Health Systems for Tuberculosis (HS4TB)

Government Contracting of Non-State Providers for Health Services:

A SYNTHESIS OF KEY PRACTICES AND LESSONS

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USAID
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About HS4TB

The USAID Health Systems for Tuberculosis (HS4TB) project seeks to transform the way country leaders and health system managers understand and work toward TB control and elimination. HS4TB is a five-year USAID contract focusing on health systems priorities that most directly support achievement of TB outcomes, with a focus on health financing and governance in the USAID TB priority countries. The project helps countries increase domestic financing, use key TB resources more efficiently, build in-country technical and managerial competence and leadership, and support policy formation and dissemination. HS4TB is led by Management Sciences for Health (MSH) in partnership with Open Development.

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ABBREVIATIONS AND ACRONYMS

ART	antiretroviral therapy
BMGF	Bill and Melinda Gates Foundation
BPHS	basic package of health services
CBS	community-based services
CBO	community-based organization
CCW	community care worker
CHT	county health team
CHW	community health worker
CLM	community-led monitoring
CSO	civil society organization
DBT	direct benefit transfer
DFID	Department for International Development
DMSC	Durbar Mahila Samanwaya Committee
DSD	Department of Social Development
EOI	expression of interest
ETICA	Eliminating Tuberculosis in Central Asia
FARA	Fixed Amount Reimbursement Agreement
FBO	faith-based organization
FDC	fixed-dose combination
GFATM	Global Fund for AIDS, TB, and Malaria
GOI	Government of India
GOL	Government of Liberia
HIV	human immunodeficiency virus
HS4TB	Health Systems for Tuberculosis
HSS	health systems strengthening

ICNL	International Center for Not-for-Profit Law
IFI	international financing institution
INR	Indian Rupees
JEET	Joint Effort for Elimination of Tuberculosis
KII	key informant interview
LIC	low-income country
LMIC	low- and middle-income country
M&E	monitoring and evaluation
MOHSW	Ministry of Health and Social Welfare
MSH	Management Sciences for Health
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	nongovernmental organization
NPY	Ni-Kshay Poshan Yojana
NSP	national strategic plan
NTEP	National TB Elimination Program
NTP	national tuberculosis program
PBC	performance-based contracting
PHC	primary health care
PIU	project implementation unit
PPIA	public-private interface agency
PPM	public-private mix
PPSA	patient provider support agency
PSE	private sector engagement
RBHS	Rebuilding Basic Health Services
RK	Republic of Kazakhstan

SACS	State AIDS Prevention and Control Society
SEA	southern and eastern Africa
SOE	statement of expenditure
SOP	standard operating procedure
SPC	Service Priorities Coordination
SSO	State Social Order
TB	tuberculosis
TI	targeted intervention
TSU	technical support unit
TWG	technical working group
UATBC	Universal Access to TB Care
UMIC	upper middle-income country
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	US Agency for International Development
USG	US Government
WA	Western Africa
WC	Western Cape
WHO	World Health Organization

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EXECUTIVE SUMMARY

The purpose of this paper is to identify and synthesize commonalities in the practice of establishing contracting out (referred to as contracting in this paper) for health services – thus highlighting issues that may be relevant to policymakers considering engaging non-government partners through this mechanism.[1] The aim is to learn from countries that have sustainable contracting practices as defined by either government funding and/or use of national health systems (e.g., procurement, payment and management systems) for contracting. Six areas were examined:

- **Political will and advocacy**, including the impetus for contracting, the importance of the government's will to contract to non-state partners, and advocacy efforts to garner acceptance by stakeholders to spend public funds to hire non-state partners (especially for technical areas in which public funds were previously used only to support delivery by public sector providers).
- **Legal and regulatory environment**, including identification of the barriers to contracting and how they were overcome.
- **Governance structures and processes**, such as the part of the government and level of the health system at which various decisions and functions of contracting took place, the mechanisms for allocating roles and responsibilities, and the process to build capacity for contracting.
- **Financing and budget**, such as the sources of funding, linkages to budget cycles, the guidance followed if using domestic funds, provider payment systems, and issues with payments.
- **Evaluation, learning, and adapting** of the contracting process, practices used to assess contracting processes, and use of evaluation results to adapt and adjust contractual terms, mechanisms, or entities.
- **Development partner roles**, including the strategic use of their support to promote sustainability.

Country selection was a lengthy and careful process to ensure that each country selected had sustainable contracting practice. Inadvertently, the countries chosen were all contracting not-for-profit organizations, which may somewhat skew findings. Review countries and topics were: India for community HIV services; Kazakhstan for general social contracting and more recent experience for HIV and tuberculosis (TB) services; Liberia for a basic package of health services (BPHS); and South Africa's Western Cape (WC) province for HIV palliative care and subsequently for prevention, treatment, and integrated community services. This paper presents the key high-level lessons in each of the areas examined (see Section 2, and Annex 1 for a summary), followed by country-level findings with context and detail.

Two essential requirements, found across all the countries examined, set the stage for sustainable contracting: high-level political will; and ongoing advocacy and stakeholder participation in the process.

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[1] In this report, we focus on the establishment of service contracts, i.e., individual contracts with specific terms of reference for a specific organization to implement specific activities. (This contrasts with another form of health provider contracting, in which general quality criteria are used to empanel large numbers of healthcare providers who then provide a broad range of health services under a national or social health insurance scheme.) These kinds of service contracts occur under a "selective regime" whereby governments "engage private actors on a selective basis to fill gaps or address pressing priorities"; see Harding, A. Managing Markets for Health: Deploying the Tools of Government. https://m4h.sps.ed.ac.uk/pluginfile.php/15/course/summary/Section%202.pdf

Political will is built on a simple and clear message around why the country would benefit from contracting. Most procurement laws do not include specific language on health service contracting; hence, support from high-level policymakers and community can be important to instill confidence in the *legal and regulatory framework* and create workarounds when necessary. *Governance* approaches evolved with experience, often becoming more decentralized and less donor-dependent over time. Countries do not make upfront plans or decisions about where various contracting functions should be housed and what they should look like, and the incremental steps that are taken are based on the organization of the country's health and administrative systems. Alignment with domestic planning and budget cycles facilitates sustainable *budgeting and financing*, with decentralized contexts providing both risks and opportunities. Countries do not have built-in systematic *evaluations* of contracting processes overall, but do evaluate individual contracts, which allows for process updates, capacity building, and decisions on contract extensions. Finally, *development partner support* was found to be catalytic in countries that already had high-level political will and a vision as to why they wished to contract. Targeted donor support contributed to advocacy efforts, landscape and regulatory assessments, piloting, scale-up, system improvements, and transition to domestic systems and funding.

The design of this work focused intentionally on uncovering answers to questions not already found in existing contracting guidelines, manuals, and tools.

Every country has its unique path, and there is no single right way to approach contracting. We found that there are no generalized steps or processes that countries ought to follow. Political will, legal frameworks, governance structures, procurement rules, budgeting and financial and payment processes, and evaluation of contracting models are unique to each country. However, this study did uncover many specific examples of the various ways in which these issues can be addressed. These case studies not only serve to validate why some of the challenges and constraints to contracting exist, but also provide examples that other countries can draw upon as they tackle their own unique context.

WHY CONTRACT SELECTED TB SERVICES?

Most high-burden TB countries face a constrained external funding outlook and need to fund efficient implementation arrangements for their programs. Many rely on nongovernment partners (NGOs, private sector) for a significant portion of their TB response but lack a channel by which domestic financing can flow to such organizations. Government contracting of health or health-related services from both NGOs and the private commercial sector has the potential for increased health system capacity, efficiency, and accountability in a domestically financed environment.

1. INTRODUCTION

Among infectious diseases, TB continues to be one of the biggest killers worldwide. In 2022, there were 7.5 million people who newly developed active TB disease. Although active TB is curable in most cases,[2] an estimated 1.30 million people died from TB in 2022. Around 87 percent of new TB patients live in the World Health Organization (WHO)'s 30 high-burden TB countries, with more than two thirds of the global total in just eight countries: Bangladesh; China; the Democratic Republic of the Congo; India; Indonesia; Nigeria; Pakistan; and the Philippines.[3]

USAID leads the U.S. Government's (USG's) global TB efforts by working with agencies and partners around the world to cure those with active infections and prevent the spread of TB. In cooperation with ministries of health, USAID provides bilateral assistance in 24 countries with high burdens of TB and provides technical assistance to 31 additional countries. As part of this effort, the goal of the USAID-funded HS4TB project is to focus on the intersection of TB and health financing and governance strategies. Under its financing and governance objectives, HS4TB's four intermediate/sub-objectives are: a) Improving resource mobilization and allocation for TB services; b) Increasing the effective purchasing of TB priority services; c) Ensuring strong technical and managerial competence and leadership in the TB sector; and d) Strengthening the ability of national TB programs (NTP) to formulate and disseminate policies and standards. By synthesizing country experiences with contracting, this report supports the project's second sub-objective to "increase the effective purchasing of TB priority services," which may lead to future advocacy, policy, and programming recommendations.

There is a wide range of different guidelines, toolkits, and manuals on contracting of health services, including high-level overviews of contracting for policymakers by John Snow Inc.;[4] the Pan Caribbean Partnership against HIV and AIDS;[5] the USAID-funded SHOPS project;[6] the World Health Organization (WHO);[7] a book-length toolkit by the World Bank[8] focusing on practical operational aspects of performance-based contracting (PBC) of health services; another publication by the USAID-funded SHOPS project describing how social contracting for HIV services is organized in Vietnam;[9] and a UNDP

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[2] World Health Organization. Global Tuberculosis Report, 2023. https://iris.who.int/bitstream/handle/10665/373828/9789240083851-eng.pdf?sequence=1.

[3] Ibid

[4] Abramson, Wendy B. "Contracting for Health Care Service Delivery: A Manual for Policy Makers." John Snow Inc, June 2004. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10351&lid=3

[5] Cenac, Veronica, and Lucien Govaard. Social contracting toolkit: a Guidance Note for Decision-Making for Country Implementation of Social Contracting. Caribbean Community (CARICOM) Pan Caribbean Partnership against HIV and AIDS (PANCAP). 2021. https://web.archive.org/web/20231023215106/https:/pancap.org/pc/pcc/media/pancap_document/PANCAP-SOCIAL-CONTRACTING-TOOLKIT.pdf

[6] SHOPS Project. *Filling the Gap: Lessons for Policymakers and Donors on Contracting Out Family Planning and Reproductive Health Services. Primer*. Abt Associates, 2012. https://shopsplusproject.org/sites/default/files/resources/Contracting%20Out%20-%20Policy.pdf

[7] Hellowell, Mark, Andrew Myburgh, Gabrielle Appleford, Pranav Mohan, David Clarke, and Barbara O'Hanlon. "A guide to contracting for health services during the COVID-19 pandemic." World Health Organization, 2020. https://cdn.who.int/media/docs/default-source/health-system-governance/2021.01.19---contracting---conferency-copy.pdf?sfvrsn=92a3e9fd_3&download=true

[8] Loevinsohn, Benjamin. *Performance-Based Contracting for Health Services in Developing Countries: A Toolkit*. Health, Nutrition, and Population. The World Bank, 2008. https://openknowledge.worldbank.org/handle/10986/6481.

[9] Center for Health and Research Development, and Health Policy Plus. "Social Contracting Guidelines for HIV Services in Vietnam." Palladium, September 2019. http://www.healthpolicyplus.com/ns/pubs/17357-17641_VietnamSocialContractingModel.pdf

guidance note for the analysis of NGO social contracting mechanisms.[10] However, there is little available on the qualitative aspects of the process of establishing contracting pertaining to decision-making, obstacles, opportunities, and processes. These can only be discovered through interviews and discussions with key stakeholders from different countries that have implemented some form of contracting health services.

1.1 Purpose, Use, and Audience

The purpose of this paper is to identify and synthesize practices in public sector contracting of non-state organizations for health services that promote the institutionalization and sustainability of contracting practice. It focuses primarily on practices during the period when contracting was first considered and established. When relevant, it also looks at practices during implementation. This paper aims to identify and synthesize country experiences (lessons) about what worked, what did not work, how contracting decisions were made, what processes were adapted or changed, and how challenges were overcome.

The intended audience for this paper is country-level policymakers, NTP senior leadership and staff involved in procurement and implementation, and development partners. It is intended to inform about the following: (1) reasons for contracting and key drivers and obstacles to garnering political will; (2) promising legal, regulatory, and policy practices; (3) procedural and operational practices to structure and govern contracting programs; (4) budgeting and financial systems; and (5) how and when evaluation of contracting programs is used to learn and adapt models. Further rationale for prioritizing these areas of investigation, based on gaps in the existing literature, are outlined in Annex 2. An additional section was added to this paper to include (6) development partner practice and their roles to support contracting.

1.2 Methodology, Country Selection, and Limitations

Methods

This study was conceptualized and developed through a desk review of pertinent literature, including journal articles, technical and white papers, and 30 semi-structured key informant interviews with global experts (6) in contracting—by email or telephone—and country-level key informants (24) [11]. Country experts included those that were either involved in the establishment and set-up of contracting or during implementation. The focus of the desk review and key informant interviews with country experts was on the five thematic areas listed above. Additional lessons and themes that were identified by key informants were also included, and based upon these themes, an additional section on development partner support was added. Information gathered via desk review was triangulated through either virtual interviews or email exchanges. Likewise, information gathered during interviews was validated through additional desk reviews.

[10] Duric, Predrag, Timur Abdullaev, and John Mccauley. "Guidance Note for the Analysis of NGO Social Contracting Mechanisms. The Experience of Europe and Central Asia." UNDP, 2019. https://www.undp.org/eurasia/publications/guidance-ngo-social-contracting-mechanisms

[11] Refer to Annexes 3 and 4 respectively, for the global and country key informant interview guides, and Annexes 5 and 6, respectively, for the global and country key informant lists.

Country Selection[12]

The main criteria for country selection[13] were discussed and agreed upon between HS4TB and USAID, and the final choice includes countries that demonstrated a high degree of sustainability and institutionalization of contracting of non-state providers. Sustainability in this sense included, to the best of their ability, the use of country health systems and domestic (or loan) funding for contracting. Countries with experience in stand-alone contracting by ministries of health for some type of health or health-related services (e.g., clinical services, lab services, disease prevention, health promotion, outreach), either through a vertical program or a package of services that could go beyond TB, were considered, including of health service delivery at the primary care level.

Countries with contracting under national or social health insurance schemes, or examples of contracting in between levels of the public health system (government), were not included in the sample. Auxiliary service contracting,[14] unless it demonstrated a clear link with health service delivery, was also not included.

Four countries/areas were selected: India's vast experience contracting NGOs for community HIV services; Kazakhstan's long history of social contracting of civil society organizations (CSOs) and more recent experience contracting for HIV and TB services; Liberia's nationwide PBC for BPHS; and the evolution of South Africa's experience in the WC province contracting for HIV palliative care, and later for HIV prevention and treatment and for integrated community services.

Limitations

The selection criteria and process for identifying countries to include in the review resulted in countries primarily focused on contracting with NGOs rather than the commercial sector. This may mean that the findings may be more relevant to countries with a similar contracting focus. When interpreting the findings, it is also important to remember that most of the information sought was not time-bound objective data or events; rather, it was subjective in nature, often non-linear, and descriptive of processes and experiences. Other limitations include the following:

- Responses to questions were at times disjointed as those interviewed did not always understand the relevance of some of the questions asked or were not directly involved in decision-making and implementation. Some key informants (KIs) tended to focus on historical references and issues which was not the intended focus of this experiential study, while others struggled with process-focused questions.

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[12] HS4TB is working to support the national TB programs in Bangladesh and India and is witnessing the different trajectories of progress on contracting and the need for guidance. India's TB program developed and implemented a robust and well-planned private sector engagement (PSE) strategy which countries can learn a great deal from, and which culminated in domestically funded contracting (see Annex 7 for a chronology of India's PSE). Both Bangladesh and India have faced varied challenges to contracting based upon the legal and regulatory environment and the political will and capacity to operationalize contracting, respectively. Ongoing lessons learnt from these two countries will add to the global experience (see Annex 8).

[13] Refer to Annex 9 for our country selection process.

[14] Auxiliary services that support health service delivery, such as information technology and major supply chain logistics functions were not included as these services are typically less complicated to procure, both politically as well as operationally. These services do not generally require changes to legislation or regulation and fall under general government procurement law.

- There were inevitable gaps in information, because:
  - The questions asked spanned many aspects, players, and stages of contracting.
  - The process was not chronological or linear: events took place at different times, and decisions involved multiple mid- and high-level implementors, policymakers, and technical assistance providers across various levels of government and agencies.
  - Even by adding KIs, many questions remain unanswered; this will be further discussed throughout the report.
- This was an entirely remote-based review with no in-country researchers, and with a limited timeframe.

2. KEY LESSONS AND COMMON FACTORS IN ESTABLISHING AND SUSTAINING GOVERNMENT CONTRACTING TO NON-STATE PROVIDERS

This paper presents a series of practices for establishing contracting of health services in the early years of contracting to non-state providers, plus some experiences beyond initial establishment and early years of contracting. These practices can be considered by countries when establishing contracting. Shifts in authority and responsibility for political, economic, fiscal, and administrative systems from national governments to regional, departmental, provincial, and local governments vary from country to country, and as such must be taken into consideration as they affect design and implementation.

To organize this analysis, as mentioned above, six distinct topics related to initiating or informing existing contracting of health services were identified:

1) Political will and advocacy, including reasons to contract, country context, and stakeholder participation.

2) The enabling environment for contracting–policy, legal, and regulatory issues.

3) Institutionalizing contracting, including various operational aspects of contracting such as governance structures and processes.

4) Financing considerations, including linkages to the national budget and budget cycle as well as information on different payment modalities.

5) Evaluation, learning, and adapting of contracting policies and practices (as opposed to monitoring and evaluating contractor performance, which is an operational activity).

6) The role of development partners at critical junctions to foster local ownership and sustainability.

The structure of this section and its six sub-sections includes some brief points from the global literature, then synthesized lessons and common factors found across the study countries, followed by disaggregated country-level findings with some context and detail. Each section includes high-level

lessons that are not necessarily mutually exclusive nor sequential. Rather, they are all important to understand and address. These lessons are followed by country-level findings pertinent to each lesson. However, not all countries are discussed in each sub-section. This is not because there were no lessons to learn, but because this type of qualitative information was difficult to uncover given the limitations of this study.

2.1 Political Will and Advocacy

Political will includes the authority, capacity, and legitimacy of key decision-makers or reformers to make change, and the extent of committed support among key decision-makers for a particular policy solution to a particular problem. Political will exists when decision-makers, with a common understanding of a particular problem, are committed to supporting a potentially effective policy solution.

To establish and sustain contracting, there are a number of fundamental factors that contribute to political will including:

- the impetus for contracting and its evolution (why contract);
- the socio-political and historical context;
- the acceptance of the need for health sector reform; and
- the process used to garner and sustain stakeholder buy-in and input.

Global literature on contracting suggests that, in general, contracting initiatives arise from: an absence of government services; the inability of government to provide quality services or adequate coverage of health services; or as an effort to improve coordination and oversight of non-state providers[15],[16],[17].

For countries that are focused on direct health service delivery by the public sector, contracting is a major reform with ideological dimensions (e.g., around the role of the state in service provision). This generates in turn a complex political economy during the process of establishing contracting. Regardless of a high-level political decision to contract out, there may be strong political and bureaucratic opposition to contracting, or an absence of a legal environment conducive to enforcing contracts[18].

When deciding to contract out, the government needs to assess the political environment to determine: who benefits from contracting and to whom contracting may be detrimental (e.g., are there strong professional and medical associations or unions that generally benefit from the status quo, or might

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[15] Abramson, W. 2004. Contracting for Health Care Service Delivery: A Manual for Policy Makers. John Snow Inc. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10351&lid=3

[16] Loevinsohn, Benjamin. 2008. Performance-Based Contracting for Health Services in Developing Countries: A Toolkit. Health, Nutrition, and Population Series. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/6481

[17] Odendaal WA, Ward K, Uneke J, Uro-Chukwu H, Chitama D, Balakrishna Y, Kredo T. Contracting Out to Improve the Use of Clinical Health Services and Health Outcomes in Low- and Middle-Income Countries. Cochrane Database Syst Rev. 2018 Apr 3;4(4):CD008133. doi: 10.1002/14651858.CD008133.pub2. PMID: 29611869; PMCID: PMC6494528. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6494528/

[18] Ibid.

changes in the system offer new opportunities); what political forces outside the health sector may oppose or support contracting; whether there might be resistance to the introduction of traditional private sector management concepts into the public realm; and if contracting might be misunderstood as "privatization" of public health functions[19].

