. Conflict of Interest | yes | yes | yes | No | not stated | yes | no | not stated | not stated |
| | 6. Board Member "Compensation" | no | no | no | No | via bonus ? | no | no | unclear | not stated |
| | 7. Provision for Reporting to Stakeholders, Incl. Community | no | no | no | not in contract | possible/qtrly | no | yes | no | no |
| | | | | | | | | | | |
| III. | Performance Monitoring | | | | | | | | | |
| | 1. Report to Whom | GOB/MOHF W/N | NSDP/USAI D | GOB/MOHF W/NNP | UNICEF | PIO/ADB/M OHFW | SCF | PKSF/DPs/G OB | BRAC | NICARE |
| | 2. What is Reported | | fin/per | Note 14 | Note 15 | per/fin | Developing | per/fin | fin/per | fin/per |

**Table 2.1. Assessment of Various Contracting Models Used in the Bangladesh HNP Sector. 2004**

| | Contract Assessment Criteria | POTENTIAL CONTRACTING OPTIONS USED IN BANGLADESH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1. GOB/MOH FW/ MOF | 2. USAID | 3. WB/NNP/M OHFW/ MOWCA/ BRAC | 4. WB/HAPP/ UNICEF | 5. ADB/ UPHCP/MO LGRD&C | 6. GLOBAL FUND/ Save The Children USA | 7. PKSF | 8. BRAC | 9. DFID/SHAP LA/ NICARE |
| | 3. What is the Impact of Reporting | not stated | bonus/sanct | not stated | not clear | bonus/sanct | unclear | fin sus (Note 18) | sanct | pmt stop |
| | | | | | | | | | | |
| IV. | Financial Management, Reporting, and Accountability Requirements | | | | | | | | | |
| | 1. Frequency of Reporting | generally qtrly | mthly/qtrly | qtrly | qtrly | qtrly | mthly | per contract | mthly | Qtrly |
| | 2. Info Required | appendix | per budget | appendix | per budget schedules | Reg. Fin. state | Reg. Fin. state | Reg. Fin. state | Reg. Fin. state | Fin. State |
| | 3. Report to Whom Clearly Defined | yes | yes | yes | not totally clear | yes | yes | yes | yes | Yes |
| | 4. Independent Auditors Conduct Regular Audits | yes/yrly | yes | yes/yrly | possibility | yrly possible | yrly possible | yrly possible | yrly possible | possible |
| | 5. Funds Securely Distributed to NGOs | elect to Bank | yes | elect to Bank | elect to Bank | elect to Bank | yes | varies | by check | not stated |
| | 6. Cash Management Procedures (Secure & Transparent) | NA | yes | NA | not discussed | probably | yes | yes | unclear | not stated |
| | 7. Local Revenue Collection & Use is Managed Locally | no | yes | NA | NA | no | yes | yes | not stated | not stated |
| | 8. Regular & Timely Financial Reporting to DPs Required | yes | yes | yes | yes | yes | yes | yes | yes | Yes |
| | | | | | | | | | | |
| V. | Dispute Resolution Procedures/Process | | | | | | | | | |
| | 1. Use the Formal Legal System | no | no | no | no | no | no | unclear | unclear | No |
| | 2. Provision for Arbitration Process | yes, w/in GOB | not clear | yes | yes | yes | yes | unclear | unclear | Yes |
| | 3. Arbitration Process is Transparent & Clear. | yes | NA | yes | yes | yes | yes | unclear | no | Yes |
| | 4. Provision Made for Resolution of | unclear | no | unclear | no | Intent or Gr | yes | no | no | yes |

**Table 2.1. Assessment of Various Contracting Models Used in the Bangladesh HNP Sector, 2004**

| | Contract Assessment Criteria | POTENTIAL CONTRACTING OPTIONS USED IN BANGLADESH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1. GOB/MOHFW/ MOF | 2. USAID | 3. WB/NNP/MOHFW/ MOWCA/ BRAC | 4. WB/HAPP/ UNICEF | 5. ADB/ UPHCP/MOLGRD&C | 6. GLOBAL FUND/ Save The Children USA | 7. PKSF | 8. BRAC | 9. DFID/SHAPLA/ NICARE |
| | Professional Mistakes | | | | | Neg | | | | |
| | 5. Provision Made for Professional Liability Insurance | unclear | no | Required | no | NGO indemnify | yes | no | no | Yes |
| | 6. Provision for Staff Dismissal & Related Conflict Resolution | not stated | yes | yes | unclear | yes | generally | unclear | unclear | No |
| | | | | | | | | | | |
| VI | Management of Facility Workers | | | | | | | | | |
| | 1. Does Management Directly Work at the Service Facility | not stated | generally yes | unlikely | not stated | yes | not required | unclear | generally | not stated |
| | 2. Does Management Conduct Training & Retraining of Staff | not stated | not stated | yes | not stated | yes | if agreed to | unclear | yes | not stated/yes |
| | 3. Frequency of Worker payment | not stated | mthly | unclear | not stated | not stated | per budget | unclear | unclear | not stated |
| | 4. Frequency of Worker Supervision | not stated | not stated | unclear | not stated | not stated | no | unclear | unclear | not stated |
| | 5. Time Spent in Worker Supervision | not stated | not stated | unclear | not stated | no | no | unclear | unclear | not stated |
| | 6. Use of Time Sheet | not stated | not stated | unclear | not stated | not clear | recommends | unclear | unclear | not stated |
| | | | | | | | | | | |
| VII. | Does Contract Spell Out the Specifics of Performance Incentives? | no | | no | no | | no | yes | no | no/but allows |
| | 1. Incentive Criteria, I.e., Who gets one?<br>• Corporate Performance Incentive<br>• Individual Performance Incentive | | <br>yes<br>yes | | | <br>yes<br>not stated | | | | |
| | 2. Criteria for Achieving Bonus Clear in Contract/Annex | no | no | no | no | yes | no | yes | no | No |
| | 3. Amt of Incentive | NA | 40 to 60% | NA | NA | deformed schedule | NA | unclear | no | not stated |
| | 4. Duration of Incentive | NA | yrly | NA | NA | yes | NA | annual | no | not stated |

**Table 2.1. Assessment of Various Contracting Models Used in the Bangladesh HNP Sector, 2004**

| | Contract Assessment Criteria | POTENTIAL CONTRACTING OPTIONS USED IN BANGLADESH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1. GOB/MOH FW/ MOF | 2. USAID | 3. WB/NNP/M OHFW/ MOWCA/ BRAC | 4. WB/HAPP/ UNICEF | 5. ADB/ UPHCP/MO LGRD&C | 6. GLOBAL FUND/ Save The Children USA | 7. PKSF | 8. BRAC | 9. DFID/SHAP LA/ NICARE |
| | 5. Other Incentives Used to Ensure LT performance (tenure, pension, civil service status) | unclear | not stated | unclear | unclear | no | not stated | unclear | unclear | not stated |
| | | | | | | | | | | |
| VIII | Methods to Improve Equity of Access & Financial Sustainability | | | | | | | | | |
| | 1. Is There a Complementary "Equity Fund" Mechanism | no | no | no | no | no | no | no | no | No |
| | 2. Does the NGO operate a Health Insurance Mechanism | no | no | no | no | no | no | no | no | No |
| | | | | | | | | | | |
| IX. | Measures of Cost-Effectiveness and Efficiency | | | | Note 13 | | | | | |
| | 1. Do Contracts Contain Such Indicators? | no | no | no | yes | performance indicators | no | derived | no | No |
| | 2. Does NGO Mgt Get Evaluated w/ Use of Such Indicators | no | no | no | yes | entire NGO | no | unclear | no | No |
| | | | | | | | | | | |
| X. | Organizational and Adm. Costs of Care | | | | | | | | | |
| | 1. Overhead Rate | no | none shown | no | not pd | no | possibly | no | no | No |
| | 2. No of Non-Service Providing Staff | no | yes in budget | can derive | can derive | can derive | can derive | can derive | no | can derive |
| | (Total Number and Share of Total Workers) | | | | | | | | | |

Notes:

1. Appendix = defined in an appendix
2. Fin = financial reports of expenditures and other financial matters
3. mthly = monthly
4. NA = Not Applicable/Available
5. Per = performance indicators specified in contract
6. pmt= payment
7. qtrly = quarterly
8. Reg. Fin. state = Regular Financial Statement

9. sanct= sanction
10. SL = short list
11. Sus= sustainability
12. yrly = Yearly
13. UNICEF evaluates the management support costs closely and has several stipulations in their budget section for UNICEF project officers to monitor regarding their costs and efficiency.
14. For the NNP, the report requirements are defined in a special annex to the contract.
15. For UNICEF reporting, activities and achievements need to be described. In the final report project outputs are required to be stated.
16. Performance reporting is not required to obtain additional funds, but a financial report is required before funds are disbursed.
17. The PKSF model of contracting is designed to provide small NGO entities with loanable funds to help create small scale enterprises, which are intended to become self sustaining enterprises. The NGOs repay the loans to the foundation by collecting the repayments from the small enterprises they help to create. The small enterprises are expected to provide a good or service that the local community is willing to pay for directly with out of pocket payments for services rendered.
18. Financial sustainability refers to financial sustainability that is reported.
19. Save the Children USA utilizes financial rules and guidelines developed in accordance with the US Government's OMB regulations

Sources:


1. GOB/MOHFW/MOF. Ministry of Planning, *The Public Procurement Regulations, 2003*, (Dhaka: Central Procurement Technical Unit, Implementation, Monitoring and Evaluation Division, MOP, September 2003). Ministry of Planning, *The Procedures for Implementation of the Public Procurement Regulations*, 2003, (Dhaka: Central Procurement Technical Unit, Implementation, Monitoring and Evaluation Division, MOP, March 2004).
2. USAID, Tendering, bid, and contract documents for use in the USAID/MOHFW/NSDP, 2004 version of documents.
3. WB/NNP, Tendering, bid, and Contract documents for use in the WB/NNP/MOHFW, April 19, 2004.
4. WB/HAAPP/UNICEF, Tendering, bid, and contract documents for use in the WB/HAPP/UNICEF, July 2004.
5. ADB/UPHCP, Tendering, Bid, and contract documents for use in the ADB/MOLGRD/UPHCP, about 2000.
6. SCUSA/GFATM, Tendering, bid, and contract documents for use in Save the Children, USA and Global Fund Tendering and Contract documents, 2004.
7. PKSF, *Annual Report, 2003*, (Dhaka: PKSF, January 2004).
8. BRAC, BRAC/Non-Formal Primary Education Program (NFPE)/WB/MOEd, January 1, 2004.
9. DFID/NICARE, Nicare/BRAC Contract no. CNTR 98 5549, for the PPP Program, SHAPLA, Bangladesh, Funded by DFID, 1998.

### *2.1.2. Findings from the Contract Assessment in Bangladesh*

(i) *Payment Basis and Mechanisms*

A review of payment basis and mechanisms, the first set of criteria for assessing contracts, shows that it is uncommon for NGOs in Bangladesh to collect revenue for services rendered or use any other mechanism to obtain funds that would enable local rewards or sanctions to be effectuated. NGOs contracting with NSDP/USAID and the UPHCP/ADB are the exceptions because they charge fees for services to and utilize those fees as they deem appropriate While currently there is little linkage of payment to performance (except for the ADB urban health project), the GOB could include this linkage in contract documents. USAID links payments to financial performance, but it could also modify its documents to more directly link payments to services or health status outcome performance, if the various parties could agree on performance indicators and their monitoring.

The ADB contract links payment to the achievement of specific performance indicators. It utilizes baseline indicators obtained by surveys of each contracted area, and bases its performance payments on the utilization of health services and the extent to which the health status of the defined beneficiaries has increased relative to the baseline. This method eliminates the problem of some defined populations having poor baseline indicators and others having relatively higher indicators. The ADB bases its performance payments on relative improvement. That is, the health status of the population is compared to their status at the outset of the project intervention.

Clearly, adjustments to the bonus criteria will be necessary over time as current indicators are completely met for some NGO operated urban-based clinics. This does not imply that that the populations will be enjoying full health. Rather, focus indicators will need to be altered as new health challenges arise. For example, some urban clinics are now beginning to monitor type II diabetes, which is emerging as a health problem among their target populations. Thus, their currently defined ESP now includes diabetes screening, with referral to appropriate secondary sources of care for those afflicted with this growing non-communicable health problem.

(ii) *Fiduciary Arrangements and Accountability*

In reviewing the second set of criteria regarding fiduciary arrangements and accountability, there is general agreement across all contract formats that the first four criteria, i.e., board functions and responsibility, meeting frequency, representation and numbers of board members, are commonly reviewed prior to contracting, usually during the process of determining a qualified "short list."

Other fiduciary indicators which are not commonly incorporated into contract documents include: (a) whether board members are paid for their service, (b) what board member's responsibility might be in situations of potential conflict of interest, and (c) whether periodic performance reporting is required to stake-holder and especially the community.

The PKSF model does provide for community reporting because many of the community members have obtained loan funds from the community-based NGOs. Within the health field, however, community reporting does not appear to be a common requirement. Simple contract language could stipulate that verifiable evidence of NGOs' meeting with communities to report on their accomplishments and difficulties is required for payments or reimbursements. By including a community reporting requirement, current accepted practices

would quickly change and accountability would increase.

(iii) *Performance Monitoring*

Third, to the extent that performance monitoring is done, typically performance is reported to the contracting entity, which then reports to the GOB and possibly to other DP. Those entities that widely report (excluding to communities) commonly do so via an annual report or an end of project evaluation, or perhaps a power point presentation held by the respective financier. Financial information regarding the use of financial resources is required by the donor community, and this type of information is also required by the GOB for financial accountability reasons.

However, most of the contracts reviewed also stipulate a set of performance measures, which must be periodically reported. The main difference between the contracts is the extent to which performance outcome and financial payments are linked. Only in the ADB urban PHC project and those established by NICARE (on behalf of DFID) is this linkage clearly defined. Currently, as a result there is little impact for non-performance because there are no financial mechanisms in the agreements to focus NGO managers on project outcomes. These "cultural management norms" need to be changed. The language of most contracts can be modified easily to redefine these norms.

It is worthy noting that the ADB's UPHCP has paid significant attention to performance. In fact, an external private consortium was established to conduct regular performance monitoring and periodic survey evaluations of health outcomes. Other contracting mechanisms do not include this additional "check and balance" among the NGOs involved in implementation or the DP financing the endeavor. The other models reviewed rely on a "middle man" contracting entity. The NGOs providing services contract with this "middle man" to monitor and evaluate performance as well as to conduct daily contract supervision for the NGOs. This type of arrangement has the potential for creating "conflicts of interest."

(iv) *Financial Management, Reporting and Accountability Requirements*

Unlike the assessment of performance monitoring, the required monitoring of expenditures and revenue is very clearly and concisely described within all of the models reviewed. All require at least quarterly financial statements (and some require monthly statements). All have language in their contracts to allow for the possibility of annual or even more frequent external audits, although most models do not implement external audits frequently because of the expense. All options require that financial statements be prepared and sent to the contracting entity, which in turn reports to the funding DP.

With one exception, all contracts have clear provisions regarding the disbursement of funds to the NGO contractor. Most commonly, funds are disbursed by electronic transfer into designated bank accounts, or via some other defined approach to ensure the secure transmission of funds to the implementing NGO.

If revenue from out of pocket payments is envisioned, as is the case in the ADB Urban PHC Project, there are clear procedures defined in the contract or related annexes as to how such funds are to be accounted for and how they will be held. But formal fee retention at a local facility represents a potentially illegal procedure according to the laws of Bangladesh.[24]

(v) *Dispute Resolution Procedures / Processes*

Virtually no dispute envisioned within the context of the current contracting procedures

relies on the formal legal system for resolution. In fact, most if not all models have established internal procedures for resolving disputes through formal mediation with the organization involved in the contracting process. Provisions also have been made to resolve disputes through various arbitration entities established locally or internationally. In those cases where the dispute resolution process is unclear, revisions to their contracts should be made prior to the launch of the upcoming HNPSP.

Both NICARE/DFID and Save the Children USA/Global Fund have clear procedures for addressing instances of professional malpractice. These and the ADB project are the only exemplars that required some form of insurance coverage for such possible occurrences. However, it is unclear where the contracted NGOs obtained such coverage. Currently, Bangladesh has no legal basis for holding medical professionals liable for any negligent behavior or services rendered. Until parliament passes an act dealing with medical profession liability, the formal legal system has no clear jurisdiction in this area except for possible legal sanctions.[25]

The arbitration procedures stipulated in most contracts are not established to address professional malpractice potentialities. There are procedures within Bangladesh to bring malpractice matters to the attention of professional authorities through the various professional medical societies, such as the Bangladesh Medical Association. However, there is no instance to date where such appeals have led to any disciplinary action against licensed medical practitioners, let alone against those who do not have any such qualifications. Because the ESP will by necessity become increasingly complex as the patterns of disease change, it will become increasingly important to address the lack of professional malpractice. This will be an important step in improving the quality of health care delivered in this country. Addressing malpractice will facilitate improvements in the quality of maternal and child health care delivery, which underlies the high maternal and infant mortality rates found in Bangladesh today.

In many European countries, professional malpractice instances are resolved through a "no-fault" process of arbitration managed by the professional societies involved in licensure, and with oversight from the MOH. These procedures could be fruitfully reviewed in any effort to improve the quality of health care delivered in Bangladesh through the next sector program.

The problem of professional liability was partially addressed during the implementation of the HPSP, through the DFID funded SHAPLA "Strengthening of Nursing Project (SNP)." Nevertheless, there are many additional professional groups and generic issues related to the quality of health care service provision that warrant systematic monitoring and review.

Finally, while most contracting models have provisions for dispute resolution in general, few if any specifically address how to resolve NGO personnel disputes regarding working conditions, pay disputes, gender equality and/or relationship issues, or other matters. Grounds for personnel dismissal is included in some contract models, for example, NSDP, NNP/WB and ADB, but many have no provisions for such potential disputes. The NSDP contract has some language addressing the grounds for dismissal, but it is an area where further improvement could be made.

(vi) *Management of Facility Workers*

With respect to provisions regarding personnel management, beyond dispute resolution, few common themes emerge from this review. Some models require NGO management staff to be on site, but others do not have such a requirement. A different subset indicates that personnel

training will be performed as a part of the management function. This provision is common in the NGO contracting context of Cambodia as a vehicle to improve the quality of care.

The amount of payment due to the NGO by the contracting entity is clearly delineated in the contract. There is no language about the frequency and amount individual staff will be paid for their work. Typically the budget indicates the amount that individuals will be paid, and financial statements show the actual amount paid to individual personnel over the reporting period. But the reporting indicates that there is great variation in the amount that is actually paid to individual workers during each accounting period. Further, there is little transparency about the disbursement of funds provided to individuals for fringe benefits or bonuses.

Time sheets are not commonly required, though one model proposed by Save the Children (USA) recommends their use. Other provisions regarding the process and the time involved in personnel supervision are generally not stipulated, though they may be used as an internal control mechanism. Most areas reviewed suggest personnel management is not yet an important part of contracts issued by DP, nor is it an issue that the GOB has any great interest in, as it is not included in its most recent revision of guidelines for public procurement.[26] Thus, personnel management is not included as a formal part of NGO contracts. Since it is not formally included in the set of issues reviewed in the process of short-listing NGOs, it may be presumed that it is not yet an area of concern that may disrupt project implementation.

(vii) *Performance Incentives*

Three of the eight contract models reviewed have provisions for some form of incentives. The NSDP has provisions for fairly generous bonuses and fringe benefits provided within the contract budgets. The ADB has worked out an elaborate procedure for determining the size of financial bonuses for NGOs, which can provide verifiable evidence of health status gains in defined populations.

Further, the recently conducted mid-term evaluation of the UPHCP demonstrated clear health outcome improvements in those clinics which received bonuses. The award of a bonus is directly tied to health outcome indicator improvement.[27]

Other documentation about the distribution of bonuses to specific individuals within an NGO may exist. However this brief review did not delve into such detail. It would be useful to learn more about how bonuses are distributed within USAID and ADB supported NGOs to ascertain whether the distribution has any relationship to actual service provision by specific health care providers.

(viii) *Methods to Improve Equity of Access and Financial Sustainability*

None of the contract models evaluated included provisions for improving the equity of service provision by incorporating an equity fund or a voucher scheme in the contract.

None of the NGOs were requested to implement some form of health insurance scheme to enhance the financing of the improved service delivery system that resulted from the contracting of facility management to NGOs. During the next HNP sector program, experimental, pilot contracts can be initiated by including some form of equity fund and community-based health insurance scheme to address supply-side management issues of service delivery, financial access for the poor, and financial sustainability concerns.

(ix) *Measures of Cost-Effectiveness and Efficiency*

Among the contract formats reviewed, there was little focus on cost effectiveness or efficiency concerns. However, some contractors did indicate interest in addressing these issues. For example, UNICEF is monitoring management support costs and would insist that efficiencies are realized regarding these cost elements. ADB also has indicators in its monitoring program that include total cost of service delivery in relationship to service outputs.

The possibility of incorporating efficiency measures into the calculation of performance bonuses could be an additional element of designing an experimental program to find ways to realize efficiency gains, and at the same time improve the output indicators of service delivery.

(x) *Organizational and Administrative Costs of Care*

Overhead rates and indicators of administrative cost, such as the ratio of service providers to administrative staff, are not included as issues that require the specific attention of NGO health facilities managers. The contracts reviewed do not contain any provision regarding such costs or the impact of these costs on the total cost of service provision.

However, in the budget sections of several contract documents there is information about the numbers of administrative staff and how much they are paid. Various calculations based on this information could be made to obtain bench mark indicators about these cost elements. Since the administrative cost of service provision could be a large share of the total cost of service provision, it is vital to initiate a systematic effort to document this cost element.[28]

## 2.2 Performance Evaluation of Selected NGO Contracting Models in Bangladesh

### *2.2.1. The Selected NGO Contracting Models to be Evaluated*

NGO contracting modalities were classified into the following models:

**Model 1**: Direct contracting and management by the Government of Bangladesh or a government entity (UPHCP and NNP); **Model 2**: A contracted manager to manage the contracting arrangements with the NGOs and organize monitoring and evaluation activities (NSDP and BPHC); **Model 3**: An autonomous trust for developmental and social service activities including health (Dhaka Ahsania Mission and Grameen Lallyan); and **Model 4:** NGOs receive direct funding from donors, usually under a contracting arrangement (BRAC, DSK, Gona Shaysthaya Kendra); A **Model 5:** A not-for-profit registered company organized or selected for managing the provision of other developmental activities (PKS and SDF) is also compared with the previous models in section 2.2.5.

