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Contracting for Reproductive Health Care: A Guide

James E. Rosen

December 2000



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CONTRACTING FOR REPRODUCTIVE HEALTH CARE: A GUIDE

James E. Rosen

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Health, Nutrition and Population (HNP) Discussion Paper

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1. Introduction

Government contracting of private organizations is an increasingly common tool to meet the growing demand for quality reproductive health care in developing nations. This guide brings together information about such contracting experiences in a way to serve the practical needs of World Bank staff and their government counterparts in developing countries interested in trying contracting.

Contracting is not a cure-all for ailing health systems, and there exists relatively little systematic evaluation of the contracting experience in developing countries. Still, many in the field recognize the potential of contracting as a powerful tool to improve reproductive health care. This guide touches on some of the reasons why governments go the contracting route. However, for a more in-depth look at the pros and cons of contracting the reader should consult publications such as Mills and Broomberg, 1998 and the forthcoming World Bank *Private Sector Participation in Health Handbook*.

This guide is intended primarily for use by Bank operations staff, especially task teams for Bank-funded projects that include a reproductive health component. It also can be used by government officials or others interested in pursuing contracting as an option for provision of reproductive health care.

The guide is meant to be used during the development of new projects or during the supervision phase, and assumes that the reader:

- has identified population and reproductive health as an issue for the health sector in a particular country or region;
- already has decided to include a reproductive health component in the loan and wants to involve the private sector actively in the project;
- is considering opportunities for contracting out of reproductive health care; or
- is looking for ideas and models for contracting.

The guide contains the following sections:

- ***Contracting Basics*** briefly reviews some of the fundamental concepts of contracting for health care.
- The ***Review of Experiences*** uses concrete examples to illustrate how contracting principles have been applied to reproductive health care.
- The ***Contracting Checklist*** contains questions intended to guide the reader through some of the “nuts and bolts” of the contracting process.
- ***Case Examples*** describe three recent experiences in contracting for reproductive health.
- The ***Suggested Readings*** summarize key reference materials.
- ***Web-based Resources*** inventories web sites where the reader can go for more information on contracting.

- The *Contracting Network* provides contact information for individuals with interest or experience in contracting for reproductive health care and willing to serve as a resource for the reader seeking more detailed information.
- The *Contracting Examples* summarizes examples discussed in the Review of Experiences section of the guide.
- The *Glossary* defines some key contracting and reproductive health terms.
- *Contracting Documents* provides a selection of contract-related documents in English, French, and Spanish.

The guide is a first step in a more comprehensive look at the range of contracting issues. It aims to point the reader towards more in-depth sources of knowledge and other resources and products being produced by the World Bank and other organizations.

Finally, this guide is a work in progress. Governments are continually trying new contracting approaches, evaluation of these experiences is improving, the circle of government, donor, and private sector officials knowledgeable about contracting is growing wider, and, as a result, our knowledge of contracting is expanding rapidly. Future versions of this guide will attempt to maintain pace with these new experiences.

2. Contracting Basics

This section briefly reviews some of the fundamental concepts of contracting for health care. For more in-depth discussion of these concepts see the forthcoming World Bank Private Sector Participation in Health Handbook. The Handbook is a comprehensive resource for developing country policy makers, program managers, and operations staff of bilateral and multilateral development agencies interested in expanding the role of the private sector in health care. The Handbook includes a detailed, “how-to” module on contracting for health care, available as a book and in electronic form on the World Bank web site.

The Purchaser

The purchaser, or contracting agency, uses the contracting relationship to obtain a service or product. The range of government purchasers will reflect a country’s underlying health system. National level ministries of health, or their regional and local equivalents may contract directly for health care. The public sector may also contract private providers through a variety of health insurance mechanisms which again may be national, regional, or local in nature. Other non-health governmental entities such as state owned companies or teachers’ groups may also directly contract for health care.

The Contractor

Also referred to as the provider or vendor, the contractor is an individual or organization that sells its services or products via the contracting agreement. Private sector contractors generally fall into the for-profit and non-profit categories:

- *For-profit providers* of health care exist to earn a profit for their owners and include private practice physicians, nurses, and midwives; traditional medical practitioners; hospitals, clinics, and health centers; and pharmacies and other retail drug and medical supply outlets.
- *Non-profit groups*, known as nongovernmental organizations (NGOs), are private but define their mission in terms of some social or public health goal. They also include professional medical and nursing associations or philanthropic groups.
- *Community organizations*, sometimes also included under the NGO category, usually are smaller and less formally constituted than an NGO, serve a limited geographic area, and are formed to serve the interests of their members alone (for example mothers’ groups or savings and village banking groups).

Public entities can also be contractors, for example when ministries of health contract with quasi-governmental medical stores for drug procurement.

Forms of Contracting Many forms of contracting for health care exist. The major types of contracting are summarized in the following table:

Table 1: Options for Government Contracting of Reproductive Health Care

Option	Description
Contracting Out (outsourcing)	The government pays a contractor to provide specific services. The contractor generally uses its own workers, facilities, equipment, and supplies to provide the service. Examples include hiring an NGO to provide primary health care, including reproductive health, for a specific geographic area. Also includes reimbursing private providers for providing reproductive health services such as voluntary surgical contraception or birthing care to a specific population.
Contracting In	The government pays a contractor to manage a public sector operation, including managing government employees and resources. Examples include hiring a private individual or organization to manage a public sector hospital or health center.
Subsidy	The government gives direct (grants) or indirect (tax exemptions) financial support to private groups for the provision of specific services. Many nongovernmental organizations, such religiously-affiliated hospitals and health centers in Africa receive such support.
Leasing or Rental	The government offers the use of its facilities to a private organization. Examples include an NGO assuming control of public sector facilities with the intention of providing primary health care, including reproductive health.
Privatization	The government permanently gives or sells public sector health facilities to a private group. Government involvement is limited to a regulatory role.

Adapted from World Bank. 2001. *Private Participation in Health Handbook. Contracting for Health Services Background Paper*. Washington, DC: World Bank. *forthcoming*

Contractor Selection

Purchasers can select contractors through one of three main mechanisms: *competitive bidding*, where competing contractors are chosen on a combination of technical skill and price; non competitive, *sole-source award*, in which purchasers identify a particular contractor based on a unique set of skills or expertise; and an intermediate mechanism, the *consulting services approach* in which contractors are chosen on the basis of their technical skill alone.

Contract Formality

A contract is generally understood to be a legally binding written agreement. However, contracting is also used to describe other types of less formal agreements between governments and private organizations. These are often referred to as “partnerships” or “agreements” that spell out the responsibilities of each party, but stop short of being legally binding arrangements (see Annex 7 for an example from Peru).

3. *Review of the Experience in Contracting for Reproductive Health Care*

This review draws on published and unpublished documents and extensive interviews with officials involved in contracting for reproductive health. The reader can find a selection of documents in Annex 7 related directly to the contracting experiences cited below. The review is organized according to the seven critical steps in contracting, detailed in the check list in section 4.

A. *Deciding whether to contract*

Governments contract for reproductive health care for essentially the same reasons as for health care more generally (see Annex 1 for specific country examples; see the *Private Participation in Health Handbook* for a more in-depth discussion of contracting rationale):

- *To improve access and quality.* In Colombia, government recognition of the shortcomings of its health system in providing poor and rural citizens with access to health care prompted broad reforms that laid the groundwork for large-scale contracting. In Indonesia, contracting of private sector midwives attempts to address the lack of access to quality public sector maternity care in rural areas. In Madagascar, contracting was tried because existing government maternal and child nutrition programs did not adequately serve poor, peri-urban areas nor did they focus on preventive nutrition activities. A similar rationale was behind the desire of the governments of Senegal and Bangladesh to contract nutrition activities to the private sector, in addition to the realization that governments could focus their efforts on services that could not be provided through private groups.
- *To improve access for the poor and for other under-served groups.* In Guatemala, contracting of primary health care, including reproductive health, aims to address inadequacy of public sector services in under-served rural, indigenous populations. Similarly, in India and Cambodia, contracting was seen as a way to reach certain under-served areas of the country and particular marginalized groups. In Senegal, Mali, and the Dominican Republic, the contracting option emerged from a recognition that NGOs could perform better than the government at delivery of essential preventive and reproductive health care, services which the respective governments had paid relatively little attention to in the past.

Looking to the Private Sector. *To their credit, public sector officials in India acknowledge that the government is not doing a good job of reaching certain communities. But the government has always struggled with deciding on how to address this problem. Their initial response was to try to build up government capacity. But in the past five to eight years, there is an emerging recognition that the public sector can't do it all, and that NGOs could provide better quality care.* Indra Pathmanathan, World Bank

- *To minimize the financial burden on the public sector.* The Bangladeshi government wanted to expand primary health care services in urban slums, but not hire huge numbers of

Introducing Flexibility in Public Services. *The government of Bangladesh was very interested in action on nutrition, because malnutrition is a high-profile problem and the few government efforts to date had been relatively small. But the finance ministry was adamantly opposed to putting another 50,000 or 60,000 community nutrition workers on the public payroll. Going the NGO contracting route seemed like a way around the hiring of massive numbers of new government personnel.* Benjamin Loevinsohn, World Bank

permanent government workers. A similar rationale was behind the decision to contract Bangladeshi NGOs for nutrition services, which was essentially a completely new area of work for the government which would have required tens of thousands of new workers.

- *To make up for lack of capacity in specific tasks.* Contracting for procurement and supply of contraceptives in Peru and Kenya was the result of a recognition of the inadequacy of government supply systems. Similarly, the Indian government—lacking the ability to make its own movies—has contracted out the production of a film on reproductive health.

Some additional reasons for contracting of reproductive health care include:

- *To avoid controversy.* Contracting can shield governments from the controversy around services such as family planning. To avoid criticism by religious conservatives, the Colombian government for decades essentially left the provision of family planning services to the private sector, and contracted private groups for specific family planning services such as sterilization.
- *To focus on prevention.* Governments typically do an inadequate job at preventive care. Several governments have contracted with NGOs, groups that are particularly well suited to preventive work, much of which occurs at the community level and depends on good relations with clients.
- *To achieve gender equity.* Women are the main beneficiaries of reproductive health programs. Women more than men tend to seek out traditional practitioners such as midwives to meet their health needs. Contracting of these providers opens up the opportunity to better meet women’s reproductive health needs. This rationale underlies the contracting of private midwives in Indonesia.

An assessment of contracting possibilities should consider regional differences, as summarized in Table 2 below. For example, contracting of reproductive health care is more advanced in Latin America and the Caribbean because of the region’s higher incomes, better-developed private sector, and a longer experience with health reform.

Table 2: Regional Differences in the Environment for Contracting of Reproductive Health Care

Region	Opportunities	Constraints
Africa	<ul style="list-style-type: none"> • Recognition of government weaknesses in prevention (HIV/AIDS especially) 	<ul style="list-style-type: none"> • Few well-run NGOs • For-profit health sector small in many countries
Latin America and the Caribbean	<ul style="list-style-type: none"> • Well developed NGO networks with reproductive health experience • Well developed for-profit health sector • Openness to health reform • Hand-off approach by government to family planning 	<ul style="list-style-type: none"> • Political sensitivity of reproductive health care, family planning in particular
Asia	<ul style="list-style-type: none"> • Strong NGO networks with reproductive health experience • Strong for-profit health sector in some countries • Strong commitment to family planning 	<ul style="list-style-type: none"> • Conservatism of health officials • Large, entrenched state family planning bureaucracies
Europe and Central Asia	<ul style="list-style-type: none"> • Strong interest in developing for-profit health sector in some countries 	<ul style="list-style-type: none"> • Tradition of state control • Undeveloped NGO and for-profit health sector

B. Deciding what to contract: the range of reproductive health services and functions governments may contract

Governments have contracted for virtually all areas of reproductive health care, although most commonly for family planning and maternal care (see Annex 7 for contract documents from many of the following examples).

- *Family planning.* Governments in a number of countries, including in Bangladesh, Brazil, Cambodia, Colombia, Costa Rica, Guatemala, India, and Peru, have contracted for family planning as part of basic health care. In Korea and Taiwan beginning in the 1960s, the public sector contracted private physicians for sterilization and IUD insertion. More recently, the Ministry of Health in the Dominican Republic contracted the establishment of surgical contraception facilities. Governments have reached agreements with private groups to procure and distribute contraceptives in Haiti, Kenya, Nigeria, and Peru.
- *Maternal health.* Governments in Mali, Senegal, and Bangladesh have used contracting mechanisms to improve maternal nutrition. Moreover, maternal health care, including prenatal, birthing care and post-natal care, is a standard element of contracts for primary health care. The Indonesian government has reached agreements with private midwives to provide maternal care in underserved parts of the country.

- *Prevention and treatment of sexually transmitted infections including HIV/AIDS.* In Senegal and Mali, HIV/AIDS prevention is the focus of government agreements with NGOs. Condom social marketing programs for prevention of STIs and HIV/AIDS prevention are another area where contracting has been tried in places like Haiti.

Contracting for AIDS Prevention. *There is a tremendous need to involve civil society in the fight against HIV/AIDS. It is now obvious that public sector agencies alone are not enough. We need to rely more on communities themselves and the private sector to have a real impact on the epidemic. To do so means identifying and promoting mechanisms to rapidly channel funds to civil society groups for HIV/AIDS prevention.*
Anwar Bach-Baouab, World Bank.

Clients in Nicaragua can use government-issued vouchers to obtain private treatment for sexually transmitted infections. In the Dominican Republic, the government has

contracted NGOs for condom distribution and procurement and distribution of materials for HIV/AIDS education.

- *Abortion and post-abortion care.* Contracting for abortion and post-abortion care relatively rare. Bangladesh is an exception. There, government contracts for reproductive health care specify that private groups provide menstrual regulation, referral for complications from abortion, and post-abortion care.

