NON-STATE PROVIDERS OF BASIC SERVICES

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COUNTRY STUDIES

Bangladesh: Study of Non-State Providers of Basic Services

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NON-STATE PROVISION OF WATER AND SANITATION IN BANGLADESH

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<th>Abbreviation</th>
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<tr>
<td>ADAB</td>
<td>Association of Development Agencies in Bangladesh</td>
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<td>APP</td>
<td>Alternative Private Providers</td>
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<td>ARI</td>
<td>Upper Respiratory Disease</td>
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<td>ANC</td>
<td>Ante-natal Care</td>
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<td>APP</td>
<td>Alternative Private Providers</td>
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<td>APR</td>
<td>Annual Performance Review</td>
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<td>BCC</td>
<td>Behavioural Change Communication</td>
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<td>BMA</td>
<td>Bangladesh Medical Association</td>
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<td>BMDC</td>
<td>Bangladesh Medical and Dental Council</td>
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<td>BPHC</td>
<td>Bangladesh Population and Health Consortium</td>
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<td>CBA</td>
<td>Combined Bargaining Association</td>
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<td>CC</td>
<td>Community Clinic</td>
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<td>CCC</td>
<td>Chittagong City Corporation</td>
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<td>CCHD</td>
<td>Chittagong City Health Department</td>
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<td>CCMG</td>
<td>Community Clinic Management Group</td>
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<td>DAB</td>
<td>Doctors Association of Bangladesh</td>
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<td>DSF</td>
<td>Demand Side Financing</td>
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<td>DWASA</td>
<td>Dhaka Water Supply and Sewerage Authority</td>
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<td>ESP</td>
<td>Essential Service Package</td>
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<td>GNNSP</td>
<td>Gender NGO Stakeholder Participation</td>
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<td>GoB</td>
<td>Government of Bangladesh</td>
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<td>HNPSP</td>
<td>Health, Nutrition and Population Sector Programme</td>
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<td>HPSP</td>
<td>Health and Population Sector Programme</td>
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<td>HPSS</td>
<td>Health and Population Sector Strategy</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>NFE</td>
<td>Non Formal Education</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NGOAB</td>
<td>NGO Affairs Bureau</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>NSP</td>
<td>Non-State Provider</td>
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<td>PAA</td>
<td>Partnership Agreement Area</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHCC</td>
<td>Primary Health Care Centre</td>
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<td>PIU</td>
<td>Project Implementation Unit</td>
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<td>PNC</td>
<td>Post-natal Care</td>
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<td>RNGPS</td>
<td>Registered Non-Government Primary School</td>
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<td>SDF</td>
<td>Social Development Foundation</td>
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<tr>
<td>SIP</td>
<td>Sector Investment Plan</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>SWAp</td>
<td>Sector Wide Approach</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>Tk</td>
<td>Taka (currency)</td>
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<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
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<tr>
<td>UPHCP</td>
<td>Urban Primary Health Care Project</td>
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<tr>
<td>VERC</td>
<td>Village Education Resource Centre</td>
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<tr>
<td>VGD</td>
<td>Vulnerable Group Development</td>
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<tr>
<td>VHSS</td>
<td>Voluntary Health Services Society</td>
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1. PURPOSE OF STUDY

1. The underlying premise of this study of Bangladesh and five other countries is that poor people get many of their basic health, education, water and sanitation services from non-state providers. DFID, the sponsor of the studies, is concerned to know how governments may work with the non-state sector so as to increase the latter's incentive to offer quality services to the poor. We are asked to analyse what makes selected government 'interventions' succeed or fail, and how donors may support effective government engagement. The primary purpose of each country study is to provide sufficient evidence to allow the researchers to draw up guidelines on working with the non-state providers that matter most to the poor, while recognizing the need for different strategies in different contexts.

2. The team of researchers, based in the UK and Bangladesh, was asked to identify and describe a few selected cases of government (or civil society organizations in place of government) intervention to support the delivery of services by non-state providers (NSP) in three service sub-sectors: primary education, primary healthcare and drinking water supply/urban sanitation. These cases are intended to be illustrative of the use of different instruments of intervention; they are not intended to be comprehensive studies of non-state provision in the three sectors. They could cover any for-profit or not-for-profit provider, but DFID asked us to give special attention to the smaller and more informal types.

3. The sector studies that are the basis of this report are annexed. They adopted a common approach to (i) selecting examples of intervention and describing their background and context, (ii) describing the intervention and analysing its performance, and (iii) explaining performance in terms of the interests, institutional and organizational constraints and opportunities affecting the intervention. The studies focused on three broad forms of government (or civil society) intervention or action:

   i) Dialogue between state and non-state actors in deciding and reviewing policy and legislation about standards, regulatory and support systems, alternative service arrangements, roles, co-ordination and forms of collaboration

   ii) The implementation of interventions to

      (a) regulate non-state providers by government and independent bodies by formal regulation, oversight

      (b) hold non-state providers accountable to clients

   iii) The implementation of interventions to

      (a) commission service delivery

      (b) facilitate or support non-state providers.

2. THE POLICY ENVIRONMENT FOR GOVERNMENT’S RELATIONSHIP WITH NON-STATE PROVIDERS

4. In Bangladesh a number of factors combine to provide both large opportunities for NSPs but a difficult environment in which to act:
   - poor capacity of government provides large gaps for NSPs to fill but presents problems of poorly coordinated government interface with NSPs
- **politicisation** of administrative functions along party lines (which in part reflect further divisions in society including between a largely secular approach to government and one influenced by religion) makes for an unstable context where there may be sudden shifts of policy and practice.
- **lobbying** is highly developed but tends to operate on the basis of defence of existing privilege or arguing for concessions from the state rather than being over fundamental policy priorities. This reinforces a patronage-based approach to politics.
- high **decentralisation** with limited use of local government and a confusing complex structure of many central ministries.

5. The confrontational nature of politics has made for difficulties in organising overall umbrella organisations of NGOs with political pressure downgrading the ability of organisations like ADAB (The Association of Development Agencies in Bangladesh) to play an effective role.

6. Bangladesh has an unusually large indigenous NGO sector (Lewis, 2003) with an estimated 22,000 organisations (DFID, 2000). The size of the sector is sometimes attributed to donor-funded filling of a vacuum in state provision when the country gained independence in 1971 but self-help and community approaches have a longer history with religious support dating back a much longer period (Lewis, 2003). The crises caused by flooding provided a particular reason for local NGOs to grow to meet the implementation needs of donor-funded emergency projects.

7. Donor support is concentrated on a small number of very large NGOs although these act as clearing houses for dispersal to smaller NGOs as well as directly spending money through their own facilities. BRAC and PROSHIKA in particular have developed an international reputation for their initiatives across a range of sectors.

8. **Education** has made significant achievements in improving coverage with estimated net enrolment at around 80%. However non-enrolment is concentrated among the poor with concerns about quality evident.

9. **Water** coverage is good, even in rural areas reaching a level estimated at 97% although arsenic contamination reduces the safe coverage to a (still impressive) 60%. Of the 10 million tube wells some 80-90% are estimated as being in private ownership. **Sanitation** coverage is less impressive at some 42%.

10. In **healthcare** state coverage of the poor is weak with some 88% of all households going to non-state providers for their healthcare. The poor are particularly users of the informal unregulated non-state sector creating problems of inappropriate care.

3. **LOCATING THE CASE STUDIES**

11. The timing of the study and difficulties caused by disruptions due to flood and political violence limited the range of case studies, especially beyond Dhaka. However we have sought to represent a range of interesting cases emphasising the key themes of the overall study i.e. with an emphasis on interventions involving smaller providers and where there were positive lessons.

12. There are cases where there is extensive non-state provision but little or no government intervention as for example in the case of the sale of drugs which represents a large proportion of the total expenditure on healthcare in Bangladesh. Because of the lack of significant government intervention these services are not covered. More generally the
cases we discuss where there is a significant government intervention are somewhat biased towards contracting or subsidy arrangements rather than to policy dialogue or to facilitation reflecting an underlying pattern in Bangladesh – at least in the sectors we studied and, to some extent, more broadly

13. In education the key interventions are in financial subsidies to the extensive non-state sector of primary education, both formal and non-formal

14. On water and sanitation we study a number of innovative practices in which non-state providers have played an important role with government permitting or encouraging the role but with limited positive intervention

15. In healthcare there is a more-rounded pattern of cases, perhaps representing a more mature sector with substantial donor support encouraging a more positive role towards NSPs and building on the de facto strength of the non-state healthcare sector relative to government provision.

Table 1: Cases Studied in Bangladesh

<table>
<thead>
<tr>
<th>Function examined</th>
<th>NSP organization</th>
<th>Type of organization</th>
<th>Relationship with government</th>
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<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Support to Registered Non-Government primary Schools</td>
<td>Individual schools</td>
<td>Community-owned schools</td>
<td>Financial subsidy</td>
</tr>
<tr>
<td>Govt contracting &amp; registering of NGOs involved in education delivery</td>
<td>Individual non-formal education providers</td>
<td>Variety of large and small NGOs</td>
<td>Regulation/subsidy</td>
</tr>
<tr>
<td><strong>Water and sanitation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban Water Supplies</td>
<td>CBA Co-operative, private contractor Dustha Shasthya Kendra</td>
<td>Mixture of for-profit and co-operative contractors</td>
<td>Contracts for water service provision with Dhaka Water Supply and Sewerage Authority</td>
</tr>
<tr>
<td>Total Sanitation</td>
<td>VERC, PLAN</td>
<td>Not-for-profit NGOs</td>
<td>Facilitation</td>
</tr>
<tr>
<td>Rural Water Supply</td>
<td>SDF</td>
<td>Various Private operators, NGOs</td>
<td>Concession with public subsidy through SDF funded by World Bank</td>
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<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Population Sector Programme</td>
<td>Multiple NSPs</td>
<td>Typically NGO umbrella bodies</td>
<td>Policy dialogue</td>
</tr>
<tr>
<td>Bangladesh Health and Population Consortium</td>
<td>BPHC</td>
<td>Lead contractor with 35 NGO sub-contractors</td>
<td>Regulation and Contracted healthcare provision</td>
</tr>
<tr>
<td>Urban Primary Healthcare programme</td>
<td>NGOs</td>
<td>NGOs</td>
<td>Contract that includes specific provision for capacity building</td>
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4. POLICY DIALOGUE

16. Policy dialogue in Bangladesh is more visible at a national cross-sectoral level than within many sectors. Indeed one of the most prominent non-state bodies involved in the policy process is named the Centre for Policy Dialogue. Pressure from such bodies and support from donors has encouraged at least the appearance of dialogue arrangements.
Many non-state participants are critical of these arrangements however with the state controlling the dialogue by determining who participates and limiting the scope and depth of the dialogue. Dialogue over policy formation is more noticeable than dialogue over implementation.