Each NGO model has its own advantages and disadvantages. The purpose of this section is to review the basic characteristics of these models and to evaluate them on the basis of the findings of the exit and facility surveys carried out for the purpose of this study (see Annex 2).

### *2.2.2. Comparison of the Models Based on the Facility Survey*

Table 2.2 shows the ranking of the four types of contracting models. In terms of supervisory visits, direct contracting models received the highest number of visits during the last six months, while the independent trusts had the lowest number

of visits. The direct contracting model receives supervisory visits from different entities. For example, the UPHCP facilities receive supervisory visits from the NGO under which the facility is organized, from the monitoring agency contracted by the project, as well as from city corporation officials who are responsible for overall management of the contracts. Direct contracting with large NGOs appears to be the worst model in terms of facility-based characteristics important for achieving the social objectives desired by NGO contracting. The contracted manager model involved the hiring of many small NGOs, and it did not rank well in specific facility-level characteristics.

**Table 2.2. Ranking of NGO Models by Facility Characteristics Based on Facility Survey Data (1=best, 4=worst)**

| Facility based indicators | Direct contract | Contracted manager | Independent trust | Large NGO |
|---|---|---|---|---|
| Supervisory visits | 1 | 3 | 4 | 2 |
| Size of facility | 3 | 1 | 2 | 4 |
| Percent exempt: immunization | 2 | 4 | 1 | 3 |
| Percent exempt: normal delivery | 1 | 3 | 4 | 2 |
| Maximum charge of immunization | 2 | 3 | 1 | 4 |
| Hours per unit of service | 2 | 3 | 1 | 4 |
| TOTAL | 11 | 17 | 13 | 19 |

Source: NGO Facility Survey 2004 (AUS Health International with ADSL Bangladesh).

Assumptions: Better situations are defined as higher supervisory visits, larger size, higher exemptions, lower maximum charge and lower hours per unit of service.

### *2.2.3. Comparison of the Models Based on NGO Personnel Survey*

NGO personnel were asked if they were satisfied working in their organization, whether they see future growth potential with the entity, etc. (Table 2.3). Personnel satisfaction is an important condition for the provision of quality services from the NGO facilities.

With regards to the above criteria, the independent trust model ranks at the top followed by bilateral contracts with large NGOs. Direct contracting and contracted manager models fall relatively behind the others in ranking.

**Table 2.3. Ranking of NGO Models by NGO Facility Personnel Opinion (1=best, 4=worst)**

| Facility personnel opinion | Direct contract | Contracted manager | Independent trust | Large NGO |
|---|---|---|---|---|
| Happy with the job | 1 | 3 | 4 | 2 |
| Future growth potential | 4 | 2 | 1 | 3 |
| Happy with salary/benefits | 2 | 3 | 4 | 1 |
| Workload at acceptable level | 2 | 4 | 3 | 1 |
| Receive salary regularly | 4 | 3 | 1 | 2 |
| Residence within 5 miles | 2 | 4 | 1 | 3 |
| Time spent traveling to work | 4 | 2 | 1 | 3 |
| Personal opinion on quality | 1 | 3 | 2 | 4 |
| Total | **20** | 24 | **17** | 19 |

Source: NGO Facility Personnel Survey, 2004 (AUS Health International with ADSL Bangladesh)

### *2.2.4. Comparison of the Models Based on Exit Interviews with Facility Clients*

Table 2.4 reports the ranking of the NGO facilities from the users' point of view. In terms of waiting time for obtaining services in the facilities, the large NGOs were ranked at the top, i.e., the users of those facilities reported the lowest amount of waiting time on average compared to the facilities of other types of NGO models. However, the clients reported a higher degree of unhappiness with the amount of time providers spent with patients in the large NGOs. Direct contracting was ranked the best in terms of time spent by providers with patients. Aggregating all the ranking values assigned by the clients to different aspects of service quality, the direct contracting model ranked first with an aggregate score of 16. Independent trusts are ranked second in terms of overall satisfaction by the clients using their services. The contracted manager model and large NGOs with direct contracting from the donors performed relatively poorly.

**Table 2.4. Ranking of NGO Models Based on Exit Interviews with Clients of NGO Facilities (1=best, 4=worst)**

| Client opinion based indicator (exit survey) | Direct contract | Contracted manager | Independent trust | Large NGO |
|---|---|---|---|---|
| Waiting time in facility | 2 | 3 | 4 | 1 |
| Provider spent enough time | 1 | 3 | 2 | 4 |
| Provider asked questions/health | 1 | 4 | 2 | 3 |
| Physical checkup was done | 2 | 4 | 3 | 1 |
| Rating of quality of service | 1 | 2 | 4 | 3 |
| Received all services expected | 3 | 2 | 1 | 4 |
| Will recommend this center | 3 | 2 | 1 | 4 |
| Received a prescription today | 3 | 4 | 1 | 2 |
| Total | 16 | 24 | 18 | 22 |

Source: Exit interview with clients of NGO facilities, 2004 (AUS Health International with ADSL Bangladesh).

### *2.2.5. Qualitative Survey and Comparison of the Models*

The information obtained from the survey of the NGO partners was used to assess the performance of NGO contracting experiences in Bangladesh on the different aspects of contracting. Based on the models' advantages and disadvantages as identified from the findings of the exit and facility survey carried out for this study, a ranking exercise was done. The survey included interviews in 53 health centers of the 16 selected NGOs. Information was gathered from 173 facility personnel and 1,224 users. The results of this ranking exercise are shown in Table 2.5.

**Table 2.5. Performance Evaluation of Selected NGO Contracting Models in Bangladesh**

| Parameters | The contracting experiences | | | | | |
|---|---|---|---|---|---|---|
| | **BINP/NNP** | **BPHC** | **NSDP** | **SDF** | **PKSF** | **UPHCP** |
| **TOTAL SCORE (mean)**<br>**Bidding Experience and Selection Process:** | **2.6** | **3.8** | **2.9** | **3.0** | **3.6** | **2.7** |
| Announcement (publishing, putting on website, etc.) | 4.0 | 4.0 | 3.0 | 4.0 | 4.0 | 4.0 |
| Bidding fairness | 1.7 | 4.0 | 2.7 | 4.0 | 4.0 | 3.7 |

**Table 2.5. Performance Evaluation of Selected NGO Contracting Models in Bangladesh**

| Parameters | The contracting experiences | | | | | |
|---|---|---|---|---|---|---|
| | BINP/NNP | BPHC | NSDP | SDF | PKSF | UPHCP |
| Clarity and completeness of bidding document | 4.0 | 4.0 | 3.3 | 2.0 | 4.0 | 3.3 |
| Timeliness in terms of concluding review, signing contract, etc. | 3.0 | 4.0 | 3.7 | 2.0 | 4.0 | 0.7 |
| Contract duration | 0.3 | 3.0 | 1.7 | 3.0 | 2.0 | 2.0 |
| **TOTAL SCORE (mean)** **Flexibility of Contracts:** | **1.35** | **4.0** | **2.5** | **1.5** | **2.0** | **0.38** |
| Autonomy or flexibility for decision making | 1.7 | 4.0 | 1.7 | 2.0 | 2.0 | 0.75 |
| Price changing rules (budgetary reallocation, changing line items, etc.) | 1.0 | 4.0 | 3.3 | 1.0 | 2.0 | 0.0 |
| **TOTAL SCORE (mean)** **Supervision and Regular Monitoring:** | **1.9** | **3.0** | **2.3** | **2.3** | **2.3** | **1.13** |
| Supervision quality | 2.0 | 3.0 | 3.0 | 3.0 | 4.0 | 1.0 |
| Provision for rewards for good work | 0.7 | 3.0 | 1.7 | 2.0 | 0.0 | 0.7 |
| Provision for punishment for non-performance | 3.0 | 3.0 | 2.0 | 2.0 | 3.0 | 1.7 |
| **TOTAL SCORE (mean)** **Maintenance of Service Quality, Training and other Partnership Supports:** | **2.23** | **3.0** | **3.1** | **1.7** | **2.0** | **2.9** |
| Scope for maintaining service standard and assuring quality | 2.7 | 3.0 | 3.3 | 3.0 | 3.0 | 3.25 |
| Training (HRD) | 2.0 | 3.0 | 3.3 | 1.0 | 3.0 | 2.75 |
| Other partnership support | 2.0 | 3.0 | 2.7 | 1.0 | 0.0 | 2.75 |
| **TOTAL SCORE MIS, benefit monitoring and evaluation** | **2.3** | **3.0** | **2.7** | **3.0** | **4.0** | **1.75** |

Keys: 0=Negative (unappreciable situation), 1=Reasonable, 2=Positive, 3=Highly Positive, 4=Excellent
Source: Survey of NGO managers and partners 2004 (AUS Health International with ADSL Bangladesh).

## 2.3. Comparative Advantages of Public Providers, NGO and Private-for-Profit Providers in Health Care Services in Bangladesh

The public sector cannot afford the "luxury" of high cost, ineffective service or inefficient provision. An alternative view holds that private providers are often not superior to the public sector in terms of quality or efficiency, and that contracting is a complex undertaking, especially in countries with limited institutional capacities (Harding and Preker, 2003; Liu, 2004). To "make or buy" health services is the question that must be asked when considering ways to improve the performance of health systems. This section presents a brief summary of the empirical evidence on these issues with a special focus on NGOs and their performance relative to the public and private-for-profit providers.

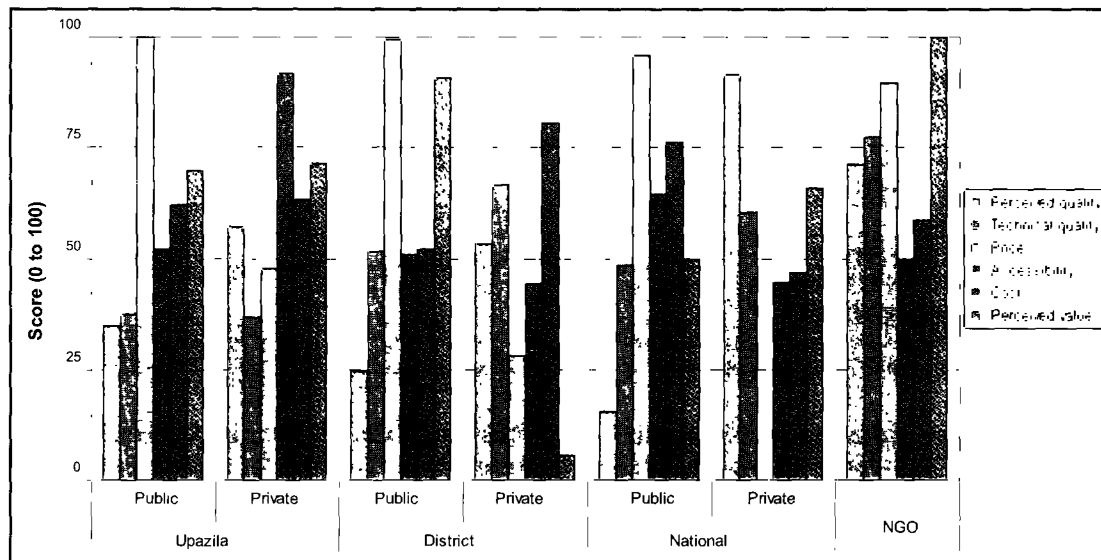
### *Multidimensional View of Performance*

The dimensions of performance covered in this section are quality (technical and perceived), price, accessibility, cost, and value (value integrates the other dimensions of performance into a single concept). The primary source of information is a survey with a sample of 50 facilities, including public, private and NGO facilities at the upazila level, and public and private facilities at the district and national levels. The next analysis refers to the performance comparison at the upazila level (Annex 3 describes the survey methodology).[29]

A first analysis of the results considered an aggregated measure of each of the dimensions of performance. For the first six dimensions---perceived quality, technical quality, price, accessibility, cost and perceived value---a relative score for each dimension was constructed based on a set of indicators captured from the facility questionnaires, exit polls and direct observations. This score ranged from 0 to 100. The worst observation received 0 and the best received 100. The derived value, the final dimension of performance, is a ratio between quality and price/cost, and may have scores in values over 100.

Figure 2.1 shows the performance dimension scores obtained for the seven domains considered by the analysis: upazila level public and private facilities, district level public and private facilities, national level public and private facilities, and NGO facilities. Perceived quality, the first dimension, is the average score between the quality perceived by the trained enumerators and the patients. The results show that perceived quality is consistently best in the private sector, at all levels. NGO facilities also obtained higher scores, which are superior to that of private facilities at the same level (upazila). Perceived quality as seen from the facility questionnaire (performed by trained interviewers) and from the exit polls (applied to patients) also shows the same tendency (see Figure 2.2 and Figure 2.3).

**Figure 2.1. Aggregated Performance Dimension Scores**

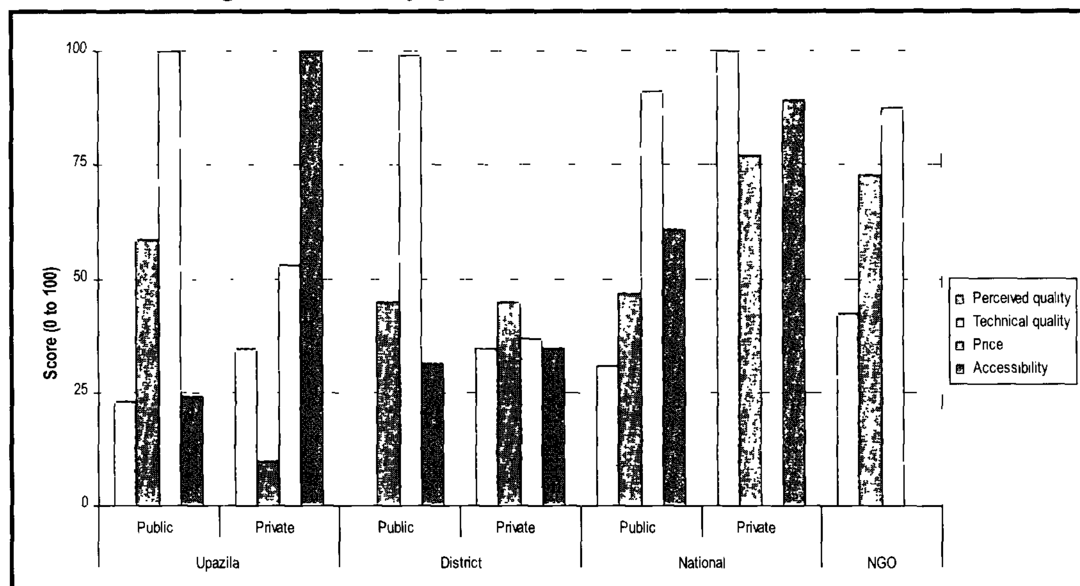



Source: Facility Survey, Exit Poll Outpatients, Exit Poll Inpatients and Direct Observation Surveys of Public and Private Providers, 2004.

Technical quality, the second dimension, is the average score between the technical quality measured through the facility questionnaire, exit polls and direct observations. The results show that technical quality increases with the facility level. There is also a tendency for private facilities to show a slightly better score than public facilities. However, NGO facilities, in spite of being similar to the upazila level facilities in terms of size and services offered, show the best scores in technical quality. A separate analysis of technical quality shows mixed tendencies. The scores obtained from the facility questionnaire, which considers aspects such as the availability of information systems, protocols, stock of drugs and supplies, training, and policies for female patients, show that public facilities are more or less homogenous at the different levels, with a technical quality score ranging from 40 to 60.

The public facility scores differ from the results obtained in the private sector, where technical quality scores increase with the facility level, from a low of 10 at the upazila level to a high of 77 at the national level. NGO facilities show a score of 73, almost as high as the private facilities at the national level. The scores obtained from the exit polls, which determined if the patient was explained the diagnosis, received instructions on the drugs prescribed, knew the amount to pay before receiving the service, and was shown a price list, show that both public and private facilities are heterogeneous. The score of public facilities increases with the facility level. The private facilities show a similar tendency, although private facilities at the national level present an abnormally low score. However, the NGO facilities obtained the most notable results, outperforming all the rest. The scores obtained from direct observations (see Figure 2.4) show a clear tendency of the private facilities to perform better in the higher levels. Except at the district level, the public facilities show relatively low scores. The score obtained by NGO facilities is relatively higher than other upazila level facilities.

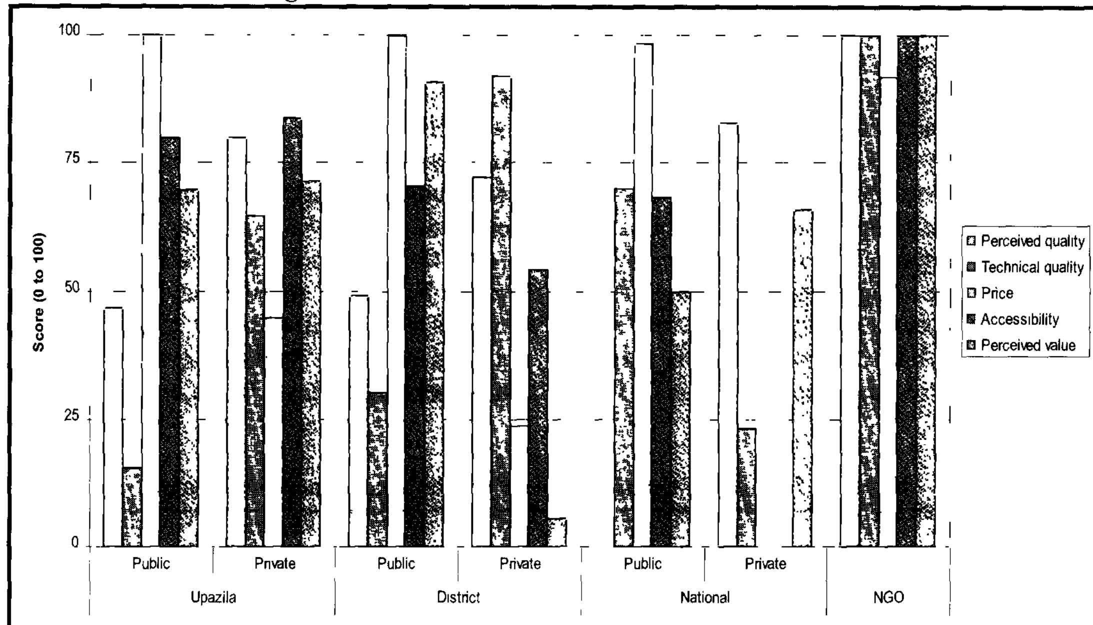
**Figure 2.2. Facility Questionnaire Performance Dimension Scores**




Source: Facility Survey of Public and Private Providers, 2004.

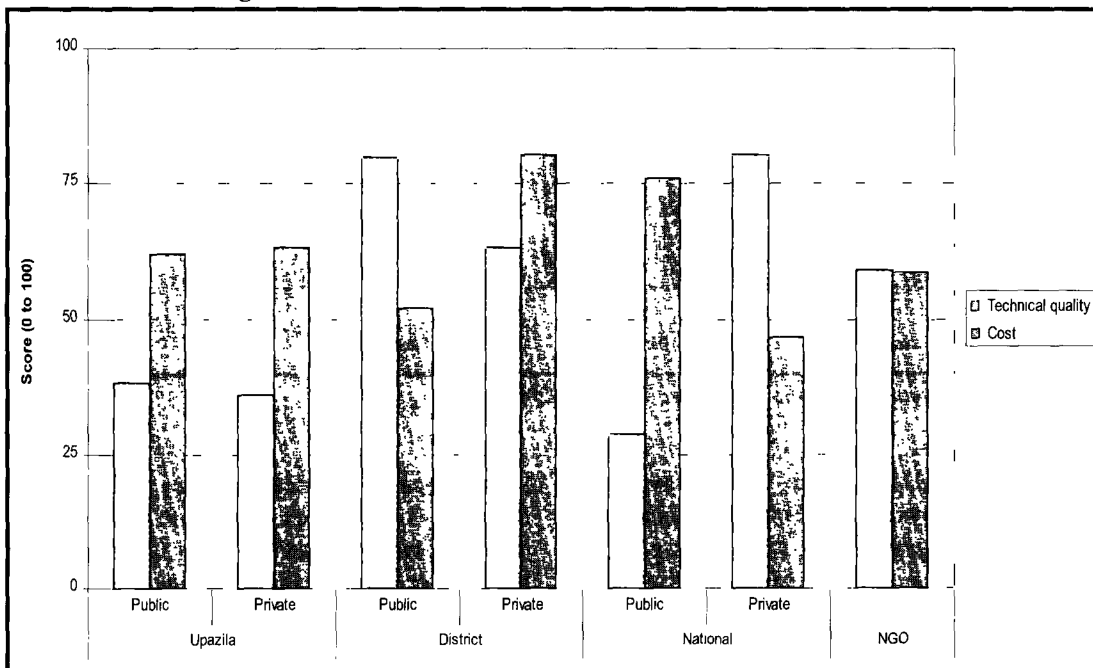
Price, the third dimension, is the average score between the price information collected in the facility questionnaire and the out-of-pocket expenses of patients interviewed in the exit polls. The results show that both out-of-pocket expenses and fees charged by the facility are consistently lower in the public sector than in the private sector. Public facility scores are always near 100, meaning they charge (if they do) the lowest fees. Private facility scores decrease with the level of the facility, meaning that higher level facilities charge higher fees and signify larger out-of-pocket expenses than lower level facilities. NGO facilities also obtain a relatively high price score, almost reaching the level of public facilities.

**Figure 2.3. Exit Poll Performance Dimension Scores**




Source: Exit poll of outpatients and exit poll for inpatients of public and private providers, 2004.

**Figure 2.4. Direct Observation Performance Dimension Scores**




Source: Direct Observation Survey of Public and Private Providers, 2004.