There is virtually no limit to the functions that governments can contract out in the reproductive health arena (see the *Private Participation in Health Handbook* for a full discussion of strategic opportunities in contracting). Examples include the following:

- *Outreach and education.* Given the preventive nature of most reproductive health services, contracting for such care has focused on community outreach and education. Governments have contracted NGOs for nutrition programs that use a strong community-based approach in several different countries including in Bangladesh, Madagascar, and Senegal. In Bangladesh, Brazil, Colombia, Guatemala and India, community-based approaches to family planning services have been contracted out to private entities, both for-profit and non-profit. The government in Indonesia is contracting with community-based midwives for safe delivery care. Many contracts with private groups have included provisions for community and client education activities in family planning, AIDS prevention, and maternal health. In Bangladesh, for example, contractors hired under the Urban Primary Health Care Project will be required to educate women and their families and communities to identify the warning signs of a complicated delivery. Governments also typically contract out mass communication efforts. For example, the government contracted for mass media activities including billboards and a feature-length commercially-shown film addressing reproductive health themes.
- *Clinical services and specialized care.* Contracts between public sector health insurers in Colombia and private groups cover emergency obstetric care and treatment of complications from miscarriage or unsafe abortion. Governments in Taiwan and Korea have contracted for specific clinical procedures such as voluntary

surgical contraception sterilization and IUD insertion, and the public sector in the Dominican Republic has contracted out laboratory testing for cervical cancer.

- *Social marketing of contraceptives and other reproductive health commodities.*

Although private organizations play the dominant role in social marketing programs, in the large majority of cases these groups are contracted directly by international donors. In a few countries, however the government has contracted social marketing services. In India and Indonesia, governments used their own funds; in Haiti, the government used donor funding to contract a private group.

Cement and Condoms. Governments, when they try to mount a social marketing effort by themselves, usually fail to do a good job. They have a lot of experience in buying cement for dams, but not in procuring packaging for contraceptives.
Dana Hovig, Population Services International

- *Training and technical assistance.* The public sector has often tapped into the specialized training capabilities of private organization working in reproductive health. In the Dominican Republic, for example, the government has hired nongovernmental organizations to train public sector employees in management of reproductive health programs, clinical contraception skills, and information, education, and communication techniques. Hundreds of municipalities in Brazil have contracted with the local affiliate of the International Planned Parenthood Federation to train city health workers in the management and provision of reproductive health care. In Mexico, the Ministry of Education contracted with an NGO to adapt its sex education curriculum into the ministry's existing curricula.
- *Research and evaluation.* Often lacking specialized research capacity, governments have contracted private groups for surveys and other evaluation tools. For example, using World Bank loan funds, the government of Pakistan contracted a private organization, the Population Council, for technical assistance in family planning operations research and evaluation.

- *Procurement and distribution of commodities and supplies.* Many governments lack the relatively high degree of technical expertise, comprehensive logistics capacity, and high-quality forecasting capacity required for procurement and distribution of contraceptives and drugs for treatment of sexually transmitted infections. Yet few governments have contracted for such services. There are,

Contracting Out Versus Doing it Yourself. *Is the contracting out approach to procurement short-sighted? People say we have to build government capacity for procurement. My view is that we have to build capacity in the proper place.* Bert Voetberg, World Bank

nevertheless, some examples of contracting for these services. The government of Peru contracted with a local NGO to estimate contraceptive needs, store commodities in a central level warehouse, and distribute supplies to districts (see Annex 7 for example of contract documents). In Kenya, the government, using money from a World Bank loan, has contracted with a private firm to procure contraceptives. In

both countries, private groups hired to manage contraceptive procurement and distribution also provided training and technical assistance to their counterparts in the Ministry of Health. The Indian government, with loan money from the World Bank, has contracted with a parastatal agency for the packaging of essential drugs and safe motherhood kits. In the Dominican Republic, the government has contracted NGOs to procure contraceptives for the public sector and to help district health officials strengthen their contraceptive supply systems.

C. *Specifying the terms of the contract*

The degree of formality, contract duration, and the incentives for good contractor performance all profoundly affect contracting outcomes.

- *Degree of contract formality.* Governments use many contracting variations, including both formal contracts and informal agreements. In Peru, for example, the government has a formal, but noncontractual agreement with the local nongovernmental organization PRISMA for contraceptive procurement, warehousing, and distribution, an arrangement which is supplemented by a formal contract between the donor organization, USAID, and PRISMA. The governments in Guatemala and the Dominican

Republic also have noncontractual agreements with NGOs for delivery of primary health care, including reproductive health. In Bangladesh, Cambodia, Colombia, Kenya, Mali, and Senegal contracts are formal

The advantages of formality *In the Dominican Republic, the Ministry of Health spent \$4 million in 1999 to subsidize 182 NGOs. The Inter-American Development Bank is encouraging the government to shift from informal agreements—under which currently the government is not demanding results—to more formal contracts. Surprisingly, NGOs are more interested than the government in formalizing the current arrangement. Why? Because the private groups have an incentive to show that they can perform well. Furthermore, without formal agreements and monitoring, NGOs fear that the whole effort to involve the private sector will be exposed to criticism that it has been a waste of time and money.*
Tonia Marek, Inter-American Development Bank

legal arrangements. The general tendency has been for governments to increase the degree of formality over time.

- *Contract duration.* Although many experts consider longer contracts better than shorter ones, cautious government officials often prefer shorter contracts. Contracts range from under a year in length, as in the case of the Haitian government’s agreement with a private organization to purchase and market condoms (see Haiti case example), to five years, the period specified in contract to provide primary health care in Cambodia. For reproductive health services in Senegal, the government signs two-year contracts—with the option of extension for a third year.
- *Specification of performance outcomes.* Some contracts aim to ensure that low-income clients receive adequate care. Many of the government contracts with private providers in Colombia require the contractor to charge less to poor patients (see

Annex 7). Government contracts with private groups in Bangladesh include indicators built into the performance clauses that evaluate the contractor based on their coverage of the poor (see Annex 7).

- *Ensuring provision of key reproductive health services.* Where contracts subsume reproductive health within a broader set of services, there exists the real possibility that contractors neglect reproductive health care. Inadequate government monitoring to ensure that contractors provide specified services is often at the root of this problem. In Colombia, although government contracts called for provision of a wide range of primary health care that included family planning, many contractors initially resisted providing family planning. Similarly, in Guatemala, despite the inclusion of family planning in government-NGO agreements to provide a broad range of primary health care, few NGOs actually offered contraceptives.
- *Ownership of assets purchased with contract funds.* Most contracts for reproductive health care have not involved purchase of buildings or other major capital investments but have tended to focus on recurrent costs of labor and supplies. Nonetheless, a concern in contract specification is who ends up with ownership of facilities and equipment that may have been purchased under the contract. For example, in Peru, the NGO PRISMA used contract funds to purchase the central level warehouse it uses to store contraceptives for the Ministry of Health. Should the ministry decide not to continue contracting with PRISMA after the current contract ends in September 2001, the ministry will have to find its own storage facility, since PRISMA owns the current warehouse.

D. Determining contract payment strategies

The way the contractor is paid is especially important to contract performance.

- *Payment mechanisms.* Contracts for reproductive health exhibit the full range of payment mechanisms including block contracts, capitation, and cost and volume contracts (see the Glossary for definitions and the *Private Participation in Health Handbook* for a full discussion of payment strategies). In Senegal, once a contract is signed with a private group, the government advances one-fourth of the contract value to the NGO and then issues subsequent advances upon receipt of financial and activity reports. The contracting of NGOs under the Reproductive and Child Health project in India employs a similar payment system. The varied nature of reproductive health care makes it difficult to say which is the best payment method. However, fee for service arrangements with contractors are potentially a more attractive arrangement, because they give providers the incentive to offer more of the service. Governments have an interest in promoting the use of many of the reproductive health services that are preventive or that have a strong public health component. Giving birth under the care of a trained health worker, for example, is something that governments actively encourage, and shares the characteristic of being relatively easy to specify and monitor in a contractual relationship. This rationale underlies the effort in Indonesia to contract with rural midwives for birthing care.

- *Specifying performance incentives.* For all health services, getting the incentives right is important to ensuring optimal contractor performance. Governments contracting for family planning services must pay particularly close attention to the specification of contract performance. Field-level health workers need incentives to provide clients with the widest possible choice of contraception. Specifying performance goals in terms of contraceptive prevalence rates, as is the case in contracts in Cambodia, is acceptable as long as individual health workers are not saddled with quotas or targets for recruitment of contraceptive users (see Annex 7 for an example of a performance-based contracting clause from Bangladesh).

E. Attracting private providers and managing the bidding process

The bidding arrangements for contracting of reproductive health care have ranged from open, international competition to non-competitive sole-source contracting. Even where contract are not competitively bid, the contract award process has been long and complex, often lasting a year or more (see Annex 7 for examples of tendering documents).

- *The availability of private groups.* The experience in attracting private groups to contract for reproductive health care has generally been positive. In most developing countries, reproductive health services are readily available from the private sector. Colombia for example saw an enormous increase in the number of private groups

The importance of the private for-profit sector to the delivery of reproductive health services. Private businesses dominate the manufacture, distribution, and marketing of reproductive health commodities. Many consumers obtain both commodities and services directly from the private, for-profit sector, although this reliance can vary for the different types of reproductive health products and services. For family planning, reliance on the for-profit sector varies according to the method of contraception. Almost half of women using temporary methods—for example, oral contraceptives—obtain their method from a for-profit source. However, the for-profit sector serves fewer than 10 percent of women using longer-acting methods such as sterilization and IUDs. Consumers are most likely to seek out private for-profit sources for delivery and abortion services, as well as for diagnosis and treatment of sexually transmitted infections. In contrast, the for-profit sector role in preventive care such as immunizations and nutritional supplementation for pregnant women is relatively insignificant.
Source: Rosen and Conly, 1999.

offering reproductive health care after its national insurance program began covering such care. For specialized reproductive health services such as female sterilization or vasectomy, however, few qualified private groups may exist. Similarly, finding private organizations with the capability to address a range of contraceptive supply issues can be difficult.

Governments wishing to contract for high-level research and evaluation work may encounter similar difficulties in finding qualified local bidders, although opening the bidding to international firms can resolve some of these problems.

- *Nongovernmental groups.* Despite a tradition of mistrust of government, nongovernmental organizations generally have a keen interest in contracting. In recent years, many NGOs working in the reproductive health arena have been to eager to diversify their funding as traditional donor sources dwindle. NGOs in countries such as Bangladesh, Colombia, and India cite funding pressures as a major reason for their interest in government contracting arrangements.
- *Community organizations.* Numerous, less-formal community groups exist in many parts of the developing world. Governments have begun to contract these groups for a wide range of development activities, mainly through donor-financed social funds. To date, social funds have financed relatively few reproductive health projects, but could potentially be an important new source of contracting opportunities for community organizations. In nutrition and reproductive health projects in Mali and Senegal, for example, community organizations are key providers of contracted services.
- *The for-profit sector.* Despite the overall importance of private for-profit firms to the delivery of reproductive health care, their role as contractors has been relatively limited. Colombia is one of the few countries where the government has extensively contracted with for-profit groups for health care, including reproductive health. In two countries where for-profit firms have been eligible to bid on contracts for primary health care that include a reproductive health component either they have expressed little or no interest in bidding (Bangladesh), or have proposed costs that too high to be competitive (Cambodia).

F. Managing the contract

Contracting for reproductive health care demands management capacity on the part of both governments and the private groups whose services will be contracted (see Annex 7

New Challenges Require New Skills *Contracting out requires new management functions for government officials. The public sector is not used to contracting. They are learning and need greater sophistication. There are many such institutional issues.* Tawhid Nawaz, World Bank

for examples of institutional arrangements for managing contracts; see the *Private Participation in Health Handbook* for a full discussion of the challenges in building government and private sector capacity for contracting). Government health units in a few countries have established expertise in contracting. For example, the Costa Rican Social Security Institute has a 15-person Directorate for Contracting, which negotiates and monitors contracts. In most countries, however, government contracting capacity in the health sector is extremely limited, placing a severe constraint on contracting efforts. Key contract management issues include:

- *Payment of contractors.* Paying contractors is a key management function but experience has been mixed. Profamilia in Colombia has experienced delays in payment by government insurers, but is large enough and has a diverse enough income base to withstand such delays. Many other smaller NGOs suffer from similar

payment delays but have little recourse when such delays happen. One international NGO contracted by the government in Bangladesh decided not to bid again on government contracts there because of payment difficulties.

- *Contracting regulatory systems.* The regulatory framework for contracting is an important but sometimes neglected area. Colombia is one of the few countries in the Latin American region with an explicit legal framework to support contracting. To qualify as a potential contractor, private institutions undergo an accreditation process and receive are graded according to their financial and technical capacity. The Ministry of Health in the Dominican Republic is strengthening its credentialing of NGOs using a similar model.
- *NGO capacity to manage contracts.* Profamilia in Colombia has 250 contracts that amount to \$5 million overall. Many are small and of short duration, thus increasing the administrative burden on the organization. Profamilia is attempting to consolidate some of these and negotiate longer contracts.

When governments have weak capacity for contracting the choices are to build such capacity, to contract out the contracting function, or to try a combination of both. With respect to reproductive health care, the following approaches have been tried.

