What Is Performance-Based Contracting?

Introduction

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

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

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

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

**How is contracting different from other approaches to organizing health services?** Contracting implies that it is the
What approaches to contracting work best in common situations? It is difficult to be prescriptive, but some situations are more conducive to specific forms of contracting than others.

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

**What Is Contracting?**

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

A few other terms related to contracting should be defined:

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

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

**Purchaser.** The purchaser is the entity that awards the contract, provides the financial and other resources for the services, and has the fiduciary responsibility for ensuring that the terms of the contract are met. Purchasers of health services are typically government agencies, parastatal organizations, insurance entities, or development partners.
Public-private partnerships. Contracting is one form of public-private partnership. A partnership sometimes implies that both parties bring financial or other resources into the relationship, but this is not always the case.

What Is Performance-Based Contracting?

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

• Clear definition of a series of objectives and indicators by which to measure contractor performance

• Collection of data on the performance indicators to assess the extent to which the contractors are successfully implementing the defined services

• Performance leading to consequences for the contractor, such as provision of rewards or imposition of sanctions. Rewards can include continuation of the contract in situations in which there is a credible threat of termination, provision of performance bonuses, or public recognition. Sanctions can include termination of the contract, financial penalties, public criticism, and debarment from receiving future contracts.

What Kinds of Health Services Can Be Contracted?

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

• Providing primary health care services in rural or urban areas

• Offering HIV prevention services among high-risk groups

• Providing HIV/AIDS treatment services to people living with HIV

• Establishing a health insurance system

• Setting up and operating a voucher project
Acting as an intermediary in providing P4P to public health care providers

Offering behavior change communication activities and information, education, and communication

Providing maintenance and cleaning services in a hospital

Providing social marketing of health products, such as contraceptives

Working as an “umbrella” agency that oversees the work of many smaller NGOs and CBOs involved in delivering primary health care, nutrition services, or HIV services

Operating an ambulance system

Acting as an intermediary with many for-profit providers, for example, in strengthening the management of tuberculosis patients

Managing a hospital

Operating diagnostic facilities within public health care facilities

Providing ancillary services such as equipment maintenance, cleaning, waste management, food preparation, and security.

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

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

Typology of Service Delivery. A number of different approaches exist for organizing health service delivery, so clarifying definitions will facilitate meaningful dialogue. Although this is a bit of a simplification, there are five important functions related to service delivery: (1) designing the services, that is, what services will be delivered, where, and with which indicators of success; (2) selecting the service provider; (3) actually managing the services; (4) establishing and controlling the “production infrastructure,” which includes personnel,
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equipment, drugs, clinics, and other facilities; and (5) financing the system (see table 2.1). As an example, under a management contract (arrangement 3 in table 2.1), a government will contract with an NSP or an individual to manage existing government services in a specified area. Under a service delivery contract (arrangement 4 in table 2.1), the government decides which services the contractor will provide and where, while the contractor will both manage and supply the production infrastructure. The arrangements described in table 2.1 are not exhaustive, and hybrids clearly exist. For example, the line between a management contract and a service delivery contract blurs when the contractor uses government health workers but pays them significantly more than their civil service salaries.

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

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

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Service design</th>
<th>Provider selection</th>
<th>Services management</th>
<th>Infrastructure setup</th>
<th>Financing</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Inter-governmental agreements</td>
<td>Government-1</td>
<td>Government-1</td>
<td>Government-2</td>
<td>Government-2</td>
<td>Government-1</td>
<td>Government transfers funds from federal to provincial governments</td>
</tr>
<tr>
<td>4. Service delivery contracts</td>
<td>Government</td>
<td>Government</td>
<td>Private sector</td>
<td>Private sector</td>
<td>Government*</td>
<td>Government hires NGO to provide services where none exist</td>
</tr>
<tr>
<td>5. Government grants to NSPs</td>
<td>Private sector</td>
<td>Government or donor</td>
<td>Private sector</td>
<td>Private sector</td>
<td>Government (w/ or w/o NGO or community contribution)</td>
<td>NGOs submit proposals to government for needs identified by community or NGO</td>
</tr>
<tr>
<td>6. Private sector services</td>
<td>Private sector</td>
<td>Consumer</td>
<td>Private sector</td>
<td>Private sector</td>
<td>Consumer or NGO/donor</td>
<td>• NGO establishes health services in slum areas using its own funds</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• For-profit providers establish private clinic</td>
</tr>
</tbody>
</table>

Source: Author.

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

a. Financing may be supplemented by formal or informal user charges.
the epidemic, fewer than 1 percent of the grants went to NGOs working with FSWs, reflecting a shortage of grant proposals for this important type of service.