Mitigating measures exist that may help to alleviate these potential obstacles. Engaging in a sensitization process along with advocacy efforts are essential for country ownership and commitment (Pan Caribbean Partnership against HIV and AIDS 2021). Where there is strong opposition to contracting from within government, and amongst politicians, listening to better understand their concerns is a first step to developing an advocacy plan and effectively engage in stakeholder dialogue[20],[21].HS4TB's work in Bangladesh on stakeholder engagement has followed a similar path and is resulting in increased understanding and buy-in for contracting (see Annex 8).

POLITICAL WILL AND ADVOCACY – LESSONS

Lesson 1A: Political will for contracting is based on a clear rationale, such as a service gap that is better filled by community-based NGOs or CSOs, a need to reorient services and priorities to community level, a need for efficiencies or more dynamic performance management, or a desire for reduced dependence on international donors. *(India, Kazakhstan, Liberia, South Africa WC)*

Lesson 1B: Political leadership and a focused vision can create flexibilities and overcome operational gaps during establishment of contracting for services. *(India, Liberia)*; Early initiation of contracting can result from a health crisis, previous private sector work by government leaders, low public sector delivery capacity, and decentralized governance. *(South Africa WC)*

Lesson 1C: Ongoing dialogue with key stakeholders and continuous improvement of contracting models are needed both to establish and maintain support for contracting. *(Liberia, South Africa WC)*

Below are some of the lessons and findings that were found across the four countries.

While all four countries were clear as to what contracting hoped to achieve, there were no examples of explicit analytical efforts to "make the case" for contracting; rather, discussions and forums took place in all countries at different times to sensitize internal and external stakeholders as to what contracting entails. Although Liberia was the only country that mentioned having had a broad-based nation-wide assessment of contracting prior to start-up, South Africa WC did conduct a fiscal analysis. In the cases of

[19] Ibid
[20] Ibid
[21] Ibid

India and Kazakhstan, the KIs were not involved prior to contracting, and therefore not aware of the details of an assessment.

The initial impetus for contracting largely came from development partners in India in response to the HIV crisis; from the government in Kazakhstan immediately following the collapse of the Soviet Union (and later on from development partners when introducing contracting for TB and HIV); and in the case of post-conflict Liberia and post-apartheid South Africa WC (where healthcare is a provincial function), leaders saw contracting as an opportunity to rebuild the health system following a humanitarian crisis.

None of the respondents were able to explicitly identify the factors that made contracting successful; rather, factors of success were a matter of opinion and varied between sources. All countries reported that its success was due to contracting becoming a country-owned and -led initiative. There was little resistance to contracting from NGOs, although there was some skepticism regarding government's ability to pay. No further information was provided regarding the receptivity of other stakeholders to contracting.

Overarching lesson: High-level leadership and ongoing stakeholder involvement are key to success. Without political will, nothing gets done.

Lesson 1A: *Political will for contracting is based on a clear rationale, such as a service gap that is better filled by community-based NGOs or CSOs, a need to reorient services and priorities to community level, a need for efficiencies or more dynamic performance management, or a desire for reduced dependence on international donors. (India, Kazakhstan, Liberia, South Africa WC)*

India: *Urgency to halt HIV spread required working at the grassroots level with vulnerable populations; this necessitated the contracting of NGOs.*

India realized early on during phase I of the National AIDS Control Program (NACP I, 1992-1997) that, to halt the spread of HIV, new activities were needed such as expansion of local surveillance networks, reaching key and vulnerable populations, and collaboration with grassroots organizations who had a presence in the communities. In 1992, the National AIDS Control Organization (NACO) was formed as an autonomous body for HIV/AIDS prevention and control to institutionalize the NACP (Lesson 1B provides further explanation of NACO). Although traditionally working directly with NGOs had not been common for most government programs in India, senior leadership of NACO understood the importance of partnering with NGOs for behavior change interventions to reach marginalized and hidden populations. This partnership resulted in the design and successful implementation of targeted interventions (TIs) (the nomenclature for contracts) with NGOs.[22] NACO's extensive and ongoing efforts over the last three decades to leverage a wide array of public and private sector stakeholders and health care partners was instrumental in the scale-up of contracting and the success of India's overall response to HIV/AIDS. Thus, overall, program needs dictated program structure.

[22] Mohammed, Suresh Kunhi, Ronald Upenyu Mutasa, and Ishira Mehta. "Targeted Interventions: India's Pathbreaking Approach to Address the HIV/AIDS Pandemic," February 2021. http://hdl.handle.net/10986/35375.

Kazakhstan: *The impetus for contracting stemmed from a desire to reduce dependence on international aid, supported by a reform-minded environment and an historical acceptance of the role of CSOs.*

Since the 1990s, CSOs in the Republic of Kazakhstan (RK) have been well-organized and highly motivated. Contracting was born from an historical focus on social protection through social services. This culture of cooperation and trust between government and CSOs combined with political will from the highest levels of government for contracting across sectors and across the country.[23] On October 24, 2000, the President of Kazakhstan announced the need to create "a system to provide funding for socially important projects to NGOs." The idea of governmental support of social NGOs also became widespread at the community level. At that time, several NGOs—including the most active, the Confederation of NGOs of Kazakhstan—conducted a long-term campaign advocating a special law on state social contracts. Five years later, in 2005, a law on contracting was passed, referred to as the State Social Order (SSO) "*socialnyi zakaz*" mechanism to procure NGO services.

In addition to advocacy by NGOs for contracting, the pathway to formulate the 2005 law on contracting is also seen as resulting from the government's desire to end their reliance on foreign funding.[24] Kazakh officials believed that donors ultimately determine the policy of the organizations which they finance, and thus they strived to supplant "foreign donors", so that the domestic government could more effectively influence the policy priorities of local NGOs.[25]

– Contracting community-based organizations (CBOs) was a logical approach to shift TB service delivery from in-patient to primary and community settings.

In the past 10-15 years, Kazakhstan has shifted from the former Soviet model of hospital-based and institutional care of TB patients to a primary care model; this is also a more logical fit for CSO support. The groundwork for contracting CSOs for TB had already been laid given Kazakhstan's long history of contracting.

Liberia: *Contracted NGOs and faith-based organizations (FBOs) filled post-conflict gaps in public sector service delivery, while allowing government to reassert its stewardship role.*

After emerging from a 14-year civil war, Liberia had significant donor funding and the capacity available among a plethora of international and local NGOs and FBOs in order to rapidly expand access to the newly developed BPHS. In 2007, the Ministry of Health and Social Welfare (MOHSW) initiated a massive health reform effort that included a new public-private partnership model for health service delivery. A national task force on health financing, housed within the Ministry's Planning and Finance Division, worked to develop a national health financing policy and strategic plan. Post-conflict Liberia's contracting policy was designed to: avoid a transition gap between war and peacetime; provide bridge funding to the health sector through development partners; and take advantage of available in-country resources. The

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[23] Ovcharenkol, Vsevolod. "Accountability, Effectiveness, and Independence - Striking the Proper Balance, Government Financing of NGOs in Kazakhstan: Overview of a Controversial Experience." *ICNL* 8, no. 4 (2006). https://www.icnl.org/resources/research/ijnl/government-financing-of-ngos-in-kazakhstan-overview-of-a-controversial-experience.

[24] Ibid

[25] Ovcharenkol, Vsevolod. "Accountability, Effectiveness, and Independence - Striking the Proper Balance, Government Financing of NGOs in Kazakhstan: Overview of a Controversial Experience." *ICNL* 8, no. 4 (2006). https://www.icnl.org/resources/research/ijnl/government-financing-of-ngos-in-kazakhstan-overview-of-a-controversial-experience.

new minister of health, a trusted confidant of the newly elected president, aspired to have the public sector directly scale up health services throughout the country. He knew that the public sector health system was in a poor state and that the government could not provide services alone. Instead of trying to build back the health system in a vacuum, the minister realized it would best be done by relying upon continued close collaboration with NGOs, including FBOs, that were still delivering most services in post-conflict Liberia.

Service delivery between 2003 and 2012 evolved, with contracting as a mechanism to:

- Transition away from costly and highly fragmented humanitarian response-oriented service delivery
- Regain public confidence in government's ability to provide stewardship of the health sector
- Expand and sustain equitable access to health services
- Leverage development partner funding and NGO capacity to prepare the county health teams (CHTs) to eventually resume management of health facilities and the workforce
- Improve the quality and efficiency of management and service provision

South Africa WC: *The motive for contracting came from an immediate need to reduce expenditures.*

The main driver of contracting for HIV services in the WC province was to reduce costs and increase efficiency. Between 1994 and 1998, a coalition was formed with two representatives each from the nine provinces and the national government to work on sector-wide reform to increase access to services, reduce expenditures, and increase resource efficiency. The WC province was required to cut expenditures by 27 percent while increasing reach to over a million who did not previously have access to health care. At the time 60-70 percent of health resources went to salaries, and the province determined that it needed to reduce its wage bill. Over the next five years, and to prepare for contracting, the WC reduced civil service headcount by 9,000, shuttered wards with 1,000 public hospital beds, and refocused the health care delivery system towards primary and community care with strict rules on up-referrals.

– Contract services where government is less effective, particularly at the community level.

Although the impetus for contracting stemmed from a need to cut costs, community organizations were the cornerstone of the WC province's strategy to reach those most in need of HIV services. Key informants working in the WC province at the time determined that, in the end, contracting what government is not defining as its core business is financially more affordable. Even more importantly, for them this is a vital part of a democracy whereby institutions of the community and the community itself are participating in health care. This notion cannot be underestimated as it creates agency while fostering innovation at the local level.

> "The smart thing for a public health service is to decide what its core business is, and what it should deliver with its own staff, and then work from there to widen its scope to contract out to the nongovernmental sector."
>
> *– Key Informant, WC province, S.A.*

Lesson 1B: *Political leadership and a focused vision can create flexibilities and overcome operational gaps during establishment of contracting for services. (India, Liberia)*

Early initiation of contracting can result from a health crisis, previous private sector work by government leaders, low public sector delivery capacity, and decentralized governance. (South Africa WC)

***India:** High-level political will enabled a more autonomous and more flexible approach to contracting.*

High-level government commitment to halt the AIDS epidemic, and strong national leadership in the health sector, led to the formation of a semi-autonomous agency to lead the country's AIDS response. An additional secretary to the Government of India (GOI) was designated to head NACO, the unit in India's Ministry of Health and Family Welfare that provides leadership to the HIV/AIDS program. The NACO head was from the elite and powerful Indian Administrative Services, which gave this position great autonomy and influence. This national body and its approach were then mirrored at the state level through 35 State AIDS Prevention and Control Societies (SACS).

NACO's status as a semi-autonomous entity enabled innovation and flexibility in implementation, including around the procurement regulations that would have otherwise constrained its options on how to contract. NACO was able to start contracting of CBOs relatively easily and to design a multi-sectoral response. The HIV/AIDS program is one of the few public health programs in India where the funding goes directly from NACO to the SACS instead of via state treasuries. Not only has this allowed for swift transfer of funds but has also given the SACS a certain sense of autonomy.[26]

***Liberia:** A clear health reform vision can overcome many operational gaps and enable contracting to take place.*

Contracting began in Liberia despite little to no financial or human resources for health, scant health information systems, poor procurement and supply chain management tools, dilapidated health infrastructure, and lack of trained clinical and managerial staff.

> "The newly elected president of Liberia chose a good health minister aligned with the aforementioned goals (transparency, accountability, and rapid scale up of health services) and a seasoned and competent former Doctors without Borders employee as director of health services to implement."
>
> *– Key Informant*

To ensure that the minister's vision was achieved, a national task force on health financing, housed within the Ministry's Planning and Finance Division, worked to develop a national health financing policy and strategic plan. The Planning and Finance Division hired an external consultant to conduct a system-wide rapid situational assessment of the country's capacity to contract NGOs to deliver a BPHS, as well as of non-state providers' ability to be contracted. It was clear from this assessment that while the non-profit sector could serve to scale up services, it was equally important for the government to serve in its stewardship role by providing guidance and regulation over the sector.

Based on this assessment and before any post-conflict development partner support for health sector, Liberia's MOHSW developed a policy on performance-based contracting to NGOs. Subsequently, with support from partners, the ministry went on to develop a strategy and operational plan.

[26] Mohammed, Suresh Kunhi, Ronald Upenyu Mutasa, and Ishira Mehta. "Targeted Interventions: India's Pathbreaking Approach to Address the HIV/AIDS Pandemic," February 2021. http://hdl.handle.net/10986/35375.

South Africa WC: *A health crisis, low public sector delivery capacity, previous private sector work by government leaders and decentralized governance led to early initiation of contracting.*

In post-apartheid South Africa, leadership in the WC province needed to address the major health crisis presented by the AIDS epidemic. Many of the WC leadership came from the not-for-profit and private sectors, so there was clear knowledge and trust in this sector. Furthermore, the government's capacity to provide lower-level services was weak. Therefore, instead of building up government capacity and control over services, senior management at the provincial level decided to outsource functions. Early partnerships with local CSOs gradually evolved to become larger, more competitive, and more standardized contracts, 10-15 years before contracting of NGOSs was instituted elsewhere in the country. In South Africa's quasi-federal structure, WC province guarded their autonomy and took a different path from the national government to formulate provincial policies, including contracting of non-state providers.

Lesson 1C: *Ongoing dialogue with key stakeholders and continuous improvement of contracting models are needed both to establish and maintain support for contracting. (Liberia, South Africa WC)*

Liberia: *A consultative policy process built acceptance for contracting.*

Though the impetus for contracting came from the Government of Liberia (GOL), it was supported by its stakeholder partners. This boded well for the acceptance of contracting. The MOHSW engaged stakeholders in the development of its contracting policy and plan, including donors, technical experts from health sector partner agencies, NGO partners, and international consulting firms. Although skeptical at first, NGO partners warmed to the concept as they learned more and as their funders informed them that this was the direction in which the health system was going to go. In 2009, while the new contracting policy was under discussion, the MOHSW held a series of workshops with partners, CHTs, local and central government, and private sector groups to gather their input. Based upon these discussions, the MOHSW performance-based financing working group and a committee on PBC within it, presented its contracting policy and implementation plan to the CHT and NGO service delivery partners at the quarterly review of BPHS implementation. This process was designed to build understanding about contracting and solicit their input in the design of the ministry's request for proposals (RFP) for a new USAID project to support contracting scheduled for July 2009.

By working closely with key stakeholders throughout the process of assessment, design, and implementation, the MOHSW ensured a relatively smooth transition from humanitarian relief to development. An authentic and documented culture of trust between development partners, NGOs, FBOs and the government, coupled with a highly participatory national assessment of the capacity of all involved, demonstrated progressive, strong leadership and thoughtful planning.

South Africa WC: *Continued dialogue and quality improvement improves acceptability of contracting.*

In the WC province, views on the desirability of the NGO contracted model varied considerably over the years and continue to generate dialogue today. In a 2013 appraisal of the model, senior provincial and district managers were firmly of the view that the NGO model should continue, although there was debate on the particulars. Positions varied from the principled: "The NGO model has a lot to offer, let's figure out how to do it better," to the pragmatic "We'd like to bring them (community health workers [CHWs]) into the system, but we'll never afford it" (i.e., to hire CHWs as government staff). At lower

levels, however, among providers and frontline managers involved in delivering and managing services, there was much stronger criticism of the NGO model.[27]

Although there were effective systems of financial management, contracts were effectively input-based, so the day-to-day performance of CHWs and NGOs was seen by some as difficult to manage and control (see Lesson 2B below). NGOs had their own (diverse) imperatives and did not necessarily share the vision of the provincial health department, stating that the system was unstable with poor retention and high turnover of CHWs due to low stipend payments; there was little direct supervision of CHWs by NGO nurse coordinators; and referral systems into the platform were complex. A related theme was the lack of clear lines of coordination, communication, referral, and accountability between CHWs, NGOs, and local private healthcare (PHC) facilities, stemming in part from the "de-hospitalization" focus of the platform. Many expressed the view that "…there needs to be (a) closer link between the facility-based and community-based services so that the facility-based services take the CHWs seriously enough"[28] (community-based services [CBS] manager).

2.2 Legal, Regulatory, Policy Considerations

Global experience shows that an essential first step for contracting is gaining an understanding of the country's legal and regulatory framework, especially as it relates to NGOs. It is important to determine at the outset if there are barriers that hinder the government from directly funding NGOs. Other issues to consider include the current legal and policy framework relating to: the registration and conduct of NGOs; the provision of health services by non-state entities; and the government's ability to fund NGOs directly from national budgets.[29] Where legal barriers to contracting are more difficult to surmount, governments have had to find alternative approaches to meet their goals.[30,31] For example, if, the legal environment is not conducive to enforce contracts, then a way to mitigate this barrier may be to ensure the contract has a dispute-resolution mechanism that is not entirely dependent on the legal system. Likewise, if there is a lack of specificity within the national legal framework, then efforts to establish, strengthen or amend contract law should be initiated.[32]

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[27] Schneider, Helen, Nikki Schaay, Lilian Dudley, Charlyn Goliath, and Tobeka Qukula. "The Challenges of Reshaping Disease Specific and Care Oriented Community Based Services towards Comprehensive Goals: A Situation Appraisal in the Western Cape Province, South Africa." BMC Health Services Research 15, no. 1 (September 30, 2015): 436. https://doi.org/10.1186/s12913-015-1109-4.

[28] Ibid.

[29] Pan Caribbean Partnership against HIV and AIDS. Social Contracting Toolkit: A Guidance Note for Decision-making for Country Implementation of Social Contracting. Pan Caribbean Partnership against HIV and AIDS. 2021. https://web.archive.org/web/20231023215106/https:/pancap.org/pc/pcc/media/pancap_document/PANCAP-SOCIAL-CONTRACTING-TOOLKIT.pdf

[30] Abramson, W. 2004. Contracting for Health Care Service Delivery: A Manual for Policy Makers. John Snow Inc. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10351&lid=3

[31] Loevinsohn, Benjamin. 2008. Performance-Based Contracting for Health Services in Developing Countries: A Toolkit. Health, Nutrition, and Population Series. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/6481

[32] Ibid.

LEGAL, REGULATORY, POLICY – LESSONS

Lesson 2A: Whether it is an enabling or restrictive environment, with support from high-level policymakers and community, each country makes do with the legal environment in which they find themselves to create the conditions and workarounds necessary for contracting. *(India, Kazakhstan, Liberia)*

Lesson 2B: A legal basis for contracting, along with a clearly substantiated contracting policy, allows contracting to progress while specificities of contracting and regulatory systems can be developed over time. *(Kazakhstan, Liberia, South Africa WC)*

Lesson 2C: Technical support to assess the legal environment for contracting is important. *(Kazakhstan, Liberia)*

Most countries' procurement acts do not include clear language on health service contracting (see Annex 10 for a rapid scan of procurement laws). In the face of ambiguity, countries have taken a variety of approaches: contracting through development partner-supported projects; issuing special executive orders to allow for exceptions (as is the case in India for HIV services); developing contracting modalities under the auspices of general procurement laws; or purposely advocating for legal reform to amend more restrictive laws.

The following section presents experience from our study countries on a number of these factors, including the legal and policy environment, process of assessment and constraints found, steps taken to address them, and overcome legal and/or regulatory barriers.

All countries in this review assessed the legal and policy environment prior to proceeding with contracting. However, these assessments were not discussed by KIs, except by those from Liberia and Kazakhstan who noted enlisting technical assistance on the legality of contracting as helpful. In Kazakhstan, there were numerous barriers requiring legal consultations and amendments for contracting health services. In Liberia, there was legal precedence for working with NGOs in the health sector and the law was not restrictive, although it needed to be more explicit. In South Africa's WC, because healthcare falls under the provincial government, leadership was able to work under the existing provincial laws. None of the respondents were able to identify who made the decision to contract nor how that decision was made, as none of the KIs were involved in these discussions or decision-making.