Accessibility, the fourth dimension, is the average between indicators measured in the facility questionnaire and in the exit polls. The viewpoint on accessibility from the facilities' side and the patients' side has opposing tendencies. On one hand, accessibility indicators measured with the facility questionnaire (Figure 2.2) show that at higher levels there is higher accessibility, except for upazila private facilities that report good

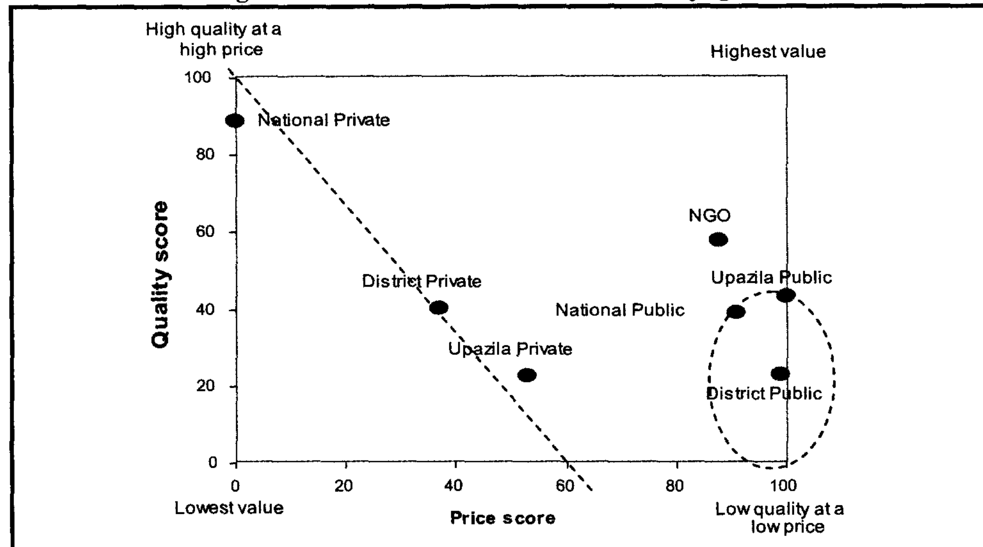
accessibility. NGOs have the lowest scores. On the other hand, accessibility from the patient's standpoint (Figure 2.3) is higher at the lower levels. NGOs have the highest accessibility score.

Cost, the fifth dimension, is the average of the cost scores obtained from the direct observation of the six selected services (Figure 2.4). At the upazila level facilities---public, private and NGO---similar cost scores are noted.

Perceived value, the sixth dimension, is measured from the patients' standpoint. Figure 2.3 shows that the lowest perceived value is that of district level private facilities, and the highest is that of NGO facilities.

Derived value, the seventh dimension, combines quality with price or cost. There are three alternative measures of derived value. The first shows the relationship between the quality score, the average between technical and perceived, and the price score, as measured by trained enumerators in the facility questionnaire (see Figure 2.5). The figure shows that private facilities lie on a straight line starting at a high quality and a high price for the national level and ending at a low quality and a moderate price for upazila level.

**Figure 2.5. Value Derived from the Facility Questionnaire**




Source: Facility Survey of Public and Private Providers, 2004.

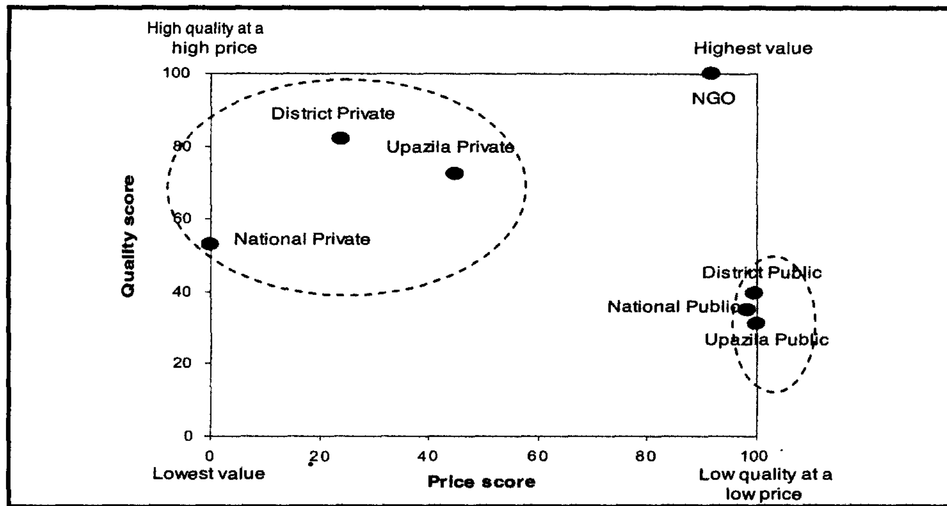
The district level lies between the national and upazila levels. This means that even though quality and price vary considerably between different level private facilities, their value ratio (quality/price) is more or less constant. In regards to public facilities, they all lie close to each other in the figure, in an area of low price and moderate quality. Public facilities have quality scores similar to those of private upazila and district level facilities, but at a much lower price. NGO facilities, however, have a price score almost as good as public facilities, but enjoy a much better quality.

The second alternative for deriving value comes from the exit polls. The quality score is the average between the perceived and technical quality scores. The price score is obtained from the out-of-pocket payments made by the patients. Private, public and NGO facilities all occupy distinct zones in the graph (Figure 2.6). Private facilities lie in a zone of moderate to good quality at a moderate to high price. Public facilities lie in a zone of very low price and moderate to low quality. NGO facilities lie in a zone of high quality at a low price. This means that NGOs show the highest value of all, while

the value of private versus public providers is more difficult to evaluate unambiguously as they lie in such different zones.

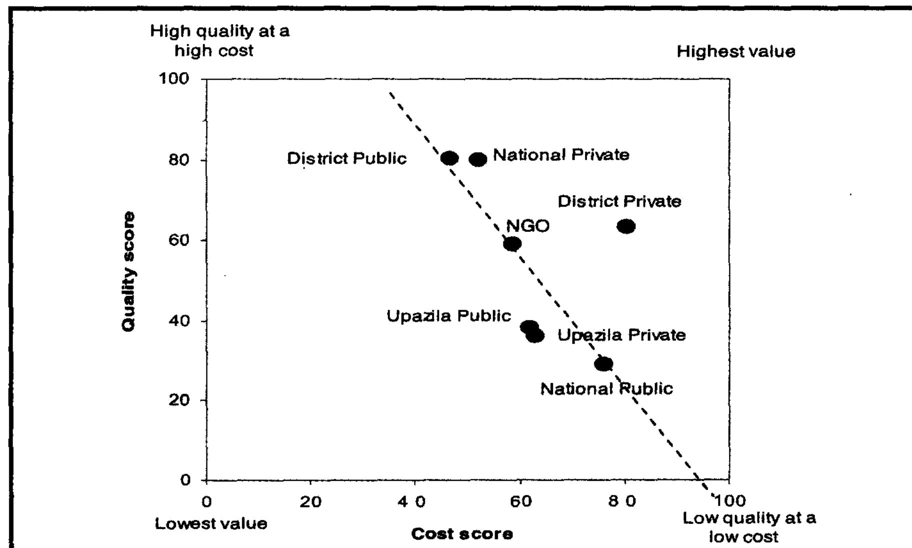
The third alternative for deriving value comes from direct observations. In this case, the relationship between quality (exclusively technical) and unit cost is used (see Figure 2.7). The figure shows that all facilities, except the district level private ones, lie approximately on a straight line starting from district level public facilities, with high quality at a moderate cost, and ending at national level public facilities with a moderate to low quality at a low cost. This means that the value ratio of these facilities is more or less constant, even if they span a wide range of qualities and costs. It may be observed that district level public facilities lie close to national level private facilities, and that upazila level public facilities lie close to upazila level private facilities. Finally, district private facilities unambiguously show a higher value than other facilities. They have lower costs than all other facilities and are only surpassed by the quality of district public and national level private facilities.

**Figure 2.6. Value Derived from the Exit Polls**




Source: Exit poll of outpatients and exit poll for inpatients of public and private providers, 2004.

**Figure 2.7. Value Derived from Direct Observations**




Source: Direct observation survey of public and private providers, 2004.

# Chapter 3. Diversification of Service Provision in the HNP Sector: Policy Options

*This chapter contains the proposal and policy strategies for the diversification of service provision in the HNP sector. These strategies were formulated keeping in mind the lessons learnt described in Chapter 2, and considering the feasibility of contracting modalities within the current social and political context of Bangladesh. This chapter will describe the options available to organize the contracting-out process and will outline the proposed policy strategy and the legal and institutional arrangements required to launch the large-scale diversification of service provision in the Bangladesh HNP sector.*

## 3.1. Options to Organize the Procurement and Monitoring Process

The Strategic Investment Plan (SIP) 2003-2010 foresees a major shift in the MOHFW role from providing services to becoming a steward of services. The MOHFW is committed to scaling-up the diversification of service provision through the contracting of NGOs, and private sector and other non-public providers for the delivery of ESD services. Under the HNPSP support, this contracting process will be implemented with pool-earmarked funds (Category 2 funds of IDA credit and grants from co-financiers).

A number of contracting models have been reviewed for their feasibility within the context of Bangladesh. There were four models outlined in the DFID financed "Scoping study."[30] These options included (a) direct GOB management, (b) not-for-profit registered company,(c) contracted manager or the management service agency (MSA), and (d) an autonomous trust/foundation. The report assessed each of these modalities in light of their flexibility and feasibility of implementation within the Bangladesh context and concluded that the MSA option should be considered the most flexible and the most easily implemented by the GOB and its DPs. Examples of this approach include the NSDP, BPHC, NICARE, and possibly the SCFUSA/Global Fund arrangement. See a schematic of this particular model below in Annex 4 (Figure IV.1).

(i) *The MSA Approach*

The MSA approach provides for an agreement between a particular DP (or conceivably more than one DP) and the GOB, via the MOHFW. The flow of funds goes from the DP to the MSA, which after working out the required tendering procedures will work with the NGO community directly, signing contracts and moving the service delivery process forward. Policy guidelines would flow from the MOHFW to the MSA. The DP would conclude an agreement with the MOHFW acting on the guidance of the GOB, and its local office in the form of some type of contractual agreement, perhaps in the form of an MOU.

A minor flow of funds may go to the MOHFW for some specific policy work to be pursued over the life of the agreement. Otherwise, cash flows from the DP to the MSA. Information flows from the MSA to the DP and the MOHFW. NGOs send periodic reports to the MSA (see Annex 4, Figure IV.1).

The MOHFW, with input from the NGO Affairs Bureau (NAB) at the Office of the Prime Minister, would define the minimum requirements for the NGOs to be eligible to

participate in the bidding for contracts through the MSA.

This MSA contracting mechanism has been established for a number of bilateral DPs for a long time, especially with regards to USAID, which has been operating in this manner for more than two decades. There are at least six international entities currently operating in Bangladesh, which have played the MSA role within the health and population sector,[31] and they all have the experience and technical expertise to perform these contracting tasks. In addition, several of the large local NGOs also have played this role in one or more projects,[32] including in health and education. Therefore, this is an option where both the GOB and DPs have experience.

All the MSAs discussed above have had the additional responsibility for providing TA services to community-based NGOs so that the package of care is developed according to the criteria determined by the MOHFW and the DPs in the project documents. The MSAs have been involved in setting up the supervision and performance monitoring procedures, and have implemented them. Thus, their annual reports and midterm and final evaluations provided the evidence of achieved outcomes. The MOHFW periodically receive debriefings from the MSA, but the MOHFW has generally not been involved in directly monitoring the MSAs' performance. The DPs have been much more involved in the oversight of their "own" MSA(s).

It is argued that the main disadvantage of this modality is that it does not yield any public sector capacity building benefits, especially to the GOB. The sustainability of this option is also often questioned. This concern is especially important if the project/program and the institutions created are necessary to maintain long-term sustainability. The MSA option does not contribute to the government's capacity of or develop an organization that over time will contribute to the long run development of the country.

However, the MOHFW's record of poor governance and contract management and the need to deliver services in the short term makes this option very attractive. Additionally, it may be very difficult to obtain agreement from the government to out-source this institutional capacity for achieving long-term sustained health sector benefits. Under extraordinary circumstances, MSA agreements were conceivable and were obtained in the case of the WB HIV/AIDS project (HAPP). Even in that case, it was agreed to out-source the contracting procedure to UNICEF, a partner UN organization.

(ii) *The Direct Management Approach*

The World Bank has tried to employ the GOB direct management approach in several of its most recent lending operations, including the Nutrition and HIV/AIDS projects. It established a project implementation or management unit within the MOHFW structure, and has tried to contract via such entities to implement the proposed work programs. However, the MOHFW has been able to implement the National Nutrition Program (NNP) only after considerable effort and long delays, and the NGO contracts are still not fully implemented.

In the case of the HIV/AIDS Project (HAPP), implementation lagged for about three years without any significant fund disbursement. The MOHFW project unit issued an expression of interest (EOI), but it did not have the capacity to respond to the more than 550 EOI applications it received. Thus, after over a year of considering various options, and several missions recommending different courses of action, the MOHFW and World Bank agreed to ask UNICEF to develop a tendering process to respond to the large numbers of EOIs, develop a "short list",

and ask those on the list to submit proposals for project implementation.

Under this option, cash flows from DPs to the MOHFW and reports flow in the opposite direction. Money and policies flow from the MOHFW to PMU. PMU reports to the MOHFW. Money flows to NGOs or other implementing agencies, and information regarding performance flows back to the PMU (see Figure IV.2 in Annex 4).

Since November 2003, when UNICEF and the GOB signed an agreement for the implementation of a HAPP component, known as the HAIF, the short list was created with the help of a private firm, proposals were reviewed, and contract negotiations have been initiated with the selected groups. Actual NGO project implementation started about nine months after UNICEF got involved. This timeline is "reasonable" for Bank supported projects in Bangladesh.

(iii) *The Modified Direct Management Approach*

The ADB has implemented the Urban Primary Health Care Project (UPHCP) through the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C). It appears that its bilateral collaborating partners, i.e., the Nordic Development Fund (NDF) and UNFPA, are relatively content with the progress made to date. The PMU resides in the offices of the Dhaka City Council. This project took over a year to begin its NGO contracting process to provide services and manage urban-based PHC facilities. Now however, it is considered a "model of success." In the review of its contract documents, this project was evaluated as "highly innovative" in the Bangladesh context because of participation by NGO providers and the local government and for its implementation of an incentive system to improve performance.

One of this project's most noteworthy achievements is its development of a performance-based incentive and bonus scheme. Specific NGOs can obtain sizeable bonuses equivalent to up to 6% of the total contract amount. The management of this mechanism, along with the performance monitoring of contract outputs, has been contracted out to a consortium of private entities, including a private international university and a local research and evaluation firm. The PMU within Dhaka City Council only serves as a middleman in this process. Figure IV.3 in Annex 4 illustrates the organization of this approach.

Whether the UPHCP experience can be replicated by the MOHFW remains the DP's primary concern generally, and the WB's concern particularly, due to allegations of poor governance within the city council of Dhaka where the PMU of the UPHCP is currently located. It remains unclear how well this model may work over time.

What other options are available? The "scoping study" suggests two options: the trust or foundation model, or the private not-for-profit registered company model (the PKSF organization is the most notable exemplar of this option). The foundation model in Bangladesh is exemplified by the Freedom Foundation, which uses a private endowment to support the ideals of freedom from poverty, ignorance and oppression.

(iv) *Bangladesh NGO Foundation Option*[33]

The GOB recently has proposed the creation of a Bangladesh NGO Foundation to support and expand NGO activities in different social areas. The proposal includes the formation of the foundation executive board accountable to a general council. The general council will formulate the foundation's rules and regulations, elect members of the executive board when applicable, approve annual budgets and audit reports among other functions. This body will have a chairman and fifteen other members appointed by the GOB. In addition, any NGO can become a member of the foundation provided that it is

has been registered for the last three years and pays a defined contribution.

The foundation's primary mission would be to provide periodic grant support to NGOs who have the capacity to deliver social services, including health care, to the poorest and most disenfranchised people in the country. The foundation's mandate is not explicit as to whether any positive outcome or performance indicators would or should be monitored. These design issues appear to have been overlooked as well as the possible conflict of interest if an NGO is both a member of the general council and an applicant for foundation funds. It appears to be a modality, which in its current design could become an important vehicle for political patronage without proper checks and balances incorporated into the GOB rules and guidelines. As currently conceived, the NGO foundation is not a sustainable option since it is does seem to be a mechanism that could be transparent or accountable enough to DPs or local communities to warrant sufficient support.

However, it might be possible to modify certain aspects and create an innovative new approach including the elements that follow.

First, the members of the general council cannot be a majority drawn from the GOB. Second, the board's chairperson would be elected by the board members. Third, the members of the board would be remunerated and would not all serve the same term lengths. . Fourth, the foundation's executive director would not need to have a formal seat on the board, but would sit "ex-officio," i.e., without a formal vote. Fifth, unlike the PKSF model, the foundation initially would benefit by being required to engage an international auditing firm for financial management purposes, and also an independent performance monitoring agency (PMA). Together, they would review monthly records of service by awardees, and also conduct periodic surveys to ascertain the achievement of outcome goals financed by the foundation's investment. In the initial phase, the DPs would be responsible for a sizeable share, but not all of the PMA's financing. The GOB would allocate the remainder of funds. A schematic diagram of how this modified NGO Foundation could operate is shown in Figure IV.5 in Annex 4.

## 3.2. The Proposed Contracting-out Strategy

### *3.2.1.* What is "Successful Contracting?"

It is essential to determine what criteria should be used to determine contracting "success" at the facility or local level. Success should be measured in terms of the following criteria:

- Whether there are sustainable institutional mechanisms in place throughout the country to assure PHC services, as defined by the ESP, and whether these services are available and delivered to the most disadvantaged groups in the population
- The existence of a transparent bidding process
- The application of performance-based financing
- The implementation of accredited quality services
- Fiduciary accountability
- Financing sustainability
- Strong community and local government participation

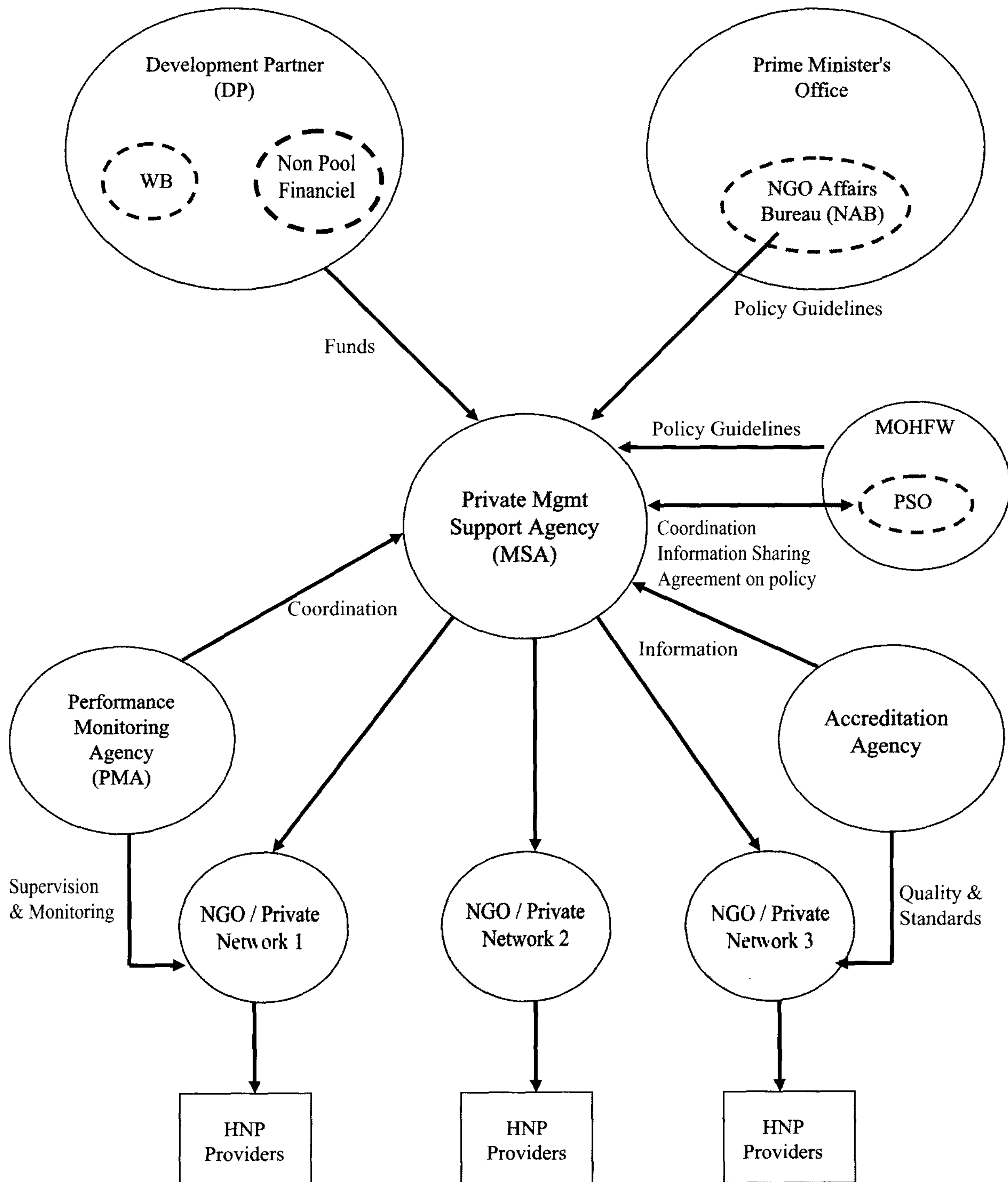
To ensure longer-term success, it will be vital to define "success" as developing locally managed institutions that can ensure the long-term delivery of healthcare services, which are financially viable entities as proposed in the future strategy outlined below. The objective is to promote the transformation of the NGOs from social entities that deliver social services to dynamic social entrepreneurs that achieve social targets with the maximum efficiency. Therefore, for monitoring and evaluation purposes, important "success" indicators of

the NGO contracting initiative are organizational and financial dynamism of the service delivery entities. The MOHFW-operated government service delivery system has not been able to assure this type of success. For long-term success, performance agreements should be considered to ensure sustainable financing support.

A main concern is the extent to which NGOs can be contracted to deliver services. The accumulated knowledge and experience attained by several NGO networks in the country (as described in Chapter 2) provide a good potential base to scale up the diversification of service provision through NGOs and also in partnership with private-for-profit providers. The proposal to increase funds for diversification of service provision by the NGO/private sector is feasible. These funds will represent about US$25 million per year, which is 20% in additional resources over the average annual expenditure incurred by NGOs on HNP activities (estimated at US$125 million).[34]

This section provides some options on **how** to implement the above described alternatives for service delivery. Since the government is searching for sustainable approaches to commission NGOs to deliver HNP services, the suggested policy options presented here include both the "what" and the "how" for expanding the diversification of service provision to help in future agreements between GOB and DPs.

**Figure 3.1. Proposed Contracting Arrangements**



### *3.2.2. The Public and Private Partnership Proposal for the Diversification of Service Provision during HNPSP*

All DPs and the GOB openly acknowledge that more flexible engagement is required with clients in their reforms, particularly since all recognize that change is iterative and incremental. The WB will need to take steps to align the next HNP operation to deliver on this strategy. The objective is to have a single MOHFW-contractor interface. The contracting agency would have full administration and budgetary control, receiving funds directly from the MOHFW. This new arrangement implies an adaptation of the contracting-out process to a new legal setting and institutional arrangement as described below.