17. Within our sectors the most notable example of policy dialogue was the HPSP case within health.

### Policy Dialogue in HPSP

The main elements of HPSP were: (a) a focus on an essential services package (ESP), (b) reorganisation of the service delivery system, (c) integrated support services, (d) hospital support services, (e) sector-wide programme management, and (f) policy and regulatory action for enhanced sustainability, accessibility, affordability and quality of services. These components were geared towards contributing towards the programme goal of improving health and family welfare status among the most vulnerable women, children and poor of Bangladesh (MOHFW 1998).

The SWAP provided an opportunity for policy dialogue between state and non-state providers, and an opportunity for donors to highlight the need for greater and more effective public engagement with the non-state sector. There was good involvement of NSPs during the formulation of HPSP. However, subsequent involvement of NSPs during implementation of the sector programme was minimal. Some NSP representatives, such as the Doctors Association of Bangladesh (DAB) and the Bangladesh Medical Association (BMA), were invited to a policy dialogue session following one of the annual performance reviews.

NSPs participated on the six task forces that were set up to guide development of the Health and Population Sector Strategy (HPSS) (which providing the guiding framework for HPSP). This included representatives of NGO apex bodies (such as the Association of Development Agencies in Bangladesh (ADAB) and the Voluntary Health Services Society (VHSS), as well as member NGOs themselves (such as Naripokho).

The private for-profit sector also participated in HPSP formulation (though on a more hands off basis than NGOs). This included the Bangladesh Medical Association (BMA) (representing the interests of private sector doctors), and representatives of rural medical practitioners, unani, ayurvedic and homeopath practitioners.

18. The fact that the most prominent example of policy dialogue in healthcare occurred within a SWAP programme raises the question to what extent this derived from donor pressure. It seems clear that donors were positive about the potential role of non-state organisations both as providers and as broader stakeholders with something useful to contribute to the policy dialogue. It is not clear however to what extent the government side consented to this or had itself seen the benefits of non-state actor involvement. The subsequent history of the programme, with disappointing performance on non-state related initiatives, suggests that perhaps the commitment of the government was limited.

19. One result of non-state actor involvement in the design stage of HPSP seems to have been a greater emphasis on the role of the non-state sector in service provision including a range of more prominent government “interventions” in non-state provision – contracting with NGOs and private providers and better regulation of private clinics.

20. The disappointing level of implementation of these ideas has led to some lesson-learning for the successor to HPSP. Whilst this programme is currently being appraised,
the intention is that it should emphasise the role of the line ministry as a purchaser of healthcare services and as a regulator of the overall sector. This may suggest that the underlying problem is that government tends to focus on its role as a direct provider to the exclusion of more innovative relationships even where, as in Bangladesh, there is substantial non-state provision already and, arguably, capacity for more.

21. Thus the positive lessons of HPSP are limited – getting NSPs into a SWAP style programme can get pro-NSP issues onto the agenda but more fundamental changes in power and institutions will be required to achieve shifts in actual delivery patterns.

22. In **water and sanitation** a National Steering Committee exists with relations between state and non-state sides reported as relatively friendly but impact in state policy appears limited. In **education** there is some effort by non-formal NGOs to influence the state’s provision of formal education but again impact appears low.

**Conclusion**

23. Policy dialogue within sectors seems limited from the studies discussed with government reluctant to empower or recognise non-state bodies. Relatively successful non-state bodies engaged in lobbying the government tend not to be providers of service but have set up as “think tank” type organisations – notably the Centre for Policy Dialogue which operates across sectors. Other bodies acting on government have adopted an academic form such as the Bangladesh Institute for Development Studies (BIDS) and a number of smaller foundations or other structures linked to members of BIDS such as Shammany which operates on the field of poverty, especially rural poverty.

24. This would seem consistent with the notion that it is difficult to combine the role of effective provider with effective lobbyist. Lobbying organisations tend to be funded externally rather than relying on funds from government for service delivery. It may also be significant that they operate cross-sectorally since that reduces their exposure to individual sectoral ministries which could be perhaps be more risky where they are critical in unwelcome ways.

5. **REGULATION**

25. Overall regulation of NGOs in Bangladesh is undertaken by the NGO Affairs Bureau (NGOAB) which registers all NGOs in receipt of foreign funding operating what is claimed as a “one-stop shop” for government registration requirements.
NGOs obtaining foreign funds have to be registered with the NGOAB. In principle, the NGOAB is responsible for registering, monitoring, and overseeing the activities of the NGOs. Other important functions include:

- Approval of projects and fund release
- Auditing and scrutinizing reports of the NGOs
- Evaluation and inspection of activities
- Liaison with donors and NGOs.

The NGOAB provides a ‘one-stop shop’ for NGOs, with the aim of cutting down on the bureaucracy. For example, if an NGO is involved in multi-sectoral activities, the NGO bureau will liaise with the ministries on their behalf. The NGOAB sends applications to appropriate focal points in sectoral ministries who pass it on to the appropriate officer within the Ministry. Ministries are given 21 days to send comments, after which if no response is obtained, it is assumed that they approve – approximately half of applications do not receive comments from the Ministry, and only a few are turned down (usually on the grounds of duplication with activities already being undertaken by the government, implying that competition between government and NGO activities is not encouraged).

The NGOAB is also responsible for receiving and checking audit and performance reports (sectoral ministries are not involved in this), as well as inspection of NGOs. In practice, this is most likely to involve visits to NGO offices, rather than monitoring of the programmes themselves. It appears that this inspection takes up a large amount of the effort of the small bureau, which could be due to the possibility of rent-seeking when visiting offices. On the other hand, there are only two auditors for all NGOs registered, with around 2000 audit reports. As a result, the auditors only focus where their attention has been drawn to potential malpractice of an NGO.

26. Its registration operates at two levels – it registers both the organisation and individual activities. The process appears burdensome with considerable paperwork to be completed. The impact of the process was hard to discern. Discussions with the NGOAB indicated that almost all registrations were ultimately accepted and all activities permitted. Two specific suspensions of registered NGOs were highlighted however. In one, the Bangladesh chapter of Transparency International was temporarily suspended. The reasons given were procedural irregularities over the governance of the NGO which were subsequently resolved. It is notable however that the government has had an uneasy relationship with TI following TI putting Bangladesh high on its list of corrupt countries.

27. In the second, much higher-profile, case the government has suspended the second largest NGO in the country, PROSHIKA, over supposed misuse of its resources. This case has caused considerable political discussion both inside and outside Bangladesh. Some observers claim that the suspension is politically motivated with the leading figure in PROSHIKA associated with the opposition political grouping. The impact of PROSHIKA’s suspension is to deny it foreign funding and it is thus rapidly shrinking as its resources dry up.

28. Some of our informants suggested that the PROSHIKA case illustrated the difficulties for large NGOs in Bangladesh – some degree of political support is necessary but the polarised political structure with power moving between two strongly opposed leading parties, meant that such a position was fragile. To be fair the example of BRAC, the
largest NGO, suggests that such fragility is not inevitable but that such a large NGO needs to adopt a carefully thought through strategy of managing its political contacts.

29. In education, organisations involved in running non-state schools may be subject to NGOAB registration if they receive foreign funding but there is further, more specific registration by the relevant sectoral ministry. This is closely linked to the provision of financial subsidies and is further discussed below. For the moment, however, it is interesting to note that it appears that some of the regulation appears designed to reduce non-state competition with state schools (for example preventing schools that are to close to existing state schools) or to limit the governments’ exposure to future financial commitments given the political pressure from unions to nationalise the non-state sector.\(^1\)

30. In water and sanitation, the sector is notable for the lack of an effective regulator role for the state despite the extensive involvement of non-state providers and despite a host of recognised problems such as arsenic contamination. The explanations of this are not obvious. A large amount of non-state involvement has developed apparently to fill in gaps in state provision and the state seems content to allow this rather than (mostly) to try to hinder it. Where formal regulation exists such as over specifications of sanitation standards, they are widely regarded as inappropriately demanding leaving NGOs to ignore them and provide facilities that command popular support with appropriate standards. On the whole observers seem to regard this non-regulation as better than the alternative of obstructive regulation which would appear likely given low capacity levels in the relevant Ministries.

31. In healthcare, regulation does exist but is focused on private clinics and hospitals where treatment is largely for the non-poor. In practice large amounts of expenditure on healthcare for the poor is through payments to Alternative Private Providers, often unqualified, and who are not subject to active regulation. This focus on the large formal non-state sector has unfortunate consequences with clear dangers of inappropriate use of drugs etc. Professional self-regulation has been limited with professional bodies tending to emphasize their trade union role rather than regulation of members.

**Conclusion**

32. Regulation appears under-provided in Bangladesh especially at sectoral level. This reflects overall low state capacity with the limited sectoral activity there is focused on larger formal providers, especially in healthcare where, perhaps, there is a clearer historical pattern of regulation to follow. Elsewhere regulation tends to happen where it is a necessary adjunct of state subsidies. The idea that regulation is a state response to problems such as market failure or information asymmetry has not taken hold.

33. The cross-sectoral regulation is mainly a response to a perceived need to control donor aid to NGOs. Whilst the idea of a “one-stop shop” has attractions, its implementation lacks real benefits other than, perhaps, some degree of convenience for NGOs that they only have one body to deal with. Interpreting the experience of the decisions of NGOAB is heavily influenced by the government actions in respect of PROSHIKA which probably originated higher in the government.

34. One positive aspect of the lack of regulation is that non-state activities have more room in which to provide and to innovate. In a system where the accountability of central

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\(^1\) Nationalisation would tend to increase costs compared with non-state provision since government subsidies fund a lower package of pay and benefits in non-state schools.
government is weak and, for some NGOs at least, is relatively stronger, then this may provide the least worst arrangement.

6. AGREEMENTS AND CONTRACTING FOR SERVICE DELIVERY

35. Contracting for service delivery is an activity present in all three sectors considered here. Donor influence has clearly shaped much non-state activity with government remaining on the sidelines or becoming involved in limited ways as an adjunct to donor financing as in the health example below.

