

Helpdesk Research Report: Non-State Providers of Health Services in Fragile States

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Query: Collect information on delivery of health services by non-state providers in fragile and conflict-affected states, highlighting any evaluations of effectiveness in terms of 1) how they contribute to supporting government policies, strategies and systems, and 2) the effectiveness of the delivery of the services. What lessons arise from these evaluations?

Enquirer: DFID

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Overview

There appears to be very little literature on the effectiveness of non-state providers (NSPs) of health services in fragile states. There is some useful case study material, particularly from Afghanistan and Cambodia although this tends to focus on the effectiveness of service provision rather than the extent to which NSPs align services with government systems and policies. Furthermore, there is no consensus on what actually constitutes 'effectiveness'. Antuono et al (2006) evaluate the involvement of NGOs in service delivery in Bangladesh and Nepal in terms of effectiveness, cost, accountability and transparency, sustainability and transferability. In most cases however, the literature offers no such clarification.

Notwithstanding these limitations, this query response is structured as follows:

- Part 1 presents literature on non-state provision of health services¹ in fragile, conflict-affected, and post conflict states, including a number of country case studies
- Part 2 explores the issue of effectiveness of non-state providers in low income countries in general

Non-state provision of services in difficult environments

There has been a recent shift in NGO thinking on service delivery in difficult environments. The distinction between vertical, stand-alone 'humanitarian' and long term, capacity building 'development' interventions is increasingly blurred at an operational level. NGOs report closer engagement with the state over the last decade, prompted by perceived advantages in terms of

¹ Due to time constraints, this query response focuses on non-state provision of health services by NGOs, although the role of for-profit providers is explored to some extent in part 2.

reach and sustainability, changing institutional contexts and the sheer length of time they remain operational in countries locked into chronic instability. However, the profusion of different systems employed necessarily makes it hard to compare projects against each other, or make overall assessments of interventions' impact on systems and sectors as a whole.

Evidence of impact

While most mechanisms that use NSPs to deliver services (contracting, social marketing, franchising, provision of training and regulation) are being applied in fragile states, they are only being done at a very small scale and with very intensive support. Furthermore, there is little formal evaluation at sectoral level over time and consequently relatively little hard data on how far NSPs build sustainable, pro-poor government systems. Most of the studies including non state providers limit themselves to very basic questions such as their location, their personnel and their infrastructure. There are, however, process-level indications of positive impact in terms of staff trained, protocols agreed and ratified etc. There is also anecdotal evidence that individual projects/approaches may have had some long-term benefits in terms of building state capacity, and some evidence to suggest that larger NGOs in particular, and CSOs in general, tend to be able to deliver services more efficiently and cost-effectively to the poorest than do governments.

The mechanism that has probably been used the most in fragile states is contracting (including performance based financing). There is some evidence which indicates that contracting can increase service utilisation, increase service quality, improve efficiency, reduce service fragmentation, and support strengthening of national capacity. However, these mechanisms are likely to address only some health system strengthening issues, and do not fundamentally address the issues raised by state fragility.

More specifically, the basic package of health services (BPHS) contracting approach is often cited as an effective mechanism for health service delivery in fragile states and states emerging from conflict, despite challenges relating to the availability and quality of services, and advocacy activities. In terms of monitoring the effectiveness of BPHS, the balanced scorecard (BSC) is widely seen as a useful M&E tool. In Afghanistan for example, it has provided a platform for standardisation of the monitoring of results across different donor, NGO, and government health-care providers, allowing the Ministry of Public Health (MOPH) to be a more useful steward of the health sector. The development and use of the BSC has become a central part of a systematic effort to build the capacity of the MOPH, with a phased transition of responsibilities from technical assistance to the government.

Other observers, on the other hand, have voiced concern that contracting can promote precipitous decentralisation and that NGO independence and impartiality may be eroded. There are also concerns about the degree to which contracting can address equity issues, as pressures to achieve contractual obligations may make trying to address the needs of 'hard to reach' populations more challenging. The fact that NGOs are generally dependent on grants and contracts to finance their activities also makes them inherently unsustainable. In some cases, competition may not exist - especially where there may be no alternative providers - contracts may be difficult to specify and monitor, management costs may wipe out efficiency gains, and contracting may in fact fragment the health system. A further weakness of NGOs in such contexts is that they are seldom able to provide an overall framework in which to operate at both national and regional levels. Because of the diversity of NGOs, and of their goals, in most countries, a national perspective may be lost. A framework to ensure that all people have adequate access to services can usually only be provided by the state. Yet governments with weak capacity to deliver services may also be weak in a stewardship role.

Case studies

Afghanistan: Contracting with NGOs is generally believed to have worked well in Afghanistan and has proved to be a rapid way for the government to gain and maintain policy leadership. By setting priorities, allocating geographical responsibility, providing financing, and carefully monitoring performance, the MOPH has been able to provide direction to what was previously an uncoordinated and chaotic system. By giving NGOs a fair degree of autonomy but holding them accountable for achieving national priorities, it has addressed serious constraints such as scarce human resources, lack of physical facilities, and logistical challenges.

Cambodia: In Cambodia both internal and external reviews have showed that after 3 years of implementation, the utilization of health services in the contracted districts improved significantly, in comparison with the control districts. Both contracting-in and contracting-out produced similar results, though the greater managerial autonomy afforded contracting-out managers appears to have enabled them to make greater strides in improving health centre management.

East Timor: Perceived strengths of non-state provision of health services in East Timor include the ability of NGOs to respond rapidly, self-sufficiency, high level of commitment and good cooperation with the central health authority (CHA). Weaknesses include a relative lack of development experience, the need of some NGOs to compete vigorously for funding, a very high turnover of NGO staff, an unsustainable level of input from donors, high per capita expenditures, and little concern for national ownership or sustainability.

Bangladesh and Nepal: NGO capacity to work at a grassroots level in Bangladesh and Nepal is seen to have given them a comparative advantage in public service delivery. NGOs were generally found to offer higher quality services at lower cost and with greater reach than the government. Furthermore, monitoring by international donors has created a climate of greater accountability and transparency within the NGO community in both Bangladesh and Nepal

Recommendations

The literature offers a number of recommendations for stakeholders involved in non-state provision of health services in fragile states. These include:

- Supporting longer term, inclusive planning and implementation processes, including alignment or shadow alignment with national processes and systems, strengthened mechanisms for involving NGOs at high-table policy planning processes, donor harmonisation of processes and systems, and providing a clear policy framework that covers both formal and non-formal NSPs
- Longer term, predictable funding to enable pro-poor system development
- More effective sectoral monitoring and evaluation: aligning behind national indicators and systems where possible, harmonising donor criteria where systems are deemed inadequate, and supporting and expanding initiatives to develop sector-wide evaluation of donor interventions.
- Developing mechanisms for improved information exchange and improving the evidence base on what works at scale and in what contexts.
- Assuring a minimal stewardship function for the government, with a strengthened regulatory capacity
- Improving both the state and the NSP's capacity to work together
- Identifying and capitalising on existing sources of capacity (even if very small) and political will as starting points for health system rehabilitation;
- Structuring service-provider contracts to create incentives for transitioning service-delivery operations from international NGOs and firms to using NGOs and firms to build local capacity and engage with public health system actors.