Overarching lesson: Most procurement laws do not include specific language on health service contracting. Countries interpret the legal environment to ensure the legality of contracting for health services.

Lesson 2A: *Whether it is an enabling or restrictive environment, with support from high-level policymakers and community, each country makes do with the legal environment in which they find themselves to create the conditions and workarounds necessary for contracting. (India, Kazakhstan, Liberia)*

India: *Flexibility of NGO registration enabled a workaround in a more restrictive procurement environment.*

An important precondition to contracting in India was a supportive environment that facilitated the registration of CSOs and their ability to receive and manage funds.[33] NGO certification and registration was initially a challenge to coordination and contracting of CSOs. To streamline contracting, many CSOs were effectively covered by the Societies Registration Act and the Indian Trusts Act, which allowed a range of independent CSOs to form as societies and trusts. This helped to facilitate easier registration and regulation of the CSOs.

Kazakhstan: *Advocacy from civil society fosters new policy and law on state support for NGOs.*

Following advocacy campaigns from civil society and NGOs, in January 2002 the government adopted a policy called the "Concept of State Support of Non-Governmental Organizations of the Republic of Kazakhstan." Financing of NGOs from the state budget was introduced in 2003, with the adoption of the program of state support for NGOs for 2003-2005. Even in a highly legalistic and centralized country like Kazakhstan with strict constitutional interpretation, pilot contracts with local CSOs working in their communities were financed a full two years before the 2005 contracting law (see below) was adopted. After successful lobbying of the new policy, the idea was accepted by the government, and the process for drafting a new law began. The International Center for Not-for-Profit Law (ICNL) provided technical assistance to both the NGOs involved and the governmental drafting group. During the drafting process, participants addressed the problem of determining the mechanism of the social contracts.[34]

– *The Kazakh Law on State Procurement did not provide an adequate mechanism for procurement of social services.*

The Kazakh Law on State Procurement was based on the United National Commission on International Trade Law Model Law on State Procurement.[35] However, it lacked Chapter 4 from that document, which included qualification requirements for bidders and other procurement procedures. It took over a decade for the procurement agency officials to develop the necessary procedures for procuring services.[36] However, with support from technical assistance agencies and advisors, there are now clear procedures and steps for the procurement of services that abide strictly to the Law on State Procurement and are applied to all social contracts, including those in the health sector.

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[33] National AIDS Control Organization. "National Strategic Plan for HIV/AIDS and STI 2017-2024: Paving Way for an AIDS Free India," December 2017. https://naco.gov.in/sites/default/files/Paving%20the%20Way%20for%20an%20AIDS%2015122017.pdf

[34] Ovcharenkol, Vsevolod. "Accountability, Effectiveness, and Independence - Striking the Proper Balance, Government Financing of NGOs in Kazakhstan: Overview of a Controversial Experience." *ICNL* 8, no. 4 (2006). https://www.icnl.org/resources/research/ijnl/government-financing-of-ngos-in-kazakhstan-overview-of-a-controversial-experience.

[35] United Nations Commission on International Trade Law. 1994. UNCITRAL Model Law on Procurement of Goods, Construction and Services with Guide to Enactment https://uncitral.un.org/sites/uncitral.un.org/files/media-documents/uncitral/en/ml-procure.pdf . This Model Law was updated in 2011; the revised Model Law is at https://uncitral.un.org/sites/uncitral.un.org/files/media-documents/uncitral/en/2011-model-law-on-public-procurement-e.pdf and the accompanying guide to enactment of the 2011 Model Law is at https://uncitral.un.org/sites/uncitral.un.org/files/media-documents/uncitral/en/guide-enactment-model-law-public-procurement-e.pdf .

[36] Ovcharenkol, Vsevolod. "Accountability, Effectiveness, and Independence - Striking the Proper Balance, Government Financing of NGOs in Kazakhstan: Overview of a Controversial Experience." *ICNL* 8, no. 4 (2006). https://www.icnl.org/resources/research/ijnl/government-financing-of-ngos-in-kazakhstan-overview-of-a-controversial-experience.

– Pragmatic interpretation of state procurement law can lead to a more sustainable contracting ecosystem.

According to a strict interpretation of the procurement law, under contract the state only pays for expenses directly related to the provision of the service. Even though there have been quite a few amendments to the 2005 law, the SSO framework has not changed this aspect of the law.[37] However, the authorities realized that it is difficult for organizations to be financially sustainable without expanded financing for their overhead costs. According to those working in-country, the government has adapted its interpretation of the law to cover some administrative expenses (e.g., office rent, reimbursement of transportation costs, communications) as well as salaries for NGO employees.

Liberia: *The GOL signed a contracting policy in 2009 to ensure more specificity under the existing procurement law to contract NGOs.*

The 2009 contracting policy served to a) facilitate the 2008/9 transition of the funding source for contracting NGOs from the UK's Department for International Development (DFID) and Irish Aid to the Ministry of Health's pooled fund, and b) ensure that the investments of USAID or any other development partner in the health sector aligned with national health policies, including on contracting. The contracting policy created new mechanisms under the law to have NGOs implement government policy and support health services on behalf of government through management contracts. It served as the springboard to determine in general terms: what to contract; how to contract; institutional arrangements for contracting; and how to finance contracting.

Lesson 2B: *A legal basis for contracting, along with a clearly substantiated contracting policy, allows contracting to progress while specificities of contracting and regulatory systems can be developed over time. (Kazakhstan, Liberia, South Africa WC)*

Kazakhstan: *Contracting scope and best practices were defined and expanded over almost two decades.*

Kazakhstan was the first country in post-Soviet Central Asia to adopt a Law on Contracting.[38] This law arose during the implementation of social contracts between government and NGOs. It has evolved and been amended numerous times: in 2008 to cover children with disabilities and the elderly with a budget line included for contracting CSOs under SSO; in 2011 to note that all state agencies (ministries and local authorities) will have to include in their budgets funding for contracting; and in 2015 to significantly

In Bangladesh, a key message from the NTP has been *caution* – there was initially a desire for a perfect legal environment before proceeding with contracting. Although this delayed the timeline for initiating contracting, local stakeholders then reached a compromise on a stepwise process for regulatory reform, with a gazette notification providing a temporary way forward even while more time-consuming legislative changes were still in process.

[37] Nur-Sultan. "Analytical Report Based on the Results of Monitoring the State Social Order for 2020-2021.," 2021.
[38] "On the State Social Commissioning, State Commissioning of Strategic Partnerships, Grants and Awards for Non-Governmental Organisations in the Republic of Kazakhstan," April 12, 2005. https://adilet.zan.kz/eng/docs/Z050000036_.

expand the scope of activities.[39] Today, a movement continues for more contracting through local authorities. Within health, a new guideline in 2019 described the procedures for obtaining SSOs based on available practical experience, approved SSO standards, regulatory and legal acts, international experience analysis, and recommendations.[40] A 2020 study of the national response to HIV and TB helped to fix the allocation of funding from the state budget to health related SSO contracts and the responsibility of the state to monitor these activities.

Liberia: *Contracting for health services required a national law; regulations on quality evolved later.*

In 1972,[41] the GOL approved the provision of subsidies to civil society and FBOs and, during the conflict era, several faith-based hospitals received government subsidies. However, there was no plan or blueprint under which the "provision of subsidies" could evolve into "performance-based contracts." Based upon the results of the situational assessment conducted in 2008, a new policy on contracting to NGOs for management and support through the MOHSW (and under the supervision by the MOHSW and CHTs) was developed and passed in 2009.

The 2008 situational assessment noted the need for a regulatory and oversight body that would provide strong supervision, monitoring, and administrative and financial tracking. As part of this process, over the next few years, the MOHSW instituted and implemented annual accreditation assessments to determine facility adherence to standards, which CHTs could then monitor.

South Africa WC: *A restrictive procurement law can limit provincial autonomy to modify governance and payment modalities.*

Given the legislative authority of the provinces, in 2014 the WC province Department of Social Development (DSD) developed a policy on funding of NGOs for the provision of social welfare and community development services. The purpose of the policy was to "ensure that transfer payments are managed in a transparent manner that promotes accountability, efficient administration, clear performance requirements, and the principles of administrative justice" (March 2014, DSD Policy, section 1.2). It sets out the roles and responsibilities of the DSD in the delivery and management of funding to NGOs.

However, under the restrictive South African Procurement Law, provincial-level policy making has its limits. In a 2018 tender, WC province moved from using a "transfer payment" to a more stringent "service level agreement" in order to increase the government's ability to monitor NGO performance. However, a legal opinion sought in 2018 in response to the auditor general's report concluded that the new arrangement did not allow for closer monitoring and governance. The following tender in 2020 therefore returned to a strict adherence to the law with "transfer payments" based on outputs at the end of each month, with partial advance payments.

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[39] Nur-Sultan. "Analytical Report Based on the Results of Monitoring the State Social Order for 2020-2021.," 2021. The expanded Law of the Republic of Kazakhstan is entitled "On SSO, Grants and Prizes for Non-Governmental Organizations in the Republic of Kazakhstan."
[40] Nur-Sultan. "Analytical Report Based on the Results of Monitoring the State Social Order for 2020-2021.," 2021.
[41] Under the Act to Amend Chapter 30 of the Executive Law.

Lesson 2C: *Technical support to assess the legal environment for contracting is important. (Kazakhstan, Liberia)*

Kazakhstan: *Technical assistance can be useful when examining the legal environment and identifying obstacles and next steps.*

In 2003 the ICNL supported the government of Kazakhstan and convened a working group, comprising representatives from the government and NGOs, tasked to identify, analyze, and debate the country's ability to contract non-state providers. The government faced a choice. Its first option was to use procurement that was open to both NGOs and for-profit providers. This could increase the quality of service provision by increasing competition, but the country was not equipped with the necessary systems for state procurement. The second option was to use a grant mechanism available only to support NGOs. However, the legal basis for this section option was unclear:

> *Kazakhstan's Constitution, in Section 5.2, prohibited state financing of public (citizens') associations. The extent of the constitutional prohibition was unclear both in terms of what qualifies as "state financing" and what qualifies as a "public association." In the Kazakh Civil Code, "public associations" are listed as 1 of 16 legal forms of non-commercial organizations. In common usage, though, the term "public associations" often referred to unregistered groups as well. So, in the absence of a clear understanding of what the Kazakh Constitution prohibits, participants decided to use a mechanism of state procurement to govern state social [grants].*[42]

In other words, the government decided to give grants, but used the constitutional ambiguity around grants by adopting the state procurement approach. Meanwhile, the Ministry of Culture, Information, and Public Accord (which oversees civil society) wanted to use the new law to limit NGO operations but, after negotiation, these provisions were not maintained.[43]

Liberia: *Technical support to analyze procurement law and develop contracting policy can be catalytic for contracting.*

As a precursor to the development of a contracting policy, the GOL, in consultation with internal and external advisors, conducted a thorough review of Liberia's public procurement laws enacted in 2005 which dictated how government may spend its funds. The team sought legal counsel from advisors situated within the MOHSW, as well as the Senior Lawyers International Program, to obtain their input and guidance on Liberia's public procurement law. Further guidance on the level of stringency of this law was subsequently clarified by the Ministries of Justice and Foreign Affairs. Once it was determined to be legal to contract NGOs, the process to develop a contracting policy began with technical assistance from development partners and advisors to the ministry.

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[42] Ovcharenkol, Vsevolod. "Accountability, Effectiveness, and Independence - Striking the Proper Balance, Government Financing of NGOs in Kazakhstan: Overview of a Controversial Experience." *ICNL* 8, no. 4 (2006). https://www.icnl.org/resources/research/ijnl/government-financing-of-ngos-in-kazakhstan-overview-of-a-controversial-experience. The original reference uses the word "contracts" here, but explains that these are "grant mechanisms called zakaz, which can be translated as "order" or "contract." This Soviet-era term was adopted because the term "grant" was largely associated with foreign assistance to governments and local NGOs."

[43] Ibid.

2.3 Governance Structures, Functions, and Processes

Contracting non-state providers requires shifting the role of government from service delivery to the financing and purchasing of services. It requires strengthening of the government's oversight and stewardship function over contracted non-state providers. There are several global recommendations and lessons as to how to best prepare for contracting, including determining what part of government will serve which function and what contracting processes ought to look like. Government must also ensure that it has the capacity to: determine what should be contracted; cost out services; develop guidelines; bid out services; review proposals; choose providers; negotiate contracts; monitor contracts; provide oversight and regulation; and pay providers[44],[45],[46],[47].

GOVERNANCE STRUCTURES, FUNCTIONS, AND PROCESSES – LESSONS

Lesson 3A: The governance structures and processes for contracting evolve as the programmatic and institutional needs evolve. *(India, Liberia)*

Lesson 3B: Contracting approaches often transition stepwise, from donor-led and centralized models to domestic, more decentralized models. *(India, Liberia, South Africa WC)*

Lesson 3C: Buy-in at the local level, including among implementers, is important to successful contracting. *(India, Kazakhstan, South Africa WC)*

Lesson 3D: Salary and capacity disparities between NGO and government staff can destabilize the contracting relationship. *(Liberia, South Africa WC)*

To fully institutionalize contracting, decisions need to be made to determine responsibilities for the various processes and functions—including the purchasing function of different government units. Governance decisions are also needed around how individual and institutional capacity will be strengthened, how human resource decisions should be made both within the civil service and contracted organizations, and how transparency and accountability in the use of public funds can be ensured.

This study found, however, that because contracting is a tool to achieve public health goals, not an end in itself, countries do not follow a sequential process to determine how and where various contracting functions should be housed, the organizational structure of contracting, nor the staffing levels necessary to manage contracts. Additionally, it is difficult to pinpoint how decisions were made, vetted, and agreed upon as to how to contract. Rather, these decisions evolved along the way and were dependent upon country context, vision, design, and the organization of the health system or the health ministry.

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[44] Abramson, W. 2004. Contracting for Health Care Service Delivery: A Manual for Policy Makers. John Snow Inc. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10351&lid=3

[45] Loevinsohn, Benjamin. 2008. Performance-Based Contracting for Health Services in Developing Countries: A Toolkit. Health, Nutrition, and Population Series. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/6481

[46] SHOPS Project. 2012. Filling the Gap: Lessons for Policymakers and Donors on Contracting Out Family Planning and Reproductive Health Services. Primer. Bethesda, MD: SHOPS Project, Abt Associates

[47] Cenac, Veronica, and Lucien Govaard. SOCIAL CONTRACTING TOOLKIT a Guidance Note for Decision-Making for Country Implementation of Social Contracting. Caribbean Community (CARICOM) Pan Caribbean Partnership against HIV and AIDS (PANCAP). 2021. https://web.archive.org/web/20231023215106/https:/pancap.org/pc/pcc/media/pancap_document/PANCAP-SOCIAL-CONTRACTING-TOOLKIT

Countries did not identify an intentional process to set up a unit dedicated to contracting or discuss how decisions were made as to where various functions ought to reside. Instead contracting functions were spread across various departments and levels of the health system depending upon the task at hand and the areas of expertise within each department, and they evolved over time as health systems changed. KIs were not aware of a set process to identify relevant guidance on the use of public funds for contracting, including budgeting processes between the ministry of finance and ministry of health.

Despite the absence of an explicit process, these early mover countries provide some clear lessons for countries that are considering contracting with regards to governance structures, functions, and processes involved with contracting.

Overarching lesson: Contracting governance responsibilities are often distributed across various levels, vary depending on country context (including the health and administrative systems), and evolve along the way.

Lesson 3A: *The governance structures and processes for contracting evolve as the programmatic and institutional needs evolve. (India, Liberia)*

India: *Streamlining of the NGO selection process was an important development.*

The decision to form NACO to combat the AIDS epidemic initially involved assigning a senior-level officer to run the program both at national and state levels, but program governance did not stop there. The nuts and bolts of India's strategy to contract out to NGOs was developed over the next two and a half decades. Pilots, monitoring and evaluation (M&E), and sociological and anthropological studies refined the technical approaches that were bid out by the 37 SACS.

The principal obstacle to implementation of contracting of NGOs was a lengthy and protracted selection process. With revamping, this process was streamlined from 9-11 months to 3 months. Previously, the contracting process involved the following steps:

a) Desk review for estimation and mapping of populations,
b) Results of desk review go to project director,
c) Publish expression of interest (EOI),
d) A joint appraisal team visits all bidders to learn about their governance structures and financial systems (and sometimes there were up to 200 organizations),
e) NGO selection, and
f) Financing and budget negotiation.

There were two separate selection committees: one for a tax review and a second for field visits. However, in the new streamlined process, there is now:

a) one selection committee that oversees all steps in the process, hence considerably reducing the time of contractor on-boarding;
b) a desk review where NGOs are ranked by a set of criteria including number of years in business, number of projects completed and underway, and whether it qualifies as a CBO; and
c) field visits are made to those that are short-listed.

Liberia: *Governance decisions took time and transaction costs were significant given the temporary nature of the decision to contract out.*

The 2007 National Health Plan envisioned the establishment of a pooled fund, but not contracting. The 2011 National Health Plan explicitly emphasized contracting but this still evolved in stages: contracting was initially funded and managed entirely by development partners (DFID, European Union, USAID); followed by a partial transition to contracting by the MOHSW through the pooled fund and under the USG Fixed Amount Reimbursement Agreement (FARA);[48] this culminated in a final stage with full government ownership.

The time required to implement governance decisions explains much of the delay in establishing contracting in Liberia. Creating and establishing the MOHSW's Pooled Fund (including to regularize its steering committee's decision-making processes, strengthen some of the ministry's internal systems, develop an NGO contracting scope of work and M&E framework, and conduct the procurement and contract award process) was a lengthy process.

GOL had complete ownership of, and steering role over, the contracting approach, and developed institutional capacity for contracting, including contract design, management, oversight, and monitoring. However, given that the vision all along was to return to public sector provision and management of health services through contracting in, the transaction costs of developing contracting capacity for the short and medium-term were high and required a great deal of human and financial resources.

Lesson 3B: *Contracting approaches often transition stepwise, from donor-led and centralized models to domestic, more decentralized models. (India, Liberia, South Africa WC)*

India: *India's approach gradually transitioned from donor and centralized models of contracting to domestic and decentralized models.*

The NACP decided early on to follow the structure of India's decentralization to the state level and put in place strong administrative capacity at national and state levels through the creation of the NACO and the State AIDS Control Societies (SACS). These were supported by technical support units (TSUs) at both levels to enhance the quality and capabilities of the targeted intervention (TI) program (contracts with NGO/CSOs).[49]

Implementation was in five phases, with gradual increases in coverage and technical approach. NACP I included pilot contracts developed by the GOI that were based upon models deployed by DFID and USAID, who were already supporting contracting throughout the county. Various models of contracting were assessed, and guidelines and SOPs were developed. Under NACP II, contracting was initially

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[48] USAID. Fixed Amount Reimbursement Agreement Activity. https://2017-2020.usaid.gov/liberia/fact-sheets/fixed-amount-reimbursement-agreement-activity and USAID. "The FARA Mechanism, Leveraging and Strengthening Local Capacity to Rebuild Basic Health Services." January 2017. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15171&lid=3

[49] National AIDS Control Organisation. "Social Contracting Under National AIDS Control Programme in India." Ministry of Health & Family Welfare Government of India. See also NACO, 2008. Operational Guidelines for NGOs/CBOs (Selection of NGO/CBO). https://naco.gov.in/sites/default/files/Annexures%20file.pdf and NACO, 2008. Guidelines on financial and procurement systems for NGOs/CBOs. https://naco.gov.in/sites/default/files/NACO%20Guidelines%20on%20Financial%20&%20Procurement%20Systmes%20for%20NGOs-CBOs.pdf

supported financially by development partners, and run entirely by the central government, but decentralization of contracting also began at the state level. Each state published an Expression of Interest (EOI) that CSOs could respond to with a proposed approach and budget. The selection process included an assessment of organizational capacity, human resources, and the financial management system. NACP III involved rapid scale-up of TIs and introduction of operational guidelines for implementing TIs, an M&E framework, and an evaluation tool and manual. Under NACP IV, scale up of TIs was revamped into four distinct models. By NACP V, TIs were fully funded under the domestic budget and SOPs on the selection of NGOs/CBOs were revised.