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

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

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

<table>
<thead>
<tr>
<th>Context/situation</th>
<th>Options to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited rural health services but with “mission” clinics or other faith-based organizations</td>
<td>• SDC for specified geographical “catchment” area with a matching grant or subsidy</td>
</tr>
<tr>
<td></td>
<td>• SDC plus MC for the management of existing government services</td>
</tr>
<tr>
<td>Poorly performing districts, provinces, or states with existing government health services</td>
<td>• MC for management services</td>
</tr>
<tr>
<td></td>
<td>• MC for management services plus P4P for health workers</td>
</tr>
<tr>
<td></td>
<td>• SDC where government health workers join NSP</td>
</tr>
<tr>
<td>Uncoordinated NGO-delivered services with multiple donors (for example, post-conflict situation)</td>
<td>• SDC for specified geographical areas</td>
</tr>
<tr>
<td>Few services of any kind, or new kinds of services required (for example, HIV prevention, nutrition services, early childhood development services)</td>
<td>• SDC for specified geographical areas with emphasis on innovation and careful evaluation</td>
</tr>
<tr>
<td>Existing government services where improved management is needed or innovations are required</td>
<td>• MC for management services</td>
</tr>
<tr>
<td></td>
<td>• MC for management services plus P4P for health workers</td>
</tr>
<tr>
<td>Urban primary health services with many different providers but limited coverage of preventive services for the poor</td>
<td>• SDC for specified geographical areas with focus on reaching the poor (slum and nonslum residents) with preventive and promotive services</td>
</tr>
</tbody>
</table>

*Source:* Author.

*Note:* MC = management contract (contracting in); NGO = nongovernmental organization; P4P = pay for performance; SDC = service delivery contract (contracting out).
How Is Contracting Related to Pay for Performance?

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

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

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

**Source:** Author.

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

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

• Don’t be overwhelmed! Contracting has proven fairly robust and has worked well even in difficult circumstances, so don’t worry excessively about getting everything perfect. Usually a limited number of key issues are present to worry about, and typically these center on
  • Defining the objectives of the contract, selecting the indicators of success, and taking equity and quality into account
  • Ensuring that contractors (and purchasers) focus on achieving the stated objectives
  • Defining the size and location of each contract “lot”
  • Defining the scope of services to be delivered
  • Maximizing the managerial autonomy of the contractors
  • Developing a contracting plan that addresses, among other things, how the contracts will be managed and how the monitoring and evaluation will be done.

• Contracting is more of an art than a science, but a systematic approach can avoid simple mistakes; the point should be to make new and interesting mistakes, not to repeat old ones.

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

**Step 1: Conduct Dialogue with Stakeholders**

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

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

- **Hold a few discussions with each set of stakeholders.** Contracting is often a new approach for many stakeholders, and so they need to hear about it a few times before they can fully appreciate its implications. Having a few discussions is generally worth the effort.
• **Get back to stakeholders with draft proposals and contracts.** After initial discussions it is worthwhile to draft the documentation (a contracting plan and the actual contract; see task 25) and then go back to stakeholders with something concrete to discuss. Otherwise, discussions can go on for a long time at a theoretical level with little progress.

**Task 2: Identify Champions**

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

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

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

• **Concerns of government health officials.** Government health officials are often deeply suspicious of contracting and may resist it vigorously. They are often the key decision makers, particularly when it comes to externally funded contracting efforts. Some ways of addressing their concerns include reviewing the evidence for contracting and suggesting that improved health services will reflect well on them. However, there are often other concerns, for example:

  • **Implicit criticism.** Health officials may perceive contracting as an implicit criticism of their own competence or performance. This impression can be dealt with by (1) indicating that much of the advantage held by private sector contractors is that they are less burdened by bureaucratic rules and regulations (which can then shift the discussion productively to how to reduce “red tape” and increase managerial autonomy in the public sector), (2) allowing
officials to take leaves of absence from the government to work with contractors, (3) allowing some “lots” (see step 2, task 8) to be managed by government officials with more autonomy than they would otherwise have, and (4) allowing new parastatal entities to be established to bid on contracts (so long as they have an arm’s-length relationship with the purchaser). Parastatal entities are linked to the government but are not constrained by civil service rules and regulations; they are run on a quasi-commercial basis.

- **Competition.** Related to the above concern, health officials may also be nervous about possible competition from nonstate providers (NSPs). Such competition, they sometimes fear, may put publicly delivered services in a poor light and lead to unflattering comparisons. A legitimate way of addressing this concern is to ensure that NSPs are provided the same level of resources as the public sector and held to the same performance standards. What is *not* helpful in addressing this issue is to put additional constraints on NSPs so that they face the same issues as the public sector. For example, forcing NSPs to obtain multiple clearances when recruiting staff will just reduce their flexibility and managerial autonomy.

- **Less control.** Government officials often fear giving up control. They may worry about having less power and prestige because they will exert less control over recruitment, postings, and transfers of health workers and procurement. In many countries, hiring and managing personnel take up much of health officials’ time and can be exasperating work. Being able to focus on interesting, strategic issues may be attractive to them. One way of aligning the incentives for government officials and the contractors is to provide performance bonuses to government officials if the contractors achieve certain measurable outputs. This incentive has been implemented successfully in Afghanistan.