**Government Involvement in Donor-funded activity: The BPHC**

The Bangladesh Health and Population Consortium (BPHC) started as a project of DFID (then the Overseas Development Administration) in 1988 with the main objective of supporting local NGOs to deliver maternal and child health and family planning services to poor and under-served communities in Bangladesh. The organisation served the following functions:

- Selection of NGOs
- Strengthening capacity of NGOs
- Channelling funds to NGOs

Since the start of the programme, a total of 100 NGOs have received support from BPHC. During HPSP, the Public-NGO Partnership (PNP) programme of BPHC moved from a model of “commissioning” NGOs to “contracting” them, using principles and procedures of competitive tendering to demonstrate to MOHFW that this was a viable mechanism of service provision. The first contracting exercise took place in 2000, and resulted in 25 NGOs being awarded contracts for ESP (Essential Service Package) delivery. A further 7 NGOs were given contracts for a more limited service package during a second round in 2002. Different tendering methods were used during the two rounds. The first tender was only partially competitive since existing BPHC partners where given preference in those areas where there were no other NGOs working. Moreover, bids were only welcome from NGOs who already had a presence in the assigned areas. The second tender was fully competitive and open to all NGOs who fulfilled minimum criteria.

Although the NGOs are contracted directly with donor funds, the government has been involved in the programme in several ways.

At the central level:
- MOHFW assigned the areas where NGO services were required
- MOHFW officials participated in the seconding tendering round
- BPHC submits quarterly progress reports to the Line Director ESP in the MOHFW.

At the local level:
- Partner NGOs report to the Civil Surgeon at the district level and the Upazila Health and Family Planning Officer at the Upazila level.
- Local health and family planning officials participate in joint monitoring activities
Government Involvement in Donor-funded activity: The UPHCP

In recognition of the need to better serve the health needs of the urban poor, four city corporations in Bangladesh (Dhaka, Chittagong, Rajshahi and Kulna) with funding from the Asian Development Bank (ADB) have entered into partnership agreements with NGOs for the delivery of primary health care (PHC) in and around urban slum areas. The project comprises four main elements: i) provision of PHC through partnership agreements; ii) strengthening the urban PHC infrastructure; iii) building capacity of the city corporations and their partners to manage, finance, plan and evaluate health care provision; and iv) support for project implementation and operations research. An overarching objecting was to “introduce structural reforms designed to change the role of the government and alter the way it relates to the private sector, including non-government organisations (NGOs)” (ADB 1997)

The four cities were divided into 16 partnership areas each corresponding to between 250,000 and 400,000 population. Partnership agreements were awarded on a competitive basis in two phases. Services to be provided included: immunisation, micronutrient support, family planning, prenatal, obstetrical and post natal care, BCC, and management of childhood ailments and TB. Partners were required to provide services from purpose built maternity centres, primary health care centres (PHCC), and on an outreach basis. However, in those areas where health facilities had not yet been built, partners provided care from rented premises. UPHCP started in 1998, the first 8 partnership areas were put out to tender in September 1999, and contracts signed in May 2000. The second round of contracting took place in late 2001. The total population served is 4 million.

A special project implementation unit (PIU) located within Dhaka city corporation was responsible for managing the contracting process. Tenders were open to any private health provider with prior experience in Bangladesh, such as NGOs, for profit private sector groups or provider associations. The city corporations themselves were also permitted to participate in the bid. To be eligible to bid, NGOs were required to be registered with the NGO Affairs Bureau, while groups of private practitioners were required to be legally incorporated and either to be members of the Bangladesh Medical Association or the Bangladesh Private Practitioners Association.

36. This example shows donor funding alongside a more active role for the government side – in this case at local government level. The project is regarded as successful and this would suggest that locating contracting responsibilities with the local corporations is possible. However the project was constructed with significant capacity development aspects including the use of a Project Implementation Unit and drawing on external consultants to support in project monitoring alongside local officials.

37. The latter example also allows for some degree of comparison between non-state and state providers since some of the contracted providers were from the state side – Chittagong City Council was one of the providers. Formal comparisons of performance are not available but informal suggestions point to CCC being perhaps less successful than NGO providers. More broadly both health cases appear to show NGOs being able to provide better services at lower costs and with a greater degree of innovation than existing state provision. Caution needs to be exercised here however. The improved results of both projects may derive more from better initial design and subsequent
monitoring than from the particular nature of the providers. On the donor side, such contractual arrangements with relatively small and weak NGOs (compared with large and, politically, strong government) may be easier to operate than with government.

38. In non-formal education, there is also heavy influence from donor financing.

### Government Involvement in Donor-funded activity: Non-Formal Education

Most NGO NFPE programmes are funded directly by external donors, although the relationship is mediated by the government through registration of NGOs. NGOs receiving foreign funds are expected to register with the government’s NGO Affairs Bureau (NGOAB), established in 1990. The majority of NGOs with NFPE programmes (i.e. those not receiving foreign funds) are registered with the Directorate of Social Welfare (89 percent), while 44 percent are registered with the NGO Affairs Bureau.

NGOs are selected by donors in a number of ways which are briefly indicated below:

- **Sole source selection:** When the services to be delivered require specialized knowledge and/or adequate administrative back up to ensure success, based on information and past record, a donor might select a particular NGO, which they feel is capable of implementing the programme. The selected NGO then approaches the NGOAB for approval.

- **Short listing of NGOs:** which have the capability to deliver services is prepared by the donor, based on information about their past record or through advertisement, and approval obtained from the NGOAB either on the initiative of the donor or through the efforts of the beneficiary NGO.

- **Joint committees:** Selection is made by committees comprising representatives of both the donor and the government.

- **Contracting by large NGOs:** Large NGOs (such as BRAC) are contracted mainly on a sole source basis and are provided with funds by the donor for implementation of programmes by smaller and mainly local NGOs (usually registered with the Directorate of Social Welfare), through a selection process agreed upon beforehand, which is both transparent and acceptable. The large NGO, after selecting the smaller NGOs then approaches the NGOAB for approval.

There has been some previous experience of donors contracting through the government. Following the 1990 World Conference on Education for All at Jomtien, the government launched the Integrated NFE Programme (INFEP), covering all non-formal education components (including primary), although this was relatively small. In 1995, the Directorate of Non-Formal Education (DNFE) was created out of INFEP with responsibility for initiating, coordinating and monitoring NFE programmes, including contracting of programmes to NGOs. With respect to NFPE, it was responsible for two projects for 6-14 year olds, offering a 2-year course aimed at providing grade III level of proficiency, encouraging transfer to mainstream primary (PMED 2000). However, the Directorate was dissolved in 2003, and the Department of Primary Education has taken over its responsibilities. Activities associated with the DNFE have been severely scaled down, so that it is no longer involved in NFPE programmes.

39. It is interesting to note that the pattern of contracting has, if anything, moved way from donors contracting through government to donors contracting direct with only some
peripheral involvement from government. This seems to reflect donor dissatisfaction with government performance in the role again confirming the relevance of low capacity within the GoB.

40. The NFE example seems to illustrate how a pro-poor emphasis can arise but it is difficult to know to what extent this derives from the donor influence rather than the NGOs themselves. The pro-poor emphasis derives in NFE from its targeting of hard-to-reach pupils and the Bangladesh experience here is a leading example globally of innovative practice. Locating centres close to homes and using well-trained and well-motivated (usually female) teachers seems to provide above-average results compared with formal schools. Interestingly one advantage is the lower wages NFE teachers receive compared with formal sector teachers enabling smaller class sizes to be achieved within available resources.

41. There is some development in Bangladesh of larger NGOs, notably BRAC, sub-contracting with smaller NGOs. In part this reflects BRAC’s undoubtedly its ability to bid for and credibly manage donor funds and its monitoring capacity make it a formidable partner. It has managed to develop capacities which are only weakly present in formal government institutions. Even it faces significant problems in controlling a wide range of organisations however.

<table>
<thead>
<tr>
<th>NGO Sub-Contracting in Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some of the larger NGOs sub-contract to smaller NGOs, these local NGOs obtain foreign funds indirectly and so do not have to register with the NGOAB. As mentioned, there is evidence to suggest that some smaller NGOs may be “briefcase” ones (i.e. claiming funds but not providing real services). BRAC is reported to be unique in having a good monitoring process to follow up on the NGOs to which they sub-contract. However, even BRAC is unable to keep fully on top of these NGOs. An example was given by an interviewee of an evaluation which uncovered examples of local NGOs obtaining funding from more than one source for the same activity, including from BRAC, and that BRAC was unaware of this. In addition, the criteria for selecting partners for BRAC’s Education Support Programme (BRAC nd) does not include any criteria to illustrate their capacity in relation to NFPE. It appears, therefore, that there is little information of the performance of some of the smaller NGOs and the registration process is not taking account of this. Overall, at present, it appears that there is considerable disparity between different kinds of NGO provision, but limited quality control, and no means of assessing the situation overall (Cummings et al 2004).</td>
</tr>
</tbody>
</table>

42. The size of the NFE market with donor funding is significant creating for some NGOs a degree of conflict in values as their interest in good services and community involvement comes up against a requirement for quasi-commercial skills in bidding. The money on offer has also created opportunities for those with less commitment to practice rent-seeking.

43. The large NFE sector in Bangladesh clearly fits the pattern of “gap-filling” by non-state providers in response to state weakness. It is interesting to speculate however how far this gap filling is desirable in the long-run. Arguably the existence of a large relatively successful donor-funded sector has taken pressure off government to expand its own formal education

44. In the water and sanitation sector more conventional contracting out has developed in smaller ways Dhaka Water Supply and Sewerage Authority (DWASA) has responded to
classic problems of billing and illegal connections by using an unusual combination of private and semi-internal providers.

**Sub-Contracting Support Services in Dhaka**

Financially DWASA presents a very grim picture. It is not able to recover the cost for the services it renders. In order to improve the financial situation DWASA contracted out revenue billing and collection activities in two of its revenue zones (Mirpur and Gulshan) to private sector contractors. This was done in 1997 under the IDA guidelines in DWASA - IV project. After couple of years IDA withdrew from the project because of non-compliance to a number of project pre-conditions. Nonetheless, DWASA continued with the contracting and succeeded in improving revenue collection. Presently CBA (Combined Bargaining Association/Union) Co-operative of DWASA is functioning in 3 zones (Mirpur, Gulshan and Lalmatia) out of the six and DWASA is contemplating on contracting out all the six zones to CBA Cooperatives in near future.

Up to 50% of water is unaccounted for; high levels of leakage (25%) are coupled with many illegal connections – local political and social pressures make this difficult to police. Water is regarded as a free commodity and so public education is required to enhance its value (a local phrase states that something that is very cheap is "just like water"). Although the borehole production costs are currently low, the water table is falling and this will raise costs, hitting the poor first.

