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HEALTH, NUTRITION, and POPULATION SERIES



# Performance-Based Contracting for Health Services in Developing Countries

*A Toolkit*



THE WORLD BANK

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# **Performance-Based Contracting for Health Services in Developing Countries**

*A Toolkit*

Benjamin Loevinsohn



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1818 H Street NW  
Washington DC 20433  
Telephone: 202-473-1000  
Internet: [www.worldbank.org](http://www.worldbank.org)  
E-mail: [feedback@worldbank.org](mailto:feedback@worldbank.org)

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## Why and How to Use This Toolkit

**Why Use This Toolkit?** This toolkit provides practical advice to anyone involved in, or who is interested in becoming involved in, performance-based contracting of health services with nonstate providers in the context of developing countries. It addresses many of the issues that may be encountered. Input from experienced contracting professionals will give newcomers increased confidence as they go forward. Experts directly involved in contracting on a large scale have contributed to the development of this toolkit.

**What Is Contracting?** Contracting is a mechanism whereby a financing entity procures a defined set of services from a nonstate provider.

**What Is This Toolkit About?** Performance-based contracting is a type of contracting with a clear set of objectives and indicators, systematic efforts to collect data on the selected indicators to judge contractor performance, and consequences for the contractor, either rewards or sanctions, based on performance.

**Intended Audience.** This toolkit has been developed for individuals working for government agencies, other purchasing entities (such as insurance companies and social insurance funds), nongovernmental organizations, faith-based organizations, private (for-profit) health care providers, World Bank staff, and development partners.

**Where to Start.** The short summary gives an overview of the toolkit. Readers can then delve into increasing levels of detail by working through the various sections and appendixes.

**Limitations of the Toolkit.** The actual task of contracting is more of an art than a science. Although a reasonable amount of evidence suggests that contracting works (see section 5), many of the “how-to” issues are a matter of experience rather than systematic evidence. As we learn more about contracting, some of what we believe now may change. Keep in mind that contracting occurs in different contexts. Some issues raised in the toolkit are not relevant in certain situations but may be crucial in others.

**Don’t Panic!** A number of issues have to be considered in contracting, but everything need not be exactly right on the first try. Beethoven scratched out more than a few musical ideas as he was writing his Ninth Symphony, and scientific scans of Leonardo da Vinci’s *Mona Lisa* show that he changed his mind about her more than once. Just like creating great art, every detail doesn’t have to be perfect every time, and certainly not right off the bat.

**Other Useful Materials.** Additional materials including key documents, such as a contracting plan, draft contract, terms of reference, and checklist, are included in the toolkit and are available in MS Word format at <http://www.worldbank.org/hnp/contracting>.

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## Outline of the Toolkit

**Section 1: Summary of the Toolkit.** This overview is useful for reference and for quick refreshers later. It will be helpful to read the summary before moving on to the main part of the toolkit.

**Section 2: What Is Performance-Based Contracting?** This section provides background on contracting, including definitions of key terms, the types of services that can be contracted, how contracting relates to other ways of organizing health services, and which contracting approaches work in different settings.

**Section 3: How to Contract.** This section provides a systematic way of thinking about contracting and how to do it in practice. It looks at seven aspects of the contracting process from initial dialogue with stakeholders through carrying out the bidding process and managing contracts. This framework will help ensure a systematic consideration of the choices and challenges (see figure 1.1).

**Section 4: Checklist for Contracting.** This checklist contains tasks and issues to address while designing and implementing a contract. The checklist can also be used to review an existing contract to see what is missing or could be improved.

**Section 5: Whether to Contract.** This toolkit assumes that the reader has an interest in contracting, but it is useful to keep asking questions. This section reviews the evidence for contracting in developing countries, explores why contracting appears to work, and addresses concerns that have been expressed about contracting.

Table 1 outlines the five appendixes to this toolkit, the purpose of each, and when they should be used.

**Table 1** Toolkit Appendixes

<i>Appendix</i>	<i>Purpose</i>	<i>Point of use</i>
A Contracting Plan: Strengthening Primary Health Care Services in Country X	Example of a contracting plan or contracting manual, which should be developed for all contracting efforts	During the design phase of a contracting effort, step 5; includes a draft agreement between the purchaser and the contractor
B World Bank Procurement Approach	Guidance for World Bank clients and staff on the procurement methods to use in different contexts	During the design phase of a contracting effort, steps 4 and 6
C Description of Evaluated Contracting Experiences	Real-world experience that can be used to see what others have done	During the design process; it may be helpful to read this appendix before dialogue with stakeholders, step 1
D Terms of Reference for Third-Party Evaluation	Example of TORs for an independent evaluation of a contracting effort	In cases in which the purchaser would like to evaluate how well the contracting effort has performed using a third party
E Terms of Reference Examples	Examples of TORs for primary health care service that lays out objectives, scope of work, roles, and responsibilities	During the design phase of the contracting effort; it would also be included in the contract

*Note:* TOR = terms of reference.

**Your Suggestions and Comments Are Welcome.** Please send us your suggestions about how this toolkit can be made more useful: <http://www.worldbank.org/hnp/contracting> or [healthpop@worldbank.org](mailto:healthpop@worldbank.org).

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## Abbreviations

ARI	acute respiratory tract infection
ARV	antiretroviral
BF	breast fed
BHC	basic health center
BHU	basic health unit
BINP	Bangladesh Integrated Nutrition Project
BPHS	basic package of health services
BPS	basic package of services
BWP	Bahawalpur
CBO	community-based organization
CCC	Chittagong City Corporation
CCSS	Centro Costaricense de Seguridad Social
CHC	comprehensive health center
CHW	community health worker
CI	contracting in
CIDA	Canadian International Development Agency
CMU	contract management unit
CO	contracting out
DP	development partner
DPT3	diphtheria, pertussis, and tetanus (vaccine, 3 doses)
EPI	expanded program on immunization
FBO	faith-based organization
FSW	female sex worker

G	government without support
GFATM	Global Fund to Fight AIDS, TB, and Malaria
GOX	Government of Country X
GS	government with support
HFA	health facility assessment
HHS	household survey
HIV	human immunodeficiency virus
HMIS	health management information system
IBBS	integrated behavioral and biological surveillance
LFA	local fund agent
LQAS	lot quality assurance sampling
M&E	monitoring and evaluation
MC	management contract (contracting in)
MCH	maternal and child health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOPH	Ministry of Public Health
MSW	male sex worker
NGO	nongovernmental organization
NSP	nonstate provider
NSSP	new sputum smear positive
NTP	national tuberculosis program
P4P	pay for performance
PAA	partnership agreement area
PBA	performance-based agreement
PHC	primary health care
PHCC	primary health care center
PHD	provincial health director
PLWHA	people living with HIV/AIDS
PPA	performance-based partnership agreement
PPHCC	Provincial Public Health Coordination Committee
PPP	public-private partnership
PubMed	U.S. National Library of Medicine

RFP	request for proposal
RYK	Rahim Yar Kahn
SDC	service delivery contract (contracting out)
SSS	single-source selection
STI	sexually transmitted infection
TB	tuberculosis
TOR	terms of reference
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCCT	voluntary confidential counseling and testing
WHO	World Health Organization

All dollar amounts are U.S. dollars unless otherwise indicated.



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## Summary of the Toolkit

### **Background: What Is Performance-Based Contracting?**

Contracting is when a financing agency (government, insurance entity, or development partner), also known as a “purchaser,” provides resources to a nonstate provider (NSP, such as a nongovernmental organization [NGO] or private sector firm), also known as a “contractor,” to provide a specified set of services, in a specified location, with specified objectives and a set of measurable indicators of success, over a defined period.

Performance-based contracting is a form of contracting that explicitly includes a clear definition of a series of objectives and indicators by which to measure contractor performance, collection of data on the performance indicators, and consequences for the contractor based on performance such as provision of rewards (such as performance bonuses or public recognition) or imposition of sanctions (such as termination of the contract or public criticism).

Many different types of health services have been successfully contracted, including offering primary health care (PHC) services in rural or urban areas, providing HIV prevention services among high-risk groups, establishing health insurance systems, acting as an intermediary with many for-profit providers to strengthen the management of tuberculosis patients, managing hospitals, and operating diagnostic services within health facilities.

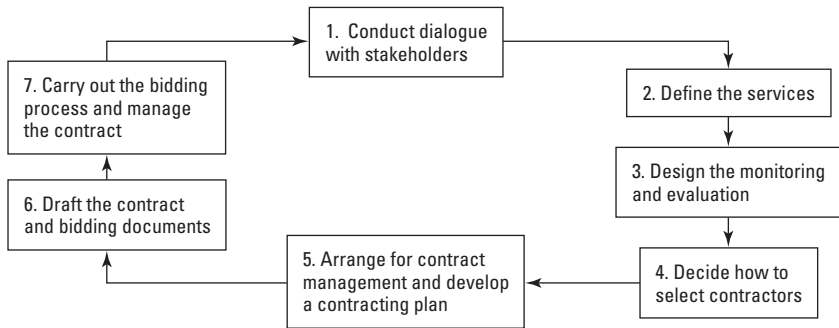
Contracting is different from providing grants because it is the purchaser, not the NSP, who determines which services will be delivered, where, and how performance will be measured. Contracting is also different from internal contracts between one level of government and another, in part because the sanctions that can be used against local governments are usually limited (for instance, they cannot generally be “fired” for poor performance). It is difficult to be prescriptive, but there are some situations that are more conducive to specific forms of contracting than others. For example, in areas in which existing government services are not achieving adequate results, there may be an opportunity to contract in management services. Contracting is often a form of “pay for performance” (P4P) and has been used sometimes to introduce P4P for individual health workers.

## How to Contract

If you believe that contracting may be an approach worthwhile to try in your situation, then you need a systematic approach. Contracting is robust and has worked well even in difficult circumstances, so don’t worry excessively about making everything perfect. Contracting is more of an art than a science, but a systematic approach can avoid some of the most common mistakes. The “contracting cycle” shown in figure 1.1 can help in this regard, as can the checklist in section 4, which summarizes in two pages most of the issues that need to be addressed.

### *Step 1: Conduct Dialogue with Stakeholders*

Designing and implementing an effective contracting system requires close consultation with stakeholders, such as government health workers, government health officials, local politicians, NSPs, development partners, and the community. After initial discussions about contracting, it is worthwhile to draft a contracting plan (see the example in appendix A) and then go back to stakeholders with concrete proposals to discuss. There is usually a need to identify “champions” among the stakeholders to support contracting efforts and overcome resistance. A few common stakeholder concerns are frequently encountered that can be addressed in a number of creative ways. For example, resistance

**Figure 1.1** The Seven Steps of Contracting

Source: Author.

from government health workers may be overcome by paying higher salaries or providing performance bonuses.

### *Step 2: Define the Services*

The process of designing a contract may involve thinking about many issues, but five are usually of central importance:

1. Defining the objectives of the contract and selecting the indicators of success
2. Ensuring that equity and quality of care are addressed
3. Ensuring that contractors (and purchasers) focus on achieving the stated objectives, possibly through the use of paying for performance
4. Defining the size and location of service of each contract “lot”
5. Defining the scope of services to be delivered.

The process of contracting must start with a clear definition of objectives and indicators. Indicators should focus mostly on outcome and outputs, be measurable, be defined as precisely as possible, and be few in number (generally fewer than 10). It is worthwhile to include indicators that ensure that the poorest people and other marginalized groups receive high-quality services. Ensuring that purchasers and contractors pay attention to the key indicators can be accomplished by P4P (for example, by using bonuses or linking payment to the number



of services provided). Paying for performance is attractive, but indicators must be independently verified and perverse incentives must be avoided. For example, paying for each additional cesarean section may lead to an excessive number being performed.

The purchaser needs to define each contract “lot,” that is, the size and location of service of each individual contract. The lots should be relatively large to achieve economies of scale, facilitate management and monitoring, and increase competition among bidders. The scope of services needs to be defined in sufficient detail so that contractors know what is expected, although the terms of reference (TORs) should generally avoid telling contractors “how” they should deliver services except to ensure compliance with national technical standards.

### *Step 3: Design the Monitoring and Evaluation*

Considerable argument is often given to which indicators should be used, but little time or effort may be given to deciding how data will be collected, for instance, through the use of a routine health management information system, household surveys, health facility assessments, or supervisory checklists. A schedule for data collection needs to be established with particular attention to collection of baseline data. It needs to be clear who is responsible for implementing the monitoring and evaluation (M&E) plan, and a sufficient budget should be allocated to ensure that the plan can actually be implemented.

### *Step 4: Decide How to Select Contractors*

**Competitive Selection Process.** The best way of selecting a contractor is through an open competition, according to clear selection criteria developed in advance, that uses a transparent and independent evaluation process. An independent and diverse bid evaluation committee comprising experts from various institutions is an important part of the process. The number of interested bidders can be maximized in a number of ways, including carrying out consultations with potential contractors before the selection process and advertising widely.

**Selection of Contractors under World Bank Guidelines.** There are two distinct methodologies for selecting contractors. When the output is an easily measured physical result (for example, maintenance of equipment or cleaning), the contractor should be selected using a

wide, competitive process in which the contract will be awarded to the bidder with the lowest price who meets the technical criteria established by the purchaser. When the output is of an intellectual nature (for example, managing a hospital or providing treatment to people living with HIV/AIDS), the contractor should be selected in conformity with procedures normally used for the selection of consultants. There are three methods that can be used in this case: selection based on quality and cost among short-listed firms, fixed budget, and single-source selection. Hybrids of these approaches exist that can also be useful. Although open competition is the preferred approach, circumstances that will be described later in the toolkit may justify the fixed budget and the single-source selections.

### *Step 5: Arrange for Contract Management and Develop a Contracting Plan*

Managing contracts requires full-time attention by a clearly defined, reasonably sized team with explicit responsibilities and authority. To function effectively, such a team requires people with a variety of skills and a sufficient budget to cover salaries, equipment, and transportation. When the number of contracts is large, consideration should be given to using contract management software. Effectively implementing a contracting effort requires a written contracting plan (most issues can be dealt with in six or seven pages, as can be seen from the example in appendix A).

### *Step 6: Draft the Contract and Bidding Documents*

**Maximizing Managerial Autonomy and Accountability.** There is increasing evidence that autonomy improves contractor performance. Maximizing managerial autonomy also allows purchasers to hold contractors accountable. Safeguarding autonomy can be accomplished by clearly defining the respective authority of the contractor and government officials, using lump-sum budgets rather than line-item budgets, giving contractors control of personnel functions (such as hiring, firing, posting, and handling pay and benefits), and leaving procurement of various supplies up to the contractors.

**Protecting the Interests of Both Parties.** Contract duration should be at least four to five years to allow both parties to get used to

the contractual relationship. To facilitate implementation of the contracts and to reduce opportunities for corruption, clear procedures must be in place for processing both mobilization payments and ongoing payments. Enforcement of a contract requires a clear process for termination, use of other sanctions, and a practical mechanism for resolving disputes.

**Reporting and Other Obligations.** Contracts should specify the content of the contractors' regular progress reports and may mandate independent financial audits. The TORs should also address whether and how contractors can levy user charges, what their responsibilities for building health worker capacity are, and who is responsible for maintenance, repair, and rehabilitation of physical infrastructure.

**Formulating a Request for Proposals.** On the basis of the considerations above, a request for proposal (RFP) or similar document should be drafted that includes instructions to the bidders on how to prepare their bids and the criteria by which contractors will be selected, the TORs, and the draft contract.

### *Step 7: Carry Out the Bidding Process and Manage the Contract*

In almost all situations, it should be possible to complete a competitive bidding process in six months. Long delays should be treated with suspicion. Because contracting involves complex relationships, the contract management unit should meet regularly with contractors and regularly report to major stakeholders. During the implementation of the contracts, the contracting plan and the contract should be reviewed regularly.

## **Whether to Contract**

A review of global experience with contracting for health service delivery is described in section 5. Fourteen evaluated examples of contracting were found; it appears that in developing countries contracting with NSPs to deliver primary health or nutrition services can be very effective and that improvements can be achieved rapidly. These results apply for a variety of services and settings. All of the studies found that contracting was successful. Ten of the 14 studies compared contractor

performance with government provision of the same services, and the contractors were found to be consistently more effective. The current weight of evidence indicates that contracting with NSPs will provide better results than government provision of the same services. Future contracting efforts still deserve to be evaluated rigorously.

The advantages of contracting include the following:

- Ensuring a greater focus on the achievement of measurable results
- Tapping the private sector's greater flexibility and avoiding bureaucratic “red tape” and unhelpful political interference
- Reducing important aspects of corruption, such as absenteeism, selling of positions, and theft of drugs
- Using constructive competition to increase effectiveness and efficiency
- Overcoming “absorptive capacity” constraints that often plague government health care systems
- Improving the availability and distribution of health workers
- Broadening the autonomy of managers on the ground
- Allowing governments to focus on other roles that they are uniquely placed to carry out, such as planning, standard setting, financing, and regulation.

The review provides some information on the concerns that have been expressed about contracting, including:

- There is a concern that contracting is unlikely to enable service delivery on a large scale. However, four of the examples studied involved populations of tens of millions of beneficiaries, and one now covers 30 million people. It does appear that contracting can be conducted successfully on a large scale.
- There has also been concern that contracting might be more expensive than government provision of the same services. Six studies provided an opportunity to test this hypothesis, and each found that NSPs performed better even when public institutions were provided similar amounts of resources.

- Sustainability also does not appear to be an issue. Twelve of the 14 examples of contracting have been continued and expanded. Six cases have been sustained for seven years or more. Provision of a basic package of primary health care by contractors costs between \$3 and \$6 per capita per year, an amount that should be affordable even in low-income settings. Thus, financial sustainability does not appear to be a serious threat.
- There is a concern that contracting will decrease equity. Three of the cases studies explicitly examined this issue; two found that NSPs were able to significantly improve health services for the poor and did a better job than government provision. The other case found no difference.
- A number of observers have been concerned that ministries of health have limited capacity to manage contracts. This review found that contract management was a significant issue in at least three of the examples studied; however, it did not prevent contractors in those instances from being successful. In addition, there were at least six examples in which contract management was done reasonably well, which suggests that the problem can be overcome.

According to the global experience so far, it appears that contracting is a practical means for improving health service delivery. Its use should be expanded, but continuing evaluation is warranted. Many concerns have been raised about contracting, but the experience so far suggests that few are so serious as to render it ineffective. The concerns that seem most serious are the following: first, contract management capacity is often weak and needs attention; second, tenders and contract management may create opportunities for fraud and corruption (even if they reduce other forms of corruption that afflict the public sector); and, third, bureaucratic opposition to contracting is sometimes deep-seated.

---

# What Is Performance-Based Contracting?

## Introduction

This section provides some background about performance-based contracting and sets contracting within the context of other ways of organizing health services. It answers the following questions:

**What is contracting?** Contracting is a mechanism for a financing entity to procure a defined set of health services from a nonstate provider (NSP). The definition of services includes what services, where, to which group of beneficiaries, for how long, and so on.

**What is performance-based contracting?** It is a type of contracting with (1) a clear set of objectives and indicators, (2) systematic efforts to collect data on the progress of the selected indicators, and (3) consequences, either rewards or sanctions for the contractor, that are based on performance.

**What kinds of services can be contracted?** Many different types of health services have been successfully contracted, including primary health care, HIV prevention services, and hospital management.

**How is contracting different from other approaches to organizing health services?** Contracting implies that it is the

purchaser (rather than the NSP) that defines what services will be provided, where, and how they will be evaluated while leaving to NSPs how resources will be managed.

**What approaches to contracting work best in common situations?** It is difficult to be prescriptive, but some situations are more conducive to specific forms of contracting than others.

**How is contracting related to paying for performance (P4P)?** Performance-based contracting is a form of paying for performance and can be used as a way of implementing P4P.

## SECTION 2

## What Is Contracting?

*Contracting* is a mechanism for a financing entity (such as a government ministry, insurance entity, or development partner) to acquire a specified set of services, with specified objectives, of a defined quantity, quality, and equity, in a particular location, at an agreed-on price, for a specified period, from a particular NSP (such as an NGO, private sector firm, or private practitioner). Like all contracts, contracts for health services are *voluntary*, meaning both parties enter them freely.

A few other terms related to contracting should be defined:

**Nonstate providers.** Nonstate providers of services include any nongovernmental entity such as NGOs, faith-based organizations (FBOs), community-based organizations (CBOs), or private for-profit entities or individuals.

**Contractor.** The contractor is the NSP implementing and managing the services defined in the contract. Another useful term for contractor is “partner,” although the term “contractor” is used throughout this toolkit for the sake of simplicity.

**Purchaser.** The purchaser is the entity that awards the contract, provides the financial and other resources for the services, and has the fiduciary responsibility for ensuring that the terms of the contract are met. Purchasers of health services are typically government agencies, parastatal organizations, insurance entities, or development partners.

**Public-private partnerships.** Contracting is one form of public-private partnership. A partnership sometimes implies that both parties bring financial or other resources into the relationship, but this is not always the case.

## What Is Performance-Based Contracting?

*Performance-based contracting* is a form of contracting that explicitly includes three characteristics:

- Clear *definition* of a series of objectives and indicators by which to measure contractor performance
- Collection of *data* on the performance indicators to assess the extent to which the contractors are successfully implementing the defined services
- Performance leading to *consequences* for the contractor, such as provision of rewards or imposition of sanctions. Rewards can include continuation of the contract in situations in which there is a credible threat of termination, provision of performance bonuses, or public recognition. Sanctions can include termination of the contract, financial penalties, public criticism, and debarment from receiving future contracts.

## What Kinds of Health Services Can Be Contracted?

A large variety of health services can be, and have been, contracted. These include the following:

- Providing primary health care services in rural or urban areas
- Offering HIV prevention services among high-risk groups
- Providing HIV/AIDS treatment services to people living with HIV
- Establishing a health insurance system
- Setting up and operating a voucher project



- Acting as an intermediary in providing P4P to public health care providers
- Offering behavior change communication activities and information, education, and communication
- Providing maintenance and cleaning services in a hospital
- Providing social marketing of health products, such as contraceptives
- Working as an “umbrella” agency that oversees the work of many smaller NGOs and CBOs involved in delivering primary health care, nutrition services, or HIV services
- Operating an ambulance system
- Acting as an intermediary with many for-profit providers, for example, in strengthening the management of tuberculosis patients
- Managing a hospital
- Operating diagnostic facilities within public health care facilities
- Providing ancillary services such as equipment maintenance, cleaning, waste management, food preparation, and security.

Sample terms of reference for some of these services are provided in appendix E; others are available at <http://www.worldbank.org/hnp/contracting>.

### **How Is Contracting Different from Other Approaches to Organizing Health Services?**

**Typology of Service Delivery.** A number of different approaches exist for organizing health service delivery, so clarifying definitions will facilitate meaningful dialogue. Although this is a bit of a simplification, there are five important functions related to service delivery: (1) designing the services, that is, what services will be delivered, where, and with which indicators of success; (2) selecting the service provider; (3) actually managing the services; (4) establishing and controlling the “production infrastructure,” which includes personnel,

equipment, drugs, clinics, and other facilities; and (5) financing the system (see table 2.1). As an example, under a management contract (arrangement 3 in table 2.1), a government will contract with an NSP or an individual to manage existing government services in a specified area. Under a service delivery contract (arrangement 4 in table 2.1), the government decides which services the contractor will provide and where, while the contractor will both manage and supply the production infrastructure. The arrangements described in table 2.1 are not exhaustive, and hybrids clearly exist. For example, the line between a management contract and a service delivery contract blurs when the contractor uses government health workers but pays them significantly more than their civil service salaries.

**Intergovernment “Contracts.”** There has been some experience with national governments signing agreements with local governments (arrangement 2 in table 2.1) that pertain to achieving certain goals. Although potentially interesting, this arrangement rarely involves a true contract that the parties enter into voluntarily and in which the contractor can be “fired” for nonperformance (although other rewards and sanctions may be available). Another issue with such contracts is that denying resources to poorly performing areas can be politically or ethically challenging.

**The Difference between Grants and Contracts.** Grants by government or donors to NSPs, often NGOs (see arrangement 5 in table 2.1), are quite common, particularly in HIV/AIDS prevention and treatment. These grants are usually given to organizations that submit a proposal to a funding agency. The most important difference between grants and contracts is who defines the services to be delivered. For grants, it is generally the NSP that decides what kinds of services will be delivered, where they will be delivered, and how they will be evaluated. As the funding agency defines more and more of the details of the services to be provided, the distinction between grants and contracts blurs. Grants can be very useful and have worked well in many situations. They are particularly helpful in beginning new types of services or providing an opportunity for creative innovations to address health problems. The downside to grants is that they can lead to an irrational distribution of services with gaps in some areas and duplication in others. For example, in Ghana epidemiologists believed that about 70 percent of HIV transmission involved female sex workers (FSWs). However, when a grant mechanism was introduced to control

**Table 2.1** Typology of Service Delivery Arrangements

<i>Arrangement</i>	<i>Service design</i>	<i>Provider selection</i>	<i>Services management</i>	<i>Infrastructure setup</i>	<i>Financing</i>	<i>Example</i>
1. Government services	Government	Government	Government	Government	Government	Government sets up public primary health care centers
2. Inter-governmental agreements	Government-1	Government-1	Government-2	Government-2	Government-1	Government transfers funds from federal to provincial governments
3. Management contracts	Government	Government	Private sector	Government	Government <sup>a</sup>	Government hires a private sector manager to manage existing government health services
4. Service delivery contracts	Government	Government	Private sector	Private sector	Government <sup>a</sup>	Government hires NGO to provide services where none exist
5. Government grants to NSPs	Private sector	Government or donor	Private sector	Private sector	Government (w/ or w/o NGO or community contribution)	NGOs submit proposals to government for needs identified by community or NGO
6. Private sector services	Private sector	Consumer	Private sector	Private sector	Consumer or NGO/donor	<ul style="list-style-type: none"> <li>• NGO establishes health services in slum areas using its own funds</li> <li>• For-profit providers establish private clinic</li> </ul>

Source: Author.

Note: Government-1 and Government-2 refer to different levels of government. NGO = nongovernmental organization; NSP = nonstate provider.

a. Financing may be supplemented by formal or informal user charges.

the epidemic, fewer than 1 percent of the grants went to NGOs working with FSWs, reflecting a shortage of grant proposals for this important type of service.

### What Approaches to Contracting Work Best in Common Situations?

Because situations and contexts vary considerably, it is difficult to be prescriptive about which types of contracts will work best in a given set of circumstances. However, some situations are more conducive to some forms of contracting than others. Table 2.2 explores some of the options. This table is not meant to limit creativity; on the contrary, it should be seen as an encouragement to innovate and explore new ways of contracting.

**Table 2.2** Types of Contracting to Consider in Some Common Situations

<i>Context/situation</i>	<i>Options to consider</i>
Limited rural health services but with “mission” clinics or other faith-based organizations	<ul style="list-style-type: none"> <li>• SDC for specified geographical “catchment” area with a matching grant or subsidy</li> <li>• SDC plus MC for the management of existing government services</li> </ul>
Poorly performing districts, provinces, or states with existing government health services	<ul style="list-style-type: none"> <li>• MC for management services</li> <li>• MC for management services plus P4P for health workers</li> <li>• SDC where government health workers join NSP</li> </ul>
Uncoordinated NGO-delivered services with multiple donors (for example, post-conflict situation)	<ul style="list-style-type: none"> <li>• SDC for specified geographical areas</li> </ul>
Few services of any kind, or new kinds of services required (for example, HIV prevention, nutrition services, early childhood development services)	<ul style="list-style-type: none"> <li>• SDC for specified geographical areas with emphasis on innovation and careful evaluation</li> </ul>
Existing government services where improved management is needed or innovations are required	<ul style="list-style-type: none"> <li>• MC for management services</li> <li>• MC for management services plus P4P for health workers</li> </ul>
Urban primary health services with many different providers but limited coverage of preventive services for the poor	<ul style="list-style-type: none"> <li>• SDC for specified geographical areas with focus on reaching the poor (slum and nonslum residents) with preventive and promotive services</li> </ul>

Source: Author.

Note: MC = management contract (contracting in); NGO = nongovernmental organization; P4P = pay for performance; SDC = service delivery contract (contracting out).

## How Is Contracting Related to Pay for Performance?

Pay for performance is a broad term that covers a number of approaches to rewarding the provision of more and better services. The basic idea of P4P is attractive because it compels providers to focus on important objectives and uses financial rewards to reinforce good performance. In some ways any contract that specifies explicit, measurable outcomes and allows for termination of the contract for nonperformance is a type of P4P. Contractors are rewarded for good performance by continuation of the contract and ongoing payment while poor performers have their contracts terminated. However, P4P is often used to refer to a more explicit link between performance and payment. Table 2.3 describes some of the forms of P4P and their relationship to contracting. Details of applying P4P in a contracting situation are given in section 3 (task 6).

For some types of P4P the evidence is compelling. Fee-for-service payments to individual providers (approach 3 in table 2.3) consistently lead to increased service provision (sometimes even too much). For other types of P4P the evidence, so far, is less strong. The use of performance bonuses in contracts makes sense and has worked well in some contexts, such as Afghanistan and Haiti, but less well in others, such as Uganda. For rewards to local governments (approach 1 in table 2.3) the evidence is still modest. This approach also suffers from an ethical issue because poorly performing areas that need the most help may receive fewer resources, which may only reinforce preexisting inequalities.

**Table 2.3** Types of Pay for Performance and Their Relationship to Contracting

<i>Type of P4P</i>	<i>Who receives the funds</i>	<i>What the funds can be used for</i>	<i>Who provides the funds</i>	<i>Example</i>	<i>Relationship to contracting</i>
1. Rewards for local governments	Local governments	Programs of local governments	National government	Burkina Faso “performance” agreements	“Performance agreements” rarely true contracts
2. Rewards to national governments	National governments	Programs of national governments	Development partners	GAVI Alliance payments for increased DPT3 coverage	Not related
3. Payment per service (fee for service)	Individual health workers	Personal uses	Government, individuals, or NSPs	Rwanda, where NGOs paid health workers based on number of services provided	May be easier to introduce in the context of contracting with NSPs
4. Performance bonuses	NSP	Other programs or at the discretion of the NSP	Purchaser	Haiti, where NGOs received bonuses for achieving specified targets	Sometimes used in health care contracting, very often used in other forms of contracting
5. Performance-based payment	NSP	At discretion of the NSP	Purchaser	Amount paid to an NSP is a function of the number of patients seen	Can be incorporated fairly easily into contracts

*Source:* Author.

*Note:* DPT3 = third dose of diphtheria/pertussis/tetanus vaccine; GAVI Alliance = formerly the Global Alliance for Vaccines and Immunization; NGO = nongovernmental organization; NSP = nonstate provider.



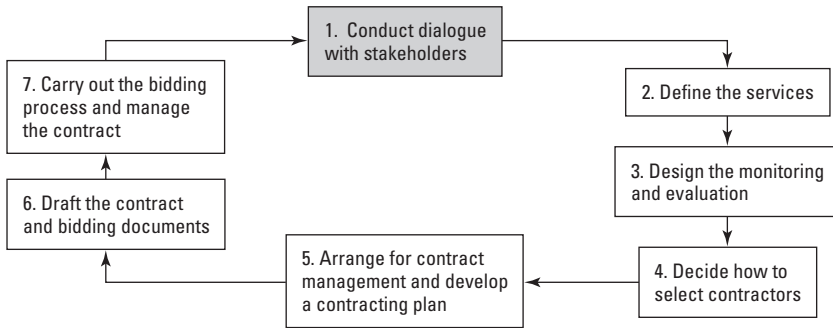
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## How to Contract

If you believe that contracting may be an approach worth trying in your situation, then a systematic approach to doing it is necessary. This chapter provides a framework for contracting, but keep a few things in mind:

- Don't be overwhelmed! Contracting has proven fairly robust and has worked well even in difficult circumstances, so don't worry excessively about getting everything perfect. Usually a limited number of key issues are present to worry about, and typically these center on
  - Defining the objectives of the contract, selecting the indicators of success, and taking equity and quality into account
  - Ensuring that contractors (and purchasers) focus on achieving the stated objectives
  - Defining the size and location of each contract "lot"
  - Defining the scope of services to be delivered
  - Maximizing the managerial autonomy of the contractors
  - Developing a contracting plan that addresses, among other things, how the contracts will be managed and how the monitoring and evaluation will be done.
- Contracting is more of an art than a science, but a systematic approach can avoid simple mistakes; the point should be to make new and interesting mistakes, not to repeat old ones.
- Contracting also allows for, and requires, *creativity* and adaptation to local circumstances.



**Figure 3.1** The Seven Steps of Contracting

Contracting is not a simple linear process, but some logical steps can be represented in the “contracting cycle”: conducting dialogue with stakeholders, defining the services, designing monitoring and evaluation, deciding how to select a contractor and establishing the price, arranging for contract management, drafting the contract and bidding documents, and carrying out the bidding process and managing the contracts (see figure 3.1).

### Step 1: Conduct Dialogue with Stakeholders

#### *Task 1: Establish a Consultative Process with Stakeholders*

Designing and implementing an effective contracting system is an iterative process that requires close consultation with stakeholders. This process is inevitable because contracting is about balancing the interests of various stakeholders, who often hold competing interests. Stakeholders usually include government health officials, government health workers, local politicians and government officials, NGOs, community-based organizations (CBOs), the for-profit private sector, the community, and other development partners or donors. Having a good consultation process during the design phase of contracting can prevent problems later during implementation. There are a couple of important aspects of the process:

- **Hold a few discussions with each set of stakeholders.** Contracting is often a new approach for many stakeholders, and so they need to hear about it a few times before they can fully appreciate its implications. Having a few discussions is generally worth the effort.

- **Get back to stakeholders with draft proposals and contracts.** After initial discussions it is worthwhile to draft the documentation (a contracting plan and the actual contract; see task 25) and then go back to stakeholders with something concrete to discuss. Otherwise, discussions can go on for a long time at a theoretical level with little progress.

### *Task 2: Identify Champions*

There is almost always a need for “champions”—people who understand the evidence for contracting and are willing to see it at least pilot-tested on a reasonable scale. These people can use their influence to overcome resistance from a number of quarters. Champions can often be found in unusual places, and some may not necessarily be in the government or even in the health sector. They may be advisers to political figures, well-respected businesspeople, or leading community figures.

### *Task 3: Address the Legitimate Concerns of Stakeholders*

Section 5 provides the evidence for and some of the commonly expressed concerns regarding contracting. The discussion there, as well as in appendix C (case studies), should be read before beginning discussions with stakeholders. On the basis of experience in a number of settings, a few common concerns often voiced by stakeholders have been identified that can be addressed in a number of creative ways:

- **Concerns of government health officials.** Government health officials are often deeply suspicious of contracting and may resist it vigorously. They are often the key decision makers, particularly when it comes to externally funded contracting efforts. Some ways of addressing their concerns include reviewing the evidence for contracting and suggesting that improved health services will reflect well on them. However, there are often other concerns, for example:
  - **Implicit criticism.** Health officials may perceive contracting as an implicit criticism of their own competence or performance. This impression can be dealt with by (1) indicating that much of the advantage held by private sector contractors is that they are less burdened by bureaucratic rules and regulations (which can then shift the discussion productively to how to reduce “red tape” and increase managerial autonomy in the public sector), (2) allowing

officials to take leaves of absence from the government to work with contractors, (3) allowing some “lots” (see step 2, task 8) to be managed by government officials with more autonomy than they would otherwise have, and (4) allowing new parastatal entities to be established to bid on contracts (so long as they have an arm’s-length relationship with the purchaser). Parastatal entities are linked to the government but are not constrained by civil service rules and regulations; they are run on a quasi-commercial basis.

- **Competition.** Related to the above concern, health officials may also be nervous about possible competition from nonstate providers (NSPs). Such competition, they sometimes fear, may put publicly delivered services in a poor light and lead to unflattering comparisons. A legitimate way of addressing this concern is to ensure that NSPs are provided the same level of resources as the public sector and held to the same performance standards. What is *not* helpful in addressing this issue is to put additional constraints on NSPs so that they face the same issues as the public sector. For example, forcing NSPs to obtain multiple clearances when recruiting staff will just reduce their flexibility and managerial autonomy.
- **Less control.** Government officials often fear giving up control. They may worry about having less power and prestige because they will exert less control over recruitment, postings, and transfers of health workers and procurement. In many countries, hiring and managing personnel take up much of health officials’ time and can be exasperating work. Being able to focus on interesting, strategic issues may be attractive to them. One way of aligning the incentives for government officials and the contractors is to provide performance bonuses to government officials if the contractors achieve certain measurable outputs. This incentive has been implemented successfully in Afghanistan.
- **Lost opportunities for corruption.** Dishonest officials will be concerned about losing opportunities for corruption or influence peddling. There are a number of ways of avoiding corruption in the contracting process that are discussed below (see tasks 8, 16 to 19, and 31), including not making the size of the contracts too small and using transparent competition for contractor selection.