Laurence, C. and Poole, L., 2005, 'Service Delivery in Difficult Environments: Transferable Approaches from the Humanitarian Community'

This paper identifies operational approaches in use by NGOs that could be adopted more widely to improve delivery of services in difficult environments with a focus on approaches that support the development of longer-term state capacity. The research, based on interviews with representatives from NGOs, academia and international and donor organisations, finds that there has been a substantial shift in NGO thinking on service delivery in difficult environments. The distinction between vertical, stand-alone 'humanitarian' and long term, capacity building 'development' interventions is increasingly blurred at an operational level. NGOs report closer engagement with the state over the last decade, prompted by perceived advantages in terms of reach and sustainability, changing institutional contexts and the sheer length of time they remain operational in countries locked into chronic instability.

The paper identifies three basic models of operation in difficult environments

- Vertical, humanitarian projects, where NGOs set up parallel structures, particularly appropriate for rapid response to emergencies
- Hybrid INGO/State model (e.g. Save the Children, Merlin and Action Against Hunger) which has become increasingly widespread in the last decade, and where NGOs work at different levels depending on the context: national level (agreeing mandate); sub-national/district community level (working through a range of existing facilities); and community level (linking communities to formal healthcare provision).
- Hybrid INGO/Civil Society Model (e.g. Christian Aid and Marie Stopes International) where organisations work through service providers outside the state including with local NGOs, civil society groups and private providers, particularly appropriate for working in relatively controversial areas, where the state is unwilling or unable to provide effective services.

The NGOs interviewed worked from the assumption that they should work through existing state systems wherever possible and use a hybrid state/NGO model where possible. The primary point of access to the state was usually at district level and below, although significant challenges included de-motivated staff, poor facilities and weak central policy-making. Further limits to effective engagements included:

- A significant degree of verticality in terms of management and reporting. The profusion of different systems employed necessarily makes it hard to compare projects against each other, or make overall assessments of interventions' impact on systems and sectors as a whole.
- Rapid and largely individually driven situation analysis by NGOs. In general, NGOs also have limited access to key government and international decision-making processes.
- Short-term, unpredictable funding, which makes it difficult to develop functioning, sustainable systems within what are by definition challenging contexts.

Health (pp 17-18)

Although health is perceived to be the easiest sector in which to engage with the state directly, certain aspects present more significant challenges (e.g. sexual and reproductive health). Marie Stopes International (MSI), for example, see themselves as a catalyser, doing model programming and aiming to build support for sexual and reproductive health (SRH) services rather than working directly through state systems. Because of this, their model is to work through local partner entities using staff from local communities to develop domestic expertise whilst advocating for governments to expand SRH provision into their service mix. Though they try to

maintain some critical distance from government, they conform to national strategies and plans where they are available and, where co-ordination systems are in place, they will shadow align or align with them.

Relatively little hard data is available on how far these approaches build sustainable, pro-poor government systems. There is relatively little formal evaluation at sectoral level over time, though initiatives are being developed to address this. There are, however, process-level indications of positive impact in terms of staff trained, protocols agreed and ratified etc. There is also anecdotal evidence that individual projects/approaches may have had some long-term benefits in terms of building state capacity. In Afghanistan, for example, several of the technically skilled people who are currently leading the government response to health were initially trained by international NGOs. There is also clear evidence that some approaches and interventions are not sustainable and do not build long-term systems and capacity.

In terms of interviewees' personal evaluation of building pro-poor government systems, a vocal minority argued that impact was broadly confined to impact mitigation and stabilising the situation. Unless the underlying issue of achieving a reliable national budget for services is addressed, service delivery would never be sustainable. One pessimistic view was that "we are effectively engaged in Humanitarian Relief. Even though we work with state systems, we do not leave much behind. We don't build capacity and we don't leave management systems. We train staff and pay them, but they'll leave when we stop paying. It is not their fault – these are difficult environments and people have to get by. Government staff have their own agenda and corruption is a big issue" (p28).

Finally, the paper offers some recommendations for donors and NGOs:

- Supporting longer term, inclusive planning and implementation processes, including alignment or shadow alignment with national processes and systems (planning cycles, administrative boundaries etc), strengthened mechanisms for involving NGOs at high-table policy planning processes, and donor harmonisation of processes and systems.
- Longer term, predictable funding to enable pro-poor system development
- Developing mechanisms for improved information exchange.
- More effective sectoral monitoring and evaluation: aligning behind national indicators and systems where possible, harmonising donor criteria where systems are deemed inadequate, and supporting and expanding initiatives to develop sector-wide evaluation of donor interventions.

Merlin and London School of Hygiene and Tropical Medicine, 2007, 'Health Service Delivery in Fragile States', Conference Report, 24-25 October

http://www.lshtm.ac.uk/hpu/conflict/files/publications/file_49.pdf

This report summarises the outcomes of a conference on 'Health Service Delivery in Fragile States for US\$ 5 per person per year: Myth or Reality?' in October 2007'. It discusses, among other things, the use of service delivery innovations such as contracting, performance based financing and other mechanisms (social marketing, franchising, etc) for working with non-state providers in fragile states. Presentations of evidence indicated that contracting and performance based financing can increase service utilisation, increase service quality, improve efficiency, reduce service fragmentation, and support strengthening of national capacity (public and non-state sectors). However, these mechanisms are likely to address only some HSS issues, and do not fundamentally address the issues raised by state fragility.

However, the evidence base around the effectiveness of NSPs is very limited, and highly constrained by the lack of impact evaluations. While most mechanisms that use NSPs to deliver services (contracting, social marketing, franchising, provision of training and regulation) are being applied in fragile states, they are only being done at a very small scale and with very intensive

support. In order to ensure that NSPs are integrated effectively into overall health systems, countries need to:

- provide a clear policy framework, that covers both formal and non-formal NSPs
- assure a minimal stewardship function, with a strengthened regulatory capacity
- improve both the state and the NSP's capacity to work together
- improve the evidence base on what works at scale and in what contexts.

Some expressed concerns that contracting NSPs could have an adverse effect on building the capacity of ministries, because contracts are more likely to focus on service delivery and not on systems development, and because salary increases provided by NSPs could contribute to skilled health staff moving out of the public sector. However it was noted that in Afghanistan, the use of contracting had been key in developing capacity and systems and that salary increases are leading to retention of health staff in the 'public' (contracted-out) health sector.