- **Lost opportunities for corruption.** Dishonest officials will be concerned about losing opportunities for corruption or influence peddling. There are a number of ways of avoiding corruption in the contracting process that are discussed below (see tasks 8, 16 to 19, and 31), including not making the size of the contracts too small and using transparent competition for contractor selection.
• **Opposition to change.** Many officials oppose contracting because it represents a change in the way they do their business, and they resist any change because they are comfortable with the status quo. This concern can be difficult to address. However, experience suggests that contracting is a pretty low-risk activity. It can increase the officials’ prestige if services improve, and they can carry out tasks that are of greater prestige and greater interest, such as strategic planning, health care financing, and tracking performance. Discussions with officials from countries that have implemented contracting can help allay fears.

• **Concerns of local politicians and local government officials.** Politicians, including local government officials, have sometimes been helpful in the introduction of contracting. Conversely, they have often been the most vociferous opponents of contracting for many of the same reasons held by national government officials. Local officials and politicians often have the most to gain from improved services, and many are the first to hear the complaints of the community about existing services. The concerns of these stakeholders generally relate to ensuring that they retain some involvement and influence over the contractor’s performance. There are a few ways to satisfy their need to have a part in the contracting process, including making them signatories or witnesses to the contract, having them review the quarterly reports of the contractors before payment, and giving them an explicit role in monitoring the contractor’s performance.

• **Concerns of government health workers.** The difference between a management contract and a service delivery contract is the degree of managerial authority the contractor has over the staff needed to deliver the services. In situations in which the staff belong solely to the contractor, this authority is generally not an issue. However, in many circumstances, including all management contracts and some service delivery contracts, government staff are still much needed, but they often fear that they will lose their job, see their wages lowered, or lose some benefits. Some options to address this issue have been tried and found reasonably successful:
  - Health workers can form cooperatives to take over existing publicly managed clinics (see box 3.1)
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Government workers can take a leave of absence to work with the contractor.

Salaries of workers selected by the contractors can be raised above the civil service norms.

Performance-based bonuses can be paid to health workers selected by the contractors.

Government workers can be selected by the contractors, and the remaining ones can be transferred to another location within the government health services.

Concerns of the private sector, including NGOs. Potential contractors (NGOs, CBOs, and other private sector entities) need to be consulted to ensure their participation and genuine commitment to the process. Potential contractors often have the following fears:

- Nontransparency in the ways contractors will be selected. This fear can be dealt with by having a clear selection process with explicit criteria included in the bidding documents and the overall contracting plan. The selection process is discussed in more detail in step 4.

- Delayed payments that interfere with their ability to implement the services. Given that most NGOs and CBOs do not have the capital to pay the staff until they receive payments, delays in dis-
bursements by the purchaser can lead to interruption of services. Mechanisms for decreasing the risk of delayed payment are described in step 6 (task 31). These include making explicit the documentation needed for payment and using professional contract managers.

- Kickbacks that must be handed over to get paid. This issue can often be dealt with by having a clear payment process described in the contract (task 31), a dispute resolution mechanism (task 33), and a third party that can certify the performance of the NGO independently.

- Unrealistic expectations coupled with inadequate resources. Potential contractors often fear being set up for failure by government officials with a vested interest in maintaining the status quo. To some extent this can be addressed by making objectives explicit, having independent assessment of performance, ensuring sufficient managerial autonomy (task 26), and having a competitively established price for the contract.

- Dislike of the idea of being “contractors.” Some nonprofit organizations (NGOs and CBOs) dislike the commercial connotations of contracting; they feel it impugns their humanitarian motives. They prefer to be seen as, and actually be, partners of the purchaser. This concern can be addressed in part by using terms such as “partnership agreements” and “public-private partnerships.” More important, NGOs should be allowed to carry out other development activities in the same area using other sources of funds (or funds that are left unspent at the end of the contract).

- **Concerns of the community.** Generally, communities care less about who is delivering services than that the services are actually being delivered and that they are of high quality. Contracting affords an opportunity to ensure greater community participation in the design, implementation, management, and monitoring of health services. Nongovernmental organizations are usually quite interested in increasing community participation, and this should be included in the contract’s terms of reference (TOR).

- **Concerns of development partners/donors.** Many development partners (DPs) support contracting, and many have much experi-
ence working closely with NSPs. Most of DPs' concerns center on ensuring that there is a continued focus on improving results, that the interests of governments and NSPs are respected, and that the contracting efforts are coordinated with existing services.

**Step 2: Define the Services**

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

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

These issues become most of the TORs for the contract.

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

Possibly the single biggest advantage of contracting is that it allows purchasers and contractors to focus on results. This focus means that objectives need to be explicit and measurable, which is why drafting a contract should start with a clear definition of the objectives and the
indicators by which they will be assessed. (See table 3.1 for an example of reasonable indicators included in a contract for delivery of primary health care. Table 3.2 includes examples of indicators that should not be used in contracts.) A few basic principles should be applied to the selection of indicators, including the following:

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

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

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

*Source: Author.*
Design bias toward outcome and output indicators. As one selects indicators, it is worthwhile to be biased toward outcomes and outputs rather than inputs or processes. Outcomes and outputs are those achievements that have direct meaning for patients or communities and, according to available scientific evidence, will likely lead to improved health status. (To be clear about terms, this toolkit uses the terminology described in table 3.3.) There is some value in using a few input and process indicators because they are often easier to measure, can be measured more frequently, and can pro-
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provide useful milestones along the road to outcomes or outputs. However, an excessive focus on input and process indicators can negate one of the main advantages of contracting, a focus on results that matter to real patients. Even within input and process indicators, it is worthwhile to concentrate on those that are as far “downstream” as possible. For example, rather than focusing on “the budget available for malaria drugs” or the “timely procurement of drugs,” it is more useful to concentrate on the availability of drugs in peripheral health facilities.