Liberia: *Liberia transitioned from using donor to domestic systems for contracting and built capacity centrally before moving to decentralize responsibility for contracting.*

In Liberia, the Department of Health Services and Department of Planning within the MOHSW both supported the design and implementation of contracting, in which NGOs were hired to manage government facilities and build government capacity. In the early stages, this was done by government execution of donor resources and reporting through the multi-donor pooled fund and outside of government by USAID's Rebuilding Basic Health Services (RBHS) project (2009-2014) contracting NGOs under a parallel system. The second phase of contracting NGOs with USAID funds was done completely using government systems and procedures through the FARA (2011-2016) mechanism, building MOHSW capacity to oversee NGO performance. The final step was to move to contracting in between the MOHSW and CHTs (initially through the use of the pooled fund and eventually using the FARA mechanism), building CHT capacity to serve as contractors and contracting to NGOs only as needed. As such, contracting was designed with a long-term plan to absorb all health care workers (who were paid incentives by the NGOs) into the civil service and eventually to return to Liberia's traditional model of public sector management and provision of health services.

The MOHSW selected highly qualified senior staff with experience in the not-for-profit and private sectors to lead the Health Planning and Finance Division and the Health Services Division to develop and establish contracting in Liberia. The situational assessment highlighted that the central ministry capacity for contracting would precede the capacity of the counties. It made sense to first build capacity to contract within the central MOHSW to strengthen administrative processes in the capital (in large part via donor-funded technical assistance; see section 2.6), and then shift responsibility outward towards the counties as county capacity was strengthened. In the stages outlined above, the central level initially contracted NGOs, bypassing the CHT; then the CHT learned to contract NGOs; and finally the central authorities contracted the CHT (which was free to further contract as they would like).

South Africa WC: *Contracting functions were decentralized over time.*

By 2011, South Africa changed policy direction and began to reorient a loosely structured and highly diverse community care system that evolved around HIV and TB into a formalized, comprehensive, and integrated PHC outreach program based on CHWs. The contracting model evolved in three important ways. First, the model of care gradually morphed between 2011 and 2013 from contracting for palliative home and hospice care to outsourcing community-based integrated disease prevention and health promotion. Second, the design, management, and oversight, was decentralized as the health system devolved from provincial to district to sub-district level each with their own set of functions and

responsibilities pertaining to contracting. Third, contracting in the WC went from a single contract to multiple contracts between the 2018 and 2020 calls for tenders.

While initially managed by a provincial CBS directorate, some of the provincial level responsibilities have been migrated and devolved to the district (e.g., conducting the calls for tenders and interviews of candidates) and to the sub-district level (e.g., oversight). Contracts are still coordinated from the provincial level, but districts are responsible for signing the contracts, monitoring projects, and oversight of funds. CBS coordinators in the sub-districts are responsible for service delivery and corporate governance by ensuring the quality of services and management over those service contracts. As the health system devolved even further, the district continued to be responsible for signing the contract and for payment, but the sub-district became responsible for planning, including announcing the procurement, reviewing proposals, speaking with contenders, and choosing a provider.

In the WC province, the 2018 call for proposals included one service package for the entire province for integrated health and wellness with services delivered through CHWs. However, under the most recent 2023-2026 call, the hiring of organizations at the sub-district level was permitted, and a total of 41 NGOs were contracted for three years. They are directly funded by the department with annual reviews to determine continuation of funding. Performance targets are aligned to departmental targets at the district and sub-district (sub-structure) levels. Contracts can be terminated and/or not renewed due to non-performance and non-compliance.

Although contracts in the WC are signed by the districts at the service level, multiple governance functions remain at the provincial level. This includes: *financial governance*, which is the responsibility of the deputy director general of corporate services, and includes standardization, policy guidelines and monitoring of funding to NGOSs; and *programmatic oversight* and *policy development*, which rest with the chief director of emergency and clinical services. Under this latter individual, the service priorities coordination (SPC) director is responsible for guidance on key interventions including updates to the service package, and the deputy director finance in the special purpose funds unit is responsible for the coordination, monitoring, and implementation support of finance instructions.

Lesson 3C: *Buy-in at the local level, including among implementers, is important to successful contracting. (India, Kazakhstan, South Africa WC)*

India: *Implementing organizations themselves can help determine contracting needs.*

India uses needs mapping and assessment along with data on service coverage and population size estimations when determining TIs. This mapping is contracted out to CSOs from domestic resources, asking them to identify needs, localities, and prioritization of underserved populations in communities as well as assess health providers to be covered through partnerships. Subsequently, TIs are contracted out to local CSOs through the SACS with targets set based upon key population size estimations and data for HIV services coverage.[50]

[50] Vannakit, Ravipa, Vladanka Andreeva, Stephen Mills, Michael Cassell, Melissa Jones, Eamonn Murphy, Naoko Ishikawa, Mark Boyd, and Nittaya Phanuphak. "Fast-Tracking the End of HIV in the Asia Pacific Region: Domestic Funding of Key Population-Led and Civil Society Organisations," Lancet HIV, 7 (2020): e336-372. https://pubmed.ncbi.nlm.nih.gov/32386723/

– India's contracting program is based on a long-standing commitment to capacity strengthening of NGOs.

NGOs are mentored and monitored by the SACS and government TSUs thereby continuously building capacity for community and locally led implementation and oversight. Community score-card methods and community-led monitoring of services are also being rolled out to ensure services are tailored to community needs. Contracting is done primarily through input-based financing, with each state publishing an EOI, and NGOs and CBOs submitting proposals. The award process follows a more traditional grants approach, with the assessment of organizational capacity as part of the selection process. Capacity strengthening is a key focus of the program, with the government providing continuous regular monitoring through the TSUs, and regular site visits and feedback every six months.

***South Africa WC:** A new contracting approach required buy-in from implementers but, once gained, local management allowed trust-based contracting relationships.*

Contracting in the WC had begun as an entirely organic phenomena of "home-based carers" (also sometimes referred to as community care workers [CCWs]), who were mostly older women and leaders in their communities providing home-based and palliative services for AIDS patients.[51,52] The dominant CCW management model in WC was of government contracts with CBOs, who in turn employed and deployed CCWs. Meanwhile, NGOs used a distinct cadre (CHWs) who were single-purpose (TB, HIV, nutrition, palliative care, etc.) and with delivery models specific to each NGO. As part of its new contracting approach, the government's wanted to move community care from palliative care to health promotion and disease prevention. This was therefore disruptive both to the CCW model (due to a move from CCWs and CBOs in the old approach, to CHWs and NGOs in the new approach) and to the NGO models (due to the need for new, more integrated scopes of work).

After initial resistance, this change was gradually accepted, and by mid-2013, the WC had a well-established CBS delivery platform provided through contracts with 72 NGO intermediaries employing 3,594 CHWs (recruited by the NGOs and supervised by nurses in a ratio of roughly 20 CHWs to 1 nurse supervisor).[53]

The sub-district, with assurance of strengthened PHC services, had a central role to play in the management of these partnerships.[54] These sub-districts first required strengthening of their capacity for managing contractual relationships via financial accounting and performance monitoring. But, once this capacity was established, local management allowed the trust relationships necessary for establishing so-called "relational" contracting systems between government and NGOs.

***Lesson 3D:** Salary and capacity disparities between NGO and government staff can destabilize the contracting relationship. (Liberia, South Africa WC)*

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[51] Western Cape Government. Provincial Strategic Plan on HIV/AIDS, STIs and TB 2012-2016. https://www.westerncape.gov.za/assets/departments/health/provincial_strategic_plan_on_hiv_aids_stis_tb_2012_-_2016_-_15_june_2012.pdf

[52] Schneider, Helen, Nikki Schaay, Lilian Dudley, Charlyn Goliath, and Tobeka Qukula. "The Challenges of Reshaping Disease Specific and Care Oriented Community Based Services towards Comprehensive Goals: A Situation Appraisal in the Western Cape Province, South Africa." *BMC Health Services Research* 15, no. 1 (September 30, 2015): 436. https://doi.org/10.1186/s12913-015-1109-4.

[53] Ibid.

[54] Ibid.

Liberia: *A plan to bring salary parity between civil servants and NGO staff overshot the mark.*

Initially salaries of NGO workers in Liberia were higher than those of government workers, and frequently government workers needed to work in the private sector to supplement their income. Along with the contracting policy, MOHSW revised the civil servant salary scale to establish parity in pay scale between the public sector and NGO staff. Eventually, however, government salaries surpassed what NGOs were paying. Many NGO staff went on strike to be put on government payroll.

By this time, government contracting capacity had also been built, and the government began to hold NGOs accountable for delivering services (whereas previously NGOs managing health facilities focused on holding government staff accountable for performance). This led the CHT/MOHSW to believe that they could manage service delivery better than the NGOs under management contracts, and ultimately led to contracting-in between the two levels of the health system.

South Africa WC: *It is vital to standardize government and NGO salaries and compensation when designing contracting models.*

In South Africa, despite many years of contracting CHW services, national stakeholders have proposed integration of CHWs into the civil service (which would effectively eliminate the need for contracts with NGOs). The absence of new government budget lines made this difficult to implement in the short term, and affordability was a concern, since the CHWs' salaries and conditions of service would have been greatly improved as government employees. But the model to absorb CHWs into government (and the likely improvement in conditions of service) was seen by many as a way to stabilize community-based services and achieve greater standardization of approaches.

Those opposed to this approach point out that it would bring CHWs into government service at the bottom of the pay scale, and they would be treated as workers on the lowest rung of the civil service. Furthermore, institutionalization of CHWs could cause them to potentially lose their community identity as they are increasingly drawn into facility-based functions.

In retrospect, according to KIs interviewed, it would have been prudent to look more closely at salary parity and the benefit structure of the NGOs contracted early on, so that CHWs could have been contracted under more favorable conditions.

2.4 Financing and Budget

In the global literature on contracting, there has been little attention to identifying lessons on: how funding for contracting was financed; how funding flows change over time; how countries secure domestic funding for contracting; and if and how domestic budgeting is aligned with contracts. By contrast, there is a plethora of resources on provider payment mechanisms, each of which generates a variety of positive and perverse incentives. There is consensus that no mechanism is perfect, and for the most part countries have moved towards "a blended payment system, which combines elements of multiple payment methods".[55] The Lancet Global Health International Commission on PHC found that

[55] Hanson, K. et al. 2022. The *Lancet Global Health* Commission on financing primary health care: putting people at the centre. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00005-5/fulltext

capitation[56] (i.e., population-based) payment is rare in low- and middle-income countries (LMICs), where input-based budgets are standard practice. Although "tying payments to inputs, as with a line-item or global budget, is a passive form of purchasing, it provides a facility and its staff with a stable income, which is especially important in hard-to-serve areas, and contains costs. However, this provider payment method generates no strong incentives for providers to address the health needs of the population in the catchment area," and do not foster flexibility across budgetary line items in accordance with changing needs.[57] The commission therefore concluded that capitation should form the core of the primary health-care financing system, because it directly links the population with services. However, combining capitation with other payment mechanisms, such as performance-based payments for specific activities, enables additional objectives to be achieved.[58] Some related dynamics arise in payment methods in health service contracts.

Contracts for health services can be financed through external development partners, special funding mechanisms, direct transfers from treasury or other national institutions, as well as on budget with finance and health ministry national processes. This review looked at (to the extent possible): how contracting was financed and how funding flowed; the processes that took place to align contracting with national budgeting cycles; challenges to securing domestic funding for contracting; the development of public financial management systems related to contracting; and any issues or obstacles that came up around how providers were paid. Other sources (see bibliography) already cover contract design issues in general, but we did address the operationalization of contract payment design. For example, output-based contracts present risks to both the non-state providers and the public sector purchasers based on the need for specific management skills for contract oversight.

FINANCING AND BUDGETING – LESSONS

Lesson 4A: Countries with sustainable contracting practice ensure that financing aligns with national planning and budgeting systems and processes. *(Kazakhstan, Liberia, South Africa WC)*

Lesson 4B: Risks from domestic financing including funding shortfalls, delays or gaps, and the need for stronger public financial management systems. *(India, Kazakhstan, Liberia)*

Lesson 4C: Longer contracts allow stability and performance-based adjustments provide incentives. *(India, Kazakhstan, Liberia, South Africa WC)*

Other than in the case of Liberia, uncovering information about the financing and budgeting was not easy to do, mainly because these decisions and processes were carried out by numerous staff at different levels of government and over an extended period. Processes to analyze the budget and identify existing line items that could be used for contracting were not identifiable. Likewise, challenges to securing domestic funding and developing financial systems to channel funds were not known by respondents, as these areas were mostly under the purview of contract managers rather than policymakers.

[56] Capitation payment is a fixed amount of money paid per patient per unit of time, paid in advance to the provider or contractor for the delivery of health care services.
[58] Ibid
[58] Ibid

The following are lessons surrounding financing, budgeting, and payment mechanisms that could be synthesized based upon the experiences of the four study countries.

Overarching lesson: Plan on how to avoid gaps in funding availability, especially during transition from donor to domestic funding. The end goal is full integration of both contract planning and contract budgeting into the overall government planning and budgeting cycle.

Lesson 4A: *Countries with sustainable contracting practice ensure that financing aligns with national planning and budgeting systems and processes. (Kazakhstan, Liberia, South Africa WC)*

Kazakhstan: *Funding for contracting is on budget with the national and regional budget cycle and aligns with internal planning and budgeting processes.*

In Kazakhstan, contracting takes place at the regional (oblast) level with four stages used to allocate funding for contracting:[59] 1) collect information and data for a situation assessment; 2) conduct a situation assessment and prepare a list of areas to contract; 3) plan areas for contracting by listing and posting on public platforms; and 4) include contracts in the budget. Budget allocation decisions are always based upon these formal needs assessments, with most funding for contracts coming from regional budgets, although national level funds are also made available under special programs, e.g., for the provision of specialized social services. These national level funds are also on the same budget cycle as the region, and contracting is implemented within the limits of the planned expenses set out in the national and local budgets.

Liberia: *To ensure transparency and accountability, external funding for contracting was integrated over time to be part of the national budgeting process and reporting system.*

The GOL originally wanted all donor funding to be on-budget (i.e., included in the national budget and approved by legislation), but development partners were reluctant to transfer funds to a new government that did not yet have financial systems in place to ensure accountability. FARA and the pooled fund were both created to institutionalize good governance. The pooled fund was not direct budget support but was nevertheless aligned with the government's annual budget cycle so that it could be part of the national budgeting process and integrated into the MOHSW's annual financial statements. Funds were initially managed by an accounting firm while public financial management systems were built and strengthened within the MOHSW.

The FARA funding mechanism served as a transition from the USAID financial systems and funding streams to domestic systems for contracting. The MOHSW used the national budget to pay NGOs directly for services, on a quarterly basis, and the Ministry of Finance then reimbursed the MOHSW through a budgetary transfer with funds received from USAID. As part of the government-to-government agreement, cost estimates were pre-calculated and directly linked to deliverables.

[59] Asembekov, B S. *Opportunities of the Use of Social Contracting to Ensure Sustainability of TB Services in Kazakhstan.* TB Europe Coalition, 2019. https://tbcoalition.eu/wp-content/uploads/2020/09/Report_SocContract_TB_Kazahstan_Eng.pdf

South Africa WC: *A plan based upon financial and health data determines the level of contracting, and NGOs submit business plans.*

In the WC, the policy department and HIV team decided what level of financing should go to each level of care (laboratory, tertiary, primary, etc.), including what level should be allocated under contracting. Funding for health is allocated to the provincial health department, and the provincial parliament also provides an annual transfer to the Department of Social Development (DSD). The DSD notifies the NGO sector annually about possible funding by "calling for proposals in the form of detailed business plans to be submitted by interested NGOs,"[60] and in 2023 the requested service packages[61] included a call for HIV and TB services.[62]

Lesson 4B: *Risks from domestic financing included funding shortfalls, delays or gaps, and the need for stronger public financial management systems. (India, Kazakhstan, Liberia)*

India: *Dependence on national budgeting and expenditure systems can be a risk to continuity of care from non-state providers, due to bottlenecks, delays in disbursement, and budgetary gaps and shortfalls.*

Funding from development partners played a significant role early on in supporting the NACP program interventions, with substantial external resources even during NACP III. After the 2007-2012 Phase III review, the World Bank provided a loan to the GOI for contracting which covered 50 percent of the on-budget support. Over the next few years, the program intentionally worked towards becoming fully funded through domestic resources, which was expected to bring sustainable integrated approaches.[63,64]

The NACP IV and financing transition plan had several risks as it unfolded, particularly in securing domestic financing. Budget allocations and actual expenditure under NACP IV were significantly less than the original budget projections, with only 67 percent of the plan being funded. In addition, a decision was made to route funds through the state treasury mechanism which led to delays in accessing funds. This slowed implementation (through the TIs with NGOs) in several states, and many trained health care workers left the system, which adversely impacted programmatic coverage and outcomes.

Due to these delays in funding, NACO (which is essentially a division of the NACP that provides leadership over the program), was granted permission to directly fund the SACS outside of the regular budgetary process.[65] The mid-term appraisal recommended strengthening fiscal management at national, state, and district levels and suggested that "NACO needs to think of innovative resource mobilization [including] … an appropriate mechanism at the national level, which can be used as a buffer fund to mitigate risks such as budget cuts, any unforeseen issues, etc." The program was able to create a

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[60] Western Cape Government. Department of Social Development: Policy on the Funding of Non-Governmental Organisations for the Provision of Social Welfare and Community Development Services. 2014. https://www.westerncape.gov.za/assets/departments/social-development/dsd_policy_on_funding_of_ngos_march_2014_0.pdf
[61] Western Cape Government. "Service Package for NPO Funding 2023/24. Metro and Rural Health Service," 2021.
[62] Western Cape Government. Call for proposals from NPOs to support health services for a 3-year cycle 2023/24- 2025/26. https://www.westerncape.gov.za/general-publication/call-proposals-npos-support-health-services-3-year-cycle-2023-24-2025-26
[63] National AIDS Control Organisation. "Mid-Term Appraisal of National AIDS Control Programme Phase IV," 2016. https://www.naco.gov.in/sites/default/files/Report%20of%20the%20MTA%20of%20NACP%20IV%20-%20August%202016.pdf
[64] Bhat, Ramesh, Kurapati Sudhakar, Thomas Kurien, and Arni S. R. Srinivasa Rao. "Strengthening India's Response to HIV/AIDS Epidemic Through Strategic Planning, Innovative Financing, and Mathematical Modeling: Key Achievements over the Last 3 Decades." *Journal of the Indian Institute of Science* 102, no. 2 (2022): 791–809. https://doi.org/10.1007/s41745-022-00331-y.
[65] Ibid.

budget-tracking system, so that the end of support from development partners did not leave any gaps in program funding.

Kazakhstan: *Decentralization of budgetary decisions can pose a risk to programs, but budgetary advocacy can help.*

Nationwide, only 5-7 percent of SSO funding in Kazakhstan was used for health since there is decentralized planning and budgeting with no earmarks for specific programs. Based on resolutions at the prime minister level, donors supported budget advocacy which recommended that regional governments allocate state funding from their local budgets for HIV services, including contracts.

Liberia: *Strong public financial management systems are key to transparency and accountability.*

To put contracting on a firm financial footing, Liberia's minister of health authorized an international accounting firm to recruit a new team within the ministry's Office of Financial Management to strengthen financial systems, put in place an electronic accounting system, and mentor staff within the financing department. At the same time, the entire Department of Procurement also had to be replaced due to corruption. Although there was a lot of push back from within the MOHSW, strong leadership built upon integrity and accountability enabled public financial management systems with strong checks and balances to be put into place.

Lesson 4C: *Longer contracts allow stability and performance-based adjustments provide incentives. (India, Kazakhstan, Liberia, South Africa WC)*

India: *After two decades of input-based payments to NGOs, contracts evolved from input-based to (partially) outcome-based, in order to link payment to performance.*

Under the initial TI (contract) model, a global budget was allocated and paid to each NGO based on a fixed cost per estimated target person in the key population. In the next phase, NGOs were required to submit their statement of expenditure (SOE) as per the prescribed format to SACS at the end of every month or quarter for reimbursement. Most recently, payment evolved to include additional funding based upon performance once verified. All payments to NGO/CBOs for TI are done through a public financial management system portal. Although some NGOs may have additional funding streams, an organization is not permitted to hold more than three TI contracts. NGOs may have contracts with other programs; however, each contract must have a separate bank account.

