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HEALTH SERVICE DELIVERY: THE STATE OF GOVERNMENT–NON-GOVERNMENT RELATIONS IN BANGLADESH

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SUMMARY

There are many examples of collaboration in Bangladesh between government and non-governmental organisations (NGOs) in the provision of services, including health care, education, water and sanitation. This article addresses the question whether such collaboration is temporary within specific projects, or whether it has brought about structural changes in the government–NGO relationship. The focus of the article is on how collaboration has been conceived, evolved and functioned within the Urban Primary Health Care Project (UPHCP). The views of both parties in the partnership are analysed. The data indicate that NGOs tend to see the government as excessively restrictive, bureaucratic in its attitudes, with a tendency to interfere in their activities, and difficult to trust. The government tends to view NGOs as lacking in capacity, sometimes being involved in corruption and less sincere and committed to the work than it is. These differences in perceptions between the two parties undermine the development of relations based on mutual respect, trust and understanding. The article concludes that current relations with government can at best be described as ambivalent. Copyright © 2011 John Wiley & Sons, Ltd.

KEY WORDS—NGO; non-state provision; service delivery; contract; Bangladesh

INTRODUCTION

This article analyses the nature and dynamics of government's relations with NGOs, showing how such relations have emerged and are structured, the factors affecting relationships and how NGOs have attempted to manage them.[1] The focus of the article is the Urban Primary Health Care Project (UPHCP), which is the largest urban health project in Bangladesh and is being implemented through collaboration between government and NGOs. UPHCP provides a case study of a specific project that illustrates the way such relationships operate in practice and serves as an example that is also applicable to service provision in other sectors such as education and sanitation.

The article describes how problems that arise during collaboration in projects such as UPHCP are rooted in three main sets of factors: (i) a miscalculation by NGOs of what is feasible; (ii) the rigidity of the contractual agreements that govern the relationship; and (iii) the contrasting attitudes of the partners towards each other and perceptions of their roles. Mistrust on the part of government functionaries regarding NGOs' capacity, commitment and honesty is matched by NGOs' preconceived notion that government officials are slow in decision making and deliberately create problems, which obstruct the 'culture of action' (Lewis, 2001: p.8) to which NGOs are accustomed.

The issue of the differences in perceptions by government and NGOs of each others' roles has long been a feature of the policy landscape in Bangladesh. In earlier work on the government–NGO relationship, Farrington and Lewis (1993: p. 317) outlined the issue in a table that compared government views on the pros and cons of collaboration with that of the NGOs. It suggested, for example, that although NGOs felt they could gain improved access to policy formulation, they feared becoming caught up in government control and bureaucracy. At the same time, although government saw collaboration as an opportunity to improve overall service delivery, it feared that NGOs

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might show it up as less efficient, or that NGOs would prove unaccountable. Today's policy landscape has changed, with new donor approaches to budget support through government and the Paris coordination and harmonisation agenda.[2] However, the research reported in this article shows how such collaboration problems persist in old and new forms within current realities.

The empirical data for the article was collected through a comprehensive literature review and in-depth interviews and group discussions with NGO staff, with government officials at the project level as well as in city corporations and ministries, and with past and present project managers of UPHCP. Furthermore, the information was elaborated through personal communication with persons who were involved in instigating and managing the project in the Asian Development Bank (ADB).

The article begins with a brief history of government–NGO collaboration in the health sector followed by a description of UPHCP and how the relationship came about and was structured. Factors contributing to this relationship are discussed. The next section attempts to capture the overarching issues in the relationship from the perspective of NGOs and government, providing a review and analysis of these two critical actors. The article ends with some observations on the possible future directions of government–NGO relations.