- *Simulated contracting.* In the Dominican Republic, USAID has encouraged the government to contract out reproductive health care to local NGOs to better reach under-served populations. In a recent exercise, government health directorates managed the contracting of NGOs in three provinces. Although USAID provided the funding for the pilot effort, government officials performed all other functions of a purchasing agency, thus gaining valuable experience and building contracting capacity. In at least one of the provinces, government officials plan to continue contracting for specific services including voluntary surgical contraception and patient transport.
- *Using an NGO umbrella group.* The approach taken under the Reproductive and Child Health project in India (see Annex 1) addresses the issues of contract management from both the government and private sector angles. By designating larger NGOs to certify smaller groups the government avoids the burden of certification and of managing hundreds of small contracts. At the same time, the more established NGOs help the smaller ones with contract proposals and strengthening their technical and administrative capabilities, thus addressing some of the weaknesses in the management of contracts from the NGO side (see Annex 7 for examples of contract documents from India). After a slow start, the approach appears to be working. Since early 1998, the government has spent \$2.5 contracting 58 larger NGOs. They, in turn, have contracted 650 smaller, field-level NGOs.

Birth of the Mother NGO *The government said, let's get a few NGOs that are reputable and that have reputations to uphold and give them responsibility to vet other potential NGOs and certify them. That's how the "Mother NGO" idea arose. Indra Pathmanathan, World Bank*

- *Contracting out the contracting.* To manage contracting for community nutrition services, the government of Senegal turned to Agetip, a civil works contracting agency with NGO status with no prior experience in health. Agetip hired a respected nutrition expert, and successfully managed the contracting process in 14 cities. The project succeeded in lowering rates of malnutrition by half. The new national nutrition project in Bangladesh will use a similar strategy of hiring a private firm to manage the contracting process.

G. Monitoring and evaluation

Although contracting has its champions within the public sector, many government officials have reservations about contracting because (1) contracting represents a challenge to their power and influence and may directly and negatively affect their careers; (2) officials are suspicious of any attempt to “privatize” health care; and (3) officials have legitimate concerns about whether contracting is more effective and more efficient than the government providing services itself. Proper monitoring and evaluation can help address these concerns (see the *Private Participation in Health Handbook* for a full discussion of key contract monitoring and evaluation issues). In practice, however, such efforts have been generally been weak.

- *Monitoring contractor performance.* Ongoing financial and technical monitoring of contractor performance is key to ensuring that contractors are accountable to program objectives. Government purchasers have, perhaps understandably, tended to focus on the financial element (see for example the India case example in Annex 1) with a consequent lack of attention to the substantive work being contracted. Supervision by government officials is often inadequate and purchasers over-rely on contractor self-reporting. Third-party monitoring and evaluation, although preferable as a way to generate objective reports, is relatively rare.
- *Specifying evaluation indicators.* Preventive services—the predominant form of services under reproductive health—are inherently harder to track than curative services, making it more difficult to measure such contracted efforts. For that reasons, governments must pay special attention to defining indicators for preventive activities. For example, contracts with private groups in Bangladesh specify HIV/AIDS prevention not in terms of numbers of talks given or pamphlets handed out, but in terms of percent of adults of reproductive age who know about HIV/AIDS and the means of prevention (see Table 3 below and full list of indicators in Annex 7).

Table 3: Evaluation Indicators for Reproductive Health Contractors, Bangladesh Urban Primary Health Care Project

- 80% of complicated pregnancy cases have reached the first level of obstetric care;
- 100% of complicated pregnancies have been referred from the first level of obstetric care to more sophisticated facilities;
- 90% of women who have been pregnant in the last 12 months had at least 1 antenatal visit with a professional health worker;
- 95% of women who have delivered in the past 12 months received at least 2 doses of Tetanus Toxoid vaccine;
- 70% of eligible couples (married women of reproductive age – 15-49) practicing family planning using modern methods;
- 70% of women who have delivered in the past 12 months have been attended by a trained health worker).
- 10% increase per year in treated STD cases and equal numbers of men and women treated;
- 60% of adults of reproductive age know about HIV/AIDS/STDs, and the means of prevention;
- 50% of married women of reproductive age will know the signs of complicated pregnancy

Source: Bangladesh Urban Primary Health Care Project, Project Implementation Unit (2000).
“Contract Agreement For Provision Of Primary Health Care Services In Urban Partnership Areas.”

- *Measuring contracting outcomes.* Officials in a number of countries including Bangladesh and Cambodia have used baseline and follow-up surveys to measure the impact of contractor performance (see Annex 7 for examples of evaluation and monitoring plans). Evaluation designs in those two countries allow comparison of the relative costs, effectiveness, and cost-effectiveness of contracting versus the government providing services itself. But surveys may be less appropriate where there are many small contracts as under the Reproductive and Child Health project in India. Where contracting is novel, as in Senegal, officials were concerned that an overly-elaborate evaluation plan early on might dampen enthusiasm for contracting. Nevertheless, even though there was no baseline survey in the areas where NGOs were contracted, the Ministry of Health will contract an external evaluation team to assess the effectiveness and overall impact of the NGO contracting effort. Meanwhile, the Ministry of Health will try to use data from already-planned national surveys to evaluate the impact of contracted NGOs on the health situation in the areas they have been working.

4. Checklist for Contracting of Reproductive Health Services

This checklist is adapted from one prepared originally by Benjamin Loevinsohn of the World Bank. The questions are intended to spur consideration of the most important aspects of contracting for the delivery of reproductive health services. However, because each contracting experience is unique, the list cannot cover all possible issues. The answers are based on contracting experience to date, much of which is still anecdotal.

The questions are organized according to seven critical steps:

Critical Steps in Contracting

Step 1:	Decide whether and what to contract
Step 2:	Specify the contract and draw up bid documents
Step 3:	Determine a contract payment strategy
Step 4:	Select a provider or source of service
Step 5:	Negotiate contract terms and conditions
Step 6:	Implement contract provisions
Step 7:	Monitor, evaluate, and modify contract performance

See the World Bank's *Private Participation in Health Handbook* for more information on each of these critical steps.

Step 1. Decide whether and what to contract

1. How will services be specified in terms of quantity, quality, geography, and equity? If services can be clearly defined then there is, at least, an opportunity to contract. For many primary health care services, including most reproductive health care, it makes sense to define services in terms of percentage coverage of a defined population to be achieved. Delimiting geographical responsibilities may be particularly important in urban areas where there are multiple providers. Contracting also provides an opportunity to improve equity of access to services, both to poor people and under-served groups such as women. If user charges are permitted, specifying and measuring coverage levels to be achieved among the poorest part of the population will be important. This will also avoid the problem of “cream skimming”, where providers concentrate on the easiest and richest part of the target clientele.

2. What forms of contracting could be considered? There are many forms of contracting and there is much overlap between the different approaches, but broadly they include: (i) “contracting out”—the most widely used option—where a contractor is paid to manage services with substantial autonomy including the right to hire and fire staff, carry out procurement of drugs and supplies, etc. (e.g. a private sector organization is contracted to recruit, train, supervise, and pay community nutrition workers, or a

government buys surgical contraceptive care for indigent patients from a private sector hospital); (ii) “contracting in”, where a contractor (either an individual or an organization) is paid to manage within an existing system (e.g. an individual from the private sector is recruited to run a tertiary care public hospital, or an NGO is recruited to manage an existing district health care system while retaining government staff and receiving logistic support through the government); (iii) “leasing” where an organization offers to manage and finance existing health facilities (e.g. an NGO offers to take over poorly performing health centers in an area they are already working in, provide additional or complete financing, and upgrade the existing staff); and (iv) “privatization” where an organization is sold or given existing public resources with the responsibility to manage and finance them in perpetuity.

3. What types of services and functions can be contracted? The opportunities to contract are limited only by our imagination, although it may be important not to overwhelm purchasers initially. Contracting has been successfully used to: (i) deliver drugs, supplies, equipment, and materials to remote health facilities; (ii) provide behavior change communication; (iii) training of health workers where payment of the contractor was partly dependent on the skills and knowledge of the health workers as assessed by a third party; (iv) increase the number of female health workers (an NGO identified rural women, supported them during their training, and helped them get established as trained mid-wives); (v) transportation of health workers to conduct outreach or supervision; and (vi) hospital ancillary services such as cleaning, laundry, and security.

4. How to deal with the issue of “existing” workers, if any? One of the most sensitive issues in contracting is what will happen to existing public sector workers who are currently performing the tasks that are to be contracted. This issue can easily derail the whole contracting process and needs to be dealt with early on in the design phase. Options include: (i) “contracting in”; (ii) allowing government workers to take leaves of absence to work with contractors; (iii) specifying that contractors will offer a certain proportion of new positions to existing workers (clearly the contractors should have the right to choose); (iv) allowing workers themselves to form entities that can bid for contracts; (v) re-training and re-deploying these workers to other tasks; and (vi) “golden handshakes.” Another approach is to “test the waters” by first contracting for ancillary services such as cleaning, security, and food services (in a hospital setting) and then contracting core clinical services provided by more politically powerful and organized medical professionals. (See the *Private Participation in Health Handbook* for a full discussion of contracting risks and benefits).

5. What will be the other political pressures on the contracting process? Addressing the political issues early on may be important to avoid problems later. Some of the issues that have come up (and ways to address them) include: (i) contracting as a way of “privatizing” health care and allowing government to avoid its responsibility to provide services for the poor (include contract provisions to ensure equity); (ii) concern that the government will be “paying twice for services” i.e., to the existing workers and then again to the contractors (minimize overlap in coverage); (iii) politicians wanting their quasi-NGOs selected (set up impartial selection process); (iv) contracting as yet another foreign idea being forced on the government by outside interests (draw on support from inside the government); (v) contracting as a way of “co-opting” NGOs and

turning them from activists into mere service providers (involve NGOs in designing contracts); and (vi) complaints that “governments can provide services just as well as NGO contractors if only they had the same resources, hence contracting is a waste of time.” (make accurate estimates of government and contractor costs).

Step 2. Specify the contract and draw up bid documents

6. How can achievement of results & contractor performance be linked to the contract? Providers of services need to understand what is expected of them in terms of tangible results. This can be done in a number of ways including: (i) providing in the terms of references specific targets (e.g. prenatal care coverage with 3 visits increases to 80%); (ii) supplying baseline survey data as part of bid documents; (iii) indicating how and when follow-on evaluation will be carried out; (iv) providing performance bonuses; and (v) specifying among the conditions for termination of contract the minimum improvements in services that are expected.

7. How to ensure managerial autonomy? One of the major advantages of contracting is that the service providers have the autonomy to manage so that they can innovate and increase effectiveness and efficiency. Generally, it will be best to specify outputs and outcomes while allowing the contractor’s managers to decide the best way of achieving them. For example, it makes sense to specify that immunization coverage should increase to 80% but it is counterproductive to specify that this must be done through house to house visits or standing on street corners. There are process issues that must be addressed when it comes to quality (e.g. that immunizations are given according to the WHO schedule) but the bias should be towards “letting managers manage.” Impediments to managerial autonomy include: (i) line item budgets; (ii) imposition of strategies or approaches that don’t have a very strong scientific basis; (iii) requiring that the purchaser pre-approve innovations suggested by the contractors; and (iv) purchasers introducing new programs or activities without extensive discussion with contractors.

8. How will the contractors know what constitutes acceptable quality of care? For contractors to provide high quality care they will need to know what is expected of them. This emphasizes the importance of clear specification of results and provision of treatment and program guidelines where they exist (e.g. national family planning service delivery guidelines).

9. What training will be required for the contractor’s staff? There will usually be a need for at least some training of the contractor’s staff, regardless of their experience and knowledge of various programs (e.g. family planning, STI prevention and treatment, post-abortion care). Training issues that will need to be addressed include: (i) who will be responsible for the conduct of the training; (ii) what will the health workers be expected to know; (iii) how will their knowledge and skills be assessed; and (iv) who will pay for the training and when will it take place.

10. What quality assurance/supervision systems will the provider put in place? Contractors will have to implement a system for quality assurance that should be

specified in their proposal (e.g. for family planning services, routine measurement of health worker competence in providing correct information about contraceptive methods and in clinical skills). A system of regular supervision of health posts and health centers will also be required.

11. What opportunities will there be for capacity building, i.e., sharing of experiences among the contractors, training, technical assistance, and operational research? During implementation of the contracts, it makes sense to have contractors share their experiences and identify areas (e.g. quality assurance) where they may require additional training, technical assistance or operational research. This will help further strengthen the capacity of contractors to deliver services effectively and efficiently. These activities must be done in an open environment which looks at enhancing capacity and not criticizing contractors.

12. How many contracts will there be and what is the contract size? As contract management is a critical issue (see below) it is important to limit the number of contracts and make them a size which takes into account both the management capacity of the contractor as well as the population to be covered.

13. What will be the contract duration? Longer contracts are generally better, but not always. For relatively complex, large-scale primary health programs, contracts of less than four years generally do not make much sense, because of the cost and practical problems of frequent contract renewal. Contracts for relatively small, well-defined set of specific activities with a community group (for example, community nutrition work) could be renewed yearly. Contracts for specific monitoring and evaluation tasks or for training will vary from a few months to a few years, depending on the scope of the activity.

14. Who will purchase drugs and supplies? Whenever possible and to the extent possible, contractors should be given responsibility for the procurement and distribution of drugs and supplies. Experience in a number of countries shows that they will do this substantially better than government. There will need to be some independent verification of the quality and availability of drugs in the contractors' health facilities. In a competitive bidding context, the cost of drugs and supplies should be included in the bidder's price. If a consulting services or sole source approach is used, then there will have to be an agreement on how these procurements will be paid for. Care needs to be taken in this context not to set up perverse incentives for contractors.

15. What equipment and infrastructure will be provided by the parties? Where equipment is needed, the contractor should be given responsibility for procurement (similar to drugs and supplies) and there needs to be explicit agreement regarding who maintains ownership of purchased equipment when the contract terminates. Where the purchaser will provide existing equipment there will need to be an inventory prior to it being given to the contractor to use. If the purchaser will "lease" an existing facility to the contractor, there may need to be agreement on its current state and who is responsible for maintenance (better if it is the contractor). Where the provider will have to rent buildings for delivering services, there will need to be agreement on whether this is included in the bid price or whether it will be financed some other way.