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

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

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

*Source: Author.
Note: DPT3 = third dose of diphtheria/pertussis/tetanus vaccine.*
indicators to examine. One issue to watch out for is indicators that can be measured only by the contractors themselves. This measurement can create an obvious conflict of interest.

- **Define indicators as precisely as possible.** Both the numerator and the denominator of indicators must be carefully defined. Also, it is important that terms are clearly defined, that is, being careful with words like “appropriate” or “sufficient.” For example, the indicator “health workers have appropriate knowledge of diarrhea management” is problematic because the numerator, the denominator, and the word “appropriate” are not defined.

- **Set targets broadly.** Much time and energy can go into specifying targets in exact detail, which is probably not worth the effort. Usually what is needed is a statistically significant and programmatically important improvement, which implies that targets should be reasonable, not obsessive. For example, if immunization coverage at baseline is 50 percent and the target is 80 percent, a contractor that achieves 78 percent coverage should be congratulated for making significant progress. That they didn’t achieve 80 percent should not much matter given measurement error (confidence intervals for immunization coverage measured through standard cluster surveys are typically plus or minus 10 percentage points) and the fact that a large improvement has been achieved. Conversely, a large sample survey could indicate that immunization coverage improved by 3 percentage points, which could be statistically significant but of not much programmatic importance.

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

It is important to make concerns about equity and quality as explicit as possible in a contract. Equity can be defined by use of services by the poor (for example, the poorest two income quintiles or people living below the national poverty line), coverage of services among the population living in underserved geographical areas, or a concentration index. Measuring equity can be challenging and often entails special efforts, including additional questions on household surveys (more details on how to do this are available at http://www.worldbank.org/analyzinghealthequity). Quality of care can also be challenging
to measure and often entails the conduct of specialized health facility surveys (see task 10).

**Task 6: Consider Pay for Performance**

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

- **Independent verification.** Pay for performance often requires data that may be most easily available from the service providers themselves, which may put them in a conflict-of-interest situation. Because the data they collect are used to determine how much they get paid, they have an incentive to overstate the amount of services they have provided. For example, service providers who are paid for the number of infants immunized on the basis of reports they generate may deliberately include in their reports children who are older than age one.

- **Perverse incentives.** There is also the danger of perverse incentives in which providers do too much of a good thing or cut corners on quality so they obtain the performance payment. Examples of potentially perverse incentives are cases in which service providers are given an incentive to increase the number of cesarean sections or to put people living with HIV on antiretroviral (ARV) therapy. Contractors may place people on drug therapy who don’t really need it. To some extent, this possibility can be avoided by strict application of treatment protocols, but even they require important clinical judgments. Giving ARVs to people who don’t need them exposes them to the risk of serious side effects and heightens the risk of ARV resistance in the broader population. Hence, in designing P4P, care is needed to avoid perverse incentives.
Quality and equity. Pay for performance can sometimes lead to an excessive focus on the quantity of services provided without equal attention given to the quality of service or to who benefits from the services. For example, if a P4P approach pays per consultation (outpatient visit), then there is no guarantee that the quality is acceptable or that many people living around the facility are using it but people living farther away are not.

Easy-to-understand terms. It is important that NSPs and individual providers understand when a bonus will be paid. Without this understanding, the P4P approach may not be particularly effective in influencing performance.

Performance incentive amount. Setting the amount of the performance incentive is challenging. If it is too small, it may not be useful, and if it is too high, it becomes too expensive for the pur-
chaser and may result in perverse incentives. In those contracts with NSPs that have included performance bonuses, the maximum bonuses that the NSPs could earn have been about 10 percent of the contract value.

- **Clearly stated financial risk.** NSPs, individual providers, and purchasers need to understand the financial risk they are taking in a P4P approach. Depending on how the performance bonus is designed, if NSPs and individuals fail to meet performance criteria, they may receive less money than they were counting on. If the performance bonuses exceed the established contract price, then the financial risk lies with the purchaser.

- **Reasonable payment criteria.** The decision to pay a performance bonus can be based on different factors, including (1) improvements from the provider’s own baseline (for example, a 10 percent improvement in prenatal care coverage), (2) achievement of a specified benchmark (for example, more than 80 percent measles coverage), (3) per unit of service provided (for example, $0.50 for each consultation), and (4) “tournament” style where the top 10 percent of providers receive bonuses.