COLLABORATION BETWEEN GOVERNMENT AND NON-GOVERNMENTAL ORGANISATIONS IN HEALTH SERVICE DELIVERY

Bangladesh's NGO sector emerged from the relief effort after the 1971 War of Liberation when the country seceded from Pakistan. The new country inherited a weak, partially formed state, and NGO service provision began to develop alongside the state's own limited services, often in a gap-filling role. A more systematic NGO collaboration with government in the health sector dates back to the middle of the 1970s, when NGO involvement in the field of health and family planning began to expand.[3] At this time, NGO activities were mainly directed towards preventive, curative and rehabilitative health care and the promotion of family planning and health care services. Some NGOs implemented independent programmes, whereas many others began to co-operate with government in strengthening as well as implementing government programmes. The government–NGO relationship developed further during the 1980s to include shared activities on tuberculosis, leprosy, immunisation, family planning and nutrition (Mercer *et al*., 2004: p.187). The relationship became more institutionalised from the late 1990s in the form of several major national programmes: the Health and Population Sector Programme (HPSP), the Health Nutrition and Population Sector Programme (HNPSP), and UPHCP. The World Bank (2006: p.iv) has found that

> the impact of NGO interventions on a range of health and nutritional indicators is striking. Cure rates averaged 85 % in the tuberculosis programme. Malnutrition rates dropped by 20 % among the poor because of the presence of NGOs in the community, after controlling for other factors.

Today, there is a large number of NGOs involved in providing basic health services, including participation in most of the components of primary health care (PHC). The World Bank's (2006) survey identified 149 NGOs involved in health and nutrition, although it found that five large NGOs dominated the sector. Much of this involvement has been outside the realm of formal contracting, until recently. In conducting the work, many NGOs have simply mobilised funding either from their own sources or from donors, but without necessarily entering into partnership or any kind of relationship with government. The formal public contracting of NGOs is therefore a relatively new phenomenon in health care provision. The question is whether the resort to formal contracts indicates a level of *trust* on the part of government in NGOs' effectiveness in health care delivery, or whether it signals *distrust* that NGOs will only act as government expects if they are placed under formal legal obligations.

During the implementation of the HPSP, the concept of an 'Essential Service Package' (ESP) was introduced to set out the services that should be provided in reproductive and child health care, communicable disease control,

[2]The Paris Declaration of 2 March 2005 is an international agreement for donors to coordinate their aid and align it to government policies - see http://www.oecd.org/dataoecd/30/63/43911948.pdf

[3]This section is based on two papers by the author (Alam, 2007a and 2007b).

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basic curative care, and behavioural change especially for poor people, women and children (Alam *et al*., 2000). Initially, it was decided to pilot ESP delivery by public sector healthcare providers at a government outdoor dispensary in a zone of Dhaka City. Later, the ESP programme in Bangladesh evolved to provide primary health care services to clients at the district level throughout the country. Currently, the ESP constitutes around 48% of the Ministry of Health and Family Welfare's total expenditure (World Bank, 2005a, 2005b). Contracts were awarded to 25 NGOs in the year 2000 and to seven in 2002 under the NGO–partnership programme. Since 2000, the UPHCP, supported by ADB as principal donor, has been developed alongside the ESP project. The main focus of the UPHCP is to provide primary health care to the urban poor. The UPHCP is based on the premise that the urban poor's primary health care lags behind even that provided to the majority rural population.

THE URBAN PRIMARY HEALTH CARE PROJECT

This section examines a specific case of contracting within the UPHCP. It analyses relations between government and an NGO—the Population Services and Training Center (PSTC)—that was contracted by government under the UPHCP, with funding from the ADB, the United Nations Population Fund, the UK aid agency (DFID) and other donors. According to the government's Project Implementation Unit (2005: p.14), 'the project has adopted a strategy for involving the NGOs, private sector groups, or providers' associations through Partnership Agreements to provide services through competitive bids. This was a unique example of Government and Non–Government Organization Collaboration in the Health Sector'.

The emphasis on the role of NGOs is in line with a government commitment to ensure health for all by expanding the role of the private sector, including NGOs, in health service delivery. It was argued by project funders that 'Competitive tendering for the provision of primary health care services will decrease prices and improve quality'(Loevinsohn quoted in Project Implementation Unit, 2005: p.11).