Step 3. Determine a contract payment strategy

16. How will providers be paid? The purchaser must decide whether to pay contractors on the basis of fee for service, capitation, global budget, or some combination (the extensive literature on provider payment mechanisms should be consulted). Where services are both “under utilized” and easy to track (i.e., hard to fake or make up) such as institutional births in South Asia and Africa, fee for service may provide a useful incentive for contractors.

17. Will contractors be allowed to introduce some form of cost recovery? If the purchaser would like to encourage some form of cost recovery by contractors there will need to be agreement on the process for doing this. This may be difficult and sensitive, particularly for NGO contractors whose philosophy commits them to providing low-cost services to the poor. The purchaser may want to put a limit on the amount of cost recovery, specify the way in which clients will be informed about it, or have bidders include it in their bid price. A critical aspect of cost recovery is ensuring equity. Monitoring should be used to ensure that contractors serve the poor (e.g. whether use of services by the poor declines as measured by exit interviews, or whether outreach services to the poor improves as measured by household surveys).

18. Will there be performance bonuses for providers? Performance bonuses are a useful signal to contractors of the importance of measurable results. If the purchaser is contemplating such bonuses, they must decide on the amount, what they will be based on, how often they will be paid, etc. In the case of family planning services, purchasers must structure performance bonuses to encourage individual health workers to provide full information about all contraceptive methods and avoid incentives that might either bias health workers towards providing a particular method or pressure clients to accept family planning services.

19. What will be the mobilization payment? Will there be a performance bond? Most contractors will require an advance of 3 to 6 months in order to start providing services and this may be controversial in some ministries of health that are used to mostly procurement of drugs and equipment. Some NGOs may have difficulty obtaining performance bonds from their banks but experience suggests that it is simply too risky to provide a large advance without some form of performance bond.

Step 4. Select a provider and source of service

20. How can prospective contractors be involved in the design of the contracting process? In most situations, particularly where contracting for health services is new, qualified providers may be reluctant to participate. Involving prospective bidders in the design of the contracting process appears, from experience, to reduce their anxiety of working with public sector purchasers and results in more transparent and fair bidding and contracting procedures.

21. How to advertise broadly to attract interested entities? In countries or sectors without many NGOs or other private sector providers, it makes sense to advertise broadly and carry out information workshops aimed at attracting potential bidders.

22. Does it make sense to split bidding/recruitment packages over time? If the bidding, evaluation, contracting, and contract management process can be carried out transparently and fairly, this will help increase the confidence of prospective service providers. In this situation, it may make sense to split the bidding/recruitment process over time. For example, a few initial packages can be let, followed 6 months later by a possibly larger, second round of contracts. One obvious disadvantage is that this can delay implementation.

23. How can barriers to entry be reduced without compromising quality? Purchasers will generally want to set very high standards for contractors in terms of their prior experience, size, financial resources, and reputation (this is not always the case, since some purchasers will want to have contractors who are less well known, smaller, and hence “more pliant”). While it is sensible to have contractors with good experience and reputations, excessively high standards can keep newer and potentially innovative entities from competing. A few ways of addressing this issue include: (i) setting aside some smaller sized packages for smaller entities (while keeping the number of contracts reasonable); (ii) allowing NGOs or other entities to form consortia to bid on packages that individually they would not be able to manage; (iii) encouraging smaller entities to “partner” with larger and more experienced “lead” NGOs (in some cases this has not been easy to do and has resulted in situations where it is difficult to track the flow of funds); and (iv) contract with larger and more experienced NGOs who then sub-contract with smaller groups.

24. Are there existing bidding documents, contracts, etc. that can be adapted? It can take considerable time, effort, and skill to put together high quality bid documents. Some examples already exist and are included in Annex 7. Other examples should be available soon through web sites currently under construction.

25. How will contractors be selected? The options for selecting contractors are essentially: (i) competitive bidding (i.e., procurement) based on both technical responsiveness and price; (ii) a “beauty contest” where contractors are selected based on technical proposals (i.e., a consulting services approach); and (iii) sole source recruitment where specific organizations have unique experience and skills. The major advantages of competitive bidding are that it will provide the least cost approach to the delivery of services, will spark competition based on effectiveness and efficiency, and provides an objective basis for selecting contractors. Some observed disadvantages of competitive bidding include: (i) very different per capita costs for bid packages that appear fairly similar which can result in potentially embarrassing situations for the purchaser; (ii) a perception that quality of care matters less than cost (this can be partly overcome by including technical “scores” in the determination of the winning bid); (iii) the process can take considerable amount of time; and (iv) bidders may quote unreasonable prices either because they do not have the financial analytical skills or because they think that once they have the contract they will be able to renegotiate the price. The consulting services approach to contractor selection may not be much faster than competitive bidding, is

unlikely to generate the lowest possible price, and may be more open to manipulation and corrupt practices both at the time of evaluation and during price negotiations. Sole source recruitment takes less time but may result in “fat and happy” contractors who do not have to innovate or improve their efficiency and have lucrative contracts.

26. How will bids be scored/evaluated? Having clear guidelines for evaluating and scoring technical proposals of bidders is important in ensuring transparency and identifying the best proposals. Since one of the principal advantages of contracting is harnessing private sector managerial capacity, it makes sense to give particular attention to the quality of the senior staff being proposed by the bidders. Conversely, the quality of the plan produced by the bidder may not be related to their ability to implement it.

27. What will be the process for bid evaluation? Is it possible to include “neutral” parties in bid evaluation? Making clear from the outset who will sit on the bid evaluation committee and exactly what procedures they will follow helps avoid corrupt practices. Experience shows that including outside experts from academe, NGOs (obviously, unconnected to any of the bidders), or international organizations (e.g. World Health Organization) increases the likelihood that bid evaluation will be done fairly, increases transparency, and helps honest government staff resist efforts to manipulate the bid evaluation process.

Step 5. Negotiate contract terms and conditions

28. What is needed to negotiate a final contract? It is essential that both the purchaser’s and the bidder’s representatives in negotiations have the power to execute a contract. Contract negotiations usually include: (1) Completing a draft contract. Negotiations are usually limited to a few specific technicalities. Parties need to rectify any discrepancies in the contractor’s ability to perform as specified – as in the loss of a key person included in the bidder’s proposal. (2) Clarifying terms of reference. The specifics of the work to be performed are most often spelled out in the terms of reference and appended to the contract itself. The date and approach for mobilizing the contractor’s team or resources needs to be determined. (3) Failure to Agree. If the purchaser is not able to reach agreement with the successful bidder after a good faith effort, they may exercise the option to terminate negotiations and begin discussions with the second highest ranked bidder. (4) Contract signing. Once agreement has been reached the contract should be signed by both parties at the earliest opportunity. Delays are costly and, if prolonged, should be subject to indemnification. (5) Notifying stakeholders. The purchaser should distribute an official notification when the contract has been finalized.

Step 6. Implement contract provisions

29. Who will manage the contracts for the purchaser? Contract management has been one of the weak points in contracting for health services and so it will be important to determine what unit(s) have the capacity for doing it well. Some of the options that have been employed include: (i) government units experienced in managing infrastructure contracts; (ii) large NGOs; (iii) project management units employing

contractual workers; and (iv) consulting firms. (See the *Private Participation in Health Handbook* for an in-depth discussion of government capacity to manage contracting).

30. What are the records the contractor must maintain? What are the accounting requirements? It is sensible to establish early on what reports contractors will have to submit on a regular basis. There should be agreement on reporting requirements for: (i) the health management information system; (ii) accounting and financial management; and (iii) staffing patterns; etc.

31. What will be the mechanism to ensure prompt payment of contractors? A commonly encountered problem is delayed payment of contractors. Contractors usually have little recourse but to wait for payment. Larger contractor with diverse funding sources can survive such delays better than smaller organizations that are more dependent on government funds and consequently have relatively little bargaining power. Delays are a key reason why some contractors withdraw from future bidding, or are reluctant to bid at all. Some of the options available for dealing with this problem that should be discussed during the design phase include: (i) incentives to project staff for on-time payment, (ii) use of a more experienced management unit with a track-record of paying contractors on time; (iii) using some sort of foundation to pay contractors; (iv) direct payment from a donor to the contractor unless there is an objection by the government (i.e., the default is that the contractor gets paid unless the government specifically objects and provides cause); (v) establishing a management board with representatives of contractors, the government, and neutral third parties involved in it.

32. How will “new/additional” services (i.e., contract revisions) be dealt with? It is almost inevitable that during the life of the contract some new services (e.g. special immunization activities for polio eradication) will be added to the responsibilities of contractors. There needs to be a clause in the contract that provides for this eventuality.

33. What will be the mechanism for resolving conflicts? Most contracts include an arbitration clause for settling conflicts that is usually too complicated and expensive to be used. Especially in settings where both provider and purchaser have little experience with contracting there should be a less dramatic mechanism for resolving disputes, e.g. payment of contractors’ bills on time.

Step 7. Monitor, evaluate, and modify contract performance

34. How will contractor performance be monitored (i.e. between evaluations)? Between formal evaluations there is a clear need for monitoring of contractor performance on an ongoing basis to: (i) help assure the purchaser that the specified services are being provided; (ii) help build greater understanding among the purchaser’s staff of the realities on the ground; and (iii) inform the contractor’s staff of concerns of the purchaser. The frequency of monitoring also needs to be considered because excessive monitoring may lead to “micro-management”. Consideration also should be given to involvement of a third party as a means for ensuring that the monitoring is actually carried out and is done fairly.

35. How can performance be evaluated independently of contractor? Being able to measure contractor performance independently is critical to the success of contracting and will likely influence purchaser's willingness to contract. Depending on the nature of the services, assessing contractor performance in terms of quantity, quality, and equity will likely require household surveys, health facility surveys, and qualitative methods to determine beneficiary satisfaction. The cost, technical difficulty, and feasibility of carrying out the kind(s) of evaluation selected may limit the number of contracts that can be let. Third party evaluation of performance may help resolve subsequent conflicts between purchaser and provider.

36. How will the purchaser determine the effectiveness and efficiency of contracting? In the long run, governments are likely to be the ones that will have to finance contracting for health services and they will need to be convinced of its effectiveness and efficiency. Hence, it will be important to be able to compare, wherever possible, the cost and results obtained by contracting with some reasonable alternative, including government provision. This will need to be designed into the project at the beginning and will require thinking about how cost and effectiveness data will be collected.

37. How will the purchaser be involved in the contracting process so they understand it better? Successful contracting will likely require an appropriate balance between maintaining purchaser involvement in the process and ensuring the managerial autonomy of contractors. Staff of the purchaser need to be involved in all aspects of the contracting process so they can understand it and perhaps become champions for it.

38. What will be the sanctions for inadequate performance? While it is usually possible to resolve problems in service delivery, it is important that there be a credible threat of contract termination if performance is inadequate. It may also be sensible to have other sanctions that can be used to resolve performance problems, for example, delaying or reducing payment. Future tenders should also take into account a contractor's past performance.

Annex 1: Case Examples

Case Example: Contracting for Social Marketing Of Condoms in Haiti

In 1998, the United Nations Population Fund (UNFPA) was ending its funding of contraceptive commodities for family planning and HIV/AIDS prevention programs in Haiti and searching for a donor to continue providing these critically needed supplies. UNFPA representatives met with World Bank and government officials to discuss using an existing World Bank health loan as a mechanism to supply condoms to the ongoing social marketing program. Population Services International (PSI), a U.S.-based nonprofit organization active worldwide in social marketing efforts, had marketed a low-cost condom in Haiti since 1989. By the end of the 1990s, PSI had sold some 50 million condoms and added oral and injectable contraceptives and the female condom to its product line.

After over a year of negotiations, the Haitian government, using funding from the World Bank's Basic Health Services loan, agreed to contract with PSI on a sole-source basis. PSI is one of the few, if not only, organization with the procurement and distribution capabilities the government was seeking. An initial contract of \$700,000 covered the costs of procuring and packaging condoms. A subsequent contract for \$400,000, currently in effect, includes \$250,000 for condom purchases and another \$150,000 for distribution and marketing. Funding from other sources continues to provide the bulk of the social marketing program's promotional and administrative costs.

The contracting effort has faced a variety of challenges. The initial reluctance of the Haitian government to use a private nongovernmental group for procurement and distribution, and thus relinquish control of loan funds, delayed the negotiations and contract signing. Despite PSI's long presence in Haiti, the government and PSI still needed considerable time and effort just to learn about each other and feel comfortable working together. The involvement of two separate donors—the World Bank and UNFPA—each with its own unique mission and administrative systems, further added to the complexity of the agreement. Even after contract signing, dealings with the government—particularly with respect to the contraceptive procurement—proved to be difficult and extremely time-consuming. Government delays in signing documents and releasing funds drove condom inventories to dangerously low levels.

One important lesson learned was the need to present early and clear estimates of the cost of contracted activities. Despite PSI's social marketing expertise, its extensive contacts with global condom producers and suppliers, and its non-profit, public health mission, officials in the Ministry of Health were initially suspicious of how PSI used the revenues earned from the sale of the subsidized condoms. In retrospect, PSI staff could have allayed some of these fears by walking government decision makers through a cost analysis to show that the small amounts PSI earned through sales were used to partially cover the cost of administration, promotion, and distribution.

The role of the donor organizations was also key to the contracting effort. Both World Bank and UNFPA officials helped to persuade the government to involve a private group, and lent credibility to PSI. These donors also provide critical financial support for other important reproductive health interventions that complement the activities of the social marketing program.

Sources: Dana Hovig, Chuck Szymanski, and Daun Fest of PSI; *Haiti Country Profile* from PSI web site.