More NSPs are being encouraged to move from working in predominantly humanitarian mode to working in transitional phases, incorporating systems and capacity building activities in the range of work they do. This raises new opportunities for NSPs, but also challenges them in terms of developing the right skills to support capacity building and systems strengthening. Possible areas for further work include more examination of whether and how to scale up very successful but very localised NSP initiatives and concentrating on the changes required to enable them to take on the new roles and responsibilities involved in helping to rebuild health systems.

Having a basic health package allows for a coherent framework for focusing service delivery on essential services, though NGOs recognise there are real challenges to determining what should be included in the package, who is setting the agenda, and how to cater for health problems that fall outside the package, or for new vertical programmes that bring in new interventions. Similarly, contracting out of a nationally determined service package promotes Ministry of Health (MOH) ownership, helps increase service coverage and provides opportunities for building national NGO capacity. However, Merlin's experience indicates that contracting out can also promote precipitous decentralisation and there are dangers that by entering into contract arrangements NGO independence and impartiality may be eroded. Particular concerns were expressed about the degree to which contracting really can address equity issues, as pressures to achieve contractual obligations may make trying to address the needs of 'hard to reach' populations more challenging.

Further issues discussed are as follows:

- There is still a significant gap within donor organisations between humanitarian assistance funds and development assistance, leading to a transitional funding gap. As multi-donor trust funds seldom fund capacity building and systems strengthening, a new type of funding mechanisms may be needed to support these critical interventions.
- More thought needs to be given to developing health sector wide strategies in fragile states, even during emergency and transition phases, to reduce fragmentation and confusion. This could include pooled funding. The WHO Health Action in Crises unit would like to lead on creating sector wide approaches in fragile states.
- Returning to the question of 'fragility', international community engagement is not only about the level of resources going in for humanitarian or other types of assistance, but also about the level of dialogue with state or proto-state actors.

Brinkerhoff, D. W., 2008, 'From Humanitarian and Post-conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs' Health Systems 20/20, Bethesda, USA

<http://www.healthsystems2020.org/content/resource/detail/2153/>

In the health sector in fragile and post-conflict states, assistance focuses on three targets of intervention that are broadly sequential: 1) Meeting the immediate health needs of conflict affected populations, 2) Restoring essential health services, 3) Rehabilitating the health system. An increasingly popular approach is for donors and country health ministries to contract jointly with NGOs for provision of a basic package of health services (eg Afghanistan, Southern Sudan and more recently the Democratic Republic of Congo.)

This sequence of intervention targets can constitute a transition to health system strengthening, through increasing engagement with government as a partner rather than bypassing state actors, and focusing more and more on service delivery as it relates to the capacity of the health system. The report highlights one example from East Timor of a transition strategy that moves from bypass to partnership with an increasing emphasis on systems issues. The strategy consisted of four phases, beginning with imported external capacity from international NGOs in Phase I while technical assistance helped to establish new institutions capable of managing an integrated public health system. See also: <http://pascal.iseg.utl.pt/~cesa/WP2EastTimor.pdf> for a more detailed discussion of the programme.

- Phase I: During the initial emergency phase, NGOs re-established essential services. An Interim Health Authority (IHA) was established in February 2000 comprising Timorese health professionals in Dili and in each district along with a small number of international experts. IHA staff made assessment visits to all districts in preparation of a first sectoral planning exercise.
- Phase II: The health authority (DHS) started work on the establishment of a policy framework, medium term planning for the sector and on national preventive programs, including immunization campaigns. During the second half of 2000, DHS signed Memoranda of Understanding with NGOs for each district; formalising district health plans service standards, and initiated a basic system for distribution of essential pharmaceuticals.
- Phase III: In April 2001, the Ministry of Health took over the financing of a majority of the NGOs in the districts. By the third quarter of 2001, the first round of recruitment of health staff had been completed. Most of these staff had previously worked with NGOs or on government. Several senior staff members in the department were also sent for public health management training.
- Phase IV: At the request of the government, NGOs gradually withdrew from the districts between September and December 2001, and the Ministry of Health assumed management control of all health facilities. A few NGOs remained to provide specialized services on a countrywide basis.

The paper then offers some suggestions for enhancing the role of international NGOs in health system strengthening in fragile states. According to the author, transitional programming needs to take into account the need for the public health system to build legitimacy among its citizens and the need to rebuild (or create) sustainable public health system capacity, including in financing, operations, and governance. The tensions inherent in the two-track problem can be diminished when donors constructively align their relief assistance with country public health agencies to:

- identify and capitalise on existing sources of capacity (even if very small; also, these may be at the community level, not the center) and political will as starting points for health system rehabilitation;
- consider how relief activities can be structured as integral components of an eventual hand-off to country actors (as the East Timor case shows); and

- structure service-provider contracts to create incentives for transitioning service-delivery operations from international NGOs and firms to using NGOs and firms to build local capacity and engage with public health system actors.

World Bank, 2005, 'Service Delivery in LICUS contexts - Balancing Short-term Provision with Longer-term Institutional Goals', Discussion Note, World Bank, Washington, D.C.
http://siteresources.worldbank.org/INTSF/Resources/395669-1126194965141/1635383-1154459301238/LICUSServiceDelivery_ConceptNote.pdf

Among other things, this paper addresses the following questions in the context of Low Income countries Under Stress (LICUS):

- Should the government eventually work towards replacing, regulating and/or strengthening non-state service providers?
- What potential forms of synergy exist between rebuilding state capacity and enhancing mechanisms of cooperation (i.e. 'social capital') in civil society?

It argues that without some clear and shared donor strategy for rebuilding a responsive and effective state, the proliferation of NGO, CSO, Community Driven Development and Social Fund initiatives will lack breadth of impact or sustainability. Civil society organisations cannot design national policies or standards, nor can they substitute in the long term for citizen/client-policy maker relations.

Appendix 1 offers a brief evaluation of the effectiveness of NSPs in LICUS:

- How successful are different types of NSPs at reaching the poorest? In the reviews of NGO evaluations, larger NGOs in particular, and CSOs in general, tend to be able to deliver services more effectively to the poorest than do governments. However, the coverage of CSOs is limited---they tend to reach only small pockets of the population. The question of how to 'scale up' successful CSO activities therefore needs to be addressed in terms of how to reach more and poorer people effectively.
- What is the quality of services that NSPs provide? Do increased resources for CSOs lead to an increase in the quality of provision? Again, the review of the major NGO evaluations does not give any generic evidence of how well CSOs perform in terms of quality, and there are many examples to support or criticize CSO practices. In many instances the quality of services that CSOs provide is high---this tends to be especially true for certain specialized services. In other cases, quality is not superior to services provided by the state.
- How efficient and effective are NSPs in service delivery? The general accepted wisdom has been that CSOs are generally more efficient and cost effective than governments. However, this is a difficult area to measure. Very little empirical data are available on this question, and CSOs themselves tend not to carefully monitor or evaluate their actions. There is a need for more well-designed empirical research to address this question.
- How sustainable are NSPs activities? CSOs are generally dependent on grants and contracts to finance their activities, which are seldom inherently sustainable. Some donors have been requiring that CSO projects become more self-sustaining; however, in the context of service provision, this would generally require CSOs to impose user fees---a strategy generally incompatible with the goal of reaching the poorest.
- What linkage exists between NSP service delivery activities and those of the state? One of the inherent weaknesses of CSOs is that they are seldom able to provide an overall framework in which to operate at both national and regional levels. Because of the diversity of NGOs, and of their goals, in most countries, a framework to ensure that all people have adequate access to services can usually only be provided by the state.