In the first round of contracting-out, two organisations were selected, the DWASA based CBA and a private sector operator. Performance targets were set by DWASA. However the private operator has not performed as satisfactorily as the CBA, perhaps due to factors such as:

- Better knowledge and experience of CBA staff
- Informal access by CBA staff to past billing records etc.
- High levels of leakage, known by DWASA staff but not by the new operator.
- Informal contacts with DWASA staff, leading to faster leak repairs, whilst the private operator had to go through the formal reporting system. Delays in leak repairs led to loss of revenue.
- Government support for the co-op as part of general civil service reform

The CBA funds all staff costs of employees and has in fact substantially increased the wages of inspectors from Tk 7000/month to Tk 12,000/month. Productivity rates have increased markedly. Strategy and progress is discussed by the CBA. Managerial aspects such as job descriptions, work plans and a unified working environment have boosted performance, in contrast to the lack of interest in the organisation’s role displayed by standard DWASA staff. The CBA have a new computerised billing system, paid for by results, with additional technical support bought in as required.

45. The use of a semi-internal co-operative body is intriguing for it suggests that the underlying problem with former direct delivery was a problem of incentives. The CBA’s superior response (both with respect to former arrangements and with the alternative private provider) does not depend on better information than DWASA itself had (in fact it is the private provider who is weak in this respect) or on better capacity (the same staff are involved to a large degree). Instead the contract would appear to give stronger incentives for CBA staff to do what is required. They are then able to use their informational and networking advantages to produce good performance. The governmental support is also
illuminating that this arrangement appears more acceptable than naked commercialism although the underlying business models is not that different from conventional private provision.

46. Another water example shows an innovative government structure providing water in rural areas.

The SDF and Rural Water Supply

The Social Development Foundation (SDF), is a legally registered company, but falling under the management of the Ministry of Finance. It is financed by the World Bank and has government officials on its board, but is autonomous from government. It covers a range of development activities, including information and communication, community infrastructure works and health. The institutional arrangements are designed to free the project from unnecessary bureaucracy and delays.

Water takes about 10 crore Taka (including investors money) of SDF’s spending. 20-30 crore Taka is spent in other sectors. (i.e. £100,000 on water with £200,000 - £300,000 spent elsewhere). The pattern in other sectors is to use PRA to identify community needs and then assist the community in providing roads, schools, social programmes and medical facilities.

Government cannot expect to address the arsenic issue by itself. In an attempt to bring in a range of players to solve the problem (and provide skills, knowledge and resources as well), SDF is running a pilot scheme, letting concessions to build, operate and maintain water supply systems for 15 years. Funding is raised by SDF (40%), by the community (20%) and by the operator (40%). Banks and donors are also being encouraged to provide investment funding.

Both the private commercial sector and NGOs were eligible to bid for concessions. During the piloting of the approach, 12-15 organisations stated they were interested and, after initial screening (based on credit worthiness and experience), 12 were invited to submit expressions of interest, of which 10 were submitted. Eight organisations were selected to take part in the pilot scheme and six eventually signed a memorandum of understanding. Two (BRAC and NGO Forum) were not selected, as they could not provide venture capital up front.

The NGOs involved had the advantage of working at grassroots and recognizing the service delivery approach, whilst the medium and large private sector has not been so involved in “welfare” projects and not so interested in rural or social issues. Piloting the scheme with NGOs should allow the profitability to be demonstrated and encourage the involvement of the private sector. The NGOs selected also could draw on a loan from core funding whilst they design and develop their schemes.

The successful organisations had to undertake feasibility studies, costing five to six lakh Taka (£5,000 -£6,000 approximately), which was reimbursed in arrears, but required to ensure an “investor” approach. SDF oversaw the studies and facilitated the process. The studies have been approved and are about to be reviewed by the World Bank, but the investors have mobilised resources, working with the communities and drilling trial holes.

47. Formal evaluation of this scheme is awaited. It aims at explicit cross-subsidy to achieve a pro-poor result and draws on community pressure to enforce payment. As with health and education however significant funding is derived from donors.
Conclusions

48. A number of interesting innovations are taking place in Bangladesh which have perhaps important lessons for non-state provision elsewhere. The dominant features of these examples however is the peripheral involvement of government with donors acting as the driving force with NGOs. Thus these examples raise some of the classic problems of donor funded project-support – they create “enclaves” of (hopefully) good practice but do not address underlying weakness within government institutions.

49. Generally the non-state providers emerging through these arrangements are not-for profit NGOs or community based organisations. This may reflect concern from donors to emphasize community accountability and it may reflect the helpfulness of NGO values in supporting the underlying aims of these activities. In Bangladesh however quasi commercial activities are often undertaken within the form of not-for profit structures and thus this distinction can be over-emphasised. Non-state bodies do however seem to have been more responsive to the opportunities offered by contracting than have government to earlier donor initiatives.

50. In many cases the schemes are at an early stage of development with non-formal education the main exception of a well-established provision. Caution therefore needs to be exercised that the excitement of a small innovation in an area previously subject to poor state provision is not over-rated. Managing the institutionalisation and scaling-up of many of these initiatives will be difficult. However the desirability of scaling-up is itself a questionable goal where a case can be made for the primacy of government taking responsibility. Thus the success of NFE is itself posing a threat to expansion of what is generally regarded as the better ultimate solution of formal education for all.

51. The political acceptability of contracting to NGOs is a helpful factor – the GoB appears to regard donors undertaking this form of contracting as allowable and this would not perhaps have been the case with more commercial provision.

7. FACILITATION OF NON-STATE PROVIDERS BY GOVERNMENT

52. Facilitation here is interpreted widely to include a range of forms of support to Non State Provision where such provision (or a degree of such provision) would have existed without government intervention. Additionally it can include cases where the government is trying to “kick-start” non-state provision that can then exist without full government support when it is established.

53. A key case of financial facilitation that has not yet been discussed is the financial support to formal non-state schools. However large elements of regulation of the non-state schools are tied to this financial subsidy. Note that these formal schools receiving subsidy are distinct from the non-formal sector where state subsidies are not present and funding is largely from donors.
Facilitation through Subsidy in Primary Schools

Registered Non Governmental Primary schools (RNGPS) became established since the change in policy towards nationalisation in the 1980s and, in some respects, resemble schools in existence before nationalisation in 1973.

Registration of non-government primary schools is based on legislation in the Bangladesh Registration of Private schools Ordinance 1962, amended by the Registration of Private Schools Ordinance of 1989 (see Appendix 3). After completing the process of registration, RNGPS receive government support through both supply- and demand-side interventions, including:

- Construction and maintenance of school buildings
- Training of teachers at Primary Teacher Institutes
- Payment of 90% of teacher salaries
- Provision of free textbooks
- Inclusion of eligible students in the government’s primary education stipend programme targeted at poor students

Once registered, these non-government schools share similarities with GPS in terms of support received indicating blurring of boundaries between state and non-state with respect to financing. The main difference between the types of schools relates to their governance – management of RNGPS is decentralised to the school level (for example teacher recruitment being made by the School Management Committee), while management of GPS is highly centralised (recruitment of teachers undertaken by the Ministry).

Officials in the Primary Education Directorate reported that almost all applications for registering non-government schools reaching the Ministry eventually gain approval, although it is possible that some are turned down by the Division before they reach the final stage (otherwise it would be possible to envisage a situation where considerably more schools than required were established). Although there are criteria for establishing a school, it was reported that in practice these have been adopted flexibly until recently. Currently there has been a slowdown in the establishment of new schools - at the last meeting, one quarter of applications were approved (approximately 100 out of 400). Reasons given for the slowdown include the view that sufficient school places are now available (although class size is still quite large), and so the criteria are beginning to be adhered to more strictly. An alternative explanation is related to the political pressure being exerted by strike action of the Non-Government Primary Teachers’ Association demanding that the schools and their jobs are nationalised, so that teachers in these schools receive the same benefits as those in government schools. Nationalisation is being resisted by the government, no doubt partly due to the financial implications. This is potentially discouraging the government from registering new schools.

54. These schools represent around 22% of total enrolment and are thus of crucial importance in Bangladeshi education. The significance of the financial subsidies, and especially the teacher salary funding means that the supposedly community-based nature of these institutions is in some doubt. It appears that often the motive for creating a new such school is to create employment opportunities. At one level this might be thought positive – there are incentives to fill gaps in existing provision (the conditions for approval require there to be a gap in provision in geographical terms at least). On the other hand this can reduce control of the school by the community and there is evidence of unofficial levies for admittance to these schools. Where there is community involvement it can be dominated by local elites.
55. The weak linking of RNGPSs to state processes call into question just how appropriate for the poor this provision is. These schools attract less monitoring and inspection that state schools and suffer more from problems of teachers emphasising private tuition. School Management Committees have greater influence than in state schools but have little training in how to deliver their functions. As with the non-formal sector there must be questions of whether the coverage provided by RNGPSs allows the government to avoid confronting its responsibilities for state education.

56. An example from water shows communities being able to take responsibility for their own provision with some facilitation or partnership with government. (See ‘Community Water Points in Dhaka’ box below)

57. This promising example of community provision shows the difficulties however in expanding a promising model with multiple obstacles. Government intervention in this case however is limited and the dominant dynamic is one of the non-state sector persuading government rather than the government facilitating the non-state sector.

58. A second water example again shows limited government support for what is essentially a non-state initiative. (See ‘VERC and Rural Sanitation’ box below)
## Community Water Points in Dhaka

Dushtha Shasthya Kendra (DSK) is a non-governmental organization based in Dhaka. It started functioning in late 1980s with an integrated programme of primary health care, savings, credit and income generation in the slums of Dhaka city. In 1992 DSK took the initiative to provide water supply and sanitation facilities to the urban poor within an integrated program.

In 1992-94, DSK had successfully implemented two water points in the slums of Dhaka city. Based on the success of these two initiatives, the UNDP-World Bank Water Supply and Sanitation Program; the Swiss Agency for Development and Cooperation and Water Aid (funded by DFID) came forward to fund DSK in replicating the model in other slum areas of the city in 1996. The water points are managed and paid for by the community themselves. In 2001 Water Aid formed a donors consortium to scale up the model through a programme which will support construction of a further 300 water points in the slums of Dhaka and Chittagong (also with NGO Forum and CWASA). The points serve between 35 and 100 people.