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

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

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

- Ensure that contractors realize they face a credible threat of being fired for nonperformance
- Have purchasers and contractors regularly discuss the status of indicators
- Ensure that field monitors discuss results on key indicators during field visits
- Provide baseline and follow-up survey data to the contractors and purchasers
• Ensure that both purchasers and contractors understand the contents of the contract (it is remarkably common for key people in the process not to fully understand or even to have read the entire contract).

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

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

- **Financial economies of scale.** Large fixed costs are associated with implementing health services, including management and administration. Hence, larger contracts will spread these fixed costs over a larger base, thereby reducing the cost per beneficiary served. This is not just a theoretical concern. In Afghanistan, using a system of competitive bidding that is based partly on price, contracts for delivering primary health care in entire provinces were 52 percent of the cost per beneficiary of contracts that covered only parts of a province ($4.10 per person per year for the large contracts compared with $7.80 per person per year for the smaller contracts). This lower cost per beneficiary means that with larger contracts more people can obtain services for the same amount of money.

- **Economies of scale in contract management.** Large lot size means far fewer contracts to manage. A number of examples exist in which purchasers who originally designed contracts for small lots realized the problems of managing multiple contracts and changed their strategy during their second round of funding.

- **Economies of scale in monitoring and evaluation.** Having fewer lots makes it easier and less expensive to monitor and evaluate each contractor’s performance. When multiple contracts must be moni-
How to Contract

• Increased competition. Large lots provide sufficient financial incentives to encourage more organizations to compete for the contract. This competition allows the purchaser to choose from among more organizations, increasing the chances that a high-performing organization will be selected. Small lots limit competition and force the purchaser to choose among fewer organizations.

• Economies of scale in capacity building. In situations in which there are few potential contractors with adequate experience, it is easier to build the capacity of a few larger NSPs rather than a large number of small NGOs or CBOs. For example, teaching 70 NGOs how to work with female sex workers (FSWs) is much more difficult than building the capacity of 7 NGOs.

• Decreased opportunities for corruption. Larger contract lots appear to reduce the opportunities for corruption. Unscrupulous officials have an easier time intimidating small NGOs or CBOs working on small lots into paying kickbacks or bribes. There is also sometimes political pressure to have many small contracts so they can be spread around among many political supporters. As mentioned earlier, larger contracts will attract greater competition, which generally reduces corruption.

Reasons for having smaller lots include the following:

• Increased diversity. The purchaser should not become dependent on only a few large NSPs because in the long run this dependency can limit competition, which results in higher costs and poorer performance. In addition, there are situations in which there is a need to study different approaches to learn which is most effective. Some people fear that having only a few large contracts will limit innovation and diversity in approaches.

• No disruption to existing providers. There are concerns that large contracts will overlap and possibly interfere with existing small-scale programs. In these cases, it may be better to contract with an umbrella organization for building capacity, coordinating existing efforts, and filling gaps in service delivery.
- **Uncertain capacity of NSPs.** Where the capacity of NSPs to carry out services on a large scale is an issue, one finds an argument for smaller lots. However, it is often difficult to assess an NSP’s capacity in advance, and purchasers often underestimate the capacity of NSPs and overestimate the alternative (the ability of state providers).

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

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

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

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

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

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

- **Routine administrative records part of the health management information system (HMIS).** The routine administrative records part of the HMIS is the way in which contractors regularly record and report their activities and should be the same as the purchaser’s system. Using this part of the HMIS has a number of advantages, for instance, it can, if working properly, provide
near real-time information, and it allows managers to easily track their own performance. The routine recording part of the HMIS has several disadvantages: (1) it is often inaccurate (see box 3.3), (2) contractors may overstate their own performance, (3) it is very expensive if you factor in staff time (see Stansfield and others 2006) although government officials see little incremental expenditure because these costs are already being met, and (4) it usually does not provide representative data on a number of important aspects of services, such as equity, community satisfaction, expenditure, and use of other services, such as from the private sector.

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

Disadvantages of HHSs include that they are relatively expensive to do, although the cost depends a great deal on the local availability of firms or organizations that can carry out surveys and the sampling strategy, and they cannot be done too often and so will not usually provide real-time information.
<table>
<thead>
<tr>
<th>Means of data collection</th>
<th>Responsibility for data collection and analysis</th>
<th>Schedule and arrangements for baseline data collection</th>
<th>Schedule for follow-up data collection</th>
<th>Budget requirement</th>
<th>Counterfactual or comparison group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household survey</td>
<td>Third party with assistance from MOH primary health care department</td>
<td>July 200_, firm will be recruited by March 200_</td>
<td>Every two years after the baseline</td>
<td>$250,000 per round times 3 rounds = $750,000</td>
<td>Some noncontracted areas (5 districts) will also be surveyed.</td>
</tr>
<tr>
<td>Health facility assessment</td>
<td>Third party with assistance from MOH contract management unit</td>
<td>July 200_, firm will be recruited by March 200_</td>
<td>Every year</td>
<td>Total = $400,000</td>
<td>Health facilities nationwide will be included in sample. Sample size will allow comparison of contracted and non-contracted facilities.</td>
</tr>
<tr>
<td>Health management information system</td>
<td>Contractor, MOH HMIS department, and MOH contract management unit</td>
<td>Already available and archived at _______</td>
<td>Quarterly assessment of data</td>
<td>Total = $300,000 for HMIS unit (does not include health workers’ time)</td>
<td>Contracted and non-contracted areas can be compared (if data quality independently assessed).</td>
</tr>
</tbody>
</table>

Source: Author.