Case Example: Contracting for Reproductive Health in India

Health officials in India have long acknowledged the difficulty in providing government services to some remote areas and hard-to-reach groups. Also, with the increasing concern over low levels of quality of care, public officials have recognized the slow pace of improvements in the quality of public sector reproductive health services. Although devising a strategy to address these shortcomings has proved difficult, a recent consensus has emerged on the need to draw more heavily on the expertise of nongovernmental organizations (NGOs) to improve the reach of services and raise quality.

In working with the non-profit sector, however, the government faces a problem. Only a minority of the thousands of NGOs operating in India have both the capability and the commitment to providing quality reproductive health care. For public sector health officials, the task of identifying those truly qualified private organizations is time-consuming. Moreover, public officials run the risk of controversy should they authorize public funding for private groups that turn out to be less than qualified. As a result, government officials have traditionally been reluctant to enlist the help of NGOs, preferring to partner with only a handful of large, well-known groups. The NGO community has, as a result, criticized the government for its failure to work with a wider range of private groups.

To break this logjam of mutual suspicion and hostility and to build upon the government's genuine desire to use NGOs to strengthen services, government and NGO officials have agreed on a multi-tiered approach to contract with NGOs for maternal and child health care. At the first level, the government contracts larger, reputable private groups, designated "Mother NGOs," to vet and certify the participation of smaller organizations. A national panel of representatives from both the public and private sector selects these Mother NGOs through a non-competitive process. The government assigns each Mother NGO roughly 6 districts of about 1 million people each. At the second level, Mother NGOs contract smaller NGOs, also chosen through a non-competitive process which includes a review of proposals by NGO and government officials at the state level. The Mother NGO monitors and evaluates the work of smaller NGOs, and helps the less-experienced groups to prepare proposals and to strengthen their technical and administrative operations.

The vast majority of the work contracted through NGOs is community promotion in support of the services provided at government facilities, usually subcenters staffed by a single, multipurpose government worker who serves a population of roughly 5,000. Typically, the contracted NGO will hire, train, and monitor part- or full-time female community workers known as volunteers, who receive a small stipend. Volunteers identify women and children in need of services, and motivate them to seek care. Some volunteers also serve as distributors of safe delivery kits, contraceptives, and essential drugs.

NGOs receive an initial grant, then are eligible for subsequent payments after submitting expense claims. The World Bank's loan to the government incorporates model terms of reference and suggested contract language, thus providing blanket approval to the contracts funded by the loan. The loan agreement also permits NGOs to contract small-scale services, such as hiring of auxiliary nurses, without prior Bank approval.

The contracting experience is still too new to have been thoroughly evaluated, but the approach appears to be working, albeit with some hitches. Since the contracting effort began in early 1998, the government has contracted 58 Mother NGOs, who in turn have contracted with 650 field-level NGOs (The relative size of the contracting effort is still small: of the \$80 million in World Bank disbursements for the Reproductive and Child Health project, just \$2.5 million has gone towards contracting.). The effort began somewhat slowly, mainly because of the time needed to generate an atmosphere of trust between the public and private sectors, and to reach agreement on an impartial mechanism for selecting Mother NGOs.

Sources: Indra Pathmanathan, World Bank

Case Example: Contracting for Reproductive Health in Colombia

To address the inadequacy of public sector health services, the Colombian government initiated a series of far-reaching reforms in the early 1990s. By giving all citizens the option of enrolling in a public or private insurance plan that guarantees access to a range of services, the reforms aim to separate the provision of health care from its financing. The national health system now has three purchasers of health services: the Social Security Institute, private health insurance groups, and subsidized government-sponsored health plans, largely run by municipalities. The national system pays these insurers a standard premium per person enrolled, adjusted by age and sex. Colombia is one of the few countries in Latin America and the Caribbean region with an explicit legal framework that supports public contracting of private health care. Laws passed in 1993 authorize the state—through its insurance organizations—to buy health services from any eligible provider, public or private.

These laws lay down general guidelines about specification of work and prices, leaving considerable leeway in defining the terms of individual contracts. Although the guidelines call for the government to award contracts through competitive bidding, in practice most contracts have been awarded non-competitively. Prices paid to providers for contracted services are open to negotiation, but often are tied closely to national rate schedules established by the Social Security Institute and private insurers, and bound by the premium amounts insurance companies receive from the national system. Contracts can specify a range of payment mechanisms including payment per service and payment per person covered (capitation). The government also mandates a sliding scale for patient fees, with poor people exempt from most co-pay requirements. Contract duration is also negotiable, but most contracts last one year or less.

The contracting reforms have profoundly altered the market for reproductive health care and the work of the largest private provider of such care, Profamilia. The nonprofit affiliate of the International Planned Parenthood Federation, Profamilia has dominated family planning in Colombia for over three decades, providing between 60 and 70 percent of services. By including basic reproductive health care on the list of covered services, the reforms created a whole new class of organizations willing to offer reproductive health care. The large growth in the number of private providers of family planning has broken Profamilia's near monopoly, yet the organization remains a powerhouse. One of Profamilia's key strategies has been to reposition itself as a provider of broader primary health care, thus attracting the interest of health insurance groups that prefer to purchase comprehensive care from a single organization.

Profamilia has fared relatively well in the new contracting environment. The organization steadily increased the number and value of its contracts, and in 1999 had some 250 contracts worth \$5 million. Meanwhile, the reforms have presented Profamilia with a number of challenges. Delayed government payments has been a frequent problem. A mismatch between facility records and information systems—a result of the decentralization of contracting authority—is partly to blame. Another factor has been the chronic financial problems of the Social Security Institute, one of Profamilia's most important public sector clients. Although Profamilia's diversified funding sources have allowed it to weather these payment uncertainties, the delays pose a significant financial risk.

Another early obstacle to contracting was that many government officials lacked detailed knowledge of the capabilities of private sector groups such as Profamilia. The time public officials spend on learning the private market, and the time and effort private organizations put into marketing their services represents a real cost. A further constraint was that, despite including reproductive health in the range of covered services, the government did little during the first years of the new health system to certify that insurance plans covered such services. Gradually, however, the government has strengthened the regulatory framework and increased its supervision to ensure that health insurers are contracting for family planning and other reproductive health care. Also, both public and private insurers have come to better understand the financial benefits of covering family planning services—realized mainly in terms of savings from fewer pregnancies and births.

Sources: Abramson 1999; Seltzer and Gomez, 1999; Monsalve Rios, 1999; Toro et al, 1997; Jaime Guevara

Annex 2: Suggested Readings*

Abramson, Wendy. 1999. Partnerships between the Public Sector and Non-governmental Organizations: Contracting for Primary Health Care Services. A State of the Practice Paper. The Latin American and Caribbean Health Sector Reform Initiative. Abt Associates. Draft.

Abramson describes in detail the contracting of nongovernmental organizations for provision of primary health care in five Latin American countries (Colombia, Costa Rica, the Dominican Republic Guatemala, and Peru). The discussion includes a review of key issues including: reasons the public sector and NGOs enter into contracts; the political environment and legal framework for contracting; and government and NGO contracting capability.

Behrman, Jere and James C. Knowles. 1998. "Population and Reproductive Health: An Economic Framework for Policy Evaluation." *Population and Development Review* 24, no. 4: 697-737.

Behrman and Knowles argue strongly that while governments do have a role in financing services for the poor, the public sector should not necessarily directly provide family planning and other reproductive health services. They argue that government subsidies should be equally available in both the public and private sectors and that poor people should be able to choose between public and private care through mechanisms such as vouchers.

Bennett S., B. McPake and Mills A. (eds). 1997. *Private health providers in developing countries: serving the public interest?* Zed Press, London, UK.

Includes the following chapters:

Chapter 12: Mills A. Contractual relationships between government and the commercial private sector in developing countries.

This chapter first reviews the rationale for contracting out; second, analyzes the main elements and issues involved in contracting out; and third, reviews the results emerging from six country case-studies of contracting done as part of the Collaborative Research Network on the Public/Private Mix supported by the Health Economics and Financing Program at the London School of Health and Tropical Medicine. The chapter ends by identifying lessons from the case studies which provide guidance on the circumstances in which contracting out should be preferred over direct provision.

Chapter 13: Broomberg J, Masobe P and Mills A. To purchase or to provide? The relative efficiency of contracting out versus direct public provision of hospital services in South Africa.

* An initial version of the list of readings was prepared by Christine Ayash and Joanne Epp of the World Bank.

Chapter 14: Tangcharoensathien et al. Private sector involvement in public hospitals: case studies in Bangkok.

Chapter 15: Bhatia M and A. Mills. The contracting out of dietary services by public hospitals in Bombay.

Chapter 16: Beracochea E. Contracting out non clinical services: the experience of PNG.

Chapter 17: Gilson L et al. Should African governments contract out clinical services to church providers.

Bennett S. and A. Mills. 1998. Government capacity to contract: health sector experience and lessons. *Public Administration and Development*: 18, 307-326.

This article integrates the literature on institutional capacity with a set of case studies of health sector contracting to explore issues relating to government capacity to contract-out. The article has three main aims: (1) to clarify what is meant by the term 'capacity' and which sorts of capacity are key in contracting-out arrangements; (2) to identify the main constraints on developing country government capacity with respect to contracting-out of health care services; and (3) to consider which measures and strategies might help increase government capacity to contract-out successfully and whether circumstances exist where government capacity is so limited that contracting-out is neither feasible nor desirable.

Bennett S., S. Russell and A. Mills. 1996. *Institutional and economic perspectives on government capacity to assume new role in the health sector: a review of experience.* Development Administration Group, University of Birmingham, 1996. Also published as PHP Departmental publication no 22, London School of Hygiene and Tropical Medicine.

The document aims to (1) review the arguments relevant to the health sector which favor changes in the role of the state, including the failure of public sector bureaucracies, and economic and institutional arguments for new forms of service provision; (2) review and analyze health sector reform experience in developing countries, focusing on selected new forms of health service financing and delivery and the lessons learnt from this experience; and (3) provide a context for subsequent country case study research, and help develop research questions on government capacity to perform its new service provision roles.

Berman P. and L. Rose. 1996. The role of private providers in maternal and child health and family planning services in developing countries. *Health Policy and Planning*, 11(2), 142-155.

This paper uses data from the Demographic and Health Surveys program (DHS) in 11 countries in Asia, Africa, and Latin America to explore the role of private sector providers in the provision of a variety of maternal and child health and family planning services. In a number of countries studied, the private sector role is significant in the provision of family planning services and in the treatment of childhood infectious diseases. For health services with a large 'public goods'

component, such as immunization and ante-natal care, the private role is much more circumscribed. Two groups of countries were identified: those where private sector involvement is high across many different types of services and those where the private sector played an important role in only one or two types of services studied. The analysis identified the lack of consistent or systematic definitions of private providers across countries. Given the significance of private provision of public health goods in many countries, the authors propose much more systematic efforts to measure the private sector role in the future.

Daly, Beth et al. 2000. Guide to Leveraging. How to Mobilize and Diversity Resources for Reproductive Health. Family Planning Service Expansion and Technical Support (SEATS II). Arlington, Virginia: John Snow, Inc.

Targeted to nongovernmental organizations, the guide contains 14 sections and lists tools, websites, a bibliography, and a series of practical worksheets. Discusses contracting opportunities for non-profits, types of contracts. Helps NGOs think through the contracting process through a series of key questions on deciding what services to offer and how much to charge.

de Silva, Samantha. 2000. "Community-based Contracting: A Review of Stakeholder Experience." Washington, DC: World Bank.

Available on the web at:

[http://wbln0018.worldbank.org/HDNet/HDdocs.nsf/2d5135ecbf351de6852566a90069b8b6/fc71c4fe5a5444718525688e005524ac/\\$FILE/ccpaper2.pdf](http://wbln0018.worldbank.org/HDNet/HDdocs.nsf/2d5135ecbf351de6852566a90069b8b6/fc71c4fe5a5444718525688e005524ac/$FILE/ccpaper2.pdf)

The paper defines community contracting (procurement by or on behalf of a community) and reviews and synthesizes experience in community contracting. The paper briefly lists a number of lessons learned and best practices. Annexes include a detailed framework of activities for stakeholders in community contracting and guidelines for participatory assessment of contracting procedures.

Development Associates, Inc. Forthcoming 2001. Final Report. Family Planning and Health Project. Santo Domingo: Development Associates, Inc.

The final report of a seven-year USAID-funded project includes a description of the "simulation" contracting carried out in three provinces of the Dominican Republic between the Ministry of Health and NGOs in 1999 and 2000. A section also describes the NGO accreditation system set up in 1998 to evaluate the eligibility of health-providing NGOs to receive subsidies from the Ministry of Health.

Domberger, S. 1998. The Contracting Organization: A Strategic Guide to Outsourcing. Oxford University.

Mostly focused on developed country experience, the book is divided into four parts. Part I begins by considering the 'make or buy' decision. This is followed by a discussion of the shifting boundaries of organizations. Part II examines in detail the benefits and costs of contracting. In Part III the strategic aspects of contracting, involving the implementation of actual policies are closely examined. Lastly, part IV

looks at structural change associated with contracting, at the level of both individual sectors and the whole economy. Case studies and specific illustrations are used extensively throughout the book. The case studies span several countries including UK, USA, Australia, New Zealand, Germany, Italy, Japan, Korea, and Brazil.

England, R. 1997. Contracting in the Health Sector: A guide to the use of contracting in developing countries. *Institute for Health Sector Development*. 1-46. (An updated version, titled Contracting and Performance Management in the Health Sector - Some Points on How to Do It, will be available in September 2000, and can be ordered through the Institute's web site at www.ihsd.org.)

This document is a guide that outlines the use of contracting in developing countries. The guide addresses the following issues (1) contracting within the public sector; (2) contracting between public and private sectors; (3) the content of contracts; (4) potential advantages of contracting; and (5) potential problems with contracting.