DSK has succeeded in convincing DWASA to provide basic service provisions to the poorest of the poor who lives in slums and squatters. As per DWASA Ordinance, water supply and sanitation facilities can only be provided to people who have legal tenure of occupancy. DSK organized and build capacity with the communities to operate, maintain and manage water supply facilities, so they understand cash flows and bills. DSK also run a micro credit scheme for the construction of pit latrines, with Tk 21 being pad over a year.

The community either pay a monthly fee (Tk 30) or Tk 1 per 30 litres (Tk 3.3/100l). This pays for the cost of the water (Tk 6/1000l – Tk 0.6/100l), a caretaker and some profit for investing, once the cost of the original construction has been paid back to DSK. 97% of bills are being paid. Some points did turn into an income generation activity for the committee, but greater community involvement is now reducing excess profits. The water points are managed by an all female committee of nine people carrying out the routine administration. They are supported by a mixed gender “advisory” committee with no formal management role but which provides a public face with more presence in relation to organised crime. DSK provide hygiene promotion staff to monitor the water points.

As land tenure is crucial to the water supply, communities are now being empowered to campaign for land rights. The majority of water points constructed have been demolished by subsequent slum clearance, significantly diminishing the actual impact of the interventions. Of the 102 water points constructed in Dhaka, only 20 - 25 are currently working, six of which have been totally handed over to the community. 15 more physically exist but are not operating due to lack of water supply from DWASA (due to many illegal connections controlled by organised crime groups) or due to slum clearances.
VERC and Rural Sanitation

A new technique was piloted by VERC (Village Education Resource Centre) taking an approach that did not rely on subsidies. Using participatory approaches, the whole community was informed of the practical health and environmental impact of poor sanitation and how the faeces of some people, e.g. the poor could affect the health of others e.g. the rich, so it is was an issue for the whole community and health benefits would not result unless open defecation was stopped completely. This motivated the rich, not only to provide their own latrines, but to support others, for example by providing land and simple materials to the landless so the poorest of the poor could also have access to a latrine. Children are encouraged to monitor progress, naming and shaming people who still defecate in the open. This message also filters into the surrounding areas. The declaration of an open-defecation free village is made by a local political officer putting up a public sign.

This approach is now being used by a variety of NGOs, such as PLAN International and is also influencing government policy. It does rely on local political support, but capacity can be lacking so local government cannot respond effectively to central initiatives. Often this results in budgets being spent on latrine construction rather than community mobilisation. The NGOs can move faster than government structures and can help train government staff so investment is made in human resources rather than inappropriate buildings. NGOs can provide co-ordination across government divisions and encourage political support. Government civil service is becoming more political (especially in health) and the changes in staff lead to a lack of sectoral experience and knowledge. NGOs can also work at very local levels, whilst government structures seem less effective below Upazila (sub-district) level.

Where hardware support is needed, this is provided through helping seed production units, providing moulds for small entrepreneurs to cast slabs or providing an initial batch of plastic pans to a tea shop for selling on, creating supply chains independent of the NGO. Subsidies for latrines are not provided – ideas and inspiration are given rather than cash, although provision does have to be made for the hard-core poor. Sanitation fairs allow people to see different latrines, not all of which are technically sound, but this encourages people to experiment and see there is not a single solution. The five original designs have now expanded to 34, adapted to local conditions. About 80% of latrines are water seal and 20% simple pits, often offset using 3’ of pipe that is flushed before and after use. The government provided water seal is not always appropriate.

Political support is growing, with the Minster writing to 4648 local government chairmen to support the approach. 20% of the total Union budget has been earmarked for sanitation only (not even including water). Up to 90% of this is still going on hardware (with some taken by other local government institutions), but the “no subsidy” approach does appear to be gaining ground (with exceptions for the very poor, such as widows or beggars). Successful programmes do appear to be less prone to corruption.
59. This is another example which says more about non-state capacity than it does about government intervention. Government has belatedly provided some (non-financial) support for this initiative but the concept and implementation derive essentially from NGOs providing appropriate solutions to community needs.

**Conclusion**

60. Positive government facilitation of NSPs seems rare beyond the significant case of registered schools. The state is supportive in principle but its efforts focus on its own activities and NSPs have to work around or against the state rather than being encouraged by it.

8. **GENERAL CONCLUSIONS**

61. Apart from the specific conclusions raised in the previous sections, the Bangladesh research team generated the following general conclusions relating to some of the hypotheses that the research as a whole is exploring.

- The pattern of NSP provision is Bangladesh is significant but despite rather than because of government intervention in the sectors we examined.

- This tends to support the hypothesis that NSP provision tends to be de facto a gap-filling response to state failure. The level of state failure in Bangladesh is significant and hence NSP provision is significant. But state intervention remains problematic (as in education where it may interfere with improving the state sector) or weak (as in healthcare where large amounts of non-state provision are effectively unregulated).

- The pattern of non-state provision derived from a range of historic and situational factors with no single dominating cause. However donor intervention is of crucial importance on many of the recent innovative practices in the sector. Government capacity to learn from and scale-up these experiences is crucially lacking.

- NSPs are very diverse and understanding them requires a subtle approach that differentiates between a range of types.

- Provision for an affluent elite was important notably in health where its existence dominated state regulatory activities. Non-state provision to the very poor was not necessarily the norm outside this group – in many cases non-state providers were forced by circumstances to provide charged for services which may be beyond the reach of the very poor. However in Bangladesh there is a strong ideological commitment to the poor amongst many of the non-state providers and this has energised a number of innovative practices especially in community involvement.

- SWAPs have provided a basis for an effective dialogue involving NSPs and there is potential to develop this further.

- Non-state provision in some cases was cheaper than state provision, partly because of the use of lower-paid staff than in the state sector, partly because financial constraints force lower terms and conditions.
• Umbrella bodies were present in many areas but did not seem to be as significant as in some countries perhaps because they were less active in coordination activities than in low-level political lobbying. Larger NGOs, especially BRAC played a pivotal role however in some activities in coordinating contracted service provision.

• Regulation by the NGOAB would be improved if sectoral stakeholders were included in the process

• NGOs had adopted a cross-sectoral role partly as a strategy to minimise their exposure to changes in funding within individual sectors.

• The role of micro-finance was important here in providing effectively a flow of funds for NGOs often deriving from a surplus earned by charging borrowers at significantly higher rates than the NGOs accessed their fund at.

• Suspicion of NSPs is reduced (but not eliminated) where they are not-for profit although the distinction is blurred in Bangladesh.

• Government capacity to regulate or manage contracts with NSPs is limited but this receives undue focus relative to government’s limited capacity to manage its own delivery

• Convincing information on the performance of non-state providers is hard to come by but this is often a result of the nature of the services they provide and would often be equally true of state provision

• Improved monitoring of non-state provision is required drawing perhaps on both state and non-state resources and on the experience of the larger NGOs (principally BRAC) who already have effective monitoring functions

• Whilst some non-state providers may have desirable values, this does not guarantee that service provision will always be in the interests of users. This suggest that long-term reliance on NSPs will lead to increased focus on NSP accountability arrangements

• NSPs have been particularly successful in providing low-cost appropriate technology where government has tended to promote high standards which are unaffordable. In this respect the lack of government capacity for effective regulation can be seen as an advantage by denying what would be inappropriate regulation.

• Particularly in water and sanitation a degree of consumer education has been crucial in empowering communities to make informed choices from private providers of equipment
NON-STATE PROVISION OF HEALTH IN BANGLADESH
Priti Dave Sen and Naushad Faiz

1. OVERVIEW AND CASES SELECTED

1.1 Background: structure, size and scope of NSPs in health

1. Patterns of health service provision and organisation in Bangladesh have been shaped by the legacy of colonisation. Since independence, the state has aimed to provide universal free public health services. However, an overall lack of public resources as well as weak institutional structures to deliver health care has resulted in a rapid growth of non-state health providers to fill gaps in provision. A number of the large NGOs were established in response to natural disasters, namely cyclone and flooding.

2. Non-state providers can be categorised on the basis of whether they are for profit or not for profit, whether they are qualified or not qualified and on the system of medicine practiced (e.g. allopathy, homeopathy, and unani). The National Health Accounts (NHA) study (MOHFW 2003) indicates that poor make use of both for profit and non-for profit NSPs. It shows that of total spending in NGO health facilities, 14% accrues to the poorest 10% of the population, while in other private health facilities, the poorest 10% contribute to 7.84% of total spend. The same study estimates that the poorest 10% capture only 7.67% of subsidies in public health sector. This would imply that NGOs are more pro poor than government services.

3. With respect to relative size and coverage, Table 1 compares number of personnel working in public and NSP sectors (including qualified and unqualified and allopathic and non-allopathic). It does not separately depict numbers of health professionals working in the NGO sector.

Table 1: Estimated Number of Health Care Providers in Bangladesh

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Public Sector</th>
<th>Non-state Sector</th>
<th>Total</th>
<th>NSP share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Qualified allopathic practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Doctors</td>
<td>11,500</td>
<td>11,500</td>
<td>23,000</td>
<td>50</td>
</tr>
<tr>
<td>b) Nurses</td>
<td>7,540</td>
<td>5,460</td>
<td>13,000</td>
<td>42</td>
</tr>
<tr>
<td>c) Paramedics</td>
<td>28,350</td>
<td>52,650</td>
<td>81,000</td>
<td>65</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>47,390</td>
<td>69,610</td>
<td>117,000</td>
<td>59</td>
</tr>
<tr>
<td>2) Alternative private practitioners (APPs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Allopathic APPs*</td>
<td></td>
<td>110,000</td>
<td>110,000</td>
<td>100</td>
</tr>
<tr>
<td>b) Traditional APPs**</td>
<td>1,730</td>
<td>171,270</td>
<td>173,000</td>
<td>99</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>1,730</td>
<td>281,270</td>
<td>283,000</td>
<td>99</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>49,120</td>
<td>350,880</td>
<td>400,000</td>
<td>88</td>
</tr>
</tbody>
</table>

Source: Calculated by the authors from Peters et al (2003)

* Unqualified and practicing allopathy
** Practicing unani, ayuverda, homeopathy and other systems of medicine

4. It shows that the number of qualified allopathic practitioners almost equals the number of unqualified providers practising allopathy. By far the largest group of providers are alternative providers practicing traditional systems of medicine. The
NGO sector has been expanding in recent years. NHA reports that health spending by NGOs accounted for only 3% of total health spend in 1996/97, and in 2000/01 this had risen to a little over 9% of total health spend.

5. Alternative private providers are the most accessible of all NSPs for the poor, both in terms of geographic access and cost. They have a presence in most villages of the country (ORG-Marg Quest 2000). Other NSPs accessible to the poor are NGOs, retail pharmacies, and government doctors who undertake private practice.