- **Opposition to change.** Many officials oppose contracting because it represents a change in the way they do their business, and they resist any change because they are comfortable with the status quo. This concern can be difficult to address. However, experience suggests that contracting is a pretty low-risk activity. It can increase the officials' prestige if services improve, and they can carry out tasks that are of greater prestige and greater interest, such as strategic planning, health care financing, and tracking performance. Discussions with officials from countries that have implemented contracting can help allay fears.
- **Concerns of local politicians and local government officials.** Politicians, including local government officials, have sometimes been helpful in the introduction of contracting. Conversely, they have often been the most vociferous opponents of contracting for many of the same reasons held by national government officials. Local officials and politicians often have the most to gain from improved services, and many are the first to hear the complaints of the community about existing services. The concerns of these stakeholders generally relate to ensuring that they retain some involvement and influence over the contractor's performance. There are a few ways to satisfy their need to have a part in the contracting process, including making them signatories or witnesses to the contract, having them review the quarterly reports of the contractors before payment, and giving them an explicit role in monitoring the contractor's performance.
- **Concerns of government health workers.** The difference between a management contract and a service delivery contract is the degree of managerial authority the contractor has over the staff needed to deliver the services. In situations in which the staff belong solely to the contractor, this authority is generally not an issue. However, in many circumstances, including all management contracts and some service delivery contracts, government staff are still much needed, but they often fear that they will lose their job, see their wages lowered, or lose some benefits. Some options to address this issue have been tried and found reasonably successful:
  - Health workers can form cooperatives to take over existing publicly managed clinics (see box 3.1)

### Box 3.1 Establishing Worker-Controlled Health Cooperatives in Costa Rica

Costa Rica has a long-established social health insurance system that provides nearly universal coverage to the population. In response to rapidly increasing costs, long waiting times, and a need to strengthen the primary health care system, the government allowed the formation of worker-controlled cooperatives that took over the management of clinics previously managed by the social security institute. The cooperatives were autonomous legal entities provided with full autonomy on the use of funds, but they had to deliver standard services and follow government guidelines and objectives. According to more than a decade of data from the social security institute, it appears that the cooperatives provided more patient services than the publicly managed clinics but at a significantly lower cost per patient. (See case 7 in appendix C and Gauri, Cercone, and Briceno 2004 for more details.)

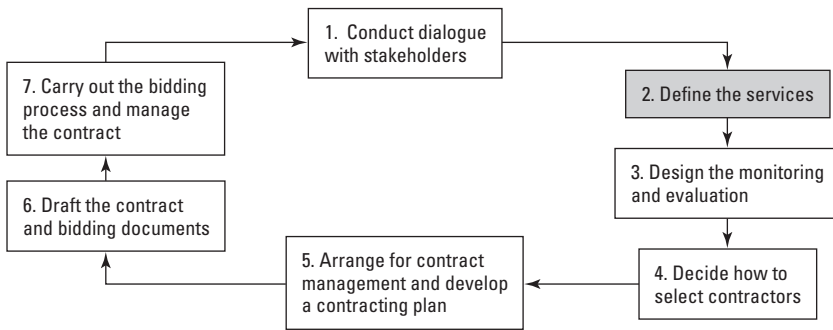
- Government workers can take a leave of absence to work with the contractor
- Salaries of workers selected by the contractors can be raised above the civil service norms
- Performance-based bonuses can be paid to health workers selected by the contractors
- Government workers can be selected by the contractors, and the remaining ones can be transferred to another location within the government health services.
- **Concerns of the private sector, including NGOs.** Potential contractors (NGOs, CBOs, and other private sector entities) need to be consulted to ensure their participation and genuine commitment to the process. Potential contractors often have the following fears:
  - Nontransparency in the ways contractors will be selected. This fear can be dealt with by having a clear selection process with explicit criteria included in the bidding documents and the overall contracting plan. The selection process is discussed in more detail in step 4.
  - Delayed payments that interfere with their ability to implement the services. Given that most NGOs and CBOs do not have the capital to pay the staff until they receive payments, delays in dis-

bursements by the purchaser can lead to interruption of services. Mechanisms for decreasing the risk of delayed payment are described in step 6 (task 31). These include making explicit the documentation needed for payment and using professional contract managers.

- Kickbacks that must be handed over to get paid. This issue can often be dealt with by having a clear payment process described in the contract (task 31), a dispute resolution mechanism (task 33), and a third party that can certify the performance of the NGO independently.
- Unrealistic expectations coupled with inadequate resources. Potential contractors often fear being set up for failure by government officials with a vested interest in maintaining the status quo. To some extent this can be addressed by making objectives explicit, having independent assessment of performance, ensuring sufficient managerial autonomy (task 26), and having a competitively established price for the contract.
- Dislike of the idea of being “contractors.” Some nonprofit organizations (NGOs and CBOs) dislike the commercial connotations of contracting; they feel it impugns their humanitarian motives. They prefer to be seen as, and actually be, partners of the purchaser. This concern can be addressed in part by using terms such as “partnership agreements” and “public-private partnerships.” More important, NGOs should be allowed to carry out other development activities in the same area using other sources of funds (or funds that are left unspent at the end of the contract).
- **Concerns of the community.** Generally, communities care less about who is delivering services than that the services are actually being delivered and that they are of high quality. Contracting affords an opportunity to ensure greater community participation in the design, implementation, management, and monitoring of health services. Nongovernmental organizations are usually quite interested in increasing community participation, and this should be included in the contract’s terms of reference (TOR).
- **Concerns of development partners/donors.** Many development partners (DPs) support contracting, and many have much experi-

ence working closely with NSPs. Most of DPs' concerns center on ensuring that there is a continued focus on improving results, that the interests of governments and NSPs are respected, and that the contracting efforts are coordinated with existing services.

## Step 2: Define the Services



A critical step in contracting is defining the services in sufficient detail. Many issues must be considered in drafting a contract. However, in most cases the following issues are the most important:

- Defining the objectives of the contract and selecting the indicators of success
- Considering pay for performance and other means of ensuring that contractors (and purchasers) focus on achieving the stated objectives
- Defining the size and location of each contract “lot”
- Defining the scope of services to be delivered.

These issues become most of the TORs for the contract.

### *Task 4: Define the Objectives of the Contract*

Possibly the single biggest advantage of contracting is that it allows purchasers and contractors to focus on results. This focus means that objectives need to be explicit and measurable, which is why drafting a contract should start with a clear definition of the objectives and the

**Table 3.1** Reasonable Performance Indicators in a Contract for Primary Health Care

<i>Indicator</i>
Number of consultations per person per year provided by the contractor
Percentage of couples of reproductive age currently using a modern family planning method
Number of sputum-positive cases of tuberculosis detected as a percentage of target based on estimated prevalence
Proportion of children age 6 to 59 months who received vitamin A supplements within the past 6 months
Percentage of children age 12–23 months who received measles immunization coverage before age 12 months
Percentage of all women pregnant during the past year receiving at least one antenatal care visit from a skilled health care provider (doctor, nurse, trained midwife)
Proportion of births in the past year attended by skilled attendants, including institutional delivery but excluding trained traditional birth attendants
Score out of 100 on an index of quality of care as judged by a third party, including the availability of drugs, quality of patient-provider interaction, patient satisfaction, and so on
Larger improvements for the bottom two income quintiles (based on asset index) and women or girls on immunization coverage and consultations per capita per year

*Source:* Author.

indicators by which they will be assessed. (See table 3.1 for an example of reasonable indicators included in a contract for delivery of primary health care. Table 3.2 includes examples of indicators that should not be used in contracts.) A few basic principles should be applied to the selection of indicators, including the following:

- **Limit the number of indicators.** The process of selecting indicators and keeping many stakeholders happy often results in a large number being identified, an outcome that should be actively resisted. Experience has shown that, not surprisingly, having many indicators leads to less data actually being collected. It also leads to “indicator inflation” in which both purchasers and contractors pay little attention to any of the indicators, even the most critical ones, because there are so many. Selecting fewer than 10 indicators is good practice.



**Table 3.2** Some Less-than-Ideal Indicators in a Contract for Primary Health Care

<i>Indicator</i>	<i>Issues</i>
Percentage of district hospitals with functioning X-ray machines	Mostly an input or upstream process indicator. It doesn't show whether the machines are being used or how many X-rays have been taken. It also doesn't indicate anything about the quality of the films.
Number of health workers receiving appropriate training	Mostly an input or upstream process indicator. It doesn't indicate if the health workers actually learned anything or if they apply their knowledge to treating patients. The definition of "appropriate" training is unclear. There is no definition of a numerator or denominator.
Percentage of community members using the clinic who are happy with the services	Unclear definition of "happy." It's also likely that people who are not using the clinic are more unhappy with the services ("voting with their feet") than those who do use the clinic. People who live near the clinic may use it more, so this indicator may hide inequity in access to services.
Low rate of health workers leaving their positions	Hard-to-collect data for this indicator. Numerator and denominator are unclear, as is the point at which the rate is "low." Those health workers who leave may be difficult to trace. This is also a process measure that may or may not affect the quality of services.
Percentage of inpatients willing to pay extra for private bed	Your assessment: <sup>a</sup>
Proportion of health centers having enough drugs	Your assessment: <sup>b</sup>

*Source:* Author.

a. It is not clear what this indicator is trying to measure. Is it quality of care or use of services by better off people? The definition of "willing" is not clear, as the number could be constrained by the number of private beds available or the cost.

b. The issue is what "enough" means and which drugs are the most important.

- **Design bias toward outcome and output indicators.** As one selects indicators, it is worthwhile to be biased toward outcomes and outputs rather than inputs or processes. Outcomes and outputs are those achievements that have direct meaning for patients or communities and, according to available scientific evidence, will likely lead to improved health status. (To be clear about terms, this toolkit uses the terminology described in table 3.3.) There is some value in using a few input and process indicators because they are often easier to measure, can be measured more frequently, and can pro-

**Table 3.3** Examples of Input, Process, Output, and Outcome Indicators

<i>Nature of indicator</i>	<i>Input</i>	<i>Process</i>	<i>Output</i>	<i>Outcome</i>
Vaccination coverage	Vaccines and syringes ordered	Vaccinators and vaccines available in health center	Levels of DPT3 or measles coverage	Decreased measles incidence or under-five mortality rate
Antimalaria drug availability	Budget available for anti-malaria drug procurement	Antimalaria drugs available in health centers	Children with malaria obtain appropriate drugs	Decreased under-five mortality rate
Training of health workers	Number of health workers trained	Health workers' level of knowledge six months after training	Health workers apply their knowledge to actual patients	Decreased under-five mortality rate

Source: Author.

Note: DPT3 = third dose of diphtheria/pertussis/tetanus vaccine.

vide useful milestones along the road to outcomes or outputs. However, an excessive focus on input and process indicators can negate one of the main advantages of contracting, a focus on results that matter to real patients. Even within input and process indicators, it is worthwhile to concentrate on those that are as far “downstream” as possible. For example, rather than focusing on “the budget available for malaria drugs” or the “timely procurement of drugs,” it is more useful to concentrate on the availability of drugs in peripheral health facilities.

**Recommendations.** Most indicators chosen for a contract should be outputs or outcomes. A few input and process indicators may be useful to include in a contract as a means of seeing whether performance is “on track.”

- **Ensure that indicators are independently measurable.** Step 3 gives some suggestions about how to measure indicators and ensure that they are independently verifiable. Generally, much more time is taken arguing about indicators than about how and whether they can actually be measured. A good rule of thumb is to spend as much time on discussing how to measure indicators as on which

indicators to examine. One issue to watch out for is indicators that can be measured only by the contractors themselves. This measurement can create an obvious conflict of interest.

- **Define indicators as precisely as possible.** Both the numerator and the denominator of indicators must be carefully defined. Also, it is important that terms are clearly defined, that is, being careful with words like “appropriate” or “sufficient.” For example, the indicator “health workers have appropriate knowledge of diarrhea management” is problematic because the numerator, the denominator, and the word “appropriate” are not defined.
- **Set targets broadly.** Much time and energy can go into specifying targets in exact detail, which is probably not worth the effort. Usually what is needed is a statistically significant and programmatically important improvement, which implies that targets should be reasonable, not obsessive. For example, if immunization coverage at baseline is 50 percent and the target is 80 percent, a contractor that achieves 78 percent coverage should be congratulated for making significant progress. That they didn’t achieve 80 percent should not much matter given measurement error (confidence intervals for immunization coverage measured through standard cluster surveys are typically plus or minus 10 percentage points) and the fact that a large improvement has been achieved. Conversely, a large sample survey could indicate that immunization coverage improved by 3 percentage points, which could be statistically significant but of not much programmatic importance.

### *Task 5: Include Objectives Related to Equity and Quality*

It is important to make concerns about equity and quality as explicit as possible in a contract. Equity can be defined by use of services by the poor (for example, the poorest two income quintiles or people living below the national poverty line), coverage of services among the population living in underserved geographical areas, or a concentration index. Measuring equity can be challenging and often entails special efforts, including additional questions on household surveys (more details on how to do this are available at <http://www.worldbank.org/analyzingtheequity>). Quality of care can also be challenging

to measure and often entails the conduct of specialized health facility surveys (see task 10).

### *Task 6: Consider Pay for Performance*

Once the effort has gone into defining the objectives of the contract, it is important to ensure that purchasers and contractors actually pay attention to achieving those results. One way of doing this is by paying for performance, sometimes referred to as performance-based financing (PBF) or output-based aid (OBA). There is increasing experience with bonuses linked to accomplishments, as in Haiti (see box 3.2) and Afghanistan, or with relating payment directly to the number of services provided, as in Rwanda. Paying for performance (P4P) is attractive, and experience in health and other sectors shows that it works well. However, a few issues must be addressed in designing P4P:

- **Independent verification.** Pay for performance often requires data that may be most easily available from the service providers themselves, which may put them in a conflict-of-interest situation. Because the data they collect are used to determine how much they get paid, they have an incentive to overstate the amount of services they have provided. For example, service providers who are paid for the number of infants immunized on the basis of reports they generate may deliberately include in their reports children who are older than age one.
- **Perverse incentives.** There is also the danger of perverse incentives in which providers do too much of a good thing or cut corners on quality so they obtain the performance payment. Examples of potentially perverse incentives are cases in which service providers are given an incentive to increase the number of cesarean sections or to put people living with HIV on antiretroviral (ARV) therapy. Contractors may place people on drug therapy who don't really need it. To some extent, this possibility can be avoided by strict application of treatment protocols, but even they require important clinical judgments. Giving ARVs to people who don't need them exposes them to the risk of serious side effects and heightens the risk of ARV resistance in the broader population. Hence, in designing P4P, care is needed to avoid perverse incentives.

### Box 3.2 Paying for Performance in Haiti

To improve the performance of NGOs delivering primary health care in Haiti, USAID through Management Sciences for Health (MSH) began paying them a bonus based on their performance on key indicators, such as immunization coverage, skilled birth attendance, and prenatal care. These indicators were measured using the health management information system but were independently verified through a data audit. As the percentage of NGOs being paid on a performance basis (that is, offered performance bonuses if they achieved specified results) increased, the coverage of these services also increased (see table).

Performance of NGOs in Haiti as Use of Bonuses Increased (Percent)

Indicator	2000	2002	2003	2004	2005
Children fully vaccinated	34	65	91	92	100
Women received at least three prenatal visits	29	50	41	48	60
Deliveries assisted by skilled attendant	58	64	57	63	77
NGOs paid on performance basis	0	35	37	44	93

Source: Based on Eichler and others (2006).

Note: Data for 2000 from Demographic and Health Survey; data for 2002 to 2005 from audited management information system.

- **Quality and equity.** Pay for performance can sometimes lead to an excessive focus on the quantity of services provided without equal attention given to the quality of service or to who benefits from the services. For example, if a P4P approach pays per consultation (outpatient visit), then there is no guarantee that the quality is acceptable or that many people living around the facility are using it but people living farther away are not.
- **Easy-to-understand terms.** It is important that NSPs and individual providers understand when a bonus will be paid. Without this understanding, the P4P approach may not be particularly effective in influencing performance.
- **Performance incentive amount.** Setting the amount of the performance incentive is challenging. If it is too small, it may not be useful, and if it is too high, it becomes too expensive for the pur-

chaser and may result in perverse incentives. In those contracts with NSPs that have included performance bonuses, the maximum bonuses that the NSPs could earn have been about 10 percent of the contract value.

- **Clearly stated financial risk.** NSPs, individual providers, and purchasers need to understand the financial risk they are taking in a P4P approach. Depending on how the performance bonus is designed, if NSPs and individuals fail to meet performance criteria, they may receive less money than they were counting on. If the performance bonuses exceed the established contract price, then the financial risk lies with the purchaser.
- **Reasonable payment criteria.** The decision to pay a performance bonus can be based on different factors, including (1) improvements from the provider’s own baseline (for example, a 10 percent improvement in prenatal care coverage), (2) achievement of a specified benchmark (for example, more than 80 percent measles coverage), (3) per unit of service provided (for example, \$0.50 for each consultation), and (4) “tournament” style where the top 10 percent of providers receive bonuses.

**Recommendations.** When feasible, it is often best to use some combination of improvement from baseline and achievement of a specified benchmark. However, the resulting combination must be easy to understand.

### *Task 7: Ensure That Purchasers and Contractors Focus on Objectives*

Besides P4P, there are other means to get contractors and purchasers to focus on key objectives:

- Ensure that contractors realize they face a credible threat of being fired for nonperformance
- Have purchasers and contractors regularly discuss the status of indicators
- Ensure that field monitors discuss results on key indicators during field visits
- Provide baseline and follow-up survey data to the contractors and purchasers

- Ensure that both purchasers and contractors understand the contents of the contract (it is remarkably common for key people in the process not to fully understand or even to have read the entire contract).

### *Task 8: Define the Size and Location of Each Contract “Lot”*

A contract “lot” is the size and location of an individual contract, which is usually defined by the purchaser. For example, a primary health care contract could cover a district with a population of 300,000, or the lot could cover a province with a population of 1.2 million. Lots are also sometimes referred to as “packages,” although this is different from a “package of services,” which describes the scope of services to be delivered (see task 9). Relatively fewer, large lots are recommended rather than many small ones. Some arguments have been made for using smaller contracts; those are explored next.

The rationale for having a few large lots includes the following:

- **Financial economies of scale.** Large fixed costs are associated with implementing health services, including management and administration. Hence, larger contracts will spread these fixed costs over a larger base, thereby reducing the cost per beneficiary served. This is not just a theoretical concern. In Afghanistan, using a system of competitive bidding that is based partly on price, contracts for delivering primary health care in entire provinces were 52 percent of the cost per beneficiary of contracts that covered only parts of a province (\$4.10 per person per year for the large contracts compared with \$7.80 per person per year for the smaller contracts). This lower cost per beneficiary means that with larger contracts more people can obtain services for the same amount of money.
- **Economies of scale in contract management.** Large lot size means far fewer contracts to manage. A number of examples exist in which purchasers who originally designed contracts for small lots realized the problems of managing multiple contracts and changed their strategy during their second round of funding.
- **Economies of scale in monitoring and evaluation.** Having fewer lots makes it easier and less expensive to monitor and evaluate each contractor’s performance. When multiple contracts must be moni-

tored, more field visits are required. Similarly, if a household survey is used to collect information, the cost can be exorbitant if the performance of many small contractors must be assessed.

- **Increased competition.** Large lots provide sufficient financial incentives to encourage more organizations to compete for the contract. This competition allows the purchaser to choose from among more organizations, increasing the chances that a high-performing organization will be selected. Small lots limit competition and force the purchaser to choose among fewer organizations.
- **Economies of scale in capacity building.** In situations in which there are few potential contractors with adequate experience, it is easier to build the capacity of a few larger NSPs rather than a large number of small NGOs or CBOs. For example, teaching 70 NGOs how to work with female sex workers (FSWs) is much more difficult than building the capacity of 7 NGOs.
- **Decreased opportunities for corruption.** Larger contract lots appear to reduce the opportunities for corruption. Unscrupulous officials have an easier time intimidating small NGOs or CBOs working on small lots into paying kickbacks or bribes. There is also sometimes political pressure to have many small contracts so they can be spread around among many political supporters. As mentioned earlier, larger contracts will attract greater competition, which generally reduces corruption.

Reasons for having smaller lots include the following:

- **Increased diversity.** The purchaser should not become dependent on only a few large NSPs because in the long run this dependency can limit competition, which results in higher costs and poorer performance. In addition, there are situations in which there is a need to study different approaches to learn which is most effective. Some people fear that having only a few large contracts will limit innovation and diversity in approaches.
- **No disruption to existing providers.** There are concerns that large contracts will overlap and possibly interfere with existing small-scale programs. In these cases, it may be better to contract with an umbrella organization for building capacity, coordinating existing efforts, and filling gaps in service delivery.



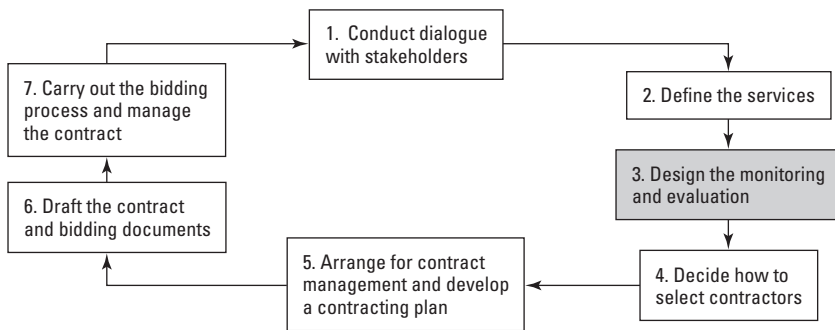
- **Uncertain capacity of NSPs.** Where the capacity of NSPs to carry out services on a large scale is an issue, one finds an argument for smaller lots. However, it is often difficult to assess an NSP's capacity in advance, and purchasers often underestimate the capacity of NSPs and overestimate the alternative (the ability of state providers).

**Recommendations.** Many advantages to having large contract lots can be named, and it generally makes sense to have between 7 and 20 lots. This number is manageable and allows sufficient diversity to ensure innovation and to reduce dependence on a few contractors. (In primary health care, lots should generally cover groups of at least 400,000–500,000 people.) Building the capacity of newer and smaller organizations can be accomplished by encouraging a larger organization to enter into joint ventures with them, recruiting umbrella organizations that can subcontract with local organizations, or setting aside a few smaller lots.

*Task 9: Define the Scope of Services—Focus on “What” Not “How”*

The scope of services to be provided needs to be defined in the contract in sufficient detail so that contractors know what is expected of them. As one defines the scope of services, the focus should be on indicating “what” services need to be delivered, but one should generally avoid telling contractors “how” they should deliver the services. For example, specifying that immunization coverage should increase is important and sensible, but indicating how immunization services should be delivered is not. Whether the contractors want to go house to house, stand on street corners, or set up mobile clinics in schools should be left up to them. What matters is that coverage increases, not how it is achieved. Two exceptions to this principle are when there is strong scientific evidence for a particular approach to how services are delivered or when it comes to ensuring that contractors comply with national technical standards regarding quality of care. For example, contractors must follow the national schedule for child immunization and should not be allowed to alter it (for example, they should immunize children with measles vaccine at 9 months and not change it to 6 months or 15 months). Many types of health services have been contracted; TORs for some of these services are included in appendix E and on the contracting Web site at <http://www.worldbank.org/hnp/contracting>.

### Step 3: Design the Monitoring and Evaluation



Agreeing on indicators is the first part of monitoring and evaluation (M&E), but this approach is meaningless if data are not actually collected, analyzed, and used for making decisions. Discussions often abound about the difference between monitoring and evaluation, but definitions are often inconsistent, and the distinction often blurs.

#### *Task 10: Decide How Data Will Be Collected*

In the overall contracting plan (see task 25) and the contract, it is useful to have a specific list of indicators similar to table 3.4 (but with a few more indicators). However, it is also important to describe the details of each means of data collection and construct a table similar to table 3.5.

A number of different methodologies can be used to collect information on the selected indicators, including (1) routinely collected data from the health management information system (referred to below as the HMIS for simplicity, even though there are other aspects to a typical health management information system), (2) household surveys, (3) health facility assessments, and (4) supervisory checklists, which are a way of systematically collecting and recording information during supervisory visits. Each approach to data collection has advantages and disadvantages.

- **Routine administrative records part of the health management information system (HMIS).** The routine administrative records part of the HMIS is the way in which contractors regularly record and report their activities and should be the same as the purchaser's system. Using this part of the HMIS has a number of advantages, for instance, it can, if working properly, provide

**Table 3.4** Examples of Indicators for a Performance-Based Contract

<i>Indicator</i>	<i>Means of data collection</i>	<i>Baseline value</i>	<i>Approximate target</i>
Percentage of all women pregnant during the last year receiving at least one antenatal care visit from a skilled health care provider	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• HHS</li> </ul>	53% (HHS)	75%
Score out of 100 on an index of quality of care as judged by third party, including adequacy of waste management, drug availability, provider knowledge, and patient-provider interaction	<ul style="list-style-type: none"> <li>• HFA</li> <li>• Supervisory checklist</li> </ul>	16 (HFA)	65

*Source:* Author.

*Note:* HFA = health facility assessment; HHS = household survey; HMIS = health management information system.

near real-time information, and it allows managers to easily track their own performance. The routine recording part of the HMIS has several disadvantages: (1) it is often inaccurate (see box 3.3), (2) contractors may overstate their own performance, (3) it is very expensive if you factor in staff time (see Stansfield and others 2006) although government officials see little incremental expenditure because these costs are already being met, and (4) it usually does not provide representative data on a number of important aspects of services, such as equity, community satisfaction, expenditure, and use of other services, such as from the private sector.

- **Household surveys (HHSs).** Household surveys, including lot quality assurance sampling (LQAS; see box 3.4), look at a statistically valid sample of households in the community and have the advantage of generally being more accurate, not being dependent on information collected by the contractors, and providing community data on coverage, equity, health care expenditures, use of the private sector, and satisfaction.

Disadvantages of HHSs include that they are relatively expensive to do, although the cost depends a great deal on the local availability of firms or organizations that can carry out surveys and the sampling strategy, and they cannot be done too often and so will not usually provide real-time information.

**Table 3.5** Means of Data Collection

<i>Means of data collection</i>	<i>Responsibility for data collection and analysis</i>	<i>Schedule and arrangements for baseline data collection</i>	<i>Schedule for follow-up data collection</i>	<i>Budget requirement</i>	<i>Counterfactual or comparison group</i>
Household survey	Third party with assistance from MOH primary health care department	July 200_, firm will be recruited by March 200_	Every two years after the baseline	\$250,000 per round times 3 rounds = \$750,000	Some noncontracted areas (5 districts) will also be surveyed.
Health facility assessment	Third party with assistance from MOH contract management unit	July 200_, firm will be recruited by March 200_	Every year	Total = \$400,000	Health facilities nationwide will be included in sample. Sample size will allow comparison of contracted and non-contracted facilities.
Health management information system	Contractor, MOH HMIS department, and MOH contract management unit	Already available and archived at _____	Quarterly assessment of data	Total = \$300,000 for HMIS unit (does not include health workers' time)	Contracted and non-contracted areas can be compared (if data quality independently assessed).

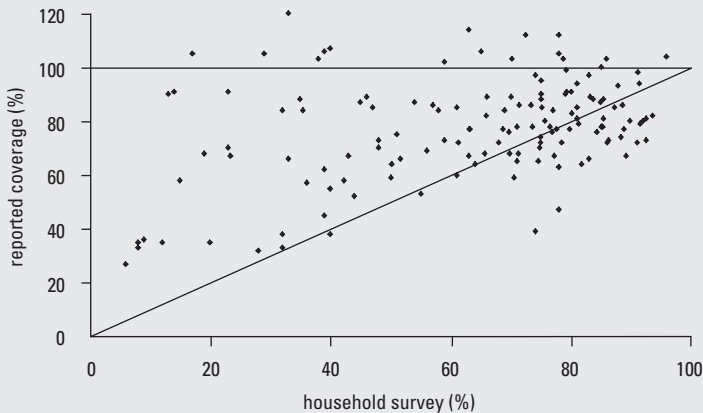
Source: Author.

Note: HMIS = health management information system; MOH = Ministry of Health.

### Box 3.3 Accuracy of the Routine Administrative Records Part of the HMIS

One of the reasons that a purchaser should not rely too heavily on data from the HMIS is that there are real issues with its reliability. For example, a number of studies have indicated that reported vaccination coverage—that is, coverage estimates that come from these systems—typically overstates success (Murray and others 2003). The figure here compares results of the HMIS from districts in Pakistan with household survey results for three doses of the vaccine for diphtheria, pertussis, and tetanus (DPT3) immunization coverage. It indicates that the HMIS-reported coverage is usually higher than the household survey data (on average 14 percentage points higher). In addition, districts that reported more than 100 percent coverage (obviously impossible) often had very poor performance. Forty percent of such districts had less than 50 percent coverage via the household survey, which means that if purchasers relied on HMIS data alone, they would have incorrectly identified these districts as good performers when, in fact, they needed to improve their performance considerably.

DPT3 Coverage Rates from Routine Reports versus Household Surveys for Districts in Pakistan, 1999–2002



Source: Loevinsohn, Hong, and Gauri 2006.

- **Health facility assessments (HFAs).** This is a sample survey of health facilities using a standardized methodology and instrument that looks at various aspects of quality of care, such as knowledge and skills of providers, patient satisfaction, and availability of inputs including drugs, supplies, equipment, and staff. The advantages of HFAs include the following: (1) they can assess quality of care from a technical perspective, (2) they are an independent and impartial

### Box 3.4 Lot Quality Assurance Sampling

Lot quality assurance sampling (LQAS) is a statistical technique that can be used to quickly and inexpensively judge performance in a defined geographical area. As such, it can be used to determine whether a contractor has achieved the specified target in a defined contract area (“lot”). LQAS is now widely used, with more than 800 such surveys carried out worldwide in the past 20 years in applications ranging from HIV/AIDS to immunization, women’s health, nutrition, diarrheal disease control, quality management, and neonatal tetanus mortality (Robertson and Valadez 2006).

To use LQAS, health system managers identify a coverage target (for example, 80 percent coverage of DPT3 immunization) and a lower threshold that represents an unacceptable level of coverage (for example, 50 percent coverage). LQAS then uses random sampling to classify lots as (1) successful, that is, at or above the target; (2) areas with unacceptably low levels of coverage; and (3) areas in between the target and the lower threshold, which are treated as similar to the nearest of the two (for example, 70 percent is treated as similar to the target of 80 percent coverage, and 60 percent is treated as similar to the lower threshold of 50 percent).

The advantages of LQAS include that only a small sample is needed to judge whether a lot has reached the predetermined coverage target, data from individual lots can be combined into an estimate of coverage for the entire program areas that consists of multiple lots, and because LQAS is essentially a hypothesis test, it can provide supervisors with a decisive judgment about whether a target has been accomplished, or not.

However, LQAS also has its disadvantages: it can be used only to determine if a predefined target has been met; it does not provide point estimates of coverage; without proper training and manuals, it can be difficult to implement and understand; and it relies on random sampling rather than cluster sampling.

With these limitations in mind, several easy-to-use manuals have been developed:

- Lwanga, S., and S. K. Lemeshow. 1991. *Sample Size Determination in Health Studies: A Practical Manual*. Geneva: World Health Organization.
- Valadez, J. J. 1998. *A Training Manual for Lot Quality Assurance Sampling to Manage Decentralized Health Programs: A User’s Handbook*. Washington, DC: OMNI.
- Valadez, J. J., W. Weiss, C. Leburg, and R. Davis. 2003. *Assessing Community Health Programmes Using LQAS: A Participant’s Manual and a Trainer’s Guide*. 2 vols. St. Albans, England: Teaching-Aids at Low Cost. (Available in English, French, Russian, and Spanish.)

assessment of what is happening in the facilities operated by the contractor, and (3) they can be done more frequently than household surveys and provide near-real-time information.

Disadvantages of HFAs include that (1) they are complex and challenging to design and implement (examples of HFA questionnaires are available at <http://www.worldbank.org/hnp/contracting>), (2) they can be relatively expensive to carry out, (3) they cannot provide information on coverage of services, and (4) the information they provide on patient satisfaction may be too optimistic (dissatisfied people stay away from the facilities and so are not included in the sample of exit interviews).

- **Supervisory checklists (SCs).** Supervisory checklists are like a short HFA, but they also yield a quantitative score that summarizes health facility performance. They can be used by the purchaser, local governments, contractors, or a third party to assess performance quickly. Although they may contain some of the same information as an HFA, they focus on fewer items and provide a way for allowing multiple visits to be included in the same form so as to judge progress. Their advantages include that (1) they can assess parts of quality of care, (2) they can be done frequently, (3) they are relatively cheap to implement, and (4) there is evidence that they improve health worker performance (Loevinsohn, Guerrero, and Gregorio 1995).

Disadvantages of SCs include that it is challenging to design a good one (there are many poorly designed SCs, and they are not often used) and that it is a challenge to ensure that they are used regularly.

**Recommendations.** It is usually necessary to use a few different approaches to collecting information, even for the same indicator. No method is perfect, but all have their uses. One thing to keep in mind in designing data collection mechanisms is ensuring *consistency* over time. For example, changing the sampling methodology, questions, or response group for household surveys may make the results noncomparable.

### ***Task 11: Collect Baseline Data***

One of the biggest issues in M&E is the lack of baseline data, which makes progress difficult to measure. Collecting baseline information is often tricky because it usually needs to be done at the same time as

services are being designed and service delivery is starting. Hence, one of the first tasks during the contracting process should be recruitment or mobilization of the organization that will actually do the baseline data collection (advanced procurement action is often required before funding is fully secured). In some situations, it may even make sense for contractors to collect the baseline data using a standard methodology, although this introduces the possibility of bias. Even if HMIS data will be used, these data should be collected and archived so that the data are readily available and consistent.

### ***Task 12: Devise a Clear Schedule for Data Collection***

It is important to have a clear schedule for data collection. Household surveys should be conducted every year or two, health facility assessments should be carried out every year, and supervisory checklists should be used every two months. HMIS data should be reviewed at least quarterly.

### ***Task 13: Look for Comparison/Control Groups***

Often judging the success of contracting and contractors requires “benchmarking,” that is, comparing the performance of contractors to each other or to other health service providers. Particularly in settings where contracting is controversial, it is worthwhile having a controlled, before-and-after comparison. This is a powerful way of learning lessons and evaluating the benefits and costs of contracting. A comparison or “control” group can be areas in which services are provided by the government sector or for-profit private sector providers. (Where possible, randomly assigning lots to contracting and control groups allows for the most rigorous type of evaluation.) Deciding on a comparison/control group has implications for data collection and the budget required.

### ***Task 14: Assign Responsibility for Collection, Analysis, and Dissemination of Data***

In situations that involve many contracts, it is sensible to make M&E someone’s full-time job. Purchasers should consider recruiting a third-party firm to help with M&E design and data collection. The advantages of this approach include factors such as (1) the purchaser

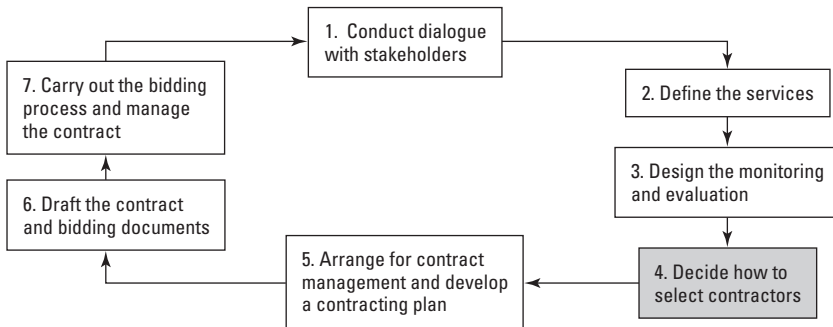


can obtain expertise it may not necessarily have; (2) the approach can allow the purchaser to focus on other aspects of contracting, including field visits and training; (3) the purchaser can collect data that does not rely on information generated by the contractor; and (4) this approach generally provides for a more impartial assessment of contractor performance. The major challenge with using a third party is maintaining purchaser involvement and commitment to M&E. Draft TORs for a third-party firm to help with M&E design, data collection, and analysis are found in appendix D.

### ***Task 15: Budget Sufficient Funds for Monitoring and Evaluation***

The conduct of M&E activities will not happen without a budget that includes funds for (1) recruitment of a third party where appropriate, (2) conduct of a sufficient number of household surveys and health facility assessments, and (3) staff within the contract management unit to work full time on M&E. Depending on the size of the contracting effort, it is not unreasonable to budget 5 percent of the value of all the contracts for M&E.

### **Step 4: Decide How to Select Contractors and Establish the Price**



### ***Task 16: Use a Competitive Selection Process***

The fairest and best way of selecting a contractor is through open competition based on clearly defined criteria. This approach has many advantages, such as (1) potential bidders want to know that there is a “level playing field” so that it is worth their while to bid and participate in the contracting process; (2) competition will generally lead to

the selection of the best organizations, the best managers, and the best ideas; and (3) competitive selection reduces the chances for corruption and is usually required under government regulations and the rules of external financiers.

By contrast, single-source selection, that is, a noncompetitive process, can be quick but it (1) is not fair to all potential contractors; (2) is not transparent and can easily become corrupt; (3) often creates resentment in the nonstate sector because contractors will be assumed to have received their contracts because of political connections or corrupt practices; (4) leads to “fat and happy” contractors who, shielded from the rigors of competition, usually become ineffective and inefficient; and (5) limits creativity and innovation.

In a small number of situations, competitive selection may not be easy or the most practical solution:

- An NGO or FBO may already be providing a significant number of services in a particular area (for example, a mission clinic that has been providing health services for 60 years)
- There is very limited competition (for example, providing services in a conflict-affected area where few NSPs or government staff want to work, and everyone is happy when even one NGO volunteers to work there)
- The NSP brings significant funds with it into a partnership
- Contracts will be made with existing private providers as is being commonly done for control of tuberculosis (see box 3.5).

In most of these situations, the purchaser can avoid many problems by using P4P approaches that put at least some of the financial risk on the contractor.