- What is the impact of government legislation? Will some NSPs be able to take advantage of their increasing role in service delivery to exert positive political influence at the local levels?

Roberts, B., Guy, S., Sondorp, E. and Lee-Jones, L., 2008, 'A Basic Package of Health Services for Post-Conflict Countries: Implications for Sexual and Reproductive Health Services Reproductive', Health Matters, Volume 16, Issue 31, May, pp 57-64

http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B73FJ-4SM75FB-6&_user=128860&_rdoc=1&_fmt=&_orig=search&_sort=d&_view=c&_acct=C000010638&_version=1&_urlVersion=0&_userid=128860&md5=dc8529cb4cdc9689ea9bb38d5c4f7ed9

This paper describes an increasingly popular response to non-state provision of health services in post-conflict countries, namely for the country's government and donors to jointly contract NGOs to provide a Basic Package of Health Services (BPHS) as the principle means of long-term health service delivery for the country's whole population. The aim is to rapidly scale-up health services with proven, affordable health interventions and replace the fragmented, uncoordinated, vertically-dominant services characteristic in many post-conflict settings. The BPHS contracting approach has been driven largely by the World Bank. Different packages are currently being implemented in Afghanistan and Southern Sudan, and planned for the Democratic Republic of Congo. Key donors include the World Bank, European Commission and individual European nations, the Asia Development Bank and the US Agency for International Development (USAID), amongst others.

Focussing on sexual and reproductive health services, the paper argues that the BPHS contracting approach could provide an important means for rapidly scaling up effective, efficient and equitable services in countries emerging from conflict. Nevertheless, there are a number of challenges relating to the availability and quality of services, and advocacy activities on sexual and reproductive health. Governments and donors involved in the Basic Package of Health Services could adopt a flexible approach to allow NGOs to provide comprehensive sexual and reproductive health services and activities, while still following a Basic Package of Health Services contracting approach. The government and donors also need to monitor and evaluate NGO performance to ensure that the full range of sexual and reproductive health services included in the Basic Package are being provided and to the required quality. Existing monitoring and evaluation mechanisms, such as the balanced scorecard system used in Afghanistan, could be expanded to include a more comprehensive range of sexual and reproductive health indicators appropriate to the country. Specialist sexual and reproductive health NGOs could help to train providers of the Basic Package of Health Services. These NGOs can also provide support to local organisations advocating on issues related to reproductive health and rights.

Case studies

Afghanistan

Palmer, N., Strong, L., Wali, A. and Sondorp, E., 2006, 'Contracting out Health Services in Fragile States. Lessons from Afghanistan.', BMJ, 332, pp 718-721

<http://www.bmj.com/cgi/content/full/332/7543/718>

This paper asks what we can learn from Afghanistan's experience of contracting out health services to NGOs, and whether it is sustainable in the longer term. In collaboration with the Ministry of Public Health (MOPH), a number of donors are now funding contracts with NGOs worth over \$140m. These contracts nominally cover an expanding proportion of the population (currently estimated at 77%). Contracts exist in all 34 provinces and last from 12 months to 36 months, with an average of 26 months. There are now 27 NGOs with contracts, 17 international

and 10 Afghan. In addition, some contracts were awarded to consortia of national and international NGOs.

If contracts are to increase transparency, the quantity and quality of services must be both clearly specified and measurable. Currently, the terms of the contracts vary. Some donors are more focused on inputs (such as numbers of trained staff), some on process indicators (such as utilisation), and some on outputs (such as immunisation rates). They also have different incentives. World Bank contracts, for example, have a performance based element. Four NGOs have recently received bonuses amounting to 1% of their contract price for good performance, which is defined as an increase of at least 10 percentage points above baseline indicators. It will be important to continue to monitor how often payment is made or withheld and the effect that this has on providers' behaviour.

Overall, issues of specification and monitoring seem to be dealt with well—to the extent that service delivery in such settings can be monitored. Performance is being taken seriously; one contract with an international NGO has already been terminated for poor performance. For all contracts, progress reports and site visits are part of the monitoring process. In addition, to ensure objective measurement of performance a third party has been contracted to monitor services, although limited sampling means it is less able to reflect on access or health outcomes for the broader community.

The biggest challenge is how to specify contracts to encourage delivery of services to the most remote parts of the population. Although the contracts nominally cover a high proportion of the population, many remain outside the catchment area of any facility. It is currently difficult to specify or monitor the extent to which NGOs extend services into these areas.

Costs and sustainability

Costs associated with monitoring and managing the existing contracts are closely linked to issues of government capacity to carry out stewardship. Currently costs are increased by expatriate technical assistance both to help develop NGO and government capacity and to strengthen contract management. These expenses reflect the costs of a well managed and monitored contracting framework where capacity is weak. They raise issues both of their magnitude in comparison to a government hierarchy for service delivery, and more relevantly, how such costs could be met without continuing substantial donor inputs. Building local capacity to manage this system would reduce costs, but this requires a long term vision of the future model of health care in Afghanistan.

Decentralisation without fragmentation

In Afghanistan, central authority is limited and in places highly compromised. Despite the existence of a basic package of health services, decentralisation to non-state providers means that fragmentation is virtually inevitable. Variation is not automatically a problem—innovation may lead to advances in service delivery. But it is important to monitor whether differences have implications for equity and efficiency in the longer term. Strong international NGOs may engage in valuable capacity building activities in their area, but a national perspective on such activities may be lost. If these issues are not addressed in the current framework, concerns over the broader reconstruction of the Afghan health system may grow as it attempts to consolidate systems for drug supply and human resources.

What happens to NGOs as they scale-up?

Although the timescale of the current contracting framework is unclear, it is likely to continue in the medium term. If there is a further phase of expansion, the capacity of NGOs to continue to scale-up is unclear. A further issue is the relationship between government and NGOs. The Afghan government is already expressing concern over the role and behaviour of NGOs in the country's reconstruction process. Although central Ministry of Public Health staff believe that delivering services through NGOs is a good option for the medium term, interviews with staff at

provincial level suggested some reluctance to accept that NGOs may be there to stay, especially international NGOs.