6. Unqualified practitioners treat a number of ailments that are key to achievement of MDGs. These include childhood ailments such as diarrhoea and ARI, as well as malaria, TB and STIs. A survey of 273 village doctors in Brahmanpara district (ORG-Marg Quest 2000) shows that the respondents usually treat diseases like fever, typhoid, scabies, asthma, cold, burns, diarrhoea, pneumonia, ulcer, hepatitis, delivery related problems, etc. These doctors were also found to treat more serious conditions, such as cancer, nephritis, angina pectoris, sexually transmitted infections, etc. Quality of care however by APPs is widely perceived to be poor, and indeed in some cases dangerous. Private nursing homes have potential to play an important role with respect to the maternal mortality MDG. Many provide safe delivery care, however currently they remain largely inaccessible to the poor as a result of high cost of care.

Correspondence with demand

7. NSPs are the major source of health care services in Bangladesh, including for the poor. The Service Delivery Survey (SDS) conducted by CIET Canada on behalf of the Ministry of Health and Family Welfare (MOHFW) found that, in 2003, 88% of households seeking health care went to non-state providers (CIET 2003). The single most important provider was the village doctor, who served 43% of the households who sought treatment. Pharmacies were found to cater to 13% of the cases. Thus, according to the CIET survey, the bulk of the services (68%) were provided by APPs. Qualified allopathic practitioners accounted for 32% of the services, which were mainly given by private doctors. Details are shown in Table 2.

<table>
<thead>
<tr>
<th>Service Providers</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Qualified allopathic providers</td>
<td></td>
</tr>
<tr>
<td>a) Private doctor</td>
<td>25</td>
</tr>
<tr>
<td>b) Private clinic</td>
<td>2</td>
</tr>
<tr>
<td>c) NGO</td>
<td>1</td>
</tr>
<tr>
<td>Sub-total</td>
<td>28</td>
</tr>
<tr>
<td>2) Alternative private practitioners</td>
<td></td>
</tr>
<tr>
<td>a) Village doctor</td>
<td>43</td>
</tr>
<tr>
<td>b) Pharmacies</td>
<td>13</td>
</tr>
<tr>
<td>c) Traditional providers</td>
<td>4</td>
</tr>
<tr>
<td>Sub-total</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
</tr>
</tbody>
</table>

Source: Adapted from CIET (2003)

8. Another survey undertaken by PRDA in 2001 found that 82% of the sampled households received treatment from NSPs. While there was no significant difference between poor and non-poor households as regards utilisation of non-state services (83% compared to 81%), a higher proportion of the poor (74%) went to APPs compared to non-poor households (62%). On the other hand, only 9% of poor
households visited private qualified doctors and NGOs, as opposed to 19% of the non-poor households.

9. Amongst APPs, village doctors are the main source of services for the poor. According to the OMQ survey (2000), about 40% of the patients visiting the sampled village doctors in Brahmanpara earned a monthly income of less than Taka 1,000 (less than a dollar a day), while the income of another 48% ranged between Taka 1,000 and Taka 5,000 per month (around three dollars a day). Only 12% of the patients had incomes of more than Taka 5,000 per month.

**Interventions to support or regulate NSPs**

10. A recent World Bank study concluded:

   “the range and magnitude of government engagement with private providers is not congruent with their presence in serving the public, including the poor. The bulk of interaction takes place in terms of regulation and with regard to private clinics and hospitals. APPs have very little interaction with government. Thus, public-private engagement has largely excluded service providers of greatest importance to the poor”. (World Bank 2003)

11. Interestingly the same study noted that most policy makers feel that the bulk of private provision is tertiary care for the rich – the exact opposite of reality.

12. There are a number of examples of contracting with NSPs (largely with the non-profit sector). For example, NGOs have been contracted to deliver nutrition services, the Essential Service Package (ESP), PHC to urban poor, TB, family planning and HIV/AIDS. Most of the contracting has been undertaken using donor funds. The degree and type of government involvement in the contracting process and in overseeing the contracts varies considerably across these examples. In some cases a special project implementation unit has been responsible for selecting, issuing and managing contracts (e.g. PHC to urban poor and nutrition). In other cases, this function is undertaken by a special implementing agency (ESP delivery and HIV/AIDS activities). In another case the government organisation itself had direct responsibility for contracting (National Aids and STI Prevention Office for HIV/AIDS prevention and care).

13. There have been some instances where NSPs have participated in policy discussions and formulation (e.g. during the design of the health and population sector programme (HPSP) and during formulation of the national health policy. However, this has not been a regular feature.

14. The main strategy for regulating NSPs is through legislation. Regulations are in place for most key inputs of health care, including; premises, equipment, and education and licensing of medical and health workers (World Bank 2003). However, they are not effective, largely due to poor capacity and lack of resources within government to enforce regulations. The other main approach to regulation of NSPs is by self regulation through professional bodies and associations. The Bangladesh Medical and Dental Council (BMDC) are responsible for undertaking and enforcing registration of doctors. However, it acts more like a trade union, serving to protect the interests of members as opposed to ensuring good practice through disciplinary actions and capacity development efforts.
**Trends in reforms and strategic choices**

15. There has been a growing acknowledgment on the part of government of the potential advantages for contracting NGOs to deliver health care. They are more willing to go to remote and underserved areas, are able to develop a good rapport with communities, and are particularly good at providing care to certain client groups (e.g. sex workers and men who have sex with men). However, thus far government contracting of NGOs has only been undertaken using special funds (loans or grants). Recently, the MOHFW has indicated an interest to contract out 350 community clinics to NGOs. Community clinics are owned by government and represent the first tier in the health delivery infrastructure.

16. The draft Sector Investment Plan for the second sector wide programme (called Health Nutrition Population Sector Plan (HNPS)) provides an indication of policy intentions with respect to the private health sector. The plan stresses the need to shift government role from one of “provider” of health care to that of “steward” of the sector. This includes taking on a more active purchasing role, as well as promoting better use of the private health sector through broad based information campaigns. Another new intervention included in the SIP is a demand side financing pilot for maternal care. Under the scheme, private providers will be accredited prior to their participating in the scheme. To date, government has not recognised the need to intervene with respect to the unqualified private sector, even though these are the most important providers for the poor.

**Selection of cases of intervention**

17. Three types (and four cases) of public intervention towards NSPs have been selected for more in depth analysis. These include:

- The Health and Population Sector Programme (HPSP) (falling under the policy dialogue category)
- The newly launched demand side financing pilot for maternal health care (falling under the regulation category)
- Two examples of NGO contracting (the Bangladesh Population and Health Coalition (BPHC) and the Urban Primary Health Care Project (UPHCP) (falling under the facilitation/support category)

18. The first case was selected as the sector programme itself provided an opportunity for policy dialogue between state and non-state providers, and an opportunity for donors to highlight the need for greater and more effective public engagement with the non-state sector.

19. The second case, though still in a very early stage of implementation, demonstrates how demand side financing can provide an alternative means to better regulate NSPs. Both for profit and non-for profit NSPs will be eligible to participate in the scheme.

20. The third case comprises in depth studies of two NGO contracting efforts. As already mentioned, NGOs are playing an increasing role in health service provision (in 2000/01 they accounted for about 9% of total health expenditure). Moreover, they are the most successful in terms of targeting the poor (14% of NGOs users are from the poorest 10% of the population). The main reason for this growth appears to be

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2 HNPSP is the successor to the first sector programme - HPSP
increased donor funding of the sector. There is no doubt that recent government interest in NGO contracting is a result of positive experiences of donor funded initiatives\(^3\) and the donor push for government to scale up NGO contracting.

2. THE CASE STUDIES

2.1 The Health and Population Sector Programme (HPSP)

21. The Health and Population Sector Programme (or HPSP), launched in 1998, marked a radical departure from previous government health plans. This was the first attempt in Bangladesh to move away from a projectised approach to supporting the health sector towards coordinated donor support of a sector wide plan. As in other Sector Wide Approaches (SWAps), the key features were:

- One plan and expenditure framework for the sector, outlining strategic priorities and objectives for the sector and allocation of resources to reflect these priorities
- Covers entire sector (public/private, rural/urban, health/non-health)
- Donor inputs coordinated in support of the sector plan
- Performance based
- Joint annual monitoring by donors and government, ending with a policy dialogue forum

22. The main elements of HPSP were: (a) a focus on an essential services package (ESP), (b) reorganisation of the service delivery system, (c) integrated support services, (d) hospital support services, (e) sector-wide programme management, and (f) policy and regulatory action for enhanced sustainability, accessibility, affordability and quality of services. These components were geared towards contributing towards the programme goal of improving health and family welfare status among the most vulnerable women, children and poor of Bangladesh (MOHFW 1998).

23. The SWAp provided an opportunity for policy dialogue between state and non-state providers, and an opportunity for donors to highlight the need for greater and more effective public engagement with the non-state sector. There was good involvement of NSPs during the formulation of HPSP. However, subsequent involvement of NSPs during implementation of the sector programme, though envisaged (e.g. participation of civil society and professional associations in the annual performance reviews), was minimal. Representatives from the Doctors Association of Bangladesh (DAB) and the Bangladesh Medical Association (BMA), participated in only one of the biannual policy dialogue sessions over the five year programme.

24. With respect to participation in design of the sector programme, NSPs were represented on the six task forces that were set up to guide development of the Health and Population Sector Strategy (HPSS) (which provided the guiding framework for HPSP). This included representatives of NGO apex bodies (such as the Association of Development Agencies in Bangladesh (ADAB) and the Voluntary Health Services Society (VHSS), as well as member NGOs themselves (such as Naripokho). The private for-profit sector also participated in HPSP formulation (though on a more hands off basis than NGOs). This included the Bangladesh Medical Association (BMA) (representing the interests of private sector doctors), and

\(^3\) Three examples of large scale NGO contracting are funded by DFID, USAID, and ADB
representatives of rural medical practitioners, *unani*, *ayurvedic* and homeopath practitioners.

25. It is difficult to comment conclusively on the degree to which NSP (and donor) participation in HPSP design influenced the way in which private sector strategies are reflected in the sector plan. However, what is evident is that HPSP gives greater emphasis to the NSP sector, than have previous plans. Three main areas were emphasised:

- Greater collaboration between government and NGOs, through contracting
- A need to better understand the capacity of the for-profit private providers to take on a greater role in ESP delivery
- Development of a new private clinic bill

26. With respect to the first area, HPSP outlines a broad framework for GOB-NGO collaboration in ESP delivery, including:

- Principles of collaboration
- Scope of NGO roles and responsibilities
- Process of involvement at national and local level policy, planning and implementation
- Fund disbursement mechanism
- Mechanism for promotion and delivery of ESP
- Mechanism for monitoring and accountability of greater transparency
- Mechanism for reviewing the legal and regulatory framework
- Review of the basis and process of collaboration

27. A special Gender NGO Stakeholder Participation Unit (GNSP) was to be established, tasked with development of a more detailed strategic framework to guide GO-NGO collaboration.