(i) *Management Support Agency for Diversification of Service Provision*

The MOHFW has some experience contracting services, and it is likely to obtain agreement of the GOB to utilize this approach to extend service delivery. There have been a few attempts to contract for services via the MOHFW, with generally poor results, e.g., the World Bank's National Nutrition Project (NNP), and the HIV/AIDS Prevention Project (HAPP). Despite problems in institutionalizing transparent contracting procedures in the Bangladesh social sectors, the tendering procedures appear to be quite transparent, and have not resulted in any significant disputes with interested NGOs. In addition, the MOHFW is interested in piloting NGO contracting for the delivery of ESP, and is engaged in conversations with other interested parties.[35]

The proposed MSA would manage the funds allocated for commissioning NGOs/private sector providers during the HNPSP support, including the management of the pool funds. The MSA would contract packages of services from NGO/private networks. The networks could contain their own management/support unit to coordinate and lead the service delivery for a group of providers (NGOs or private providers running health facilities).

The strategy for purchasing services from NGOs will require definition of the following items:

- The key elements of the contract: size and specifications of the contract packages to be purchased, what services will be covered, length of contracts, and whether they will be bid partly on the basis of prices or whether they will be fixed price contracts. The contracts must allow the experimentation of several models of service provision to ensure a reasonable size. The latter is essential to ensure financial economies of scale, improved supervision and contract management, and decreased monitoring and evaluation costs;
- The criteria for choosing the geographical areas of interventions. One possibility would be to start in the unions where there are already NGOs delivering HNP services and to focus in the underserved poor areas;
- The procedures to monitor and supervise the performance of the NGOs/private sector networks;
- The establishment of the contract agreements and well defined bidding process (such as letter of invitation, instructions to bidders, evaluation criteria, involving professional experts in the selection process, etc.);
- The payment mechanisms to providers. The MSA can also experiment with a combination of options;
- Bonus incentives to providers and whether to give the contracted providers the possibility of retaining user fees.

The MSA, a private institution, is proposed to lead the process of contracting, assisted by other accreditation and supervision agencies. The NGOs' audits will

be carried out by private sector auditors hired by the MSA. The MSA would be responsible for the following:

- The implementation of MOHFW's decision of what services to contract out
- The decision of from whom to purchase services
- The definition of the contract payment option
- To negotiate the terms of the contract with the selected provider(s)
- To supervise and to monitor the performance of the contracted provider(s)
- To modify contracts based on performance
- To promote the formation of public and private health networks at the union level

The performance of the MSA and its contractors would be evaluated by a third party every year. This assessment activity would be financed by the DP and would provide the justification for whether an alternative option needs to be considered in the future. The alternative option refers to a non-profit registered company (such as the PKSF Model), which commissions NGO/private sector networks for HNP service delivery (see Figure 4.4). Great emphasis would have to be placed on the initial assessment of the prospective NGO partners' and private sector's capacity, and for designing and sustaining new organizations and legal settings. In addition, efforts to build local capacity of community boards to strengthen social control and accountability will have to be promoted.

The MSA would have a board and would work as a semi-state agency with formal management procedures. It would lead the process for contracting out HNP services to NGO networks, and in the future to other non-public providers. This agency could also encourage contracts with NGO networks that promote the formation of Community-Based Organizations (CBOs) (PPP/NICARE approach) to supervise NGOs providing HNP services.

Other key institutional conditions that need to be developed for further contracting are the following:

*(ii) Accreditation*

Some elements of the NGOs' accreditation are de facto being done and updated in Bangladesh already, but with different standards. The following entities/projects have undergone pre-screening exercises to contract NGOs in order to implement WB and other DP projects and programs in the social and other sectors: PKSF, BRAC, UNICEF, UPHCP, NNP, BPHC and NSDP. This pre-screening function also occurs in the NAB, a Bureau located at the Prime Minister's Office. In the late 1980s and early 1990s, the DPs requested that the GOB develop a NGO registration system to facilitate the short-listing process. Since 1990, the NAB has registered NGOs for a five-year period, which may be extended by reregistering for another five years. The registration process also helped the GOB and DPs learn more about the NGOs financial backing from official DPs, and from many other international groups involved in humanitarian and development assistance around the world.[36]

If an NGO is not registered with the NAB, it is not eligible to obtain financial support from externally financed projects or programs. The NAB, along with the other groups identified above, have extensive screening criteria that they use to determine which NGOs are qualified to contract with DPs to implement development activities.

Despite the fact that the NAB conducts its assessments of the NGO's viability, there are delays in conducting assessments and issuance of the registration document required to obtain international support. Officially, the maximum time period required for registration is 45 days, but it

may take twice as long. The review function for the health sector could be housed in the NAB, but it could also be reconfigured and set up as an independent review body which could accredit NGOs instead of formally registering them.

To perform this function, NAB's role will need to change from a government supervisory body to an entity that is fully acknowledged by all involved parties as having a transparent, simple and prompt process to certify that a NGO is a legitimate entity, has a performance track record of actual service delivery, and complies with quality standards defined by the agency.

The accreditation agency, wherever located, will develop a national data base on the performance of all potential contracting entities, and certify that each NGO is a legal entity with a home base that meets basic minimum operating standards. Such an agency could also monitor the quality of service provision and the organizational capacities to deliver a minimum quality of service.

African countries, such as Zambia and South Africa, have institutionalized accreditation bodies in the health sector. Asian countries, including China, Thailand, Korea, and Japan, also have such bodies. There are a number of examples of health sector regulation in Europe, including those from the former Soviet block, e.g., Lithuania, the Kyrgyz Republic, and the Czech Republic.

However, the literature appears mixed regarding the effectiveness of regulatory bodies in improving quality and cost-effectiveness performance.[37] Most regulatory bodies have had a positive impact on improving process indicators of service delivery, especially in large hospitals and among the medical profession, but their impact on cost and outcomes awaits further investigation.

The National Accreditation Agency for HNP (NAAH) would work with consumers, the MOHFW, health care purchasers, NGO networks, legislators and the providers to develop standards for public and private providers in Bangladesh. Participation in accreditation and certification programs would be voluntary during the first five years, and would then become mandatory for all NGOs or non-public providers applying for funds from the NGO trust fund management body. This would create incentives for good providers and incentives for long-term investments, distinguishing them from providers who offer poor quality services.

The NAAH should evaluate health care in three different ways:

- Through accreditation (a rigorous on-site assessment of key clinical and administrative processes)
- Through provider health plan data if they exist
- Through comprehensive users' and providers' surveys

Regulation is usually costly. Therefore, accreditation should ensure a minimal set of standards on health service provision. To improve NGO services, non-regulatory interventions or incentives would also be essential, such as bonuses to personnel and providers for achieving health targets, increases in contract length, and capitation due to good performance, etc.

The NAAH would use a number of factors to establish rankings of health facilities (or NGO networks) measuring five core areas: (a) clinical services, (b) client satisfaction, (c) infection prevention, (d) management system, and (e) facilities and supplies. Indicators for these core areas could include the following:

a. *Clinical Services*

- Number of doctors and specialists in relation to the number of patients
- The adequacy of resources--human (health personnel), equipment, and health facility infrastructure
- The existing health care services in the health facility
- Access to training by health workers and practitioners in the health facility
- Availability of drugs and diagnostic testing facilities
- Qualifications of providers
- Whether doctors are licensed and trained to practice medicine
- Whether the users are satisfied with the services received
- How facility managers deal with poor practices and complaints against their practitioners or health workers
- The level of cleanliness in the health facility
- The access to water, electricity and other services in the health facility
- The quality of the food provided by the health facility
- The ratio of practitioners/administrative workers in the health facility
- The existence or absence of clear and written standards and protocols for treatment and diagnosis
- The average waiting time of a patient before he/she receives treatment
- Fatality rates from surgery of various types
- The extent to which patients recover effectively from illness

b. *Users' Satisfaction*

Indicators to measure user satisfaction would include the users reported level of comfort, promptness of service, treatment by the doctors and health workers, privacy, availability of services and food received.

To be eligible for accreditation, a health facility/provider would need to be in operation for a minimum of two years. The ranking of providers should be simple and easy for the pubic to understand, e.g., excellent, good, satisfactory, below average, and poor

The NAAH could use two modalities for accrediting health care providers:

a. The NAAH would conduct inspections directly;
b. Contract inspectors from other NGOs and private institutions.

The inspection team prepares the accreditation report and makes recommendations to the NAAH.

*(iii) Performance Monitoring Agency (PMA)*

An independent/autonomous unit, known as "Performance Monitoring Agency (PMA)," would be created. This agency's existence is justified because the GOB is required to monitor the quality and performance of the contracts prepared and managed by the MSA to guarantee value for money, accountability and proper checks and balance of the contracting process. The MOHFW would provide overall policy guidelines for this agency. The PMA would be given the mandate to supervise, monitor and evaluate the performance of each contractor (and sub-contractor if applicable), and to provide information to the management contracting body, NGO networks and MOHFW. Each contractor would submit to the PMA two reports at the end of each quarter: (1) Performance Report and (2) Financial Report. Both these reports would follow a pre-defined standard format.

Based on the quarterly performance evaluation reports (performance evaluation index), the MSA would compare the performance of each contractor against pre-defined performance criteria. A yearly evaluation could be commissioned to an external party. This could be a renowned research and survey firm (preferably international). The evaluation would be given to the MSA and should impact upon

the following year's budget allocation for the contractors.

Performance would be measured using four categories and the following weights:

- Production of services (20%)
- Organization (20%)
- Management (20%)
- Quality and outcomes (40%)

For each component a goal would be set and points assigned accordingly. The maximum score could be 100, and bonuses would be allocated for a score of 75 points, including incremental bonus increases above that score. The scoring would be made by external consultants hired by PMA.

These indicators will be measured using independent studies based on user-exit polls, household surveys, sample registration of vital events and other available techniques. Some indicators suggested for setting performance targets and assessing progress are described below.

Outcome Indicators:

- Infant Mortality Rate reductions in the target populations, with a significant decrease in rich/ poor and male/female ratios.
- Under-5 Mortality Rate reductions in the target populations, with a significant decrease in rich/poor and male/female ratios.
- Maternal Mortality Ratio (or suitable proxy) reductions, with a significant decrease in rich/poor ratio.
- Fertility rate reductions in the target populations.

The last four indicators might be measured every two years to capture the trend of the indicators.

Output indicators:

- Percentage of children fully immunized against the six diseases within the first year of life
- Proportion of women with obstetric complications treated at facilities
- Discontinuation rate of contraception
- Proportion of women who receive antenatal care
- Proportion of women who receive post-natal care
- Proportion of poor users who utilize services
- Payments made by poor users at the health facility
- Proportion of poor users who are exempt from user fees
- Proportion of poor users who receive free medicines at the health facility
- Proportion of users who report a satisfactory level of service
- TB case detection rate and cure rate
- Vitamin A coverage

Management Indicators:

- Number of complaints related to procurement
- Number of audit objections in each NGO network
- Unit cost of ESD

At the beginning of the contracting process, the NGO short-listing criteria can be constructed on the basis of information obtained from independent performance evaluations conducted on the NGO's previous work. These evaluation documents need to be verified with international partners providing the financial support. The key to successful NGO/private sector provider performance include: concrete mechanisms to improve service quality, performance monitoring linked to incentive scheme, continuous on-the-job staff training, referral guidelines, and basic diagnostic methods for the most common health problems in the specific geographic area of the facility.

*(iv) HNP Observatory*

The HNP observatory function can be commissioned to a private agency located in Bangladesh and financed by grants from DPs. The main activities of the Health

Observatory can be grouped into the following categories:

a. *Advocacy*

Help to educate, assist and protect individual's rights through consumer information, consumer participation, consumer advocacy programs, data collection and independent quality oversight. Draft model policies or legislation on specific areas of interest. Help consumers to know about options for coverage, provision and treatment.

b. *Form Coalitions*

Broaden coalitions by creating worker/consumer partnerships at the local and national level. Implement a quality watch-line (toll free number), which would collect cases of poor quality of care from consumers or health workers in the country. These would be real life stories, which would be useful for the design of pro-consumer strategies in the HNP sector.

The coalition will work at the community level in coordination with the local health watch groups, comprised of members with local credibility, legitimacy and leadership potential, for example, local advocates, teachers and business men/women.

c. *Participation in Quality Measurement*

Ensure that the consumer's voice is included in all forums and working groups related to legislation or decisions regarding the HNP sector.

d. *Accountability*

The Health Observatory should be independent of providers and those financing health care, and free from conflicts of interest.

(v) *Legal Aspects*

*a. Retention of User Fees*

Another legal issue of concern has been user fee retention at the local health facilities. According to the Republic of Bangladesh Constitution, article 84 states that any funds raised or collected for services rendered must be submitted as revenue to the government's general consolidated fund. This interpretation has not enabled any government entity to hold funds collected from patients/clients for the purpose of operating the facilities. Whether this interpretation will remain a barrier to any expanded utilization of user charges by NGO contractors is a potential issue for scaling-up the use of NGOs/private providers in delivering the ESP.

This issue may be mitigated by a government ruling regarding ownership of the health facilities through which the proposed service package will be delivered. For example, if the ESP is delivered in community clinics which are built on land contributed by the local community and with the community's involvement in the facility's construction, it may be possible to argue that article 84 does not apply, especially when the ESP staff are seconded or NGO employees who are not current GOB staff.

In addition, the ADB supported UPHCP health facilities apparently have been charging user fees for the past several years with the full knowledge of the MOLGRD&C. This "exception" needs to be investigated to understand why and how these facilities have been granted an exemption from this constitutional requirement.

There also may be ways to legally retain fees at the point of collection, as there is ambiguity in the current interpretation of the word "revenue" in article 84. If the fee collections are not considered "revenue," but rather as cost recovery or otherwise,

then the constitutional requirement may be a moot issue. Certainly if NGO contracting is envisioned for hospital level services, there may be a need to directly address ways to revise the current understanding of article 84 and related implementation, to allow facilities the ability to charge user fees and retain a proportion of the fees at the facility level.

Since, the utilization of user fees as a means of financing contracts can create equity concerns, proper targeting mechanism should be in place to identify the poor and exempt them from paying such fees. To identify the poor, a proxy mean test formula and community participation combined needs to be applied by all NGO modalities under contract. These NGO/private sector networks may also implement other targeting mechanisms. The government's role here is to ensure that there is a strict exemption policy in place and that it is being implemented.

One possible mechanism is the provision of a health card to each beneficiary. The health cards may be color coded. For example, a patient with a red health card would be charged a different scale of user fees than a patient carrying a green health card. Red, for example, could indicate a poor patient, and hence exempt them from user fees. While green could indicate a slightly higher socio-economic status, thus signaling facilities to charge user fees to those patients with green health cards. Strong community involvement is recommended to identify poor households and individuals. Until further refined, targeting mechanisms can be employed based on the several criteria/methodologies adopted by the current NGO modalities.

The charging of user fees may be seen as a strategy of 'cross-subsidization.' That is those patients who can afford to pay subsidize the services for those who cannot. Furthermore, the fee received from curative care services may be used to subsidize the fee for preventive services. Without the ability to raise user fees, the NGOs will experience difficulty raising a substantial part of their operating budget.

It is suggested that providers contracted under the proposed contracting arrangements be allowed to charge user fees. They would be required to display their price list in front of the health facility. This percentage may increase subject to satisfactory achievement of the key social targets. The provider would retain the user fees to provide financial incentives.

*b. Payment Mechanism*

Contracting payment mechanisms may refer to block grants, capitation rates, case based and fee-for-service, labor and material payments, cost and volume, and set price. Each of these options has positive and negative aspects. The contractor may choose to use one specific option, or a combination for different service packages.

It is proposed that each provider receives an initial payment or fixed amount for a specified volume of services. Excess volume may be paid on a fee-per-case basis, with a maximum number of visits that can be billed for during a specified period. The contracting agency would develop a cost-based provider financing system and will reimburse providers each quarter with agreed prices and contract ceilings.

At the end of each quarter, a certain percentage would be allocated for each provider/facility as a '*performance bonus.*' That extra (bonus) amount would be given to the facilities if they meet the pre-specified performance targets. For instance, 60% of these extra funds would be translated into bonuses for the facility's staff and distributed among the staff according to pre-specified proportions. The remaining 40% would be channeled into a basket known as the '*Facility Maintenance Fund,*' which would be used by the health facility's management

for day-to-day facility maintenance, e.g., hiring private security guards or cleaners, laundry, maintenance of electrical appliances, equipments, and other utilities, etc.

On the other hand, if the facilities fail to meet their targets, they would not get this extra fund to give to their staff as bonuses and to put into the Facility Maintenance Fund. These funds would instead be re-channeled to those facilities that performed well and met the targets. This bonus system would act as an incentive to encourage good or adequate performances by the facilities

*c. Incentive Scheme*

Charging user fees could also be tied to an incentive scheme, such as a *fee-sharing scheme* with the physicians/clinical doctors. The physicians can be paid a certain pre-determined share of the revenues their services generated through user fees. This would serve as an extra bonus to their regular salary. For example, if a doctor saw a specific number of patients in a month and helped to generate Tk.100 in user fees, the revenue from those services would be divided perhaps 40/60 between the physician and the facility respectively. An additional incentive could be introduced for physicians who work on weekends and/or in remote rural areas. They could be offered a higher percentage of the revenues generated by user fees. In this case, perhaps revenues would be divided 60/40 between the physician and the facility respectively. Under this scheme a no-tolerance rule for illegal payments to utilize public health services would apply.

This fee-sharing scheme could lead to 'cream skimming' that is treating patients who are capable of paying (i.e., the more user fees generated, higher the amount of revenue sharing), and bypassing the poor patients who are exempt from user fees. One mechanism to counter-act this undesirable outcome is that the contract terms will indicate that the NGO/private sector providers and thereby the physicians would have to reach the target of a specific proportion of poor patients exempt from user fees to qualify for remaining in the fee/revenue-sharing scheme.

*d. Procurement of Government Drugs and Medical Supplies*

Another legal issue to consider is whether government-owned health facilities managed by NGOs/private provider organizations must only use GOB supplied pharmaceuticals and related supplies from the Central Medical Stores Department (CMSD). Can contracted NGOs/private provider organizations procure pharmaceuticals and medical supplies from any other vendor available, at possibly a lower price?

In the context of Cambodia, NGOs continued to receive pharmaceutical items for local clinics through the public mechanism such as the CMSD, and they procured locally only when it was "medically necessary." This approach appears to be a pragmatic solution to a potentially complex problem.

The GOB has issued its new procurement guidelines recently. However, the procurement process will remain far from transparent until there is strict enforcement of the existing rules and regulations. The DPs and the GOB have yet to agree upon test piloting a third party agent to procure goods.

It is proposed that a separate fixed fund, the '*Drugs & Clinical Supplies Fund,*' to be used to buy drugs and supplies would be given to the contractors on a yearly basis as part of each contract. As was done in the Urban PHC project, the contractor (i.e. the NGOs) could be given the responsibility of purchasing the drugs and supplies, with some exceptions such as vaccines, contraceptives and micro-nutrients, etc. The NGOs would procure these drugs from pre-qualified suppliers identified by the MSA and agreed upon by the MOHFW. Where applicable, the contractor would follow either the government procurement regulations or the

lead donor procurement regulations, whichever is deemed more feasible. With regards to contraceptives, vaccines and micro-nutrients, the procurement would be done through government's own logistic system.

An *Essential Drug List,* comprised of drugs considered to be the most effective and reasonably priced, could be drawn up by the MSA in coordination with the government and the DPs. The contractor would be ultimately responsible for ensuring that all drugs on that list are available at the facilities. Availability of drugs and supplies on the *Essential Drug List* could be included as one of the contractor's performance targets that must be met.

The establishment of a drug pricing committee could be considered to ensure the best purchase price, quality of drugs and some standardization throughout the country.

Patients would have to pay a certain amount of fees to obtain essential drugs from the provider (with the exception of vaccines, contraceptives, micronutrients, etc.). The fees for those drugs would be subsidized so that they are less than the price at the drug store/pharmacy. This would encourage patients to purchase the drugs from the contracted providers rather than paying the full price at the drug store. At the same time it would allow providers/contractors to generate a certain amount of revenue, which would be used for procuring more drugs and supplies.

An exemption policy would apply here as well. Patients carrying red health cards (i.e. the poor patients) would be exempt from paying fees for drugs and would receive free drugs and supplies from those providers. End of year evaluation would show whether the demands of poor patients for drugs and supplies have been adequately met by the providers. Meeting those demands could be made one of the performance targets.

*e. Staffing*

NGOs/private provider organizations would have autonomy regarding the delivery of HNP services, but only in accordance with the government's health policy and guidelines. They would also be bound by the contract to achieve certain health targets. The NGOs/private sector providers could have complete authority over hiring, firing and paying staff.

The contractor would sign individual contracts with the health facility staff. The public health facility staff could in turn be contracted by the NGOs/private sector organizations. The staff would be paid more than their government salary out of the yearly fixed contract funds. In order to be contracted by the NGO/private sector organizations, the GOB staff would have to take leave from their government jobs to work for the contractor. However, the GOB will need to provide adequate legal arrangements to allow those contracted staff to continue the same career path as they would have had in their government jobs. Those staff would get additional incentives, such as the *fee-sharing scheme* and the *performance bonus scheme* as outlined above.

*f. Community Participation*

One potential innovative model involving community participation is the NICARE approach which was implemented during the HPSP period through the DFID funded SHAPLA project. It has had some initial success in developing a community based organization, which was facilitated by partner NGOs that provided locally based TA. This option sought to determine the extent to which the community organizations could become self-sustaining in providing a quality package of services and ensuring equity of access to the ESP.

In this model, the NGOs are facilitators in mobilizing community support to implement

quality ESP through the almost 11,000 abandoned community clinics (CC) that exist throughout the country. The NGOs also work with locally based private clinicians to facilitate collaboration with well-established private care providers. This model had not yet been scaled up into a large pilot endeavor.[38] Thus, it would be useful if the MSA widely promoted this approach as an additional contracting modality.

In order to improve local accountability, each CC would adopt a functional Community Group (CG) consisting of civil representatives elected by the community. The CG will manage the CC. The MOHFW may directly promote and coordinate this process and assist this kind of NGO network in applying for MSA funds under the defined competitive bidding conditions.

### *3.2.3. Building the NGO Service Delivery System: Plan of Action*

The design and implementation of the future results framework for commissioning NGOs and private sector providers to deliver good quality primary and secondary health care services require DP assistance to build suitable managerial skills and institutional arrangements. The MOHFW will develop the legal and institutional arrangements for this purpose. Selected technical assistance should be provided through DP grants and the pooled trust fund managed by the WB.