In the first phase (1998–2005), 14 NGOs were selected to implement the project in 16 'partnership areas' of four cities. A partnership area represents one or more wards within a city corporation and comprises between 300,000–400,000 persons. In the second phase, the number of areas was increased to 24, and 20 NGOs were involved in the implementation of project activities. The objective of the project was described as follows:

> The primary objective of the project was to reduce preventable mortality and morbidity, especially among women and children by increasing access to primary health care services, which included child health with immunisation, reproductive health care, limited curative care, nutrition related services, health education and assistance for women who are victims of violence. And the ultimate goal of the project was to improve delivery of primary health care (PHC) services by strengthening the capacity of local governments in planning, managing, financing, coordinating, monitoring and evaluating PHC services.
>
> (Project Implementation Unit, 2005: p.11)

How the relationship came about: conditioning factors

An analysis of the project philosophy, strategy and history reveals the gradual emergence of forms of government–NGO cooperation in primary health services in the urban areas of Bangladesh. Different stakeholders had important roles in shaping the relationship: donors provided money and encouraged the participation of NGOs, whereas government agreed to provide mechanisms for implementation through relevant government departments and agencies. The relationship of NGOs with government in UPHCP emerged through a process of contact, consultation, dialogue and workshops. All these means were supposed to provide scope for the parties to get to know one another and ultimately agree to work together.

However, in practice, the prior contacts and consultation did not contribute much to creating better understanding in the implementation of the project by NGOs. As is the case with many such projects in Bangladesh, UPHCP is basically a donor-driven government initiative. Although the wishes of government and donors influenced the projects, only a few of the concerns of NGOs in what was supposed to be a collaborative endeavour were actually

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reflected in the final document. NGOs were given a pre-fixed contract paper, and little opportunity to comment and request modifications, as was revealed in interviews conducted with NGO field staff and personnel in charge of project management in Dhaka.

The idea that the UPHCP could be implemented through public–private partnership (PPP) came from a lead health specialist of the ADB, Dr Loevinsohn, who was based in Manila in 1996–1997. A proposal for PPP was made to senior Bangladeshi officials of the Ministry of Health and Family Welfare and also to the Ministry of Local Government, Rural Development and Cooperatives. Government officials were aware that health services were in a very poor state in the major cities and also in smaller cities and towns in Bangladesh. The Ministry of Local Government had responsibility for health in urban areas, but had practically no financial or human resources to provide the service, with the result that urban health facilities were extremely weak.

At the same time, NGOs had already gained a level of reputation and experience in providing primary health care, and Loevinsohn argued that they could fill the gap in urban areas. After a series of discussions with ADB staff, government officials and NGOs, these stakeholders agreed to the venture. Further, intensive discussions were held with at least 12 leading NGOs in the development of the project. All said that they were interested in the idea of UPHCP. However, government officials were concerned that almost all the funds would go to the NGOs, and very little to the ministry. The ADB, as the main funder, took the lead in convincing the government of the benefits of collaboration with NGOs.

Changes in the flow of donor funds

The precise reasons for the two sides agreeing to enter into a partnership are complex and can only be understood by reference to contextual factors. By the early 2000s, there were changes and uncertainties around the flow of external funds and aid modalities by donors. The rise of 'budget support' approaches favoured a more direct approach by donors to working with government and less direct funding of NGOs by donors. This change had put many established NGOs into a state of financial insecurity and disarray. A World Bank Report on Bangladesh revealed that

> although direct donor support to NGO health programmes rose in absolute terms between 1999 and 2002, the share as a proportion of total NGO health funding declined from 78 to 67 %. This declining share reflects the sharp growth in resources channelled through government to NGOs, which rose from 12 to 26 % of total funding for NGO health programmes between 1999 and 2002 (World Bank, 2006: p. 27).

In brief, funding that NGOs would have hitherto expected to receive directly from donors was increasingly being channelled though government, implicitly giving government greater control. This was part of a general move by donors, during the late 1990s and 2000s, to coordinate their aid and align it with recipient governments' policies and priorities—leading to the Paris Declaration of 2005 and the Accra Agenda for Action of 2008 (OECD, 2005 and 2008).

Anticipating a further squeeze of direct donor funding, many NGOs in Bangladesh therefore found that it was advisable to undertake at least some government projects, even though this meant winning their funding through the uncustomary routes of competitive bidding and contractual agreements. Our research on the health, education and sanitation sectors found that NGOs often entered these relationships cautiously in the belief that they might become an increasingly important route to funding. They feared that other NGOs might compete for government contracts if they did not, and that it was therefore important at least to show willingness to avoid the risk of missing out. This was an informed but not a very enthusiastic choice, rather a 'survival strategy' to remain in the business. In this way, NGOs participated in these new arrangements as 'reluctant partners', to use the phrase popularised by Farrington and Bebbington (1993). However, it is important, as Farrington and Bebbington (1993: p. 19) point out, that

> the interest in NGOs' linkages with the state requires that decision makers in government, donor, and NGO circles think carefully about terms on which this relationship can be structured.