Foreit, Karen. 1992. Private Sector Approaches to Effective Family Planning. Policy Research Working Paper 940, Population and Human Resources Department. Washington, DC: *World Bank*.

A broad overview of the private sector and family planning. Provides selected examples of contracting out of family planning services.

Fronczak, Nancy. 1999. "Description and Assessment of Contracting Health Services Pilot Project, January 1997-November 1999." Ministry of Health, Government of Cambodia.

This reports describes in detail the experience of the government of Cambodia in contracting NGOs for primary health care, including reproductive health. In two districts, the government contracted out; in three districts, the government contracted in. The report describes the bidding and contract award process, achievements of the first year of contracting, and problems and issues of concern. Annexes include the terms of reference for both the contracting in and contracting out models; procedures for resolving project implementation issues; evaluation of contractor work including indicators and performance goals; and evaluation criteria for technical proposals.

Harvey, Philip. 1999. *Let Every Child be Wanted: How Social Marketing is Revolutionizing Contraceptive Use Around the World*. Westport, Connecticut: Auburn House.

The first chapter examines in detail the experience in starting the world's first contraceptive social marketing program—the Nirodh condom program in India. Harvey describes the government of India's desire to maintain management control of the program in its early stages (rather than using private contracting), and some of the resulting difficulties.

JSA Healthcare Corporation. 1991. Facilitating Corporate Investments in Family Planning and Maternal Child Health Services: The TIPPS Experience. (*Technical Information on Population for the Private Sector (TIPPS)*).

The USAID-funded TIPPS project developed a unique and successful approach to convincing corporation to invest in family planning and or maternal and child health services. This approach focused on both the supply side (service provider) and the demand side (companies). The TIPPS approach incorporated the following principal activities: (1) conducting assessments to target and qualify participating countries; (2) selecting appropriate companies, research organizations and service providers; (3) conducting cost-benefit analyses utilizing KAP surveys and a cost benefit model to develop critical data on the benefits and costs of providing services; (4) Designing and delivering professional, business-like presentations to corporate management; (5) Planning and organizing information dissemination and workshops for business leaders to achieve a multiplier effect; and (6) providing technical assistance to public and private service providers and to private sector companies.

John Snow Inc. 1991. Market-Based Family Planning: The Enterprise Program Experience. *The Enterprise Program & John Snow Inc.*

The goal of the USAID-funded Enterprise project in the market-based sector has been to develop, test, and document a number of program strategies and models, and to assess their strengths and weaknesses in terms of four objectives: (1) creating sustainable family planning services, (2) attracting family planning acceptors; (3) using resources for family planning cost-effectively, and (4) leveraging private sector funds for family planning investments. This paper analyzes the experience and identifies market-based strategies that have demonstrated impact on expanding family planning service delivery in the private sector. The rest of the paper is organized in four sections. The second section describes the market-based sector and explores its importance in expanding family planning service delivery. In the third section, the authors discuss how Enterprise identified market-based providers and how they were motivated to participate effectively in new family planning ventures. The fourth section describes specific market-based strategies and models that Enterprise developed, and analyzes them according to their potential for significant impact in terms of the objectives. In the fifth section, the last section, the authors present conclusions relating to the trade-offs required to maximize a particular objective.

Knowles, James C. 2000. "Consultant's Report of Technical Assistance Provided to the BDD Sustainability Component of the Safe Motherhood Project, 15-26 May, 2000." Draft. June 14.

The report assesses a number of issues related to the Targeted Performance-based Contracting (TPC) pilots currently being implemented under the BDD Sustainability Component of the Safe Motherhood Project in Indonesia. The pilots involve a change in the type of contract used by district health offices to remunerate village midwives. In addition to a paying midwives a fixed honorarium for assisting in the government health center, the district reimburses midwives for maternal-child health and family planning services provided to poor women who present government-issued vouchers. An annex, written for economists or at least those with an intermediate knowledge of microeconomics, provides some basic microeconomic analysis of the TPC pilots.

Loevinsohn, Benjamin. 2000. Contracting for Health Services: Lessons from Two Large Projects in Bangladesh. Draft.

This draft paper examines the experience of large-scale contracting under the Bangladesh Integrated Nutrition Project (BINP) and the Bangladesh Urban Primary Health Care Project (UPHCP). BINP has contracted with 7 NGOs to provide nutrition services to 10 million people; UPHCP has contracted NGOs to provide primary health care to about 4 million people in 4 large cities. The study found that contract management issues have been significant under the BINP project. The study also found that neither project has yet provided definitive evidence about the effectiveness and efficiency of contracting compared to government provision of services.

Management Sciences for Health. 1998/99. Forming Partnerships to Improve Public Health. The Manager. Volume VII, Number 4. Available on the web at <http://erc.msh.org/planning/tools/prtisen.htm>

This edition of MSH Manager series to improve management of health and family planning services is a practical guide for forming public-private partnerships. It includes examples of both contractual and noncontractual public-private partnership agreements. A short section on formal contracting arrangements includes a glossary of contracting terms, outlines seven steps in the contracting process, and discusses contracting out of public health services in the U.S. state of Massachusetts. A case study looks at a public-private partnership to reduce the incidence of low-birthweight babies.

Marek, T., I. Diallo, B. Nkdiaye, and J. Rakotosalama. 1999. "Successful Contracting of Prevention Services: Fighting Malnutrition in Senegal and Madagascar." *Health Policy and Planning*, vol. 14, no. 4: 382-389.

In both countries, donors were the principal financial backers of nutrition projects that use "delegated" contracting, whereby the government has designated an agency or unit to manage the contracting out of community nutrition services aimed at children and pregnant and lactating women. The report describes in detail the types of services contracted and the contracting arrangements between the contract management units and NGOs (for supervision), individual nutrition workers (for services), training institutions (for training), and research institutions (for operations research). The study shows evidence that contracting is successful for improving access to preventive nutrition services and lowering rates of malnutrition.

Mills, A. 1998. To contract or not to contract? Issues for low and middle income countries. *Health Policy and Planning*. 13(1), 32-40.

Many low and middle income countries have inherited publicly funded and provided health services, often operating at relatively low levels of technical efficiency. Changing ideas about the management of the public sector, in particular stemming from new public management theory, are spreading to these countries, whether directly or via the recommendations of multilateral and bilateral aid agencies. This paper draws evidence from five country case-studies of contractual arrangements, in Bombay, Papua New Guinea, South Africa, Thailand, and Zimbabwe. A common evaluative framework was applied in each country to selected, existing contractual arrangements. This analysis is used to identify which aspects of the contracting process

and the context in which it takes place are important in influencing whether or not contracting with the private sector is a desirable means of service provision.

Mills, A. and J. Broomberg. 1998. Experiences of Contracting: An Overview of Literature. Technical Paper 31. *Macroeconomics, Health and Development Series*, No. 33.

Despite the extensive debate and descriptive literature on reforms, there remains very limited information, from either developed or developing countries, on the impact of marketisation reforms on the efficiency of providers and of the health system more generally, on equity and other social objectives, on the costs of the reforms. This literature review focuses on these questions in the context of developing countries, with specific emphasis on contracting as a the key manifestation of the general trend towards marketisation. The review identifies from the literature (1) the definition of contracting in use; (2) the theoretical rationale for governments to contract out services; (3) issues relating to the design and implementation of contracts; (4) results of contracting out; and (5) conditions conducive to successful contracting. It also focuses on the contracting of health services for the general population.

Mills A. 1997. Improving the efficiency of public sector health services in developing countries: Bureaucratic versus market approaches. In, Colclough C (ed) *Marketizing Education and Health in Developing Countries: Miracle or Mirage?* Clarendon Press, Oxford.

The purpose of this paper is to raise the question of the best means of remedying the widely acknowledged inefficiencies of the public health systems in developing countries, and in particular to ask whether improvement is best pursued by a continuation and reinforcing of attempts to improve government policy-making, planning and management structures relating to public provision, or whether there is value in market-oriented reforms that retain public financing but encourage competition between providers. The main concern of this paper is how to improve efficiency, in terms of how to use existing resources to greater effect as with simple cost savings.

Ministry of Health of Peru, PRISMA, and John Snow Inc. 1999. System Assessment and Lessons Learned Evaluation of the Ministry of Health Contraceptive Logistics System. Final Report.

This report describes how a local NGO, PRISMA, was contracted to provide technical assistance for the contraceptive supply system of the national reproductive health program within the Ministry of Health. Main lessons learned include: the outsourcing model has worked in Peru, and functions well in a country with geographic and communication constraints; the outsourcing model has not built significant logistics management capacity at the central ministry level, as most of these functions are handled directly by PRISMA; training and supervision has resulted in an adequate management of the contraceptive supply system at the district and local levels.

Monsalve Rios, Elena. 1999. Experiencia Colombiana en la Contratación entre ONGs y Sector Público para la promoción de la Salud Sexual y Reproductiva (The Experience of the

Colombian Public Sector in Contracting with NGOs for Sexual and Reproductive Health)
Unpublished.

Briefly describes changes in the contracting environment brought about by health sector reforms in the early 1990s and aspects of the relationship between the Ministry of Health and nongovernmental groups. The paper also gives examples of contracts between the government and NGOs for reproductive health care, including for training; information, education, and communication campaigns; technical assistance for the development of national service guidelines; research; and provision of services.

Palmer, Natasha. 2000. "The Use of Private-Sector Contracts for Primary Health Care: Theory, Evidence and Lessons for Low-Income and Middle-Income Countries". *Bulletin of the World Health Organization* 78, no. 6: 821-829. Available on the web at <http://www.who.int/bulletin/tableofcontents/2000/vol.78no.6.html>

The author first reviews the worldwide trend towards the "new public management," one element of which is the split between government as purchaser and provider of services. She then reviews the theory of contracting and describes the contracting experience of the UK's National Health Service. She suggests that "incomplete, relational contracts" (more flexible and long-term relationships between purchaser and provider) may be the most efficient approach to primary health contracting in developing countries.

Perrot, Jean and Orville Adams. 2000. *Applying the Contractual Approach to Health Service Delivery in the Developing Countries. A Discussion Paper.* Geneva: World Health Organization.

This paper, from two economists at the World Health Organization, lays out the rationale for how contracting can improve health service delivery. After briefly reviewing the evolution of health systems in developing countries, with particular emphasis on the roles of the public and private sectors, the paper discusses three different contracting approaches: "having it done" (contracting out); "doing it better" (contracting in); and "working together" (the complex public-private arrangements now evolving under decentralization and other trends, including the separation of provision from financing, and provision from ownership). The paper stresses the complexity of real-life contracting experiences, then describes the steps in contracting and key elements to success. Chief amongst these is the skills in management, monitoring and performance needed by both sides of the contracting agreement. Includes references to real life examples of contracting arrangements, successes and pitfalls. The paper looks at health broadly and does not focus on reproductive health.

Pick de Weiss, S., J.C. Hernandez, M. Alvarez, and R. Vernon. 1998. "Family Life Education Increases Contraceptive Knowledge and Use by Mexican Use." *Operations Research Summaries*, Population Council, New York. Available on the web at http://www.popcouncil.org/frontiers/orta/summaries/youth_mex.html

Briefly describes an operations research project carried out in the early 1990s to improve the sex education in Mexican schools. A main outcome of the study was the

decision by the Mexican Ministry of Education to contract the nongovernmental organization IMIFAP to adapt its sexuality education curriculum for use at the national level.

Preker, Alexander, April Harding, and Phyllida Travis. 2000. “‘Make or Buy’ Decisions in the Production of Health Care Goods and Services: new Insights from Institutional Economics and Organizational Theory.” *Bulletin of the World Health Organization* 78, no. 6: 779-790. Available on the web at <http://www.who.int/bulletin/tableofcontents/2000/vol.78no.6.html>

The authors propose a conceptual framework to examine the core production activities in the health sector, with a view to helping governments to arrive at more rational “make or buy” decisions on health care goods and services. They conclude that governments can buy most inputs for the health sector, with the exception of human resources and knowledge, from the private sector. They point out, nonetheless, that moving from public to private production of health care is not easy, requiring time and capacity-building in contracting, regulation, and the coordination of nongovernmental providers.

Rosen, J. and S. Conly. 1999. Expanding the Private Commercial Sector’s Role in Meeting Reproductive Health Needs. *Population Action International*. Available on the web at http://www.populationaction.org/forms/pub_new/socioeconomic.htm.

This study examines how developing country governments and international donors can stimulate private sector involvement in the reproductive health arena, with a particular emphasis on improving the availability of commodities such as contraceptives, drugs for treatment of sexually transmitted infections (STIs), and nutritional supplements. The report aims to help policymakers in both developing and donor countries better understand the crucial role of private business in expanding access to reproductive health care.

Seltzer, J., J. Brady, E. Murphy, and R. Stern. 1996. Evaluation of Promoting Financial Investments and Transfers (PROFIT) Project. *USAID and Population Technical Assistance Project*. Available on the web at <http://www.poptechproject.com/pdf/PROFIT44.pdf>.

The PROFIT project has been implemented by a prime contractor, Deloitte Touche Tohmatsu. The objective of the contract was to increase developing country resources for family planning by encouraging greater private sector resources (funds, services, and commodities). PROFIT’s goals were to (1) act as a catalyst for creating models showing that family planning in the private sector can be profitable and sustainable; (2) establish 20 large subprojects; (3) leverage USAID funds; (4) achieve a measurable impact; (5) provide a central resource of financial and managerial expertise for USAID/Washington and Missions and Cooperating Agencies (CAs). Through its investment subprojects, PROFIT has demonstrated that it is possible to make investments in the private, for-profit sector of family planning and health with very good prospects for recovering the principal sum invested.

Shaw, R. Paul. 1999. New trends in Public Sector Management in Health: Applications in Developed and Developing Countries. *World Bank Institute, WBI Working Papers*.