A **preliminary action plan and timeline** are suggested in the chart below, conditional upon an agreement with the GOB.

| ACTIVITY | 2005 | | | | 2006 | | | | 2007 | | | | **2008-10** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | |
| Installation of MSA | | | | | | | | | | | | | |
| Delivery of contracts by MSA | | | | | | | | | | | | | |
| Formation of CCMG & MOU signing with local authority (upazila level) | | | | | | | | | | | | | |
| Establishment of NAAH | | | | | | | | | | | | | |
| NAAH at work | | | | | | | | | | | | | |
| Law to enact retention of user fees | | | | | | | | | | | | | |
| Establishment of PMA | | | | | | | | | | | | | |
| PMA operational | | | | | | | | | | | | | |
| The MOHFW PSO "will develop a cost-based NGO financing system | | | | | | | | | | | | | |
| Establishment of Health Observatory | | | | | | | | | | | | | |

# Chapter 4. Main Messages and Policy Options

*This chapter contains information from different sections of the study and suggests policy options to assist the Government of Bangladesh in scaling up the government's role in purchasing HNP services from the NGOs and the private sector.*

## 4.1. Key Findings

1. The GOB has considered contracting as one of the alternative strategies to diversify health care service provision to increase the consumption of quality services by the poor and to increase the likelihood of achieving the MDGs. The new approach of contracting out services implies a greater focus on outputs and results, increased autonomy permitting providers to respond quickly to new scenarios, and more flexible working arrangements and incentives for staff and providers to achieve social targets. It demands non-public providers to be responsible for achieving social targets, to work with transparency and accountability, and to promote a new role of stewardship for the government, emphasizing increased capacity to perform the functions of a purchaser of services, rather than trying to micro-manage the provider's business.

2. There are a number of areas where improvements might be achieved, mostly in the components of supervision and evaluation, and in formulating the incentive structure for rewarding good provider and NGO staff performance. Nevertheless, there will be difficulties in implementing interventions aimed at enhancing efficiency, financial sustainability and management oversight.

3. Contracting is not the only solution to increase coverage, improve quality of services and provide greater access to the poor. Nonetheless, evaluation findings show potentialities of contracting which, if properly considered and guided, could result in higher returns to the public budget. Clearly, contracting should be implemented when society will reap the benefits. The evaluation recommends the establishment of a contracting-out system, which will have a number of attractive features that can enhance transparency and improve performance. The results will provide positive outcomes in the medium as well as long term.

4. Over the last few years, NGO service delivery activities funded by both direct DP financial support and public sources have increased substantially. About 769 NGOs are working in the HNP sector, and the number is increasing steadily. NGOs incurred an average annual expenditure on HNP activities of US$125 million, which is approximately 8.4% of total health expenditures. DPs are the major financiers of these activities, contributing 73% of the total NGO funds. NGOs have also developed a significant labor force; they employ about 21,000 people. NGOs have started to develop mechanisms to target the poor and to charge user fees. Their capacity to target the poor has been thus far assessed to be better than the public health facilities' capacity.

5. A number of NGOs charge user fees. There is evidence that NGOs are more effective in exempting poor people from user fee payments in the rural areas than the government health facilities. The NGOs still face difficulties in targeting poor users in the urban areas, however.

The level of user satisfaction and availability of drugs in the NGO facilities is more acceptable compared to the public sector. NGOs also have built mechanisms to monitor and supervise the performance of their contracts.

6. A group of selected NGO contracting experiences were identified and a comparative analysis was undertaken. **Model 1**: Direct contracting and management by the Government of Bangladesh or a governmental entity; **Model 2**: A contracted manager to administer the contracting arrangements with the NGOs and organize monitoring and evaluation activities; **Model 3**: An autonomous trust for developmental and social service activities including health; and **Model 4:** NGOs receiving direct funding from donors, usually under a contracting arrangement. These models present advantages and disadvantages to be considered in case of potential future support to the contracting process.

7. Findings show that supervision under direct contracting with large NGOs is not extensive. The satisfaction of personnel is an important condition for workers to provide quality services. Worker satisfaction was the highest in the independent trust model, followed by the bilateral contracts with large NGOs model. While direct contracting and contracted manager models fell relatively behind the front runners in their personnel satisfaction scores.

   The performance in the bidding process, bidding fairness, and clarity and completeness of the bidding document varies across different models. The contracted manager model BPHC performs the best in this category, followed by the PKSF contracted NGOs. The BINP/NNP and the UPHCP, which are both directly run by the government of Bangladesh, did not have satisfactory scores.

   Autonomy and flexibility of decision-making is crucial in the management of NGO providers. BPHC and NSDP had the highest performance in this regard. NGO partners from both these networks are allowed up to 15% of budgetary reallocation/changes with acceptable justifications. These networks also present strong quality of supervision, support from the contracting agencies, and effective systems of reward and punishment.

   The partners of BPHC, NSDP, SDF, PKSF and UPHCP all held positive impressions of their emphasis on quality assurance. The government-managed contracting model BINP/NNP received the lowest score in this aspect. In addition, NSDP and PKSF have the most comprehensive MIS and database decision-making capability, including various performance-based programs and results-focused trend analyses. BPHC and SDF reported relatively high scores for MIS and monitoring and evaluation. However, NGO networks generally process data manually, which contributes to poor quality of data transmission and analysis.

8. There are good prospects for contracting-out certain services at certain levels. At the *upazila* level, NGO facilities yield the best value indicators, as well as the best accessibility from the patients' perspective. Thus, in principle, the government could purchase from NGOs (such as those included in this research) the preventive, promotional, or simple curative services at low additional cost and with large quality improvements over public provision. At the national level, private facilities present better quality than public facilities for all six services studied. This offers the prospect for possible contracting-out arrangements. However, the government would have to negotiate volume discounts with private providers to obtain lower price levels that

are more in line with current public sector delivery costs.

## 4.2. Recommendations

*A. Contract Provisions*

The HNPSP will prioritize diversification of service provision through public-private partnerships as a way to increase coverage and quality of services in the sector. In this framework, there are a number of recommendations for a successful contracting experience.

1. Government should contract out contract management functions in order to promote the diversification of service delivery. The contract design should give considerable autonomy to providers to implement innovations and allow rapid adjustments to emerging conditions. Contracts should be linked to tangible results and be monitored and evaluated consistently. The contracting of NGO/private organizations should ensure the receipt of value for money, not only for first and second level health care services. High quality services must also be received for other HNP related services and for NGO contracting for community interventions on nutrition services and multisectoral HIV/AIDS activities, demand-side financing options, and capacity building and training.

2. The diversification of service delivery and the MOHFW's stewardship role are complementary. While the GOB continues to be financier and provider of HNP services, it will also strengthen its capacity to provide services by establishing the legal and institutional arrangements for the expansion of non-public service providers. Recommendations for the next sector program are offered in the spirit of encouraging debate and are based on quantitative evidence as well as the suggestions of focus groups and discussions with civil society, health professionals and public officials. Basically, these recommendations are related to the establishment of three independent agencies that will operate as checks and balances: (1) a Management Support Agency (MSA) for diversification of service provision will be responsible for contract management. Special disbursement financial management arrangements are recommended to mobilize resources directly from the pool fund and/or other sources of financing to this contracting agency; (2) an accreditation agency will certify minimum operating standards of non-public HNP providers; (3) the performance monitoring agency will supervise, monitor and assess the functioning of each contractor and provide inputs to the MSA for further contract decisions. The NGO Affairs Bureau of the Prime Minister's Office as well as the MOHFW would continue to be responsible for preparing policy guidelines and promoting information sharing with the above three agencies.

3. The report recommends initiating the contracting out process to NGO/private sector, defining services to be contracted, identifying and focusing in poor underserved areas (upazilas, unions, facilities) and ensuring quality of services. It is recommended that this function be assigned to a Management Support Agency (MSA). The MSA should be hired through an international competitive bidding process. The DPs would participate in the selection committee of the procurement process for all agencies involved in the proposed contracting arrangements. The MSA will be made responsible for the management of the pool funds allocated for diversification of HNP service provision under special financial management arrangements, including a separate account. The modality to prepare contracts has been improved because other legal and

institutional arrangements are proposed to strengthen the government's new stewardship role as a purchaser of services. These would include: a supervisory and monitoring body to follow-up on the performance of the contracted non-government providers, and an accreditation agency to secure a minimum level of quality standards from contracted providers. The accreditation process will be voluntary for a defined period. Thereafter the process would become mandatory for all potential applicants who apply for MSA funds. Finally, the formation of a health observatory is recommended. It would operate to advocate and protect the rights of HNP service users. This new arrangement is expected to improve transparency and accountability in the usage of public funds and to strengthen the supervision of contracts by means of performance incentives. The consumer's voice will serve as a check and balance in the delivery of HNP services. This option is sustainable in the long-term because the GOB could continue to contract through the MSA using the proposed framework and its proper funds if DP funding decreases in the future.

All matters related to contracting-out services to NGOs and private providers should be overseen by a Joint Steering Committee with representatives from the GOB, the DPs, and civil society. The GOB and the DPs will review nominations and agree jointly on committee members. A set of proposed actions in the areas of contracting modalities, contract provision, financial settings, regulation, supervision and monitoring are presented in a policy options matrix in Annex 4. It proposes explicit strategies, the actors involved, which action should be taken, where it worked, and outlines the potential implementation risks and bottlenecks.

4. Performance-based payment mechanisms need to be established, with performance indicators that clarify what the payer/purchaser wants and also provides what the financial incentives to providers will be for achieving those targets. We recommend the implementation of a bonus scheme for providers upon their successful achievement of indicators. The bonus criteria will have special provisions for incorporating new health problems/diseases into performance monitoring procedures. Weighting the proposed performance indicators may need adaptation once achievement of an existing set of indicators is realized.

5. The MSA will conduct a competitive bidding process to select the NGOs and private sector organizations. This process should be done for clearly defined geographical areas (mainly poor undeserved areas) and service packages. Each package can vary in terms of the type of payment mechanisms, and incentives. It might also include procurement of goods and commodities as well as incentives to promote investments of NGO/private organizations at the health facility level. All payments should be made on time by the contracting agency.

6. It is recommended that during HNPSP several experimental pilots be initiated on different contracting modalities to incorporate supply-side management issues of service delivery. To address the issues of financial access for the poor and financial sustainability concerns, some form of equity fund, mechanisms for strengthening community participation, and social control of the health facility management also should be included. Contracts for underserved areas where patients have a heavy disease burden, should consider including higher reference prices to avoid sub-optimal

quality and service provision.

7. In those cases where the dispute resolution process is unclear, revisions should be made to the contract's provisions prior to the funding and commissioning of the NGOs/private sector providers under HNPSP. Outside experts will act as referees for any potential conflict resolution activities.

*B. Contracting Modalities*

1. There is no *a priori* "best possible" contracting modality available to the GOB. Each modality has its strengths and weaknesses. The report suggests a two-stage approach be initiated with the immediate implementation of a modified private contracting management support agency (MSA). The MSA will be contracted under competitive basis and would be financed by the pool fund. This will leave open the future option of receiving funds from other DPs and from the government.

   To the extent possible, it will be important to work with communities to develop their individual contracting arrangements with facilitating CBOs, which may over time become a duly designated local NGO. While the supporting evidence is still vague, this approach has the best potential for achieving long-term sustainability of ESP service delivery at the community level in Bangladesh, and improving social control and accountability. This constitutes one way, although not an exclusive one, to deliver the ESP to hard-to-reach and marginalized populations.

2. The establishment of an independent accreditation agency and monitoring entity is crucial to ensure quality standards.

3. Funding modality: the WB trust fund can support the contracting process, including either the MSA (short-term strategy) or the not-for-profit registered company model (long-term option)[40] through the HNPSP credit. These resources have been proposed as part of category 2 expenditures in the development credit agreement between the GOB and the WB. The WB and the GOB will agree on a timeline for using these resources as well as for setting the adequate legal and institutional arrangements for proper functioning of these entities.

*C. Laws and Regulations*

There are a number of instances where the GOB has provided an adequate legal framework to engage in NGO contracting and other options towards the diversification of service delivery. However, some pending actions remain, including the following:

1. The Management Services Agency (MSA) will manage the Diversifying Service Provision objective within HNPSP on behalf of the Government of Bangladesh. The MSA would be primarily responsible for efficiently administering contracts with non-public providers. The MSA will also contract out activities under demand side financing pilots. The Agency will also support capacity building efforts for management of the publicly financed providers.

   The MSA should ensure value for money in coordinating budgets with individual projects and their activities. It also will make decisions on what to contract out, from whom to purchase services, the definition of the contract payment option, negotiating the terms of the contract with the selected provider(s), supervising and monitoring the performance of the contracted provider(s), modifying contracts based on performance, promoting the formation of public and private health networks at the union level, and contracting providers to deliver demand side financing schemes.

The MSA will be expected to work collaboratively with its Steering Committee (SC) or Board, Performance Monitoring Agency (PMA), the World Bank, and other stakeholders to deliver those project's outputs for which it is not solely responsible. The GOB and DP representatives and skilled and recognized professionals from Bangladesh appointed by the GOB and the HNP consortium will conform the MSA's SC. The Board will oversee MSA activities. The MSA manager will provide quarterly reports to the Board, but the Board will not interfere with the MSA's independence or make technical decisions established in its terms of reference.

2. An HNP observatory will be created to oversee consumer rights. The observatory will be an accreditation body to certify NGOs' minimum operating standards as well as a monitoring agency to supervise the NGOs' performance. These institutions will be funded by DP grants, and overseen by the MOHFW's Program Support Office (PSO).

3. The processes implemented by a number of DPs for developing their short listed NGOs should be assessed in greater detail at the outset of the implementation of the forthcoming HNPSP, so as to determine the feasibility of implementing a more formal accreditation entity, and thereby reduce the NAB's role and its bureaucratic control over the NGO registration process. It is therefore important to determine the relative benefits and costs of establishing an independent accreditation entity as a vehicle for reducing the lengthy process currently administered by the NAB. Our belief, *a priori*, is that the potential benefits of accreditation will pay off in the long term. In the short to medium term, there is some valid information to ascertain which NGO/private sector networks are competent in which areas and to identify their strengths and weaknesses. In the future, the continuous information generated by the performance monitoring agency would serve as key data to identify the ranking of NGO/private networks that apply to access and use of public funds.

4. Determine a means to retain locally raised funds from user fees or other user charges, and to authorize GOB staff to work for NGOs/private sector under a special rule.

5. If quality improvement is to be addressed over time, laws will need to be enacted that addresses medical malpractice as well as the establishment of processes to resolve such matters. Addressing this aspect of quality improvement will ensure that personal negligence becomes clearly articulated in Bangladesh. It will facilitate interest in reducing the probability that medical errors occur and are tolerated by the people. Without a legal basis for defining a negligent act or practice, enforcement of any financial claim through Bangladesh courts will be impossible. Any headway in this area will require parliamentary action.

6. In summary, this study has shown that contracting private entities for public service delivery is a feasible instrument to meet public health goals and to strengthen the stewardship role of the MOHFW. In order to diversify service provision, the MOHFW and local governments need to develop the capabilities to become active service purchasers and engage in partnership with NGOs and private providers. The pattern of service provision will be adjusted over time as contracts and commissions increase for NGOs and private providers to deliver primary and secondary care in areas where they have shown to have comparative advantages.

7. The MSA management of contracting should create incentives for improved

performance and increased accountability, support capacity building efforts, and may offer a new opportunity for making better and more efficient use of public resources. It may also provide the government with new ways to reach the poorest. Contracting with public funding and the DPs TA will require transparent bidding procedures, well-designed contracts, specific performance obligations and well-established procedures for monitoring and evaluation. Because the purpose of contracting is to increase the utilization of quality services, the GOB with the assistance of the DPs need to focus on how to design and properly implement a mechanism to contract HNP services, otherwise the risk of mismanagement and waste of resources will be latent. The challenge lies ahead, future benefits will be the result of the decisions and joint efforts made now.

8. Finally, because of the relative convenience of contracting NGO/private sector services, the government may wish to adopt a mixed strategy whereby some services would continue to be provided in the public sector and others could be purchased in the private sector. No matter which strategy the government might choose, harnessing the private sector participation in the provision of public health services necessarily implies the strengthening of the regulatory framework to guarantee quality standards, cost containment, ensure technical efficiency, etc., in order to ensure that social objectives continue to be met

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# ANNEXES

# Annex 1: International Review of Contracting Experiences

Contracting is not a new idea. Many countries throughout East and Southern Africa, which gained their independence from the UK in the 1960s and 1970s, signed contracts or had MOUs with non-governmental organizations to operate hospitals and other PHC facilities throughout their respective countries. The examples of both Tanzania and Uganda warrant special mention. In Uganda, the MOH seconded certain staff to mission hospitals operated by both protestant and catholic churches. The MOH also provided tax exemptions for imported drugs and other items. In Uganda, where there was no government facility, the government provided a budget supplement to the non-governmental facility, in some instances. And before the restriction prohibiting a non-government facility in the same area as a public one, the government provided budget supplements to all private hospital facilities through the respective church organizations operating those facilities.[41]

Different countries have used different modalities for contracting health, nutrition and population (HNP) services. In Cambodia, for instance, the government piloted two forms of contracting: contracting-in as well as contracting-out. The contractors in the contracting-in districts were given the responsibility to manage the district health services. The staff remained government servants, and medicines and supplies would be received via the traditional Ministry of Health logistics system. In the case of the contracted-out districts, the contractors had full authority over hiring, firing and paying staff, as well as procuring drugs and supplies, and for all recurrent operating costs from the contract funds. The health staff were contracted by the contractors and paid about ten times more than their government colleagues. In both types of contracting, contractors received a budget supplement to dispense incentives and bonuses to staff.

Evaluation shows that contracting-in seems not to perform as well as contracting-out. The Government of Karnataka in India, much like Cambodia, contracted-in private providers (i.e., NGOs) to manage primary health care services within the public sector context. There was very little flexibility. The providers operate within the confines of the government/civil service rules and regulations. Thus, the contract is too rigid to allow for innovation.

Bangladesh also has experience contracting HNP services. Under the National Integrated Population and Health Program (NIPHP), supported by USAID, the NIPHP directly contracts NGOs to deliver primary health care services through NGO clinics. However, under the Urban Primary Health Care Project (UPHCP) the approach is slightly different. The GOB contracts-out to NGOs through its Project Implementation Office. In the case of the National Nutrition Project (NNP) and the HIV/AIDS Prevention Project (HAPP), which is supported by the WB, the MOHFW delegated the management of the contracting process to UNICEF.

Depending on the country context, using less formal ways of contracting may be more feasible. In Guatemala, agreements known as "*convenios*" were used as the 'contracting instruments' to sidestep the lengthy contracting process and procedures stipulated under the Public Contracting Law. Similarly, in Burkina Faso the government entered into quasi-contractual agreements, referred to as "*Implementation Agreements,*" with their counterparts in the different regions and districts, because the ministry cannot formally contract with its own employees.

Community contracting is another possible mode of contracting HNP services. Community contracting is procurement by or on behalf of a community. It has the potential to improve transparency and lowers costs compared to centralized bidding. The Malawi Social Action Fund (MASAF) is an example of community contracting. It is a quick-disbursing facility that routes money directly to communities and assists communities in contracting health services, and water supply and sanitation. Similarly in Peru, Local Health Administration Associations (known as CLAS) were formed and comprised mainly of community members. These associations are self-administered organizations, which receive funds directly from the Ministry of Health and sign contracts with regional health authorities for the delivery of HNP services according to their own local health plans.

The payment mechanism used for compensating providers has a significant potential to influence the performance of the providers and hence the outcomes. The introduction of incentives to reward good performance and the use of sanctions in case of non-performance are important measures in shaping the providers' performance. The challenge for the purchaser/contracting agency is to choose the right payment strategy to best achieve the desired goals.

In Guatemala, the providers would receive advance capitated payments based on the population size covered in the particular geographical area. The payment would cover direct costs plus administration expenses. This is a fairly low cost method, and caps costs effectively. Furthermore, it is easy to administer and particularly useful where the contracting agency has limited experience and/or ability in contracting. However, the disadvantage is that it may lead to lower quality and "cream skimming" of patients.

An approach similar to the cost and volume method of payment was introduced in Colombia. In this case, 50 percent of the payment was prospective per-capita payment based on an estimated volume of services, while the remaining 50 percent was case-based reimbursement. Each month the contractor would invoice the Ministry of Health for the balance as determined by the legally established case-based charges. This strategy inherently encourages increased volume, sometime to the extent that the provider has the incentive to undertake more activities than specified as long as a greater flow of revenue results. Moreover, this approach is likely to encourage providers to increase volume in those services that entail greater profit margins, and neglect the less well-reimbursed services. As a result, a high degree of monitoring is required for this type of payment mechanism, and therefore, the transaction costs are much higher.

The fee-for-service mechanism generates higher transaction costs as well. The providers have no incentive to reduce costs as they are reimbursed in full. As can be seen from the case of Zimbabwe, the fee-for-service system and the failure to exempt the eligible patients properly prevented adequate cost control. However, some variations in this method can be made, for instance by capping the maximum number of episodes that can be billed during a specified period. The Romanian government piloted a scheme of output-based contracting between doctors and district health authorities. The payment to doctors combined capitation (fixed payment based on their patient list) and reimbursement for about thirty fee-for-service health related items. Capitation was increased for doctors who worked in remote areas, and reduced for doctors not providing services at night and/or on weekends.

The ability to raise and retain user fees at the facility level should be considered when contracting HNP services. Under the UPHC project in Bangladesh, NGOs recover about 20 to 30 percent of their costs through user fees. In the case of Bolivia, a strategy of cross-subsidization was implemented, whereby those who could afford to pay subsidized the services for those who could

not. Also, the fee received for curative care services subsidized the fee for preventive services. Furthermore, revenue from clinics in better-off areas was used to subsidize the clinics in the poorer areas. However in some cases, such as in the case of Karnataka, contractors cannot charge user fees that are not normally levied in a public facility. In the absence of the ability to raise user fees, an NGO contractor can have difficulty raising a substantial part of the operating budget.

An expenditure-based financing mechanism, whereby the contractors are reimbursed for expenses upon submission of cost reports, may not be the best approach. The contractor has no incentive to become more efficient, to improve management or to reduce costs below the maximum permitted ceiling, as they are reimbursed in full for the reported expenditures. Payment is not tied to the achievement of results, and therefore contractors are not motivated to improve performance.