Note: HMIS = health management information system; MOH = Ministry of Health.
**Box 3.3  Accuracy of the Routine Administrative Records Part of the HMIS**

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

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

![Graph showing DPT3 coverage rates](source: Loevinsohn, Hong, and Gauri 2006.)

- **Health facility assessments (HFAs).** This is a sample survey of health facilities using a standardized methodology and instrument that looks at various aspects of quality of care, such as knowledge and skills of providers, patient satisfaction, and availability of inputs including drugs, supplies, equipment, and staff. The advantages of HFAs include the following: (1) they can assess quality of care from a technical perspective, (2) they are an independent and impartial
Box 3.4 Lot Quality Assurance Sampling

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

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

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

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

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

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

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

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

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

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

**Task 11: Collect Baseline Data**

One of the biggest issues in M&E is the lack of baseline data, which makes progress difficult to measure. Collecting baseline information is often tricky because it usually needs to be done at the same time as
services are being designed and service delivery is starting. Hence, one of the first tasks during the contracting process should be recruitment or mobilization of the organization that will actually do the baseline data collection (advanced procurement action is often required before funding is fully secured). In some situations, it may even make sense for contractors to collect the baseline data using a standard methodology, although this introduces the possibility of bias. Even if HMIS data will be used, these data should be collected and archived so that the data are readily available and consistent.

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

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

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

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

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

In situations that involve many contracts, it is sensible to make M&E someone’s full-time job. Purchasers should consider recruiting a third-party firm to help with M&E design and data collection. The advantages of this approach include factors such as (1) the purchaser
can obtain expertise it may not necessarily have; (2) the approach can allow the purchaser to focus on other aspects of contracting, including field visits and training; (3) the purchaser can collect data that does not rely on information generated by the contractor; and (4) this approach generally provides for a more impartial assessment of contractor performance. The major challenge with using a third party is maintaining purchaser involvement and commitment to M&E. Draft TORs for a third-party firm to help with M&E design, data collection, and analysis are found in appendix D.

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

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

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

1. Conduct dialogue with stakeholders
2. Define the services
3. Design the monitoring and evaluation
4. Decide how to select contractors
5. Arrange for contract management and develop a contracting plan
6. Draft the contract and bidding documents
7. Carry out the bidding process and manage the contract

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

The fairest and best way of selecting a contractor is through open competition based on clearly defined criteria. This approach has many advantages, such as (1) potential bidders want to know that there is a “level playing field” so that it is worth their while to bid and participate in the contracting process; (2) competition will generally lead to
the selection of the best organizations, the best managers, and the best ideas; and (3) competitive selection reduces the chances for corruption and is usually required under government regulations and the rules of external financiers.

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

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

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

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

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

### Task 17: Develop Clear Selection Criteria

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

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

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

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

Fourteen of these kinds of public-private collaborations, in eight countries, have been evaluated, and they appear to be quite successful. Treatment success rates have averaged almost 90 percent, and case detection rates have increased by a median of 16.5 percentage points. In 7 of the 14 evaluated cases, NGOs have been used as intermediaries, and it appears that these efforts were even more successful. Where NGO intermediaries were used, the treatment success rate was 8.1 percentage points higher (90.1 percent vs. 82.0 percent) than those cases in which the NTP itself managed the collaboration with private providers. (See appendix C, case 11, or Lonroth, Uplekar, and Blanc 2006 for more details.)
of some reasonable amount of funds in the last three years, (3) a copy of the organization’s registration as a company or an NGO under the relevant acts of the particular country, and (4) some indication that the organization has experience of the type that would allow it to deliver the services.

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

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

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

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

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

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

**Task 20: Select a Contractor**

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

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

- **Competition** has the following advantages: (1) it provides the lowest prices in the long run, thereby allowing limited resources to cover the largest number of beneficiaries; (2) it is a very transparent means for establishing the price because each bidder’s price is called out publicly at the opening of the financial proposals; (3)
facilitates innovation by encouraging bidders to develop the most efficient means for delivering services; and (4) it reflects the local realities of the particular lot.

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

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

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

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

The disadvantages of the fixed budget approach are the following: (1) it is rigid as if “one size fits all,” (2) it discourages innovations and efforts to reduce costs through more efficient means of service delivery, and (3) it is often hard to estimate in advance how much services will cost resulting in prices that are too low or too high. Costing studies to determine what the fixed budget should be are complicated to carry out, can take considerable time, and often come up with results that subsequently appear to be wrong. For example, in Bangladesh, the bid prices (that is, the market price that organizations thought the services would cost) were 35 percent lower than the estimates from a detailed costing study. In Cambodia the bid prices were nearly three times higher than the costing study indicated they should be.
**Recommendations.** Transparent approaches are important in avoiding corruption and argue against negotiations behind closed doors. Approaches can also be modified to make them more appropriate. For example, the fixed-budget approach can specify a cost per beneficiary and increase the price for mountainous or remote areas.