**Recommendations.** In most situations, it is best to use a competitive process to select contractors. Noncompetitive processes should be used only when there are compelling reasons. For World Bank borrowers and staff, the matrix in appendix 2 provides guidance on what kind of competitive selection process to use.

### *Task 17: Develop Clear Selection Criteria*

During the design phase, it is important to develop explicit criteria for selecting the contractors. These criteria should be clearly defined

### Box 3.5 Collaborating with Private Practitioners to Treat Tuberculosis

Traditionally, TB control efforts have focused on the public sector even though many patients with TB symptoms, including the poor, receive their care in the private sector. There has been broad concern about the quality of care provided by private practitioners because they have not been using state-of-the-art techniques for diagnosis, treatment, and case management. To address this issue, national TB programs (NTPs) in more than 15 countries have begun collaborating with private providers through the use of “soft contracts.” In return for free drugs and recognition, private practitioners are expected to follow NTP technical guidelines, including recording and reporting requirements.

Fourteen of these kinds of public-private collaborations, in eight countries, have been evaluated, and they appear to be quite successful. Treatment success rates have averaged almost 90 percent, and case detection rates have increased by a median of 16.5 percentage points. In 7 of the 14 evaluated cases, NGOs have been used as intermediaries, and it appears that these efforts were even more successful. Where NGO intermediaries were used, the treatment success rate was 8.1 percentage points higher (90.1 percent vs. 82.0 percent) than those cases in which the NTP itself managed the collaboration with private providers. (See appendix C, case 11, or Lonroth, Uplekar, and Blanc 2006 for more details.)

before the beginning of the selection process and be known to all participants, should not be excessively detailed so as to prevent the evaluators from using their judgment, and should not be unrealistic. Purchasers sometimes set the criteria too high and then cannot find contractors who meet the exacting standards. (For an example of suggested selection criteria, see the contracting plan in appendix A.) Often it is useful to first short-list bidders on the basis of some minimum criteria before going to the trouble of evaluating their detailed technical proposals. (However, this approach does not apply in situations in which World Bank borrowers are using the Bank’s procurement guidelines [*Red Book*], in which case the criteria below are judged on a pass-fail basis for all organizations submitting bids.)

- **Short-list criteria.** These criteria are meant to ensure that the organization has the minimum size, skills, and reputation to deliver the health services described in the contract. They can include (1) copies of three years of audited accounts for the organization, (2) proof (in the audited accounts) that the organization had a turnover

of some reasonable amount of funds in the last three years, (3) a copy of the organization's registration as a company or an NGO under the relevant acts of the particular country, and (4) some indication that the organization has experience of the type that would allow it to deliver the services.

- **Technical proposal evaluation criteria.** For organizations that meet the short-listing criteria, it makes sense to evaluate their technical proposals using the following criteria: (1) the experience of the organization (its track record) in delivering similar services, because this is a critical means for judging how they are likely to perform; (2) the qualifications, experience, and reputation of key managers (usually the most important three or four in the team that will actually implement the contracted services), because their abilities and expertise are much of what the purchaser is actually buying; and (3) the proposed work plan or strategy to see whether the bidder's approach is practical and creative. Experience in the field shows that it is reasonably easy to put together a plan that sounds good, but that this provides little insight into what the organization will be able to accomplish. For this reason, it is recommended that the evaluation of the work plan be given the least weight compared with the other two criteria.

### *Task 18: Establish a Transparent and Independent Evaluation Process*

As important as the selection criteria is the evaluation process that must both be transparent and appear to be transparent. The best way to ensure this is by having an independent and competent evaluation committee whose members individually rate proposals. It is recommended that members of the evaluation committee come from outside the purchaser's organization and include representatives of international agencies (such as UNICEF or WHO [but not the World Bank, whose procurement guidelines prohibit Bank staff from being involved in the evaluation of bids that will be financed with Bank funds]) and the NGO community (for example, someone from the umbrella organization of NGOs), although the latter must not work for an NGO that has submitted any proposals to avoid conflict of interest. Experience indicates that having members of the committee from outside the

purchaser ensures a more transparent evaluation process that follows established procedures, and it actually speeds up the bidding process (for example, there are fewer complaints).

### ***Task 19: Maximize Interest of Possible Contractors***

Given the value of transparent and competitive selection process, it is worthwhile to try to maximize the number of organizations that apply for each lot. Some actions that can increase interest include the following:

- Carrying out consultations with potential contractors before the selection process
- Advertising widely, such as through Development Gateway, United Nations Development Business, and other Web sites
- Sending information directly to organizations that might be interested
- Holding information sessions or “pre-bid conferences”
- Keeping the request for proposal (RFP) documents as simple as possible and the selection process transparent and understandable
- Allowing smaller NGOs to form consortia
- Avoiding bid and performance bonds.

### ***Task 20: Select a Contractor***

(For World Bank borrowers and staff, appendix B and task 20A provide guidance on how to select a contractor.)

For purchasers not bound by World Bank procurement guidelines, there are basically three ways of selecting a contractor and setting the price of the contract: (1) competition, wholly or partly based on bid price; (2) negotiation; and (3) establishing a fixed budget before the competition.

- *Competition* has the following advantages: (1) it provides the lowest prices in the long run, thereby allowing limited resources to cover the largest number of beneficiaries; (2) it is a very transparent means for establishing the price because each bidder’s price is called out publicly at the opening of the financial proposals; (3) it

facilitates innovation by encouraging bidders to develop the most efficient means for delivering services; and (4) it reflects the local realities of the particular lot.

The disadvantages of competition include the following: (1) it takes a few weeks longer than other approaches; (2) it can result in inconsistent prices so that similar-looking lots have very different prices, which can result in difficulties wherein journalists or others raise concerns about corruption; and (3) especially early in the contracting experience, competition can result in prices that are either too high or too low because bidders have limited experience and knowledge of the true cost of delivering the services.

- *Negotiation* between the purchaser and the bidder achieving the highest score on its technical proposal has the following advantages: (1) it is a fairly rapid way of establishing the price, (2) it can reflect local realities, and (3) if the purchaser is well motivated and savvy, it can result in a reasonably good price.

The disadvantages of negotiation include the following: (1) it is not transparent and can easily be, or perceived to be, corrupt; (2) it can also result in inconsistent prices for similar-looking lots; and (3) it is difficult to know whether the negotiated prices are “reasonable” from the purchaser’s perspective.

- *Fixed budget* is where the purchaser fixes the budget available for each “lot” in advance of publishing the request for proposal. It has the following advantages: it is transparent because every bidder knows what the fixed budget is, and it is fairly quick.

The disadvantages of the fixed budget approach are the following: (1) it is rigid as if “one size fits all,” (2) it discourages innovations and efforts to reduce costs through more efficient means of service delivery, and (3) it is often hard to estimate in advance how much services will cost resulting in prices that are too low or too high. Costing studies to determine what the fixed budget should be are complicated to carry out, can take considerable time, and often come up with results that subsequently appear to be wrong. For example, in Bangladesh, the bid prices (that is, the market price that organizations thought the services would cost) were 35 percent *lower* than the estimates from a detailed costing study. In Cambodia the bid prices were nearly three times *higher* than the costing study indicated they should be.

**Recommendations.** Transparent approaches are important in avoiding corruption and argue against negotiations behind closed doors. Approaches can also be modified to make them more appropriate. For example, the fixed-budget approach can specify a cost per beneficiary and increase the price for mountainous or remote areas.

### *Task 20A: Select a Contractor*

For World Bank borrowers and staff, two distinct ways may be used for selecting contractors. When the contract results in an easily measured physical output, such as cleaning services or equipment maintenance in a hospital, the contractor should be selected using a wide competitive process in which the award will go to the bidder with the lowest price who meets the technical criteria established by the purchaser. When the output is of an intellectual nature, such as management of a hospital or designing and implementing a behavior change campaign, the contractor should be selected in conformity with procedures normally used for the selection of consultants. There are three methods that can be used in the latter case: (1) selection based on the quality of the technical proposal and costs, (2) fixed budget, and (3) single-source selection. Hybrids of these approaches exist that can also be useful.

Open competition is the preferred approach. However, circumstances may justify other selection methods, such as the following:

- **Selection based on quality and cost.** This method uses a competitive process among short-listed organizations that takes into account the quality of the proposal and the cost of the services in the selection of the successful bidder. Cost as a factor of selection is used judiciously. The relative weight to be given to the quality and the cost should be determined for each case, depending on the nature of the assignment.
- **Fixed budget.** This method is appropriate only when the assignment is simple and can be precisely defined and when the budget is fixed. The RFP should indicate the available budget and request that the bidders provide their best technical and financial proposals in separate envelopes, within the budget. The TORs should be particularly well prepared to make sure that the budget is sufficient

for the consultants to perform the expected tasks. Evaluation of all technical proposals should be carried out first. Then the price proposals should be opened in public and the prices read aloud. Proposals that exceed the indicated budget should be rejected. The bidder who has submitted the highest-ranked technical proposal among the rest should be selected and invited to negotiate a contract.

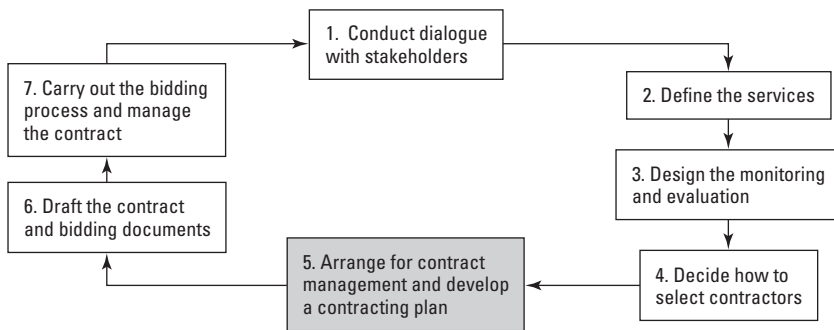
- **Single-source selection (SSS).** This method of selecting bidders does not provide the benefits of competition in regard to quality and cost, lacks transparency in selection, and could encourage unacceptable practices. Therefore, SSS should be used only in exceptional cases. It may be appropriate only if it presents a clear advantage over competition: (1) for tasks that represent a natural continuation of previous work carried out by the firm; (2) in emergency cases, such as in response to disasters and for consulting services required during the period of time immediately following the emergency; (3) for very small assignments; or (4) when only one firm is qualified or has experience of exceptional worth for the assignment.

The disadvantages of SSS or negotiations include that it is not transparent and can easily be, or perceived to be, corrupt (it can also result in inconsistent prices for similar looking lots), and it is difficult to know whether the negotiated prices are “reasonable” from the purchaser’s perspective.

- **Hybrids.** Hybrids of the above approaches are also possible, and there is much scope for creativity. For example, a fairly common and sensible compromise between selection on the basis of quality and cost and fixed budget is where the amount of money for service delivery itself is fixed but the bidders compete on the basis of their overhead costs. (The RFP documents for such an approach are available at <http://www.worldbank.org/hnp/contracting>.) Another option, although it is a little complicated, is to have contractors compete on what proportion of the fixed budget would be provided to them on the basis of performance. (For example, one bidder would have 50 percent of the funds provided as a fixed budget and the remainder would be provided on the basis of performance as prescribed by the purchaser. Another bidder could bid 70 percent as fixed and 30 percent on the basis of performance.)



## Step 5: Arrange for Contract Management and Develop a Contracting Plan



Contract management is the aspect of the contracting process that usually gets the least attention, often because it is not explicitly addressed in any document (such as the contract or the RFP). This is one reason that drafting a written contracting plan (or contracting manual) is so important. The major functions involved in contract management include the following:

- Ensuring both parties adhere to the terms of the contract
- Paying contractors on time so as to avoid disruption of services
- Avoiding corruption or the appearance of corruption
- Ensuring that proper monitoring and evaluation of contractor performance is carried out so that the purchaser can be confident that resources are being effectively used
- Solving the problems that can arise in any complex relationship
- Maintaining purchaser stewardship and ownership while avoiding micromanagement of the contractors.

Addressing these issues requires considering who is responsible, the staff needed, and the available budget.

### *Task 21: Define Responsibility and Clarify the Contract Management Structure*

Managing contracts requires full-time attention by a clearly defined, reasonably sized team with explicit responsibilities and authority. Dif-

ferent approaches have been taken to the location of the contract management unit, including within the Ministry of Health (or other state organizations such as national AIDS committees), local governments, or special government procurement units. Although different approaches have been used in many countries, issues have arisen with all of them.

- **Central Ministry of Health.** Many ministries of health have limited experience and knowledge of contract management, and they are sometimes constrained from hiring staff or consultants who do have the knowledge. In addition, there is often real opposition within the MOH to contracting, and contractors fear that the MOH will deliberately sabotage their efforts. Advantages of having contract management in the MOH (or related organization) include greater ownership and better technical knowledge of the sector. This approach has been used in many countries, including Bangladesh and Cambodia.
- **Local government.** Economies of scale exist in contract management, and there is a fear that building the capacity for effective management at local levels is inefficient. However, the possible advantages of this approach include greater involvement of local officials and better monitoring of contractor performance. This approach has been used in a few countries, including Guatemala and Pakistan.
- **Specialized procurement unit.** This approach limits the stewardship function of the MOH, and specialized procurement units may be less motivated than organizations whose mandate is to improve health. Conversely, such units usually have extensive procurement experience, have more experience with contract management, and generally do a good job in regard to timely payment of contractors. This approach has been used in Africa, including in the Democratic Republic of Congo and Senegal.

**Recommendations.** Where possible, it appears that having contract management based in the MOH or other line agency is the best long-term approach. It ensures ownership and long-term stewardship of the sector. It also ensures that people who are technically expert on the health services to be delivered will be involved in the process. This approach can be strengthened by (1) recruiting consultants or other

skilled staff to support the MOH, (2) involving local governments in contract management (for example, review of quarterly reports) and field monitoring, and (3) ensuring that members of such a unit have an incentive to help contractors perform well.

***Task 22: Ensure Proper Staffing of the Contract Management Unit***

Without making contract management units too large, they will need (1) a senior person who can effectively manage relationships and communicate with stakeholders, (2) skilled people who can spend considerable time in the field troubleshooting and monitoring performance, and (3) someone with a background in financial management. If the unit will also be responsible for recruitment of contractors, then someone with procurement expertise may be required. Because many ministries of health have limited experience with contracts, it often makes sense and leads to better results to recruit local consultants (paid market wages) into the unit.

***Task 23: Allow Sufficient Budget for Contract Management***

Purchasers tend to underestimate the resources that are required for a contract management unit to be effective. The budget for managing the contracts needs to reflect (1) the cost of staff or local consultants; (2) equipment, computers, and software; (3) the cost of transportation and per diems that facilitate field visits for monitoring; and (4) possible incentives for the contract management staff linked to the results achieved by contractors or timely payment of contractors.

***Task 24: Consider Computerization of Contract Tracking***

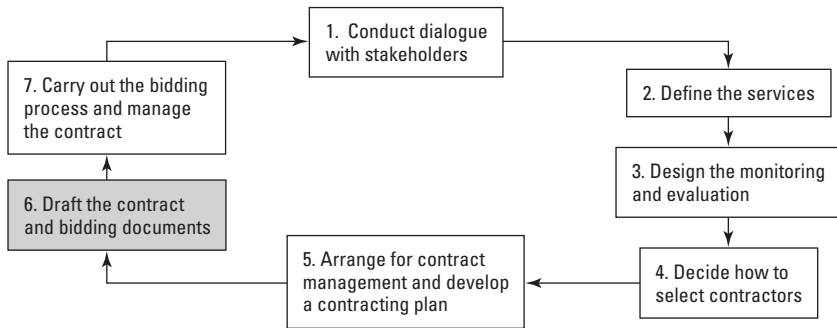
When more than six or seven different contracts must be managed, it becomes difficult to do it by hand. In cases in which larger numbers of contracts are involved, it makes sense to obtain contract management software.

***Task 25: Develop a Written Contracting Plan***

The purchaser needs to develop an overall contracting plan (sometimes referred to as a manual of procedures or contracting manual) to avoid serious gaps or mistakes. Such a contracting plan should summarize the entire contracting process, including how contracts will be

managed and how they will be monitored and evaluated. (An example of a contracting plan is found in appendix A.) Developing such a plan should not be seen as a burden, because most important aspects can be dealt with in six or seven pages.

## Step 6: Draft the Contract and Bidding Documents



Drawing on the considerations in steps 1 to 5 and the content of the contracting plan, the next step in the process is to draft a contract incorporating the scope of work developed in step 2 and the issues listed below. Appendix A provides an example of a contract (or an agreement). Finally, it will be necessary to formulate bidding documents, such as the request for proposal. An example of a World Bank RFP document, including the draft contract, is available at <http://www.worldbank.org/hnp/contracting>.

### *Task 26: Maximize Managerial Autonomy*

One of the principal advantages of contracting is that NSPs are less constrained by the “red tape” and political interference that often plague governmental efforts at service delivery. Giving contractors significant managerial autonomy improves results for several reasons:

- Management decisions are made by the people who are closest to the reality on the ground and can make the most informed decisions about how to tackle problems that arise.
- It is easier for purchasers to hold contractors accountable for results because the latter cannot claim that the action, or inaction, of others has interfered with their performance. For example, if a contractor

is responsible for hiring staff and setting wages, it cannot blame anyone else if it is unable to deliver services because of a staff shortage.

- Managerial autonomy allows and actually encourages the innovations that can lead to improved performance. In Cambodia, an NGO introduced performance-based bonuses for the staff, which increased performance dramatically (Soeters and Griffiths 2003).
- It allows the contractor to take advantage of the nonstate sector's inherent flexibility. For example, in urban Bangladesh an NGO manager arranged a raffle of a TV set as a way of informing the community about the opening of a new clinic, which was soon packed with patients. It would have been very difficult for a public sector manager to arrange for such a raffle.

There are a number of ways of increasing the managerial autonomy of contractors:

- **Clarify the authority of both parties.** When the authority of the purchaser and the contractor are not clear, the purchaser usually tries to assert control. Making the roles and responsibilities of both parties explicit in the contract can avoid important problems that may later interfere with effective delivery of services.
- **Focus on “what” not “how.”** As mentioned, it is important to define the scope of services by what services are delivered rather than how they are delivered.
- **Discover other ways of increasing autonomy.** There are a few other important ways of providing contractors with appropriate autonomy that are discussed in more detail below, such as (1) allowing contractors normal management prerogatives over health workers; (2) using lump-sum budgets rather than line-item budgets; (3) leaving procurement of goods, supplies, and medicines to the contractor; and (4) not applying inappropriate public sector accounting rules and procedures to the nonstate sector.

### *Task 27: Ensure That Contractors Can Manage Personnel Effectively*

A very important part of successfully implementing health services is to be able to manage the staff effectively. Giving contractors control of the personnel function is an important aspect of managerial autonomy without which performance can be compromised (see box 3.6).

In practice, this approach means that contractors should be given the normal management prerogatives of hiring, firing, posting, handling pay and benefits, setting terms of employment (such as performance bonuses), and establishing staffing levels. In management contracts in which the contractors use existing MOH health workers, the management prerogatives of the contractor may be limited by civil service rules. However, it still should be maximized to the extent possible. In a number of countries, contractors have succeeded in getting health workers into isolated locations that had previously been underserved (see box 3.7). Purchasers can reasonably expect that contractors recruit qualified staff with recognized credentials, ensure that health

### **Box 3.6 Results of a Government Maintaining Control of Staff Assignments**

In the Democratic Republic of Congo contractors were allowed to manage government health workers. However, decisions about the assignment of staff were made by the Ministry of Health, and during the first round of contracts the MOH used its authority regarding staff posting. The result was that an excessive number of health workers were transferred into the contracted areas because the pay was higher and the working conditions were better. For the second round of contracting, the contracts specified that the government would follow predetermined staffing patterns that ensured reasonable numbers of health workers.

### **Box 3.7 Attracting Health Workers to Underserved Areas**

In Cambodia, a contractor in one district was able to increase the number of doctors working there dramatically by paying wages that were much higher than the government rate (but still only \$250 per month). Combining a higher salary with certain benefits, such as a motorcycle and a performance-based bonus, allowed the NGO to attract five doctors to work in the district that previously had no doctors.

In Afghanistan, contractors offered inducements to female health workers to relocate to remote rural areas. Besides better pay, this offer included employment for a male relative (very important in the cultural context), housing near the health center, and a small generator that provided light and entertainment (such as a DVD player). The results were impressive. Before the contracts, only 24 percent of health centers had trained female health workers. After two years of the contracts, 82 percent of the health centers had trained female staff.

workers receive training to further enhance their skills, and respect national labor laws.

### *Task 28: Use Lump-Sum Contracts*

Lump-sum contracts are those in which contractors receive an agreed-on amount of funds on a regular basis that is *not* reimbursement for specific expenditures they have incurred. (Even payment according to the number of services provided is a type of lump-sum payment because it is not tied to reimbursement of expenditures.) Lump-sum budgets provide an amount up to which managers can spend without worrying about the amount of a specific line item (line items limit the amount that can be spent on a particular type of expenditure, such as \$85,000 for drugs and \$120,000 for equipment). Lump-sum budgets have a number of important advantages:

- They give managers the flexibility to move money to where it is most needed
- They prevent “micromanagement” by the purchaser’s contract managers, which can stifle creativity (micromanagement can result where line-item budgets are used)
- They facilitate implementation because it is not necessary to seek permission for changes in line items or to engage in the endless arguments between accountants over what items should be reimbursed, which often result in delays
- They ensure that purchasers and contractors focus on the outcomes and outputs of the contract, not merely the inputs, of which money is one.

Lump-sum budgets do not preclude careful financial management. They are consistent with proper accounting and allow line-item descriptions of expenditures in reports provided by contractors (these reports facilitate subsequent costing studies).

### *Task 29: Leave Procurement of Supplies, Equipment, and Services to Contractors*

In most situations it is better to leave the procurement of medicines, supplies, and equipment to the contractor. Experience has generally shown that decentralizing procurement to individual contractors en-

### Box 3.8 Decentralizing Drug Procurement in Afghanistan

In Afghanistan, the government signed contracts with NGOs that gave them responsibility for procurement of medicines and other supplies. At the same time, other contracts stipulated that medicines would be procured centrally by an organization with long-term experience in drug procurement and distribution. In addition, in a few provinces drug procurement and distribution were handled by the central Ministry of Health. An independent assessment showed that the availability of drugs improved much more in the places where individual contractors were responsible for procurement and distribution (see table).

Effects of Decentralized Procurement on Drug Availability Index (Maximum Score = 100) in Afghanistan

<i>Approach to drug procurement and distribution</i>	<i>Baseline</i>	<i>Endline</i>	<i>Change</i>
Decentralized to individual NGOs	62.4	92.1	29.7
Centralized, nonstate organization responsible for procurement and distribution	70.3	83.0	12.7
Centralized, public sector procurement and distribution	57.1	71.2	14.1

*Source:* Bloomberg School of Public Health, Johns Hopkins University.

sure better availability of supplies at the point of service delivery (see box 3.8). Although there may be economies of scale gained from central procurement, they must be weighed against not having supplies where needed. As for the quality of drugs, there appears to be no consistent difference between medicines procured by governments and those purchased by the nonstate sector (if anything, the latter may have an advantage). The purchaser should indicate in the contract the list of items to be procured and include specifications and standards (such as for drugs). The contract should also stipulate that the purchaser can carry out spot checks to evaluate drug quality. Some supplies and drugs, particularly vaccines, should be procured centrally.

#### *Task 30: Ensure That Duration of the Contract Is Sufficiently Long*

Experience in other sectors and increasingly in health sectors indicates that the minimum duration of a contract should be four to five



years. There are a number of good reasons: (1) it takes time for both parties to understand and get used to the contractual arrangements and to develop a solid working relationship, (2) it makes sense to give contractors a reasonable amount of time to implement their plan, and (3) continuity—especially when dealing with local communities—is a clear advantage. No advantage can be seen to short-duration contracts that need to be renewed frequently. They just take up time, lead to delays, increase opportunities for conflict and corruption, increase costs, and result in gaps in services. Purchasers, legitimately, want to have the opportunity to terminate the contracts of organizations that are performing poorly. However, better than having frequent renewals of short-duration contracts is to have clear termination clauses and regular reviews of contractor performance.

### *Task 31: Have Clear Procedures for Making Payments*

There are two types of payment in a typical contract: an initial mobilization payment and regular payments during the life of the contract (usually every three or six months).

- **Mobilization payments.** Because contractors for health services are often NGOs or CBOs, they have no “capital,” and it is important for them to receive a mobilization payment on signing the contract. This can usually be 10 percent of the contract amount. It is *not* recommended that a performance bond or bank guarantee be used with nonprofit contractors because it can lead to serious delays, it is often unfair since NGOs are not set up on such commercial terms, and there are other ways of ensuring that money will be properly used by relying on the social collateral of such NGOs. (Suggested wording for a letter from an NGO in lieu of a performance guarantee is available at <http://www.worldbank.org/hnp/contracting>.) Where NGOs have had previous contracts and have a “track record,” the risk of providing a mobilization payment is low (partly because poorly performing NGOs can be “blacklisted”).
- **Regular payments.** Subsequent, regular payments should be made on a lump-sum basis on submission by the contractor to the purchaser of acceptable reports (see task 34) that are explicitly described in the contract. Payments should be made on a quarterly or six-

month basis because this reduces the transaction burden on both parties and increases the likelihood that contractors are paid on time. As argued above, lump-sum payments reduce transaction time and effort, increase managerial autonomy and flexibility, and reduce the number of disputes. The prerequisites for claiming payment and processing payments should include submission of a quarterly activity report, an invoice, and a financial report. The actual calendar dates for payment should also be agreed to by the parties.

### ***Task 32: Establish a Clear Process for Termination and Imposing Other Sanctions***

The contract needs to spell out clearly the procedures and rules governing the termination of the contract. This clarity is important for the purchaser's peace of mind and helps it meet its responsibilities for carefully managing public funds. It makes sense to use a dispute resolution mechanism (task 33) before terminating the contract. Besides termination, the contract should spell out other sanctions that the purchaser can employ in the case of poor contractor performance. A few things that appear to work include (1) having face-to-face meetings with key contractor officials, (2) writing letters first to the project manager and then to the board of directors of the organization (embarrassment seems to work quite well, particularly when there is objective evidence of poor performance), (3) demanding the replacement of key staff if other efforts have not produced the desired results, and (4) limiting the opportunity of the contractor to avail itself of other purchaser-sponsored contracting opportunities (for example, it cannot bid on new contracts, so-called blacklisting or debarment).

### ***Task 33: Establish Dispute Resolution Mechanisms***

Most disputes can be settled through discussion and, although rarely required, it is worthwhile to describe in the contract a fair method for resolving disputes. These descriptions should be kept fairly simple, and the first step can simply be appointment of a mediator acceptable to both parties. If this step fails to resolve the issue, it is worthwhile using an arbitration panel composed of people of known integrity. (The annex to appendix A has an example of a contract clause on dispute resolution, part K of the draft agreement.)

***Task 34: Define Reporting Requirements of the Contractor***

The reporting requirements of the contractor should not be excessive. We recommend that contractors submit a quarterly report that includes the following:

- A description of progress made against the work plan
- Problems encountered and solutions undertaken
- A summary of health management information system data (HMIS forms should also be sent to the purchaser regularly, usually monthly)
- A financial statement
- A bank account statement; contractors should also be expected to provide an annual external financial audit report.

***Task 35: Have an Explicit Policy on User Charges***

The imposition of user charges or fees for health services is controversial. However, many NGOs or private providers that end up being contractors may already be implementing user charges, and so the contract should be explicit about whether and how contractors can levy such charges. If user charges are permitted, they should comply with guidelines established by the purchaser. These should specify that (1) user charges will not interfere with the accomplishment of greater equity as stipulated in the objectives of the contract, (2) the level of the user charges will be reasonable and publicly displayed, (3) there will be explicit exemption procedures for the poor, and (4) the funds collected can be retained in the location where they are collected.

***Task 36: Ensure That Contractors Use Independent, Private Sector Auditors***

In other types of contracts, such as for construction of a road, the purchaser would not usually ask for an audited financial statement from the contractor. This makes sense because the purchaser is really interested in the timely construction of a road of acceptable quality. A similar approach should be used in contracting for health services. However, some purchasers, to allay their own fears, expect contractors

to provide regular financial reports and audited financial statements at the end of the year. If such audited statements are required, experience in the field strongly suggests that contractors should be allowed to use independent auditors, which ensures proper financial management while avoiding overly constraining bureaucratic rules.

***Task 37: Ensure That Contractors Build the Capacity of Health Workers***

The contractor should be responsible for ensuring that the health workers delivering services have the capacity to do a good job and to meet the technical standards stipulated in the contract. This task is particularly important in cases in which quality of care needs to be improved (which is almost everywhere). The contract should stipulate the following:

- The qualifications of the health workers to be employed (purchasers need to be careful that they are realistic in what they expect and contractors should not be employing cardiac surgeons in rural clinics)
- The obligations of the contractor for training and capacity building for their staff
- How contractors will obtain access for their staff to government-run or -financed training courses.

***Task 38: Address the Capacity Needs of Contractors***

Purchasers are sometimes reluctant to address the capacity needs of contractors; they argue that they want to hire NSPs who already have the needed capacity. However, building the capacity of contractors is in the purchaser's best interests. Techniques and approaches are evolving in many aspects of service delivery, and it is helpful if everyone is aware of the state of the art. For example, in HIV prevention services, there has been a steady movement toward more participatory approaches in which members of the high-risk groups actually manage and implement services themselves. Showing NGOs how this works will make them more effective, which will be a benefit to the purchaser as they have an interest in seeing that public funds are used efficiently. Purchasers may also want to help contractors with their M&E systems, financial management and reporting, and the facilitation of the sharing of experiences among NSPs.

**Task 39: Clarify Responsibilities for Physical Infrastructure**

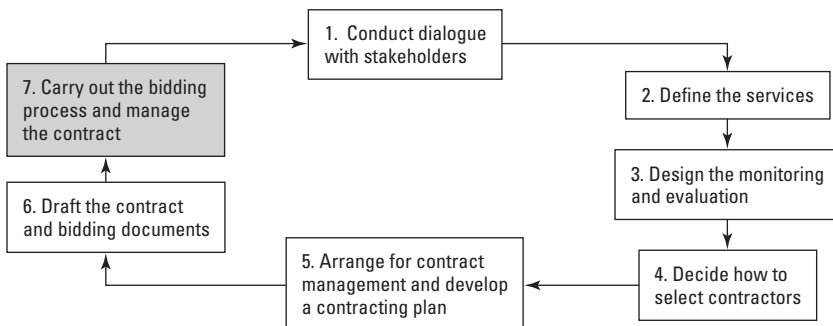
The contract needs to stipulate what happens to the physical infrastructure during and after the contract period. It is recommended that equipment become the property of the purchaser after the contract, but that during the life of contract it should be the contractor's responsibility to maintain. The ownership of buildings should also be clearly stipulated in the contract. During the life of the contract, maintenance, repair, and rehabilitation of buildings should be the responsibility of the contractor.

**Task 40: Formulate the Bidding Documents**

The request for proposal (RFP, or its equivalent) is the document that will be given to interested bidders (NSPs) and will guide the bidding process. Typically an RFP contains the following components:

- A letter of invitation to bid
- Instructions to the bidders on how to prepare and submit their bids, which will also describe the process and criteria by which contractors will be selected
- The form of the technical proposal
- The form of the financial proposal
- The terms of reference
- The draft contract.

Examples of World Bank RFPs are available online at <http://www.worldbank.org/hnp/contracting>.

**Step 7: Carry Out the Bidding Process and Manage the Contract**

Once the previous steps have been completed, the bidding process needs to be carried out in compliance with the procedures laid out in the RFP document (or its equivalent). Once the contract with the winning bidder is signed, M&E activities and contract management need to be implemented in keeping with the contracting plan and the signed contract.

### ***Task 41: Track the Schedule of the Bidding Process***

It is worthwhile to keep careful track of the bidding process described in the bidding documents and the contracting plan. In almost all situations, it should be possible to complete a competitive bidding process in six or seven months. This schedule means that recruitment of contractors should begin as soon as possible, even before financing is fully secured. One way of diagnosing corruption is to keep careful track of how long the evaluation process takes and how long it takes to finalize the contract. In negotiations in which processes are corrupt, it takes time for the parties to go back and forth arranging their deals. A useful rule of thumb is that the likelihood of corruption increases if it takes more than three weeks from the time of the final bid evaluation to the time the contract is ready for signing.

### ***Task 42: Conduct Regular Monitoring Visits***

Successful contract management entails regular monitoring visits to the sites where the health services are being provided. As with other types of supervision, monitoring visits should be systematic and use a checklist that examines key aspects of performance, such as the following:

- Assessment of results from the routine recording system
- Availability of key inputs (such as medicines, equipment, and vehicles)
- Availability and morale of health workers
- Satisfaction of key stakeholders
- Quality of care or related processes.

In addition to assessing performance, monitoring visits are also good times to cement relationships among all stakeholders, identify issues, and solve problems early on. If monitoring visits are carried out systematically, doing them frequently will have a real effect.

***Task 43: Meet with Stakeholders Frequently***

Contracting involves complex relationships that need to be established and then nurtured. To do this takes frequent discussions that allow issues to be identified and solved or prevented. Experience in the field shows that three actions can be particularly worthwhile: (1) hold regular and frequent (every one or two months) meetings between the contract management unit and contractors, (2) establish a mechanism for contractors to share experiences and ideas among themselves without the purchaser necessarily being present, and (3) regularly report to major stakeholders, particularly the purchaser and local governments, on the progress of the contracts.

***Task 44: Review the Contracting Plan and the Contract***

The unit responsible for contract management for the purchaser and the contractors should use the contract as the basis for ensuring smooth implementation of the services. The purchaser should review the contract and the contracting plan to ensure that the contractor is performing well on its contractual obligations, as well as systematically implementing the contract management and M&E functions.

## Checklist for Contracting

Task numbers in this checklist correspond to paragraph numbers in Section 3, “How to Contract.” Highlighted tasks should receive particular attention.

✓	Task	Comments
<b>Step 1: Conduct Dialogue with Stakeholders</b>		
	1. Establish a consultative process with stakeholders: <ul style="list-style-type: none"> <li>• Hold a few discussions with each set of stakeholders</li> <li>• Get back to stakeholders with draft proposals and contracts</li> </ul>	
	2. Identify champions	
	3. Address the legitimate concerns of stakeholders: <ul style="list-style-type: none"> <li>• Government health officials</li> <li>• Local politicians and government officials</li> <li>• Government health workers</li> <li>• Private sector, including NGOs</li> <li>• The community</li> <li>• Development partners and donors</li> </ul>	
<b>Step 2: Define the Services (Develop TORs)</b>		
	4. Define the objectives of the contract: <ul style="list-style-type: none"> <li>• Limit the number of indicators</li> <li>• Design bias toward outcome/output indicators</li> <li>• Ensure that indicators are independently measurable</li> <li>• Define indicators as precisely as possible</li> <li>• Set targets broadly</li> </ul>	
	5. Include objectives related to equity and quality	
	6. Consider pay for performance	
	7. Ensure that purchasers and contractors focus on objectives	
	8. Define the size and location of each contract “lot”	
	9. Define the scope of services—focus on “what” not “how”	
<b>Step 3: Design the Monitoring and Evaluation</b>		
	10. Decide how data will be collected: <ul style="list-style-type: none"> <li>• Health management information system</li> <li>• Household surveys</li> <li>• Health facility assessments</li> <li>• Supervisory checklists</li> </ul>	
	11. Collect baseline data	
	12. Devise a clear schedule for data collection	
	13. Look for comparison/control groups	
	14. Assign responsibility for collection, analysis, and dissemination of data	
	15. Budget sufficient funds for monitoring and evaluation	



✓	Task	Comments
<b>Step 4: Decide How to Select Contractors and Establish the Price</b>		
	16. Use a competitive selection process	
	17. Develop clear selection criteria	
	18. Establish a transparent and independent evaluation process	
	19. Maximize interest of possible contractors	
	20. Select a contractor	
<b>Step 5: Arrange for Contract Management</b>		
	21. Define responsibility and clarify the contract management structure	
	22. Ensure that proper staffing of the contract management unit	
	23. Allow sufficient budget for contract management	
	24. Consider computerization of contract tracking	
	25. Develop a written contracting plan (or contracting manual)	
<b>Step 6: Draft the Contract and Bidding Documents</b>		
	26. Maximize managerial autonomy: <ul style="list-style-type: none"> <li>• Clarify authority of both parties</li> <li>• Focus on “what” not “how”</li> <li>• Discover other ways of increasing autonomy</li> </ul>	
	27. Ensure that contractors can manage personnel effectively	
	28. Use lump-sum contracts	
	29. Leave procurement of supplies, equipment, and services to contractors	
	30. Ensure that duration of the contract is sufficiently long	
	31. Have clear procedures for making payments: <ul style="list-style-type: none"> <li>• Mobilization payments</li> <li>• Regular payments</li> </ul>	
	32. Establish a clear process for termination and imposing other sanctions	
	33. Establish dispute resolution mechanisms	
	34. Define reporting requirements of the contractor	
	35. Have an explicit policy on user charges	
	36. Ensure that contractors use independent, private sector auditors	
	37. Ensure that contractors build the capacity of health workers	
	38. Address the capacity needs of contractors	
	39. Clarify responsibilities for physical infrastructure	
	40. Formulate the bidding documents	
<b>Step 7: Carry out the Bidding Process and Manage the Contract</b>		
	41. Track the schedule of the bidding process	
	42. Conduct regular monitoring visits	
	43. Meet with stakeholders frequently	
	44. Review the contracting plan and the contract	

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## Whether to Contract

This section reviews the global experience with contracting with non-state providers, including nongovernmental organizations (NGOs), for improving health care delivery. Short descriptions (one to three pages) of specific examples are also provided in appendix C. The 14 evaluated examples indicate that contracting for the delivery of primary care appears to be effective and improvements can be rapid. These results were achieved in a variety of settings and services. There have been one randomized trial and five other controlled, before-and-after studies of contracting in developing countries, and many of the anticipated difficulties with contracting were either not observed in practice or did not compromise its effectiveness. Twelve of the 14 cases have been sustained and expanded, often to a very large scale. Many contracts have been in place for more than seven years. Provision of a package of basic services by contractors costs between approximately \$3 and \$6 per capita per year in low-income countries. The current evidence suggests that contracting for health service delivery should be expanded, and future efforts should include rigorous evaluations.