Under the Haiti Health Systems project, an expenditure-based financing system failed to achieve the desired goals. Later the project introduced a performance-based financing mechanism whereby contractors were contracted to work under a fixed price, award fee type of contract. NGOs would get 95 percent of their target budget to meet the agreed service delivery goals, with payments issued at intervals. A performance incentive of 10 percent of the target budget is given to contractors when all targets are substantially met. That results in an extra 5 percent over the target budget for the contractor. While, failure to meet the targets results in an incentive reduction, which usually means that no incentive payment is given to the contractor and projected operation costs are reduced by about 5 percent. In Nicaragua, the Ministry of Health signed performance agreements with the hospitals and health centers. Each agreement clearly specified the actions to be taken and the goals to be achieved, as well as the system for monitoring achievements and measuring the performance against pre-determined categories. A minimum score needs to be achieved to receive bonuses.

In the Urban Primary Health Care Project of Bangladesh, the providers (i.e. the partner NGOs) are paid on a cost-based financing system. Performance is linked to payment such that NGOs have the opportunity to earn an additional bonus of up to 6 percent depending on health impact made in the area covered. Bolivia introduced an innovative financial incentive scheme of fee-sharing with physicians. The doctors were encouraged to work weekends by offering them a higher proportion of revenues generated on weekends compared to weekdays. A risk-sharing incentive scheme was introduced for specialists. A fee per visit was established for physician specialty services. The fee was shared 50/50 between the contractor and the doctor.

Incentives can also be non-financial in nature, such as the case of the NGOs involved in urban immunization in Bangladesh. There was no explicit contract signed for the provision of services, and the NGOs were not given any additional money or resources for conducting the immunizations and immunization campaigns. The NGOs only received the vaccines, supplies and some training, and that provided the incentive for becoming involved in the program. Similarly, in the Nepal TB control program, the NGOs involved are not contractors in the strict sense of the term as there is no official contract other than registering the facility as a Directly Observed Treatment (DOT) program facility. The NGOs or private providers do not receive any financial assistance from the government. The participating providers' major incentive is the signboards confirming that they are accredited by the National TB Program.

A strong and effective monitoring and evaluation (M&E) system, for both technical as well as financial aspects, is an important requirement for contracting to work successfully. Ideally, M&E is accompanied

by provider incentives and sanctions. A strong M&E system is therefore necessary to track providers' performance in order to link performance with payment. In Costa Rica, the COOPESALUD's M&E system has been evaluated and considered to be a very strong system. M&E in that initiative was seen as a key activity. The contracts include a list of indicators to gauge performance as well as an evaluation protocol defining all the necessary details. Ideally, the M&E system should focus on explicit output-based and outcome-based targets rather than specifying the processes. Those targets should be specified clearly in the contracts. There is substantial evidence that contracting-out positively improves access to priority health services, i.e., access is measured in terms of coverage, availability, and quantity of services provided (Lui, 2004). In addition, Loevinson and Harding (2004) found that in a sample of six projects, private contractors were more effective in increasing access to health services than the government.

These favorable results can be explained in part due to the efforts that many contracting-out projects have concentrated directly on improving access, including in such areas as mother child care, primary care and curative care. For example, most governments in Central America have chosen contracting-out to NGOs to expand primary health care coverage in rural areas where public providers are absent or where some population groups are too remote to have effective access to government-provided care. Additionally, access is also the dimension that researchers have most frequently examined in order to assess the performance impact of contracting-out primary health care services.

While Mills and Bloomberg (1998) show that contracting of ancillary services can initially save 20 to 30 percent of costs, an assessment of savings in clinical services is more difficult to undertake. Limited information from the United States on such contracting indicates the establishment of long-term relations based on trust, an ensuing decline of competitive tenders, and the decreasing importance of prices after the first round of contracting. Initial contracting is competitive, but renegotiation is not. Information from the United Kingdom points in the same direction.

# Annex 2: Evaluation of NGO Contracting Models In Bangladesh

## Sample of Health Service Facility/Center by NGOs (Including NNP, BBF, Dhaka Ahsania Mission)

| Model | Name of NGOs | No. of Filled-in Questionnaires | | | | No. of Visited Center |
|---|---|---|---|---|---|---|
| | | Form A: Exit Interview with clients | Form B: NGO Facility Survey | Form C: Interview of Facility Personnel | Total | |
| Model 1: UPHCP and NNP (Directly managed by GOB) | **UPHCP:** | | | | | |
| | Marie Stopes | 90 | 3 | 9 | 102 | 3 |
| | PCC | 69 | 3 | 12 | 84 | 3 |
| | Mamata | 75 | 3 | 12 | 90 | 3 |
| | **NNP:** | | | | | |
| | SHED | 98 | 4 | 8 | 110 | 4 |
| | HEED Bangladesh | 91 | 4 | 8 | 103 | 4 |
| | TMSS | 96 | 4 | 11 | 111 | 4 |
| | BBF | 0 | 0 | 0 | 0 | 3 |
| | Sub-total | **519** | **21** | **60** | **600** | **24** |
| Model 2: NSDP and BPHC (Service delivery through NGOs and contracted manager) | **NSDP:** | | | | | |
| | PSKP | 75 | 3 | 12 | 90 | 3 |
| | JTS | 88 | 3 | 20 | 111 | 3 |
| | Mamata | 72 | 3 | 12 | 87 | 3 |
| | **BPHC:** | | | | | |
| | Nari Moitree | *71* | *3* | 9 | 83 | *3* |
| | **Al Falah Bangladesh** | 27 | 1 | 5 | 33 | 1 |
| | Sub-total | **333** | **13** | **58** | **404** | **13** |
| Model 3: Autonomous Trust (Service delivery through Autonomous Trust) | Dhaka Ahsania Mission | *25* | *1* | 4 | 30 | 1 |
| | Grameen Kallyan | 71 | 3 | 12 | 86 | 3 |
| | Sub-total | **96** | **4** | **16** | **116** | **4** |
| Model 4: Large NGOs delivering PHC | BRAC | 187 | 7 | 23 | 217 | 8 |
| | DSK | 59 | 3 | 11 | 73 | 3 |
| | Gona Shaysthaya Kendra | 30 | 1 | 5 | 36 | 1 |
| | Sub-total | **276** | **11** | **39** | **326** | **12** |
| Model 5: PKSF and SD (Not-for-profit registered company) | | No organization has been selected under the PKSF model as it is not contracting any NGO for any health service delivery activities. However, DSK & TMSS received micro-credit support from PKSF. | | | | |
| | **Total** | **1224** | **49** | **173** | **1446** | **53** |

# Annex 2 (continued): Evaluation of NGO Contracting Models In Bangladesh

## Sample of Health Service Facility/Center by NGOs (Without centers of NNP, BBF, and Dhaka Ahsania Mission)

| Model | Name of NGOs | No. of Filled-in Questionnaires | | | | No. of Visited Center |
|---|---|---|---|---|---|---|
| | | Form A: Exit Interview with clients | Form B: NGO Facility Survey | Form C: Interview of Facility Personnel | Total | |
| Model 1: UPHCP (Directly managed by GOB) | **UPHCP:** | | | | | |
| | Marie Stopes | 90 | 3 | 9 | 102 | 3 |
| | PCC | 69 | 3 | 12 | 84 | 3 |
| | Mamata | 75 | 3 | 12 | 90 | 3 |
| | Sub-total | **234** | **9** | **33** | **276** | **9** |
| Model 2: NSDP and BPHC (Service delivery through NGOs and contracted manager) | **NSDP:** | | | | | |
| | PSKP | 75 | 3 | 12 | 90 | 3 |
| | JTS | 88 | 3 | 20 | 111 | 3 |
| | Mamata | 72 | 3 | 12 | 87 | 3 |
| | **BPHC:** | | | | | |
| | Nari Moitree | *71* | *3* | 9 | 83 | *3* |
| | **Al Falah Bangladesh** | 27 | 1 | 5 | 33 | 1 |
| | Sub-total | **333** | **13** | **58** | **404** | **13** |
| Model 3: Autonomous Trust (Service delivery through Autonomous Trust) | Grameen Kallyan | 71 | 3 | 12 | 86 | 3 |
| | Sub-total | **71** | **3** | **12** | **86** | **3** |
| Model 4: Large NGOs delivering PHC | BRAC | 90 | 3 | 11 | 104 | 3 |
| | DSK | 59 | 3 | 11 | 73 | 3 |
| | Gona Shaysthaya Kendra | 30 | 1 | 5 | 36 | 1 |
| | Sub-total | **179** | **7** | **27** | **213** | **7** |
| Model 5: PKSF and SD (Not-for-profit registered company) | No organization has been selected under the PKSF model as it is not contracting any NGO for any health service delivery activities. However, DSK & TMSS received micro-credit support from PKSF. | | | | | |
| | **Total** | **817** | **32** | **130** | **979** | **32** |

# ANNEX 2 (continued): Evaluation of Ngo Contracting Models In Bangladesh

## Sample of NNP Centers

| Model | Name of NGOs | No. of filled-in questionnaires | | | | No. of Visited Center |
|---|---|---|---|---|---|---|
| | | Form A: Exit Interview with clients | Form B: NGO Facility Survey | Form C: Interview of Facility Personnel | Total | |
| Model 1: NNP (Directly managed by GOB) | **NNP:** | | | | | |
| | SHED | 98 | 4 | 8 | 110 | 4 |
| | HEED Bangladesh | 91 | 4 | 8 | 103 | 4 |
| | TMSS | 96 | 4 | 11 | 111 | 4 |
| | Sub-total | **285** | **12** | **27** | **324** | **12** |
| Model 3: Autonomous Trust (Service delivery through Autonomous Trust) | Dhaka Ahsania Mission (DAM) | *25* | *1* | 4 | 30 | 1 |
| | Sub-total | **25** | **1** | **4** | **30** | **1** |
| Model 4: Large NGOs delivering PHC | **NNP:** | | | | | |
| | BRAC | 97 | 4 | 12 | 113 | 4 |
| | Sub-total | **97** | **4** | **12** | **113** | **4** |
| | **Total (NNP)** | **382** | **16** | **39** | **437** | **16** |
| | **Total (DAM)** | **25** | **1** | **4** | **30** | **1** |
| | **Grand Total** | **407** | **17** | **43** | **467** | **17** |

# Annex 3: Method and Data for Assessing the Comparative Advantage of Public and Private Providers in Bangladesh

***1. Evaluation dimensions: perceived quality, technical quality, price, accessibility, cost, perceived value and derived value***

***2. Sampling of public, private for-profit and private not-for-profit facilities.***

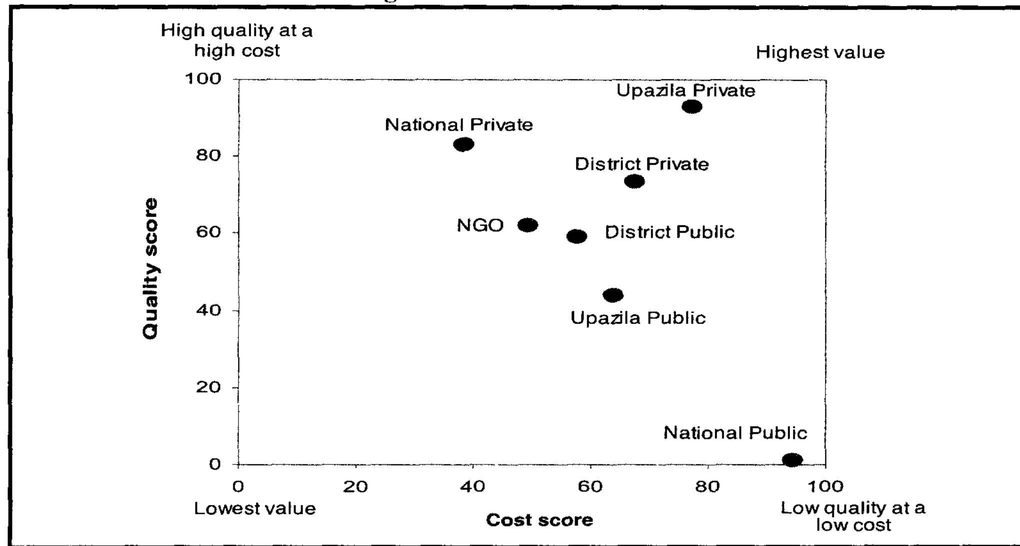
A sample of health facilities in four districts in Bangladesh included 50 facilities. The sample was designed to provide estimates for the national level at the foremost tertiary hospitals (2 public and 4 private), the district level at the general acute care hospitals (4 public and 8 public), and the upazila level at the primary care facilities (8 public, 16 private for profits and 8 NGOs). A three multi-stage sampling design was employed to draw information from each of the represented levels. Data collection instruments included the following:

**Table 3A. Inventory of Data Collection Instruments**

| Instrument | Respondent | Dimensions observed | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Perceived quality | Technical quality | Price | Accessibi lity | Cost | Perceived value | Derived value |
| 1. Facility questionnaire[42] | Person in charge of the facility | X | X | X | X | | | X |
| 2.a Exit poll for outpatients[43] | Outpatient who already received services | X | X | X | X | | X | X |
| 2.b Exit poll for inpatients | Inpatients prone to be discharged | X | X | X | X | | X | X |
| 3. Direct observation * (6 sub-questionnaires – one for each service selected)[44] | Direct observation (outpatients) Medical records inspection (inpatients) | | X | | | X | | X |

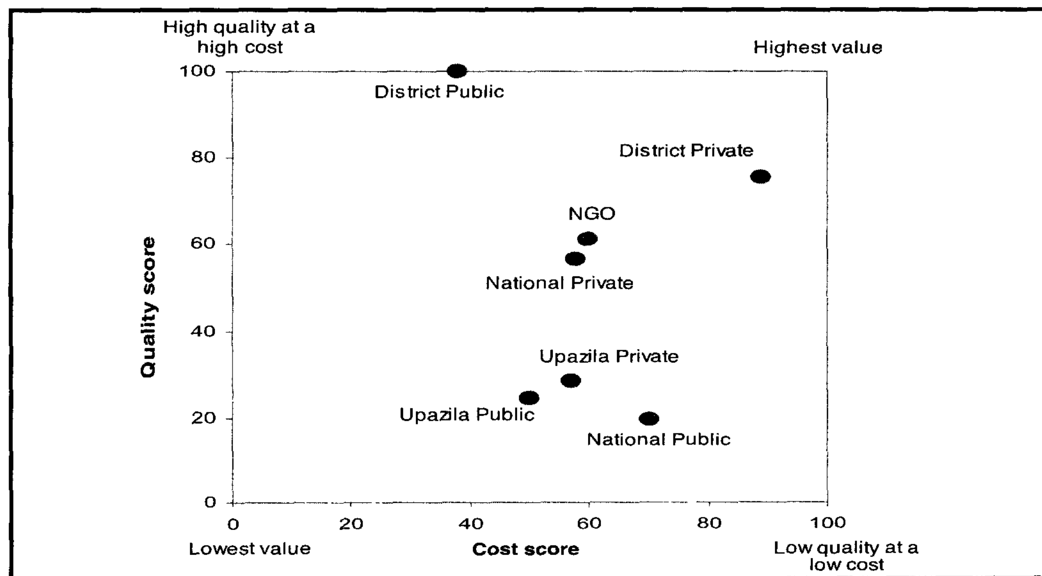
# Annex 3 (continued): Value Derived for Six Selected Services

**Figure 3A. Value Derived for ARI**



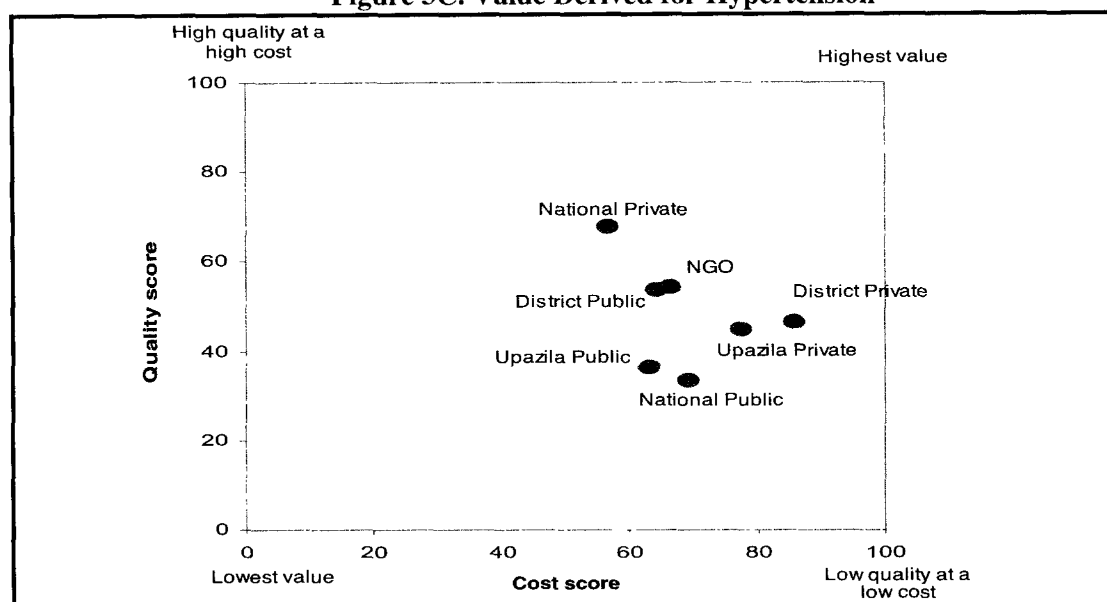

Source: Facility Survey, Exit Poll Outpatients, Exit Poll Inpatients; Direct Observation: Antenatal Care; Direct Observation: ARI; and Direct Observation: Hypertension, (Bitran and Associates, 2004).

**Figure 3B. Value Derived for Antenatal Care**




Source: Facility Survey, Exit Poll Outpatients, Exit Poll Inpatients; Direct Observation: Antenatal Care; Direct Observation: ARI; and Direct Observation: Hypertension, (Bitran and Associates, 2004).

**Figure 3C. Value Derived for Hypertension**




Source: Facility Survey, Exit Poll Outpatients, Exit Poll Inpatients; Direct Observation: Antenatal Care; Direct Observation: ARI; and Direct Observation: Hypertension, (Bitran and Associates, 2004).

**Table 3B Outpatient quality (percent)**

| | Upazila | | | District | | National | |
|---|---|---|---|---|---|---|---|
| | Public | Private | NGO | Public | Private | Public | Private |
| Was explained diagnostic | 80 | 91 | 100 | 94 | 89 | 85 | 100 |
| Women attended by female doctor | 11 | 20 | 66 | 45 | 31 | 36 | 65 |
| Bothered by not being attended by female doctor | 24 | 18 | 0 | 0 | 23 | 11 | 0 |
| Declared treated with courtesy by staff | 87 | 99 | 99 | 89 | 93 | 77 | 98 |
| Rank cleanness of waiting room (percent ) | | | | | | | |
| Clean | 32 | 48 | 62 | 26 | 65 | 48 | 75 |
| Regular | 64 | 49 | 38 | 64 | 34 | 48 | 25 |
| Dirty | 3 | 3 | 0 | 11 | 1 | 5 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Rank cleanness of consultation room (percent ) | | | | | | | |
| Clean | 58 | 58 | 82 | 38 | 80 | 75 | 80 |
| Regular | 41 | 42 | 18 | 62 | 20 | 25 | 20 |
| Dirty | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Rank cleanness of toilets (percent ) | | | | | | | |
| Clean | 10 | 25 | 35 | 6 | 29 | 15 | 44 |
| Regular | 41 | 43 | 38 | 29 | 36 | 15 | 31 |
| Dirty | 14 | 2 | 0 | 38 | 2 | 35 | 0 |
| Did not use it | 34 | 30 | 28 | 27 | 33 | 35 | 25 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Source: Facility Survey of Public and Private Providers, 2004.