Peters, D. H., Noor, A. A., Singh, L. P., Kakar, F. K., Hansen, P. M. and Burnham, G., 2007, 'A Balanced Scorecard for Health Services in Afghanistan', *Bulletin of the World Health Organization*, February, 85:2

http://www.jhsph.edu/refugee/publications_tools/publications/additional_pdfs/Peters_2007-balanced_scorecard_Afghanistan.pdf

Shortly after the fall of the Taliban regime, Afghanistan's Ministry of Public Health (MOPH) pursued a strategy to rebuild services provided by the MOPH as well as contracting with NGOs to provide a basic package of health services (BPHS). The MOPH developed a balanced scorecard (BSC) to regularly monitor the progress of the BPHS. At the design workshops, six domains were identified for incorporation into the BSC: patient perspectives, staff perspectives, capacity for service provision (structural inputs), service provision (technical quality), financial systems, and overall vision for the health sector. For these domains 29 indicators and benchmarks were then developed.

Nationally, health services were found to be reaching more of the poor than the less-poor population, and providing for more women than men, both key concerns of the government. However, serious deficiencies were found in five domains, and particularly in counselling patients, providing delivery care during childbirth, monitoring tuberculosis treatment, placing staff and equipment, and establishing functional village health councils.

According to the author, the BSC has proved itself to be a useful tool for the MOPH, NGOs, and other stakeholders, and has become one of the cornerstones of the government's monitoring and evaluation system. It has provided a platform for standardization of the monitoring of results across different donor, NGO, and government health-care providers, allowing MOPH to be a more useful steward of the health sector. The development and use of the BSC has become a central part of a systematic effort to build the capacity of the MOPH, with a phased transition of responsibilities from technical assistance to the government. The BSC has also helped stakeholders to focus on particular provinces, as well as on specific areas for improvement. NGOs are also taking the scorecard as an objective assessment and as useful for informing their decisions, and its findings are incorporated into decisions on performance bonuses and continuation of contracts.

The author also identifies a number of limitations of the BSC, including the fact that it has relatively little information on health-service coverage or health-status outcomes, and that the BSC is only measured at functional health facilities, and thus does not take into account places where the BPHS is not being provided.

Loevinsohn, B. and Sayed, G. D., 2008, 'Lessons From the Health Sector in Afghanistan: How Progress Can Be Made in Challenging Circumstances', *JAMA*, 300(6): pp 724-726

This article offers some analysis of the Afghan Ministry of Public Health's (MOPH) policy of contracting NGOs to deliver a basic package of health services (BPHS).

A key element of the BPHS is monitoring and evaluation, through household surveys, health care facility assessments, and a strengthened health management information system. The author finds that results thus far have been encouraging. There was a 136% increase in the number of functioning primary health care facilities between 2002 and 2007 and an increase in the proportion of those facilities having female physicians, nurses, or midwives from 24.8% to 83.0%. There was nearly a 4-fold increase in the number of outpatient visits between 2004 and 2007. There have also been significant improvements in the coverage of reproductive and child health

services. Even as the number of health care facilities was increasing and security was deteriorating, the quality of care improved significantly. Independent assessments were conducted in more than 60% of rural health centres and used to construct an index of quality of care that examined a large number of areas, including staffing; the knowledge of physicians, nurses, and midwives; the quality of observed patient– health worker interactions; and drug availability. The overall index derived from these health care facility assessments increased 32% from 2004 to 2007. It appears that health outcomes in Afghanistan also have improved in the last 6 years. The United Nations estimates a 22% and 26% decline in the rates of infant mortality and under 5-year mortality rate respectively between 2002 and 2006.

The author concludes that contracting with NGOs has worked well in Afghanistan and has proved to be a rapid way for the government to gain and maintain policy leadership. By setting priorities, allocating geographical responsibility, providing financing, and carefully monitoring performance, the MOPH has been able to provide direction to what was previously an uncoordinated and chaotic system. By giving NGOs a fair degree of autonomy but holding them accountable for achieving national priorities, it has addressed serious constraints such as scarce human resources, lack of physical facilities, and logistical challenges. Carrying out regular, independent, and rigorous monitoring and evaluation of health sector performance is expensive. However, it is a key aspect of the stewardship function and has allowed the MOPH to identify problems, act quickly to resolve them, and track whether progress has actually been achieved.

See also:

Waldman, R., Strong, L., and Wali, A., 2006, 'Afghanistan's Health System Since 2001: Condition Improved, Prognosis Cautiously Optimistic', Afghanistan Research and Evaluation Unit, Kabul

[http://www.reliefweb.int/rw/RWFiles2006.nsf/FilesByRWDocUnidFilename/KH11-72J7PB-full_report.pdf/\\$File/full_report.pdf](http://www.reliefweb.int/rw/RWFiles2006.nsf/FilesByRWDocUnidFilename/KH11-72J7PB-full_report.pdf/$File/full_report.pdf)

Strong, L., Wali, A. and Sondorp, E., 2005, 'Health Policy in Afghanistan: Two Years of Rapid Change', London School of Hygiene and Tropical Medicine, London

Cambodia

Soeters, R., Griffiths, F., 2003, 'Improving Government Health Services Through Contract Management: A Case from Cambodia, Health Policy and Planning; 18(1), pp 74-83

<http://heapol.oxfordjournals.org/cgi/content/abstract/18/1/74>

This paper describes contracting as a possible tool for Ministries of Health to improve health service delivery more rapidly than the more traditional reform approaches. In Cambodia, the Ministry of Health started an experiment with contracting in eight districts, covering 1 million people. Health care management in five districts was subcontracted to private sector operators, and their results were compared with three control districts. Both internal and external reviews showed that after 3 years of implementation, the utilization of health services in the contracted districts improved significantly, in comparison with the control districts. There was adequate competition in awarding the contracts. A Ministry of Health Project Co-ordinating Unit measured the performance of the contractors, and contributed pro-actively. There was no evidence of rent-seeking practices by either the contracting agency or the contractors.

This paper then describes in more detail the successes and failures in one of the contracted districts, where Health-Net International applied the contracting approach. Despite significantly increased official user fees, constituting 16% of recurrent costs, the utilization of services was equally increased. Patients thought the fees were reasonable because they were still lower than the fees demanded if government health workers charged informally. They also thought that the

services were of better quality than in the unregulated private sector. Another important result was that combining strict monitoring with performance-based incentives demonstrates a decrease in total family health expenditure of some 40% from \$18 to \$11 per capita per year. Innovative and decisive management proved to be essential, which is more likely to be achieved by a contracted manager than by regular government managers with life-long employment.