### **The Evidence on Contracting**

Substantial improvement in the delivery of health services will be necessary to achieve the health-related Millennium Development Goals (MDGs). For example, it has been estimated that 63 percent of childhood deaths in developing countries could be prevented through the full implementation of a few effective and low-cost interventions (Bryce and

others 2003). Hence, discovering better ways of delivering these services is critically important. Although many countries undoubtedly need to allocate more resources to health services, previous experience suggests that more money alone may not solve the problem of service delivery. There appears to be no consistent relationship between the amount spent on health and health outcomes (World Bank 2004). Another response to the challenge of improving service delivery has been to use public funds to contract with nonstate providers (NSPs). This section reviews the global experience with contracting for primary health care and related services, taking into account the methodological rigor of the evaluations, and summarizing the evidence from 14 evaluated examples. Appendix C provides more detailed descriptions of each example.

## Methodology

This review focuses on evaluated instances in developing countries of contracts between governments, international organizations, or their agents with identifiable NSPs for delivery of primary health care services, including nutrition (but excluding referral hospital care or ancillary services, such as food provision in hospitals).

**Inclusion Criteria.** To be included in the review, the evaluation had to measure quality of care, outputs such as increase in volume of services provided, or effect on health status. The evaluations also had, at a minimum, to involve before-and-after or controlled designs. Hence, evaluations were excluded that described the contracting process but that did not measure some tangible outputs. Also excluded were studies that just provided “after” evaluations with no “before” data or without contemporaneous controls. Although instances of contracts with for-profit entities were not excluded, only two of the contracting initiatives reviewed (TB control with private providers, case 11, and improving management of childhood diseases among for-profit providers, case 14) involved for-profit entities.

**Search and Review Methodology.** To find as many examples of contracting as possible, experts from a variety of institutions were asked for examples of contracting of which they were aware. Previous reviews of contracting in developing countries were also examined (Mills 1998; Abramson 1999; Palmer 2000; Slack and Savedoff 2001; Loevinsohn and Harding 2005; Liu, Hotchkiss, and Bose 2008). A

computerized search of the published literature was also carried out using ECO (Electronic Collections Online, a broad database covering scholarly journals in a wide variety of fields); Periodical Abstracts (covering general and academic journals in business and economics, including transcripts of television and radio news programs); Econ-Lit (covering journals, books, working papers, and dissertations in economics); WorldCat (covering books and other resources in a large number of libraries); PAIS (Public Affairs Information Service, providing selective subjects and bibliographic access to periodicals, books, hearings, reports, gray literature, government publications, Internet resources, and other publications from 120 countries); and PubMed (the U.S. National Library of Medicine's search service for access to Medline and other related databases).

The electronic search was supplemented by a manual review of journals that often publish articles related to health systems in developing countries (*Health Policy and Planning*, *Bulletin of the World Health Organization*, and *Social Science and Medicine*). Personal contact was also made with people known to be involved in contracting efforts. Written reports or presentations of the evaluated examples were reviewed and summarized, and considerable attention was given to the evaluation methodology used. Then an attempt was made to conduct structured interviews with people who had intimate knowledge of particular examples. The summaries were modified accordingly, and the same people were asked to review the summaries before they were finalized.

**Analysis.** In the instances where before-and-after data were available from experimental and control groups, the “double differences” were calculated. The *double difference* is the difference between follow-up and baseline results in the experimental group minus the difference between follow-up and baseline results in the control group. Wherever possible, differences are expressed as percentage points (see note on page 95).

## Results

**Contracting Can Quickly Improve Service Delivery.** According the 14 studies summarized in table 5.1 (pages 74–80), contracting with NSPs appears to deliver effective primary health or nutrition services, and impressive improvements can be achieved rapidly. Good results have been achieved in a variety of settings and for a variety of different services.

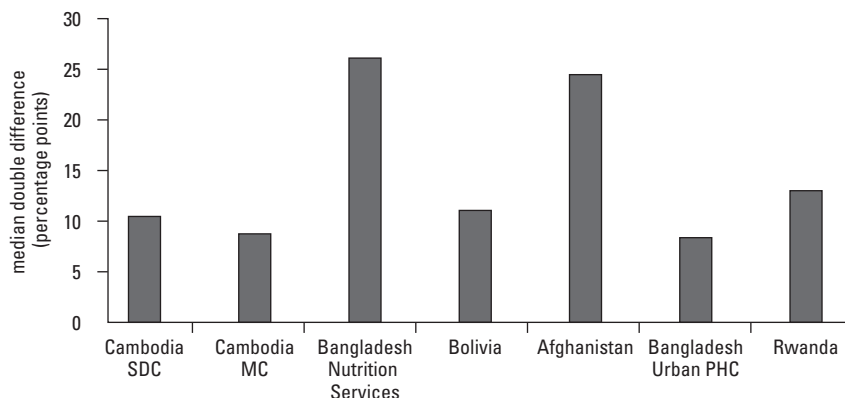
All the studies found that contracting yielded positive results, and the most rigorously evaluated cases demonstrated the largest effect. In the six studies in which it was possible to calculate the double difference, the median double differences ranged from 8.3 to 26 percentage points (figure 5.1).<sup>1</sup> All the median double differences were positive. Larger double differences were observed for parameters that are easier to change, such as immunization, vitamin A, and antenatal care coverage. Smaller changes were observed in parameters that require important behavioral changes, such as family planning. Some of the other studies, while not using controlled, before-and-after designs, provide some compelling additional evidence of the effectiveness of contracting.

**Contractor versus Government Performance.** Of the 14 studies, 10 compared contractor performance with government provision of the same services. All 10 found that the contractors were more effective than government, on the basis of a variety of parameters related to both quality of care and coverage of services. In the studies reviewed here, the differences between contractor and government performance also tended to be large (see box 5.1).

## Discussion

**Methodological Limitations of This Review.** This review was based partly on papers in the gray literature, some of which had not

**Figure 5.1** Median Double Differences in Coverage Rates from Studies with Controlled, Before-and-After Methodology



Source: Author.

Note: MC = management contract; PHC = primary health care; SDC = service delivery contract.

undergone peer review (8 of the 14 examples are described in articles from scholarly journals). The review included 14 contracting examples, which is a reasonable, but not huge, number. It is likely that other unidentified examples of contracting could be found. Other experiences may not have been written up because the results were poor, which would lead this review to more positive conclusions than are warranted. This type of positive results bias is usually more profound when only published articles are used.

**Applicability of Findings.** All the cases summarized in table 5.1 focused on primary care and nutrition services, in which outputs are relatively easy to measure. Other health services, such as specialist inpatient care, present much larger measurement challenges related to quality of care. Also, the providers in these cases were usually nonprofit organizations. Contracting with for-profit entities, especially self-employed physicians, is common in industrial and middle-income health systems, but there is limited experience in low-income countries (there are only two examples among the cases reviewed).

### **Box 5.1 Contractor versus Government Performance in Industrial and Middle-Income Countries**

There are few examples of contracts initiated for primary health care services in industrial countries. Most countries that contract have always done so. In countries where both contracted and public (salaried) physicians deliver primary health care services, the distinct reimbursement approaches make it virtually impossible to assess the effect of contracting alone (as distinct from that of the payment basis). Hence, opportunities to compare performance are rare. Nevertheless, a few scholars have attempted to assess the difference.

Several European countries have initiated contracting for packages of primary health care services. Where contracted services have been compared with those still provided by salaried physicians, results have generally been favorable. In Croatia, evidence of higher productivity was found in contracted practices, including indicators of patient accessibility (Hebrang and others 2003).

In Estonia, where salaried physicians converted to contracted status, a “before-and-after” analysis found improvements in allocative efficiency indicators, technical efficiency indicators (for example, annual number of visits per doctor, number of visits per inhabitant), and immunization rates (from 74 percent to 88 percent) (Koppel and others 2000).

**Table 5.1** Summary of Evaluated Contracting Experiences

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
1. <b>Cambodia</b> Rural PHC and district hospital services	SDC and MC compared with government provision of services (CC).	1.5 million population	Competitively bid, formal contract, managed by special unit of MOH. Some problems ensuring good relations with provincial officials. NGOs were paid on time.	Randomized controlled study with 12 districts as experimental units. Household and health facility surveys conducted before and after 4 years of implementation.	SDC and MC much better than CC. Median double difference <sup>a</sup> on seven indicators for SDC vs. CC was 10.4%; <sup>b</sup> for MC vs. CC double difference was 8.7%. Poor better served in contracted districts, and quality of care was 19.3% better.	Expanded to twice as many districts	Impressive results in contracted districts achieved quickly. SDC performed better than MC initially, but both outperformed government provision. Rigorous methodology. SDC and MC more expensive than CC, but reduced out-of-pocket expenditure by community.
2. <b>Bangladesh</b> Rural community nutrition services	SDC with NGOs compared with control areas with no organized nutrition services (that is, normal government health services with no nutritional component).	15 million population	Fixed-price MOU. Initially sole-source selection of NGOs, then competitive. Serious problems with payment and other aspects of contract management.	Controlled before-and-after study with 6 experimental and 2 control upazilas (subdistricts). Household surveys conducted by third party.	Malnutrition rates declined 18% in SDC upazilas compared with 13% in controls (double difference = 5%). Double difference for vitamin A was 27%.	Expanded to more than 30 million population	NGOs were able to implement nutrition interventions successfully on a very large scale. Modest difference in change in nutrition status, but larger in coverage of related services. No indication of how government would have done implementing nutrition services.

**Table 5.1** Summary of Evaluated Contracting Experiences (*continued*)

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
3. <b>Bangladesh</b> Urban PHC	15 SDCs with NGOs. NGO working in Chittagong compared with government provision of services by CCC.	4 million population	Competitively bid formal contracts, managed by special unit of local government division. Difficulties encountered paying contractors on time and adequate monitoring.	Controlled before-and-after study with an NGO contract in Chittagong compared with two areas implemented by CCC. Household and health facility survey by third party.	Median double difference favoring the NGO of 8.3% on six coverage indicators. 10.1% double difference among the poor. NGO did 11% better on a broad quality-of-care index.	Contracting with NGOs expanded to many more cities, more than doubling coverage	NGOs performed better in coverage of services and quality of care in spite of having the same amount of resources. CCC unable to provide broad package of services in newly built facilities. NGOs better able to reach the poor.
4. <b>Bolivia</b> Urban PHC	Limited MC in phase 2. MC with expanded authority in phase 3. Control area had continued public sector management.	250,000 population	Single-source contract with NGO. Contract management by committee, including community representatives.	Controlled, before-and-after design, but data from routine reporting system. Only a few indicators examined.	Double difference for deliveries between MC and control was 21%, and 1% for bed occupancy.	Unknown	Relatively small-scale study showed large changes in MC district. Methodological issues. Contract giving greater autonomy to NGO resulted in larger changes.

*(continued on next page)*



**Table 5.1** Summary of Evaluated Contracting Experiences (*continued*)

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
<b>5. Afghanistan</b> Rural PHC	SDC and MC compared with grants and government provision without management support.	6 million population for the SDC and MC	Competitively bid contracts with NGOs for SDCs. Competitively recruited individuals for MC. Contracts managed successfully by government. NGOs paid on time.	Controlled, before-and-after study. Third-party evaluation of quality of care using broad index based on satisfaction, knowledge, and quality of patient-provider interaction.	Double difference for SDC and MC compared with government itself was 24.3%. Compared with grants to NGOs, double difference was 5.3%.	Contracts expanded and now cover more than 20 million people	Large-scale performance-based contracts (using performance bonuses) led to a rapid increase in quality of care. Awaiting results from coverage surveys.
<b>6. Rwanda</b> Performance-based pay for PHC in rural areas	Provision of performance-based pay to centers (and indirectly to health workers) using NGO as intermediary.	388,000 and 620,000 (two provinces)	NGO signed contract with managers of individual health facilities. Monitoring done by district health team.	In one province a controlled, before-and-after study with a comparison group and based on reported data. Other province before-and-after study based on household surveys.	Median double difference of 12.9%, including 17% double difference in TT2+ and 9% double difference for DPT3. Large increase in institutional delivery but no effect on family planning.	Expanded to most of the rest of the country	NGO as an intermediary in implementing pay-for-performance project. Program appears to have been successful but little data on quality of care. Controlled part of the case uses reported data of unknown quality.

**Table 5.1** Summary of Evaluated Contracting Experiences (*continued*)

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
<b>7. Costa Rica</b> PHC provided by worker cooperatives	Worker-owned cooperatives given SDC to manage clinics previously managed by government.	150,000–300,000 beneficiaries	Cooperatives given contracts granting considerable autonomy on use of capital payment.	Time series over 10 years comparing cooperatives to publicly managed facilities based on reported data	22% more general visits and 42% more dental visits in cooperatives but at lower cost.	Expanded to include other nonstate providers, continuing for more than 15 years	Worker cooperatives taking over publicly managed clinics results in increase in services at lower cost. No data on patient satisfaction or technical quality of care.
<b>8. Global Fund</b> Support for AIDS, TB, and malaria	Global Fund (GFATM) grants to NSPs and government entities to fight the three diseases.	448 grants to programs in 136 countries worth \$6.8 billion; 134 grants included in the evaluation.	Grants (rather than contracts) in which NSPs and governments designed the interventions. CCM and LFA monitored performance.	Grading of project after 2 years of implementation based on progress, disbursement, and country context.	Taking into account other factors, NSPs 16.7% more likely to receive highest rating and 16.8% less likely to receive lowest ratings.	GFATM continues to fund NSPs on a very large scale	Very large-scale evaluation of NSP vs. government performance in implementing GFATM grants. Endpoints were more outputs and process rather than outcomes.

*(continued on next page)*

**Table 5.1** Summary of Evaluated Contracting Experiences (*continued*)

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
9. <b>Guatemala</b> Rural PHC in mountainous areas	MC in selected municipalities and SDC in more remote areas, compared with government provision (control).	3.4 million population	Competitively bid contracts with NGOs. Difficulties with financial management and supervision of contracts.	Controlled design based on household survey conducted by third party 3 years after contracting began.	Median difference between MC and control on five indicators was 11% (range 5–16%).	Started as small pilot but expanded rapidly, now covers 27% of country	MC appeared to make modest difference in service delivery. Difficult to assess SDC because of remoteness. No baseline data available.
10. <b>Haiti</b> Bonuses for NGOs delivering PHC in rural areas	NGOs with SDCs offered performance bonuses based on agreed-on targets.	1.3 million population	Input type of contract changed to one focused on outputs with greater managerial autonomy.	Before-and-after (over 6 years) design based on baseline household survey carried out by third party. Follow-up data from HMIS validated by third party.	Average of follow-up minus baseline ranged from +19% (skilled birth attendance) to +64% (vaccination coverage). Results improved as percentage of NGOs using performance-based contracts increased.	Initially covered 500,000 people, now expanded to cover 1.3 million people, 19% of Haitian population	Large change in important indicators with the introduction of performance bonuses and increased autonomy. “Dose-response” curve makes for compelling evidence, in spite of no control group.

**Table 5.1** Summary of Evaluated Contracting Experiences (*continued*)

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
<p><b>11. Various countries</b> TB control services through private providers</p>	<p>14 examples of “soft contracts” with private providers who received drugs in return for following national guidelines. Sometimes compared with publicly managed services.</p>	<p>11–17 million total population (17,000 sputum-positive cases)</p>	<p>In 7 of 14 cases, there were NGO intermediaries with formal contracts with TB programs. Some NGOs provided their own resources.</p>	<p>Combination of before-and-after and controlled designs with data from recording system verified by TB experts, including some from third party.</p>	<p>Private providers achieved 89.6% treatment success rates and increased case detection rates by 16.5%. Having NGO intermediary led to 8% better treatment success rate. Cost per successful treatment lower than public services.</p>	<p>Initiatives 3–12 years old, and now 40 such initiatives in 15 countries</p>	<p>Working with private practitioners was successful in improving treatment success and case detection. Having NGO intermediary achieved even better results, often at lower cost than public sector.</p>
<p><b>12. Pakistan</b> Rural PHC</p>	<p>MC for the 104 BHUs in one district compared with neighboring district as control.</p>	<p>3.3 million population</p>	<p>Sole-source MOU with NGO by local government. Vague objectives. Received monthly tranche of funds regularly.</p>	<p>Controlled comparison with another similar district using household and health facility surveys and before-and-after data from routine recording system.</p>	<p>50% higher use of BHU services, less use of unqualified providers, and increased satisfaction in MC district. No change in coverage of preventive services.</p>	<p>Expanded to 12 districts in the Punjab and now being replicated in other provinces</p>	<p>Large increase in outpatient visits achieved with same budget. Vague contracts interfered with improving coverage of preventive and promotive services.</p>

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**Table 5.1** Summary of Evaluated Contracting Experiences (*continued*)

<i>Location and service type</i>	<i>Contract and intervention type</i>	<i>Scale of effort</i>	<i>Contracting arrangement</i>	<i>Evaluation methodology</i>	<i>Main results</i>	<i>Subsequent history</i>	<i>Comments</i>
<b>13. Madagascar and Senegal</b> Community nutrition services	Madagascar: SDCs with 50 NGOs. Senegal: SDCs with NGOs that worked through small groups of unemployed youth.	460,000 in Madagascar; 490,000 in Senegal	In Madagascar, contract management was done by unit in office of the president; in Senegal, by parastatal. No serious problems encountered.	Before-and-after (17 months) household survey of nutrition status in Senegal. Third-party survey of participation in project and control areas.	Severe and moderate malnutrition declined 6% and 4%, respectively. Participation was 72% in project and 35% in control areas.	Continued with NGOs in both countries, but in different format	Modest effect on malnutrition, but effect size uncertain because of absence of control group. NGO successfully used unemployed youths to deliver services.
<b>14. India</b> Improved quality of care by private practitioners	SDC for NGO working with private providers to improve MCH services.	54,000 population	NGOs applied for grant from U.S. Agency for International Development and then informally contracted with private providers.	Before-and-after (6 months later) design based on household surveys by community health workers.	Rapid improvement in provider skills ranging from 25% to 57% compared with baseline.	Unknown	Small-scale, uncontrolled study, but large and rapid improvement achieved in quality of care.

*Source:* Author, based on interviews and cited references.

*Note:* BHU = basic health unit; CC = control/comparison; CCC = Chittagong City Corporation; CCM = country coordination mechanism; DPT3 = third dose of diphtheria/pertussis/tetanus vaccine; GFATM = Global Fund to Fight AIDS, Tuberculosis, and Malaria; HMIS = health management information system; LFA = local fund agent; MC = management contract; MCH = maternal and child health; MOH = Ministry of Health; MOU = memorandum of understanding; NGO = nongovernmental organization; NSP = nonstate provider; PHC = primary health care; SDC = service delivery contract; TB = tuberculosis; TT2+ = two or more dosages of tetanus toxoid.  
a. Double difference = difference between follow-up and baseline results in the experimental group minus the difference between follow-up and baseline results in the control group.

**Possible Study Biases.** Of the 14 examples of contracting that met the inclusion criteria (that is, that had at least before-and-after data or data from contemporaneous controls), 6 had before-and-after controlled designs, 2 involved long time series (that amounted to more than just before-and-after designs), 2 had controlled designs with a single measure in time, 2 were before-and-after evaluations, and 1 was a mixed design because it reviewed a large number of different studies. There was one randomized trial. A pilot-test bias may have been present in the examples considered because contracting is novel. These efforts may have received extra attention from managers, donors, and the NSPs, thereby limiting the external validity of the studies. It is difficult to know how serious this problem is. There is some comfort in the fact that many of the contracting examples were done on a very large scale and provided services to many millions of beneficiaries. In addition, the history of contracting for social service delivery in the United States and Australia suggests that the initial experiences were problematic and that results improved as governments and contractors ironed out the difficulties they encountered (Domberger 1999; Savas 2000).

In light of the methodological concerns about the cases studied, there is still a need for future contracting efforts to include rigorous evaluations. However, the current weight of evidence indicates that contracting with NSPs will provide better results than government delivery of the same services.

**Alternatives to Contracting: Some Success Stories of Government Provision.** The apparent success of contracting and its superior performance when compared with government delivery of services raises an obvious question: Why are there successful examples of public provision of health services such as in Costa Rica, Cuba, Kerala State in India, Sri Lanka, and Vietnam? These examples indicate that it is certainly possible for governments to do a reasonable job of delivering health services. The cases included in the review suggest that NSPs will perform better, not that governments will always perform badly. In these five jurisdictions, there have been few counterfactuals. Except for the example of Costa Rica, contracting with NSPs in these countries has rarely been compared with the existing public system. In addition, these particular cases have been singled out (since at least the early 1980s), and their successes have not been widely replicated.

## Why Does Contracting Work?

Contracting for health service delivery has a number of attractive features that may help explain its success (Loevinsohn 2000).

**Focus on Results.** The very act of drafting a contract can help the purchaser define exactly what services are needed and help make objectives explicit. Particularly when the contract defines objectively verifiable outputs and outcomes, the contracting process can ensure that both the purchaser and contractor focus on the achievement of measurable results. The presence of performance bonuses and the credible threat of sanctions or termination of the contract probably help motivate contractors to achieve better results.

**Flexibility.** NSPs have the important advantage of being less constrained by “red tape” (excessive regulation), bureaucratic inertia, and unhelpful political interference. In many circumstances, this is the largest advantage of NSPs over government delivery of the same services. Because of its greater flexibility, contracting allows for more innovation and creative responses to problems. It may also help avoid patronage and unhelpful political interference, such as hiring not solely based on merit.

**Reduction of Important Aspects of Corruption.** Contracting appears to reduce some aspects of corruption that plague public health care systems, such as absenteeism, theft of drugs, selling of positions, leakage of funds on their way to peripheral health facilities, and informal payments to providers. The most serious corruption issues surrounding contracting involve the selection process and the payment of invoices. The issue of corruption is dealt with in more detail below.

**Constructive Competition.** Contracting uses constructive competition to increase effectiveness and efficiency. Nonstate providers are impelled through competition to develop the most effective and efficient ways of delivering services, both during the bidding process and during implementation. Friendly competition (when NSPs or the government work in different areas) over which organization can best deliver services is a big gain for poor people living in isolated areas, or people with AIDS who are not yet receiving services. In a number of settings, competition from NSPs under contract has pushed public sector providers to improve their own performance and deal with issues within government, such as limited managerial autonomy or “red tape.”

**Improved Absorptive Capacity.** Nonstate providers are usually better at overcoming “absorptive capacity” constraints that often plague government health care systems and prevent them from effectively using the resources made available. This results in part from the greater flexibility of NSPs and the fact that they face fewer bureaucratic regulations that constrain the efficient use of funds.

**Better Distribution of Health Workers.** As a result of greater flexibility and innovative approaches, NSPs can often improve the distribution of health workers and help ensure that skilled health workers are available and working in underserved areas. This has been particularly noticeable in Afghanistan and Cambodia, where the distribution of health workers, including doctors, improved very quickly as a result of contracting.

**Managerial Autonomy.** Contracts, if drafted properly, provide managerial autonomy and decentralize decision making to managers closest to the ground. Instead of people in distant capitals making decisions on issues they can’t know much about, the people closest to the real-life situation are given authority to solve problems.

**Government Focus on Stewardship Role.** Contracting provides a greater opportunity for government to focus on roles that it is uniquely placed to carry out, such as planning, evaluation, standard setting, financing, and regulation. When government is directly involved in service delivery, it often has little time or inclination to play a stewardship role. This is not simply a theoretical concern. In one South Asian Ministry of Health, a study found that 75 percent of all letters written by the ministry and 78 percent of all files had to do with postings and transfers of personnel. Contracting can free up time normally spent on personnel issues so that government officials can spend more time on stewardship and public health functions.

### **What Are the Concerns about Contracting?**

A number of potential issues have been raised in connection with contracting (England 1997; Mills 1998; Abramson 1999; Palmer 2000; Slack and Savedoff 2001; Frick-Cardelle 2003; Soderlund, Mendoza-Arana, and Goudge 2003; Liu, Hotchkiss, and Bose 2007). Some of the common concerns expressed by decision makers are summarized



in table 5.2 (see pages 86–87) along with the global experience thus far. Most of the concerns are addressed in more detail in the following discussion.

**Scale of Contracted Services.** The concern that contracting is unable to provide services on the large scale needed to make a difference at the country level is no longer warranted. It used to be true that contracts (or, usually more often, grants to NGOs) were implemented on a small scale. That is no longer the case. Four ongoing examples of contracting (Afghanistan, Bangladesh, the Democratic Republic of Congo, and Pakistan) involve populations of tens of millions of beneficiaries. Contracts for nutrition services now cover a third of rural Bangladesh, more than 30 million people, and close to 20 million people in Afghanistan currently receive primary health care services from contractors. There are a number of other countries (many described in the review) where contracts covering millions of beneficiaries have been successfully implemented.

**Cost of Contracting.** Contracting is not necessarily more expensive than government provision of the same services, as the examples from Afghanistan, urban Bangladesh, Costa Rica, Pakistan, Rwanda, Uganda, and the work on TB by private providers suggest. Nonstate providers performed better, even when public institutions were provided with similar amounts of resources. Two examples of contracting exist in which it was more expensive than government delivery of the same services (Cambodia and the Democratic Republic of Congo), although baseline expenditures were very low in these cases. In every example where it was assessed, the contracting efforts saved people in the community money by reducing out-of-pocket health expenditures. Although the services provided under the different contracts are not strictly comparable, a basic package of primary health services ranged from \$0.65 per capita per year in urban Bangladesh to \$6.25 per capita per year in rural Guatemala. The low price in Bangladesh likely reflects the fact that the better-off urban residents received their care from for-profit providers. Nonetheless, large examples from low-income countries demonstrate that basic primary health care services, including first-level hospital care, can be delivered for \$3 to \$6 per person per year.

**Equity.** The concern that contracting will make health services less equitable appears to be unwarranted, although the data on this issue are sparse. The effect of contracting on the poor was measured

in three cases. In two of the cases (urban Bangladesh and Cambodia) contractors did better than the government in improving services for the poor. In the third case (Pakistan), there was no difference between the NGO and the government. In this last case, there was no mention in the contract about a focus on reaching the poor, whereas this was explicit in the contracts used in urban Bangladesh and in Cambodia. When contracts include explicit targets for reaching the poor, contractors appear able to improve health services for them significantly. The idea that NSPs will not want to work in remote or difficult areas or do not want to focus on the poor is not consistent with global experience.

**Sustainability.** Given its apparent success, the sustainability of contracting is a genuine concern and a difficult one to address simply. There are a few important findings that have a bearing on the sustainability of contracting:

- In 12 of the cases that were reviewed above, the contracting efforts have been continued and usually expanded, often dramatically. Some of the contracts have been in place for 12 years, and 6 of the cases have been sustained for more than 7 years. In at least 10 cases the scope of contracting has more than doubled from its initial scope.
- As described above, real-world experience, based on actual contract prices, in more than seven low-income countries indicates that contractors can successfully deliver a basic package of primary health care services for between \$3 and \$6 per capita per year. This suggests that contracting is not particularly expensive and can achieve good results at a level of investment most countries should be able to afford.
- In most settings, NSPs on contract have achieved better results than the public sector even when provided the same or fewer resources. This implies that contracting is more efficient and that in many cases sustainability is only a matter of maintaining health expenditures at their current levels.
- In those cases in which contracting was more expensive than public provision of services, such as the service delivery contracts in Cambodia, out-of-pocket expenditures by the community, particularly the poor, were reduced by a larger amount than the contract cost. In these cases, sustainability is an issue of whether there is sufficient political will to improve services and efficiently subsidize the poor.

**Table 5.2** Some Common Concerns about Contracting and the Global Experience

<i>Concern</i>	<i>Experience so far</i>
“Contracting can be done only on a small scale.”	Contracting was done on a small scale until the late 1990s; however, it is now being implemented on a very large scale. In Afghanistan, Bangladesh, the Democratic Republic of Congo, and Pakistan, contractors provide services to tens of millions of beneficiaries. In other low-income countries, many millions of people receive their health services from contracted providers.
“Contracting is more expensive than government delivery of services.”	This statement has been true in some settings such as Cambodia and the Democratic Republic of Congo, where previously expenditures on health were very low. In other places such as Bangladesh, Guatemala, and Pakistan, contractors achieved good results even if provided the same or fewer resources than those made available to the public sector.
“Contracting will worsen inequity, partly because NGOs and other NSPs will not want to work in remote areas.”	The effect of contracting on equity has been measured in a few cases. Where it has been measured, equity has either been better or no worse than in noncontracted areas. If given clear responsibilities and direction, NGOs and other NSPs have successfully worked in remote and underserved areas.
“Even if successful, contracting will not be sustainable.”	Some contracting efforts have been going on for more than 10 years, and 85 percent of the examples evaluated so far have been sustained and even expanded.
“Contracting will lead to increased opportunities for corruption.”	Preventing corruption is a difficult issue and requires constant vigilance. Although empirical data are limited, contracting may avoid some aspects of corruption that plague publicly provided health services, such as absenteeism. Nonetheless, corruption has been an issue in some settings where contracting has been implemented, particularly during contractor selection and payment. There appear to be actions that can prevent or limit these types of corrupt practices.
“Governments have limited capacity to manage contracts effectively.”	Contract management has been an issue in some settings and deserves careful attention. In a number of countries, including some with limited experience in this area, contract management has been done well, indicating that the problem may be solvable. Even where contract management has been done poorly, NSPs have still been able to deliver services effectively.
“Contracting reflects a political agenda aimed at weakening the role of the state and privatizing health care.”	Contracting is fully consistent with public financing of health services. By bringing patients back from the private sector (particularly from nonqualified providers) into publicly financed facilities, it actually strengthens the role of the state. In most developed countries, publicly financed services are provided through some form of contracting, and that has not weakened the involvement of the state in financing health services.

<p>“Contracting will increase the presence of foreign NGOs.”</p>	<p>In countries with many existing NGOs, most contracts have been won by local NSPs. However, in countries with few local NGOs, the first batch of contracts went to international NGOs, but subsequent contracts have often been awarded to local NGOs. In the long run, it appears that local NGOs will predominate, at least in part, because they have lower costs.</p>
<p>“Contracting in post-conflict situations will weaken the state at a time when it should be strengthened.”</p>	<p>Where contracting has been implemented in postconflict settings, it does not appear to have weakened the state. This seemingly paradoxical finding arises from the government being better able to coordinate private efforts and the fact that patients and communities just want better services with little concern about who is actually delivering them.</p>
<p>“Contracting will lead to duplication of effort where there are existing public services.”</p>	<p>Contracting has been successfully used to strengthen existing public services in a number of countries including Afghanistan, Cambodia, the Democratic Republic of Congo, Guatemala, Pakistan, and Rwanda. By using management contracts, existing health services have been significantly improved without duplication of services.</p>
<p>“Contracting is a donor-driven initiative.”</p>	<p>It is true that many contracting initiatives in low-income countries have been financed by development partners. However, this has not always been the case. In Pakistan, a very large contracting effort was developed, implemented, and financed entirely through a local initiative. In southern Sudan, the government is using its own resources to finance contracted services.</p>
<p>“Contracting will ‘co-opt’ NGOs and limit their advocacy role.”</p>	<p>There are some situations in which NGOs may not wish to enter into a contractual relationship with a purchaser because of concerns about the legitimacy of the latter. Clearly, such judgments should be respected because a contract, by its nature, is voluntary. Discussions with NGOs actually involved in contracting indicate that they do not feel constrained in their advocacy role.</p>
<p>“NSPs and governments are wary of each other and so will not be able to work together effectively.”</p>	<p>In many settings, NSPs, particularly NGOs, and the government do not have an easy relationship. Contracting has in some, but not all, situations improved the relationship by making explicit the roles and responsibilities of each party.</p>
<p>“Contracting will lead to ‘fragmentation’ of the health care system.”</p>	<p>In almost all developing countries, the health care system is already fragmented with a large part of expenditures occurring in the private sector. By increasing the use of publicly funded services, contracting may actually reduce fragmentation and strengthen the stewardship role of government.</p>
<p>“Contracting does not improve the quality of health services.”</p>	<p>As with equity, quality of care has been measured in only a few cases, a situation that should be improved. In those cases in which it has been measured, NSPs have done better, often considerably better, than governments in improving quality of care.</p>

Source: Author.

**SECTION 5**

- Many of the NSPs that have been given contracts are local or have a long-term presence in the country where they operate. For example, some of the faith-based organizations (FBOs) in Africa and South Asia have been present in the countries for many decades (sometimes longer than the countries themselves have been in existence).
- There are examples of low-income countries, including Pakistan and southern Sudan, that have used their own resources to contract for health services.
- Contracting, especially for primary health care, is an approach that is the norm in high-income countries and is fully consistent with public financing or social health insurance. The use of contracting for health services in developed countries has been going on for decades and has been sustained.
- In other sectors, governments in developing countries have successfully changed over to a contracting model with improved efficiency. For example, many developing countries had their civil works built by “public works departments” up until the 1960s and 1970s. These public works departments now do very little construction themselves and instead have become purchasers of construction services.

**Long-Term Prospects.** Some argue that contracting does not need to be sustainable because it is just a temporary approach until the government can take over the health services. Others argue that, so long as the costs are comparable, there is no reason why contracting should not become the norm, just as it is in developed countries. People should take an empirical approach based on whether contracting does a better job in their setting of effectively, efficiently, and equitably delivering health services. If it does, then there is no obvious reason why it should be only temporary.

**Corruption.** Currently only limited empirical data are available on the extent to which corruption affects contracting, although it has clearly been an issue in some settings. As more contracting is carried out, the issue of corruption is likely to become more prominent. In publicly provided services, there is increasing evidence on the extent of corruption, in part reflecting the fact that public provision is the dominant mode in developed countries and has been for a long time. Corruption turns out to be a very serious and widespread problem in

public sector provision of health services (Lewis 2006; Transparency International 2006) and includes issues such as the following:

- Absenteeism, which has been found to be a widespread problem, particularly in rural areas (among doctors working in rural areas in Bangladesh and Uganda, 74 percent and 68 percent were absent, respectively)
- Purchase of public positions (25 percent of public hospital positions were bought in Ghana)
- Drug leakage and poor procurement (32 percent of respondents in Costa Rica knew of drug theft from public facilities, and 30 percent of drugs in China were counterfeit or expired)
- Corruption in the supply chain (11 percent of costs could have been saved in Colombia if public tendering rules had been followed, and in four other Latin American countries there is very wide variation in prices paid for standard commodities, suggesting irregularities in procurement)
- Leakage of public funds, where public expenditure tracking surveys have found between 40 percent to 81 percent leakage in four countries (Ghana, Peru, Tanzania, and Uganda)
- Informal payments to providers, which are very common (55 percent of patients say they had to make informal payments in Cambodia; the figure is 82 percent in Sri Lanka) and often quite high (informal payments for hospital visits are greater than 25 percent of monthly per capita income in 8 of the 12 countries where the issue has been studied).

The experience with contracting thus far suggests that it can prevent or limit some of these forms of corruption, including absenteeism. Health facility assessments in Afghanistan, Bangladesh, and Cambodia, among other countries, found almost no absenteeism in contractor facilities. Purchase of positions is simply not an issue in contracting. Drug supply management is almost always better under contracts as judged by the availability of medicines in clinics, and it is likely that more resources actually make it to the health facility, which explains in part the better absorptive capacity of contractors.

Exit surveys carried out as part of health facility assessments indicate much lower rates of informal payments in clinics managed by contractors compared with publicly managed facilities in the same country. In one example, it was only through the presence of an NGO contractor that the central government and the donor discovered the extent of local government corruption.

In contracting for health services, the major issues of corruption arise during the selection of contractors and the processing of payments. The best way of preventing corruption is constant vigilance, but there also appear to be some specific, practical ways of dealing with these issues, including (1) using competitive selection procedures, (2) having large contract “lots” that attract more competition and larger NSPs, (3) making the bid evaluation process more transparent by having clear selection criteria and involving multiple stakeholders in the evaluation process, and (4) having clear and explicit conditions for payment of invoices. These and other means for reducing corruption are described in more detail in section 3.

**Contract Management.** Contract management is often difficult for governments, partly because they (particularly Ministries of Health) often have limited experience with service delivery contracts. Experience thus far shows that contract management is an important issue that requires careful attention. Contract management has been done well in some settings, such as Afghanistan and Senegal. (For example, the Ministry of Public Health in Afghanistan had no experience with contract management but has still been able to manage 14 large contracts successfully as judged by careful monitoring of performance and timely payment of contractors.) Generally, countries with successful contract management appear to have benefited from recruitment of local consultants, provision of sufficient resources, and having a manageable number of larger contracts rather than hundreds of smaller ones. While ensuring competent contract management is important, contracting has been successful even in those situations where it has not been done well. In rural and urban Bangladesh and Guatemala, where observers believed contract management was problematic, contractors still successfully implemented large programs and achieved good results.