**Table 3C Facility quality (percent)**

| | Upazila | | | District | | National | |
|---|---|---|---|---|---|---|---|
| | Public | Private | NGO | Public | Private | Public | Private |
| Ownership status of facility (%) | | | | | | | |
| Own | 100 | 25 | 13 | 100 | 75 | 100 | 100 |
| Rented | 0 | 75 | 88 | 0 | 25 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Main source of drinking water (%) | | | | | | | |
| Piped water | 13 | 0 | 25 | 0 | 0 | 50 | 75 |
| Tank | 38 | 19 | 0 | 0 | 13 | 0 | 0 |
| Hand pump/deep tube well | 50 | 81 | 75 | 100 | 88 | 50 | 25 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Main source of electricity (%) | | | | | | | |
| Public electricity | 50 | 38 | 100 | 50 | 38 | 0 | 0 |
| Public & generator | 50 | 63 | 0 | 50 | 63 | 100 | 100 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Sewerage system of the facility (%) | | | | | | | |
| Sewer | 13 | 6 | 0 | 0 | 0 | 50 | 75 |
| Septic tank | 88 | 94 | 100 | 100 | 75 | 0 | 25 |
| Pots regularly emptied | 0 | 0 | 0 | 0 | 25 | 50 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| % separate toilets for men and women | 100 | 75 | 38 | 75 | 75 | 100 | 100 |
| Cleanliness and functionality rating of toilets (%) | | | | | | | |
| Dirty | 0 | 0 | 13 | 50 | 0 | 0 | 0 |
| Regular | 100 | 81 | 75 | 50 | 88 | 100 | 25 |
| Clean | 0 | 19 | 13 | 0 | 13 | 0 | 75 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Location of most toilets (%) | | | | | | | |
| Attached to wards/rooms | 100 | 93 | 100 | 100 | 100 | 100 | 100 |
| Detached outside | 0 | 7 | 0 | 0 | 0 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Overall maintenance status of the facility (%) | | | | | | | |
| Very well maintained | 0 | 0 | 0 | 0 | 0 | 0 | 25 |
| Well maintained | 25 | 25 | 88 | 50 | 50 | 50 | 75 |
| Somewhat maintained | 75 | 75 | 13 | 50 | 38 | 50 | 0 |
| No maintenance in last 3 months | 0 | 0 | 0 | 0 | 13 | 0 | 0 |
| Rundown | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Channel for appointments (%) | | | | | | | |
| Call in by phone | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Comes earlier to make appointment | 25 | 38 | 0 | 0 | 13 | 50 | 25 |
| Just walk in | 63 | 56 | 100 | 100 | 88 | 50 | 75 |
| Referring doctors | 13 | 6 | 0 | 0 | 0 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Organization of appointments | | | | | | | |
| First come-first serve | 100 | 88 | 100 | 100 | 88 | 100 | 100 |
| By disease severity | 0 | 13 | 0 | 0 | 13 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| % with staff trained in patient handling issues covered in training | 13 | 0 | 75 | 33 | 43 | 0 | 75 |
| Counselling (%) | 0 | 0 | 50 | 33 | 43 | 0 | 75 |
| Personal hygiene (%) | 13 | 0 | 50 | 0 | 14 | 0 | 25 |
| Customer service (%) | 0 | 0 | 25 | 0 | 14 | 0 | 50 |
| Respect of religion (%) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Sensitivity to gender issues (%) | 0 | 0 | 25 | 0 | 0 | 0 | 0 |
| Others (%) | 13 | 0 | 13 | 0 | 0 | 0 | 0 |
| % policy for female patients | 13 | 6 | 0 | 0 | 0 | 0 | 0 |
| % keeps daily patients records | 100 | 50 | 100 | 100 | 75 | 100 | 100 |
| % keeps medical records for all patients | 75 | 38 | 88 | 50 | 50 | 50 | 75 |
| % provides doctors with medical records | 38 | 31 | 88 | 50 | 63 | 0 | 75 |
| % do outreach activities | 13 | 0 | 75 | 33 | 0 | 0 | 0 |
| Provide patients' needs for diagnostic and treatment (%) | | | | | | | |
| Yes | 0 | 0 | 25 | 0 | 25 | 0 | 50 |
| No | 38 | 93 | 75 | 25 | 63 | 0 | 25 |
| Sometimes | 63 | 7 | 0 | 75 | 13 | 100 | 25 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| % where patient must bring | | | | | | | |
| Drugs | 100 | 88 | 75 | 75 | 75 | 100 | 50 |
| Medical supplies | 75 | 88 | 75 | 50 | 75 | 100 | 50 |
| Linen | 0 | 13 | 0 | 50 | 13 | 0 | 0 |
| Other | 0 | 13 | 0 | 0 | 25 | 0 | 25 |
| % written medical protocol | 25 | 0 | 63 | 25 | 25 | 100 | 100 |
| % protocol available to all medical staff | 100 | nd | 100 | 100 | 100 | 100 | 100 |

Source: Facility Survey of Public and Private Providers, 2004

**Table 3D Facility median prices (tk)**

| | Upazila | | | District | | National | |
|---|---|---|---|---|---|---|---|
| | Public | Private | NGO | Public | Private | Public | Private |
| Outpatient consultation | 3 | 90 | 10 | 4 | 200 | 5 | 100 |
| Follow-up consultation | NA | 50 | 10 | NA | 100 | NA | 100 |
| Specialist consultation | 3 | 200 | 20 | NA | 200 | 5 | 25* |
| Complete Blood Count | 20 | 90 | 20 | NA | 100 | 30 | 175 |
| Stool R/M/E test | 10 | 30 | 20 | NA | 28 | 20 | 35 |
| Urine test | 10 | 30 | 20 | NA | 28 | 20 | 35 |
| Chest X-ray | 54 | 100 | NA | 50 | 120 | 50 | 110 |
| Abdomen X-ray | 54 | 100 | NA | 50 | 120 | 50 | 110 |
| Ultrasounds test | 150 | 350 | NA | 220 | 350 | 160 | 650 |
| Inpatient day | NA | 100 | NA | NA | 175 | NA | 300 |
| Normal delivery | NA | 1000 | NA | NA | 1500 | NA | 1750 |
| Cesarean section | NA | 5500 | NA | NA | 4100 | NA | 7500 |
| Minor surgery | NA | 750 | 50 | NA | 2400 | NA | 1750 |

NA Not available; *Not significant

**Table 3E Outpatients Accessibility**

| | Upazila | | | District | | National | |
|---|---|---|---|---|---|---|---|
| | Public | Private | NGO | Public | Private | Public | Private |
| Total of interviews | 90 | 176 | 144 | 66 | 122 | 40 | 80 |
| Distance traveled (km) | 3.9 | 4.8 | 1.9 | 5.5 | 11.3 | 8.9 | 16.7 |
| Travel time (minutes) | 38 | 25 | 16 | 32 | 40 | 46 | 54 |
| Type of transport (percent ) | | | | | | | |
| Public bus | 10 | 12 | 3 | 12 | 32 | 38 | 23 |
| Private motor vehicle | 3 | 6 | 7 | 9 | 11 | 15 | 36 |
| Bicycle | 1 | 2 | 1 | 2 | 3 | 0 | 0 |
| Riksha | 33 | 32 | 47 | 52 | 43 | 30 | 36 |
| On foot | 29 | 13 | 35 | 20 | 3 | 5 | 0 |
| Other | 23 | 35 | 6 | 6 | 7 | 13 | 5 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

| Reason for choosing the facility (percent ) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Been here before | 21 | 22 | 45 | 22 | 23 | 40 | 43 |
| Close to home | 37 | 28 | 18 | 24 | 14 | 20 | 8 |
| Appreciate quality | 7 | 11 | 10 | 17 | 10 | 5 | 8 |
| Doctor has good reputation | 13 | 23 | 12 | 15 | 22 | 10 | 20 |
| Referred | 14 | 15 | 13 | 19 | 27 | 15 | 23 |
| Doesn't know any other facility | 3 | 0 | 20 | 2 | 1 | 0 | 0 |
| Other | 4 | 1 | 2 | 2 | 3 | 10 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| With appointment (%) | 1 | 15 | 0 | 8 | 10 | 13 | 19 |
| Attended at appointed time (%) | 0 | 52 | Nd | 100 | 58 | 0 | 53 |
| Waiting time (minutes) | 29 | 36 | 12 | 22 | 31 | 53 | 32 |
| Think waiting time is acceptable (%) | 58 | 66 | 89 | 69 | 64 | 32 | 60 |
| Acceptable waiting time (minutes) | 23 | 26 | 18 | 21 | 25 | 17 | 20 |

Source: Exit poll of outpatients of public and private providers, 2004

**Table 3F Facilities Access**

| | Upazila | | | District | | National | |
|---|---|---|---|---|---|---|---|
| | Public | Private | NGO | Public | Private | Public | Private |
| Distance | | | | | | | |
| Average distance to three nearest facilities (km) | 2,0 | 0,9 | 2,3 | 2,1 | 1,1 | 1,6 | 1,7 |
| Distance to nearest facility most used by patients (km) | 1,5 | 0,7 | 2,2 | 2,0 | 1,6 | 1,7 | 1,8 |
| Type of three closest facilities (percent ) | | | | | | | |
| Public | 8 | 31 | 45 | 11 | 33 | 33 | 8 |
| Private | 88 | 67 | 55 | 89 | 67 | 67 | 92 |
| NGO | 4 | 2 | 0 | 0 | 0 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Days per week open (percent ) | | | | | | | |
| 6 days | 88 | 0 | 100 | 50 | 50 | 100 | 75 |
| 7 days | 13 | 100 | 0 | 50 | 50 | 0 | 25 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Hours per day open (percent ) | | | | | | | |
| 24 hours | 0 | 6 | 0 | 0 | 0 | 0 | 0 |
| 12:00 to 23:59 hours | 0 | 13 | 0 | 0 | 0 | 0 | 25 |
| 8:00 to 11:59 hours | 0 | 50 | 50 | 0 | 50 | 0 | 0 |
| 6:00 to 7:59 hours | 63 | 6 | 50 | 75 | 13 | 100 | 75 |
| Less than 6 hours | 38 | 25 | 0 | 25 | 38 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Average hours per day open | 5,6 | 9,0 | 7,8 | 5,9 | 6,9 | 6,2 | 7,6 |
| Attends emergencies (percent ) | 100 | 75 | 50 | 100 | 63 | 100 | 100 |
| Attends emergencies 24x7 (percent ) | 100 | 50 | 25 | 100 | 63 | 100 | 100 |
| Time most patients come (percent ) | | | | | | | |
| Morning | 100 | 79 | 100 | 100 | 50 | 100 | 50 |
| Lunch time | 0 | 7 | 0 | 0 | 0 | 0 | 0 |
| Afternoon | 0 | 7 | 0 | 0 | 50 | 0 | 25 |
| No significant difference during the day | 0 | 7 | 0 | 0 | 0 | 0 | 25 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Source: Facility survey of public and private providers, 2004

**Table 3G ARI direct unit costs**

| | | Upazila | | District | | National | | NGO |
|---|---|---|---|---|---|---|---|---|
| | | Public | Private | Public | Private | Public | Private | |
| | | | | | | | | |
| 1 | Total (tk) (2+3+4+5) | 33.3 | 31.8 | 32.4 | 66.6 | 66.4 | 66.5 | 19.4 |
| | | | | | | | | |
| | By type of input (tk) | | | | | | | |
| 2 | Building (8) | 0.2 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 |
| 3 | Labor (16) | 8.2 | 5.4 | 6.4 | 5.7 | 6.2 | 6.0 | 2.3 |
| 4 | Drugs (46) | 5.8 | 6.9 | 6.5 | 18.2 | 9.1 | 12.2 | 6.1 |
| 5 | Exams (57) | 19.1 | 19.4 | 19.2 | 42.6 | 51.0 | 48.1 | 10.9 |

Source: Direct observation survey 2004

**Table 3H Antenatal care direct unit costs**

| | | Upazila | | District | | National | | NGO |
|---|---|---|---|---|---|---|---|---|
| | | Public | Private | Public | Private | Public | Private | |
| | | | | | | | | |
| 1 | Total (tk) (2+3+4+5) | 116.1 | 262.1 | 178.9 | 117.3 | 284.8 | 365.2 | 107.1 |
| | | | | | | | | |
| | By type of input (tk) | | | | | | | |
| 2 | Building (8) | 0.3 | 0.2 | 0.5 | 0.1 | 0.2 | 0.1 | 0.4 |
| 3 | Labor (16) | 12.0 | 7.4 | 12.4 | 5.1 | 5.1 | 8.7 | 4.2 |
| 4 | Drugs (46) | 37.2 | 32.6 | 5.5 | 0.0 | 0.0 | 9.6 | 67.6 |
| 5 | Exams (57) | 66.7 | 221.9 | 160.5 | 112.0 | 279.4 | 346.8 | 35.0 |

Source: Direct observation survey 2004

**Table 3I Hypertension direct unit costs**

| | | Upazila | | District | | National | | NGO |
|---|---|---|---|---|---|---|---|---|
| | | Public | Private | Public | Private | Public | Private | |
| | | | | | | | | |
| 1 | Total (tk) (2+3+4+5) | 90.9 | 151.3 | 150.8 | 156.9 | 533.6 | 612.0 | 45.3 |
| | | | | | | | | |
| | By type of input (tk) | | | | | | | |
| 2 | Building (8) | 0.2 | 0.2 | 0.3 | 0.1 | 0.2 | 0.1 | 0.4 |
| 3 | Labor (16) | 13.2 | 5.2 | 7.0 | 4.9 | 2.0 | 6.4 | 5.0 |
| 4 | Drugs (46) | 3.8 | 35.5 | 0.9 | 1.3 | 1.5 | 426.1 | 34.6 |
| 5 | Exams (57) | 73.7 | 110.4 | 142.6 | 150.7 | 529.9 | 179.4 | 5.3 |

Source: Director observation survey 2004

## ANNEX 4. Alternative Contracting-out Modalities

### Figure IV.1 Private Management Service Agent Model

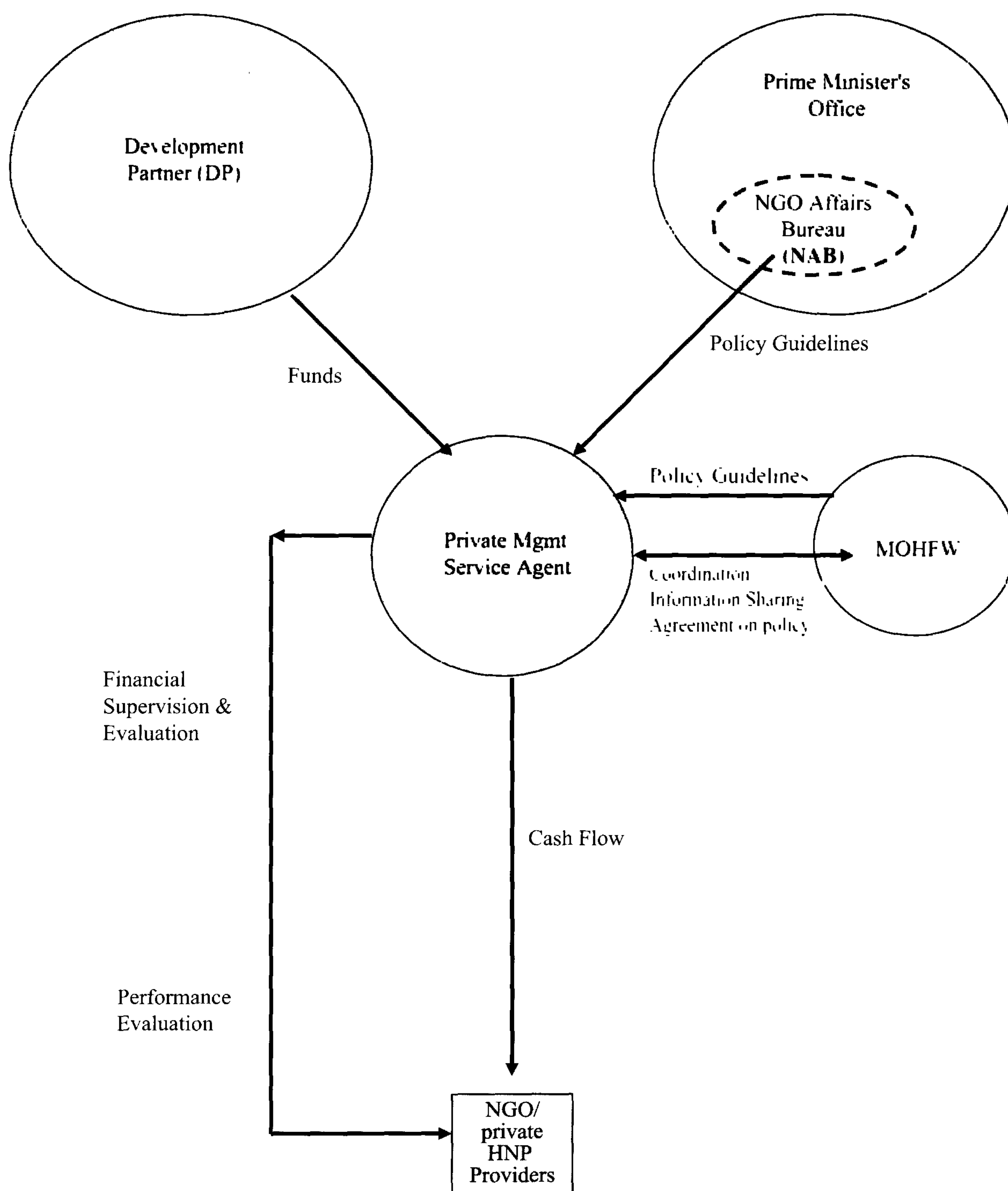


**Figure IV.2 Direct GOB Management Model**

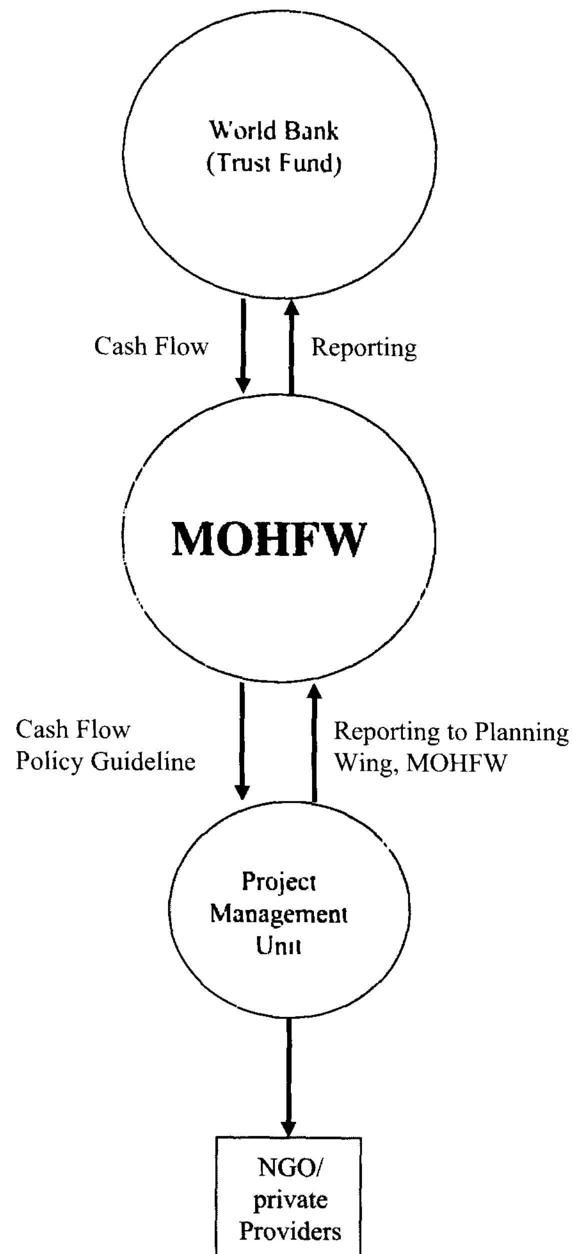
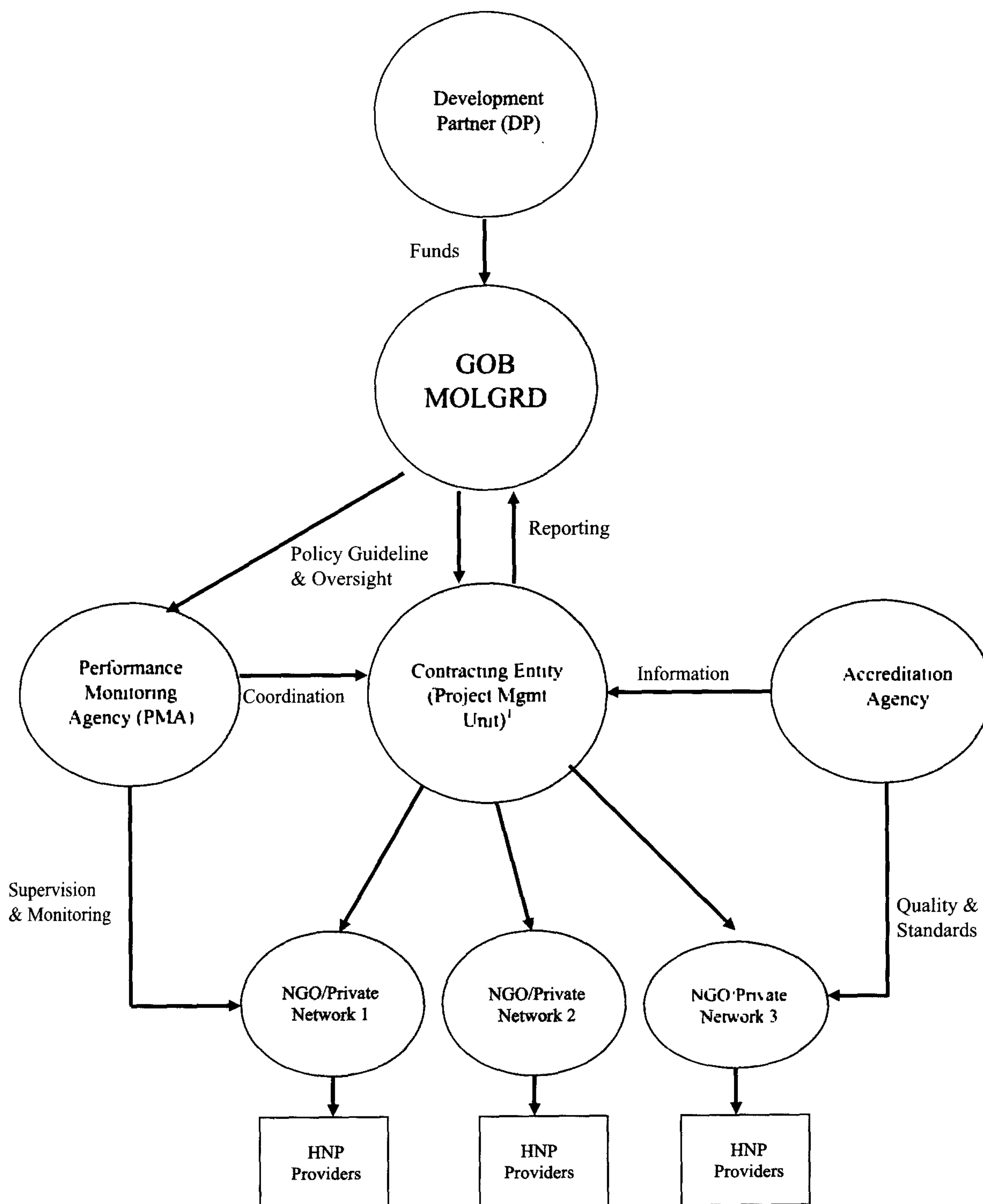