Bhushan et al., 2007, 'Contracting for Health: Evidence from Cambodia', Brookings Institution, Washington D.C.

http://ipl.econ.duke.edu/bread/papers/0605conf/bread0605_clingingsmith.pdf

The Contracting of Health Services Pilot Project in Cambodia contracted out management of public facilities to NGOs and increased public health spending on those facilities. The author finds that the project led to increases in targeted service outcomes of about one-half standard deviation on average. Two models were used for this project: contracting-in, which provides private sector management within a largely public sector set-up, and contracting-out, which provides complete control over staff and budget to the district contractor. Both approaches produced similar results, though the greater managerial autonomy afforded contracting-out managers appears to have enabled them to make greater strides in improving health centre management. There is no evidence that contractors shifted resources away from non-targeted outcomes, though non-targeted service outcomes did not show any larger improvement than the comparison group. There is some limited evidence of improvements in individual health. Although the programme increased use of public providers, contracting led to lower perceived quality of care among users. The project reduced private health expenditure, so total health expenditure likely decreased or stayed constant, suggesting that the approach was a cost-effective way to improve health service delivery in the Cambodian districts where it was implemented.

It is difficult to assess to what extent health services could be improved simply by spending more money in the existing public sector. The authors suggest that simple spending is unlikely to have been as effective as the contracting programme given the cross country evidence and the large programme effects. They argue that the combination of institutional change and some additional public spending is of considerable policy interest because it is feasible. Given the low public salaries of government health workers, it may not have been feasible to implement a purely institutional change without increased spending. Requiring providers to be present more often without paying them more might have violated individual participation constraints, and almost certainly would have been politically infeasible.

Overall, the contracting project was very effective in improving service delivery in the project area. Unlike other reviews of health care contracting around the world, the Cambodia project implemented contracting using a randomized design, which, according to the authors, makes it a particularly valuable example to learn from.

See also:

Loevinsohn, B., 2004, 'Improving the Performance and Equity of Primary Health Care: Contracting in Cambodia', draft

Asian Development Bank, 2002, 'Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia', ERD policy brief 6, ADB, Manila

<http://www.adb.org/Health/contracting-materials/Pub-7.pdf>

East Timor

Tulloch, J. et al, 2003, 'Initial Steps in Rebuilding the Health Sector in East Timor', the National Academies Press, Washington, D.C.

http://www.nap.edu/openbook.php?record_id=10702&page=R1

This online book includes an assessment of the strengths and weaknesses of non-state provision (NGOs) in East Timor (pp 26-28):

Strengths:

- ability to respond rapidly and their operational self-sufficiency. In East Timor, they moved in quickly, employed local health staff, and were the predominant source of health care for many months. Their contribution to saving lives and preventing suffering in East Timor was enormous.
- high level of commitment of most of their international staff and a willingness to work in remote areas and under tough conditions.
- A third very positive aspect of their presence in East Timor was their ultimately good cooperation with the central health authority (CHA). This can probably be attributed to the very frequent contact between the NGOs and the CHA and the fact that they were recognized and treated as genuine partners in the development process. Without this close collaboration, the task of re-establishing a health system and transferring responsibility for it to East Timorese health professionals would have been very much more difficult.

Weaknesses:

- Relative lack of development experience among their personnel.
- Provision of services under severe conditions often means high per capita expenditures and little concern for national ownership or sustainability.
- A very high turnover of NGO staff. Some NGOs recognized their limited capacity in development and voluntarily withdrew after the emergency phase and that others are specifically adapting themselves to post-conflict development. Addressing these problems requires expertise in reform and management of health systems in developing countries; the post-conflict context is only one dimension of a complex problem.
- The relatively high cost of their operations. In the East Timor context, the combined communication and logistics capacity of the NGOs working in the health sector dwarfed the capacity of the CHA. Funding for both NGOs and the CHA came ultimately from the same donors; cost-effectiveness and sustainability should have been one of their concerns.
- An unsustainable level of input from donors resulting in the need to scale back operations progressively and to transfer responsibility to national staff as the date of departure approached.
- The enormous variability in capacity of the NGOs and the need of some to compete vigorously for funding. The need to compete and to be seen to be performing led to considerable overstatement of capacity in some cases. From the perspective of the CHA, the best NGOs were those with a clear institutional definition of their intended role in East Timor, that worked in collaboration with the CHA, that knew their true capacity and limitations, that ensured they had capable staff on the ground, and that had sufficient financial resources to achieve their objectives.

For a summary of the issues covered in this paper see:

ODI, 2003, 'Rebuilding Health Services after Conflict: Lessons from East Timor and Afghanistan', ODI, London

<http://www.reliefweb.int/rw/rwb.nsf/AllDocsByUNID/728dcebad50f486085256dd5006fd68a>

Antuono, L. et al., 2006, 'Evaluating NGO Service Delivery in South Asia: Lessons for Afghanistan' Workshop in Public Affairs, International Issues Public Affairs, 860
<http://www.lafollette.wisc.edu/publications/workshops/2006/servicedelivery.pdf>

This paper evaluates NGO maternal and child health care, based on a comparison of NGO and government performance, using the criteria of effectiveness, cost, accountability and transparency, and sustainability (pp 12-17). Key findings include:

Effectiveness NGO capacity to work at a grassroots level in Bangladesh and Nepal has given them a comparative advantage in public service delivery. In Nepal, networking within the NGO community has been the key factor of the organisations' success, while the efficient use of community workers has been one of the factors of NGO success in Bangladesh.

- Bangladesh: Higher quality service; high rates of success in curbing child and maternal mortality rates; higher rates of immunisation, administration of vitamins, treatment of diarrhoea; more rapidly declining maternal mortality and malnutrition rates; greater ability to women efficiently to deliver services in villages and remote areas; financial incentives to improve staff performance; and greater capacity to expand activities and reach remote areas without losing efficiency
- Nepal: Successful use of local radio to convey messages that are vital to maternal and child health care efforts; and an increase in the number of women seeking prenatal care.

Costs: NGOs appear to have the capacity to deliver high quality services at lower costs in both Bangladesh and Nepal.

- Bangladesh: Lower cost of treatment per patient; lowering of real costs through insurance schemes and generic drug manufacturing; extensive use of (often voluntary) community health workers; subsidised maternal services.
- Nepal: NGO user fees correspond with the improvement of services.

Accountability and transparency: Monitoring by international donors has created a climate of greater accountability and transparency within the NGO community in Bangladesh and Nepal.

- Bangladesh: NGOs are accountable to donors, to the beneficiaries of their services, and to the government. Many NGOs have mechanisms that allow them to conduct in-depth evaluations of projects to strengthen their activities and publicise their findings. NGOs have also developed a participatory approach in which they help the community become a part of the management of the health organisation.
- Nepal: NGOs are performing in a relatively more transparent fashion than equivalent government service providers.

Sustainability: NGOs have facilitated the creation of health centres administered by local communities in Bangladesh and Nepal.

- Bangladesh: cost recovery fees; localised insurance programmes to promote internal self-sufficiency; efforts to enable local communities to own and manage their own health facilities. However, international NGO salaries can attract the most skilled workers from the public health sector.
- Nepal: increased involvement of community members in initiatives; introduction of user fees; local fundraising; and preparing groups to manage and eventually take over programmes.