**Role of Government.** Some people argue that contracting with NSPs arises out of an ideological desire to “privatize” publicly financed

health services and ultimately to limit or end government involvement in health care (Turshen 1999; Pfeiffer 2003). Discussion with people actually involved in contracting in developing countries suggests that they are motivated by more practical concerns. Most contracting initiatives arise either from an absence of government services or from frustration with the poor quality and coverage of health services, especially for poor people. Most advocates of contracting express a desire for increased government financing so that services in the community can be expanded and improved. They also want to see governments engage with private providers, which already deliver the bulk of curative services in developing countries (in South Asia, for example, more than 70 percent of outpatient care is provided by the private sector), to improve quality of care, access, and coordination.

Much of the disagreement over the role of contracting comes from a failure to recognize the difference between provision of services and financing of services. Table 5.3 outlines the different scenarios of financing and provision and emphasizes that contracting does not entail privatizing the financing of services. In fact, contracting is fully consistent with public financing of health care from tax revenues or social insurance premiums. Most developed countries in the Organisation for Economic Co-operation and Development (OECD) use some form of contracting and still have public financing of health services. (Only 4 of the 28 members of the OECD provide primary health care through salaried civil servants.) For example, in Norway in 2001, 66 percent of primary care services were delivered by private, contracted physicians and only 19 percent by salaried physicians (Sorensen and Grytten 2002). Seventeen of the top 20 performing health systems in

**Table 5.3** Financing and Provision of Services

<i>Provision</i>	<i>Financing</i>	
	<i>Public</i>	<i>Private</i>
Government	Typical public services without user fees or informal payments	Typical public services with significant informal payments or user fees
Nonstate providers	Contracting	Typical private provision, usually fee for service

Source: Author.



the world (as judged by the World Health Organization in its 2000 World Health Report) use some form of contracting, either implicit or explicit, to deliver health services.

No part of this discussion is meant to diminish the challenges associated with contracting in low-income countries. The intent is merely to underscore that contracting for primary health care services is a widely practiced and accepted means of ensuring delivery of publicly financed primary care.

Under contracting, the government's role becomes more strategic and less directly involved in service delivery. Governments will still need to finance health services and carry out essential public health functions, such as setting policy and technical standards, collecting information, monitoring and evaluating performance, responding in emergencies, and coordinating all the partners. Because actual service delivery takes up so much time and attention, contracting may well make governments better able to carry out their other, unique roles. If governments want to be stewards of the health sector, they will have to find creative ways of working with the private sector.

**Influence of Foreign NSPs.** In countries with many indigenous NGOs, such as Bangladesh, competitive bids have been almost always won by local NGOs. The extent to which contracting efforts encourage the growth of local NGOs is not yet clear, although access to predictable funding flows is a key determinant of NGO sustainability in virtually all settings (Green 1987). In Afghanistan, large-scale contracting has increased the number of local NGOs working in the health sector, such that now they are winning most of the new contracts. In Cambodia, contracting seems to have had only a modest effect on the number of local NGOs working in the health sector. Bidding procedures that are at least partly based on price will, in the long run, select for local NGOs because expatriates are much more expensive than local professionals.

**Strengthening of the State in Postconflict Settings.** The experience in a few postconflict settings, particularly Afghanistan and the Democratic Republic of Congo, is that, far from weakening the state and how it is perceived, contracting can actually strengthen the state. This, somewhat counterintuitive, finding results from the following factors:

- **The NGO Sector Is Better Coordinated.** In most postconflict settings, there are usually many NGOs that are providing health

services but with limited coordination. In addition, because the NGOs receive funds from many different sources, they often follow the direction of their financiers, rather than the priorities of the government. Contracting allows the Ministry of Health to ensure that NGO activities are better aligned with government priorities.

- **Communities Care Mostly about Better Services.** Because it rapidly improves service delivery, contracting enhances the population's perceptions of publicly funded services. For example, in Afghanistan, extensive focus group discussions found that people in the community did not differentiate between publicly and NGO-provided services. What most interested them was improved services, rather than who delivered the services.
- **Government Can Focus on Key Issues.** Most postconflict states have difficulties directly managing health services themselves, and when they do, the services take up so much of their time that they cannot undertake all their other key roles. Contracting services allows them to focus on strategic issues, such as establishing technical guidelines, setting priorities, and coordinating their development partners.

**Quality of Care.** While measuring the quality of health services can be technically challenging, it is something that should be done more often. Quality of care has been measured in four of the evaluated cases, Afghanistan, urban Bangladesh, Cambodia, and Pakistan. In three of the four settings, NSPs performed significantly better on quality of care, and in the fourth there was little difference. Using scores derived from health facility assessments, the double difference was 24 percentage points in Afghanistan and 19 percentage points in Cambodia. The single difference in Bangladesh was 11 percentage points.

### **In What Context Will Contracting Work (or Not Work)?**

Contracting has been successfully implemented in many situations and for a wide variety of health services. It is not clear from the experience thus far if there are environments where contracting is not possible. Certainly, there are concerns that arise in some contexts that may require creative solutions. However, for the most common concerns

**Table 5.4** Common Concerns about the Environment for Contracting

<i>Concern</i>	<i>Comment</i>	<i>Example</i>	<i>Mitigation measures</i>
“The legal environment needed to enforce a contract is missing.”	In many settings, particularly postconflict, the legal environment is difficult, but it still allows contracts to be successful.	The Democratic Republic of Congo has successfully implemented contracts in spite of having limited contract law and an underdeveloped judicial system.	Ensure the contract has dispute resolution mechanisms that are not entirely dependent on the legal system. Parallel efforts to establish or strengthen contract law should be initiated.
“There are few potential contractors.”	This lack can be a problem, although new NSPs may enter the “market” or shift from related activities.	Cambodia successfully implemented contracting in spite of limited competition.	Advertise widely and limit obstacles to “market entry.” Hire individuals (rather than organizations) on contract for the management of services.
“Potential contractors have limited capacity.”	Rarely is the capacity of existing public providers questioned. It is difficult to judge in advance which NSPs will work well.	In Pakistan, most NGOs working on HIV/AIDS had very limited experience. The majority, but not all, worked out well when provided a contract.	Invest in developing the capacity of NSPs, particularly in new areas like HIV/AIDS.
“The political and bureaucratic opposition to contracting is strong.”	This attitude can be a serious problem and may require considerable dialogue (see details below).	In Afghanistan there was initial opposition to contracting from many civil servants and a few politicians. In spite of this, contracting has been successful.	Engage in extensive dialogue and discuss global experience. Have officials from other countries who have implemented contracting discuss issues with their counterparts.

*Source:* Author.

*Note:* NGO = nongovernmental organization; NSP = nonstate provider.

there are examples in which contracting has been successful in spite of what, at first, looked like an unpromising environment (see table 5.4).

**Political and Bureaucratic Opposition.** Often the contextual issue that makes contracting the most difficult is opposition from government officials and, sometimes, politicians. Their concerns are often

legitimate and meant to ensure the best use of public resources. Understanding their concerns is a prerequisite for having a useful dialogue. In addition to the concerns mentioned above (“What Are the Concerns about Contracting?”), there are a number of issues that officials will be reluctant to talk about openly but have been stumbling blocks in some settings, including the following (means for addressing these concerns are described in section 3, task 3):

- **Implicit Criticism of Their Performance.** Many government officials see contracting as an implicit criticism of their ability to manage health services effectively. They sometimes argue that things are going well, so there is no need for contracting. If they admit that there are problems in service delivery, they will argue that the solution is more resources.
- **Competition Not Wanted.** Contracting can provide competition to the public sector, and some officials fear that this will put public performance in an unfavorable light. Having NSP-provided services with which public sector services can be compared may increase criticism of public sector performance. It is very likely to increase accountability.
- **Reduced Control.** Government officials fear that contracting will reduce their control, power, *and* prestige. For example, they sometimes fear that giving up control over the recruitment, posting, and transfer of health workers will reduce their bureaucratic and political power that comes from “clientelism” and they will lose the ability to provide favors to influential people. Similarly, they fear giving up direct control over some of the budget.
- **Fear of Change.** As with any new approach, some officials will resist change simply because it is different from the system in which they have worked (often for many years) and feel comfortable.

## Note

1. As an example of the way the double differences were calculated, in Cambodia, baseline prenatal care coverage was 13.5 percent in service delivery contract (SDC) districts and 10.4 percent in the control

districts. The prenatal care coverage rates found at the end-line survey were 66.8 percent and 34.6 percent, respectively. This yields a double difference (follow-up minus baseline in the experimental group minus follow-up minus baseline in the control) for SDC versus control of 29.1 percentage points ( $[66.8 - 13.5] - [34.6 - 10.4]$ ). The range and median double differences for the seven indicators included in the contracts are described in the Cambodia example in appendix C.

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## Example of a Contracting Plan (or Manual) Strengthening Primary Health Care Services in Country X

### A. Background

**Challenges.** The Government of Country X (GOX) has committed itself to dramatically improving the health and well-being of Country X. Achieving this improvement will require, among other things, a strengthened primary health care system that can deliver high-impact preventive, curative, and promotive services. These services, if of sufficient quality and reach, will help reduce child and maternal mortality, contain the spread of infectious diseases, and reduce other threats to good health. Currently, the primary health care system faces a number of important challenges including (1) low use of primary health care centers (PHCCs) for curative and promotive services, (2) low coverage of preventive services, (3) inconsistent and often poor quality of care, (4) frequent absenteeism of staff and a shortage of staff in remote areas, and (5) inequitable coverage of services so that the poor and those living in remote rural areas have limited access.

**Basic Approach.** In response to these challenges, the GOX is interested in undertaking public-private partnerships (PPPs). The current proposal for a PPP envisages an area/community-based approach for delivering primary health care (PHC) services in PHCCs and their surrounding catchment areas. The basic approach for the PPP is (1) the

private sector partner of the GOX (hereafter referred to as the “Partner”) is accountable for achieving tangible results (described below) in delivering a package of PHC services; (2) in order for the Partner to achieve the expected results, the GOX will provide it adequate and timely financial resources; (3) careful monitoring and evaluation will be carried out so that the GOX can be confident it is getting value for its money; (4) both parties will focus on outputs and outcomes more than inputs and processes, which means that the GOX will specify what results should be achieved and services delivered but that the Partner will be given latitude on how to implement those services; (5) the Partner will be provided with sufficient managerial autonomy so it can flexibly respond to local conditions and introduce innovations aimed at improving service delivery; and (6) an explicit agreement will facilitate the relationship between the GOX and the Partner by making roles and responsibilities explicit.

**Consultations with Stakeholders.** Initial consultations have already been carried out with the existing government health workers, local government officials, members of the communities, and 15 different non-governmental organizations (NGOs). This plan tries to address their expressed concerns, and a series of meetings will be held with stakeholders in which it will be discussed before being finalized.

## B. Objectives and Indicators of Success

**Objectives.** This PPP project aims at achieving the following objectives:

1. Significantly strengthen PHC in PHCCs and their associated catchment areas to ensure the widespread delivery of a standard package of preventive, curative, and promotive services that will help improve the health and well-being of Country X.
2. Dramatically improve the coverage and use of services, quality of care, and equity of access to services by geographical areas, income levels, and women and children.
3. Ensure that patients and communities are increasingly involved and satisfied with the publicly financed health services and facilitate the community’s participation in the design, delivery, and evaluation of health services.

**Indicators of Success.** Achievement of those objectives will be assessed by the indicators and targets described in table A.1. By the end of the four-year period covered by this PPP, it is expected that significant progress will have been made toward the targets in table A.1. These targets may be revised as data become available and are meant to be indicative rather than exact. What will matter is significant progress along these parameters.

**Table A.1** Key Performance Indicators and Targets

<i>Indicator</i>	<i>Baseline<sup>a</sup></i>	<i>Approximate target</i>	<i>Means of measuring indicator</i>
Number of consultations per person per year provided by the PHCC and its outreach activities	0.3	1.0	HHS and HMIS
Contraceptive prevalence rate: percentage of couples of reproductive age currently using a modern family planning method	9%	15%	HHS
TB case detection rate (number of sputum-positive cases detected as percentage of target based on estimated prevalence, that is, case finding)	26%	45%	HFA and HMIS
Proportion of children 6 to 59 months who have received vitamin A supplement within last 6 months	36%	55%	HHS and HMIS
Vaccination: measles immunization coverage before 12 months of age	28%	50%	HHS and HMIS
Coverage of antenatal care: percentage of all pregnant women receiving at least one antenatal care visit from a skilled provider	22%	50%	HHS and HMIS
Proportion of births attended by skilled attendants (includes institutional delivery but excludes trained traditional birth attendants)	14%	25%	HHS and HMIS
Score out of 100 on an index of quality of care as judged by third party, which includes provider knowledge and patient satisfaction	46	70	HFA
Improved equity: ratio of poorest to richest income quintiles (based on asset index) on number of consultations	0.42	0.60	HHS

*Source:* Author.

*Note:* HFA = health facility assessment; HHS = household survey; HMIS = health management information system; PHCC = primary health care center; TB = tuberculosis.

a. Baseline values may be modified based on available data.



**Pay for Performance.** Failure of the Partner to achieve adequate progress on the above indicators will result in the termination of its contract or the imposition of other sanctions listed in the draft agreement. To ensure a focus on achieving tangible results, the Partner will also be able to earn performance bonuses based on achievement of certain measurable improvements. Based on the annual health facility assessment, a Partner can earn a performance bonus of 2 percent of the contract amount if its score on the quality-of-care index improves by 10 points from its previous highest score or it achieves a score of 85 percent. When the midterm household survey results are available, a Partner will receive a bonus worth 5 percent of the contract amount if it has achieved the targets on four of the nine indicators listed in table A1.1. When the end-line household survey results are available, a Partner will receive a bonus worth 3 percent of the contract amount if it has achieved the targets on seven of the nine indicators listed in table A1.1.

### C. Description of Services

**Package of Services.** The PPP aims to strengthen the delivery of a package of standard PHC services, including (1) maternal and child immunization; (2) antenatal, obstetric, and postpartum care; (3) family planning services, including all modern methods (injectables, intrauterine contraceptive devices, condoms, and pills) and including family planning operations (no-scalpel vasectomies and tubectomies); (4) diagnosis and treatment of major infectious diseases, including tuberculosis, malaria, and kala-azar; (5) basic curative services normally available at PHCCs; (6) nutritional support, including improving micronutrient deficiencies (vitamin A, iron, iodine), therapeutic feeding, and breast-feeding promotion; (7) participating in special health activities, such as national immunization days and other types of campaigns; and (8) carrying out public health functions, such as disease surveillance and recognition/response to epidemics. The partners will comply with the current national technical guidelines (such as for TB and the expanded program on immunization [EPI]) and those that are developed during the life of the agreement.

**Size of Each PPP Lot.** On the three districts of Province Y, four districts of Province Z, and three districts of Province W, all the 105

PHCCs and their catchment areas will be involved in the PPP project. Each district will constitute one “lot” and has an average population of 450,000 (the smallest has a population of 380,000 and the largest 520,000).

#### D. Monitoring and Evaluation

**Evaluation Methodology.** The achievement of the indicators in table A1.1 and certain other aspects of health care (such as community satisfaction, health expenditures, and use of unqualified providers) will be assessed using the following methodologies:

1. **Household surveys.** In each of the 10 PPP lots and 10 comparison areas, 10 clusters will be randomly selected and 20 households will be interviewed per cluster (that is, 200 households per PPP lot, 2,000 for the contracted area, and another 2,000 households for the comparison area, for a total of 4,000 households). The baseline survey will be done in June 2009 with a midterm survey in July 2011, and the endline survey will be carried out in June 2014.
2. **Health facility assessments.** Five PHCCs in each of the 20 areas (10 PPP lots and 10 comparison areas, for a total of 100 PHCCs) will be randomly selected and visited annually to assess the quality of care and other related indicators, such as staff morale.
3. **Health management information system.** Health management information system data will be used by the provincial health departments to monitor, on a monthly basis, the performance of the PPP and the comparison PHCCs.

**Arrangements for Surveys.** The household and health facility surveys will be carried out by a third-party firm, which will also be responsible for analysis of the results. The contract management unit of the Ministry of Health (MOH) will be responsible for recruiting the third-party firm, overseeing the surveys, and disseminating the results to stakeholders, including the Partners. The estimated cost of the surveys is US\$900,000. For true baseline data to be available, the third-party firm will be recruited as soon as possible.

## E. Agreement between the GOX and Partners

**Content of the Agreement.** The relationship between the GOX and its private sector Partners will be governed by an agreement, a draft of which is in the following annex. The agreement sets out the basic approach of PPP and includes (1) the objectives of PPP and the indicators selected to judge its success, (2) the scope of services, (3) the location and duration of services, (4) reporting requirements of the private sector Partners, (5) the authority and responsibilities of the GOX and the private sector Partners, (6) methods of payment and financial reporting, and (7) dispute resolution mechanisms and sanctions.

**Linkages.** The draft agreement specifically addresses the issue of how to ensure strong linkages of the private sector Partners with the subcenters and health workers below the level of the PHCC. It also addresses how to ensure appropriate referrals to the PHCCs and first-referral hospitals above the PHCC.

## F. Price of the Services

**Fixed-Cost Approach.** The private sector Partners will receive a fixed amount per year based on the population of the district. According to budget allocations in the last few years and actual expenditures, it is estimated that the annual cost per capita will be US\$4.10. A similar amount will be allocated to the comparison districts.

## G. Selection of Partners

**Competitive Selection of Partners.** The private sector Partners of the GOX will be selected on the basis of an open competition that is carried out transparently. The announcement of the competition will be published in the newspapers and on the GOX Web site and given to potentially interested Partners through associations of health care providers, such as the Country X Voluntary Health Association. Sufficient time (about 45 days) will be provided to interested parties to sub-

mit their proposals to the contract management unit (CMU) of the MOH. The details of what should be included in the proposals, the selection criteria, and the content of the agreement will be available on the government Web site, which will be listed in the advertisement.

**Selection Criteria.** A two-stage selection process will be used. During the first stage, those proposals that have arrived on time will be assessed quickly to see whether they meet the initial screening criteria: (1) three years of audited accounts for the organization, (2) proof (in the audited accounts) that the organization had a turnover of at least US\$100,000 per year in the last three years, (3) a copy of its registration under the Societies Act or other relevant acts, and (4) a certified check made payable to the GOX for US\$100 as proof of the bidder's earnestness. Only those organizations that meet these criteria will have their technical proposals reviewed by the evaluation committee during the second stage. The suggested criteria and weights for this second stage are the following:

1. **Experience of the organization** (its track record) in delivering health services in Country X or similar settings—45 percent, comprising:
  - Documented success of the organization in delivering health services in Country X or similar countries (25 percent)
  - Proven ability to manage a large budget, including financial, administrative, and logistic aspects of health services (15 percent)
  - Knowledge and understanding of the social, physical, political, and economic characteristics in the geographical area of the particular lot (5 percent).
2. **The work plan/strategy** devised by the organization for delivering the services stipulated in the agreement—20 percent, comprising:
  - Practicality and innovativeness of the approach to service delivery (10 percent)
  - Practical means for working with the existing public health system, including PHCCs, subcenters, and communities (6 percent)
  - Practical means for working with existing private sector organizations and health care providers (4 percent).

3. **Qualifications and experience of key managers** who will be responsible for implementing the PPP—35 percent, comprising:

- Project manager with more than six years of management experience, particularly in the successful delivery of health services (15 percent)
- Deputy project manager (technical) with at least four years of experience in field implementation of health services delivery (10 percent)
- Deputy project manager (administrative) with at least four years of managing the administrative aspects of successful field implementation of social services (10 percent).

The individual candidates will be judged according to the following criteria:

- General education, length of experience, and positions held (35 percent)
- Adequacy for the project: track record and experience in health or social sector project management and implementation, knowledge of health programs, and knowledge and experience with primary health care (65 percent).

**Structure of Proposals.** To keep the review process feasible, technical proposals should be kept to a maximum of 30 pages comprising three sections: (1) experience of NGO in delivering health services, (2) work plan and strategy for implementing the PPP, and (3) the signed curriculum vitae of the three managers.

**Selection Process.** The contract management unit (CMU), in keeping with its existing practice, will establish an evaluation committee having diverse membership. The committee will include a total of seven members, two from the provincial health departments, two from the CMU, and one each from UNICEF, WHO, and the Country X Voluntary Health Association (any representative from the last named must not have formal linkages with any of the organizations that have submitted proposals). The members of the evaluation committee will individually rate proposals based on the above criteria. For each lot, the organization whose proposal receives the highest average score will be invited to finalize the draft agreement.

**Consortium of Organizations.** An organization may associate with a maximum of three other organizations to submit a proposal. However, the lead organization (“member in charge”) must be clearly identified. All the other organizations must sign letters indicating their agreement to work under the lead organization’s direction. Failure to submit such letters may result in rejection of the proposal. The lead organization must provide copies of its last three years’ audited financial statements.

**Number of Bids per Organization.** An organization or consortium of organizations may submit proposals for a maximum of 3 of the 10 lots.

## H. Contract Management Arrangements

The existing CMU of the MOH will be responsible for managing the contracts, including support, monitoring, and payment. The CMU will assign one public health professional from one of the concerned provinces, an epidemiologist and monitoring specialist from the university, a financial management specialist hired from the private sector, and two assistants to work on management of the 10 contracts. The special subunit will be provided a budget of US\$30,000 per year and an initial capital budget of US\$40,000 for appropriate transportation and office equipment.

## I. Schedule

**Next Steps.** The next steps for the implementation of the PPP described in this proposal are described in table A.2.

**Table A.2** Next Steps for Agreement Implementation

<i>Action</i>	<i>Party responsible</i>	<i>Start/completion dates</i>	<i>Comments</i>
Evaluation firm recruited	CMU	May 9–June 15, 2009	Terms of reference will be shared with the GOX for comment
Contract signed with evaluation firm	CMU	June 15, 2009	Contract will not be signed until approval of proposal by the GOX and availability of other funds
Baseline survey conducted	Evaluation firm	June 15–September 30, 2009	Survey instruments already exist but will need to be customized
Broad advertising of PPP	GOX (CMU)	June 15, 2009	Will need to finalize texts of advertisements and information for Partner organizations
Closing date for proposals	Private sector organizations	July 31, 2009	45 days for organizations to submit bids
Evaluation of proposals	Evaluation committee	August 15, 2009	Evaluation committee will have to be formally notified
Agreements signed	CMU and Partner	September 1, 2009	October 2, 200x, at the latest

*Source:* Author.

*Note:* CMU = contract management unit; GOX = Government of Country X; PPP = public-private partnership.

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## Agreement between Ministry of Health and (Nonstate Partner): *Strengthening Primary Health Care Services in Country X*

**Reader:** This draft agreement/contract is meant for discussion as part of the development of the contracting plan. It is not a contract that can be used by World Bank borrowers, but it contains most of the elements needed in a contract.

### A. General Approach

To strengthen primary health care, the Government of Country X (GOX) would like to use public-private partnerships (PPPs) for the delivery of services in primary health care centers (PHCCs) and their surrounding catchment areas. The basic approach for this PPP is the following: (1) the private sector partner of the GOX (hereafter referred to as the “Partner”) is accountable for achieving tangible results (described below) in delivering a package of primary health care services; (2) for the Partner to achieve the expected results, the GOX will provide it with adequate and timely financial resources; (3) careful monitoring and evaluation will be carried out so that the GOX can be



confident it is getting value for money; (4) both parties will focus on outputs and outcomes more than inputs and processes, which means that the GOX will specify what results should be achieved and services delivered but that the Partner will be given latitude on how to implement those services; (5) the Partner will be provided with sufficient managerial autonomy so it can flexibly respond to local conditions and introduce innovations aimed at improving service delivery; and (6) an explicit agreement such as this agreement facilitates the relationship between the GOX and the Partner by making roles and responsibilities explicit.

## **B. Objectives**

The Partner of the GOX will be responsible for achieving the following objectives:

1. Significantly strengthen primary health care in its assigned PHCCs and their associated catchment areas so as to ensure the widespread delivery of a standard package of preventive, curative, and promotive services that will improve the health of Country X.
2. Dramatically improve the coverage and utilization of services, quality of care, and equity of access to services by geographical areas, income levels, and women and children.
3. Ensure that patients and communities are increasingly involved and satisfied with the publicly financed health services and facilitate the community's participation in the design, delivery, and evaluation of health services.

## **C. Key Performance Indicators and Targets**

Achievement of the above objectives will be assessed by the indicators and targets described in table AA.1. By the end of the two-year period covered by this agreement, it is expected that the Partner will have achieved the targets in that table, although these targets may be revised as data become available and are meant to be indicative rather than exact. What matters is significant progress along these parameters.

**Table AA.1** Key Performance Indicators and Targets

<i>Indicator</i>	<i>Baseline<sup>a</sup></i>	<i>Approximate target</i>	<i>Means of measuring indicator</i>
Number of consultations per person per year provided by the PHCC and its outreach activities	0.3	1.0	HHS and HMIS
Contraceptive prevalence rate: percentage of couples of reproductive age currently using a modern family planning method	9%	15%	HHS
TB case detection rate (number of sputum-positive cases detected as percentage of target based on estimated prevalence, that is, case finding)	26%	45%	HFA and HMIS
Proportion of children 6 to 59 months who have received vitamin A supplement within last 6 months	36%	55%	HHS and HMIS
Vaccination: measles immunization coverage before 12 months of age	28%	50%	HHS and HMIS
Coverage of antenatal care: percentage of all pregnant women receiving at least one antenatal care visit from a skilled provider	22%	50%	HHS and HMIS
Proportion of births attended by skilled attendants (includes institutional delivery but excludes trained traditional birth attendants)	14%	25%	HHS and HMIS
Score out of 100 on an index of quality of care as judged by third party, which includes provider knowledge and patient satisfaction	46	70	HFA
Improved equity: ratio of poorest to richest income quintiles (based on asset index) on number of consultations	0.42	0.60	HHS

*Source:* Author.

*Note:* HFA = health facility assessment; HHS = household survey; HMIS = health management information system; PHCC = primary health care center; TB = tuberculosis.

a. Baseline values may be modified based on available data.

**Monitoring and Evaluation.** The achievement of the above indicators and the objectives listed in part B will be assessed through baseline and follow-up assessments using the following methodologies:

1. **Household surveys.** The government will use the results of a special household survey to assess, for example, coverage of services, use of family planning, and use of services by the poor.
2. **Health facility assessments.** These assessments will be conducted by third parties and will examine, for example, the quality of care and TB treatment success rates. The Partner will provide unimpeded access to any of its PHCCs for such purposes.
3. **Health management information system.** Examination of the HMIS data will be done jointly by the GOX and the Partner.
4. **Monitoring visits.** Unannounced visits by the district and/or provincial health officials will also be conducted to guide, support, and supervise implementation.

#### **D. Scope of Services**

**Rapidly Ensuring Delivery of a Package of Primary Health Care Services.** The Partner will be responsible for ensuring the delivery of a package of standard primary health care (PHC) services, including (1) maternal and child immunization; (2) prenatal, obstetric, and postpartum care; (3) family planning services, including all modern methods (injectables, intrauterine contraceptive devices, condoms, pills, and referral for voluntary surgical contraception) and including family planning operations (no-scalpel vasectomies and tubectomies); (4) diagnosis and treatment of major infectious diseases, including tuberculosis, malaria, and kala-azar; (5) basic curative services normally available at PHCCs; (6) nutritional support, including improving micronutrient deficiencies (vitamin A, iron, iodine), therapeutic feeding, and breast-feeding promotion; (7) participating in special health activities such as national immunization days and other types of campaigns; and (8) carrying out public health functions, such as disease surveillance and recognition/response to epidemics. The Partner will be responsible for managing all aspects of PHC services.

**Following National Guidelines and Ensuring Quality of Care.**

In carrying out the services described above, the Partner will comply with the current national technical guidelines (such as for TB and expanded program on immunization [EPI]) and those that are developed during the life of the agreement. The Partner will also be responsible for ensuring high quality of care more generally through quality assurance mechanisms appropriate for rural areas.

**Staffing PHCCs.** The Partner will mobilize an adequate number of skilled health workers to deliver the package of primary health care services in their PHCCs and the associated catchment areas. The Partner may recruit additional health workers if necessary. The Partner will ensure that there is a fully trained and certified doctor, preferably a woman doctor, working in the PHCC and its catchment area.

**Capacity Building.** The Partner will be responsible for ensuring that its health workers have the necessary skills to deliver services and will be accountable for training and supervising its health workers. The capacity of its health workers will be judged by their knowledge and the quality of the patient-provider interaction as determined by the third-party health facility assessments.

**Procurement of Drugs, Supplies, and Basic Equipment.** The Partner will be responsible for the procurement of essential drugs (those on the GOX's essential drug list, although the Partner may procure additional drugs if it feels this is appropriate) and supplies of acceptable quality from reputable suppliers. The Partner will be able to access the rate lists for drugs established by the GOX. It is the responsibility of the Partner to ensure the quality of the drugs in PHCCs, which may be tested on a random basis during the health facility assessments. The Partner will also be responsible for ensuring the presence of basic equipment (for example, examining tables and stethoscopes) and furniture needed for its PHCCs. The Partner will provide the provincial and district governments with lists of equipment and furniture procured under the agreement along with location and unique identifying number of each.

**Linkages with Health Workers.** Existing health workers will continue to be paid by the GOX, and the Partner will work closely with them to improve health services. The Partner, at its sole discretion, may provide performance bonuses to health workers that it believes are doing a particularly good job in strengthening services.

**Communications.** The Partner will ensure that each PHCC has the ability to communicate, by radio or telephone, with the nearest first-referral hospital.

**Recording and Reporting.** The Partner will have to implement the standard recording and reporting system, including the monthly HMIS reports. Other reporting requirements are detailed in section G.

**Medicolegal Cases.** The Partner will refer all medicolegal cases to the closest appropriate GOX facility. However, it should provide all necessary first aid to the patient prior to transfer.

**Health Care Waste Management.** The Partner will be responsible for properly implementing health care waste management procedures in keeping with the rules and regulations of the GOX.

**Refurbishment of Facilities and Outreach.** The Partner may use part of the funds it receives to refurbish the PHCCs in the districts in which it works. It may also purchase or rent a vehicle for provision of mobile services.

## E. Location and Duration of Services

The above mentioned services will be delivered to the entire population in District \_\_\_\_\_. The services will be provided over four years beginning \_\_\_\_\_.

## F. Data, Services, and Facilities Provided by the CMU

The contract management unit (CMU), on behalf of the GOX, will provide the Partner with the following inputs: (1) relevant available information about facilities, health care status of population, results of surveys and special studies, and other factors; (2) use of the PHCCs in the listed districts at nominal rent; (3) copies of standard reporting and recording forms; (4) access to government training courses; (5) existing technical guidelines and new ones developed during the agreement period; (6) an inventory of the buildings provided to the Partner; and (7) technical assistance when needed for special services or campaigns.

## **G. Reporting Requirements**

The Partner will provide the CMU and the concerned provincial health departments quarterly reports related to activities undertaken in fulfillment of this agreement. The report will include the following sections: (1) progress made against achieving the objectives of the agreement; (2) problems encountered and solutions undertaken; (3) relations with stakeholders, such as community institutions, the community, and other NGOs operating in the district; (4) a financial statement limited to simple line-item expenditures (remuneration, capital costs, nonremuneration recurrent costs); and (5) a summary of HMIS results with analysis. Such reports will be furnished within one month of the end of the calendar quarter (that is, by January 31, April 30, July 31, and October 31 of each year).

## **H. Authority and Responsibilities of the Government**

The CMU and the provincial health departments have the authority to perform the following:

1. Visit any Partner-managed facility at their sole discretion at any time and to obtain such relevant information as to allow proper support, guidance, and monitoring of the Partner and its staff
2. Convene a meeting with the management of the Partner to discuss and resolve issues related to the agreement and its implementation
3. Ensure that the conditions of the agreement are met by the Partner
4. Ensure that the GOX's facilities are properly maintained throughout the period covered by this agreement
5. Terminate the agreement in keeping with the specific provisions of part L if the Partner fails to meet the conditions of the agreement
6. Take other actions short of termination (also described in part L) to ensure that the services covered by this agreement are being properly implemented
7. Consult with the local village councils and directly with communities regarding the implementation of services covered by this agreement

8. Review the quarterly report of the Partner and provide feedback to the Partner and the GOX.

The government has the following responsibility:

1. Paying the Partner in a timely manner
2. Not subjecting the Partner to excessive and unnecessary bureaucratic procedures
3. Resolving quickly such reasonable complaints brought by the Partner that the latter feels interferes with its performance under this agreement
4. Paying the remuneration and emoluments of existing government staff, in a timely fashion.

### **I. Authority and Responsibilities of the Partner**

The Partner will have the following authority:

1. It will enjoy sole discretion in the procurement of drugs, supplies, equipment, furniture, and other resources needed to meet obligations under this agreement.
2. It will also enjoy sole discretion in the use of resources purchased or provided under the agreement. (However, the Partner will not refuse reasonable requests for the use of such resources by the GOX officials for implementing important health-related services, such as the use of the facility during emergencies or immunization days.)
3. It may raise voluntary contributions in kind or cash from the community (not patients; that is, no user charges are permitted) or from outside the community for delivering health services.
4. It will enjoy sole discretion over the hiring, firing, posting, remuneration, and customary managerial prerogatives over staff recruited by the Partner. The staff recruited by the Partner shall have no claims against the CMU, the GOX, or local governments.
5. For existing GOX health workers, the Partner may provide performance bonuses in a manner it considers appropriate and at its own

discretion so long as the criteria and process are clear and written. It may ask district health officials to transfer health workers that it feels are not working properly or who are actively interfering with the Partner's work under the agreement.

The Partner will be responsible for the following:

1. Ensuring the proper maintenance and repair of government physical assets provided to it, as well as physical assets procured with funds provided under the agreement
2. Cooperating with any monitoring and evaluation process authorized by the CMU
3. Resolving quickly such deficiencies that are reasonably pointed out by the CMU
4. Ensuring government resources are used efficiently for delivery of health care services.

## **J. Financial Management and Payment**

**Financial Management.** The Partner will maintain a separate set of accounts for the funds received under this agreement and will maintain those funds in a separate bank account. The Partner will also provide an annual, independently audited financial report to the CMU and/or its representatives. Such an audit report will be furnished within three months of the end of the fiscal year. The cost of the audit will be borne by the Partner out of the funds it receives under this agreement. The Partner will also provide the CMU with a list of equipment and furniture procured with funds provided under the agreement.

**Payment.** It is understood that this is a lump-sum contract based on performance and not on the reimbursement of specific expenditures. The Partner will be paid the amount of [US\$ \_\_\_\_\_] upon signing this agreement as a mobilization advance. The total annual payment to the Partner will be [US\$ \_\_\_\_]. Payments to the Partner will be made within two weeks of receipt of an acceptable quarterly report and will be equal to one-quarter of the annual payment mentioned above. There is no other requirement on the Partner before payment is affected.



**Performance Bonuses.** According to the annual health facility assessment, the Partner will be paid a performance bonus of 2 percent of the contract amount if its score on the quality-of-care index improves by 10 points from its previous highest score or has achieved a score of 85 percent. When the midterm household survey results are available, the Partner will receive a bonus worth 5 percent of the contract amount if it has achieved the targets on four of the nine indicators listed in table AA.1. When the endline household survey results are available, the Partner will receive a bonus worth 3 percent of the contract amount if it has achieved the targets on seven of the nine indicators listed in the table.

## **K. Settlement of Disputes**

The parties to this agreement will use their best efforts to settle amicably all disputes arising out of or in connection with this agreement or its interpretation. The Partner may bring to the attention of the CMU any serious complaint that it feels interferes with accomplishment of the objectives and services described in this agreement. Any dispute between the parties as to matters arising pursuant to this agreement that cannot be settled amicably within 30 days after receipt by one party of the other party's request for such amicable settlement may be submitted by either party for settlement in accordance with the following provisions:

1. First, referral to an arbitrator appointed by the Secretary of Health of the GOX. To encourage reasonableness in disputes that are primarily monetary, the arbitrator will use "swing arbitration," that is, both parties will state their "most reasonable offer," and the committee can accept only one or the other. To discourage frivolous referrals, the arbitrator can assess costs against the losing party.
2. If the dispute has not been resolved to the parties' satisfaction, either party may refer it to a committee comprising two members of the provincial government, two members from the NGO community (not involved in the dispute), and one member from the federal government. The findings of the committee shall be binding.

## L. Sanctions and Termination

**Sanctions.** The government may, at its sole discretion, (1) insist on a meeting with the senior management of the Partner regarding any failures to meet the conditions of the agreement; (2) write directly to the board of directors of the Partner and expect a specific written reply to its concerns; (3) ask for the replacement of field-level managers of the Partner, although it is understood that this will not be requested in a frivolous manner; (4) bar the Partner from receiving further contracts; and (5) make public the results of independent assessments of the Partner's performance.

**Termination of the Agreement by the Government.** The GOX may terminate this agreement, by not less than 30 days' written notice of termination to the Partner to be given after the occurrence of any of the events specified below, but in keeping with part K, regarding the settlement of disputes:

1. If the Partner does not remedy a failure in the performance of its obligations under the agreement, within 30 days after being notified or within any further period as the government may have subsequently approved in writing
2. If the Partner becomes insolvent or bankrupt
3. If, as the result of force majeure, the Partner is unable to perform a material portion of the services for a period of not less than 60 days
4. If the Partner, in the judgment of the government, has engaged in corrupt or fraudulent practices in competing for or in executing the contract. "Corrupt practice" means the offering, giving, receiving, or soliciting of anything of value to influence the action of a public official in the selection process or in contract execution. "Fraudulent practice" means a misrepresentation of facts in order to influence a selection process or the execution of the agreement.