Kazakhstan: *Contracts are for up to three years, enabling providers to carry out longer-term planning.*

To create incentives for NGOs to serve as contractors, it was important to ensure funding would not be disrupted due to short term contracts \ Contracts are divided into short-term (3–12 months), medium-term (1–2 years), and long-term (2–3 years).[66] Financial transfers are provided through the NAO Civil Initiatives Support Center—an NGO itself, which effectively serves as an operator in the field of grant financing to NGOs.

[66] "On the State Social Commissioning, State Commissioning of Strategic Partnerships, Grants and Awards for Non-Governmental Organisations in the Republic of Kazakhstan," April 12, 2005. https://adilet.zan.kz/eng/docs/Z050000036_.

Liberia: *Performance-based payment helped create incentives to reach administrative and health service targets.*

Under the USAID bilateral project, 12 service delivery indicators and 6 administrative indicators were developed. These were tied to funding to monitor key service delivery and management areas. Failure to reach administrative indicators was linked to a penalty of up to 5 percent of the budget, whereas meeting the targets for the service delivery indicators was linked to a bonus of up to 6 percent of the budget. Implementing partners ensured the earned bonus benefited all stakeholders, including health facilities. Additionally, non-PBC indicators were monitored to ensure that no service delivery area was neglected. This PBC approach was subsequently adopted by the pooled fund for the contracts managed by the MOHSW.

South Africa WC: *Multi-year contracts serve to increase continuity of care and provide greater financial stability to the non-profit sector.*

Initially NGOs in the WC province had one-year contracts, but this plus budget cuts created much uncertainly for the NGOs and threatened to interrupt service delivery. The subsequent shift from one to three-year contracts was consistent with the South African government's 1998 budgetary policy reform to move to a three-year medium-term expenditure framework, which allocated funding for three years with an annual authorization.

– Input-based funding can lead to doubts and uncertainty around performance, results, and accountability.

In a 2013 appraisal of community-based health services in the WC province,[67] a number of concerns were raised about what was being gained from the investment, accountability for results, and insufficient M&E, all of which led to an unwillingness to commit additional resources. Thus, a focus on process rather than results can threaten the survival of a contracting ecosystem.

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[67] Schneider, Helen, Nikki Schaay, Lilian Dudley, Charlyn Goliath, and Tobeka Qukula. "The Challenges of Reshaping Disease Specific and Care Oriented Community Based Services towards Comprehensive Goals: A Situation Appraisal in the Western Cape Province, South Africa." *BMC Health Services Research* 15, no. 1 (September 30, 2015): 436. https://doi.org/10.1186/s12913-015-1109-4. The relevant section from this paper reads as follows:

> Despite the low levels of remuneration and very limited resources for transport, communication and uniforms, and the small proportion of total provincial health expenditure devoted to CBS (estimated to be less than 2 %), senior managers expressed uncertainty about the large amounts of money *"signed off"* in NGO contracts on an annual basis. *"If you ask me for the millions we spend on this programme, what exactly is the outcome of that, I can't tell you, I have no idea."* (District Manager) While financial management and NGO governance systems were adequately monitored, NGOs were not being held accountable for their performance. *"…there are NGOs who are performing and those who are not performing. (The Department) cannot just continue to fund for the sake of funding. NGOs need to display that they do actually have disciplinary procedures that they use in order to ensure the quality of their work."* (NGO Manager)
>
> This concern also related to the perceived absence of monitoring and evaluation systems. "*There is no M & E framework…adequate attention is not paid to the impact and what is being provided there."* (Provincial Manager) At the time of the appraisal NGOs were in reality returning routine monthly activity reports through an elaborate CBS information system that involved 46 data elements and extensive form filling. This system produced information that was regarded as being of poor quality and which no one trusted. There is difficulty in capturing, in a set of routine indicators, a diffuse and shifting service delivery platform, and CBS has fallen largely outside of quarterly and annual systems of review and reporting, entrenching its marginal status.
>
> Thus, while CBS was being seen as holding great potential, there was reluctance to consider allocation of additional resources: *"There are many expectations from CBS but no resources committed to it."* (Sub-district Manager)

2.5 Evaluation, Learning, Adapting

EVALUATION, LEARNING, ADAPTING – LESSONS

Lesson 5: Regular evaluations of individual contracts allow for process updates, capacity building, and decisions on contract extensions. *(India)*

Some results-based and impact evaluations of country-specific contracting experiences have been designed and carried out, but there is little in the global literature on routine evaluations of contracting practices for furthering and improving contracting models. The intent of this section is to focus on evaluation, learning, and adapting of the overall contracting approach and practice, not on the operational aspects of evaluating individual contracts.

None of the stakeholders interviewed identified any explicit systems in their country for periodic evaluation of contracting processes and practices, but they focused instead on evaluation of contracts, providers, and internal systems (this was especially the case in India). We therefore could not answer questions related to how results were used or whether any contracting processes were amended or changed based upon evaluations. See also the earlier sections for examples of contracting reforms that arose not from formal evaluations, but from thoughtful and analytical contracting units.

Overarching lesson: Contracting reforms do not require systematic evaluation of contracting processes.

Lesson 5: *Regular evaluations of individual contracts allow for process updates, capacity building, and decisions on contract extensions. (India)*

India: *Ongoing review of contracting practices including technical support to NGOs is crucial to maintaining and improving contract execution and quality of care.*

Although there is not a systematic review of the contracting process itself, there are two types of contract evaluations in India under the NACP, both of which have provided information for adapting the contracting process. The first is the NACP's internal cycle of review, which is conducted via TSU-led site visits every six months. It influences revision of the guidelines for TIs and allows ongoing capacity development of CSOs and NGOs by the TSUs, who provide formal feedback. While TIs are initially contracted for three years, they may be granted annual contract extensions based upon an internal performance assessment carried out by the SACS/TSU.

The second type of contract evaluation is external, based upon an evaluation manual and conducted at the end of contract year three. While the government originally performed these evaluations, there is now a network of regional institutions who have taken over this role and perform third-party independent evaluations. TIs are evaluated with a standardized evaluation tool and manual developed by NACO. They are evaluated based on 48 indicators which include 25 program delivery indicators, 13 finance indicators, and 10 organizational capacity indicators.

2.6 Development Partners and their Roles

Countries that have successfully developed and sustained contracting models in health all had strong leadership, vision, and political will from the highest level of government. However, development partner support can be catalytic as national support and political will are created, capacity is built, and systems and funding are transitioned to domestic channels. Several key aspects of contracting, including advocacy and stigma reduction efforts, piloting of new models, testing of innovative approaches, and scale-up have been funded by partners. What all this support has in common is that the decision to contract came from the government and was not imposed upon the country. Regardless of why a country decides to contract, successful models have been those that have been country-led and owned.

DEVELOPMENT PARTNERS AND THEIR ROLES – LESSONS

Lesson 6: Development partner support can support piloting (including the creation of standard packages of activities that are amendable to contracting), scale-up and transition planning, deliberations on health system reforms, and efforts to improve contracting practices. *(India, Kazakhstan, Liberia)*

Overarching lesson: Development partner support can be catalytic in countries that already have high-level political will and a vision as to why they wished to contract. It can be strategic in supporting contracting and pushing for sustainable practices.

Lesson 6: *Development partner support can support piloting (including the creation of standard packages of activities that are amendable to contracting), scale-up and transition planning, deliberations on health system reforms, and efforts to improve contracting practices. (India, Kazakhstan, Liberia)*

India: *Technical support for piloting, scale-up, and refinement of approaches at strategic stages in the contracting process has been instrumental in moving India's model forward over the last two decades.*

From the beginning, NACO was supported both technically and via funding by development partners such as the World Bank, the Bill and Melinda Gates Foundation (BMGF), the Global Fund, and the Joint United Nations Program on HIV/AIDS (UNAIDS) who worked closely with the organization to design India's response to the epidemic. [68] Early consultations and discussions built political will for the HIV response generally, but also around the importance of linking to key populations including through contracting of CSOs. Cost sharing with the World Bank (see lesson 3B) enabled a shift to domestic funding and domestic contracting.[69] And the NACP V, with support from the US President's Emergency Plan for AIDS Relief, is now working on innovative ways to ensure that voices from those in the

[68] Mohammed, Suresh Kunhi, Ronald Upenyu Mutasa, and Ishira Mehta. "Targeted Interventions: India's Pathbreaking Approach to Address the HIV/AIDS Pandemic," February 2021. http://hdl.handle.net/10986/35375.
[69] Bhat, Ramesh, Kurapati Sudhakar, Thomas Kurien, and Arni S. R. Srinivasa Rao. "Strengthening India's Response to HIV/AIDS Epidemic Through Strategic Planning, Innovative Financing, and Mathematical Modeling: Key Achievements over the Last 3 Decades." *Journal of the Indian Institute of Science* 102, no. 2 (2022): 791–809. https://doi.org/10.1007/s41745-022-00331-y.

communities are heard through piloting of a community-led monitoring (CLM) system using community scorecards.

India: *It is essential that development partner support includes a transfer of knowledge, skills, and capacities.*

A lost opportunity occurred early on when USAID and DFID's efforts in developing, monitoring, and strengthening the capacity of NGOs and CBOs to serve as contractors was not effectively transferred to the GOI. The work of these development partners—including supporting institutional capacity building of NGOs—dwindled and it was observed that many of the CBOs vanished as their leadership left, and with it their capacity to serve as providers through contracts. NACO is now trying to revive community system strengthening under a new Global Fund grant where government itself will strengthen ("capacitate") CBOs.

> "I wish we, as government, had been more engaged when partners were supporting strengthening of CBOs in order to continue to support NGOs and CBOs after partner support had ended. The transition from partner support to the GOI created bottlenecks (and set us back), as there was little capacity building and knowledge shifting from partners to the GOI. Basically, in Phase II of the NACP during and after piloting, NGOs were brought to maturity, and once partners left, they collapsed."
>
> *– Key Informant GOI*

Kazakhstan: *Technical assistance served to streamline the contracting process and plan for sustainable financing of TB contracting.*

While the impetus for domestically funded TB contracting came from the government, adjusting the contracting model and adapting it to the health sector was supported by a number of development partners, among them USAID and the Global Fund. These partners helped provide evidence for the shift from hospital to outpatient treatment of TB patients and the integration of vertical delivery systems into PHC, both of which increased the relevance of contracting to the health sector.

To expand Kazakhstan's contracting model to the health sector, a number of development partners joined the TWG on contracting established by the Almaty city government. Partners advocated for the inclusion of TB in state contracting. For example, the USAID Eliminating Tuberculosis in Central Asia (ETICA) Project[70] supported an analytical report on financial mechanisms for improving the TB service delivery system. The TWG on contracting also recommended improved conditions for CSOs' participation in state social procurement, and development partner support helped Kazakhstan to streamline what one KI identified as "the highly inefficient and cumbersome contracting process by the state that was followed in order to comply with the Public Procurement Law under the SSO." Further recommendations also emerged to improve the processes for assessment of needs, coverage, tariffs, and oversight of contracting for HIV.[71]

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[70] On a regional level, the USAID ETICA Project became an active member of national and regional working groups on resource mobilization for social contracting where it advocated for amendments in key regulations to attract CSO interest in TB funding mechanisms.

[71] Demchenko, Maxim, Elena Dmitrienko, Taras Gritsenko, Nurali Amanzholov, Tatyana Davletgaliyeva, and Makhabbat Espenova. "ASSESSMENT OF READINESS OF THE REPUBLIC OF KAZAKHSTAN to Ensure Sustainability of HIV-Related Services with Funding from the State Budget." The Global Fund, 2020. https://kncdiz.kz/files/00007914.docx

Kazakhstan: *Targeted development partner support can be instrumental to scale up contracting.*

The Global Fund grant was catalytic in bringing contracting for TB up to scale nationwide and requiring a sustainable transition plan. Under its grant, technical assistance was provided to initiate local government-funded social contracts by first costing out services to be provided by NGOs before calling for proposals, and next to advertise TB competitions both locally and nationally.

By the end of 2019, the government procurement portal[72] (where SSOs are placed) contained information on more than 3,000 tenders organized according to the SSO procedure, including procurement of TB- and HIV-related services. Before awarding a contract, SSO projects are evaluated against eight qualitative indicators, including work experience, project compliance with customer requirements, and action plan. A separate criterion is the cost of the project, which is calculated using the notional price method.[73]

The Global Fund grant included a transition plan to gradually decrease Global Fund support for TB contracting and replace it with government funding (in the context of the government's integrated approach) to address the needs of key populations via contracting. Domestic funding for contracting of HIV and TB services has increased, but the country's commitment to reach 50 percent of funding for social contracts from domestic budgets by 2022 has not yet been achieved.

Liberia: *Development partner support to finance contracting enabled the GOL to envision and build a new health system based upon contracting of NGOs for health facility management.*

The MOHSW's new contracting policy, procedures, and processes guided the efforts of development partners who supported contracting activities in Liberia: both those that were managed from within the health ministry and those that were managed by development partners. This included contracting supported by the pooled fund, the RBHS USAID bilateral project, and the later FARA approach. The FARA approach, which had not previously been used in this context, allowed reimbursements to be made when milestones were verified, instead of providing budget support, thereby reducing financial risk to USAID. With this unconventional use of a FARA mechanism, there was a lot to learn, and both parties acknowledged that aspects would need to be modified as USAID and the MOHSW navigated this new way of doing business. In addition to this funding for contracting itself, a number of partners provided technical support to build systems to manage and oversee contracting, and to strengthen health system functions (e.g., health information systems and supply chain) that enabled contracting to work.

CONCLUSIONS

The contracting experiences covered in this report include a variety of country contexts and health systems: the India example being HIV-focused; South Africa WC also being HIV-focused but later more integrated; Kazakhstan covering social services and subsequently expanded to HIV and TB; and Liberia

[72] goszakup.gov.kz

[73] Demchenko, Maxim, Elena Dmitrienko, Taras Gritsenko, Nurali Amanzholov, Tatyana Davletgaliyeva, and Makhabbat Espenova. "ASSESSMENT OF READINESS OF THE REPUBLIC OF KAZAKHSTAN to Ensure Sustainability of HIV-Related Services with Funding from the State Budget." The Global Fund, 2020. https://kncdiz.kz/files/00007914.docx

involving health facility management and capacity building for a BPHS. Reflections on how these issues compare to the HS4TB experiences in TB contracting in Bangladesh and India are in Annex 8.

Every country has its unique path to contracting, and there is no single right way to approach contracting. Political will, legal frameworks, governance structures, procurement rules, budgeting and financial and payment processes, and evaluation of contracting models are unique to each country. Each country must analyze its own situation, including health system context, government policies, and existing capacities, and devise its own roadmap for how contracting and public funding can be used to ensure sustainable approaches to achieving public health goals. Still, it is possible and important for countries to draw on other countries' practices and lessons learned as discussed in this paper, including looking at potential solutions. The commonalities found across the six topic areas in this report are important for NTPs and development partners to understand. They are summarized below.

Political will and stakeholder buy-in: The decision to contract out for health services generally stems from a public agency's weakened capacity to perform a select function, or the ability of a contractor to provide the service or function more efficiently, effectively, or flexibly than the public entity. Although the reasons for contracting vary, the examples where the greatest strides have been made in contracting in terms of uptake, transition from development partner support, and sustainability, are those where there is clarity and vision surrounding the reasons for contracting (e.g., an epidemic out of control and little government capacity to reach communities and vulnerable populations [India, South Africa WC]; the need to instill trust in a new government in a post-conflict environment through maintenance and rapid scale up of services [Liberia]; and a way to maintain social services and social order closer to communities [Kazakhstan]).

High-level leadership and ongoing stakeholder involvement are key to success. This should include communicating a vision from the highest levels of government as to why a decision has been made to contract, and how government wishes to partner with non-state providers. Leadership from the highest level of government can create flexibilities during the establishment of contracting, and ongoing dialogue with key stakeholders allows for continuous improvement of contracting models.

Legal and regulatory framework: Governments have been able to contract initially either through development partner-supported projects (India, Liberia), through special agency status (India), or by careful attention to legal language and concepts (Kazakhstan, Liberia, and South Africa WC). Sometimes countries will develop specific policy to expand upon general procurement laws (Liberia and South Africa WC), while others will work hard at legal reform to advocate for amendments to the law (Kazakhstan). Most procurement laws do not include specific language on health service contracting, so support from high-level policymakers and community can be important to instill confidence and create workarounds (India, Kazakhstan, South Africa WC), while some countries sought technical assistance to interpret the legal environment (Kazakhstan, Liberia) to ensure the legality of contracting for health services.

Governance structures and process: Countries do not generally have an intentional process for decision-making on how governance for contracting should be organized. Governance approaches for contracting evolve with experience, rather than arising from a one-off process to determine: how and where various contracting functions should be housed; the organizational structure of any contracting

units; or the staffing levels necessary to manage contracts. Contracting governance structures and processes are entirely dependent upon country context, including the organization of the country's health and administrative systems (India, Liberia, South Africa WC), and often transition stepwise from donor-led and centralized models to domestic, more decentralized models (India, Kazakhstan, Liberia, South Africa WC). Throughout this journey, it is important to consider how and where capacity needs to be built, including among individuals, institutions, and systems, and to ensure that the right people are selected to manage the process (e.g., the choice of a high-level officer to lead in India, and of a minister of health and directors from the NGO world to set the direction in Liberia).

Budget and finance: In some countries, attempts have been made to establish new service purchasing organizations outside of ministries of health. However, without substantial sector reforms, these autonomous or outside agencies tend only to be given control of donor grants/loans or of special funds through international financing institutions (e.g., Liberia, India), often as an initial step in learning how to contract. For the more common situation of general health sector budget flows, alignment with domestic planning and budget cycles serves to facilitate sustainable financial planning (India, Kazakhstan, Liberia partially, and South Africa WC). Decentralization of budget allocation decisions can threaten program budgets (due to variability in local decision-making), but budgetary advocacy can help (Kazakhstan). In other contexts, decentralization can create openings to mobilize funds for contracting: opportunities that may not exist at the national level (South Africa WC). In terms of contract structure, multi-year contracts serve to increase continuity of care and provide greater financial stability to the non-profit sector (Kazakhstan, South Africa WC). And on payment, countries have chosen to either: contract with NGOs through input-based payment mechanisms (India, Kazakhstan, South Africa WC); transition from input-based modalities to at least partially output-based approaches over time (India); or start off with performance-based payments (Liberia) (which come with greater transaction costs as they require more oversight, monitoring, and verification).

Evaluation, learning, and adapting: Countries do not have built-in systematic evaluation of contracting processes. Contracting processes evolve and adapt in ways that are unique to country context and health systems. Countries do focus on evaluation of operational aspects of contracting such as contractor performance (India, Kazakhstan, Liberia, South Africa WC), regular audits (South Africa WC), or established institutional structures for ongoing feedback, learning, and adaptation (India). This allows for process updates, capacity building, and decisions on contract extensions.

Development partners and their roles: Development partner support was found to be catalytic in countries that already had high-level political will and a vision as to why they wished to contract. Targeted donor support for national advocacy efforts (India, Kazakhstan, Liberia, South Africa WC), piloting (India, South Africa WC), testing approaches (India), scale-up (India, Kazakhstan, Liberia, South Africa WC), and transition to domestic systems and funding (India, Kazakhstan, South Africa WC) have served to further sustainable contracting practices. Development partners can also establish (through their own contracts) standard packages of activities that are amendable to contracting, help assess the landscape for contracting (including the regulatory framework) and provide technical assistance on efforts to improve contracting practices.

Final words: Based upon this review, decisions surrounding contracting are much more circumstantial than planned, but countries can learn from how others have approached and implemented contracting.

As contracting to non-state providers is a major policy decision requiring health system reform, there are two essential requirements, found across all of the countries examined, that set the stage for sustainable contracting: *high-level political will*, and *advocacy and stakeholder participation* in the process.