In the first section of this paper the author reviews the broad motivations behind the New Public Sector Management (NPSM), including intrinsic differences between public and private organizations that appear to affect incentives and performance. Part I also reviews the experience in selected OECD countries where the financing and delivery of social services is heavily socialized with a strong public sector role. The second section of the paper describes the NPSM paradigm in terms of three building blocks that influence the performance of public agencies and the behaviors of employees who work for them. It explains how leverage points within the NPSM paradigm are expected to create incentives for improved performance. This part of the paper gives the reader a working model of NSPM. The third section of the paper illustrates five organizational strategies that can be used to introduce NSPM into public agencies. The organizational strategies include (i) increased accountability in personnel performance management, (ii) performance-related budgeting, (iii) autonomous agencies, (iv) managed competition and contracting, and (v) corporation. The last section is a concluding section that acknowledges that an “adequate environment” must be in place if NPSM reforms are to take hold and be sustainable (includes a checklist of specific conditions).

Slack, K. and W. Savedoff. 2000. Public Purchaser – Private Provider Contracting for Health Services: Examples in Latin America and the Caribbean.

The authors examine 29 examples of health contracting from 15 countries in Latin America and the Caribbean. Key information on 40 features of the examples are compiled in a database. The authors identify 3 key issues: provider payment mechanisms; quality assurance and monitoring and information systems; and market and policy environment—and draws on the country examples to show the impact on contract outcomes. For an electronic copy of the database (in Microsoft Access) containing full information on the 29 case examples, send an email to bills@iadb.org with the words “contracting database” in the subject.

Slater, S. and C. Saade. 1996. Mobilizing the commercial sector for public health objectives: a practical guide. UNICEF, USAID, BASICS. Available on the web at <http://www.basics.org/Publications/Mobilizing/Mobilizi.htm>

The purpose of this guide is to provide the map, compass, and tools needed to explore and develop alliances between the public and private health sectors. This document has been written for health professionals worldwide who face the challenge of enhancing public health while struggling with limited resources, ranging from government officials to donor agency staff and social marketing consulting. This guide describes the process for conducting an initial exploration of the potential for a public/private partnership in a given commercial and health environment. It enumerates steps to be taken to establish the partnership and identifies the roles and responsibilities of each partner. The guide then details the activities the partnership should plan to achieve the public health objectives it sets.

Stanback, J. 1997. Perspectives on the local manufacture of contraceptives. *Profit*.

This report examines the issue of donors' support for the local manufacture of contraceptives in developing countries. Decisions about the feasibility and advisability of local manufacturing must be made on the basis of the factors specific to the particular project and location. Donors and manufacturers should assess not only the economic and technical feasibility of potential projects but also the social and political factors that may affect the success of the venture. These include the interests, motivations, actions, and interactions of those involved, including multinational and local pharmaceutical firms, donors, government officials, and consumers. An appendix includes a checklist of questions and issues to be considered.

Standing, Hilary. 1997. "Gender and equity in health sector reform programs: a review." *Health Policy and Planning*, 12, no.1: 1-18.

Sections 5 and 6 specifically address contracting out and working with the private sector. The author notes that little systematic evidence is available regarding the impact of contracting out on women's access to reproductive health care and on reproductive health outcomes. There is some potential for "managed competition" including contracting of services to improve access, but much would depend on contracts or arrangements that would reach many of the nonformal providers to which many women turn first.

Toro, R., L. M. Arcila and F. Gomez. 1997. Profamilia vis-à-vis Law 100 of 1993: Is it possible to substitute subsidies with contracts? 40 pages plus annexes.

This study attempts answers the question How can PROFAMILIA mobilize resources they obtain from the agreement established by Law 100 to finance family planning programs for low income populations? The first chapter presents an overview of the demographic change experienced in Colombia, highlighting the role played by PROFAMILIA in this transformation. The second chapter analyzes how PROFAMILIA financed its activities and the importance of international contributions in the composition of the institution's resources. The third chapter summarizes the main components of the reform, particularly with regards to sexual and reproductive health and family planning. The fourth chapter analyzes the actions designed by PROFAMILIA and those they may start to assure its connection to the new health system. The fifth and last chapter includes conclusions and recommendations for PROFAMILIA to attain financial self-sufficiency through service sales (contracts) to health institutions.

World Bank. forthcoming 2001. Private Participation in Health Handbook. Contracting for Health Services Background Paper. 41 pages including bibliography.

A broad overview of contracting for health services, the document is intended to provide background for the Handbook being prepared for the World Bank's Health Systems Development Thematic Group. Includes a discussion of the benefits and risks of contracting; the array of purchasing options available to governments; the steps in contracting out; monitoring and evaluation of contract performance; and government and private sector capacity in contracting out. Includes a bibliography.

World Bank. 1995. *Bureaucrats in Business: The Economics and Politics of Government Ownership*. New York: Oxford University Press.

Chapter 3 discusses contracting as it relates to the performance of state-owned enterprises in developing countries. The study looks at three types of contracts: performance contracts between governments and public managers; management contracts where governments contract the management of state owned firms to private managers; and regulatory contracts that define the relationship between governments and regulated privately-owned monopolies. The study found that, in general, the greater the degree of privatization the better the subsequent performance of the state owned (or formerly state owned) enterprise. The study also found that such contracts were used relatively infrequently.

World Bank and Population Action International. 1999. *Building Effective Partnerships: The World Bank and External Technical Agencies in Population and Reproductive Health*. Report of a Seminar organized by the World Bank and Population Action International.

Describes the experience of two international technical assistance agencies that received Bank funding. In Pakistan, the government awarded a technical assistance contract to the Population Council using World Bank loan funds. In Vietnam, the Bank funded the Futures Group directly.

World Health Organization Regional Office for Europe. 1996. *European Health Care Reforms: Analysis of Current Strategies*. Available in summary form on the web at http://www.observatory.dk/frame_index_main.htm

This volume provides a broad overview of the health and health sector challenges faced by policy-makers in the European Region in the second half of the 1990s, and reviews the available evidence on the impact of key reform strategies. It is conceptual as well as empirical in approach, combining epidemiological, economic, organizational and managerial perspectives on the current status of health systems in both the eastern and western parts of the European Region. The study's findings are based on over 30 background papers written by a team of scholars from all parts of Europe, as well as from Canada, the World Bank and WHO. Includes a discussion of government contracting for health care.

Annex 3: Web-based Resources

The Challenge of Health Reform: Reaching the Poor. www.worldbank.org/lachealth Case studies from this conference held in May 2000 in Costa Rica are available on the web site of the World Bank's Latin America and Caribbean Region. Several of the case studies address contracting issues.

Commercial Market Strategies. www.cmsproject.com This USAID-funded project provides technical assistance in the areas of policy, finance, economics, research and evaluation supporting private sector provision of family planning and other reproductive health services in the developing world.

Community Contracting Website.

<http://www.worldbank.org/html/fpd/water/topics/commcontracting.html>

The site provides users with a variety of tools essential for doing community based contracting. In addition to providing descriptions of sample projects and the different community contracting models used, it also provides resources (such as World Bank staff with relevant experience, links to organizations, and key readings) and "good practices" - Interviews with World Bank Task Managers.

The European Observatory on Health Care Systems. www.observatory.dk The Observatory, a partnership between a number of European and international organizations, supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. The Country Profiles on the Observatory's web site give detailed information on health care reform efforts in Europe and the Central Asia, and include discussion of government experience in contracting for health care.

The Institute for Health Sector Development. www.ihsd.org IHSD was established in 1995 with support from the Department for International Development (DFID) of the British Government. Since then, it has been DFID's Resource Center for Health Sector Reform. The web site includes a number of the Institute's publication on-line, including country health briefing papers for over a dozen developing countries, and lists upcoming conferences on health reform topics.

Latin America and Caribbean Regional Health Sector Reform Initiative. www.americas.health-sector-reform.org A partnership between the Pan American Health Organization and the U.S. Agency for International Development and three of its technical assistance cooperating agencies, the Initiative supports national health reform processes in the region. The clearinghouse on the Initiative's web site includes announcements of events, publications of the Initiative, a library of "gray literature," profiles of health systems in the region, official health reform policy documents, and network of contacts working in health sector reform.

Partnerships for Health Reform. www.phrproject.com This USAID-funded project provides technical assistance, applied research, information training, and other services to improve health systems worldwide. The web site provides on-line access to a number of the project's publications.

Annex 4: Contracting Network*

Organization	Name	Telephone	Email	Regional Expertise	Interests
World Bank					
World Bank	Anwar Bach-Baouab	202-473-35037	Abachbaouab@worldbank.org	Africa	HIV/AIDS
World Bank	Kevin Casey	202-473-2871	Kcasey@worldbank.org	Asia	Procurement
World Bank, Pan American Health Org.	Jillian Cohen	202-458-8587; 202-974-3357	cohenjil@paho.org ; jcohen@worldbank.org	Asia, Latin America	Drug Supply
World Bank	Samantha de Silva	202-473-1774	Sdesilva@worldbank.org	Africa	Community Contracting
World Bank	Hugo Diaz-Etchevehere	202-458-2368	hdiatzetchevehere@worldbank.org	Asia, Latin America	Health Reform
World Bank	Joanne Epp	202-473-1083	Jepp@worldbank.org		RH, contracting
World Bank	Manish Gangal	91-141-220162	Manishgangal@yahoo.com	Asia	Drug Supply
World Bank	Ramesh Govindaraj	202-473-2948	Rgovindaraj@worldbank.org	Asia	NGO Contracting
World Bank	April Harding	202-458-7371	Aharding3@worldbank.org		Health Reform, Contracting
World Bank	Eva Jarawan	202-473-4028	Ejarawan@worldbank.org	Middle East, N. Africa	Lebanon, Tunisia hospital food services,
World Bank	Iqbal Kabir	880-2-9669301-8	Akabir@worldbank.org	Asia	Nutrition
World Bank	Marzena Kulis	tel. + 48 22 520 80 00, 520 80 23	Mkulis@worldbank.org	Poland, E. Europe	General health contracting
World Bank	Gerard La Forgia	202-458-9730	Glaforgia@worldbank.org	Latin America	Primary health care
World Bank	Ben Loevinsohn	202-473-7948	bloevinsohn@worldbank.org	Asia	Primary health care
World Bank (seconded to IADB Dominican Republic)	Tonia Marek	1-809-562-64-00	Toniam@iadb.org Tmarek@worldbank.org	Latin America, Africa	Nutrition; contracting; health sector reform; monitoring and evaluation
World Bank	Tazim Mawji	202-473-1614	Tmawji@worldbank.org	Asia	Tuberculosis
World Bank	Tom Merrick	202-473-6762	Tmerrick@worldbank.org	Worldwide	RH
World Bank	Tawhid Nawaz	202-458-0363	Tnawaz@worldbank.org	Asia	Health Systems Development Project in India
World Bank	Indra Pathmanathan	202-458-0730	IPathmanathan@worldbank.org	Asia	RH, NGO contracting
World Bank	Sandra Rosenhouse	202-473-32747	Srosenhouse@worldbank.org	Latin America	RH
World Bank	Fadia Saadah	202-458-2022	Fsaadah@worldbank.org	Asia	Reproductive Health
World Bank	Tshiya Subayi	202-473-0695	Tsubayi@worldbank.org	Africa	RH, FGM, NGO Contracting
World Bank	Denise Vaillancourt	202-473-3428	Dvaillancourt@worldbank.org	Africa	HIV/AIDS
World Bank	Bert Voetberg	202-458-1149	Avoetberg@worldbank.org	Africa	Contraceptive procurement; STI/HIV/AIDS
Other Multilateral Institutions					
Inter-American Development Bank	William Savedoff	202-623-1932	Bills@iadb.org	Latin America	Contracting
Inter-American Development Bank	Isabel Nieves	202-623-1943	Isabeln@iadb.org	Latin America	Health reform, contracting

* The *Contracting Network* consists of individuals at the World Bank and other organizations with expertise or interest in contracting of reproductive health care. It is intended to provide the reader with contacts when seeking more detailed information about the contracting experience in a particular region or subject area. This preliminary list is not meant to be exhaustive. The *Network* is open to all interested individuals.