28. There appears to have been good participation of NSPs in design of the sector programme, and some success at including key interventions towards the private sector into HPSP. However, the key question remains “to what extent was HPSP able to take forward and implement the proposed NSP initiatives?”

29. An independent technical review (ITR 2003) conducted towards the end of the sector programme concluded “HPSP had created very little change in public-private (including NGO) relationships”. In particular, the report pointed to the lack of progress with NGO contracting for the delivery of BCC and HIV/AIDS targeted prevention programmes.

30. Donors continued to raise the need for more effective policy towards NSPs during each biannual policy dialogue. MOHFW asked BPHC (the DFID funded NGO programme) to assist them in the development of a government–NGO collaboration strategy. The strategy was to outline the scope and role of NGOs in health care, identify options for funding the sector, develop commissioning principles, and propose an institutional mechanism for operationalising the strategy. Although a start was made with Strategy development, it has still to be completed.

31. Very little progress was made with passing of the new private clinic bill. The clinic bill aimed to update the clinic act of 1982. The bill was strongly resisted by the Bangladesh Medical Association (BMA) and the Doctors Association of Bangladesh. The latter exerted considerable pressure on government to withdraw the “penalisation
clause”. The bill is currently with the Ministerial Committee for their comments and consideration.

32. An in-depth private sector assessment was conducted towards the end of HPSP (World Bank 2003), aimed at better understanding the structure, size, and scope of the non-state health sector, and make recommendations on how best to harness the sector to help meet national health goals. Findings of the study appear to have informed to some extent the design of HNPSP (the second sector programme currently at appraisal stage). For example, HNPSP mentions the need for increased emphasis on the role of MOHFW as purchaser of health and more effective steward of the sector overall. However, HNPSP still makes no reference to the need for a strategy aimed at the unqualified sector.

33. Although the SWAp appears to have been somewhat successful in getting NSP interventions onto the health agenda (and in promoting some dialogue between government, NSPs, and donors), there has been mixed success with respect to implementation of the strategies. Direct commissioning of NGOs by government departments did not get off the ground during SWAp period. The main reason appears to be institutional and technical capacity constraints, as well as possibly a lack of willingness to use government funds for contracting. The mid-term review of the World Bank’s HAPP Project (which intended to contract NGOs to deliver HIV/AIDS prevention and control activities) suggests that lack of progress was due to inadequate preparation of the project before approval, unclear implementation arrangements, and lack of capacity.

34. The change of government midway through the sector programme also resulted in considerable implementation delays. The new government did not accept several of the key proposed reforms, which led to the stalling of the entire programme.

35. The main reason for failure to adopt the new private clinic bill appears to be the continued opposition of the professional bodies.

2.2 Demand side financing for maternal health

Introduction

36. To date almost all public health subsidies in the country have been provided through supply side financing approaches, mainly through the funding of publicly owned, staffed, and run health facilities. In some cases financing has been provided to private health providers through purchasing or contracting agreements. A major drawback of such supply side financing approaches is that they do not provide an accurate means for targeting scarce public resources on poor and vulnerable populations. There is evidence in Bangladesh that the better off are disproportionately benefiting from public health subsidies. Contracts with private providers often include an agreement to provide free beds and/or subsidised care to the poor. These agreed subsidies for the poor are rarely forthcoming, largely because they are difficult to enforce and/or monitor.

37. Demand side financing (DSF) provides a means for better targeting the poor and vulnerable since resources go directly to beneficiaries and it is they who are responsible for gaining access to services. DSF is defined as a means of transferring purchasing power to specified groups for the purchase of defined goods and services. Purchasing power can be in the form of vouchers, stipends, grants, or loans, and scholarships. DSF has widely been used in the education sector in Bangladesh,
through provision of a stipend to girls to encourage school enrolment. Vouchers entitle the beneficiary to discounted or free goods and services. Typically, such schemes provide consumers an element of provider choice.

38. Apart from potential equity gains, DSF can have a number of other advantages (Standing and Harding 2003). Chief amongst these are improvements in quality standards by introduction of greater competition and choice between providers, including the private sector.

**Description of the intervention**

39. Promotion of skilled attendance at delivery has been identified as one of the most effective interventions for lowering maternal and neo-natal mortality. At present in Bangladesh the majority of deliveries take place in the home, attended by traditional birth attendants (TBA) (either trained or untrained). International evidence suggests that TBAs, even when they are trained, have limited impact on maternal and neo-natal mortality. A demand side financing pilot scheme has recently been launched by the MOHFW with support from WHO, aiming to increase levels of skilled attendance at birth among the poor (WHO 2003). It is to be introduced initially in 31 Upazillas (a sub-district administrative unit serving approximately 0.25 million population). Currently preparation activities are underway in the pilot sites.

40. Under the scheme, poor pregnant women will be given vouchers, which they will be able to exchange for a package of maternal services from a panel of accredited providers (both public and private). The contents of the package includes: ANC, PNC, normal delivery and if needed emergency obstetric care (include caesarean). The value of the voucher is estimated at Taka 500 ($10.00) of which normal delivery accounts for Taka 150.

41. Poor pregnant women are to be identified on the basis of an existing poverty reduction scheme – the Vulnerable Group Development (VGD) Programme. The programme is run by the Department of Women Affairs and the Directorate of Relief and Rehabilitation, with support from the World Food Programme. A local committee is responsible for identifying eligible women (categorised as those owning less than 0.15 acres and a household income of less than Taka 300 ($6.00) per month. It is anticipated that half of all pregnant women in pilot sites will be eligible to receive the DSF voucher.

42. Pregnant women with vouchers are required to register with an accredited provider of their choice. These are pre-approved providers who have been judged to have met certain minimum standards of quality. A number of checklists have been developed defining standards to be met with respect to skills of medical personnel, availability of supplies and equipment, and physical infrastructure (e.g., laboratory, labour room etc). Accreditation is to be undertaken by a special body (comprising officials from professional bodies, such as the Obstetric and Gynaecological Society of Bangladesh and the Bangladesh Nursing Council). Although, the pilot has been launched accreditation of providers is still to take place. Certain professional bodies objected to the use of the word "accreditation", and it has been replaced with the word "designated" providers. Designated providers are still required to meet the same quality criteria.

43. The DSF pilot protocol does not contain much information on the types of private providers who are likely to participate in the scheme, nor does it provide information on their relative numbers and distribution. For example, are most of the participating
private providers likely to be small nursing homes or individual practitioners operating from their home?

**Institutional arrangements**

44. Special committees are to be established at the Union level (sub-Upazilla unit) to oversee and manage the DSF scheme. Membership is to comprise Union Parishad members (locally elected bodies) (particularly female elected representatives), government health workers, NGO representatives and schoolteachers. Responsibilities of committees includes selection and distribution of vouchers to eligible pregnant women, disseminating information regarding the scheme, A Union Parishad DSF committee will support and oversee the Union committee. An important task of this committee will be reimburse providers on submission of vouchers.

**Factors likely to effect performance**

45. Since the intervention is still not up and running, it is not possible to report on performance as yet. However, factors that are likely to influence performance, and particularly the successful reaping of benefits inherent in DSF are discussed. As already mentioned the main benefits of DSF are increased equity of health spend and improvements in the quality of care. Equity improvements will rely on how reliable and precise the targeting approach for vouchers is. The VGD is an up and running targeting scheme and therefore well tried and tested. However, scope still exists for leakage of vouchers to the non-poor through corrupt practices.

46. Competition theory tells us that in the event of a fixed price, providers will compete on the basis of quality. However, for this to happen there needs to be a sufficient number of providers available, willing and able to participate in the scheme. The likely pool of available private providers is uncertain (the pilot protocol makes no mention of types and numbers of providers likely to be present within an Upzailla or Union). There is also the risk of collusive behaviour among providers and for anti-competitive practices to take place. It remains to be seen whether the scheme will provide sufficient incentives to public providers to perform well. The scheme proposes paying public providers a financial incentive for their participation. Support from both public and professional associations will be critical to its success. As mentioned, they objected to the use of the term accreditation, agreeing for it to be re-placed with the term with designated.

47. The scheme requires considerable capacity within the Upazilla and Union committees to manage and oversee the pilot. There is a risk of corrupt practices if sufficient checks and balance are not introduced to DSF management, for example the vouchers could be bartered in the open market or collusion could take place between DSF committee and providers.

48. On a positive note, policy makers have clearly shown an interest in this new financing approach, even though it diminishes their direct control over health resources. The Sector Investment Plan (SIP) of the second sector wide programme (HNPS) includes the scaling up DSF based on the outcome of the pilot. It remains to be seen whether it will be a success in the Bangladesh context.

**2.3 NGO Contracting**

49. Public contracting of NGOs for health care delivery has mostly been undertaken with use of special funds (either donor loans or grants). However, there is increasing recognition among government officials of the advantages of entering into partnership
with the NGO sector. A main objective of NGO contracting is the expansion of service delivery to the poor (in both urban and rural settings). NGO are seen to be more willing and motivated to serve in remote and difficult settings. Another reason is that they are seen to be better able to address health concerns of certain clients groups, such as sex workers, men who have sex with men, and injecting drug users.

50. Contracting theory suggests a number of advantages over direct government provision. It:

- Allows policymakers to focus on outputs not inputs
- Helps overcome absorptive capacity constraints
- Takes advantage of the private sector’s greater flexibility and autonomy
- Uses competition to increase effectiveness and efficiency
- Makes transparent cost, quality and quantity (and therefore a powerful regulatory instrument as well)

51. However, a number of potential difficulties are associated with contracting. It:

- Can only be done on a small scale and therefore cannot make a difference at country level
- Is more expensive than government provision and therefore not sustainable
- Will not help reduce inequities in health service delivery

(Loevinsohn, B and Harding, A 2004)

52. Two cases of contracting out in Bangladesh are examined and an assessment made of the extent to which they were able to reap the benefits inherent in contracting, and overcome identified difficulties.