**Termination of the Agreement by the Partner.** The Partner may terminate this agreement, by not less than 30 days' written notice to the government, such notice to be given after the occurrence of any of

the events specified below, but in keeping with part K, regarding the settlement of disputes:

1. If the government fails to pay any monies due to the Partner pursuant to this agreement and not subject to dispute within 45 days after receiving written notice from the Partner that such payment is overdue
2. If, as the result of force majeure, the Partner is unable to perform a material portion of the services for a period of not less than 60 days.

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Signed and dated by:  
on behalf of the Contract Management Unit

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Signed and dated by:  
on behalf of the Partner

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Signed and dated by:  
on behalf of the Provincial Health Department

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## World Bank Procurement Approach to Contracting for Health Services

To help guide clients and task teams on how to procure health services, services should be judged according to (1) how easy they are to define in terms of outcomes, technical content of the services, and the organization of services (if that is likely to matter); (2) the “intellectual content” of the services; and (3) the ease, precision, and frequency of independent measurement of results at a reasonable cost. Generally, the more difficult services are to define, the greater their intellectual content, and the more complicated their measurement, the more the Consulting Services (Green Book) guidelines should be used. Some detailed examples are provided on subsequent pages.

### Examples of the Application of the Typology

Below are two examples of how the typology in table A2.1 can be applied to real-world situations.

#### *Example A: Managing a Clinic That Provides Antiretroviral Medicines to People Living with HIV/AIDS*

**Definition of Services.** Providing antiretroviral (ARV) drugs to people living with HIV/AIDS (PLWHAs) is hard to define in all its details. Although national guidelines often exist about how such services should be provided, their application usually relies on clinical judgment that takes into account the entire social and clinical con-

**Table B.1** Procurement Approaches to Use in Different Situations

<i>Type</i>	<i>Examples</i>	<i>Ease of definition</i>			<i>Intellectual content</i>	<i>Measurement of results</i>			<i>Recommended guidelines</i>
		<i>Outcomes</i>	<i>Organization</i>	<i>Services</i>		<i>Ease</i>	<i>Precision</i>	<i>Frequency<sup>a</sup></i>	
Ancillary services	Equipment maintenance, cleaning, security, waste management, ambulance services	Easy	Easy or does not matter	Easy	Low	Easy	High	Frequent or very frequent	Procurement (Red Book)
Private-public financing partnerships for infrastructure	Build-operate-transfer approach for hospitals, private provision and operation of equipment in public hospitals	Moderate	Does not matter	Moderate	Moderate	Easy	High	Frequent	Procurement (Red Book)
Private-public financing partnerships for services	Public subsidies to existing mission clinics, contracts with existing private providers (for example, "soft" contracts related to TB control), provision of financing to public facilities by private sector entities	Moderate to hard	Moderate to hard	Variable (moderate to hard)	Moderate to high	Hard	Moderate to low	Infrequent or rare	According to the Project Implementation (Operational) Manual

**Table B.1** Procurement Approaches to Use in Different Situations *(continued)*

<i>Type</i>	<i>Examples</i>	<i>Ease of definition</i>			<i>Intellectual content</i>	<i>Measurement of results</i>			<i>Recommended guidelines</i>
		<i>Outcomes</i>	<i>Organization</i>	<i>Services</i>		<i>Ease</i>	<i>Precision</i>	<i>Frequency<sup>a</sup></i>	
Hospital management	Individual or firm contracted to manage existing hospital, treatment provided to PLWHA	Hard	Hard and does matter	Hard	High	Hard	Low	Infrequent	Consulting Services (Green Book)
Intermediary services	• Franchise with private providers, voucher program	Moderate to hard	Hard and does matter	Variable (moderate to hard)	High	Hard	Low	Infrequent or rare	According to the Project Implementation (Operational) Manual
	• Establish health insurance, performance-based pay to public providers, umbrella NGO overseeing many smaller NGOs/CBOs	Moderate to hard	Hard and does matter	Variable (moderate to hard)	High	Hard	Low	Infrequent or rare	Consulting Services (Green Book)

*(continued on next page)*

**Table B.1** Procurement Approaches to Use in Different Situations (*continued*)

Type	Examples	Ease of definition			Intellectual content	Measurement of results			Recommended guidelines
		Outcomes	Organization	Services		Ease	Precision	Frequency <sup>a</sup>	
Population-based services	Behavior change communications, condom social marketing	Moderate	Hard and does matter	Moderate	High	Hard	Low	Infrequent or rare	Consulting Services (Green Book)
Delivery of preventive, promotive, and simple curative services	Service delivery contract for PHC, management contract for PHC, provision of HIV prevention services to high-risk groups, provision of antiretroviral medicines to persons with HIV/AIDS	Moderate to hard	Hard and does matter	Variable (moderate to hard)	High	Hard	Moderate to low	Infrequent or rare	Either Consulting Services (Green Book) or Procurement (Red Book) (will be reviewed based on experience)

Source: Author and agreed to by the World Bank's Operations Policy and Country Services unit.

Note: CBO = community-based organization; NGO = nongovernmental organization; PHC = primary health care; PLWHA = people living with HIV/AIDS;

TB = tuberculosis.

a. Very frequent = more than once a month; frequent = between once a month and once a quarter; infrequent = once a quarter to once a year; rare = less than once a year.

text. Aspects of the organization of the clinic, such as making clients feel welcome, ensuring that they receive other support services, and ensuring confidentiality, are hard to write into a contract and matter very much to the broad outcomes of the services. The outcomes for such services are also hard to define. PLWHAs who meet certain clinical criteria need to be on ARVs; however, it may be perverse to use the percentage of patients on ARVs as a measure of success. (These are toxic drugs to which the virus becomes resistant if they are not properly used. Hence, putting people on ARVs who don't really need them should be actively discouraged.) Similarly, using the death rate of people who are put on ARVs may also have unintended consequences. Clinics may not take on patients who are very ill and have a poor prognosis or other "difficult" patients, such as injecting drug users who don't adhere easily to therapy.

**Intellectual Content.** Perhaps the criterion for judging the intellectual content is whether a reasonably intelligent person, with no special training in the particular field, could do a good job in providing the services. By this standard, the intellectual content of such services is extremely high. It requires a specialized physician with extensive training and very good clinical judgment. There are aspects of each case that are different and important to take into account while developing the optimal management strategy for the patient. Also, the knowledge in this field is rapidly changing, which means that even specialists need to keep up to date with recent developments.

**Measurement of Results.** Not only are the outcomes of such services difficult to define, but they are also difficult to measure. They would likely involve chart reviews by experts who would still need to be specially trained and go through a reasonable number of records. (The desired content of the patient records would also have to be defined in advance.) The judgments of these experts would also be subjective (low precision), and this could be done only once or twice a year.

### *Example B: Cleaning Services in a Hospital*

**Definition of Services.** The definition of such services is obvious and easy. The location and type of cleaning to be done could be specified. The organization of the services generally doesn't matter as long as they get done. The outcomes are evident to the nose and can also be easily tested by carrying out bacterial swabs of specified surfaces.



**Intellectual Content.** Using the criterion of whether a reasonably intelligent person, with no special training in the particular field, could do a good job in providing the services, cleaning is pretty low in content. Almost anyone could understand what needs to be done and could actually do it.

**Measurement of Results.** Not only are the outcomes of such services obvious, but they are easy to measure, the precision of measurement is high, and the outcomes of interest can be measured frequently (daily if desired) at low cost.

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## Description of Evaluated Contracting Experiences

### Case 1. Cambodia: Rural Primary Health Care Services

**Background.** Many years of war and political upheaval left Cambodia with a limited health infrastructure, particularly in rural areas. Health worker morale was poor, management capacity at the district level was very weak, and access to service was inadequate. A 1998 demographic and health survey found that, nationwide, only 39 percent of children were fully immunized and 21 percent of mothers had received any prenatal care during their last pregnancy. To address these serious issues, the Ministry of Health (MOH) devised a “coverage plan” that focused on delivery of a minimum package of activities comprising basic preventive and curative services, such as immunization, family planning, antenatal care, and provision of micronutrients.

**Description of Intervention.** With financing provided by the Asian Development Bank, the government contracted with nongovernmental organizations (NGOs) in two different ways: (1) a service delivery contract (SDC, called “contracting out” in the original study) in which the contractors had complete line responsibility for service delivery, including hiring, firing, and setting wages; procuring and distributing essential drugs and supplies; and organizing and staffing health facilities; and (2) a management contract (MC, referred to as “contracting in” in the original) in which the contractors worked

within the MOH system and had to strengthen the existing district structure. The MC contractors could not hire or fire staff, although they could request their transfer. Drugs and supplies were provided to the district through the normal MOH channels. The MC contractor received a budget supplement of \$0.25 per capita per year to spend on incentives for staff, operating expenses, and other costs. In a control area, the management of services remained in the hands of the district health management team (DHMT); and drugs and supplies continued to be provided through normal MOH channels. As with the MC, the DHMT received a budget supplement of \$0.25 per capita per year to spend on incentives for staff, operating expenses, and so on. Technical assistance and training on management were provided to the DHMT. This approach is referred to as “government with support” (GS). Three districts that were assigned to contracting were not successfully contracted (in two cases because there were no technically responsive bidders, and in the other district because government considered the bid price to be too high). These three districts had health services implemented by the MOH with no budget supplement, technical assistance, or training and are referred to as “government without support” (G).

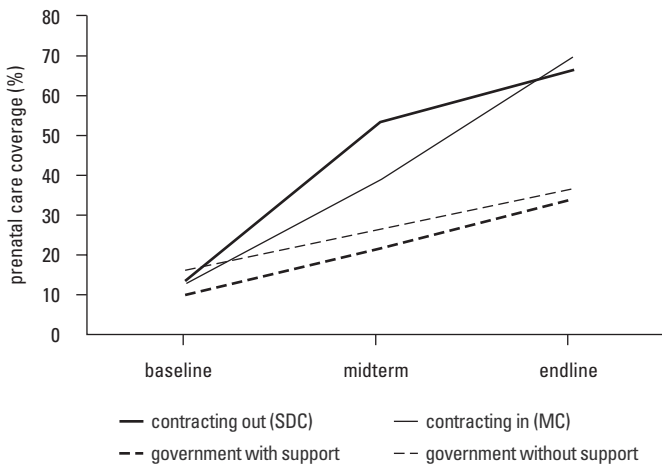
**Contracting Arrangements.** The MOH used a formal competitive process for selecting the NGOs based on both the quality of the technical proposals and cost. Contracts were for four years. All the winning bidders were international NGOs with previous experience working in Cambodia. At the time the contracts were bid, there were almost no Cambodian NGOs active in the health sector. Contract management was carried out by a special unit of the MOH using local consultants. The unit appears to have functioned well in ensuring that NGOs were paid on time; however, much time and effort were needed to solve problems between provincial and district authorities and the NGOs.

**Evaluation Methodology.** Twelve districts with a combined population of 1.5 million were randomly assigned to the three different approaches and baseline household, and health facility surveys were carried out in late 1997. Contracts were signed with the NGOs in December 1998, and follow-up surveys were carried out in August 2001 and June 2003, about four years after implementation began. The surveys were carried out by a third party, and data were collected on the parameters stipulated in the contract. The wealth of each household was assessed using an asset index.

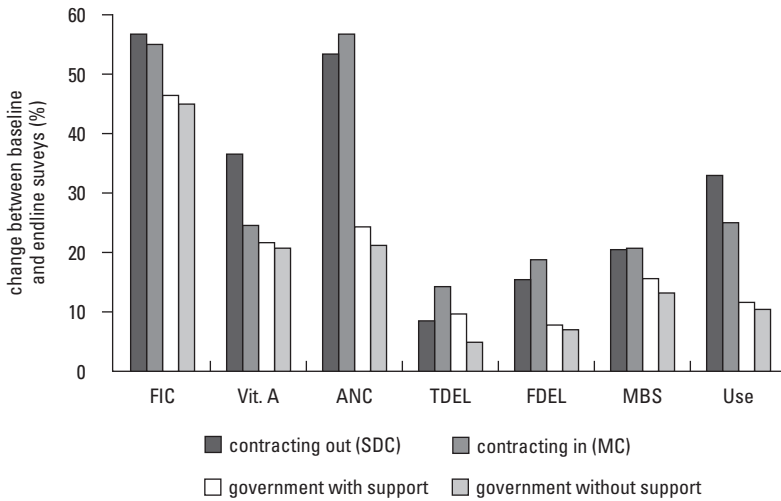
**Results.** There were much larger improvements in prenatal care coverage in the SDC and MC (contracting out [CO] and contracting in [CI], respectively) districts than in the control districts (see figure C.1) although they were quite similar at baseline. The government with support did no better than the government without support, although both groups made progress during the four years of the experiment. The story is similar for other important indicators, as illustrated in figure C.2. For example, use of a health facility if the respondent was sick in the last month increased 33 percentage points in the SDC (CO) group, compared with 25 percentage points in the MC (CI) districts, 12 percentage points in the government with support control group, and 10 percentage points in the government without support group. At baseline, use was similar in all the groups (0.7 percent, 0.9 percent, 1.0 percent, and 1.5 percent, respectively).

The median double difference between SDC and the GS districts for the seven indicators explicitly mentioned in the contract was 10.4 percentage points (range -1.3 to 29.1), and for the MC districts the comparable figure was 8.7 percentage points (range 2.9 to 32.5). These changes represent more than half a baseline standard deviation, a very large improvement. The changes occurred even in parameters that are generally believed to change slowly, such as use of family planning and institutional deliveries. The SDC and MC groups also did significantly better on improving the quality of care compared with the GS

**Figure C.1** Coverage of Prenatal Care by Approach Used



Source: Author.

**Figure C.2** Change between Baseline and Endline Surveys

Source: Based on Schwartz and Bhushan (2003).

Note: ANC = antenatal care coverage, one or more visits; FDEL = proportion of infants delivered in a health facility; FIC = percentage of children 12–23 months of age fully immunized; MBS = proportion of couples with children 12–23 months of age and who are using a modern form of spacing births/contraception; TDEL = proportion of deliveries attended by a trained health worker; Use = proportion of people sick in the last month who used a government health facility; Vit. A = proportion of children 6–59 months of age who received vitamin A supplements in the last 6 months.

and G groups, even though this was not specified in the contract. The double difference between the contracted and government districts was 193 points on a scale of 1,000 (that is, 19.3 percent).

The poor appear to have benefited disproportionately from contracting, as can be seen in table C.1, which describes the change in the concentration index from baseline to follow-up evaluation, that is, the extent to which health services became more or less pro-poor. (Negative values mean that services became more pro-poor, and positive values indicate that services became less pro-poor.) With the exception of the use of modern methods of spacing births and vitamin A, services in SDC districts became more pro-poor followed by the MC districts. The control districts became less pro-poor.

The cost of SDC to the government was higher than the MC or the control groups but led to a considerable savings in out-of-pocket expenditures by people in the community (table C.2). Thus, contracting in this context was an effective and equitable way of subsidizing

**Table C.1** Changes in the Concentration Index of Health Services, Follow-Up Minus Baseline

Type	FIC	Vit. A	ANC	TDEL	FDEL	MBS	Use	Average
SDC	-0.213	0.013	-0.151	-0.081	-0.222	-0.116	-0.175	-0.135
MC	-0.115	-0.036	-0.007	-0.014	0.033	-0.006	-0.036	-0.026
GS	-0.018	-0.030	0.088	0.061	0.210	-0.196	0.104	0.031
G	0.010	-0.007	0.083	0.112	0.027	-0.129	0.041	0.020

Source: Based on Schwartz and Bhushan (2003).

Note: Negative values indicate a more pro-poor distribution of services. ANC = antenatal care coverage, one or more visits; FDEL = proportion of infants delivered in a health facility; FIC = percentage of children 12–23 months of age fully immunized; G = government without support; GS = government with support; MC = management contract (contracting in); MBS = proportion of couples with children 12–23 months of age and who are using a modern form of spacing births/contraception; SDC = service delivery contract (contracting out); TDEL = proportion of deliveries attended by a trained health worker; Use = proportion of people sick in the last month who used a government health facility; Vit. A = proportion of children 6–59 months of age who received vitamin A supplements in the last 6 months.

**Table C.2** Annual Total Health Expenditures per Capita, 2003 (US\$)

Source of funds	Contract out (SDC)	Contract in (MC)	Government with support (GS)	Government without support (G)
Private out-of-pocket	14.29	16.72	19.86	19.99
Public, recurrent	4.83	3.47	1.74	1.70
Total	19.12	20.19	21.60	21.69

Source: Based on Schwartz and Bhushan (2003).

Note: MC = management contract; SDC = service delivery contract.

the cost of health services. From society's point of view, contracting was also the most efficient way of delivering health services.

**Comments.** The results of this randomized controlled study showed that contracting with NGOs can significantly improve service delivery within a short time. It appears that the greater autonomy provided to NGOs under SDC enabled a faster improvement in performance, but the MC NGOs later caught up. Overall, contracting with NGOs was considerably more successful than government delivery of the same services, benefited the poor disproportionately, was the most efficient

approach, and was achieved at a reasonable cost. One possible argument is that if the control districts had been given the same amount of resources, they could have done just as well. The success achieved with contracting has been expanded during a subsequent project, financed by the U.K. Department of International Development (DFID), the Asian Development Bank, and the World Bank, that now covers about 20 percent of the population of Cambodia. (More information is available in Bhushan, Keller, and Schwartz 2002; Bloom and others 2006; Loevinsohn 2000; Schwartz and Bhushan 2003, 2004; Soeters and Griffiths 2003.)

## Case 2. Bangladesh: Rural Nutrition Services

**Background.** Bangladesh suffers from one of the highest malnutrition levels in the world, and until the 1990s the government of Bangladesh (GOB) had not mounted a coordinated effort to address the problem. Based on experience gained from the Tamil Nadu Integrated Nutrition Project in India, the GOB was interested in introducing community nutrition services on a large scale. It was initially thought that these services would be delivered by the Ministry of Health and Family Welfare (MOHFW). However, two major concerns with this approach were expressed. The finance ministry was reluctant to expand the size of the MOHFW staff greatly, and there was general skepticism that the MOHFW could rapidly and effectively deliver community-based services, something with which they had little experience. A consensus emerged that it would be sensible to work systematically with NGOs to deliver community nutrition services. Out of this consensus grew the Bangladesh Integrated Nutrition Project (BINP), undertaken by the MOHFW with funding from the GOB, the World Bank, and the United Nations Children's Fund (UNICEF).

**Description of Intervention.** The Bangladesh Integrated Nutrition Project employed a large number of female community nutrition promoters (CNPs), women from the community who have at least an eighth-grade education, to undertake growth monitoring and promotion among young children, nutritional support for pregnant and lactating women, behavior change communication about nutrition and related issues for the whole community, and supplementary feeding for

severely malnourished or growth-faltering children under two years of age, as well as pregnant and lactating women. Training, supervision, payment, and support of the CNPs were carried out by NGOs, who signed a memorandum of understanding with the MOHFW. Non-governmental organizations were provided a fixed budget, the amount of which had been decided in advance by the MOHFW, to run the program in selected upazilas (administrative entities comprising more than 300,000 people). By the end of the BINP, 59 upazilas, comprising more than 15 million people, were covered by seven NGOs. The cost of the community nutrition intervention was \$0.96 per capita per year, or \$20.00 per child under age two per year.

**Contracting Arrangements.** In the initial phase of the BINP, NGOs were selected on a sole-source basis based on their track record. During subsequent phases, NGOs were selected competitively based on the quality of their technical proposals. Winning bidders were given a fixed-price contract and assigned to specified upazilas by the MOHFW. Contract management was done by a special project unit of the MOHFW but turned out to be problematic. Significant delays in payments to NGOs and limited field supervision occurred. Obstacles to managerial autonomy under the BINP also arose, including (1) line-item budgets wherein contractors could not use savings in one line item to offset expenditures in another, (2) the need for prior approval for innovations suggested by the contractors even when these involved no additional cost, and (3) the MOHFW ordering contractors to undertake new activities without any discussion or consideration of cost.

**Evaluation Methodology.** A controlled, before-and-after design was used to evaluate the BINP. Baseline, midterm, and endline household surveys in 1995, 1998, and 2003, respectively, were conducted in six upazilas that were included in BINP and two control upazilas that were not subject to the BINP nutrition activities. The surveys were conducted by a third party under contract to the MOHFW. The stated objective of the evaluation was to discern a change in nutritional status, particularly in the proportion of young children who were moderately and severely underweight.

**Results.** Reductions in rates of moderate and severe malnutrition were slightly greater in project upazilas compared with control upazilas, although both sets of upazilas made considerable progress (see table C.3). Although they were not specifically mentioned as indicators of



**Table C.3** Changes in Key Indicators from Baseline to Endline in Project and Control Upazilas

Parameter	Baseline (Oct. 1995)		Endline (Feb. 2003)		Change (% points)		Double difference (% points)
	Project (%)	Control (%)	Project (%)	Control (%)	Project	Control	
Child was moderately and severely underweight (weight for age Z score < -2 SD)	52.6	50.7	34.9	37.3	-17.7	-13.4	4.3
Women attended antenatal checkup	11.8	13.7	81.0	55.1	+69.2	+41.4	27.8
Children received vitamin A capsule	17.1	16.8	83.2	56.1	+66.1	+39.3	26.8
Children initiated breastfeeding immediately after birth	14.5	11.9	84.0	56.2	+69.5	+44.3	25.2

Source: Based on Karim and others (2003).

success during the design of the project, levels of vitamin A coverage and prenatal care coverage improved more in the project upazilas than in the control upazilas. The cost-effectiveness analysis indicated a cost per malnutrition-related death averted of \$1,745, and a cost per case of severe malnutrition averted (that is, changing a severely malnourished child to at least a moderately malnourished child) of \$366.

**Comments.** In a controlled, before-and-after evaluation, NGO delivery of community nutrition services appeared to have had a modest effect on nutritional status, although significant improvements were seen in other health services. The intervention was likely better than the control; however, the benefits were achieved at a relatively high cost. Although the effectiveness and cost-effectiveness of the BINP nutrition interventions remain controversial, the issue with regard to contracting is whether the NGOs successfully implemented the program as designed. They appeared to do this despite difficulties with MOHFW management of the contracts and the very large scale on which the NGOs had to work. Based on the perceived success of the BINP, the National Nutrition Program (NNP) was undertaken to expand commu-

nity nutrition services further. The NNP currently covers 105 upazilas, or about a third of rural Bangladesh, encompassing more than 30 million people, with continued reliance on NGOs to deliver services. (More information is available in Karim and others 2003.)

### **Case 3. Bangladesh: Urban Services**

**Background.** As in other developing countries, the provision of urban primary health care (PHC) services in Bangladesh is chaotic and often ineffective at reaching the poor. In the large cities of Bangladesh, primary care is provided by a bewildering number of providers, including (1) a large for-profit private sector with many individual providers of varying level of skill, (2) a large number of for-profit hospitals and clinics, (3) a few federal government clinics, (4) a few city corporation clinics, and (5) a relatively large number of NGO facilities. The result of these uncoordinated efforts is that the coverage of PHC services among the poor is worse than in remote rural areas.

**Description of Intervention.** The government, with funding from the Asian Development Bank, divided four large cities into partnership agreement areas (PAAs) and contracted with competitively selected NGOs to deliver a package of PHC services. Each PAA covered a population of about 250,000–400,000 and included five to eight project-financed health centers that were built on government land. An NGO was expected to provide outreach services as well as to operate health centers, and its contracts specified coverage targets as well as provided considerable autonomy. The cost of the contracts averaged \$0.65 per capita per year, although the low cost partly reflected the fact that many urban residents obtain their PHC services from other sources. In the center of Chittagong, the country's second largest city, the Chittagong City Corporation (CCC) was given the opportunity to operate two PAAs with the same level of funding on a per capita basis as was provided to the NGOs. Another PAA in Chittagong, similar to the one operated by the CCC, was successfully tendered to an NGO.

**Contracting Arrangement.** Competitive bidding was carried out for each of the PAAs with NGOs competing both on the technical quality of their proposals and price. All the winning bidders were Bangladeshi NGOs, which were awarded four-year contracts. Contract

management was done by a project unit working in the Dhaka City Corporation. Project managers admitted problems with paying NGOs on time and carrying out adequate monitoring of performance.

**Evaluation Methodology.** This project used a prospective, controlled before-and-after design to evaluate the difference between NGO and CCC provision of services. Baseline household surveys were carried out by an independent third party in all the PAAs, including the two operated by CCC. Three years later, a health facility survey was carried out and was used to create a broad index of quality of care (scaled from 0 to 100). A household survey was also undertaken among the general population and then among the poorest half of the population (mostly people living in slums or dilapidated housing).

**Results.** As can be seen in table C.4, the NGO did considerably better in improving the coverage of maternal and child health services (except for immunization) with a median double difference of 8.3 percentage points. The broad index of quality of care was also significantly higher in the NGO area compared with the government-run facilities. The NGO also did better than the government in improving the coverage of services among the poorest 50 percent of the population with a median double difference of 10.1 percentage points (see table C.5).

**Comments.** Using a before-and-after controlled evaluation, it appears that the NGO was able to provide more and better-quality health services even though it had the same amount of resources as the Chittagong municipal government. Based on the success of this experiment, the government, working with the Asian Development

**Table C.4** Changes in Coverage (Percentage Points), 2000–03

<i>Area</i>	<i>ANC</i>	<i>CPR</i>	<i>SBA</i>	<i>FIC</i>	<i>Vit. A</i>	<i>BF</i>	<i>QOC</i>
CCC (government)	18.8	-5.5	7.7	25.8	13.3	6.8	65
NGO	29.2	14.8	14.0	19.1	24.3	11.1	76
Double difference	10.3	20.3	6.3	-6.7	11.0	4.3	11 <sup>a</sup>

*Source:* Based on Bonu (2006).

*Note:* ANC = antenatal care coverage; BF = children breastfed for at least six months; CCC = Chittagong City Corporation; CPR = contraceptive prevalence rate; FIC = coverage of full child immunization; NGO = nongovernmental organization; QOC = quality of care; SBA = skilled birth attendance; Vit. A = vitamin A coverage among children 6–59 months of age.

a. Single difference on a scale from 0–100.

**Table C.5** Changes in Coverage (Percentage Points) among the Poorest 50 Percent, 2000–03

<i>Area</i>	<i>ANC</i>	<i>CPR</i>	<i>SBA</i>	<i>FIC</i>	<i>Vit. A</i>	<i>BF</i>
CCC (government)	23.5	-5.0	3.4	22.7	15.7	8.1
NGO	36.4	15.2	17.9	19.0	23.0	12.0
Double difference	12.9	20.2	14.5	-3.7	7.3	3.9

*Source:* Based on Bonu (2006).

*Note:* ANC = antenatal care coverage; BF = children breastfed for at least six months; CCC = Chittagong City Corporation; CPR = contraceptive prevalence rate; FIC = coverage of full child immunization; NGO = nongovernmental organization; SBA = skilled birth attendance; Vit. A = vitamin A coverage.

a. Single difference on a scale from 0–100.

Bank and other development partners, has expanded the contracts with NGOs to cover more urban areas. (More information is available in Bonu 2006 and Mahmud, Ullah, and Ahmed 2002.)

#### **Case 4. Bolivia: Urban Primary Health Care**

**Background.** Bolivia's maternal and infant mortality rates, at 370 per 100,000 and 67 per 1,000, respectively, are among the worst in the Americas. In response to these high rates, in 1996 the government began a concerted effort to provide a basic package of services to the entire population. The package aimed at addressing the most common causes of maternal and child deaths and at controlling communicable diseases. Part of this effort also included working with nongovernmental providers to expand service delivery and improve the quality of care.

**Description of Intervention.** The intervention took place in one district of El Alto, Bolivia's fourth largest city with a population of 570,000, which suffered from limited human resources and physical health infrastructure, considerably less than the national average. In the late 1990s, assistance from the Dutch government and the World Bank led to the building of eight health centers and strengthening of the district hospital. Despite these investments, service delivery was of poor quality, and use was low during this period (the six months prior to July 1999, called phase 1). To improve management of the hospital,

an NGO was given a management contract starting in August 1999 (called phase 2). The contract did not include specific indicators of success or objectives and did not provide the NGO with authority over the staff of the hospital. Out of concern that the original contract was having little demonstrable effect, the nature of the contract with the NGO was changed starting in February 2000 (called phase 3) to include clear objectives, responsibility for managing the health centers, and more control of human, physical, and financial resources.

**Contracting Arrangements.** The contract was managed by a “management contract committee” comprising representatives from the municipality, MOH, and two community representatives. The NGO was responsible for all aspects of management of the hospital and eight health centers.

**Evaluation Methodology.** The effectiveness of the contract with the NGO was evaluated using a before-and-after comparison with a similarly sized control district, also in El Alto, in which management had remained in the public sector. The data were obtained from the routine recording and reporting system and were available on only a few indicators. The data for each phase were for a six-month period.

**Results.** As can be seen in table C.6, the NGO was able to increase the number of deliveries by 41 percent compared with 20 percent in the control district (a double difference of 21 percentage points). Both achieved similar improvements in bed occupancy rates for their gynecological and obstetric services. The number of outpatient visits increased 55 percent in the NGO district. It appears that in the NGO-managed district the introduction of a new contract providing the NGO with more autonomy and authority resulted in real improvement. There was a 14 percent increase in deliveries (compared with 5 percent in the control area) and a 24 percent increase in outpatient visits between phases 2 and 3.

**Comments.** A large and rapid change in service delivery was seen in the NGO-managed district, and the new contract, which provided clear objectives and greater autonomy, further increased performance. No cost data are available. Although this study involved a controlled before-and-after design, confidence in the conclusions is weakened by reliance on reporting system data of unknown accuracy, availability of data on only a few indicators, short periods of observation, and comparison of only two districts. (For more information see Lavadenz, Schwarb, and Hendrik 2001.)

**Table C.6** Changes over Time in NGO and Publicly Managed Districts in El Alto

Parameter	NGO district			Public sector district			Percentage change phase 3 minus phase 1	
	Phase 1	Phase 2	Phase 3	Phase 1	Phase 2	Phase 3	NGO	Public sector
	Deliveries	1,252	1,552	1,766	944	1,081	1,135	41
Bed occupancy rate (%)	74	70	87	65	76	77	13 <sup>a</sup>	12 <sup>a</sup>
Outpatient visits	25,086	31,378	38,885	—	—	—	55	—

Source: Based on Lavadenz, Schwarb, and Hendrik (2001).

Note: — = not available.

a. Change in percentage points.

## Case 5. Afghanistan: Rural Primary Health Care

**Background.** When the Taliban fell in 2001, Afghanistan had some of the worst health indicators in the world. The estimated under-five mortality rate was 256 per 1,000 births, and the total fertility rate was 6.8 children per woman. Very serious inequities were also seen between the urban and rural areas for outcomes and availability of services. The maternal mortality ratio was found to be 15 times higher in one province than in the capital of Kabul, and diphtheria/pertussis/tetanus (DPT3) immunization coverage was 58 percent in urban areas but only 19 percent in rural ones. There was a serious shortage of health services in much of the country, and what few rural clinics existed were run mostly by NGOs. There was a serious shortage of female health workers, particularly in remote areas. To assert its stewardship role and rapidly improve services, the Ministry of Public Health (MOPH) decided to contract with NGOs to deliver a basic package of health services (BPHS). The latter included basic preventive, promotive, and curative services, such as immunization, prenatal care, skilled birth attendance, tuberculosis control, well-child care, and curative services for diarrhea and pneumonia.

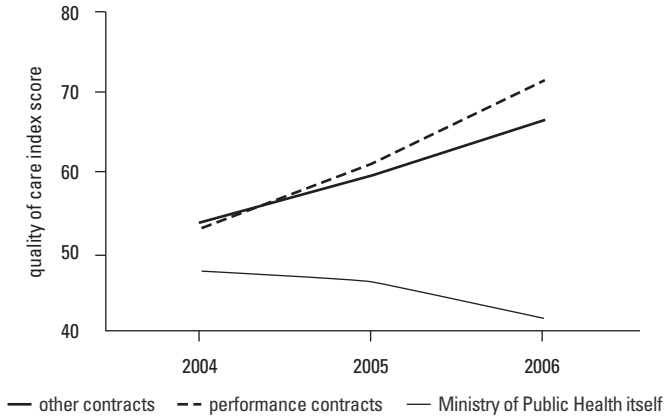
**Description of Intervention.** The MOPH, with funding from the World Bank, recruited international and local NGOs to provide the BPHS in eight provinces with about 4.1 million population. These service delivery contracts, known as performance-based partnership

agreements (PPAs), focused on the delivery of services and offered performance bonuses to the NGOs if they achieved specified improvements in the quality of care and the coverage of services. The PPAs gave the NGOs considerable autonomy in how to spend the funds they received, but the NGOs were responsible for complying with the technical standards in the BPHS. In three other provinces, the MOPH signed management contracts with individuals to strengthen the health services provided by the MOPH itself. The MOPH also carefully assessed performance and provided performance bonuses based on actual accomplishments. In most other parts of the country, other development partners, predominantly the U.S. Agency for International Development (USAID) and the European Union, provided grants to NGOs to deliver the BPHS. In a few areas, services were provided by the MOPH with modest external support or by NGOs who did not follow the BPHS.

**Contracting Arrangements.** The PPA NGOs were competitively recruited based on the quality of their personnel, track record, quality of their plans, and cost. The contracts were managed by a grants and contracts management unit (GCMU) in the MOPH made up of competitively recruited, local consultants. The GCMU, despite managing other projects for the ministry, was able to pay the NGOs in a timely fashion and carry out regular monitoring visits.

**Evaluation Methodology.** Health facility assessments were carried out each year in more than 600 facilities nationwide by a third party. Based on these assessments, the third party formulated an index reflecting many different aspects of the quality of care, including, for example, (1) availability of staff, equipment, and medicines; (2) quality of patient-provider interaction; (3) staff knowledge; and (4) patient satisfaction. The maximum score on the index was 100.

**Results.** Health facilities that were contracted showed large improvements in quality of care (nearly an 18 percentage point improvement in two years), whereas facilities managed by the government (without contracting in of management) appeared to have experienced a worsening in the quality of services they provided (nearly a 7 percentage point decline over the same period). The double difference on quality of care was 24.3 percentage points. There was a smaller difference between facilities with performance contracts compared with grants to NGOs with a double difference of 5.3 percentage points (see figure C.3). The change observed in the index of quality among the performance-based

**Figure C.3** Scores on a Broad Index of Quality of Care

Source: Author.

Note: Maximum = 100.

contracts was more than one baseline standard deviation, which represents a very large improvement.

**Comments.** Under difficult circumstances, performance contracts were able to make a large improvement in the quality of care. Other types of contracts and grants were slightly less successful, but the government facilities performed least well. The contracting effort in Afghanistan now covers more than 20 million people out of a population of about 25 million. (For more information on this case, see Waldman, Strong, and Abdul 2006.)

### Case 6. Rwanda: Performance-Based Payments for Primary Health Care

**Background.** After the 1994 genocide, Rwanda faced a difficult challenge in rebuilding its health services. It readopted the district health system model in which provincial and district health management teams in the public sector were given complete responsibility for running health services. In 2001, the annual public budget for health was \$3 per capita, of which it is estimated only \$1 made it to the frontline facilities, which generated 60–80 percent of their revenues from user fees. In 2001, a series of contracting efforts was started in different parts of the country by international NGOs. These NGOs acted as



intermediaries (“fund-holders”) and shifted the resources given to health centers from a fixed amount to one based on performance. Two of the contracting examples are described here.

**Description of Intervention.** In early 2002, an international NGO working with funds from a bilateral agency began a “performance initiative” in two health districts of Butare province with a combined population of 388,000 served by 19 rural health centers. These health centers had previously received a fixed budget, and per diems were paid to health workers regardless of their productivity (a “top-up”). Management committees in each health center signed contracts with the NGO that provided the health centers specified amounts based on the provision of five key services. The amount provided for each were as follows:

- Institutional delivery, almost \$5.00
- Antenatal care (as measured by tetanus toxoid, at least two doses), \$0.50
- Family planning new acceptor, \$2.00
- Immunization (completion of measles and DPT3), \$1.00
- Curative care consultations, \$0.10 for each new one.

The management committees had considerable autonomy in how they used the funds they received. The performance initiative cost an additional \$0.24 per capita per year, of which 62 percent went to the health centers, 27 percent went in incentives to the district and provincial staff, and 11 percent covered transaction costs of the new project. In early 2003, a similar effort was also begun in Cyangugu province, which has a population of about 620,000 and is situated in the mountainous southwest of the country. The health centers were mostly government owned, but about 40 percent were run by faith-based organizations. In Cyangugu, the administrative costs of contracting were estimated to be around 25 percent of the total contracting costs.

**Contracting Arrangements.** The approach is described as using a four-phase model in which during the first phase the health centers developed business plans and the international NGO purchased essential services through a written contract with individual health centers or hospitals. During the second phase, the health centers and hospitals delivered services with considerable autonomy in personnel decisions

and how to spend the funds they received. The third phase involved monitoring and evaluation by the district health management team, the international NGO, and the community. In the fourth phase, the contract was renewed (on a regular basis) based on feedback regarding outputs, quality of care, and patient satisfaction.