**Task 20A: Select a Contractor**

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

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

- **Selection based on quality and cost.** This method uses a competitive process among short-listed organizations that takes into account the quality of the proposal and the cost of the services in the selection of the successful bidder. Cost as a factor of selection is used judiciously. The relative weight to be given to the quality and the cost should be determined for each case, depending on the nature of the assignment.

- **Fixed budget.** This method is appropriate only when the assignment is simple and can be precisely defined and when the budget is fixed. The RFP should indicate the available budget and request that the bidders provide their best technical and financial proposals in separate envelopes, within the budget. The TORs should be particularly well prepared to make sure that the budget is sufficient
for the consultants to perform the expected tasks. Evaluation of all technical proposals should be carried out first. Then the price proposals should be opened in public and the prices read aloud. Proposals that exceed the indicated budget should be rejected. The bidder who has submitted the highest-ranked technical proposal among the rest should be selected and invited to negotiate a contract.

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

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

- **Hybrids.** Hybrids of the above approaches are also possible, and there is much scope for creativity. For example, a fairly common and sensible compromise between selection on the basis of quality and cost and fixed budget is where the amount of money for service delivery itself is fixed but the bidders compete on the basis of their overhead costs. (The RFP documents for such an approach are available at http://www.worldbank.org/hnp/contracting.) Another option, although it is a little complicated, is to have contractors compete on what proportion of the fixed budget would be provided to them on the basis of performance. (For example, one bidder would have 50 percent of the funds provided as a fixed budget and the remainder would be provided on the basis of performance as prescribed by the purchaser. Another bidder could bid 70 percent as fixed and 30 percent on the basis of performance.)
Step 5: Arrange for Contract Management and Develop a Contracting Plan

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

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

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

Task 21: Define Responsibility and Clarify the Contract Management Structure

Managing contracts requires full-time attention by a clearly defined, reasonably sized team with explicit responsibilities and authority. Dif-
different approaches have been taken to the location of the contract management unit, including within the Ministry of Health (or other state organizations such as national AIDS committees), local governments, or special government procurement units. Although different approaches have been used in many countries, issues have arisen with all of them.

- **Central Ministry of Health.** Many ministries of health have limited experience and knowledge of contract management, and they are sometimes constrained from hiring staff or consultants who do have the knowledge. In addition, there is often real opposition within the MOH to contracting, and contractors fear that the MOH will deliberately sabotage their efforts. Advantages of having contract management in the MOH (or related organization) include greater ownership and better technical knowledge of the sector. This approach has been used in many countries, including Bangladesh and Cambodia.

- **Local government.** Economies of scale exist in contract management, and there is a fear that building the capacity for effective management at local levels is inefficient. However, the possible advantages of this approach include greater involvement of local officials and better monitoring of contractor performance. This approach has been used in a few countries, including Guatemala and Pakistan.

- **Specialized procurement unit.** This approach limits the stewardship function of the MOH, and specialized procurement units may be less motivated than organizations whose mandate is to improve health. Conversely, such units usually have extensive procurement experience, have more experience with contract management, and generally do a good job in regard to timely payment of contractors. This approach has been used in Africa, including in the Democratic Republic of Congo and Senegal.

**Recommendations.** Where possible, it appears that having contract management based in the MOH or other line agency is the best long-term approach. It ensures ownership and long-term stewardship of the sector. It also ensures that people who are technically expert on the health services to be delivered will be involved in the process. This approach can be strengthened by (1) recruiting consultants or other
skilled staff to support the MOH, (2) involving local governments in contract management (for example, review of quarterly reports) and field monitoring, and (3) ensuring that members of such a unit have an incentive to help contractors perform well.

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

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

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

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

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

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

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

The purchaser needs to develop an overall contracting plan (sometimes referred to as a manual of procedures or contracting manual) to avoid serious gaps or mistakes. Such a contracting plan should summarize the entire contracting process, including how contracts will be
managed and how they will be monitored and evaluated. (An example of a contracting plan is found in appendix A.) Developing such a plan should not be seen as a burden, because most important aspects can be dealt with in six or seven pages.

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

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

**Task 26: Maximize Managerial Autonomy**

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

- Management decisions are made by the people who are closest to the reality on the ground and can make the most informed decisions about how to tackle problems that arise.

- It is easier for purchasers to hold contractors accountable for results because the latter cannot claim that the action, or inaction, of others has interfered with their performance. For example, if a contractor
is responsible for hiring staff and setting wages, it cannot blame anyone else if it is unable to deliver services because of a staff shortage.

- Managerial autonomy allows and actually encourages innovations that can lead to improved performance. In Cambodia, an NGO introduced performance-based bonuses for the staff, which increased performance dramatically (Soeters and Griffiths 2003).