The effectiveness of non state providers of health services in low income countries

Loevinsohn, B., and Harding, A., 2005, 'Buying results? Contracting for health service delivery in developing countries', *Lancet* 2005; 366: 676–81

http://www.cgdev.org/doc/ghprn/Lancet_harding.pdf

This article reviews global experience with contracting non-state entities (including NGOs) for improving health care delivery, focusing on cases where the outcomes, costs and scale have been explicitly evaluated. It finds that the potential difficulties often associated with contracting (e.g. increased inequities and lack of government capacity to manage the contract) were not observed in practice, or at least did not compromise contracting's effectiveness.

The case studies (Cambodia, Bangladesh (2 cases), Bolivia, Guatemala, Haiti, India, Madagascar and Pakistan) each involve contracting with nonprofits. The author notes there is little experience with contracting for-profit providers for primary health care in low-income countries. All of the cases are either management or service delivery contracts. The line between a management and service delivery contract blurs when the contractor uses government health workers but pays them substantially more than their civil service salaries. Government or donor grants to NGOs in which the NGOs define where and what services are delivered are common, particularly in HIV/AIDS prevention and treatment, but these are not true contracts since government generally has little say in what services are delivered, where, or how they will be assessed.

The major findings from the review are:

- Even in cases where contract management was not done well, contractors were still successful in delivering large-scale programmes. "The cases with successful contract management seem to have benefited from either external management support or having only a few contracts." (p. 679)
- The cases suggest, but do not prove, that the most successful approaches to contracting maximise the amount of autonomy given to contractors (e.g. in Cambodia where service delivery contracts did better than management contracts).
- The successful approaches focus on outputs and outcomes, rather than inputs. This approach requires careful monitoring and assessment, and so to achieve economies of scale need to be of a fairly large size – probably more than 500 000 beneficiaries.

Patouillard et al, 2007, 'Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature', *International Journal for Equity in Health*, 6:17

<http://www.equityhealthj.com/content/pdf/1475-9276-6-17.pdf>

This paper presents the results of a systematic literature review on the effectiveness of working with private for-profit providers of health services to reach the poor. It finds that few studies provided evidence on the impact of private sector interventions on quality and/ or utilization of care by the poor. It was, however, evident that many interventions have worked successfully in poor communities and positive equity impacts can be inferred from interventions that work with types of providers predominantly used by poor people. Better evidence of the equity impact of interventions working with the private sector is needed for more robust conclusions to be drawn.

A preliminary review identified eight areas of intervention involving the government or NGOs working with the private for-profit sector: social marketing, use of vouchers, pre-packaging of drugs, franchising, training, regulation, accreditation and contracting-out.

Available data indicate that poor people make significant use of the private sector, and that the quality of services they receive is at best variable. While a case can be made, therefore, for using public funds to work with for profit providers, there is a need for much stronger evidence that such interventions can lead to health improvements for poor people.

The review confirms that international interest in working with the private sector has been translated into a significant number of innovative schemes. Yet despite this large number of studies, relatively few qualified for inclusion as impact evaluations. Notwithstanding, it is clear that the ability of these interventions to produce a significant impact on quality and utilization of care is far from fully demonstrated.

Even fewer studies reported data on the average socio-economic status of populations served, and therefore, of the beneficiaries of any improvements in quality or utilisation of care. However, although detailed data were lacking in the majority of studies, it is evident that many interventions have worked successfully in poor communities. For example, even where specific information about socio-economic status is not provided, rural districts in low-income countries are very likely to contain populations defined as absolutely poor by any standards and successful interventions in these contexts are likely to produce equity improvements.

Liu, X. et al., 2004, 'Contracting for Primary Health Services: Evidence on Its Effects and a Framework for Evaluation', PHR plus

<http://www.who.int/management/resources/finances/ContractingPrimaryHealthServicesEvidence.pdf>

In chapter 3 of this report (pp 9-24) the authors review the available evidence on the impact of contracting out health services in developing countries, using the following performance indicators:

- Quantity of services provided
- Percentage of target population receiving specified services
- Quality of service (examples include waiting time, user satisfaction, and composite quality scores)
- Utilization of contracted services by target populations
- Hospital care indicators
- Health status (e.g., percentage of children with malnutrition)

From the literature, there is substantial evidence that contracting out can increase access to contracted services by increasing provision, utilization, and coverage of health services, particularly in underserved areas where public providers are not available or are less available. Contracting out also appears to have the potential to improve equity in both access and financing if services are well targeted. It is uncertain whether contracting out can improve quality of care, but it appears that contracted initiatives are more likely to result in improved quality if quality indicators are well and clearly developed and there is an established link between quality indicators and service provision. It may also be possible that quality is easier to improve where objectives are more narrowly defined. While contracting appears to lower unit and production costs, it has not been possible to demonstrate that contracting increases the efficiency of the overall health system, or lowers overall costs to purchasers.

Overall, despite the growing experience with contracting out of health services in developing countries, little evidence exists on the impact these programmes have had on equity, quality, and efficiency. Additionally, problems and flaws with the methodologies of studies cloud the validity of findings and generally prohibit generalization of results. For example:

- Performance measures at the programme level are not necessarily consistent with national level health system objectives.

- Aggregate performance measures, such as infant mortality, are not specific to contracting out, and so it is difficult to attribute causality
- Analyses of equity, quality, and efficiency are rarely performed.
- Most programme evaluation are poorly designed, due to a lack of baseline data and/or data from a control group necessary for estimating programme effects.
- There is a lack of studies on the determinants of program effects. Most M&E research currently is done on an individual program basis.
- There is the potential for both providers and implementation agencies receiving donor support to overestimate their performance
- There has been a lack of an overall M&E framework that guides the evaluation of contracting-out projects and the assessment of whether contracting out should be adopted as a national policy for improving health system performance.

Liu, X. Hotchkiss, D. and Bose, S., 2007, 'The Impact of Contracting-out on Health System Performance: A Conceptual Framework', Health Policy, Volume 82, Issue 2, pp. 200-211
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-4M57GX9-1&_user=122868&_rdoc=1&_fmt=&_orig=search&_sort=d&_view=c&_acct=C000010083&_version=1&_urlVersion=0&_userid=122868&md5=f11b154a39ac42fb95529f47b0196ff4#secx5

This paper argues that published evaluations of contracting-out in health have “generally failed to provide a full description of the contracting-out program in question in a consistent and standardized way, and do not enable cross-program analysis, which is considered necessary for generalizing scientific evidence using data from a sample of contracted-out programs”. (p.210) Most studies, it claims, have neglected to provide details of the conditions under which results were generated, including the specific design characteristics of contracts or the environment in which they operate. The authors present a conceptual framework for more rigorous, standardized and comprehensive evaluation of contracting to better support the study of the determinants of effectiveness and assess the impact of contracting-out on all dimensions of health system performance. In particular, the framework is designed to assess the effects of contracting at health system level. Under the framework, information is to be collected in four main areas: 1) features of the intervention, characteristics of contractor, provider and contractual relationship 2) the external environment 3) the (behavioural) response of providers and purchasers both within and outside the contracting-out scheme; 4) the impact of the contracting intervention.