Although these are the necessary conditions to establish contracting, they are not enough to bring it to scale and sustain it. There is no single best practice for how to approach the *legal environment* for contracting, other than the fact that an assessment of national procurement laws for contracting out health services is imperative prior to commencing. Leaders need to be able to: work under the existing legal framework of the country; access technical support advisors as needed; call upon a wide array of stakeholders and partners to garner political support; amend laws and consider creative ways to succeed in contracting if there is a restrictive legal environment; and develop new policies. Public procurement of any kind, including contracting of health services, should be efficient, transparent, and offer value for money while safeguarding quality and public safety. The emphasis on good public procurement law is to protect the public interest by defining procedures that seek to reduce the potential for corruption.

Contracting needs to work within the existing organizational *governance structures* of the health system by first assessing its strengths and challenges, and then by simply beginning the contracting process. Given that contracting arrangements will be unique to each country's geopolitical and economic circumstance and health system, it is difficult to prescribe how to do it. Starting small through targeted pilots involving community groups and advocates, adapting as the environment changes, and gradually building systems seems to be the most practical way forward. Rather than plan and build full capacity prior to contracting, stakeholders should begin with what exists and build capacity along the way via an iterative process.

Contracting may require sector-wide *financing policy reform*. Ministries of health and certain stakeholders are not naturally enthusiastic about using public finances to purchase private services—whether they are commercial for-profit or not-for-profit services—since this implies a divergence from the way core population-based public health services have been delivered in the past. It is for this reason, when *development partners* are funding contracting, a focus on both financial and programmatic sustainability (via use of government resources and processes) should be contemplated early on and positioned as part of a country's agenda.

The design of this work focused intentionally upon uncovering the answers to questions not found already in the literature (e.g., guidelines, manuals, and tools). There may be a reason that these areas had not been addressed previously, namely that these areas are unique to context and because of this there are no generalized steps nor processes that countries ought to follow. However, these findings validate why certain shortcomings to contracting exist and outline some of the approaches to overcome these barriers and promote the sustainability of contracting.

Definitions

The following are some common definitions of terms used throughout this report.

Contracting out

Contracting out occurs when a contract is awarded to another party to deliver a set of predefined services. Deliverables or results are specified with a budget and a timeline in the contract, and the contractor is fully responsible for management of the work and achievement of the results. The contractor hires its own staff, manages its resources, and provides reports on achievement of milestones. The contracting party (e.g., the government) provides oversight, monitors progress, and provides coordination and input, but leaves management of the contract to the contractor. Examples include contracting with an NGO/FBO to provide a package of services to a specific geographic area or target population; outsourcing a defined set of services (housekeeping, maintenance, catering, transportation, security, laundry); outsourcing ancillary clinical services (e.g., laboratory, radiology, pharmacy); or core clinical services (e.g., family planning, surgery).

Contracting in

Contracting in is when one level of government or a public institution—for example, a central ministry of health—contracts with a lower level of government (e.g., a county, district, a province, or facility) to deliver services. Contracting in serves as a way to introduce private sector concepts and business strategies into public sector management in a non-threatening way, as decision-making and resources are retained within the public sector[74].

Management contracts

Management contracts are a variation of the contracting model whereby another party, for example an NGO/FBO, is contracted to manage a government-staffed facility or service while working under the civil service framework. An example would be hiring an NGO/FBO to manage a public sector hospital, health center, or clinic, where the ministry retains the management of government employees and financial resources, but the contracted organization is responsible for ensuring service delivery.

Non-state providers

Non-state providers are defined as all entities existing outside the public sector, whether they operate as for profit or not for profit entities with commercial, development, or charitable motives. These providers can take a wide variety of organizational forms including private commercial firms, multinational corporations, financial institutions, foundations, universities, concessionaires, cooperatives, NGOs, FBOs, and CBOs of either national or international standing. Among the non-state private providers there is a mix of formal and informal, legally constituted, and non-licensed.

Input-based payment

[74] Abramson, Wendy B. "Contracting for Health Care Service Delivery: A Manual for Policy Makers." John Snow Inc, June 2004.

This type of payment involves the transfer of funds from the government to a provider based on the resources deployed/inputs. These usually include salaries, consumables, equipment, and use of facilities. Payments are often made in the following sequence: 1) initial installment before starting the services, and 2) second installment based on the submission of financial and/or programmatic report. Payment does not consider whether outputs are achieved. Input-based payment was an option used among most countries participating in a 2017 meeting.[75]

Output-based (e.g., fee for service)

Payment is based on the number of services, tasks, or procedures provided to patients, with unit costs defined by the purchaser. The units of service are quantifiable and verifiable. Usually, this is based on the number of clients reached with a specific package of services or on the number of specific referrals.

Performance-based payment (incentives, bonus)

Payment for services is linked to outcomes such as coverage or quality of interventions. As in the output-based payment, a significant part of the payment is based on the results, whether the estimated number of services provided or by the percentage coverage multiplied by an agreed tariff. However, the amount is then subject to adjustment if agreed criteria are (or are not) met, which means that good performers will be rewarded with extra payment while bad performers will be penalized. The selection of the right indicators is therefore crucial and should be suitable for the local context.

[75] Open Society Foundations, The Global Fund, and UNDP. A Global Consultation on Social Contracting: Working toward Sustainable Responses to HIV, TB, and Malaria through Government Financing of Programmes Implemented by Civil Society. New York City, NY. 2017. http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf

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ANNEXES

Annex 1 – Summary of lessons from this study

1 Political Will and Advocacy

Lesson 1A: Political will for contracting is based on a clear rationale, such as a service gap that is better filled by community-based NGOs or CSOs, a need to reorient services and priorities to community level, a need for efficiencies or more dynamic performance management, or a desire for reduced dependence on international donors. (India, Kazakhstan, Liberia, South Africa WC)

Lesson 1B: Political leadership and a focused vision can create flexibilities and overcome operational gaps during establishment of contracting for services. (India, Liberia)

Early initiation of contracting can result from a health crisis, previous private sector work by government leaders, low public sector delivery capacity, and decentralized governance. (South Africa WC)

Lesson 1C: Ongoing dialogue with key stakeholders and continuous improvement of contracting models are needed both to establish and maintain support for contracting. (Liberia, South Africa WC)

2 Legal, Regulatory, Policy

Lesson 2A: Whether it is an enabling or restrictive environment, with support from high-level policymakers and community, each country makes do with the legal environment in which they find themselves to create the conditions and workarounds necessary for contracting. (India, Kazakhstan, Liberia)

Lesson 2B: A legal basis for contracting, along with a clearly substantiated contracting policy, allows contracting to progress while specificities of contracting and regulatory systems can be developed over time. (Kazakhstan, Liberia, South Africa WC)

Lesson 2C: Technical support to assess the legal environment for contracting is important. (Kazakhstan, Liberia)

3 Governance Structures, Functions, and Processes

Lesson 3A: The governance structures and processes for contracting evolve as the programmatic and institutional needs evolve. (India, Liberia)

Lesson 3B: Contracting approaches often transition stepwise, from donor-led and centralized models to domestic, more decentralized models. (India, Kazakhstan, Liberia, South Africa WC)

Lesson 3C: Buy-in at the local level, including among implementers, is important to successful contracting. (India, Kazakhstan, South Africa WC)

Lesson 3D: Salary and capacity disparities between NGO and government staff can destabilize the contracting relationship. (Liberia, South Africa)

4 Financing and Budget

Lesson 4A: Countries with sustainable contracting practice ensure that financing aligns with national planning and budgeting systems and processes. (Kazakhstan, Liberia, South Africa WC)

Lesson 4B: Risks from domestic financing including funding shortfalls, delays or gaps, and the need for stronger public financial management systems. (India, Kazakhstan, Liberia)

Lesson 4C: Longer contracts allow stability and performance-based adjustments provide incentives. (India, Kazakhstan, Liberia, South Africa WC)

5 Evaluation, Learning, Adapting

Lesson 5A: Regular evaluations of individual contracts allow for process updates, capacity building, and decisions on contract extensions. (India)

6 Development Partners and their Roles

Lesson 6A: Development partner support can support piloting (including the creation of standard packages of activities that are amendable to contracting), scale-up and transition planning, deliberations on health system reforms, and efforts to improve contracting practices. (India, Kazakhstan, Liberia)

Annex 2 – Rationale for topic selection

To understand what gaps might exist in current guidance on contracting implementation, we reviewed 21 previously identified documents related to contracting to get a sense of what resources already exist and categorized them into four groups. The first group includes three publications funded by the Gates Foundation,[76] DFID,[77] and the World Bank[78] that each present research which found contracting to be an effective means of purchasing health services, and another by the World Bank that concludes that most inputs for the health sector, with the exception of human resources and knowledge, can be efficiently produced by and bought from the private sector.[79] The second group comprises publications on country-specific experiences with contracting different types of health services, including 2017[80] and 2019[81] global consultation conference reports by the UNDP, another report by the UNDP with eight country case studies[82] from Africa, the Caribbean, Eastern Europe and Latin America, Botswana's funding strategy[83] for civil society-led HIV services, a study on contracting-out urban primary health care in Bangladesh,[84] and a book on public-private partnerships in healthcare in India.[85] The third group includes a range of different guides and toolkits on contracting health services that either provide high level guidance or a narrow focus on one topic, including high level overviews of contracting for policy makers by John Snow Inc.,[86] the Pan Caribbean Partnership against HIV and AIDS,[87] the USAID-funded

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[76] Legard, M. et al. 2009. The impact of contracting out on health outcomes and use of health services in low and middle-income countries. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD008133. https://researchonline.lshtm.ac.uk/id/eprint/4670/1/Lagarde_et_al-2009-The_Cochrane_library.pdf

[77] England, R. 2004. Experiences of contracting with the private sector: a selective review. DFID https://assets.publishing.service.gov.uk/media/57a08cd140f0b64974001476/Experience-of-contracting-with-the-Private-sector.pdf

[78] Loevinsohn, B. et al. 2005. Buying results? Contracting for health service delivery in developing countries. Lancet 2005; 366: 676–81. https://shopsplusproject.org/sites/default/files/resources/2830_file_Lancet_art_final_Contracting_BL_AH.pdf

[79] Preler, A. et al. 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, 2000, 78 (6). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2560779/pdf/10916915.pdf

[80] Open Society Foundations, The Global Fund, and UNDP. A Global Consultation on Social Contracting: Working toward Sustainable Responses to HIV, TB, and Malaria through Government Financing of Programmes Implemented by Civil Society. New York City, NY. 2017. http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf

[81] UNDP. Public financing of service provision by civil society organisations in national responses to HIV, TB and malaria. New York: 2019. https://www.undp.org/sites/g/files/zskgke326/files/migration/eurasia/2019-Social-Contracting-Global-Consultations-Meeting-Report_ENG.pdf

[82] UNDP. Using Social Contracting in National HIV Responses: Country case studies from Africa, the Caribbean, Eastern Europe and Latin America. New York: 2019. https://drive.google.com/file/d/1BZ6DFZMNPQjz_kwngGPObwXTaiN2tism/view

[83] Ministry of Health. 2019. Botswana's Fund Strategy for Civil Society-Led HIV Services. Gaborone: Government of Botswana. http://www.healthpolicyplus.com/ns/pubs/17369-17670_HIVFundStrategyDec.pdf

[84] Islam, R. et al. 2018. Contracting-out urban primary health care in Bangladesh: a qualitative exploration of implementation processes and experience. International Journal for Equity in Health (2018) 17:93. https://equityhealthj.biomedcentral.com/counter/pdf/10.1186/s12939-018-0805-1.pdf

[85] Raman, V. et al. 2009. Public-Private Partnerships in Health Care in India: Lessons for developing countries. Routledge Studies in Development Economics. https://www.amazon.com/Public-Private-Partnerships-Health-Care-India/dp/0415467284

[86] Abramson, W. 2004. Contracting for Health Care Service Delivery: A Manual for Policy Makers. John Snow Inc. https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10351&lid=3

[87] Cenac, Veronica, and Lucien Govaard. SOCIAL CONTRACTING TOOLKIT a Guidance Note for Decision-Making for Country Implementation of Social Contracting. Caribbean Community (CARICOM) Pan Caribbean Partnership against HIV and AIDS (PANCAP). 2021. https://web.archive.org/web/20231023215106/https:/pancap.org/pc/pcc/media/pancap_document/PANCAP-SOCIAL-CONTRACTING-TOOLKIT.pdf

SHOPS project,[88] and WHO,[89] plus a book-length toolkit by the World Bank[90] focusing on operational aspects of performance-based contracting of health services, another publication by the SHOPS project describing how social contracting for HIV services is organized in Vietnam,[91] an operational manual for TB contracting in India,[92] and a UNDP guidance note for the analysis of NGO social contracting mechanisms.[93] The fourth group is comprised of conceptual frameworks related to contracting, including a matrix of activities by actor (donor, government policy makers, and civil society) for developing government social contracting to civil society[94] by the USAID-funded Health Policy Plus project, a strategic purchasing progress tracking framework by the Strategic Purchasing Africa Resource Center (SPARC)[95], and finally a theory of change figure on performance-based financing as a pathway to strategic purchasing of health services also by SPARC.[96] Reviewing these documents from a global perspective, we find that there is sufficient evidence on the effectiveness of contracting health services in group one and a trove of documented country experiences in group two, but there are gaps among existing guidance documents and toolkits in group three across the range of topics related to contracting health services.

This third group merited more analysis, and a more detailed comparison of what guidance already exists versus what might require further exploration. To organize the analysis, we identified five distinct topics that are related to initiating or informing existing contracting of health or health-related services: 1) Why contract: Making the country-specific case for contracting (recognizing that policy makers will have neither the time nor interest to review global research on the merits of contracting and the need to persuade both policy makers and sceptics of the value of pursuing contracting in their country); 2) The enabling environment for contracting – policy, legal and regulatory issues, including the political economy around contracting; 3) How to contract, including the design and various operational aspects of contracting; 4) Financing considerations, which include linkages to the national budget and budget cycle

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[88] SHOPS Project. 2012. Filling the Gap: Lessons for Policymakers and Donors on Contracting Out Family Planning and Reproductive Health Services. Primer. Bethesda, MD: SHOPS Project, Abt Associates. https://shopsplusproject.org/sites/default/files/resources/Contracting%20Out%20-%20Policy.pdf

[89] Hellowell, Mark, Andrew Myburgh, Gabrielle Appleford, Pranav Mohan, David Clarke, and Barbara O'Hanlon. "A GUIDE TO CONTRACTING FOR HEALTH SERVICES DURING THE COVID-19 PANDEMIC." World Health Organization, 2020. https://cdn.who.int/media/docs/default-source/health-system-governance/2021.01.19---contracting---conferency-copy.pdf?sfvrsn=92a3e9fd_3&download=true

[90] Loevinsohn, Benjamin. Performance-Based Contracting for Health Services in Developing Countries: A Toolkit. Health, Nutrition, and Population. The World Bank, 2008. https://openknowledge.worldbank.org/entities/publication/f9d1dc78-6228-58b6-bb1e-fc9def8e796a

[91] Center for Health and Research Development, and Health Policy Plus. "Social Contracting Guidelines for HIV Services in Vietnam." Palladium, September 2019. http://www.healthpolicyplus.com/ns/pubs/17357-17641_VietnamSocialContractingModel.pdf

[92] National Tuberculosis Elimination Programme. 2023. Operational Manual for Partnerships under National TB Elimination Programme. https://tbcindia.gov.in/showfile.php?lid=3705

[93] Duric, Predrag, Timur Abdullaev, and John Mccauley. "Guidance Note for the Analysis of NGO Social Contracting Mechanisms. The Experience of Europe and Central Asia." UNDP, 2019. https://www.undp.org/sites/g/files/zskgke326/files/migration/eurasia/NGO_socialcontracting_EN.pdf

[94] Health Policy Plus. 2018. Social Contracting: Supporting Domestic Public Financing for Civil Society's Role in the HIV Response. Palladium. http://www.healthpolicyplus.com/ns/pubs/7190-7335_SocialContractingFactsheet.pdf

[95] Changing the Conversation: Making progress on strategic health purchasing in sub-Saharan Africa. Strategic Purchasing Africa Resource Center (SPARC). https://sparc.africa/2021/05/changing-the-conversation-making-progress-on-strategic-health-purchasing-in-sub-saharan-africa/

[96] Is Performance-Based Financing a Pathway to Strategic Health Purchasing in Sub-Saharan Africa? A Synthesis of the Evidence. Strategic Purchasing Africa Resource Center. https://sparc.africa/wp-content/uploads/2021/06/SPARC_Topic_Brief_PBF-Pathway_L6b_noCIT.pdf

as well as information on different payment modalities; and 5) Evaluation, learning, and adapting of contracting policies and practices (as opposed to monitoring and evaluating contractor performance, which is an operational activity). We then reviewed the documents in this group three, plus an unpublished document from HS4TB Bangladesh, to identify which of the five topics they covered and to what extent. See the end of this Annex for a table summarizing the findings of this review.

Our analysis found that none of the documents in this group three provide guidance on how to make the case for proceeding with contracting in a given country and, in some cases, (e.g. the World Bank PBF Toolkit) make the assumption that the country has already decided to contract health services and that there are no legal, regulatory, or policy barriers. Other documents within this group provide definitions, describe different contracting models, and/or make a general argument for the merits of contracting, but they do not provide guidance how to make a compelling country specific case (return on investment, cost-benefit, the political value, etc.) to motivate the national decision makers to endorse proceeding with a legal, regulatory and policy analysis. Therefore, we envision that the proposed HS4TB contracting guideline document would cover this important aspect and ideally provide examples of how this was accomplished in other countries.

We found that under the legal, regulatory, and policy topic, most of the documents mentioned the importance of these considerations, but only the PANCAP guidance provided any detail about what specifically might need to be considered. It did not, however, provide a description of how to go about assessing these issues and what to do if there is a lack of clarity on any aspect of them. The HS4TB Bangladesh document provides an excellent example of how such a lack of clarity can lead to misunderstanding about what is or is not permissible and provides a description of how potential solutions were identified. We envision this proposed HS4TB guidance document will provide detailed guidance on how to assess legal, regulatory, and policy issues related to contracting and provide suggestions for what to do when the findings of the assessment indicate barriers to contracting exist.

The World Bank PBF Toolkit book covers topic three (How to contract) fairly well, including a detailed seven-step process to contracting and an accompanying checklist, and it is complemented by additional narrative description on how to contract within most of other documents reviewed, but in lesser detail. However, the World Bank PBF Toolkit does not include guidance on the need for, potential composition of, and suggested procedures for a contracting governance structure that would ensure that contracting efforts are aligned with relevant policy goals, that a redress mechanism exists for dispute resolution, and that the best interests of the population are safeguarded, nor does it provide sufficient guidance on where contracting managers and functions could be located within government. Therefore, under topic 3, we inquired about the processes and structures needed to contract, the importance of a governance structure and its potential functions, and where contracting managers and functions could be located within government. For the seven-step process for contracting, readers may refer to the World Bank PBF Toolkit and other resources for more information. The TB operational manual from India is also an excellent example of a detailed contracting manual that has built on years of country experience with contracting.

In the area of financing considerations, several documents mentioned financing topics, such as the PBF aspect of the World Bank Toolkit, risks around different payment models in the JSI document, and

reference to potential sources of funding in the PANCAP document. Only the Vietnam social contracting guidelines went into detail on the country-specific planning and approval processes within the government's budget cycle and the relevant budget procedural guidance that must be adhered to. What is missing in the Vietnam document is any description of the process the authors went about to identify legal, regulatory, and policy issues, including procurement requirements, and all aspects of the financial considerations around the national budget. There is therefore a need to explain how to identify relevant national budget guidance as well as how to analyze the national budget for potential areas where contracting health services might be feasible (e.g., by identifying specific health activities with distinct budget lines that could potentially be contracted and develop linkages to Topic 1 and making the case for contracting). Another area that could be explored in much greater detail is the potential payment modalities (cost plus, fixed fee, fee for service, capitation, diagnosis related groups, PBF/RBF, comparing the concepts of output-based vs input-based payments vs a blended approach, etc.) that could be used in contracting and the situations in which they would be most appropriate.

The final area we considered was around evaluation, learning, and adapting of contracting policies and processes, which are important to ensure that the policy and approach to contracting is achieving its intended purpose and that they evolve according to lessons learned and changes in the context (political, fiscal, technical etc.). We found that while both the PANCAP and SHOPS documents mention the need for sustainability, neither describes how the contracting policy and processes (e.g., governance structures) would be evaluated, learned from, and adapted to ensure their sustainability. There is therefore scope to explain why evaluation, learning, and adapting are important, how to go about different aspects of it, how to address challenges when they arise, and why it is important to document and share the country's experience.