**Figure IV.3 Modified Direct GOB Management Model**




[1] Located in the Dhaka City Council

**Figure IV.4 Modified Non-Profit Registered Company Model**

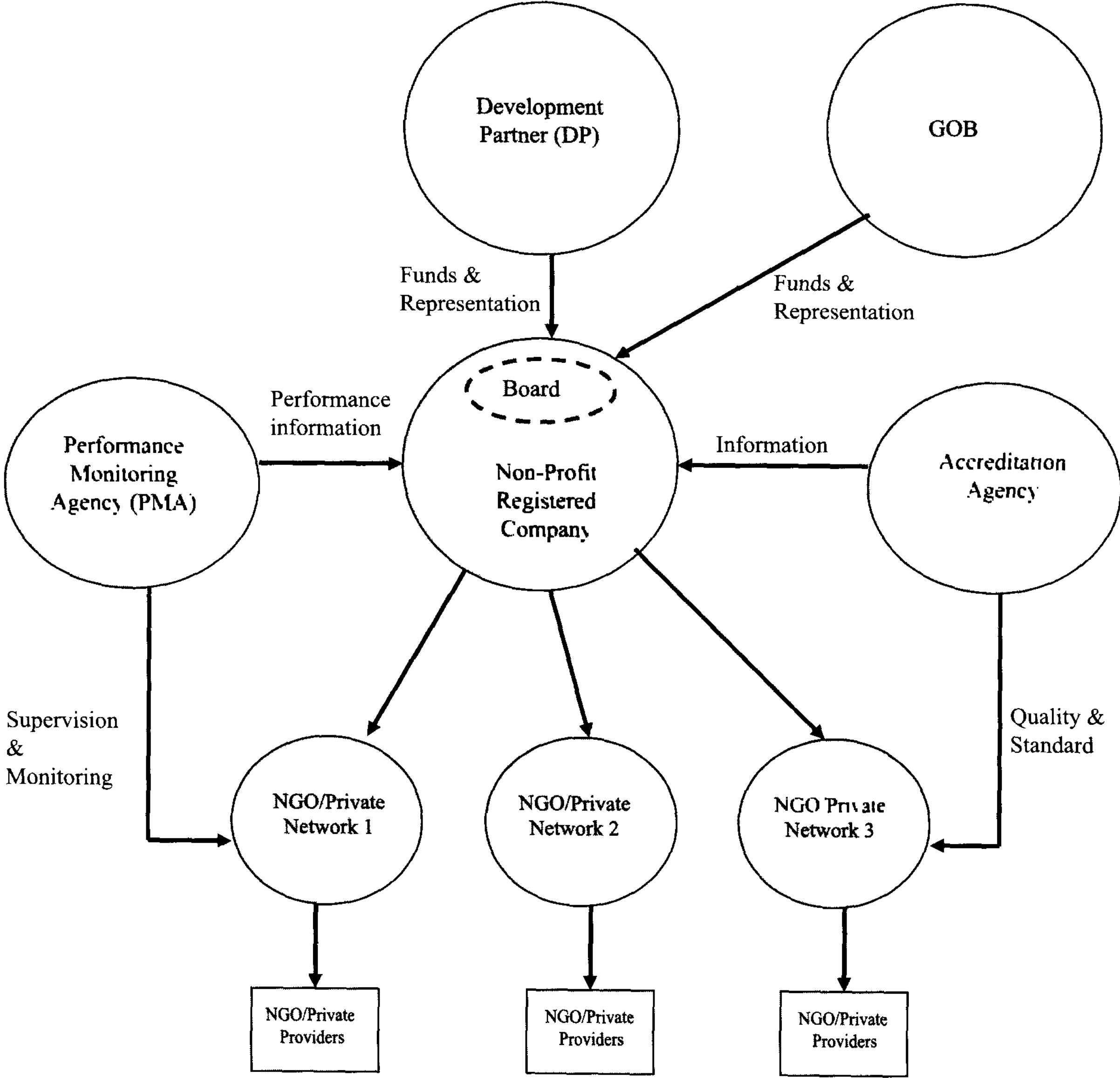
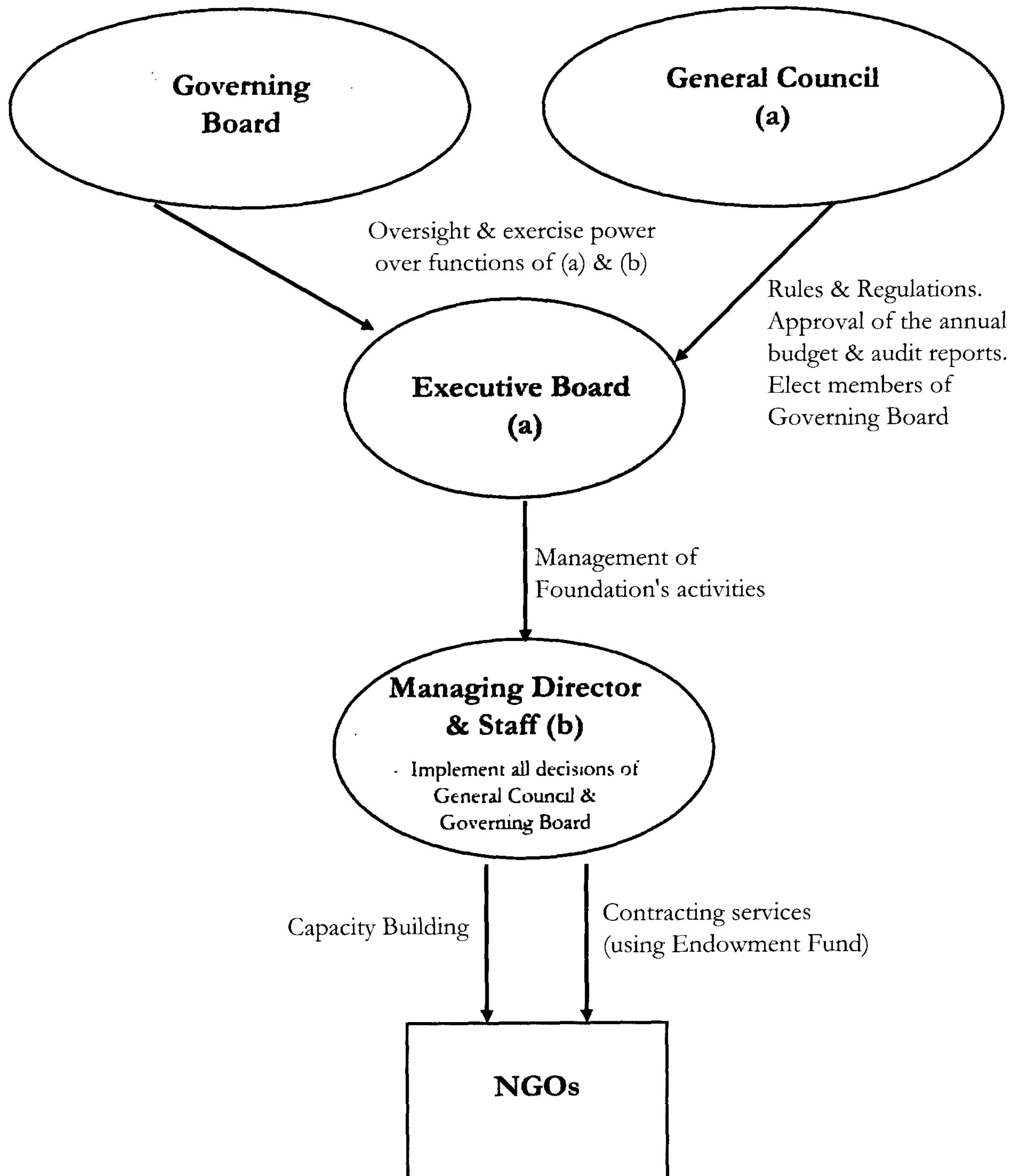
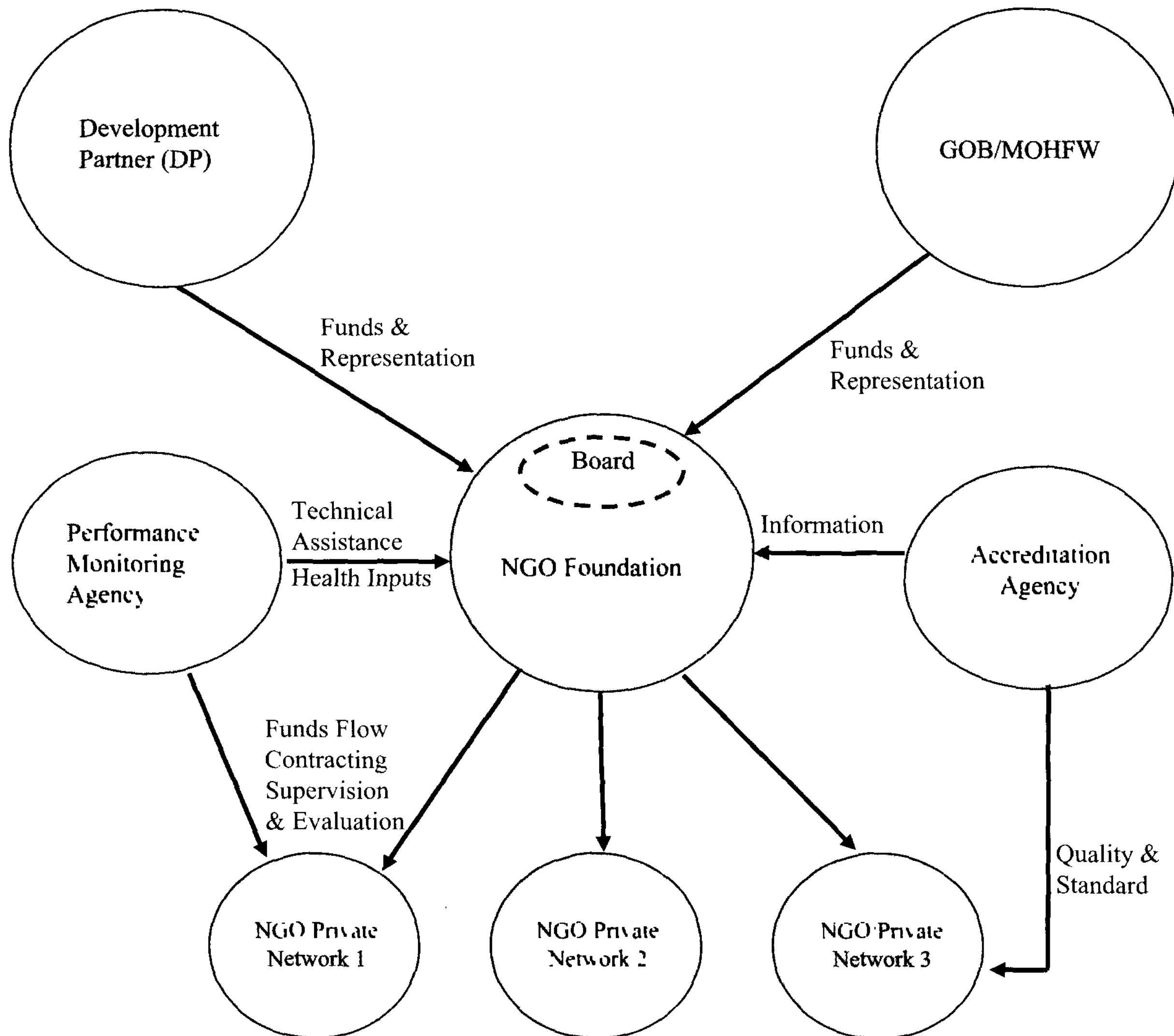


**Figure IV.5: NGO Foundation**



## Figure IV.6 Modified NGO Foundation Model



# ANNEX 5: Summary of Issues and Suggested Policy Options

| AREAS | STRATEGIES (POLICY OPTIONS) | WHO IS INVOLVED (ACTORS) | WHAT TO DO (ACTIONS) | WHERE DID IT WORK? (EXPERIENCES) | RISKS AND BOTTLENECKS |
|---|---|---|---|---|---|
| **Contracting modality** | Reaching the poor | NGO<br>Community | Establishment of "equity" targets to reach a defined proportion of poor households | Bangladesh | Periodic surveys are not carried out together with benefit incidence analysis to measure the access to services and financing by the poor |
| | Fees exemptions | NGO<br>Community | Health cards given to the poor as identified by CG and/or proxy mean tests | Colombia<br>Peru | |
| | | | | | |
| **Contract provision** | User fees linked with incentive payments | NGO management staff of NGO providers | To include it in the contracts | Cambodia | |
| | Contracts include funds for medical equipment and procurement of goods by contractor | NGO management<br>MSA/non profit registered company | To include it in the contract | Cambodia | |
| | Bonus subject to performance up to an additional 6% of contract value depending on health impacts in coverage area | NGO<br>PMA<br>MSA/NPRC | To be included in the contract | Bangladesh (ADB, Urban Primary Health Care Project) | |
| | Training component of NGO contracts | NGO<br>APP | To include it in the contracts, an in-house training component. | N/A | BMA may resist |
| | Training for primary health care doctors working in NGO networks under contracts. | Doctors<br>NGO networks | DP funds | Albania | |
| | Essential drug list | NGO/PSO/MSA/NPRC | To be included in the contracts | Albania | |
| | TA assistance to NGOs in strategic planning, financial management, pricing, costing and revenue analysis, HR, quality control, etc. | NGO<br>PSO/MOHFW | TA to be coordinated by PSO/MOHFW | N/A | Limited capacity of PSO team |
| | | | | | |
| **Financial settings** | Payment mechanisms | NGO<br>MSA/NPRC | Capitation<br>Bonus incentive to staff and organization for good performance | Cambodia<br>Chile<br>Brazil<br>USA<br>Kyrgyzstan | Lack of a strong supervision and evaluation system |

| AREAS | STRATEGIES (POLICY OPTIONS) | WHO IS INVOLVED (ACTORS) | WHAT TO DO (ACTIONS) | WHERE DID IT WORK? (EXPERIENCES) | RISKS AND BOTTLENECKS |
|---|---|---|---|---|---|
| | Bonus to staff | NGO staff | 100% bonus added for staff practicing in remote or low-income areas, and additional financial incentive for higher professional qualifications. | Romania | |
| | | | | | |
| **Laws and Regulation** | Enact law to address medical malpractice | BMA<br>MOHFW<br>Parliament<br>Users<br>Consumer rights groups | Pass and approve law in the Parliament | Most countries in the world, especially Europe and the Americas | Resistance from BMA.<br>If law is approved, it may be difficult to be enforced |
| | Doctor rural service law | BMA<br>MOHFW | Pass and approve law in the parliament | South Asian countries, LAC and others. | Not very likely |
| | Retention of users fees by NGOs | NGO<br>MOHFW<br>MOF | MOF should enact the norm allowing for this | Cambodia, Thailand, Bangladesh Latin American Countries and others. | Agreement between MOF and MOHFW, poor management of retained funds at the local level |
| | Procedure manual for the functioning of CBO | NGO<br>MOHFW | MOHFW should enact the norm | Peru<br>Bangladesh | Full compliance of the norms, given management flexibility to CBO |
| | Authorizing GOB staff to be on leave and to work in NGOs/private organizations | GOB staff<br>MOHFW<br>MOE | Legal norm cleared by the Prime Minister | Cambodia | |
| | Establishing the procedures for formal resolution of disputes between the NGO contractor, MOHFW and the Contracting agency | NGO<br>MSA/NPRC/MOHFW | Contracting out the dispute resolution services to an international firm | Cambodia | GOB may not support the action |
| | Accreditation agency (NAAH) | NGO networks<br>NGO providers<br>MSA/NPRC/MOHFW<br>Users | To be prepared by MOHFW with the assistance of DP, and approved by Prime Minister | South Africa<br>Thailand<br>Egypt<br>Brazil<br>Zambia | No interest shown by relevant GOB departments<br>Opposition from NGOs |

| AREAS | STRATEGIES (POLICY OPTIONS) | WHO IS INVOLVED (ACTORS) | WHAT TO DO (ACTIONS) | WHERE DID IT WORK? (EXPERIENCES) | RISKS AND BOTTLENECKS |
|---|---|---|---|---|---|
| | | | | | |
| **Supervision and evaluation** | HNP observatory to protect and oversee consumer rights | Consumer groups<br>NGO<br>MOHFW | To be prepared by MOHFW with the assistance of DP, and approved by Prime Minister | | Opposition from BMA and MOHFW |
| | Creation of the Performance Monitoring Agency (PMA) | NGO<br>MOHFW | Designed by MOHFW with the assistance of DP. | | Opposition from NGO and MOHFW |
| | Formation of Community boards (community groups) in the community clinics | NGO<br>MOHFW | Registration of CG as non-profit institutions and transfer management of the health facility and all related assets to them. | Bangladesh<br>Senegal<br>Sub-Saharan<br>Madagascar<br>Malawi | |
| | Performance-based financing agreements and supervision | MSA/NPRC/NGO | A weighted score system based on agreed categories and weights Supervision and evaluation plan are to be included in the contracts | Nicaragua<br>Guatemala<br>Costa Rica<br>Haiti | |
| | Local authorities given budget to carry out their work programs | MSA/NPRC/NGO/ MOHFW | Each district has an implementation agreement with the MOHFW | Burkina Faso | |
| | Drug and policy committee | MOHFW<br>NGO | To be created. | Albania | Interest groups dominate the committee |
| | | | | | |

[1] In Laos, the World Bank with Belgium Aid and the Swiss Red Cross demonstrated the benefits of contracting with NGOs.

[2] R. Taylor, Harding and Preker, eds., 2003, p. 157.

[3] Cambodia, Shahrzad, 2004, and Dunlop, Cambodia paper, 2004.

[4] World Bank, 1993.

[5] Chaudhury, N. and J. S. Hammer, *Ghost Doctors: Absenteeism in Bangladeshi Health Facilities*, Research Working Paper 3065, World Bank, May 2003.

[6] Service Delivery Survey, CIET, 2003.

[7] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[8] Harding and Preker eds., *Private Participation in Health Services*, World Bank, Washington D.C., 2003.

[9] The administrative structure of the country includes 6 divisions, 64 districts, 496 upazilas, and 4451 unions.

[10] Field survey instruments utilized in the study are available at www.health-swap2.com.

[11] An Evaluation of NGO contracting in Bangladesh: Contracting NGO for the delivery of health services, AUS Health International in association with ADSL. Report commissioned by the World Bank, November 2004.

[12] Section 3.2 of Chapter 3 describes the characteristics of several modalities of NGO service delivery. Additional information can be found in C. Cummings *et al.*, March 2004.

[13] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[14] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[15] The following is based on survey results of NGO facilities, health care providers of NGO facilities, and users of NGO services, which was carried out as part of the study. See Annex 1. In total, the survey team visited 53 health centers of the selected 16 NGOs to collect information from facility personnel (173 interviews) and clients (1,224 exit interviews). A comparative analysis was made of 32 health centers with comparable data, including 817 exit interviews with users and 130 facility personnel interviews.

[16] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[17] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[18] User satisfaction level of NGOs compared to public and private sector are shown in Annex 3.

[19] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[20] The NGO facility personnel survey included 130 interviews with NGO personnel to obtain information about their opinions on service delivery and the NGO's practices. Out of these 130 personnel, 84 were service providers, including physicians, nurses, midwife, etc.

[21] All the quality scores were used to calculate the average score. The average score was multiplied by 10 to arrive at a range from 0 to 100 for the aggregate value.

[22] Household, Income and Expenditure Survey 2000.

[23] RDP Medi Vision International, *Bangladesh Urban Primary Health Care Project-2, Midterm Report and Situation Analysis*, Project Preparation Technical Assistance PPTA 4165, (Zeist, The Netherlands: for the GOB and the ADB by RDP Medi Vision International, April 2004).

[24] See Section 6 below for additional discussion regarding this issue of fee legality.

[25] Comments of Prof. Mynuddin, Legal Counsel to the Dhaka Office of the World Bank, July 27, 2004.

[26] See MOP, *The Procedures for Implementation of the Public Procurement Regulations*, 2003, (Dhaka: GOB, March 2004).

[27] See G. Angeles, P. Hutchinson and S. N., Mitra, *2001 Urban Family Health Partnership Evaluation Survey*, (Chapel Hill, NC: Measure Evaluation and Mitra and Associates, February 2003).

[28] See David Dunlop, "Financing and Cost of Child health Care in Cambodia, Circa 2004: Are We Out of Balance?," draft paper prepared for URC/USAID, (Phnom Phen: URC, May 16, 2004). In this analysis the author was able to document the fact that administrative overhead costs amounted to about 50% of the total cost of PHC service delivery in a rural based PHC clinic/health center.

[29] For detailed information see "Comparative advantages of public and private providers in health care service in terms of cost," Bitran & Associates, WB/HPSO, December, 2004.

[30] See Chris Cummings, *et al.*, *Scoping Study of Potential Mechanisms for Strategic Financing of NGO Provision of Education and Health Services*, (Dhaka: Options/DFID, March 2004).

[31] These entities include: HLSP, PHD/BPHC, and NICARE funded mainly by DFID, NSDP (USAID), Save the Children USA currently funded by GFATM and possibly by USAID, and UNICEF a UN organization, funded by the MOH via the WB HAPP project.

[32] These NGOs include BRAC, TMSS, and undoubtedly others as well.

[33] This concept has been discussed in several reports and documents. See the following materials: B. Foseberg and J. Sundewall, *Contributions to the HNPSP Planning*, (Stockholm: Karolinska Institute, June 30, 2004); and S. M. Jahangir, "NGOs to Come Under Regulatory Framework," *Financial Express*, vol. 11, no. 234, July 14, 2004,

[34] Bangladesh National Health Accounts, 1999-2001, HEU, MOHFW, 2003.

[35] The three-year community pilot program suggested by the MOHFW includes a technical assistance (TA) team responsible for contracting on the MOHFW's behalf following the GOB procurement regulations. This TA team would be supervised by a Community Clinic Program Implementation Committee (CCPIC) which will establish the TA team, approve NGO selection, secure inter-ministerial and inter-agency coordination and liaise with DPs. The program envisions the formation of a local Community Clinic Management Group (CCMG) with community member representatives. The CCMG would continue to operate the CCs. The CCMG would sign a MOU with the MOHFW at the union level and above, and local NGOs would support the contracting process. (M. M. Shawkat Ali, Chris Minnett, Md. Osman Ali, Community Clinic Pilot Programme, DFID support to the MOHFW, August 2004).

[36] See Mokbul Morshed Ahmed, "The State, Laws and Non-Governmental Organizations (NGOs) in Bangladesh," *International Journal of Not-for-Profit Law*, 3 3 (March 2001).

[37] See Chapter 4 in A. Harding and A. Preker eds., 2003 for a more detailed review of regulatory mechanism that have been applied and what they have achieved.

[38] As of January 1, 2004, the PPP/NICARE approach had been implemented in 41 community clinics, with an additional 29 sites targeted for implementation during 2004. They would like to expand to 200 sites to fully test this approach. See PPP/NICARE, *Proposals for Functioning of Community Clinics Based on GO/NGO/Community Partnership*, (Dhaka: NICARE, about July, 2004).

[39] The Program Support Office (PSO) will be located in and managed by the MOHFW to promote and support the implementation of the HNPSP. The GOB and the WB have agreed to this as part of the implementation arrangement of the HNPSP support.

[40] In the meantime, the proposed NGO Foundation will need to follow up on recommendations proposed by this study to ensure transparency and to reduce the prospect of inappropriate fund diversions.

[41] See David Dunlop, *The Economics of Health Service Delivery in Uganda: Implications for Health and Economic Planning*, Ph.D. dissertation, (East Lansing, MI: Michigan State University, December 1973).

[42] Provides a description of the facility. It was composed of six subsections: Main facility survey, services utilization section, staffing section, infrastructure and equipment section, drugs and supplies section, and recurrent costs.

[43] Information was collected directly from the facility's users regarding their socio-demographic characteristics, level of satisfaction with the service received, expenses incurred (both formal and informal payments) and the facility's accessibility for them. Outpatients generally were interviewed outside the facilities and sometimes in the waiting rooms.

[44] Outpatient care: Antenatal Care (reproductive care and essential component of the ESP), ARI (child care - ESP), Hypertension (adult care – ESP). Inpatient care: Severe Diarrhea (Non-surgical curative care – ESP), Normal (Vaginal) Delivery (maternal care – ESP), Caesarean section (surgical intervention and maternal care – ESP). Data on the direct medical services received by ***outpatients*** was collected by observing the treatment protocol of a sample of outpatients at the selected facilities. Information on direct medical services, drugs and supplies received by ***inpatients*** were collected primarily from medical records of a sample of patients who had completed treatment and were waiting to be discharged. Some information was also collected through interviews with patients, and in some cases, interviews with the attending relatives/friends.