**Evaluation Methodology.** The evaluation of the first contracting effort in Butare province was based on routine reporting system data, which was compared with similar data from the rest of the country. In Butare, district health staff and independent monitors examined registers in the health centers, and contractors faced stiff punishment if they exaggerated their reporting. The use of reporting system data allowed for a controlled before-and-after analysis, comparing intervention areas in Butare with the rest of the country (that is, rural areas). The published data on the Cyangugu case come from before-and-after household surveys carried out in early 2003 and late 2005.

**Results.** As can be seen in table C.7, large improvements were achieved in the intervention areas of Butare province in almost all the services designated in the contracts. The median double difference was 12.9 percentage points, and the only double difference that was negative was related to the number of new family planning acceptors. Table C.8 displays the results of before-and-after household surveys in Cyangugu province. In less than three years, the proportion of deliveries occurring in institutions with skilled providers more than doubled, consistent with the results from Butare.

**Comments.** This case combined a controlled, before-and-after study (in Butare) based on health center records with a before-and-after study (in Cyangugu) based on household surveys. The results are consistent and demonstrate large improvements in health system performance through a creative contracting mechanism that involved NGOs that controlled the money (fund-holders), greater autonomy for health facility managers, and individual performance bonuses for health workers. It is possible that other interventions, in particular the advent of prepayment projects (*mutuelles*), influenced the outcomes. Also, it is not clear what happened to other indicators that were not included in the pay-for-performance contracts. The use of contracting and, more broadly, pay for performance has expanded considerably in Rwanda and will soon cover the entire country. (More details on this case are available in Meessen and others 2006 and Soeters, Habineza, and Peerenboom 2006.)

**Table C.7** Reported Data on Service Delivery in Butare Intervention Area Compared with the Rest of the Country (Rural Areas)

<i>Parameter</i>	<i>Butare 2001</i>	<i>Butare 2004</i>	<i>Rest of the country 2001</i>	<i>Rest of the country 2004</i>	<i>Double difference</i>
New consultations per capita per year	0.40	0.67	0.22	0.29	0.20
Deliveries at facility per health center	73.1	241.1	114.8	176.2	106.7
New family planning acceptors per health center	22.2	88.4	80.5	146.9	-0.2
TT2+ coverage (%)	39.7	67.6	43.0	54.0	16.9
DPT3 coverage (%)	71.6	80.5	73.0	73.0	8.9
Measles coverage (%)	69.1	77.6	67.0	69.0	6.6

*Source:* Author's calculations based on Meessen and others (2006).

*Note:* DPT3 = third dose of diphtheria/pertussis/tetanus vaccine; TT2+ = two or more doses of tetanus toxoid among pregnant women.

a. Single difference on a scale from 0 to 100.

**Table C.8** Before-and-After Results of Household Surveys in Cyangugu

<i>Indicator</i>	<i>Jan. 2003</i>	<i>Oct. 2005</i>	<i>Change (2005-03)</i>
Out-of-pocket expenditure per capita (\$)	9.05 (7.3-10.8)	3.43 (2.5-4.3)	-62%
Deliveries occurring in institutions (%)	25 (15-35)	61 (49-71)	+36%
Contraceptive prevalence rate (%)	5.4 (3-8)	11.6 (9-14)	+6%
Unmet need for family planning (%)	23 (19-27)	11 (8-14)	-12%
Percentage of respondents knowing the risk of HIV transmission through skin piercing	35 (29-41)	58 (53-63)	+23%

*Source:* Based on Soeters, Habineza, and Peerenboom (2006).

*Note:* Numbers in parentheses represent 95 percent confidence intervals.

## Case 7. Costa Rica: Cooperatives Delivering Primary Care

**Background.** Costa Rica established a social security institute (Centro Costarricense de Seguridad Social, CCSS) in the 1940s to provide universal access to health services. Although the CCSS helped the country achieve some of the best health status indicators in Latin America, by the late 1980s the system faced serious challenges. Expenditures had risen to nearly 9 percent of the gross domestic product (GDP), waiting lists for treatment were often 12–18 months, and a changing epidemiological profile underscored the need to expand coverage and strengthen the primary care model. One of the reforms introduced to try to address these challenges was the establishment of worker-controlled health care cooperatives in facilities previously managed directly by the CCSS.

**Description of Intervention.** In three primary care clinics that covered between 50,000 and 100,000 people, the health workers formed cooperatives that were autonomous legal entities that assumed responsibility for managing the existing clinic. They were obliged to provide the same services as the publicly managed clinics, were not allowed to charge fees, and could obtain inputs (such as drugs and medical supplies) from the CCSS or from the market. Legally, all the workers in the cooperatives became shareholders, and the cooperatives had full autonomy in the use of funds received from the CCSS, contracting, and management of personnel and resources. In return for funding from the CCSS, the cooperatives were required to follow the guidelines and policy objectives of the CCSS and the Ministry of Health. They were responsible for providing general outpatient primary care, including pharmaceuticals, laboratory and radiology, minor surgery, some specialized medical services, dental care, and emergency services.

**Contracting Arrangements.** The cooperatives received payments based on the population of their catchment areas. This then shifted to the use of historical budgets, and in the end the cooperatives functioned under management contracts in which targets for service production and coverage were set. The cooperatives were obliged to provide annual financial reports to the CCSS for audit purposes but could retain all earnings and assumed all losses from their operations. The cooperatives were required to evaluate their own performance, but the CCSS also appointed independent auditors to monitor the cooperatives.

**Evaluation Methodology.** Data were available for 21 CCSS-managed clinics and three cooperatives from the annual statistical bulletin of the CCSS from 1990 to 1999. Demographic data were available from the census and from regular studies carried out by the CCSS. Hence, this was a time series analysis comparing the cooperatives since their establishment with all the CCSS-managed clinics.

**Results.** The cooperatives provided more general, specialist, and emergency visits per capita than the CCSS-managed clinics (see table C.9). At the same time, the cooperatives provided fewer medicines per visit, which likely reflects improved quality of care in a region where polypharmacy is seen as a widespread problem. A regression analysis that controlled for the socioeconomic conditions in the community demonstrated that the cooperatives provided 22 percent more general visits and 42 percent more dental visits per capita, while reducing the annual per capita expenditure by about \$11.

**Comments.** When worker-owned cooperatives took over CCSS-managed clinics, this appears to have increased the level of service delivery while reducing costs, implying a large increase in efficiency. This pilot was done on a relatively small scale involving 150,000 to 300,000 beneficiaries. Unfortunately, limited data are available on technical quality of care or patient perceptions. Nonetheless, the approach provides an interesting model for improving the performance of publicly financed health services. As a result of the experience of using

**Table C.9** Comparison of Cooperatives and CCSS-Managed Clinics, 1990–99

<i>Indicator</i>	<i>Clinic type</i>	<i>1990</i>	<i>1995</i>	<i>1999</i>
General practitioner visits per capita	Cooperative	1.45	1.77	1.84
	CCSS	1.41	1.33	1.02
Specialist visits per capita	Cooperative	0.57	0.45	0.48
	CCSS	0.54	0.55	0.32
Emergency visits per capita	Cooperative	0.39	0.39	0.47
	CCSS	0.16	0.32	0.41
Medicines provided per patient visit	Cooperative	1.67	2.03	2.08
	CCSS	3.04	3.11	3.08

*Source:* Based on Gauri, Cercone, and Briceno (2004).

*Note:* CCSS = Centro Costarricense de Seguridad Social.

cooperatives, the CCSS has now transferred responsibility for other health facilities and health zones to other NSPs. (More information on this case is available in Gauri, Cercone, and Briceno 2004.)

## **Case 8. Global Fund Support for AIDS, Tuberculosis, and Malaria Control Services**

**Background.** By the end of 2006, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) had provided \$6.8 billion worth of grant financing to countries to control these diseases. Based on proposals received from country-coordinating mechanisms (CCMs), the Global Fund uses an independent technical review panel to assess whether the proposal should be funded. The most common “principal recipients” of Global Fund resources are government ministries or national programs, church groups, NGOs, or the United Nations Development Programme. Given the large amount of money disbursed and the large number of grants the Global Fund has financed, the performance of the principal recipients can be assessed.

**Description of Intervention.** The Global Fund uses a grant-making approach in which a broad array of groups can apply based on their perceptions of need. The CCM mechanism allows NGOs an opportunity to submit proposals so that governments are not the only entities that can apply. Although Global Fund financing should be seen as more of grant than a contract, there is a specific agreement negotiated on what is supposed to be achieved and how success will be measured. Also, the CCM ensures that there is a broad discussion of the needs of the specific country.

**Contracting Arrangements.** Most of the grants are for five years, but after two years the Global Fund classifies the performance of the grants into four categories: (A) meeting or exceeding expectations, (B1) adequate, (B2) inadequate but potential shown, or (C) inadequate. The board of the Global Fund decides, based on the category, whether to continue the funding as is, continue the funding if the recipient meets certain conditions, continue the funding only if targets and budgets are substantially modified, or discontinue the grant. The categorization is based on (1) an appraisal of results comparing services delivered with targets specified in the grant agreement, (2) an assessment of progress on procurement and monitoring and evaluation, and (3) a review of the

country context, including conflict and natural disasters. The Global Fund usually uses a local fund agent (LFA) to carry out financial management, and the LFA is usually the local office of an international auditing firm.

**Evaluation Methodology.** In 2006, the Global Fund had evaluated the first two years of 134 grants to individual countries. The performance of the grants was assessed according to the classification made by the Global Fund. A multivariate analysis was carried out examining a large number of predictor variables, including whether the principal recipients were a government or a nongovernmental entity, size of the grant, context of the country such as size of the economy, performance of the health system in the country, and a host of other variables.

**Results.** Of the 134 grants studied, 21 percent were classified as A, 54 percent were classified as B1, and 25 percent were classified as B2 or C. Taking into account all the other factors studied, grants in which the principal recipients (PRs) were government ministries or national programs were 16.7 percent less likely to be classified as A than those in which the PRs were nongovernmental entities ( $p < 0.05$ ). Conversely, grants in which the PRs were government entities were 16.8 percent more likely to be classified as B2 or C ( $p < 0.01$ ). The finding that programs with government principal recipients receive weaker evaluation scores is consistent with previous studies regarding the speed of disbursement.

**Comments.** This case is essentially a cohort study of Global Fund proposals that were actually funded. Its strength comes from the relatively large number of grants examined. The authors of this study conclude that the results “should encourage countries to facilitate programs with nongovernment actors alongside government programs.” Although the Global Fund grants left program design up to the NSPs submitting proposals, the other aspects of the grants look like contracts as they are governed by specific agreements. (More details on this case are available in Radelet and Siddiqi 2007.)

### Case 9. Guatemala: Rural Primary Health Care Services

**Background.** As part of peace accords ending many years of civil war, the government of Guatemala (GOG) was obliged to improve the delivery of health services rapidly to the indigenous people who make

up about half the population. The indigenous communities, many in mountainous areas, suffered from infant mortality rates that were much higher than the national average and had limited access to PHC services. The GOG concluded that it would be difficult to expand the government health care system rapidly to meet its obligations. This, combined with the indigenous community's lack of trust in the government and the presence of a large number of NGOs working in the rural areas, led to a large-scale effort by the GOG to work with NGOs to improve PHC.

**Description of Intervention.** The GOG, using funds from the Inter-American Development Bank, contracted with NGOs to deliver a defined package of PHC services focused on maternal and child health as well as communicable disease control. The services were to be provided to the mostly indigenous populations living in mountainous areas in the north of the country and used three models: (1) a service delivery type of contract (called the “direct” model) in which NGOs provided services themselves although they sometimes worked with other NGOs who provided administrative support, (2) a management contract (or “mixed” model) in which an NGO administered the health services within the existing MOH system, and (3) a control group (the “traditional” model), which was essentially the traditional mode of delivery via publicly operated clinics. The contracting effort began in 1997 and was considerably scaled up beginning in 1998 and continued to expand. It now covers about 27 percent of the entire population, more than 3.5 million people. The contracts with the NGOs each covered an area with about 10,000 people and were fixed-price at \$6.25 per capita per year.

**Contracting Arrangements.** The initial groups of NGOs were selected based on their previous experience and presence in target areas, and without much competition. However, over time the process became more competitive and based on the quality of the technical proposals submitted by NGOs. By 2002, there were 160 contracts with 88 NGOs, and contract monitoring was done mostly at the district level. Payment of contractors was done centrally and, despite efforts to improve it, has remained an issue. A few NGOs decided not to participate in subsequent rounds of contracting because of delayed payment.

**Evaluation Methodology.** No baseline data were available for this intervention; however, three years after the contracting process began (in 2000), household surveys were carried out in randomly selected



areas implementing the three different approaches. Unfortunately, the areas implementing the service delivery contracts appear to have been more isolated and had less physical access to services than the other experimental groups (see table C.10). The management contract and control areas sampled appeared to be quite similar.

**Results.** Preliminary results from the household survey found that the management contracts achieved the best results in prenatal care, immunization, and receipt of oral rehydration salts (ORSs) by those young children with diarrhea (table C.11). The management contracts resulted in a median 11 percentage point (range from 5 to 16 percentage points) difference in the coverage of services when compared with the control group (that is, traditional government provision of services). The success of the service delivery contracts is difficult to evaluate because they were implemented in more remote and difficult areas compared with the two other groups, and no baseline data are available by which to judge changes over time.

**Comments.** Contracting with NGOs using management contracts appears to have been somewhat more successful than government provision of services; however, the lack of baseline data makes it difficult to be sure of the actual effect size. The effectiveness of the service delivery contracts is difficult to assess because they were implemented in more remote areas and no baseline is available. The rapid expansion of the contracting effort and its continuation despite a change of government suggest that the contracting approach is sustainable in

**Table C.10** Characteristics of the Areas Implementing the Different Approaches Used in Guatemala (Percent)

<i>Household characteristic</i>	<i>Control</i>	<i>Management contract</i>	<i>Service delivery contract</i>
Mayan speaking	96	95	98
Illiterate	60	65	62
Households with MOH facility less than 10 km away	70	80	44
Households with MOH facility more than 21 km away	11	8	24

*Source:* Based on Danel and La Forgia (2005).

*Note:* MOH = Ministry of Health.

**Table C.11** Results of the Different Approaches to Service Delivery in Guatemala (Percent)

<i>Parameter</i>	<i>Control</i>	<i>Management contract (MC)</i>	<i>Difference MC-control</i>	<i>Service delivery contract</i>
Coverage of prenatal care	75	87	12	78
Coverage of tetanus toxoid among pregnant women	63	68	5	57
Coverage of DPT3 immunization among children	69	80	11	63
Coverage of measles immunization among children	54	61	7	51
Coverage of oral rehydration therapy among children with diarrhea	39	55	16	36
Median difference from control		11		-3

*Source:* Based on Danel and La Forgia (2005).

*Note:* DPT3 = third dose of diphtheria/pertussis/tetanus vaccine.

this context. Contracting was also successful despite difficulties with contract management. (More information is available in Danel and La Forgia 2005 and La Forgia, Mintz, and Cerezo 2005.)

### **Case 10. Haiti: Performance Bonuses for NGOs Providing Primary Health Care**

**Background.** After conflict and neglect had seriously diminished the government of Haiti's ability to deliver health services, in 1995 USAID began support to NGOs providing primary health care in rural areas. However, household surveys conducted in 1997 found a very large variation in the coverage of basic services provided by NGOs. For example, vaccination coverage varied from 7 to 70 percent of children 12–23 months of age, and expenditure per visit, which ranged from \$1.35 to \$51.93, was not correlated with performance. The unevenness in success on the ground led to a consideration of different approaches to paying NGOs, which had previously been paid on the basis of inputs. Nongovernmental organizations had been reimbursed for actual

expenditures up to a negotiated amount regardless of what they actually accomplished.

**Description of Intervention.** Nongovernmental organizations were offered the opportunity to receive 95 percent of their original contract amount in exchange for the opportunity to receive performance bonuses worth 10 percent of the contract amount if they achieved agreed-on targets for service delivery. The performance-based contracts were based on lump-sum payments rather than reimbursements of actual expenditures. Seven specific indicators of service delivery were chosen, including vaccination coverage, coverage of prenatal care (at least three visits), and use of oral rehydration therapy (ORT). A proportion of the bonus was provided to the NGO if it met the agreed-on target for each indicator (for example, 25 percent of the bonus if it achieved the target for immunization, or 20 percent if it achieved the prenatal care target). The targets were negotiated based on results of a baseline survey. Two indicators, one related to waiting time in clinics and another to community participation and coordination with the MOH, were subsequently dropped because they either were not a valid indicator of performance or were difficult to measure.

**Contracting Arrangements.** Over the course of a few years, most of the NGOs providing primary health care with USAID financing shifted to performance-based contracts. The change to performance-based contracts resulted in less administrative burden for the NGOs. It is not clear whether contract management was easier, but it certainly meant a shift from tracking inputs to tracking outputs through improved monitoring. Payment of the NGOs was timely.

**Evaluation Methodology.** Baseline data on coverage rates were available from a demographic and health survey in 2000. Subsequent data on the key indicators were obtained from the HMIS but were independently verified through a data audit.

**Results.** As the percentage of NGOs being paid on a performance basis (offered performance bonuses if they achieved specified results) increased, the coverage of these services also increased (see table C.12).

**Comments.** The effects of performance bonuses on NGO achievements appear to have been quite positive. That there was a “dose response,” that performance increased as the number of NGOs paid by performance-based financing increased, provides good evidence of the

**Table C.12** Performance of NGOs in Haiti as Use of Bonuses Increases (Percent)

<i>Indicator</i>	<i>2000</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>
Children fully vaccinated	34	65	91	92	100
Women received at least three prenatal visits	29	50	41	48	60
Deliveries assisted by skilled attendant	58	64	57	63	77
NGOs paid on performance basis	0	35	37	44	93

*Source:* Based on Eichler and others (2006).

*Note:* Data from 2000 from Demographic and Health Survey; data for 2002 to 2005 from audited management information system.

effect of this approach. The change to lump-sum contracts could also have contributed to the improved performance. Performance-based contracts have now been expanded to the point where they cover about 1.3 million people. (For more information see Eichler and others 2006.)

### **Case 11. Eight Countries: Tuberculosis Control Using Private Providers**

**Background.** National tuberculosis programs (NTPs) in many developing countries have concentrated on the provision of TB diagnosis and treatment in the public sector. However, a large proportion of patients, including the poor, seek care for TB symptoms from private health care providers. There has been concern that these private practitioners provide care of questionable quality at high cost to the patient. In an effort to improve TB diagnosis and management, an increasing number of NTPs are implementing “public-private” initiatives, whereby they provide TB drugs to private practitioners in exchange for the latter complying with national standards of TB care. In half the 14 such initiatives evaluated thus far, NGOs have been used by the NTPs as intermediaries. The efforts of the NTPs provide an opportunity to look at two types of contracts: the so-called soft contracts with private providers and the more formal agreements that NTPs sometimes have with NSPs to act as intermediaries.

**Description of Intervention.** In all the initiatives evaluated, private providers were trained in the NTP guidelines on diagnosis, treatment, and patient management. In 13 of the initiatives, drugs were

provided free from the NTPs to the private practitioners on the condition that they (1) follow recommended diagnostic procedures and treatment regimens, (2) dispense the drugs free of charge to patients, and (3) follow national standards for referral, recording, and reporting. In one initiative, drugs were provided through an NGO at a subsidized rate to the for-profit providers. In those situations in which NTPs used NGO intermediaries, the latter were usually responsible for sensitization, training, supervision, and monitoring of the individual providers. The intermediaries included national branches of international NGOs, a charitable hospital, a medial association, research institutions, and a national TB association.

**Contracting Arrangements.** These “drugs for performance contracts” were always verbal in nature, although certificates or signposts stating that the provider had been “accredited” by the NTP were used in some cases. Direct monetary incentives were used in one initiative, and none of the initiatives used formal competitive tenders. The contract could be ended either by the private provider or by the NTP (or the intermediary NGO) withholding further drug distribution. In all 7 of the 14 evaluated initiatives that involved NGOs as intermediaries, a formal agreement with the NTP defined the division of roles and responsibilities. Two had contractual agreements detailing payments made by the NTPs to the not-for-profit organizations, and the not-for-profit organizations contributed their own financial resources in four other cases.

**Evaluation Methodology.** The 14 initiatives used different methodologies, but most involved before-and-after designs with information available from the routine recording and reporting system. In a number of cases, these data were reviewed by independent experts. Information was available on the number of new sputum smear positive (NSSP) tuberculosis cases, NSSP treatment success, NSSP default rate, and change in the NSSP case detection rate.

**Results.** Combining all the studies, the private practitioners were able to achieve a treatment success rate (that is, NSSP cases were treated in accordance with successfully completed directly observed therapy–short course [DOTS] treatment) of 89.6 percent (range 75 percent to 96 percent). The change in case detection rates attributable to the collaboration with private practitioners was evaluated in eight studies and ranged from 9 to 36 percent with a median of 16.5 percent (see table C.13).

**Table C.13** Results from 14 Evaluated Initiatives

<i>Name of project</i>	<i>Number of NSSP cases evaluated</i>	<i>NSSP treatment success (95% CI)</i>	<i>NSSP default rate (95% CI)</i>	<i>Change in NSSP case detection</i>	<i>Involvement of NGO intermediary</i>
Damien Foundation, Bangladesh	14,035	90 (90–90)	NE	NE	Yes
Hyderabad, India	908	96 (95–97)	5 (4–6)	NE	Yes
Yogyakarta, Indonesia	386	75 (71–79)	NE	NE	No
Katmandu Valley, Nepal	309	92 (89–95)	1 (0–2)	15%	Yes
Mumbai, India	296	81 (77–85)	12 (8–16)	11%	Yes
Dhaka, Bangladesh	263	93 (90–96)	4 (2–6)	10%	No
Delhi, India	168	81 (75–87)	14 (5–23)	36%	Yes
Mandalay, Myanmar	114	90 (88–93)	5 (3–8)	28%	No
Ho Chi Minh City, Vietnam	107	61 (52–70)	34 (25–43)	18%	No
Yangon (SQH Franchise), Myanmar	99	84 (77–91)	8 (3–13)	9%	Yes
Kannur, India	85	92 (86–98)	5 (0–10)	19%	No
Nairobi, Kenya	55	84 (74–94)	5 (0–11)	NE	Yes
Makati, Philippines	37	84 (72–96)	5 (0–12)	NE	No
Yangon (Shwepyitha), Myanmar	32	88 (77–99)	3 (0–9)	NE	No

*Source:* Based on Lonroth, Uplekar, and Blanc (2006).

*Note:* CI = contracting in; NE = not evaluated; NSSP = new sputum smear positive.

**Use of an NGO Intermediary.** The seven initiatives in which NGO intermediaries were used achieved a NSSP treatment success rate of 90.1 percent (95 percent, CI: 89.6–90.5) compared with an 82.0 percent (95 percent, CI: 79.4–84.2) in those cases in which the NTP itself managed the collaboration with private providers. Similarly the default rate was significantly lower in the cases with NGO intermediaries than

those cases without (6.4 percent versus 9.4 percent, respectively). There was not a statistically significant difference when it came to changes in case detection rates, but the data on this indicator cannot be calculated from all the studies.

**Comments.** The results of this review indicate that working with private practitioners can achieve high rates of treatment success and increase case detection rates. Using an NGO intermediary appears to increase the chances of success and yields a higher treatment success rate. The 14 examples of working with private providers have been in place for between 3 and 12 years, and 12 of the initiatives have been continued. The only two that were not sustained were those run by NTPs themselves. More than 40 such initiatives are now being implemented in 15 countries, which suggests that the approach is spreading. (More information is available in Lonnroth, Uplekar, and Blanc 2006 and Murthy, Frieden, and Yazdani 2001.)

## Case 12. Pakistan: Rural Primary Health Care Services

**Background.** There is a widespread feeling in Pakistan that first-level facilities known as basic health units (BHUs) are providing only a limited amount of services to the rural population despite the investment of large amount of resources in their construction, staff, equipment, and supplies. Based on ideas from a well-placed “champion” in the government of Punjab, the district government in Rahim Yar Khan (RYK) decided to have its BHUs managed by a local NGO.

**Description of Intervention.** In a poorly performing district of Punjab, an NGO, the Punjab Rural Support Program, was given a management contract to run all the BHUs and considerable autonomy to implement changes in organization and management. The NGO was also given the same amount of budget as had previously been allocated for the BHUs. The NGO quickly introduced innovations, including (1) recruiting managers at market salaries and holding them accountable for results; (2) addressing the shortage of doctors and high rates of absenteeism by increasing the salaries of selected doctors by 150 percent, who then had to cover three different BHUs instead of one; and (3) improving the supply of drugs available in the BHUs without increasing the budget. The RYK district comprised 104 BHUs and about 3.3 million people.

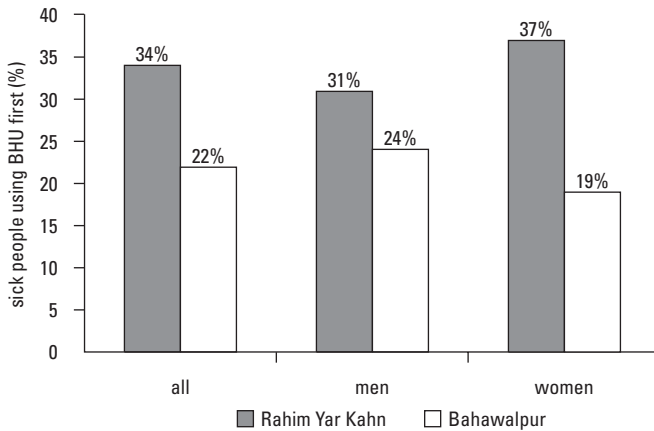
**Contracting Arrangements.** The NGO was well known in the Punjab and signed a memorandum of understanding with the district government. It received a monthly tranche of funds based on the same annual allocation as had previously been provided to the local health authorities. The NGO had to provide the government with the same standard reports as providers in other districts.

**Evaluation Methodology.** Before data collection, the independent evaluation team formed a hypothesis that curative services in the BHUs had improved as a result of the experiment but that preventive services would be little affected. The evaluation used a retrospective, controlled, before-and-after design, with a nearby, similar district, Bahawalpur (BWP), serving as the “control” area. An independent firm carried out health facility assessments in 20 randomly selected BHUs in RYK and another 20 BHUs in BWP. Household surveys were also carried out in the village closest to each BHU and in another village randomly selected from the BHU’s catchment area.

**Results.** Based on household survey results and HMIS data, it appears that use of the BHUs was more than 50 percent higher in RYK than in BWP (see figure C.4). Women and children under five who were sick in the last month were significantly more likely to use BHUs in RYK than in BWP, and there was less use of unqualified providers (7 percent and 16 percent, respectively). There was no difference in use of BHUs in the two districts among the poorest third of the population. Levels of community satisfaction also appear higher in RYK, with 40 percent of survey respondents indicating there had been an improvement in BHU services compared with the two years before the survey (before the NGO took over), whereas the comparable figure was only 12 percent in BWP. The health facility survey found that the physical condition of BHUs in RYK was much better than those in BWP. Out-of-pocket expenditures for BHU services were found to be lower in RYK than in BWP. The coverage of preventive services, such as prenatal care and immunization, is low in both districts, and the rates of progress appear to be similar. This was expected because the management of female health workers, vaccinators, and other outreach workers was not given to the NGO.

The intention had been that the Punjab Rural Support Program (PRSP) would be given the same budget to operate the BHUs as had been allocated the previous year. In fact, the budget allocations between the year before PRSP took over (2002–03) and the year after



**Figure C.4** Use of BHU by Respondents Reporting Illness in the Last Month

Source: Loevinsohn and others (2006).

Note: All differences between districts are statistically significant ( $p < 0.05$ ); the differences between men and women in a district are never significant.

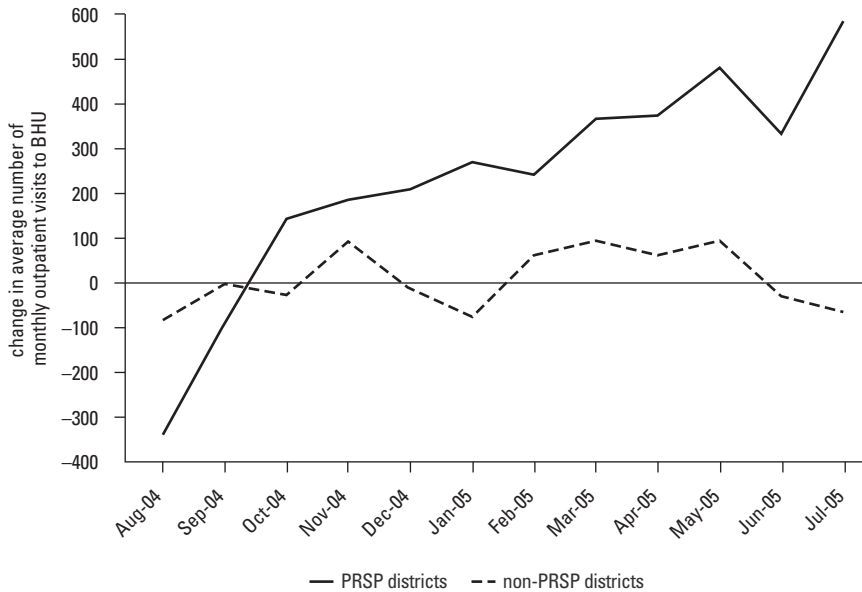
it took over (2003–04) were quite similar. The cost per patient visit in RYK was less than half of what it was in BWP.

**Comments.** The original hypothesis, that the contracting approach would improve BHU services, appears to be confirmed. Contracting resulted in an improvement in BHU use, patient satisfaction, physical condition of the BHUs, and reduced out-of-pocket expenditure for BHU services. These improvements were accomplished at lower absolute cost and a considerably lower cost per visit than in BWP. The RYK model has already been expanded to 12 other districts in Punjab at the request of their district governments (see figure C.5) with good results. The approach is now being expanded to all the other provinces in Pakistan. (More information on this case is available in Loevinsohn and others 2006.)

### Case 13. Madagascar and Senegal: Community Nutrition Services

**Background.** Because of worsening economic conditions, the rates of severe and moderate malnutrition were increasing in Senegal and Madagascar, as in much of the rest of Sub-Saharan Africa in the 1990s. Both countries had seen very little involvement by the government in

**Figure C.5** Change in the Average Number of Outpatient Visits to BHUs per Month, Compared with Same Month of Year before in NGO (PRSP)-Managed Districts and Government-Managed Districts



Source: Loevinsohn and others (2006).

Note: For any given month, the number of visits in the same month of the year before is subtracted from the number of reported visits to calculate the change. PRSP = Punjab Rural Support Program.

addressing nutrition issues, and the limited experience there to date had not been successful. To address worsening nutritional status, both governments wanted to work with NGOs to implement community-based nutrition interventions.

**Description of Intervention.** In Madagascar and Senegal, the governments used World Bank and World Food Program resources to contract with NGOs to deliver community-based nutrition interventions. The projects were launched in poor periurban areas of Senegal and rural areas in Madagascar and reached 457,000 and 490,000 women and children, respectively. Both projects provided monthly growth monitoring, weekly nutrition education to mothers, food supplementation for malnourished children, and referral to health services for unvaccinated children, pregnant women, and severely malnourished children. The cost per direct beneficiary was \$48 in the Senegal project and \$15 in Madagascar. In Senegal, the community

nutrition activities were undertaken by more than 300 small groups of unemployed youths who received training and supervision from an NGO. In Madagascar, 50 NGOs were directly responsible for service delivery, and they hired local community nutrition workers to help in the villages.

**Contracting Arrangements.** In Senegal, overall management of the project was carried out by Agence d'Exécution des Travaux d'Intérêt Public (AGETIP), a parastatal organization (although legally an NGO) with considerable experience in contract management in a number of sectors. AGETIP contracted with local NGOs, which trained the youth groups that provided the community services. Supervisors were hired mainly from among unemployed medical doctors. In Madagascar, the NGOs contracts were managed by a body in the office of the president. Both projects had to comply with MOH standards and policies. It appears that contract management was done well in both countries and that NGOs were paid on time.

**Evaluation Methodology.** In Madagascar, only project records on participants were available. In Senegal, the project was evaluated using a before-and-after design based on household surveys. There were also nonproject (control) communities in Senegal; however, these neighborhoods were “contaminated” by a large proportion of children who participated in the program. An independent study examined the coverage of monthly growth monitoring in one Senegalese city.

**Results.** Before-and-after surveys in one project community in Senegal found that severe malnutrition among children 6–11 months old declined from 6 percent to 0 percent in 17 months, and moderate malnutrition among children aged 6–35 months declined from 28 to 24 percent. The independent study showed that monthly growth monitoring attendance was 72 percent in project neighborhoods compared with 35 percent in nonproject neighborhoods. The project records in both Senegal and Madagascar found that there was a 20 to 30 percentage point reduction in malnutrition rates among cohorts of project participants.

**Comments.** The results of the before-and-after evaluation in Senegal suggest that the project may have had a modest effect on malnutrition rates as a result of effective implementation of community nutrition interventions. However, the absence of a control group makes it difficult to be certain about the actual effect size. From a contracting point of view, the NGOs appeared to have done a good job in

implementing the program as designed; however, it is unknown how well the government would have done. Both governments continued the NGO nutrition efforts, albeit in different formats. One important aspect of the Senegal experience was the use of a large number of small groups of unemployed youths to deliver community services in their own communities. (More details on this case are available in Marek and others 1999.)

### **Case 14: India: Improving Quality of Care from Private Providers in Bihar**

**Background.** Bihar suffers from the third-highest level of under-five mortality among the states in India. Much of it is due to common childhood diseases, such as acute respiratory tract infections (ARIs) and diarrhea. It is believed that 85 percent of cases of such childhood diseases are treated by private practitioners, many without formal training, and there is widespread concern that the quality of care provided by these practitioners is very poor. The government of India, with assistance from the World Health Organization (WHO), developed guidelines for management of common childhood illnesses. A major challenge is how to get private practitioners to employ these guidelines and therefore improve the quality of care they provide.

**Description of Intervention.** With funding from USAID, three local NGOs were recruited to identify local private practitioners who were treating childhood illnesses and provide them with training and follow-up aimed at improving case management based on WHO guidelines. The intervention took place in 110 villages with a population of 54,000 located in two districts of Bihar. The female literacy rate was less than 20 percent. Using community health workers (CHWs) to interview parents, 67 private practitioners were identified and provided support using a model called information feedback contracting and ongoing monitoring (INFECTOM), which comprised *IN*formation on case management, *FE*edback on their current practices, agreeing to an informal *Con*tract by which they would comply with the WHO case-management guidelines, and *Ongoing* Monitoring of their practices by the CHWs. The private providers received no remuneration or expenses for participating in the intervention. The cost of the intervention is estimated to be \$15 per capita per year.

**Contracting Arrangements.** Two types of contracts were used, one with the NGOs who provided training, outreach, and monitoring, and another series of “subcontracts” between NGOs and providers for changing their practice behaviors. The NGOs submitted applications for financing to USAID and were reimbursed on the basis of expenses. The “contracts” with the private practitioners were managed by the CHWs and the NGOs.

**Evaluation Methodology.** This study used a before-and-after design in which household surveys, called verbal case reviews (VCRs), were undertaken with the parents of children under five who had ARI, diarrhea, or fever in the previous two weeks. At baseline, 600 VCRs were carried out by CHWs, and seven months after implementation of the INFECTION intervention, a follow-up survey of 300 parents using the VCR was carried out.

**Results.** A large improvement was seen in the management of childhood illnesses by private practitioners in the area covered by the intervention, ranging from 25 to 57 percentage points on selected indicators. As can be seen in table C.14, improvements were achieved in both those behaviors private practitioners did well and those in which they did not before the training.

**Comments.** This relatively small-scale before-and-after study tested an interesting approach in using NGOs to change the behaviors of private practitioners. Although the changes were large and likely of practical importance, the short time frame, seven months, makes it difficult to know whether these behavior changes were maintained for a significant period. (More details on this case are available in Chakraborty and Frick 2002.)

**Table C.14** Change in Private Provider Behaviors

<i>Practitioner behavior</i>	<i>Before intervention (%)</i>	<i>After intervention (%)</i>	<i>Change (%)</i>
Used watch or timer to measure respiratory rate	14	71	57
Recommended ORS for diarrhea cases	16	48	32
Asked about history of illness	60	93	33
Touched child as part of examination	71	96	25

*Source:* Based on Chakraborty and Frick (2002).

*Note:* ORS = oral rehydration salt.

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# Terms of Reference for a Third-Party Evaluation of the Contracting Effort in Country X

## Background

This example is based on the contracting effort described in appendix A, which would serve as the background for these terms of reference.

**Pilot Test of Public-Private Partnership (PPP).** The Government of Country X (GOX) is interested in evaluating whether this type of PPP can achieve the following objectives:

- Significantly strengthen primary health care in primary health care centers (PHCCs) and their associated catchment areas to ensure the widespread delivery of a standard package of preventive, curative, and promotive services that will help improve the health and well-being of Country X.
- Dramatically improve the (1) coverage and use of services, (2) quality of care, and (3) equity of access to services by geographical areas, income levels, and women and children.
- Ensure that patients and communities are increasingly involved and satisfied with the publicly financed health services and facilitate the community's participation in the design, delivery, and evaluation of health services.

A third-party firm or organization is required to design, conduct, and analyze the baseline and follow-up studies that will evaluate the PPP pilot test.