Summary of Available Contracting Documents' Coverage Across the Five Topics Related to Contracting Health Services.

No.	Document title	1) Why contract: how to make the country case for contracting	2) Legal, regulatory, policy issues	3) How to contract	4) Financing considerations	5) Evaluation, learning, & adapting
1	World Bank: Performance-Based Contracting for Health Services in Developing Countries A Toolkit, 2008	This toolkit assumes that the user has already decided to use contracting. It reviews global evidence for contracting in developing countries and why contracting appears to work.	Not discussed.	Effectively and thoroughly lays out seven detailed steps for contracting: 1. Conduct dialogue with stakeholders. 2. Define the services. 3. Design the monitoring and evaluation. 4. Decide how to select contractors. 5. Arrange contract management & develop a contracting plan. 6. Draft the contract and bidding docs. 7. Carry out the bidding process and manage the contract.	No linkages to the national budget cycle and lacks real description of different types of payment models beyond PBF-based models.	Not discussed.
2	JSI: Contracting for Health Care Service Delivery A Manual for Policy Makers, 2004	Provides definitions and high-level pros and cons of contracting, explanation of contracting in versus contracting out, but nothing about how to make the case for contracting.	States that legal and policy issues are important, but provides no guidance on how to assess or change them.	Descriptively speaks to choosing from two different types of providers (NGO and commercial), the capability needed by government to contract (regulation, information, costing, payment), the steps in contracting, and the components of a contract, but this document lacks the detail of the WB PBF toolkit.	Describes financial risks associated with some payment models and provides definitions of these models.	Not discussed

3	PANCAP: A Guidance Note for Decision-making for Country Implementation of Social Contracting. Caribbean Partnership against HIV and AIDS. 2021.	Provides definitions, key principles, and descriptive rationale for governments needing to develop social contracting models as they transition off of donor funding. Also describes the need for advocacy to make this happen.	Describes a 4-stage contracting process: **Stage 1** Readiness Assessment: Includes a list of topics that should be considered when assessing. ● Political will ● Legal/regulatory analysis related to funding CSOs.	**Stages 2 & 3** are much shorter descriptive sections about steps in the planning and preparation process and elements of the implementation process that are covered by the WB and JSI documents.	**Stage 1** also briefly describes different financing considerations (linkages to national budget, health insurance, tax revenue)—i.e., how to potentially pay for contracting.	**Stage 4** briefly relates to sustainability and the need to build CSO capacity, monitor program and financial performance of the contracts, and revise policies and laws as needed.
4	SHOPS: Filling the Gap: Lessons for Policymakers and Donors on Contracting Out Family Planning and Reproductive Health Services, 2012.	Makes the general case for contracting FP&RH services, definitions and provides a typology of different types of contracts.	Provides 3 country case studies (Columbia, Cambodia, Bangladesh) that include aspects of legal, regulatory and policy issues.	Divides the contracting process into six steps which generally align with the WB toolkit, which it references as a source document, but does not go into detail in each step area.	Not discussed.	Includes a section on sustainability and learning lessons and provides a list of mistakes to avoid.

5	WHO: A Guide to Contracting for Health Services During the COVID-19 Pandemic, 2020.	Provides some description and pros and cons of 3 different types of contracts (entry, service, concession) and how they could be used to contract different COVID-19 services.	Not discussed.	The contracting process is broken down into summary description of four steps: 1. Purpose and structure of the contract 2. Plan the procurement process; 3. Procure and sign the contract; 4. Monitor the contractual relationship. Again, the WB document is much more descriptive and useful. Like the JSI document, it is more descriptive and aimed at policy makers versus implementers.	Not discussed.	Not discussed.
6	HP+: Social Contracting Guidelines for HIV Services in Vietnam, 2019.	Assumes Vietnam has decided to do contracting. It is a country specific experience of what exists and what the gaps are. Unfortunately, this document is the product of an undocumented process. It's the process that would be most useful.	Describes the need to include CSOs and contracting into existing policies, and the permissive legal context in which contracting would work.	Provides an overview of which HIV services could be contracted, the procurement requirements for selecting CSOs, costing services, bidding, and contracting requirements, evaluating bids, and the reporting requirements. In short, it describes the local requirements that a contracting toolkit would need to follow (e.g., WB PBF toolkit).	Describes Vietnam's budget policies and guidelines applicable to contracting, steps in the budget planning process, when contracting should be included, and steps in the budget approval process.	Not discussed.
7	UNDP: Guidance note for the analysis of NGO social contracting mechanisms, 2019.	Provides the steps in developing a country "factsheet" on the status of contracting for HIV and how to summarize the status of the HIV epidemic using key data points.	Describes the need to identify and review laws, regulations, policies, NGO licensing, and the role of NGOs.	Recommends reviewing NGO service quality standards and reporting requirements.	Provides guidance on how to summarize the GFATM country funding situation for NGOs.	Not discussed.

8	Regulatory options to permit contracting of NGOs to deliver TB and health services in Bangladesh (HS4TB Bangladesh; unpublished)	It assumes that there is political will to pilot NGO contracting if a legal solution can be found.	Provides a useful description of how the legality of NGO contracting was interpreted too narrowly and how potential solutions were identified.	Provides extensive, country-specific history of NGOs, in what capacity they have been funded by donors, and their eligibility / barriers to participate in government contracting of health services.	Not discussed.	Not discussed.
9	NTEP India, 2023: Operational Manual for Partnerships under National TB Elimination Programme	The case for contracting is not discussed as contracting has been going on for years, but it does describe the importance of doing an extensive patient and health system Needs Assessment as the first of 5 steps in the implementation process.	Includes a short description of the need to build service provider capacity around legal requirements and compliance issues.	This operations manual has three objectives: 1) Provide operational directions for streamlining partnership projects. 2) Provide additional technical clarity on performance-based contracting 3) Build capacity on different modalities of procuring services. It describes 5 key steps in the process: -Needs Assessment & resource planning -Designing a partnership, -Procurement of services, -Supervision and monitoring, and -Verifications of deliverables & payments Includes a useful section on roles and responsibilities of the actors involved and annexes such as draft scopes of work and provider eligibility and selection criteria.	Provides extensive description of lessons and discrepancies around verification of services prior to payment.	Not discussed.

Annex 3 – Key Informant Interview Guide – Global Experts

Background: HS4TB is developing a paper on the state of the practice in public sector contracting of services. We are considering political, programmatic, and financial sustainability as key factors. We are in the initial stages of developing a framework to define which aspects of contracting would be most useful to countries, and identifying countries where lessons can be learned from ministry experiences on contracting.

Although there is a lot of literature on the web on low- and middle-income country (LMIC) experiences, and a number of tools and guidelines on contracting, we would like to get your help in exploring the following:

1. In your opinion, ***when and how*** is public sector contracting best used to expand access to services?
2. What do you see as the ***main gaps in guidance and knowledge*** – either in theory or in practice - in public sector contracting for services (for TB or otherwise)?
3. We are looking for ***country examples*** we may consider exploring to capture processes and lessons surrounding these gaps. Are you aware of any promising practices where countries are directly contracting using domestic funding and/or their own financial and administrative systems (entirely or partially)?
    a. Do you have names/contacts of who we could call upon to explore further?
    b. Are there any reports or documents on these countries you suggest we review?
4. What have been some ***key obstacles to*** contracting, what hasn't been done well, and which countries best illustrate some of these obstacles? Do you know if the country overcame these obstacles, and how?
    a. Do you have names/contacts of who we could call upon to explore further?
    b. Are there any reports or documents on these countries you suggest we review?
5. Is there anyone else you recommend we speak with?

Annex 4 – Key Informant Interview Guide – Country Experts

HS4TB is developing a paper on the state of the practice in public sector contracting to private and/or not-for-profit providers of health services. The purpose of this study and follow-on work is to fill in some gaps in practical guidance on how to establish contracting and thus to support TB programs to best utilize non-state providers for TB services. For this study, we are casting a wide net to look at ministry of health experiences in contracting health services at the primary care level (e.g., package of basic health services, TB, HIV, FP/RH, EPI, bundles of services, outreach) as many of them will be relevant for NTPs. What we are not looking at is contributory contracting experiences under national, social, or private health insurance schemes.

We are particularly interested in learning from you what worked, what didn't work, how your country decided to contract out, what processes and actions were taken, as well as how challenges were overcome. We hope that this can be an interactive interview based around a set of key questions. We may need to interject to ask for clarification or for some discussion, or to elaborate upon a point made. There may also be some follow-up questions asked to clarify aspects of the literature consulted during the desk review that remain unclear.

In order to be most efficient with our time, we intend to keep the interview to 60 minutes, so we ask that your responses be as concise as possible. Is it okay to record our discussion?

1. GENERAL QUESTIONS

- What did you hope to accomplish with contracting, and were you successful in this effort, why or why not?
- Was there a country-wide assessment looking at all components of contracting prior to start-up? Did this assessment include a scan of the political environment; legal, regulatory, and policy framework; financing options and budgetary systems; private sector supply and their willingness and capacity to be contracted by government; ministry capacity to design, compete, assess, manage, monitor, and verify contracts? Who led it? And how were the results used?
- If so, do you have any terms of reference and/or final report for this assessment you could share?

2. POLITICAL WILL AND ADVOCACY

a. Where did the initial impetus for contracting come from (country-led, donors, other)?
b. How was political will generated? Please explain the process. How was it sustained throughout the process, and how were any challenges addressed?
c. How was the case for contracting made with policymakers and other stakeholders? Please explain the steps (return on investment, cost-benefit, political value, a means to continue donor-funded implementation arrangements under domestic funding, qualitative arguments, other).
- If there are tools used to "make the case" would you be willing to share them?

d. Which stakeholders were more supportive to contracting and which were more resistant, and why? How was any resistance overcome?
e. Were there challenges in coordination with government and/or non-governmental stakeholders, and if so, how were they addressed?

3. LEGAL, REGULATORY, POLICY

a. Was there an assessment of the legal, regulatory, and/or policy environment prior to implementing contracting? And if so, at what point was this done? Who led it? And how were the results used? If not, why not?
b. Were there legal, regulatory, or policy constraints to contracting, and if so, would you explain the steps taken to overcome or work around these barriers? How long did it take to make changes to the regulatory environment (if changes were needed), and did this require any changes in legislation?

    Is there a description of this process you could share?

c. If the legal/regulatory environment was unclear (e.g., contracting health services was not explicitly allowed, but not explicitly disallowed either), who made the decision on whether to proceed, and how did they make that decision?

4. GOVERNANCE STRUCTURES, PROCESSES, AND FUNCTIONS (institutionalizing) contracting

a. What steps were taken to develop a unit for contracting, and how was this decided? Was a unit set up within the ministry of health fully integrated within government systems and processes, including planning, budgeting, procurement, financial management, and reporting? Or did contracting follow a special set of rules (such as World Bank or Global Fund for AIDS, TB, and Malaria [GFATM] rules and procedures)? Please describe the process.

- Is there documentation that describes this that you could share?

b. What process took place to decide the organizational structure of contracting? (Where purchasing of health services would be located?)

    Were the people with contracting expertise (those familiar with the mechanics and legalities of contracting) co-located with the people with subject-matter technical expertise (those who knew what services needed to be contracted), or were these two areas of expertise located in different parts of the bureaucracy?

    How was it decided whether to centralize or decentralize these contracting unit(s) and expertise?

c. How was it determined how many people were needed to staff/support/manage contracting, what types of skills did they require, what training and capacity building were needed, and the cost of setting this up?

- Do you have terms of references/position descriptions for the unit and individual staff, manuals, handbooks, guidance, or other documents that you would be willing to share with us that other countries may benefit from?

d. What was done to ensure that the ministry had the capacity to successfully plan for, budget, procure and award, manage, monitor, and oversee contracts on an ongoing basis?

- Was a plan developed for building capacity and institutionalizing contracting that you could share?

e. What was the process to identify relevant guidance on the use of public funds for contracting, including budgeting processes between the Ministry of Finance and Ministry of Health?
f. How were issues related to transparency, accountability, and anomalies that may have risen overcome?

- Do you have guidance you could share that may help countries address these issues?

5. FINANCING AND BUDGET

a. How was contracting financed (e.g., sources of funding, channels through which money flowed) and how did funding flows change over time?
b. Describe the process that took place to align contracting with the national budget cycle?
c. Describe the process taken to analyze the budget and identify existing line items that could be used for contracting. Which departments (and ministries) participated in this analysis?
d. Were there any challenges to securing domestic funding and developing financial systems to channel funds, and if so, how were these challenges overcome?
e. How are providers paid – based on inputs, outputs, or via a blended approach? On what basis did country stakeholders reach this decision about how to pay? Is this working well? If not, why not?

6. EVALUATION, LEARNING, ADAPTING

- Were there evaluations of the contracting process, and if so please explain the process to carry them out (who initiated them, how paid for them)?
- How were the results used?
- Were any contracting processes amended or changed based upon these evaluations?

7. OTHER

a. With any new service delivery model there are always going to be challenges, what is your understanding of these challenges from the provider side?
b. What did you wish someone had told you when you began the contracting process that would have helped you?
c. Is there anything you would like us to know about the country's experience in contracting, including lessons learned or promising practices that may be useful to other countries? What about documents, tools, guidance that may be useful to other countries?
d. Has contracting of non-clinical services (e.g., information technology, supply chain functions including transport, other) been used as an example and entry point for establishing contracting of more clinically related services? Any reflections on the connection between clinical and non-clinical services?

Annex 5 – Global Expert Key Informant List

	Last Name	First Name	Institution	Title
1	Loevinsohn	Benjamin	The Gavi Alliance	Director of Immunization Financing and Sustainability
2	Gatome-Munyua	Agnes	Results for Development/Strategic Purchasing Africa Resource Center	Program Director, Strategic Purchasing
3	Stallworthy	Guy	The Bill and Melinda Gates Foundation	Global Lead for TB Private Provider Engagement
4	Suarez	Pedro	Management Sciences for Health	Global Technical Lead, Population Health
5	Tavanxhi	Nertila	The Global Fund, private sector expert	Manager of Country Financing Support

Annex 6 – Country Expert Key Informant List

#	Last Name	First Name	Country	Institution	Title
1	Kushwaha	Bhawani Singh	**India**	National AIDS Control Organization, Ministry of Health and Family Welfare	Deputy Director
2	Davletgalieva	Tatyana	**Kazakhstan**	Project implementation unit (PIU), Kazakh Scientific Center of Dermatology and Infectious Diseases	Global Fund National coordinator, HIV component
3	Ismailov	D-r Shakhimurat	**Kazakhstan**	Project Implementation Unit (PIU), National Scientific Center of Phthisiopulmonology of MoH of RK	Project Manager GFATM TB Grant
4	Maxim	Corina	**Kazakhstan**	The Global Fund	Sustainability and Transition Specialist
5	Demeuova	Ryssaldy	**Kazakhstan**	UNDP	Coordinator of the CCM Secretariat
6	Abramson	Wendy	**Liberia**	Independent	Independent consultant, Strategic Investment Sustainable Financing expert, Global Fund Technical Review Panel (TRP)
7	Dahn	Bernice	**Liberia**	College of Health Sciences at the University of Liberia	Dean
8	Hughes	Jacob	**Liberia**	Management Sciences for Health (MSH)	Senior Technical Director, Health Systems Strengthening
9	Abdullah	Fareed	**South Africa**	Office of AIDS & TB Research, South African Medical Research Council, (former Deputy Director-General, Western Cape Department of Health)	Director
10	Firfirey	Nousheena	**South Africa**	Western Cape Department of Health	Deputy Director
11	Goeiman	Hilary	**South Africa**	Western Cape Department of Health	Director
12	Naledi	Tracey	**South Africa**	University of Cape Town, Social Accountability and Health Systems	Deputy Dean
Additional informants					
13	Stuikyte	Raminta	**Central Europe**	Independent	Independent consultant, Vice-Chair, HIV expert, Global Fund Technical Review Panel
14	Duric	Predrag	**Eastern Europe**	Independent	Independent consultant, Global Fund Technical Review Panel
15	Claeson	Mariam	**India**	Independent	Former director for GFF at the Bank; Regional program manager for HIV in India 2009-2012
16	Deryabina	Anna	**Kazakhstan**	ICAP at Columbia University	Regional Director for Eurasia
17	Grieder	Olga	**Kazakhstan**	The Global Fund	Senior Program Officer
18	Vinichenko	Tatyana	**Kazakhstan**	The Global Fund	Senior Fund Portfolio Manager
19	Desano	Chesa	**Philippines**	MSH	Technical Director and Deputy Project Director
20	Pan	Huiling	**Philippines**	Health Equity Matters	Senior Technical Officer, Health Financing
21	Young	Felicity	**Australia**	Health Equity Matters	Principal Director, International Programs & Director, SKPA-02
22	Barton	Iain	**South Africa**	Health 4 Development	Founding Principal
23	Thetard	Rudi	**South Africa**	Management Sciences for Health (MSH)	Global Technical Lead

24	Mills	Stephen	**Thailand, Asia**	FHI 360 EpiC Project, Asia-Pacific Regional Office (Thailand)	Project Director
25	Borromeo	Maria Elena	**Vietnam**	UNAIDS, Vietnam	Country Director
26	Orya	Breshna	**Vietnam, Philippines**	The Global Fund against HIV, TB and Malaria, Health Finance Department - Strategy Investment and Impact Division	Advisor, Value for Money & Health Finance

Annex 7 – India's Private Sector Engagement and Move to Contracting for TB

India's work in TB contracting under the National TB Elimination Program (NTEP) is relatively recent compared with its HIV experience and was not the subject of this review. However, the country is in the process of scaling up contracting and its experience with private sector engagement and the move towards contracting has significant lessons for national TB programs looking for guidance. The following chronology has been extracted primarily from a Working Paper by the World Bank.[97]

The GOI's national scale-up of innovative PSE models was preceded and informed by pilots implemented with the support of the BMGF, USAID and the GF from 2014 to 2020. In these pilots, the public and private sectors worked together to achieve results in TB control. What follows is a chronological account of how the public-private partnership model evolved to culminate in output-based contracts.

2012: In 2012, under the TB national strategic plan (NSP) 2012-2017, 764 TB public-private mix (PPM) coordinator positions were sanctioned to facilitate TB case notifications from the private sector and to supervise and support the private provider engagement activities of intermediary agencies.

2012: GOI mandated electronic notification reporting. In June 2012, the GOI also banned the import, sale, and use of serological tests for TB diagnosis due to inaccurate and inconsistent test results. The objective of the policy reform was to improve the quality of diagnostics in the private sector.

2012: The first-ever nationwide TB drug resistance survey in 2014 found that more than 25 percent of TB patients in India had resistance to one or more TB drugs. This raised alarms about sub-standard treatment, thus creating greater interest in engaging private providers.

2014: TB drugs were declared as Schedule H1 drugs, so pharmacists could only provide them based on prescriptions and had to maintain a record of buyers and prescribers. This allowed creation of a database of doctors who were treating TB, and assisted with tracking patients who did not complete treatment. Standards of care were also published for TB.

2014-2017: Patient Provider Interface Agencies (PPIAs) were piloted under the BMGF-funded Universal Access to TB Care (UATBC) program. The PPIA was an intermediary agency for: mobilizing and engaging the private sector; improving notification of TB cases by the private sector; verifying adherence to Standards of TB Care in India (STCI) regimens; and deploying innovative mechanisms to realign provider incentives. The intermediary agencies were drawn from the private sector and leading not-for-profit agencies. The project was implemented in three sites; an assessment in 2016 demonstrated significant gains in TB case notification and treatment success rates in the private sector.

2015: Private labs were mandated to notify patients. In addition, the MOHFW extended the fixed-dose combination (FDC) drugs free of cost to the private sector.