Organization	Name	Telephone	Email	Regional Expertise	Interests
International Finance Corporation	Guy Ellena	202-458-8139	gellena@ifc.org	Latin America	Private sector and health
World Health Organization	Jean Perrot	41-22-791-2206/3490	Perrotj@who.ch	Worldwide	Contracting
Bilateral Donors					
DFID	John Worley	0171-917-0341		Worldwide	Health Reform
USAID	Karen Cavanaugh	202-712-5859	Kcavanaugh@usaid.gov	Latin America	Health Reform
USAID, Guatemala	Ed Scholl	502-332-0202/1472	Escholl@usaid.gov	Latin America	Health reform, contracting
International Technical Assistance Agencies					
Abt Associates	Sara Bennett	301-913-0500	Sara_Bennett@abtassoc.com	Worldwide	Health Reform
Abt Associates	Catherine Connor	301-913-0500	Catherine_Connor@abtassoc.com	Latin America	NGO Contracting, HIV/AIDS
Abt Associates	Courtney Barnett	301-913-0500	Courtney_Barnett@abtassoc.com	Latin America	HIV/AIDS
Development Associates, Dominican Republic	Leonel Valdivia	809-688-7950	Devassdr@tricom.net	Latin America	NGO Contracting, RH
Management Sciences for Health	Rina Eichler	703-524-6575	Reichler@msh.org		Primary health care
Population Services International	Dana Hovig	202-728-0072	dhovig@psiwash.org		Social marketing
Population Services International	Chuck Szymanski	202-785-0072	cszymanski@psiwash.org		Social marketing
Developing Country Nongovernmental Organizations					
BEMFAM, Brazil	Marcio Thome	55-21-210-2448 or fax to 55-21-220-4057	Mthome@bemfam.org.br	Latin America	Reproductive Health; NGO Contracting
Prisma, Peru	Miriam Rojo	511-464-0490 x 300	Mrojo@prisma.org.pe	Peru	Contraceptive procurement & logistics
Profamilia, Colombia	Jaime Guevara Delgado	571-338-3160 fax: 571-338-3159	jguevara@profamilia.org.co	Latin America, Colombia	NGO Contracting
Academics and Others					
Health Innovations International	Abby Bloom	612-9267-9254	Healthinnovate@optusnet.com.au	Worldwide	Contracting for general health services; health reform
George Washington University	Charlotte Leighton	202.994.4835 fax: 202-.994.0900	lphcxl@gwumc.edu	Worldwide	Reproductive Health, Health Reform
Consultant	James Rosen	703-841-0275	Jimrosen@bellatlantic.net	Worldwide	Reproductive Health
Harvard University	Kate Slack	617-576-1695	Kslack@mba2001.hbs.edu	Latin America	Health Reform, contracting

Annex 5: Contracting Examples*

Country, Year Started	Purchaser	Contractor	Reproductive Health Services	Functions
Latin America and the Caribbean				
Bolivia 1980s to present	Ministry of Health	Prosalud NGO	Primary health care including reproductive health	Clinical services and outreach/IEC
Brazil 1980s	Over 1000 municipal governments and 3 state governments	BEMFAM	Family planning and other reproductive health services	Clinical services and capacity building for municipal health workers
Brazil 1994	Ministry of Health	Over 200 NGOs and community-based organizations	HIV/AIDS	Prevention, care and support, advocacy
Colombia 1990s	Ministry of Health, Social Security Institute	Profamilia, other NGOs, and private for-profit	Primary health care, including family planning	Clinical, IEC
Dominican Republic 1999	Ministry of Health Directorates in 3 regions, USAID	3 Reproductive health NGOs	Mainly family planning	Training in clinical services and program management; contraceptive logistics management; clinical services
Guatemala	Ministry of Health	70 NGOs in indigenous areas	Primary health care, including family planning	Clinical services and outreach
Haiti 1999	Ministry of Health	Population Services International (NGO)	Family planning and HIV/AIDS prevention	Procurement and social marketing of condoms
Mexico 1990s	Social Security Institute	NGOs: FEMAP and MEXFAM	Family planning	Clinical services and IEC for factory workers and adolescents
Nicaragua 1990s	Ministry of Health	NGOs	STI prevention and treatment	Clinical services, testing, treatment
Peru 1990s	Ministry of Health, USAID	PRISMA NGO	Family planning	Procurement and supply of contraceptives
Africa				
Kenya 1997	Ministry of Health	NGO, GTZ	Family planning	International procurements of contraceptives and other medical supplies. Management of the logistics and distribution of the purchased goods.
Madagascar 1994	Office of the Prime Minister and central and regional management units	NGOs and community organizations in 534 rural villages	Maternal and child nutrition	Outreach services, training, and supervision
Mali 1998	Social fund	NGOs and community organizations	Primary health care, including reproductive health	Clinical services and outreach

* This table summarizes the Contracting Examples discussed in the Review of Experiences section of the guide.

Country, Year Started	Purchaser	Contractor	Reproductive Health Services	Functions
Senegal 1996	National Commission against Malnutrition within the Presidency of the Republic, Agetip	NGOs and community organizations in 14 cities	Maternal and child nutrition	Outreach services, training, and supervision
Senegal 1998	Ministry of Health	7 contracts awarded to NGOs of between \$50,000 and \$250,000 per year.	Primary health care, with an emphasis on reproductive health (in particular, AIDS prevention)	Clinical services and outreach
South Africa 1999	Ministry of Health	NGO	HIV/AIDS	Evaluation of Life Skills course and HIV/AIDS prevention training programs
Asia				
Bangladesh 1997	Ministry of Health	NGOs in 40 “thanas” with coverage of 10 million people	Maternal and child nutrition	Selection of community nutrition promoters and community nutrition organizers; payment honoraria to the community workers; management and supervision field activities; procurement of selected items such as supplementary food packets and growth monitoring cards
Bangladesh 2000	Ministry of Health	NGOs	Primary health care, including family planning	Clinical services, outreach
Cambodia 1997	Ministry of Health	5 NGOs in 5 districts serving 770,000 people	Primary health care, including family planning, prenatal, and obstetrical care	Clinical services, outreach and education, procurement of medical supplies
India 1998	Ministry of Health	58 large and mid-size NGOs and 650 smaller NGOs	Broad reproductive and child health	Outreach and referral
India 1998	Ministry of Health	Parastatal organization	Maternal health	Packaging of safe motherhood kits
Indonesia 1999	Ministry of Health	Private midwives	Maternal-child health, including family planning	Clinical services and outreach
Korea, Taiwan 1960s to 1970s	Ministries of Health	Private doctors	Family Planning, especially sterilization	Vouchers for clinical services
Pakistan 1990s	Ministry of Population Welfare	Population Council— International NGO	Family planning and other reproductive health	Evaluation and research

Annex 6: Glossary of Key Terms

Accreditation

Also known as prequalification, accreditation is the process through which potential contractors gain eligibility to bid on contracts. “the requirements a contractor may be required to fulfill in order to be eligible to submit a bid or proposal. Prequalification requirements might include proof of the organization’s legal incorporation and tax exempt status, a financial report, a list of the organization’s board members, and information about their services or products. Some contracts, especially those related to the delivery of clinical services, may require the contractor to be accredited by a recognized accreditation body.” (MSH Manager, 1998)

Agreement

A less formal arrangement than a contract, agreements usually are not legally binding. However, they do often closely resemble contracts in that they clearly spell out the responsibilities of each party to the agreement and their commitment to mutually agreed upon goals.

Competitive Bidding (Tendering)

The process by which purchasers select contractors using a combination of technical and cost criteria. The mechanism the purchaser uses to collect bids includes announcing the contract opportunity, distribution of bidding documents, request for separate technical and cost proposals, setting a deadline for submission of bids or proposals, and providing information to all potential bidders. *Open bidding* allows any potential contractor to submit a proposal. *Selective bidding* allows only accredited or prequalified providers to bid.

Contract

A legally binding, written agreement between two or more parties, that specifies something provided, such as services or products, and something received in return (payment for the services or product). (MSH Manager, 1998)

Payment Mechanisms

Block grant or fixed price. Payment of single fixed amount (including direct and indirect costs and profit) for all specified services for a specified period. A block grant functions much like a global budget.

Labor and Materials – payment of total direct costs (labor and materials) with an additional percentage for indirect costs, management, and profit.

Cost and Volume – payment of a fixed amount for a specified volume of service. Excess volume may be paid on a fee-per-case basis.

Fee-for-Service – payment based on an agreed price per procedure or test

Capitation – payment based on an agreed amount per person covered or enrolled for a specified package of covered services

Set Price – purchaser establishes payment amount in advance and requests bidders to propose how much they can provide for that price.

Prepayment – payment provided in advance for specified services to be rendered. Akin to Saltman’s “hard” contracts.

Indemnification – payment provided after service has been rendered. Akin to Saltman’s “soft” contracts.

(Source: World Bank. 2001. *Private Participation in Health Handbook*. Contracting for Health Services Background Paper. *Forthcoming*.)

Performance-based Contracting

A contracting approach that emphasizes the achievement of measurable results, for example raising immunization rates or improving nutritional status. Performance based contracts typically give contractors a financial reward for meeting or exceeding agreed-upon goals and penalize them for sub-par performance.

Private Sector

The private sector for health care comprises both for-profit and non-profit private individuals and organizations. *For-profit commercial providers* of health care exist to earn a profit for their owners and include private practice physicians, nurses, and midwives; traditional medical practitioners; hospitals, clinics, and health centers; and pharmacies and other retail drug and medical supply outlets. *Non-profit groups*, known as nongovernmental organizations (NGOs), are also private but define their mission in terms of some social or public health goal. Many have ties to religious groups.

Reproductive Health

Reproductive health care comprises a range of services including: family planning information, counseling, and services; care for women before, during, and after pregnancy; prevention and treatment of sexually transmitted infections including HIV/AIDS; abortion and post-abortion care; and information, education and counseling on human sexuality, reproductive health and parenthood. For more information on reproductive health care see *Improving Reproductive Health: The Role of the World Bank* available on the web at http://www.worldbank.org/html/extdr/hnp/population/imp_rh/default.htm

Social Marketing

Social marketing programs use marketing and communications techniques to motivate healthy behaviors. Most social marketing programs sell subsidized contraceptives and other health products through pharmacies and other retail outlets, or via the service delivery infrastructure of nongovernmental organizations. For more information on social marketing programs visit the web site of Population Services International at www.psiwash.org.

Sole-Source Award

A noncompetitive process in which the purchaser selects a particular contractor based on a unique set of skills or expertise.

Tendering

See competitive bidding

Transaction Costs

“The costs imposed through the use of the market for the provision of goods and services, as opposed to in-house provision.” (Domberger, 1998)

Annex 7: Examples of Contracting Documents*

The following documents are available on the web version of the Guide.

Description of types of services to be contracted

1. Scope of Work for Partnership Area Activities, Bangladesh Urban Primary Health Care Project (English, 5 pages)



Descriptions-A.pdf

2. Scope of Work for Contracting under the Contracting Health Services Pilot Project, Cambodia (English, 4 pages)



Descriptions-B.pdf

Bidding Documents

1. Letter of Invitation, Bangladesh Urban Primary Health Care Project (English, 5 pages)



Bidding-A.pdf

2. Instructions to Bidders, Bangladesh Urban Primary Health Care Project (English, 14 pages)



Bidding-B.pdf

3. Evaluation Criteria for Technical and Financial Proposal, Bangladesh Urban Primary Health Care Project (2 pages)



Bidding-C.pdf

4. Special Procedures and Terms of References for the Contracting of NGO Health Services by the Ministry of Health of El Salvador (9 pages, Spanish)



Bidding-D.pdf

5. Evaluation Criteria for Technical Proposals for Administration and Management of Health Services under the Contracting Health Services Pilot Project, Cambodia (English, 3 pages)

* The web version of the Guide includes the full set of contract documents. This print version includes only the Terms of Reference for “Mother NGOs”, National and Medium Sized NGOs, and Small NGOs participating in the Reproductive and Child Health Program of the Ministry of Health and Family Welfare of India.



Bidding-E.pdf

Performance-based Contracting Clauses

1. Partnership Agreement Objectives (Specific Measurable Results of Project Activities), Bangladesh Urban Primary Health Care Project (English, 2 pages)



Performance-based-A.pdf

Other Examples of Contract Specifications

1. Terms of Reference for Partnership Agreements, Bangladesh Urban Primary Health Care Project (English, 8 pages)



OExamples-A.pdf

2. Sample Contract Agreement, Bangladesh Urban Primary Health Care Project (English, 17 pages)



OExamples-B.pdf

3. Sample Partnership Agreement, from the *MSH Manager* Winter 1998/00. (1 page)



OExamples-C.pdf

4. Agreements between 3 Provincial Health Departments in the Dominican Republic and 3 nongovernmental organizations (Spanish, 6 pages each)



OExamples-D.pdf

5. Agreement between the Ministry of Health of the Dominican Republic and the nongovernmental organization Profamilia (Spanish, 5 pages)



OExamples-E.pdf

6. Health services contract between the Department of Antioquia, Colombia and the nongovernmental organization PROFAMILIA (Spanish, 11 pages)



OExamples-F.pdf

7. Operations Guide for Partnerships Between the Government of Senegal and Nongovernmental Organizations (French, 10 pages)



OExamples-G.pdf

8. Model agreement between the Ministry of Health of Senegal and nongovernmental organizations (French, 6 pages)



OExamples-H.pdf

9. Contract between the Ministry of Health of El Salvador and the nongovernmental organization CALMA to provide basic preventive health services in rural communities (Spanish, 5 pages)



OExamples-I.pdf

10. Partnership Agreement between the Ministry of Health of Peru and the NGO PRISMA for the distribution of contraceptives (Spanish, 2 pages)



OExamples-J.pdf

11. Terms of References for Contracting of Primary Health Care Services in Cambodia (English, 13 pages)



OExamples-K.pdf

Institutional Arrangements for Managing Contracts

1. Procedures for Resolving Project Implementation Issues, Bangladesh Urban Primary Health Care Project (English, 2 pages)



Institutional-A.pdf

2. Contract forms (Request for Payment; Quarterly Financial Report; Quarterly Program Progress Report; Quarterly Monitoring Report;) Bangladesh Urban Primary Health Care Project (English, 17 pages)



Institutional-B.pdf

3. Terms of Reference for the NGO Management and Follow-Up Unit of the Sector Investment Program (French, 1 page)



Institutional-C.pdf

4. Terms of Reference for “Mother NGOs,” National Medium Sized NGOs, and Small NGOs participating in the Reproductive and Child Health Program of the Ministry of Health and Family Welfare of India (English, 17 pages)



Institutional-D.pdf

5. Procedures for Resolving Project Implementation Issues, Contracting Health Services Pilot Project, Cambodia (English, 3 pages)



Institutional-E.pdf

6. Monitoring of Contractors under the Contracting Health Services Pilot Project, Cambodia (English, 2 pages)



Institutional-F.pdf

Evaluation and Monitoring

1. Performance Evaluation and Indicators for Evaluation of Performance, Bangladesh Urban Primary Health Care Project (English, 4 pages)



Evaluation-A.pdf

2. Evaluation of Contractors under the Contracting Health Services Pilot Project, Cambodia (English, 14 pages)



Evaluation-B.pdf



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THE WORLD BANK

1818 H Street, NW
Washington, DC USA 20433
Telephone: 202 477 1234
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org

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