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The donor as a conditioning factor

Four types of agency were involved in the implementation of the second phase of the UPHCP from 2005–2011: the Local Government Division (LGD) of the Ministry of Local Government, city corporations and municipalities, NGOs and donors (Ministry of Local Government and Rural Development, 2005). Here, we focus on the particular case of the primary health centres managed by the Population Services and Training Center in Dhaka, but the same structure was also followed in other major cities.

Government maintains relations with NGOs through the terms and conditions of the contract. A project management unit (PMU) and a project implementation unit (PIU) were established jointly by the LGD and Dhaka City Corporation for the overall administration and supervision of the project. The ADB, as the lead donor, also participates in the PMU and effectively has considerable control: ADB can accept and reject any staff that government recommends for PMU. In the project pro-forma (Government of Bangladesh, 2005:17) it is stated that

> The LGD shall also ensure that (a) the PMU is managed and operated by a full-time Project Director, *acceptable to ADB*, who will work under the supervision of the Chief Project Coordinator; and (b) the Project Director is supported by 35 competent full-time personnel *acceptable to ADB*, including, at least, a Deputy Project Director, Administration and Finance, and a Deputy Project Director, Technical, and other staff. [Emphasis mine]

Furthermore, it is stated in the project pro forma that the LGD, as project executing agency, should be responsible for

> (c) coordinating and submitting timely and accurate reports to ADB and the co-financers, and (d) *submitting to ADB for its approval, the detailed program for the implementation of fellowships, training and study tours, prior to implementation thereof.* [Emphasis mine]

It is not clear how ADB could know and determine which civil servant was competent to become project director, or to decide the competence of the other personnel in the project. However, this built-in role of ADB in the selection of key personnel has an important effect in shaping the relationship between the donors and government, and between government and NGOs.

Participation of Population Services and Training Center in competitive bidding: the emergence of a formal relationship

The emergence of the PSTC's relationship with government has evolved through a procedure on the basis of competitive bidding—a process that was previously little known to NGOs in Bangladesh. An announcement inviting bids was published in newspapers, and some NGOs were contacted directly by PMU. NGOs wishing to compete in the bid had to fulfil eight minimum qualifying criteria relating to their legal status, experience, financial solvency, management and governance. Those fulfilling the minimum criteria became eligible to submit technical and financial proposals separately to the PMU under the second phase of UPHCP.

The PMU asked the potential bidders to prepare their bid proposals following the Bid Document that contained an invitation for bids, instruction to bidders and contract agreement. This was a very comprehensive document, which spelled out, in minute detail, guidelines for the bidders' engagement with government under the UPHCP II. The bid document was 225 pages in length, with eight sections and 10 appendices. The sections included the formal invitation to bid, instructions to bidders, general information, guidance on eligibility to bid, contents of bidding documents, preparation of bids, contents of the technical and financial proposal, and statements on the bidding process, the process of evaluation of bids and the award of the contract. The nine appendices included evaluation criteria for technical and financial proposals, terms of reference for partnership agreements, scope of work in partnership areas, performance evaluation, equipment, furniture, clinical supplies and drugs, proposal forms, baseline survey results, partnership area maps and a list of ADB's member countries. (Government of Bangladesh, 2006)

The bid process involved several steps, which shaped the emerging formal relationship between government and PSTC. PMU organised one pre-bid meeting with the potential bidders and explained the various aspects of the bid document, answered queries, and clarified issues not clear to the bidders. Therefore, in principle, NGOs that participated in the bid process had prior knowledge regarding how the project would be implemented and also the

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nature of relations that would emerge through this process. What they did not anticipate were the practical implications of the terms and conditions of the contract and the problems they might encounter in implementing the project activities. So, when NGOs later raised questions regarding the mobilisation deposit, performance guarantee, procurement policy, salary structure and delays in getting funds released, the PMU office was always able to refer them back to the bid document and agreement.