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[97] Mutasa, Ronald Upenyu, A. Venkat Raman, Anagha Khot, Manu Bhatia, Gyorgy Bela Fritsche, Di Dong, Lung Vu, and Sapna Surendran. Private Sector Engagement for Tuberculosis Elimination: India's Journey from Pilots to National Scale-up (2012–2021). The World Bank, 2023. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099447203162313246/idu0c355d530019b80453d0b9070996ca75cbd4d

2017: The TB NSP 2017-2025 set ambitious targets for patients to be notified from the private sector at 1.2 million in 2025 as compared to the baseline of 0.19 million in 2015. The new NSP supported engaging the patient provider support agency (PPSA) model to undertake end-to-end engagement with private providers, including mapping, mobilizing, and advocacy. It emphasized the provision of free medicines and diagnostic tests to TB patients in the private sector to reduce costs, attract more private providers and their patients into the program, and ensure quality of care. Social schemes—such as direct benefit transfers (DBTs) and nutritional incentives—were extended to TB patients in the private sector.

2018: A legally binding gazette made TB notification mandatory, unlike the 2012 executive order.

2018-2020: The Global Fund supported PPSA scale-up under the Joint Effort for Elimination of Tuberculosis (JEET), which built on the earlier PPIA (interface agency) models.

2019: A World Bank loan on TB PSE built on the lessons from the BMGF pilots and the GF-supported programs in 9 states. It allowed the GOI to move toward direct financing of PSE programs through India's domestic budget. The NTEP moved from 'grants-in-aid' or input-based to output-based financing and developed a Guidance Document on Partnerships[98] to provide guidance to states while emphasizing the flexibility and autonomy of each state to design and establish its own approach.

Key lessons from India's trajectory towards contracting non-state providers for TB:

- India had instituted guidelines for PPM in 1999, but uptake was low. Regulations and guidelines alone were not enough.
- True partnership requires an understanding of private sector behavior and the need for incentives. As a precursor to contracting, the NTP worked gradually to build up performance incentives for both private providers and patients.
- As most of the private sector providers are small, dispersed outlets, an intermediary model based on an interface between government and private providers was created. This model was initially tested on a small scale with experienced private sector partners. The intermediary NGO was contracted to work closely with the private providers and represent the interests of the government, providing support to the private hospitals in sample referral, diagnosis, registration, free treatment, and follow-up of patients.
- To scale up the initial pilot, the GOI then adopted output-based contracting to standardize results while at the same time giving providers budget flexibility to deliver. Some capacity building was required to enable local NGOs to operate as government contractors.

With such a huge scale-up of public-private partnership from 2012 to 2022, government capacity has been an issue. Regulatory and oversight functions were built up over time. The CTD has put out

[98] Central TB Division, Ministry of Health and Family Welfare, Government of India. Guidance Document on Partnerships. Revised National Tuberculosis Control Programme. 2019. https://tbcindia.gov.in/WriteReadData/l892s/9531588006Guidance%20Doucument%20on%20Partnerships%20RNTCP%202019.pdf

comprehensive guidelines[99] and actively leverages development partner support to build capacity of state- and district-level staff in contract procurement and management.

[99] Ibid; Central TB Division, Ministry of Health and Family Welfare, Government of India. Operational Manual for Partnerships under the National TB Elimination Programme.
https://tbcindia.gov.in/showfile.php?lid=3705

Annex 8 – Lessons from HS4TB Bangladesh and HS4TB India

HS4TB is providing support for TB contracting in both Bangladesh and India. The work in Bangladesh is focused on helping the government establish systems for TB contracting, while in India the project is assisting the government to expand and improve existing TB contracting efforts (see Annex 7 for details about India TB PSE work prior to HS4TB India).

The current study did not include formal interviews with Bangladesh and India project staff, but following are some brief lessons from this ongoing technical assistance work, with particular attention to the six areas examined in the main body of this report.

India

The Government of India (GOI) has contracted out health services since the 1990s, as part of a wider trend of privatization and market-oriented reforms in the country. Initially, the private sector focused on the provision of clinical services, with the government continuing to provide most public health services. Over time, however, the government began to contract out a wider range of health services, including primary care, health promotion, and disease prevention programs, as well as some specialized services, such as laboratory testing and radiology.[100]

The primary rationale for contracting of TB services has been the recognized need to engage the private sector as a means of expanding the national TB program's reach and effectiveness. As detailed in Annex 7, the Indian TB program's private sector engagement has a long history, building upon the political push from the Prime Minister to end TB by 2025.[101] Contracting for TB services is now at a relatively mature stage and an accepted approach in most states, and central government financing is made available to complement state-level financing. By 2023, over 300 partnerships had been forged in over 250 districts in the country with the Patient Provider Support Agencies (PPSA) model being the most common one.[102]

However, there remain key challenges with implementation of contracting for TB services:

● Current contracting, administrative, and legal frameworks and contract management capacity at state and district government levels impede the effective and timely implementation of contracting. Staff at state and district levels who are responsible for the procurement and contracting process do not often have the necessary knowledge and skills. Despite the existence of comprehensive guidance[103] on how to contract, there is a lack of: uniform implementation of these guidelines; defined processes and

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[100] Report on Best Practices in Contract Management, 2024, USAID Heath Systems for TB (HS4TB). https://pdf.usaid.gov/pdf_docs/PA021H61.pdf. This report outlines challenges and solutions for TB contracting throughout the entire contract management cycle.

[101] https://2017-2020.usaid.gov/india/championing-tb-free-india. See Raising Awareness through Political Advocacy https://2017-2020.usaid.gov/india/championing-tb-free-india for how an external partner's support was utilized to conduct advocacy for TB.

[102] Public health is on the State List in India i.e. states have the exclusive authority to make laws on the subject. The Central TB Division is limited in the extent to which it can direct or require states to follow their guidelines. States adapt CTD guidelines to their systems and processes.

[103] Central TB Division, Ministry of Health and Family Welfare, Government of India. Operational Manual for Partnerships under the National TB Elimination Programme. https://tbcindia.gov.in/showfile.php?lid=3705

procedures for operational functions such as verification, validation, and payment of invoices; and experience implementing needs assessments to determine gaps in TB services that can be filled by private providers.

● The government's processes and capacity for administrative and payment-related functions of contract management result in very slow decision making. The time between the release of a request for proposal and the final contract award can stretch over a couple of years. There are also significant delays in invoice submission, approval, and payment of invoices, resulting in disrupted services.

● There are capital and cash-flow problems for participating NGOs due to the requirement for upfront bonds for contracting, and the structure of results-based payment and long payment delays; these threaten both the NGOs' financial viability as well as their willingness to participate in the program.

While some of these challenges specifically relate to PPSAs, the root causes persist across the various health services contracting mechanisms deployed by state governments.

The government of India recognizes these constraints and the need for additional technical support to the state TB Cells. In 2019, leveraging donor support (a World Bank loan), it set up Technical Support Units (TSUs) in nine high TB burden states. The TSUs provide broad support, from giving expert advice on strategic purchasing and private sector engagement to facilitating the provision of direct benefit transfers (DBT) to patients.

In 2022, the CTD worked with USAID's HS4TB project to set up more specialized technical support units called Partnership and Innovation Units (PIUs) in five additional states.[104] PIUs build the capacity of the state TB Cells in contracting with the private sector – from conducting the pre-contracting needs assessment, to drafting requests for proposals (RFP) and undertaking the entire contracting process, and finally to ensuring effective implementation of the contract, including timely invoice verification and payment.[105]

As the findings of this synthesis report illustrate, ongoing collaboration to address challenges in contracting is essential to foster trust and build more efficient and effective partnerships. At present, there is no such forum in the TB program in India. The existing general review meetings are one-sided reviews by State TB Offices of their projects with little collaboration or learning across the full set of TB contracting actors. To address this gap, the CTD is planning to introduce, with HS4TB support, a partnership and learning collaborative (PLC) in each state where HS4TB is present. The PLCs will be a venue to discuss implementation best practices and find solutions to common contracting issues including adherence of government and partners to these practices.

Bangladesh

[104] Andhra Pradesh, Telangana, Gujarat, Odisha, and Delhi

[105] HS4TB India has developed a suite of tools and learning materials on all aspects of the contract management process (pre-contracting, contracting, post-contracting). Nearly 1,000 individuals have been trained; knowledge products developed include a contract management best practices report, an assessment of the causes for long delays in payment of invoices and recommended solutions, and an analysis of promising innovative financing options to increase access to capital for PPSAs.

In Bangladesh, HS4TB works with the National TB Program (NTP) and Ministry of Health and Family Welfare (MoHFW) units such as the Health Economics Unit (HEU) and the Central Procurement Technical Unit (CPTU) to help initiate contracting for health services in the TB program.

Here, the rationale for contracting is the need to transition the country's NGOs from donor to domestic funding. The country has a long history of non-governmental organizations providing TB services, but these NGOs have been almost entirely funded by external development partners, notably the Global Fund and USAID. In general, the Global Fund's grants to NGOs are channeled to them following Global Fund processes.

Bangladesh is a lower middle-income country and is projected to attain middle-income status by 2030. Its access to external funding will soon decline and leaders of the NTP have recognized the country's need to mobilize domestic resources and put systems in place to ensure the uninterrupted participation of NGOs in the TB program. Sustainability planning not only needs increased resources, but also a policy shift to enable purchasing of health care services from NGOs, developing the necessary legal and policy mechanisms and tools, and developing capacity for implementation.

This context has spurred government (MOHFW/NTP) efforts to:

1. Mobilize additional resources for the NTP and national TB response (to cover existing funding gaps, and to replace the Global Fund (GF) and other Development Partner (DP) funds)

2. Establish a political and legal pathway for the government to contract selected TB services directly to non-governmental entities (following public procurement system)

Contracting NGOs is a politically sensitive topic in Bangladesh, and effective stakeholder engagement is essential to build the government ownership and political will necessary for the proposed legal and regulatory adjustments, and funding for contracting[106]. A stepwise and focused approach to engage with the stakeholders over the last two years has resulted in the first major achievement, i.e., commitment of funds for contracting TB/health services in upcoming MOHFW Operational Plans.

HEU and NTP are leading the ongoing efforts to work with key stakeholders, understand their incentives and influence, and provide clear, actionable messages. They have established two governance structures: a steering committee (SC)[107] and a technical working group (TWG) to oversee the implementation of their contracting Roadmap and Action Plan.[108] The two structures have allowed the HEU and NTP to gain valuable feedback and critical buy-in from high level stakeholders in the MOHFW. This consultative process ensured collective consensus around the purpose and structure of foundational documents before they were drafted. There continue to exist, however, pockets of protective behavior within agencies/organizations, including GOB agencies and NGOs/CSOs that are resistant to change. At times, this has slowed progress and made it difficult to come to a consensus. There is also some competition among different GOB administrative agencies, who are often opposed to changes that might shift existing mechanisms and structures and diminish their influence.

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[106] This section is based on USAID HS4TB's document, Engaging and mobilizing stakeholders for TB service contracting in Bangladesh: Case study (forthcoming January 2024).
[107] The SC includes the additional secretary, joint secretary and director-level officials from MOHFW units and the Planning Commission, Ministry of Planning (MOP).
[108] Roadmap and Action Plan for Contracting of Tuberculosis Services in Bangladesh 2023–2028. HEU/NTP/USAID HS4TB https://pdf.usaid.gov/pdf_docs/PA00ZWRQ.pdf

Regulatory change has presented a special challenge in Bangladesh. Unlike the countries studied in the main report above, who were able to find workarounds in their regulatory environments, in Bangladesh, there is a clear desire to have all policies and procedures in place before embarking on contracting of NGOs. This caution is compounded by a lack of clarity and/or misunderstanding among key stakeholders about what is or is not permissible.[109] The Public Procurement Act of 2006 and Public Procurement Rules limit the ability of NGOs to take part in the Government of Bangladesh (GOB) public procurement system. Revising the public procurement system to allow for the participation of NGOs is seen to be essential for the country to sustain the momentum of the TB program.

Three critical legal and regulatory barriers to contracting NGOs through the public procurement system to deliver TB and other health services are: 1) Health and TB services are not explicitly and clearly included in the definition of "physical services," the procurement category under which health services fall; 2) No legal tender instruments, e.g., Standard Tender Document (STD), exist for the procurement of health and TB services; and; 3) NGOs are not explicitly included in the list of eligible tenderers. The project is supporting the government to undertake the necessary legal and regulatory amendments to address these barriers. This includes amendments to the Public Procurement Act and Rules (PPA/PPR) to facilitate the eligibility of NGOs to participate in the public procurement process and include health services in the definition of physical services; and developing a standard tender document (STD) for contracting health services and adapt it for use in TB. Since amendments are complex, multi-year reforms, the government is also considering medium-term fixes such as a gazette notification stating that health services can be included as physical services; a regulatory guideline for the participation of NGOs; and a written consent by CPTU to allow the temporary adoption of a draft STD for health services.

[109] Source: 'Regulatory Pathways Memo to Allow Contracting of NGOs to Deliver TB Services Through the Public Procurement System', HS4TB Bangladesh (unpublished)

Annex 9 – Country Selection Process

Prior to country selection, interviews were held with HS4TB buy-in countries (Bangladesh, India, and Kenya) where contracting for TB services is being supported. The purpose of these discussions was to determine if these countries had any specific requests for information from this work that would be helpful to them in contracting TB services.

The main criteria for country selection were degree of sustainability and institutionalization of contracting of non-state providers, with sustainability including a) use of country health systems and domestic (or loan) funding for contracting, and b) the degree to which the establishment of contracting was country-led and owned in order to draw lessons from these experiences. Finally, country selection included an effort for representation from a variety of health systems and multiple sub-categories under each of the following criteria:

A. Funding sources, procurement/financial/administrative/management system

- Donor funds, using national government budgeting and financial management systems
- Domestic funds, utilizing development partner or international financing institution (IFI) systems
- IFI loans, utilizing national/ministry procurement, financial, management systems
- Domestic funds, using national procurement, financial, and management systems
- Domestic funds, utilizing national budget, government procurement system outside of Ministry of Health

B. Geographic region

- Eastern Europe & Central Asia
- South and East Asia
- Central Africa
- Western Africa (WA)
- Southern and eastern Africa (SEA)
- Middle East and North Africa

C. Income level

- Low-income country (LIC)
- LMIC
- Upper middle-income country (UMIC)
- High-income country

D. Level of maturity with contracting

- Mature
- Building systems

Country selection followed a four-step process:

Step one: An initial desk-based review took place, casting a wide net globally looking for examples of contracting to non-state providers for health or health-related services without limitations on types of experiences. Published and unpublished literature, technical papers, and reports were systematically searched. The search topic was defined as health ministry contracting to non-state (or private or not-

for-profit) providers for health services. Approximately 50 countries were identified to have had some experience in contracting.

Step two: Key informant interviews (KIIs) were held with eight global experts with experience and knowledge in contracting in the health sector. One of the questions towards the end of the interview was to identify country experiences in contracting that are sustainable and could provide useful models or lessons to NTPs in high-burden countries. Based upon KIIs with global experts and the initial scan of approximately 50 countries, further desk-based research, and conversations with additional experts in the field, a list of countries with potentially relevant learnings was developed, including: Afghanistan, Argentina, Brazil, India, Liberia, Malawi, South Africa, the Philippines, Ukraine, and Vietnam.

Step three: This list was discussed with USAID by looking at the unique characteristics of each, and the following countries were identified as being pertinent to this study: Brazil, India, Liberia, the Philippines, Vietnam (or Ukraine), and Argentina, if time permitted.

Step four: Key contacts (identified through interviews with global experts in step one, or through project and consultant's network) who have familiarity with contracting in these countries were contacted in order to determine: a) who might be the most knowledgeable key informant to interview, and b) develop further certainty whether these would be the most useful examples to study or if there were others that may be more relevant. Upon further emails and discussions as well as additional desk review, a more refined list of countries was identified for inclusion. Some of the initial countries were eliminated and others were added. Those that were eliminated include: Argentina as the example resembled social insurance at the national level; Brazil as there are many similarities to South Africa's experience; the Philippines as the contracting example is quite new and locating information and a KI was proving to be unsuccessful; Ukraine as it was difficult to get reliable information on the state of the practice and identify a key informant; and Vietnam as contracting was in its initial stages. Those that were added include: Kazakhstan as this country has two decades of government-led experience in contracting, including most recently for HIV and TB services; and South Africa WC given its long history of government-led contracting. The table below includes the final list of countries: India, Kazakhstan, Liberia, and South Africa WC province and their reasons for inclusion.

Table 1. Final list of countries, characteristics, and criteria for inclusion

Country	Financing/ Systems	Region/ Income	Maturity	Reason for Inclusion
India	Domestic/ domestic	Southeast Asia/LMIC	Mature	* Transitioned from donor to domestic funding and systems; 2012-2017 NACP to domestic budget support *HIV program through special status/provisions to the law, high-level political will. *High-level political will, stakeholder involvement
Kazakhstan	Domestic & donor/domestic	Central Asia/ UMIC	Mature	*In 2005, Kazakhstan was the first post-Soviet country in Central Asia that adopted a law on contracting to "delegate provision of the specialized social services closer to the community" as part of its "social protection" agenda. * Since 2012 there has been contracting for HIV services, and since 2018 for TB services. A GF grant in 2019 was approved to

				support the existing national modality. *High-level political will, stakeholder involvement
Liberia	Donor/domestic	WA/LIC	Building systems	*2007 onwards post-conflict country. *CO as a transition from development partner funds and projects to domestic systems and funding. *Notable efforts to build country-owned sustainable contracting practice. *High-level political will, stakeholder involvement
South Africa WC province	Domestic/domestic	SEA/UMIC	Mature	*25-year experience in WC province: Community care system around HIV and TB transitioned from home-based care to shift to prevention and promotion where provincial government contracts an NGO as intermediary to manage all CHWs. Transition from single purpose contracts (e.g., HIV, TB, nutrition) to integrated model. *High-level provincial political will, stakeholder involvement.

Table 2. List of countries explored and considered by step

HS4TB recommendation (6/21) – Step 2	Selection from discussion w/ USAID (6/22) – Step 3	HS4TB revised recommendation (7/24) – Step 4
Afghanistan	Argentina (time permitting)	India
Argentina	Brazil	Kazakhstan
Liberia	Liberia	Liberia
Philippines	Philippines	South Africa WC province
Vietnam/Malawi (TBD)	Vietnam/Ukraine	
Ukraine (back-up)	India	
India (back-up)		
Brazil (back-up)		
South Africa (back-up)		

Annex 10 – Summary of rapid scan of procurement laws

Through a quick desk review, HS4TB scanned the procurement laws of USAID's 24 high TB burden priority countries by tracking down the following for each country: (a) the Act that governs government procurement in each country; and (b) the regulatory body that is responsible for overseeing implementation of that Act. We reviewed the relevant Acts for language around service contracting.

It was challenging to find countries' procurement laws and Standard Tender Documents (STDs). For some countries, this was straightforward, but for others it took some digging. We were able to track down procurement laws, acts or decrees for 23 countries[110]. In our review of their procurement laws, we found that only 2 of the 23 countries' laws (those in Ukraine and Vietnam) include health service contracting language. Laws provide a clear explanation of national procurement standards, authorities, and processes that the health ministry must comply with when contracting. However, for example in Bangladesh, the Public Procurement Act allows for the procurement of commodities, infrastructure, and intellectual services but there is no provision for the procurement of other types of (non-intellectual) services. In our review of countries' available STDs, we were not able to find eligibility criteria or clauses that allow for health services contracting or eligibility criteria or clauses that allow for NGO participation.

Every country's legal framework is different, and some are complex, so diligence and thoroughness are necessary during the legal assessment process. An expanded search beyond the specific procurement law is needed to better answer questions related to contracting health services. Such investigations include:

- Reviewing national health laws for legal prohibitions to contracting.
- Further exploring what countries actually consult in order to initiate contracting; based on the current study, it appears that countries do not always need contracting language specifically related to health in order to do health services contracting.
- Exploring whether the government can procure from both for-profit and not-for-profit organizations. For example, Bangladesh's system is set up for procurements from for-profits only; all the clauses and conditions are set up assuming that only for-profits will be applying.

[110] Afghanistan, Bangladesh, Cambodia, Democratic Republic of Congo, Ethiopia, India, Indonesia, Kenya, Kyrgyz Republic, Malawi, Mozambique, Nigeria, Philippines, South Africa, Tajikistan, Tanzania, Uganda, Ukraine, Uzbekistan, Vietnam, Zambia, Zimbabwe (only Burma did not have a public procurement law or legal framework)