## Objectives and Design of the PPP Effort

**Indicators of Success.** Achievement of the above objectives will be assessed by the indicators and targets described in table A4.1. By the end of the four-year period covered by PPP, it is expected that the significant progress will have been made toward the targets in table A4.1. These targets may be revised as data become available and are meant to be indicative rather than exact. What matters is significant progress along these parameters.

**Evaluation Methodologies.** The achievement of the indicators in table A4.1 and certain other aspects of health care (such as community satisfaction, health expenditures, use of unqualified providers) will be assessed using the following methodologies:

- **Household surveys.** In each of the 10 PPP lots and 10 comparison areas, household surveys will be carried out. The baseline survey will be done as soon as possible, with a midterm survey in July 2011, and the endline survey in June 2014.
- **Health facility assessments.** An in-depth health facility assessment will be carried out annually among a random sample of health facilities in PPP districts and comparison areas. The assessment will examine the quality of care, broadly defined, and other related indicators such as staff morale.
- **Health management information system.** Health management information system data will be used by the provincial health departments to monitor, on a monthly basis, the performance of the PPP and the comparison PHCCs.

## Objectives of the Consultancy

This consultancy aims to (1) design, conduct, and analyze the different types of studies needed for judging the effectiveness of the PPP in

improving health services in Country X; (2) design the overall evaluation such that it provides the strongest evidence for decision makers; and (3) build the capacity of the Ministry of Health (MOH) to conduct, analyze, and use such information.

**Table D.1** Key Performance Indicators and Targets

<i>Indicator</i>	<i>Baseline<sup>a</sup></i>	<i>Approximate target</i>	<i>Means of measuring indicator</i>
Number of consultations per person per year provided by the PHC and its outreach activities	0.3	1.0	HHS and HMIS
Contraceptive prevalence rate: couples of reproductive age currently using a modern family planning method	9%	15%	HHS
TB case detection rate (number of sputum-positive cases detected as % of target based on estimated prevalence, that is, case finding)	26%	45%	HFA and HMIS
Children 6–59 months who have received vitamin A supplement within last 6 months	36%	55%	HHS and HMIS
Vaccination: measles immunization coverage before 12 months of age among children 12–23 months of age	28%	50%	HHS and HMIS
Coverage of antenatal care: pregnant women receiving at least one antenatal care visit from a skilled provider	22%	50%	HHS and HMIS
Proportion of births attended by skilled attendants (includes institutional delivery but excludes trained TBAs)	14%	25%	HHS and HMIS
Score out of 100 on an index of quality of care as judged by third party, which includes the adequacy of waste management	46	70	HFA
Improved equity: ratio of poorest to richest income quintiles (based on asset index) on number of consultations	0.42	0.60	HHS

*Source:* Author.

*Note:* HFA = health facility assessment; HHS = household survey; HMIS = health management information system; PHC = primary health care; TB = tuberculosis; TBA = traditional birth attendant.

a. Baseline data are approximate and will have to be updated.



## Scope of Services

The selected firm/organization (the consultant) will work closely with the GOX and under the direction of the GOX's task manager to carry out the following:

- Carefully discuss the PPP pilot with the GOX staff and provide an evaluation design that provides the information necessary to judge the effectiveness of the PPP intervention.
- Develop household survey instruments that build on international best practice in measuring use of health services, health outcomes, satisfaction with care, cost to consumers, and quality of care.
- Also building on international best practice, develop the instruments and methods for a health facility assessment that examines quality of care broadly defined, and other related indicators, such as patient satisfaction and staff morale.
- In consultation with the GOX, determine the sample sizes required to attain reasonable statistical power.
- Ensure that the household and health facility instruments are discussed with the GOX and subjected to peer review, after which they will be field-tested and modified accordingly.
- Maintain the schedule agreed on during negotiations for carrying out the baseline surveys expeditiously.
- Ensure that surveyors are properly trained and supervised. Design and implement a quality assurance mechanism for data collection and entry acceptable to the GOX.
- Enter and clean the data using best-practice techniques and prepare the data for analysis, including getting the data in a state where the data could be made publicly available on a Web site.
- Analyze the baseline data and prepare a concise and user-friendly report for the GOX and other stakeholders, including the private sector partners. Carry out such additional analysis as the stakeholders reasonably request to make use of the data.
- Repeat the household survey and conduct a health facility survey 18–24 months after the baseline evaluation using the same meth-

odology and instruments. Although questions may be added to address key issues that arise during the study, only in unusual circumstances would questions in the baseline surveys be dropped.

- Analyze the endline data and prepare a concise and user-friendly report evaluating the whole experiment for the GOX and other stakeholders, including the private sector partners. Carry out such additional analysis as the stakeholders reasonably request to make use of the data.
- Develop an explicit plan, acceptable to the GOX, for building the capacity of GOX staff and decision makers in the design, conduct, and analysis of household and health facility surveys.
- Implement the capacity-building plan with due attention to quality and timeliness.
- Present the data during meetings and workshops set up by the GOX to disseminate the results of the study. Prepare the results for publication in the international health literature.
- Carry out such tasks as the GOX's task manager reasonably requests to ensure efficient, high-quality, and expeditious design, collection, analysis, and dissemination of the data.

### **Location and Duration of Services**

The successful firm/organization must maintain a presence in Country X during the baseline and endline evaluations. The exact districts have yet to be determined. It is expected that the consultancy will have a total duration of about 26 months. However, limited work will be needed between baseline and endline assessments.

### **Qualifications and Experience**

The successful firm/organization will have the following qualifications and experience:

- A minimum of five years of experience in evaluating health or other social services, with extensive experience in developing countries

- A successful track record of carrying out high-quality evaluations in developing countries
- Staff who have published articles in peer-reviewed journals on evaluation of health services
- Staff with facility in English, both written and verbal
- A demonstrated ability to get along easily with governments and NGOs and deal successfully with disagreements
- A facility with computers and a variety of software
- Knowledge of country X, which would be an advantage.

### **Services and Facilities Provided by the GOX**

The GOX will take the following actions:

- Provide the firm/organization with relevant information related to the consultancy, such as previous similar evaluations and existing survey instruments and
- Ensure that its staff are available for periodic meetings as needed.

### **Consultant's Responsibilities**

It is the responsibility of the consultant to have its own computers. The consultant will also be expected to provide electronic and hard copies of all materials developed during the consulting assignment. Electronic files should be presented in formats used by common-use software.

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# Terms of Reference Examples

**Reader:** This appendix provides examples of detailed terms of reference that can be used in contracts. The two specific examples deal with delivering primary health care and HIV prevention services among female sex workers.

## Example 1: Primary Health Care

### *Background*

**Health Status.** The health status of the approximately 21 million citizens of Country Y is among the worst in the world. The infant mortality rate is thought to be 140 per 1,000 live births, and a recent study estimated the maternal mortality ratio to be 1,600 per 100,000 live births. The same study indicated that about 74 percent of maternal deaths could have been prevented and that distressingly few of the women who died had access to basic reproductive health services. Only 12 percent had any prenatal care, 11 percent had received tetanus toxoid, 5 percent were delivered by a skilled attendant, and 4 percent had ever used family planning. The nutritional status of children and women is also very poor.

**Limited Access to Basic Health Services.** A recent study of all existing health facilities indicated that most of the population of Country Y does not have access to the basic services that could make a large difference to their health. This has led to low levels of cover-

age for important preventive, promotive, and curative services. For example, routine immunization coverage (diphtheria/pertussis/tetanus) is estimated to be only 19.5 percent. Even that part of the population with access to health facilities is not receiving adequate services because of a lack of trained staff, particularly female staff, and equipment. Seventy-five percent of existing health facilities do not have trained female staff, and the uneven distribution of health workers can be extreme, with one doctor per 100,000 population in Province A and one per 1,000 population in the capital.

**Government Collaboration with NGOs.** The Ministry of Health (MOH) recognizes and appreciates that nongovernmental organizations (NGOs) are already helping deliver much of the primary and hospital health care available to the citizens of Country Y's population. The MOH would like to work collaboratively with NGOs and other private sector organizations to expand rapidly the availability of basic health services, improve the quality of care, build the capacity of citizens of Country Y health workers and managers to deliver the basic package of services (BPS), ensure greater equity in access to health services, ensure smooth coordination between the government and NGOs as well as among NGOs working in the same areas, and strengthen the citizens of Country Y.

**Performance-Based Agreements.** To achieve these objectives the government, through the MOH, would like to enter into performance-based agreements (PBAs) with reputable NGOs, private sector firms, and other organizations (hereafter referred to, for convenience, as service providers) to deliver the BPS. The idea of the PBA is that the MOH will specify a set of basic services (the BPS) that the winning organization will be responsible for delivering in a specific geographical location, Province B. The performance of the organization will be judged against progress on specific, measurable indicators that will be evaluated regularly. Failure to make progress, and ultimately achieve these objectives, will be grounds for remedial action including termination of the contract, whereas there will be bonuses for good performance. The MOH aims to encourage successful innovation. Hence, exactly how these objectives are achieved will mostly be up to the organization selected so long as it complies with the technical guidelines, standards, and laws of the government.

### *Objectives*

The service provider will be responsible for achieving the following objectives:

- Foremost, ensure that the provision of the BPS in Province B is significantly expanded. The service provider is free to provide other services it feels are important (using funds from other sources) in the province, but it must provide all components of the BPS.
- Ensure that the health services provided comply with the quality-of-care standards established by the MOH.
- Pay careful attention to the needs of patients and communities and ensure that they are increasingly involved and satisfied with the publicly financed health services that are available. Facilitate the participation of communities in the design, delivery, and evaluation of health services.
- Ensure that the managerial capacity of MOH staff to successfully coordinate, plan, implement, supervise, monitor, and evaluate the BPS at the provincial level is strengthened.
- Build the technical capacity of citizens of Country Y health staff working in the province to deliver the BPS. Provide preservice training to health workers in line with the human resource development policy of the MOH.
- Support the strengthening of the citizens of Country Y by helping ensure that the community views the services as being provided through government efforts (that is, that credit for service delivery is shared with the MOH).
- Ensure effective and efficient coordination of health activities in Province B through the Provincial Public Health Coordination Committee (PPHCC).
- Deliver services throughout the province, in coordination with other partners through the PPHCC, to ensure equity of access between social classes and among ethnic groups, and increase access to women and children under five.

- Implement innovative interventions identified and agreed to by the MOH (such as diarrhea prevention through the safe water system or novel approaches to health care financing on a pilot basis to test their feasibility in a field setting in Country Y).
- Ensure that health services are focused on the community by using community health workers (CHWs) and carrying out needed outreach and satellite clinic activities.
- Rationalize the number and distribution of health workers in the province in line with the MOH's human resource development policy.

### *Indicators*

By the end of the three-year PBA period, it is expected that the targets described in table E.1 will be achieved. These targets may be revised based on data collected during the baseline household survey (HHS) and health facility assessments (HFAs). Using a standard formula, the various indicators will be combined to yield a single index of overall service provider performance. Table E.2 provides other management indicators for judging success of the service provider.

### *Scope of Services*

**Rapidly Expanding Coverage of BPS.** The service provider selected by the MOH will be responsible for implementing the plan developed in concert with the provincial health department, including mobilizing an adequate number of skilled health workers, providing services to more isolated areas through community-based activities including satellite clinics and outreach activities, and supporting CHWs.

**Identifying Optimal Location of Health Facilities.** As part of its efforts to expand coverage, the MOH will decide on the number of new first-referral hospitals, comprehensive health centers (CHCs), and basic health centers (BHCs) that a province requires (its “envelope”) based on the number of existing facilities, its population, density, and geography. Within the envelope, the provincial health director (PHD) and the service provider will, using a consultative process, determine where exactly the new health facilities should be located and the priority in which they should be built.

**Table E.1** Targets for the PBA

<i>Indicator</i>	<i>Baseline<sup>a</sup></i>	<i>Target for end of project</i>	<i>Means of measuring indicator</i>
Under-five mortality rate	250/10,000	20% reduction	HHS
Maternal mortality ratio	1600/100,000	10% reduction	HHS
Contraceptive prevalence rate: women 15–49 years currently using a family planning method (modern)	5.1%	15%	HHS
Treatment success rate among TB cases detected (cohort analysis)	80%	85%	HFA and HMIS
Children 6–59 months who have received vitamin A supplement within last 6 months	90%	90%	HHS and HMIS
DPT3 coverage among children 12–23 months	19.5%	55%	HHS and HMIS
Provider knowledge score (% correct answers)	51%	70%	HFA
Increase in health facilities with women health workers	24.8%	80%	HFA and HMIS
Number of consultations per person per year	0.23	1.0	HMIS and HHS

*Source:* Author.

*Note:* Targets are meant to be indicative and not exact. What matters is significant progress along these parameters in the project area. DPT3 = third dose of diphtheria/pertussis/tetanus vaccine; HFA = health facility assessment carried out by MOH with assistance from \_\_\_\_; HHS = household survey; HMIS = health management information system; TB = tuberculosis. a. These are nationwide estimates. Estimates for individual provinces have been calculated where possible.

### **Establishing First-Referral Hospitals, CHCs, and BHCs.**

According to its plan, the service provider will have to rapidly establish first-referral hospitals, CHCs, and BHCs using whatever buildings are available and appropriate. This may include renting temporary facilities or houses. As part of establishing hospitals, the service provider will be responsible for ensuring that the province has a functioning referral system.

**Coordinating with MOH, the Community, and Other Service Providers.** The PBA service provider will coordinate its activities with all stakeholders present in the province through PPHCC.



**Table E.2** Management Indicators for the PBA

<i>Indicator</i>	<i>Baseline data</i>	<i>Target</i>	<i>Means of measuring indicator</i>
Coverage of antenatal care: coverage of all pregnant women receiving at least one antenatal care visit	4.6%	35%	HHS and HMIS
Pregnant women receiving at least two doses of tetanus toxoid	31.5%	60%	HHS and HMIS
Births attended by skilled attendants (excluding trained TBAs)	6%	16%	HHS and HMIS
TB case detection rate (number of sputum-positive cases detected as percentage of target based on estimated prevalence, that is, case finding)	23%	50%	HFA and HMIS
Children 6–18 months who received breast milk and appropriate complementary food in the last 24 hours	67.8%	75%	HHS
Children 0–6 who were exclusively breastfed in the last 24 hours	82%	90%	HHS
Proportion of parents able to name spontaneously the danger signs of diarrhea and ARI and the appropriate response	—	50%	HHS and HMIS
Measles coverage among children 12–23 months	75.6%	85%	HHS and HMIS
Score out of 100 on the “balanced scorecard” that summarizes quality of care in BHCs and CHCs	44.8	55	HFA
Decrease in variation between clusters in HHS for coverage of basic services (that is, reduction in variance)	—	50% decrease from baseline	HHS
Number of CHWs per 1,500 population submitting monthly reports	—	2	HMIS

*Source:* Author.

*Note:* Targets are meant to be indicative and not exact. What will matter is significant progress along these parameters in the project area. — = not available; ARI = acute respiratory tract infection; BHC = basic health center; CHC = comprehensive health center; CHW = community health worker; HFA = health facility assessment carried out by MOH with assistance from \_\_\_\_; HHS = household survey; HMIS = health management information system; TB = tuberculosis; TBA = traditional birth attendant.

**Training Health Workers and Ensuring That They Are in Place.** In keeping with the MOH's human resource development plan and the BPS, the service provider will be responsible for ensuring that training and supervision of community midwives (CMWs) are effectively carried out (training may be done in existing accredited CMW schools, but the service provider is responsible for ensuring that an appropriate number of women from the cluster are being trained). Training and supervision of CHWs will also be effectively implemented. The service provider will also be responsible for ensuring that each health facility has at least one female staff trained to provide maternal and child health (MCH) services. Service providers will, where appropriate, give priority to hiring existing MOH staff.

**Ensuring Competency of Health Staff.** The service provider must ensure that all the health workers it employs have minimum competencies in the BPS as judged by tests carried out during the health facility assessments. The service provider will coordinate with the MOH human resource unit to decide how best to do this and how to carry out continuing education.

**Building Capacity of MOH Managers.** The service provider will be responsible for building the capacity of MOH managers, particularly the provincial health director, and selected senior officials under the overall guidance of the central MOH. The service provider will be responsible for ensuring that these selected managers develop, at the least, the knowledge and skills needed for planning, budgeting, data analysis, monitoring, supervising, and evaluating health system performance.

**Recording and Reporting.** The service provider will have to implement the MOH standard recording and reporting system, both the existing health management information system (HMIS) and new forms developed for particular vertical programs. Records will also have to be kept for community-based activities. The service provider will be responsible for providing assistance to the provincial HMIS unit in data collection and analysis, provision of feedback, and transfer of data to central MOH offices.

**Promoting Special Health Activities.** The service provider will have to participate in special MOH activities, such as national immunization days and other mass campaigns. In addition, the service pro-

vider will have to respond appropriately to epidemics and other health emergencies and carry out other such activities in which the MOH is expecting all other provinces to be involved.

**Procuring Drugs, Supplies, and Basic Equipment.** The service provider will be responsible for the procurement of essential drugs (on the MOH's essential drug list) and supplies of acceptable quality from reputable suppliers for the provincial hospital and CHCs and BHCs in keeping with the MOH's emerging pharmaceutical policy. The quality of the drugs might be tested on a random basis during the health facility assessments. The service provider will also be responsible for procuring the basic equipment (such as examining tables and stethoscopes) needed for the temporary CHCs and BHCs that need to be established in the province. Where MOH specifications exist (for example, for furniture) the service provider will be responsible for ensuring that the procured furniture meets the specifications.

**Being Sensitive to the Needs of People with Disabilities.** The service provider will ensure that disabled people can access health facilities and will make best efforts to recruit disabled people as CHWs and auxiliary midwives.

**Improving Waste Management in Health Facilities.** The service provider will be responsible for implementing improved waste management procedures consistent with the MOH's environmental management plan.

### **Location and Duration of Services**

The above-mentioned services will be delivered to the entire population in Province B. The services will be provided over four years, starting approximately March 25, 2009.

### **Compliance with Technical Guidelines**

In carrying out the services described above the contractor will comply with existing MOH technical guidelines and those that are developed during the life of the PBA.

### **Authority and Responsibilities of the Service Provider**

The Service Provider will enjoy sole discretion in the following areas:

- The procurement of drugs, supplies, equipment, and other resources needed to meet contractual obligations
- The use of resources purchased or provided under the PBA contract (however, the NGO will not refuse reasonable requests for the use of such resources by the PHD needed for implementing the BPS)
- Hiring, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the NGO.

The Service Provider is responsible for helping build the capacity of citizen of country Y health workers, including MOH staff. This may involve training or offering alternative opportunities to existing staff at the discretion of the Service Provider. The Service Providers will have the authority to bar MOH staff from clinics that the Service Provider operates, if the Service Provider feels their presence interferes with effective service delivery. The Service Provider will not provide any payments, benefits, or other material resources to the PHD, his or her staff, or families. Any resources needed by the PHD will be provided through the central MOH.

### ***Authority and Responsibilities of Provincial Health Director***

The PHD has the authority to visit Service Provider's facilities at his or her discretion and to obtain such relevant information as to allow proper monitoring and supervision of the Service Provider and its subcontractors. The PHD may convene a meeting with the management of the Service Provider at any mutually agreeable time to discuss and resolve issues related to the PBA and its implementation. The PHD also has the authority to review the quarterly report of the Service Provider and provide additional comments to the central MOH. The PHD will have sole discretion over resources provided to the provincial health office by the central MOH, such as vehicles and communications equipment. However, the PHD will not refuse reasonable requests for the use of such resources by the Service Provider in implementing the PBA. The PHD will not seek from the Service

Provider any payments, benefits, or other material resources for the PHD, his or her staff, or families. The PHD and key provincial staff may be provided a performance-based bonus, if the Service Provider achieves exceptionally good performance and is rewarded with a bonus under the PBA.

## Example 2: HIV/AIDS Prevention Services for Female Sex Workers

**Background.** The HIV situation is changing rapidly in Pakistan. Recent evidence indicates a concentrated epidemic among injecting drug users (IDUs) across the country and among male sex workers (MSWs) and *hijras* (male transvestites) in Karachi. Although HIV prevalence among female sex workers (FSWs) is still below 1 percent, the evidence from various cities indicates high-risk behavior among this group, including low condom use and close interaction and overlap with other high-risk populations, such as IDUs and MSWs. The Sexually Transmitted Infection Survey found that nearly one-third of IDUs and 25 percent of MSWs in Lahore and Karachi had visited FSWs in the past month. Mapping studies further categorizes different subgroups among FSWs. Only a small proportion of FSWs are brothel based; a majority operate from residential localities (*kotbikhana*s) or undertake street-based work, making access to these population groups more challenging and difficult.

Given the evidence of risky behaviors in Pakistan and the experience of other Asian countries, the epidemic is almost certain to spread from IDUs to the commercial sex networks and possibly from there to the general population. The Pakistan Enhanced HIV-AIDS Program that was launched in 2003 with assistance from the World Bank, Canadian International Development Agency (CIDA), U.K. Department for International Development (DFID), and other development partners includes a core component of support to targeted intervention for FSWs, IDUs, and other high-risk groups. The key challenge facing the Enhanced Program is to scale up HIV prevention services to high-risk populations, including FSWs, early enough to contain the epidemic.

The Provincial AIDS Control Program, Department of Health, Government of Pakistan, intends to hire the services of an NGO/organization for the delivery of a defined package of services for FSWs

aimed at controlling and preventing the spread of HIV. The five-year provincewide contract will aim to cover all major cities of the province to ensure coverage of an estimated \_\_\_\_\_ FSWs based on results of mapping studies or outbreak investigations become available. The contract will include provisions for expansion to other urban centers, thereby enabling a flexible response to the emerging epidemic. This approach will have the advantage of easier management with lower transaction costs, more effective use of technical assistance, easier attribution, and greater accountability. Existing contracts for female sex workers that end by December 2008 will fold into this provincewide contract.

The contract will be a lump-sum contract and therefore output based rather than focused on inputs. The selected organization will have considerable autonomy in deciding service delivery mechanisms to achieve project objectives. Payments will be made primarily on the success of the organization in making progress toward the specified targets measured annually by a third party. Other sources of data for judging progress will include the management information system and integrated behavioral and biological surveillance (IBBS). Achievement of results on the ground will be considered of primary importance.

**Objectives.** The objective of this contract is to control and prevent the spread of HIV/AIDS in the FSW population in the Punjab. The contractor will deliver a defined package of services for primary health care, sexually transmitted infections (STIs), sexual and reproductive health, and behavior change services (described in the subsequent paragraphs) that will be provided to all categories of FSWs, including those operating in brothels and residential localities and as street-based workers. The work will be done in close coordination with the Provincial AIDS Control Program and under the technical guidance of the National AIDS Control Program (NACP) during contract execution. Services will be implemented in accordance with written NACP guidelines.

The objectives to be achieved by June 2012 are that (1) HIV prevalence remains below 5 percent among FSWs in the project area (monitored through HIV serosurveillance), (2) syphilis infection is reduced by half from baseline (assessed through HIV serosurveillance), and (3) condom use occurs in at least 60 percent of penetrative sex acts in the project area of FSWs. Table E.3 provides a complete list of indicators.

**Table E.3** Impact, Output, and Process Indicators for FSW HIV Prevention Services Contract

<i>Indicator</i>	<i>Means of data collection</i>	<i>Baseline value</i>	<i>Approximate target<sup>a</sup></i>
Impact indicators			
HIV prevalence among FSWs	• IBBS	1%	< 5%
Prevalence of syphilis among FSWs	• IBBS	To be established	Reduced by 50% from the baseline
Output indicators			
Sampled sex workers using a condom during last penetrative sex act	• IBBS	To be established	60%
FSWs who can identify that condoms can prevent STIs	• IBBS • Third-party evaluation	To be established	60%
FSWs who score above 80% on a standardized test of HIV knowledge	• IBBS • Third-party evaluation	To be established	60%
Sex workers carrying a condom	• IBBS • Third-party evaluation	To be established	60%
Process indicators			
FSWs reached through counseling in contract area	• HMIS	To be established	60%
Sex workers who can correctly demonstrate the use of condom	• HMIS • Third-party evaluation	To be established	60%
FSWs accessing STI services	• HMIS • Third-party evaluation	To be established	60%

*Source:* Author.

*Note:* FSW = female sex worker; HMIS = health management information service; IBBS = integrated behavioral and biological surveillance; STI = sexually transmitted infection. a. Targets are to be achieved at the end of five years; when signing the contract, break down targets into yearly targets to ensure that the implementation is on track.

**Targets.** Based on independent evaluations, FSWs in selected areas of Punjab, by the end of June 2012, will have acquired the following knowledge and skills:

- **Safer sex behavior:**
  - Sixty percent of FSWs report using a condom during last penetrative sex act with client.
  - Sixty percent of FSWs carry a condom when working and can show it to an interviewer.
  - Sixty percent of FSWs report using a condom during last penetrative sex act with a regular sex partner.
- **Knowledge.** Eighty percent of FSWs surveyed in the project area can spontaneously, without prompting, correctly identify the following:
  - Two ways that HIV infection is transmitted
  - Three ways to prevent transmission of HIV infection, including the use of condoms
  - That the use of condom can prevent the occurrence of other STIs
  - At least two sites for obtaining condoms
  - A local clinic or private doctor that provides treatment for STIs
  - The location of a center for voluntary confidential counseling and testing (VCCT) services.

**Scope of Services for FSWs.** The implementing NGO will provide the following package of services to the FSWs to enable them to improve their knowledge, attitudes, skills, behavior, and health:

- Establish safe and attractive drop-in centers at which training and other activities take place daily, with clinic facilities operating at least twice per week
- Increase use of safer sex practices and improve healthcare-seeking behavior through behavior-change interventions implemented through a peer outreach program
- Provide condom use and negotiation skills and ensure that condoms are widely available to the FSWs



- Provide a selected set of primary health care and STI services based on syndromic approach using updated national guidelines
- Promote empowerment and social development activities among FSWs
- Promote an enabling environment to support project implementation
- Provide education on sexual and reproductive health including STIs
- Continuously strengthen the organization's capacity to deliver the above services.

The design of the interventions will be developed on the basis of formative research behavioral studies. Formative research should be accomplished within three to four months and is essential to development of the project design. The qualitative assessment will provide insights into the life of sex workers and sex work dynamics, including issues related to personal partners; children; financial, health, and legal issues; and various forms of discrimination and victimization. Regular feedback and inputs from FSWs will be required through participatory design workshops to inform the development and review of the service delivery strategies.

- Establish drop-in centers for the sex workers to gather and meet and provide a safe place for the following:
  - Group discussions, psychosexual counseling, advice, information, and support toward building a sense of community among FSWs. The approach should combine education with entertainment.
  - Skill building on proper condom use and disposal, negotiation skills, STI knowledge and recognition, interpersonal communication, and reducing drug and alcohol abuse.
  - Clinic facilities that operate at least twice a week.
  - Bringing FSWs together to develop self-help groups and empowerment activities.
- Implement behavior change intervention to increase safer sex and health-seeking behavior through an outreach program of peer educators:
  - Develop a program to meet health and safety needs of FSWs based on formative research with involvement of the FSWs. The

- program should incorporate effective peer education methodologies, interpersonal communication strategies, field staff recruitment, and skill building.
- Hire and train supervisors and peer educators from different subpopulations of FSWs. Ensure continued training and effective supervision of peer educators.
  - Train peer workers to build skills of FSWs in proper condom use and disposal, negotiation skills, STI knowledge and recognition skills, personal communication skills with sexual partners, and reducing drug and alcohol abuse.
  - Ensure that materials and activities include education on condom skills, sexual and reproductive health including family planning and STIs, legal rights, and VCCT. Educational and skill-building material should be drafted with the aid of peer educators.
  - Review and revise strategy and activities based on project experience and behavioral surveillance results, and in light of issues raised during implementation.
  - Provide a select set of primary curative services, including STI treatment:
    - Develop a detailed education and services delivery plan for sexually transmitted infections based on discussions with FSWs.
    - Provide a select set of primary curative services, including for STIs and provision of condoms to FSWs through clinic services and drop-in centers.
    - Train local service providers who are used frequently by the FSWs in provision of services for STIs using a syndromic approach.
    - Regularly review and monitor the quality of services for STIs used by the FSWs in the project area, using mystery clients, exit interviews, and sex worker clinic guidance committees and support the improvement and maintenance of quality services.
    - Implement a referral system for specialist services.
  - Provide access to VCCT services:
  - Establish VCCT services so that FSWs have effective and appropriate access to a VCCT service package or refer or accompany them to existing VCCT centers where accessible.

- Phase in introduction of antiretroviral medicines (ARVs) where VCCTs are available to sex workers.
- Provide VCCT training to project staff to ensure accessible and acceptable services to FSWs and partners.
- Monitor the experience of FSWs in accessing VCCT services and take remedial action to improve VCCT educational activities and testing facilities.
- Refer or accompany HIV-positive cases to ARV treatment centers.
- Provide condom distribution and skills in use and negotiation:
  - Ensure that condoms are easily available in the project area, including primary health care clinics and drop-in centers.
  - Promote condom use through free distribution of condoms through drop-in centers, peer educators and outreach workers, and local STI services.
  - Provide skills in condom use and disposal and negotiating condom use with clients through drop-in centers and peer education, and include this information in materials developed for behavior change intervention.
  - Review and revise condom education and distribution activities based on project experience and behavioral surveillance results.
- Promote an enabling environment to support program implementation:
  - Identify potential individuals and groups or others who could hinder progress of the project. Develop a plan to promote a more positive environment for HIV prevention among FSWs in the project area.
  - Undertake advocacy and educational activities to promote understanding of local police officials and other public sector officers toward the importance of HIV prevention and in working with FSWs for HIV prevention.
  - Create an advocacy plan and implementation that should include sex trade managers (madams, pimps) and other gatekeepers as necessary.

- Monitor harassment and violence against sex workers by police and other local power brokers and take appropriate steps as needed.
- Promote empowerment and social development activities among FSWs:
  - Initiate self-help groups of sex workers around primary social and economic needs, such as literacy and saving projects.
  - Develop referral systems for other key support activities, such as schooling for children, microcredit, and women's legal rights groups.

**Staffing.** In addition to program staff, the NGO will be required to have at least the following full-time managerial staff on its payroll: project manager; monitoring and evaluation/research officer, financial officer, advocacy officer, and training officer. In addition, field managers will be required at each intervention site.

**Monitoring Progress.** The implementing NGO will provide quarterly progress report within 20 days after the end of each quarter of the project period. The primary means for judging progress will be the independent assessment of the appropriate indicators described above. In addition, and of secondary importance, the client will judge progress toward achieving the targets described above by examining whether the NGO is demonstrating progress toward accomplishing objective semiannual milestones, which are described below. In the case that data on the above-described indicators are not available, the Provincial AIDS Control Program will judge the progress based on information from the management information system, progress toward process milestones (see below), and appropriate field monitoring. Any decision to terminate the contract or take other remedial action specified in the contract will be based on past progress of the NGO; the existence of extraneous constraints, challenges, or impediments; a summary of all available quantitative information; and the latest results of behavioral surveillance and serosurveillance.

#### **Milestone one by the end of the first six months:**

- Senior project staff have been recruited and trained in the basic principles of HIV interventions for sex workers.

- A specific staff member is delegated and trained to conduct advocacy for an enabling environment; an advocacy program is begun with police, sex trade managers, or other important gatekeepers.
- At least a few active sex workers regularly advise project staff or are included as a staff member in a defined position that contributes to decision making.
- Basic infrastructure, that is, transportation and main office, has been completed.
- Peer education manuals are drafted, and criteria for recruitment of peer educators and their supervisors are developed.
- A specific staff member is delegated and trained for monitoring and evaluation, and needed computer programs are installed and operating.
- Baseline research has been undertaken and completed, a draft report submitted, and a completed report submitted no later than the end of month 6.

### **Milestone two by the end of the year:**

- A participatory project design workshop has been held with sex workers (several may be needed if different types of sex workers as well as power holders are included) and options explored and discussed, and the most feasible decided on collectively, including location of drop-in centers or other safe spaces for meetings and/or training of sex workers.
- Staffing is completed based on size estimation results and accessibility of sex workers.
- Knowledge and skills in the technical aspects of STI management for FSWs and/or *bijras* are improved with appropriate technical assistance.
- Infrastructure—that is, computer programs, clinics, safe spaces, and drug supplies—is secured and operating.
- Peer education and peer supervisor training have begun with at least 40–50 peer educators graduated from the first three-week course.

- All staff are trained in the principles and practices of behavior change interventions and nondiscrimination, including medical staff and auxiliary staff, such as drivers; this training should include issues relating to empowerment and social inclusion.
- The process of bringing sex workers together to develop self-help groups has begun and specific “empowerment” activities selected, that is, literacy, savings projects, and microcredit.
- Materials (printed, video, audio, musical) used in discussions among sex workers are developed in participatory workshops.
- Monitoring and evaluation framework is completed, including indicators for coverage, exposure to intervention and changes in safer sex behaviors, STI treatment-seeking behaviors, and quality of STI care and effectiveness and of advocacy for an enabling environment, and at least three months of process data are collated and available.

**Duration of Contract and Geographical Spread of Services.**

The Provincial AIDS Control Program will sign the contract with the successful NGO, which will remain effective for a period of five years subject to satisfactory execution of the contract. The executing NGO will provide services to FSWs in major urban centers of the province as identified by the program. Coverage could be extended to other cities in response to mapping studies or discovery of other “hot spots.” Existing projects in Lahore and Multan will be incorporated into the project on completion of the contract in December 2008.

**Compliance with National and Provincial Guidelines.** The executing NGO will follow national guidelines (current guidelines or those that will be developed during the period of contract execution) for delivery of services to the FSWs. While procuring essential drugs, including condoms, the executing firm will ensure that they meet the specifications and standards laid down by the provincial Department of Health. Where such standards or specifications do not exist, the specifications and standards laid down by the World Health Organization will govern.

**Items That Will Be Provided by the Government.** The Department of Health, through its AIDS Control Program, will provide the following facilities to the successful NGO during the execution of the contract:

- Social assessment study of high-risk groups and results of surveys, including IBBS
- Reports of mapping studies of FSWs
- Updated national guidelines for management of STIs, VCCT standards, and ethical guidelines
- Training of drop-in center staff in HIV rapid testing
- Standard recording and reporting formats, to be developed jointly through mutual consultation
- Authorization from the government to work with FSWs
- Invitation to attend World AIDS Days, AIDS-related training, conferences, and key seminars with expenses for participation to be borne by the NGO
- Copies of key reports and related research carried out in Pakistan
- Support for in-training and capacity-building activities, whereas the NGO will bear the cost of travel and boarding/lodging for its participants
- Access to public sector health services for FSWs registered with the NGO
- Access to public sector HIV testing facilities
- Access to ARV treatment centers.

**Recording and Reporting Requirements.** The minimum recording and reporting requirements will be as follows:

- Maintenance of a daily log of activities by the NGO's staff (including peer educators or outreach workers) in sufficient detail to allow a review and assessment by the supervisory personnel
- Maintenance of a log of the number of clients per day using the services and the regularity of clients in using services
- Maintenance of stock registers to allow monitoring and reporting of shortages of essential commodities
- Maintenance of a register of patients at the drop-in center and for

VCCT services in sufficient detail to allow data analysis and interpretation, but maintaining the confidentiality of records from people not related to program management and implementation

- Maintenance of income and expenditure statements of the project proceeds for an external annual financial audit, and provision of a copy of the audit report to the client or its representative within three months after the completion of a fiscal year (July 1–June 30), the financial audit to be used solely for determining whether the organization is financially viable.
- Preparation of quarterly progress reports and their submission to the client and the management firm within 20 days after the completion of every quarter, taking the contract signing as the reference date; the quarterly progress report will provide at least the following information:
  - Progress made against the agreed on work plan
  - Progress made in achieving the agreed on semiannual process/output target(s)
  - Challenges encountered and options used to resolved them
  - Relations with stakeholders like FSWs and their clubs (if any)
  - Unions/associations, local police, and community leaders.

**Accountability and Working Relationship.** The NGO will be accountable to the Provincial AIDS Control Program for the satisfactory delivery of the services defined here. It will work in close collaboration with the National AIDS Control Program, the World Bank, other relevant development partners, and other NGOs working with FSWs.





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**D**espite the presence of effective interventions, many developing countries are not on track to achieve the Millennium Development Goals for health due to the inadequate delivery of health services to the population. Contracting, particularly with nonstate providers, can improve the situation.

This *Toolkit* draws on a review of 14 real-life examples of health services contracting in different developing countries to conclude that performance-based contracting can rapidly secure improvements in the coverage and quality of publicly financed health services.

Contracting is a mechanism for a financing entity to procure a defined set of services from private or nongovernmental sources. Performance-based contracting hinges on a clear set of objectives and indicators, systematic data collection to assess contractor performance, and some consequences for the contractor (rewards or sanctions) based on performance.

The systematic approach described in the *Toolkit* provides guidance on how to effectively contract, and it addresses issues, such as how to

- Have a constructive dialogue with all stakeholders;
- Define health services, in terms of what services are to be delivered, where, the number of beneficiaries to be served, equitable access, and quality of care;
- Design appropriate monitoring and evaluation systems;
- Select contractors fairly and transparently;
- Draft contracts and bidding documents;
- Carry out the bidding process; and
- Arrange for effective contract management.

This practical “how-to” guide for successful contracting of health (and similar) services will be particularly useful to staff of government agencies, insurance companies, social insurance funds, nongovernmental organizations, faith-based organizations, and private health care providers, as well as international development partners.

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