Formal rules: the contractual agreement

The PSTC's relation with government is guided and governed by the formal agreements that it had signed with PMU. These bring contractual obligations: the signing of the contract means that PSTC has agreed to follow the rules, regulations and restrictions in providing services, following the stipulated procurement policy, spending money and maintaining financial records (Government of Bangladesh, 2006). The government also agreed to facilitate PSTC's activities by releasing the money on time, providing technical support, and helping to solve any problem that might crop up in the implementation process. Although the relationship is based on a formal agreement, the perception of government was that there was hardly any scope for informal or 'off the record' interactions or relationships. One NGO official remarked that the 'agreement is like the Bible to the government officials'. This is in spite of the fact that formal contracts elsewhere in the world are frequently accompanied by relational understandings and a level of informality that allows some flexibility between the partners, as Batley (this volume) points out.

The contract agreement has several sections that elaborate what is called the client's (i.e. Dhaka City Corporation's) relations with the partner NGOs. These sections include the following:

> Services to be provided, personnel to be employed, payment to the partner NGO, currency of payment, conditions of payment to the partner NGO, standards of performance required for payments to be made, evaluation of contract works, undertakings of the clients, payment of taxes and duties, other privileges and exemptions, services, facilities and equipment, undertakings of the partner NGO, confidentiality, terms for independent contractors, indemnifications, proprietary rights of the client in reports and records, implementation of the contract, settlement of disputes, suspension and termination of the contract by the partner NGO and miscellaneous.

The agreement appears all inclusive and complete, setting out the inputs the contractors were to make, the nature and type of activities that the NGOs would provide, and how they would relate to the client. Officials of PMU therefore argue that there is no logical reason for the NGOs to raise any objections or to complain about the terms of the agreement when they knew everything prior to the signing of the contract. One high official of PMU pointed out in an interview that 'nothing was imposed against the will of the NGOs'. He added that 'we cannot do anything that is not written in the contract. We conduct our activities following the different provisions in the contract'.

How the non-governmental organisation and government perceive the relationship

The PSTC is perturbed by the fact that NGOs that were to be seen as 'partners' have become bound into a rigid, non-relational contract with government. They see this as a status that is appropriate to profit-making organisations, where the quid pro quo for acting as government's agent is that they are able to retain profits—an option that they see as unavailable to NGOs. PSTC does not like to be branded as a contractor. The Executive Director of PSTC argued in an interview that the bidding process in effect destroyed the spirit of collaborative relations, and precluded the development of genuine partnership between government and NGOs. His view was that the bid process was 'another barrier to creating relations', with a built-in assumption that the relationship was one of profit.

The large security deposit and performance guarantees are considered a burden by PSTC. From the point of view of the PMU Office, these serve a particular function, agreed upon by donors and NGOs. They both provide cover in case an NGO fails to fulfil its contract and government has to step in. Incidentally, they are also a means of restricting the competition to financially solvent and competent NGOs, because they allow the elimination of NGOs with a poor track record and those unable to fulfil the requirements.

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Moreover, government is perceived by PSTC as failing to fulfil its side of the agreement. A common problem is that funds are not released on time, mainly because of the complexity of procedures. These include a process of 'pre-audit' by which government checks proposals before expenditures are incurred. Delay hampers the implementation of the project and raises dissatisfaction among service seekers. There is no provision in the contract for how PSTC should maintain contracted services in the absence of payment. However, the threat to its reputation leads PSTC to try to manage the situation by borrowing funds from its other funded projects.

The PIU and PMU's explanation of the delay in the release of funds is different. They stated in interview that NGOs did not submit their bills or reports on time, and that this delayed the processing and ultimately the payment. Financial documents may not be prepared following the financial manuals of Dhaka City Corporation, delaying the processes of scrutiny and disbursement. Bills and vouchers pile up and the city corporation lacks the manpower to chase and check them. The project officer faces a situation where, if he fails to detect financial irregularities, then he will be liable for the mistake.

The contrasting perceptions of government and NGOs are presented in Table 1. By bringing in the issue of formal contracting, this table updates an earlier perceptions table provided in Farrington and Lewis (1993: p. 317) that set out the contrasting perspectives of government and NGOs around the pros and cons of collaborating with each other. The search by government for the application of clear and strict contractual terms is met by NGOs' search for a flexible and understanding relationship. Although NGOs' perceptions are based on the PSTC study, these views were checked and confirmed with NGOs more widely.