Among the characteristics of the contractual relationships to be assessed are service type, the formality and duration of the contract, provider selection, performance requirements and payment mechanisms. In relation to service type, the paper stresses the importance of 'service contractibility', defined as measurability, monitorability, and contestability. Single services, services where there is a clear level of need, services with practical guidelines, technically simple services and services where there is a close correlation with health outcomes are seen as more likely to be contractible. A typology of health services by their level of contractibility is provided in table 1 (p. 203).

World Health Organisation, 2005, 'Working with the Non-State Sector to Achieve Public Health Goals', working paper 2, WHO, Geneva
http://www.who.int/management/working_paper_2_en_opt.pdf

This paper aims to develop consensus about key challenges and effective strategies in working with the non-state sector to achieve public health goals in the developing world. A review of evaluations of non-state provision of health care produces the following tentative results

Effectiveness of interventions to promote greater coverage of services through NSPs:

- Social marketing: tends to increase uptake of marketed commodity, but concerns about crowding out existing private sector
- Vouchers and business-targeted subsidies: positive impact on uptake but relatively little experience with this mechanism and administratively complex to target
- Contracting-out: Mixed findings leaning towards the positive; may lower costs, expand coverage, but requires appropriately structured contracts
- Public/private co-investment: Only anecdotal evidence regarding effectiveness in low-income countries
- Franchising: may increase uptake of services and increase quality of services. Very limited data.

Effectiveness of interventions to improve quality of services through NSPs:

- Information management (dissemination of information on non-state providers): limited evidence on how this affects user choice of provider and decision to seek care in the non-state sector.
- Providing resources to private providers: only anecdotal evidence of effectiveness.
- Franchising: May increase uptake but requires user willingness to pay.
- Accreditation: Mixed effectiveness at ratcheting quality in low-income countries. May be more effective when initiated in conjunction with a powerful purchaser (eg social health insurance scheme).
- Certification: Limited empirical evidence but may be more effective when initiated in conjunction with a powerful purchaser.
- Regulation: Substantial evidence of regulations remaining weakly implemented or being perverted by powerful vested interests.
- Training for private providers: Findings vary as to the extent to which training alone will solve quality problems, versus the need for a package of interventions which also create better incentives to provide good quality care.

A key message is that government has a responsibility to set the 'rules of the game'. Two critical roles are the ongoing collection and analysis of information about the non-state sector and regulation. To the extent possible, NSPs should be integrated into routine health information systems.

Recommendations for action include:

1. Define and establish a clear role for government with respect to NSPs
2. Strengthen basic regulatory functions
3. Build institutional capacity in the non-state health sector
4. Build public sector capacity to work with NSPs
5. Build capacity at the district level to support NSPs
6. Build capacity amongst civil society to play an advocacy role and hold NSPs and decision makers to account
7. Strengthen the empirical evidence base on effective non-state interventions, particularly for interventions which have been scaled-up
8. Strengthen the collection, analysis of information about non-state provision of health services

International Development Department, University of Birmingham (2004-2005): Non-state Provision of Basic Services

http://www.idd.bham.ac.uk/research/Service_Providers.shtml

This research project looks at whether and how governments, civil society organizations and donors may support non-state provision of pro-poor basic services, and to draw up guidelines for

donors wishing to support governments and civil society organizations in making appropriate interventions.

It includes six country studies (Bangladesh, India, Pakistan, Malawi, Nigeria and South Africa), each of which adopted a common approach to (i) selecting examples of intervention and describing their background and context, (ii) describing the intervention and analysing its performance, and (iii) explaining performance in terms of the interests, institutional and organizational constraints and opportunities affecting the intervention.

The studies focus on three broad forms of government (or civil society) intervention or action:

- Dialogue between state and non-state actors in deciding and reviewing policy and legislation about standards, regulatory and support systems, alternative service arrangements, roles, co-ordination and forms of collaboration
- The implementation of interventions to (a) regulate non-state providers by government and independent bodies by formal regulation, oversight; and (b) hold non-state providers accountable to clients
- The implementation of interventions to (a) commission service delivery; and (b) facilitate or support non-state providers.

Palmer, N., 2006, 'Non State Providers of Health Services', briefing paper for DFID policy division, London School of Hygiene and Tropical Medicine, London

http://www.idd.bham.ac.uk/research/pdfs/health_paper_June06.pdf

This paper considers the following key issues with regards to NSPs in the health sector:

- The scale, importance and comparative advantage of non state provider (NSP) activity in each of the sectors;
- The limits and potential for expanding state purchase of services through contracting of NSPs;
- The limits and potential for different forms of regulatory approach

Four lessons emerge from the discussion:

- to achieve successful and sustainable collaboration between governments and NSPs, there is a need to foster trust between them. Donors may find a useful investment in establishing fora which allow interaction and discussion between these groups.
- governments and donors tend to focus most on NGOs when they attempt to approach NSPs. However, the smaller scale for-profit providers may be the ones that are most widespread in reaching the poor.
- It is difficult to engage with scattered small scale providers (legal and illegal practitioners and drug sellers). This is compounded by the difficulty of monitoring their activities.
- A myriad of pilot projects has done little to solve any of these complex challenges. Most of the approaches demonstrated in the cases examined in this paper were ad hoc, small scale and without any clear agenda either for comprehensive evaluation or for subsequent scaling up.

An initial range of choices could include:

- Developing a specialist unit for monitoring and regulating private sector activity at national and regional levels.
- Investing in the establishment of incentive regulation approaches on a large scale and the specific monitoring needs of these approaches
- Investing in the fostering of better relationships between government and NSPs in the belief that such activity will better align their incentives

- Using the resources to improve government service delivery, thereby potentially reducing the use of NSPs

5. Additional information

Author

This query response was prepared by **Andrew McDevitt**: Andrew@gdrc.org

Contributors

Tom Barker (IDS)
Fiona Campbell (Merlin)
Jeff Barnes (Abt Associates)
Abdul Wali (Ministry of Public Health, Afghanistan)
David Peters (John Hopkins School of Public Health)
Benjamin Loevinsohn (World Bank)
Charlotte Laurence (Independent consultant)
Olga Bornemisza (LSHTM)
Anne Mills (LSHTM)
Angela Kearney (UNICEF)
Claire Mcloughlin (GSDRC)

Websites visited

Google, Google scholar, PSP-one, USAID, Health and Fragile States Network, High-Level Forum on the Health MDGs, Reliefweb, WHO, IDS, Eldis, GSDRC, INTRAC, World Vision, World Bank, LSHTM, Actionaid, The Alliance for Health Policy and Systems Research, DFID HRC, Health Systems 20/20

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