- It allows the contractor to take advantage of the nonstate sector’s inherent flexibility. For example, in urban Bangladesh an NGO manager arranged a raffle of a TV set as a way of informing the community about the opening of a new clinic, which was soon packed with patients. It would have been very difficult for a public sector manager to arrange for such a raffle.

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

- **Clarify the authority of both parties.** When the authority of the purchaser and the contractor are not clear, the purchaser usually tries to assert control. Making the roles and responsibilities of both parties explicit in the contract can avoid important problems that may later interfere with effective delivery of services.

- **Focus on “what” not “how.”** As mentioned, it is important to define the scope of services by what services are delivered rather than how they are delivered.

- **Discover other ways of increasing autonomy.** There are a few other important ways of providing contractors with appropriate autonomy that are discussed in more detail below, such as (1) allowing contractors normal management prerogatives over health workers; (2) using lump-sum budgets rather than line-item budgets; (3) leaving procurement of goods, supplies, and medicines to the contractor; and (4) not applying inappropriate public sector accounting rules and procedures to the nonstate sector.

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

A very important part of successfully implementing health services is to be able to manage the staff effectively. Giving contractors control of the personnel function is an important aspect of managerial autonomy without which performance can be compromised (see box 3.6).
In practice, this approach means that contractors should be given the normal management prerogatives of hiring, firing, posting, handling pay and benefits, setting terms of employment (such as performance bonuses), and establishing staffing levels. In management contracts in which the contractors use existing MOH health workers, the management prerogatives of the contractor may be limited by civil service rules. However, it still should be maximized to the extent possible. In a number of countries, contractors have succeeded in getting health workers into isolated locations that had previously been underserved (see box 3.7). Purchasers can reasonably expect that contractors recruit qualified staff with recognized credentials, ensure that health

Box 3.6 Results of a Government Maintaining Control of Staff Assignments

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

Box 3.7 Attracting Health Workers to Underserved Areas

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Regular payments.** Subsequent, regular payments should be made on a lump-sum basis on submission by the contractor to the purchaser of acceptable reports (see task 34) that are explicitly described in the contract. Payments should be made on a quarterly or six-
month basis because this reduces the transaction burden on both parties and increases the likelihood that contractors are paid on time. As argued above, lump-sum payments reduce transaction time and effort, increase managerial autonomy and flexibility, and reduce the number of disputes. The prerequisites for claiming payment and processing payments should include submission of a quarterly activity report, an invoice, and a financial report. The actual calendar dates for payment should also be agreed to by the parties.

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

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

**Task 33: Establish Dispute Resolution Mechanisms**

Most disputes can be settled through discussion and, although rarely required, it is worthwhile to describe in the contract a fair method for resolving disputes. These descriptions should be kept fairly simple, and the first step can simply be appointment of a mediator acceptable to both parties. If this step fails to resolve the issue, it is worthwhile using an arbitration panel composed of people of known integrity. (The annex to appendix A has an example of a contract clause on dispute resolution, part K of the draft agreement.)
**Task 34: Define Reporting Requirements of the Contractor**

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

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

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

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

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

In other types of contracts, such as for construction of a road, the purchaser would not usually ask for an audited financial statement from the contractor. This makes sense because the purchaser is really interested in the timely construction of a road of acceptable quality. A similar approach should be used in contracting for health services. However, some purchasers, to allay their own fears, expect contractors
to provide regular financial reports and audited financial statements at the end of the year. If such audited statements are required, experience in the field strongly suggests that contractors should be allowed to use independent auditors, which ensures proper financial management while avoiding overly constraining bureaucratic rules.

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

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

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

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

Purchasers are sometimes reluctant to address the capacity needs of contractors; they argue that they want to hire NSPs who already have the needed capacity. However, building the capacity of contractors is in the purchaser’s best interests. Techniques and approaches are evolving in many aspects of service delivery, and it is helpful if everyone is aware of the state of the art. For example, in HIV prevention services, there has been a steady movement toward more participatory approaches in which members of the high-risk groups actually manage and implement services themselves. Showing NGOs how this works will make them more effective, which will be a benefit to the purchaser as they have an interest in seeing that public funds are used efficiently. Purchasers may also want to help contractors with their M&E systems, financial management and reporting, and the facilitation of the sharing of experiences among NSPs.
**Task 39: Clarify Responsibilities for Physical Infrastructure**

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

**Task 40: Formulate the Bidding Documents**

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

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

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

**Step 7: Carry Out the Bidding Process and Manage the Contract**
Once the previous steps have been completed, the bidding process needs to be carried out in compliance with the procedures laid out in the RFP document (or its equivalent). Once the contract with the winning bidder is signed, M&E activities and contract management need to be implemented in keeping with the contracting plan and the signed contract.

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

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

**Task 42: Conduct Regular Monitoring Visits**

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

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

In addition to assessing performance, monitoring visits are also good times to cement relationships among all stakeholders, identify issues, and solve problems early on. If monitoring visits are carried out systematically, doing them frequently will have a real effect.
Task 43: Meet with Stakeholders Frequently

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

Task 44: Review the Contracting Plan and the Contract

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