Both sides have a legitimate position. The strictness of the government's contracting procedures, backed by donors, and their commitment to due process can be understood as a protection against corruption and fiduciary risk. NGOs' wish for a more flexible relationship reflects their previous experience in dealing with external funders, their 'culture of action', their unfamiliarity with formal contracting, as well as their experience that contractual terms do sometimes need to be changed in the light of experience. The final article by Batley in this Special Issue indicates how these different positions can be accommodated in a formal contract that is also backed by 'relational understandings'.

Table 1. Contrasting views of contractual conditions in Urban Primary Health Care Project Phase II

	Government	NGOs
Competition for contracts	This was by an open competitive tendering process. Floor (minimum) prices were set as a defence against under-bidding.	Completely open bidding was new to NGOs, although they were exposed to some competition in the first phase. Most NGOs treated floor prices as ceilings, assuming that exceeding them would make bids uncompetitive.
The basis of the agreement	The terms were stated in a comprehensive bid document, specifying required inputs and outputs. The terms and contractors' bids form a binding contract.	Previous experience including in the first phase of UPHCP was that contracts could be adjusted, in the light of experience of executing the agreement.
Application of the terms	The terms, including detailed specification of resource inputs and their allocation to budget heads, are applied strictly.	NGOs' attempts to get adjustment of the terms and to revise allocations of funds within the budget are refused.
Deposits by contractors	The contract requires NGOs to maintain banked deposits of 10% of their initial advance payment and 10% of the contracted budget as a guarantee of their performance. These can be used to cover the costs if an NGO fails to perform.	These commitments tie up a large amount of NGO funding before they earn anything back from the contract. They also imply that the government distrusts them.
Payment	Payments should be made within a month of quarterly invoices, but NGOs keep poor records and submit incomplete and late invoices.	Payments take up to 6 weeks because of bureaucracy, including the checking of vouchers through multiple tiers of government.

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CONCLUSIONS

Historically, NGOs in Bangladesh evolved within a context that was favourable to their development: government provided a good deal of space by supporting NGOs' role in service provision. As we have seen, immediately after the Liberation of Bangladesh in 1971, the need for relief and rehabilitation was predominant. Later, in recognition of government's inability to provide services, donors supported NGO provision particularly in the areas of health, education, agriculture, water and sanitation. NGOs' relative efficiency in providing basic services initially created a positive environment for the development of government–NGO collaboration. Lewis (2001: 68) sees NGOs' role at this point as implementers, catalysts and partners with government.

The NGOs in Bangladesh work within the framework of laws and regulations enacted by government. The establishment of the NGO Affairs Bureau reflected government policy to bring NGOs under tighter control, to make them accountable and transparent and to enable smoother working relations. The tightening up did not discourage the opening of new NGOs, and indeed, through the 1980s and 1990s, there was a robust growth in their number, an increase in the nature and type of activities and also an increase in the amount of funds received by NGOs. Government could not meet the demand for services for the growing population, and NGOs took this opportunity to fill the gap. They were supported by external donors in a system we have described as one of 'parallel funding', where both government and NGOs had their own sources and their own activities, which operated separately or within only a very broad policy framework.

Since the beginning of the 2000s, there seems to have been some adjustment of donor funding flows, at least for some donors in some sectors, towards a channelling of their funding through government to NGOs. The case should not be overstated because most NGOs in the service sectors that we have examined (education, health and sanitation) continue to rely on their own direct funding. However, the NGOs we studied have felt the need to demonstrate their willingness to work directly with government. NGOs foresaw that contracts with government for projects funded by donors could become the dominant model, and that they would then have no option, but to participate in such projects.

Government–NGO collaboration spearheaded by donors provides an opportunity for NGOs to extend their services, but it also brings more stringent terms and conditions stipulated in contractual agreements. These constrain the freedom of NGOs to implement activities in the way they choose, creating a type of regulated relationship. The conditions attached to government contracts are both built on and create tension, distrust and misunderstanding. NGOs feel that their independence is being eroded. In public discourse, government officials describe NGOs as important actors in service provision but, in private, they are critical of NGOs' motives, cost effectiveness, accountability and transparency.

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