2.3.1 The Bangladesh Health and Population Consortium (BPHC)

Background

53. In 1998, the Government of Bangladesh (GOB) embarked on implementation of the country’s first sector programme in health – The Health and Population Sector Programme (HPSP). A central component of the programme was targeting of public resources on delivery of an essential service package (the ESP), aimed at improving health and family welfare of women, the poor and other vulnerable groups. This included contracting NGOs to deliver the ESP to remote and disadvantaged populations. Another key strategy of HPSP was the establishment of a new tier of health facility at the village level – called the community clinic. In 2003, the MOHFW requested three intermediary NGOs to take over the management of community clinics on a pilot basis. Based on this experience, government has decided to contract out the management of a further 350 community clinics to NGOs.

Description of the intervention

54. Under the broad umbrella of HPSP, the Bangladesh Population and Health Consortium (BPHC) (through its Public-NGO Partnership (PNP) programme) has contracted a total of 35 NGOs to deliver different components of the ESP to remote and underserved rural populations. Together, the NGOs serve approximately 2 million people. BPHC was one of the three intermediary NGOs requested to participate in the community clinic pilot. Six of BPHC’s contracted NGOs took on management
responsibility of six government community clinics for a period of one year. This case examines BPHC’s experience with both NGO contracting for ESP delivery as well as with management of government community clinics.

**i) NGO contracting for ESP delivery**

55. BPHC started as a project of DFID (then the Overseas Development Administration) in 1988 with the main objective of supporting local NGOs to deliver maternal and child health and family planning services to poor and under-served communities in Bangladesh. The organisation served the following functions:

- Selection of NGOs
- Strengthening capacity of NGOs
- Channelling funds to NGOs

56. Since the start of the programme, a total of 100 NGOs have received support from BPHC. During HPSP, the Public-NGO Partnership (PNP) programme of BPHC moved from a model of “commissioning” NGOs to “contracting” them, using principles and procedures of competitive tendering to demonstrate to MOHFW that this was a viable mechanism of service provision. The first contracting exercise took place in 2000, and resulted in 25 NGOs being awarded contracts for ESP delivery. A further 7 NGOs were given contracts for a more limited service package during a second round in 2002. Different tendering methods were used during the two rounds. The first tender was only partially competitive since existing BPHC partners where given preference in those areas where there were no other NGOs working. Moreover, bids were only welcome from NGOs who already had a presence in the assigned areas. The second tender was fully competitive and open to all NGOs who fulfilled minimum criteria.

57. Although the NGOs are contracted directly with donor funds, the government has been involved in the programme in several ways.

58. At the central level:

- MOHFW assigned the areas where NGO services were required
- MOHFW officials participated in the seconding tendering round
- BPHC submits quarterly progress reports to the Line Director ESP in the MOHFW.

59. At the local level:

- Partner NGOs report to the Civil Surgeon at the district level and the Upazila Health and Family Planning Officer at the Upazila level.
- Local health and family planning officials participate in joint monitoring activities

60. BPHC and their partner NGOs were also called upon to facilitate stakeholder consultations during the Annual Programme Review (APR) of the Health and Population Sector Programme (HPSP).

**Contracting process**

61. A limited tendering approach was adopted during the first bidding round. In areas where there were no other NGOs offering services, BPHC invited existing partner NGOs to directly submit proposals. However in those areas where other NGOs were working, expression of interest were invited from both BPHC and non-BPHC NGOs.
Based on these principles, BPHC identified 63 upazilas where its partner-NGOs were providing services. A total of 70 NGOs (of which 36 were already BPHC partner NGOs) were invited to submit expressions of interest. Of these, 56 were invited to submit full proposals. The proposals were reviewed and scored first by a member of the professional staff of BPHC, and then by the Team Leader or an external consultant. The scores obtained from the two reviews were averaged to arrive at a final score. In case of a large discrepancy between the two reviews, the proposal was sent to an external reviewer for scoring. 28 NGOs were successful and received contracts (of which 26 were existing BPHC partner-NGOs).

62. The second tendering round was more open and competitive. A newspaper advertisement was placed inviting NGOs to submit proposals to deliver select interventions (HIV/AIDS, safe motherhood services and adolescent care) in pre-selected areas. 179 NGOs collected the information pack (containing a TOR and information on the bidding process), and 59 NGOs submitted proposals. The proposals were scored by internal and external reviewers. Eleven NGOs were short listed, and a final selection was made on the basis of field visits to the NGOs sites. Seven NGOs received contracts (none of whom were previous BPHC partners).

**Monitoring and evaluation**

63. BPHC is responsible for monitoring the performance of contracted NGOs. A management information system has been established which provides details on health status, service coverage, and financial progress. NGOs are required to submit monthly progress reports.

**ii) NGO management of community clinics**

64. In 2003, 6 BPHC contracted NGOs took over management responsibility for 6 community clinics in 6 Divisions of the country on behalf of the MOHFW. The main aim of the pilot was to develop an effective, sustainable and replicable model of a community clinic that could be rolled out on a national basis. The specific objectives of the project were to:

- strengthen the capacity of community groups to manage the CCs;
- examine the facilitation role of NGOs in the management of CCs;
- develop systems to effectively target the poorest in the community;
- develop an effective referral mechanism;
- examine the willingness of the community to pay the cost of quality services; and
- develop the ownership of the community.

65. Each NGO signed a Memorandum of Understanding (MOU) with the Directorate General of Health Services (DGHS) and Union Parishad (sub Upazilla administrative unit) of the area assigned to it. This MOU, like a contract, laid down the terms and conditions under which the NGOs were required to operate the CCs. The main terms and conditions were:

- The selected NGO would provide specific ESP components from the CC through two qualified staff members without any manpower assistance from the government.
- The clinic would also provide specific domiciliary services.
- The cost of running the CC would be fully borne by the NGO/donor.
• The government, for its part, would provide the CC with all drugs, contraceptives, equipment and consumable supplies that it normally provided to other CCs.
• The CC would be operated by the NGO in collaboration with a Community Clinic Management Group (CCMG) formed by the Union Parishad according to set guidelines. One of the NGO staff assigned to the CC would serve as the Member-Secretary of CCMG.
• The NGO would be responsible for running, managing and supervising the CC with BPHC’s facilitation. Local government health officials would also exercise routine oversight of CC operations in keeping with their responsibility to monitor the provision of basic health services in their jurisdiction.
• The NGO would document the number of clients served, commodities supplied and specific services rendered in the CC on standard reporting formats and provide service statistics to the respective Upazila health officials on a monthly basis.

(BPHC 2003)

Performance of NGO contracting

i) ESP delivery

66. Performance with respect to health impact and service coverage

67. Table 3 compares key health performance indicators for the 27 BPHC NGOs contracted during the first bidding process in 2000 with the national average. NGO performance is based on the programme’s management information system, while the national figures are derived from a variety of surveys (source years vary for BPHC and national indicators, however they still provide a rough comparison).

Table 3: Comparison of Key Health Indicators

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>27 BPHC NGO Areas</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Service coverage (%)</td>
<td>(2002)</td>
<td>(1999-00)</td>
</tr>
<tr>
<td>a) Three or more visits for ANC by pregnant women</td>
<td>73.2</td>
<td>17.3</td>
</tr>
<tr>
<td>b) Two TTs for pregnant women</td>
<td>89.7</td>
<td>61.8</td>
</tr>
<tr>
<td>c) Deliveries attended by qualified persons</td>
<td>12.4</td>
<td>8.6</td>
</tr>
<tr>
<td>d) At least one PNC within 42 days after delivery</td>
<td>72.8</td>
<td>16.1</td>
</tr>
<tr>
<td>e) Use of modern contraception</td>
<td>57.9</td>
<td>43.4</td>
</tr>
<tr>
<td>f) Measles vaccination of children (12-23 months)</td>
<td>78.2</td>
<td>68.9</td>
</tr>
<tr>
<td>g) Treatment of ARI among children under 5 years</td>
<td>89.2</td>
<td>27.2</td>
</tr>
<tr>
<td>a) Infant mortality (per 1000 live births)</td>
<td>32.5</td>
<td>66.3</td>
</tr>
<tr>
<td>b) Child mortality (per 1000 live births)</td>
<td>9.6</td>
<td>29.7</td>
</tr>
<tr>
<td>c) Maternal mortality ratio (per 100,000 live births)</td>
<td>203</td>
<td>377</td>
</tr>
</tbody>
</table>


68. It shows BPHC NGOs perform above average for all health indicators. The most striking difference is for the infant mortality rate. IMR among BPHC NGOs is half that of the national average.
69. The output to purpose review conducted by Lenton et al notes that contracting has led to lower service costs. Cost per client served by the 27 NGOs decreased from Taka 241 in 1999 (before contracting) to Taka 61 in 2002 (after contracting) – a reduction of almost 75%. The review cautions that a decrease in price should not be at the expense of quality or of targeting the most underserved populations (who are often more costly to reach). Unfortunately, it is not possible to comment on this, since the programme has not systematically monitored quality of care or proportion of poor users prior to and after contracting.

70. The review also compared the costs of the contracting process in 2000 and 2002. These calculations show that the cost of the first bidding was almost twice that of the second (Taka 1.8 million compared to nearly Taka 1.0 million). The difference is mainly made up of the costs involved in conducting a technical and financial review of the short-listed proposals and final contract negotiations. The value of contract per contracted Taka (i.e. the total value of contracts divided by total costs of contracting) was almost 5 times higher in 2000 (Taka 77 compared to Taka 16).

6 Performance with respect to reaching the poor

71. The extreme poor account for 33% of all clients served by the 27 NGOs. Prior to this phase of contracting, the extreme poor accounted for 23% of BPHC NGO users (Lenton et al), implying all other things being equal that contracting had actually served to increase access by the poor. This compares to government health facilities where the poorest 5th of the population account for only 14% of all users (MOHFW 2004).

ii) Community clinic management

Performance with respect to services provided

72. BPHC managed community clinics provided a broader range of services than government run community clinics. In addition to core ESP services (such as maternal health, child health, communicable diseases control, limited curative care, and health education), some of the clinics were also providing pathological tests, such as blood grouping, pregnancy test, and blood sugar test.

Performance with respect to client numbers

73. Client numbers rose substantially after the NGOs took over management responsibility for community clinics - from 12 clients per day to 39 clients per day (this excludes those participating in health education classes).

Performance with respect to reaching the poor

74. Unfortunately, it is not possible to compare use of services by poor before and after NGO management. However, it is estimated that approximately 35% of the clients

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4 Cost of ESP service delivery included the cost of (a) preventive and curative services, (b) visits to every household in the catchment areas by field workers every 1-2 months, (c) village-level health promotion activities, and (d) BPHC supervisory/technical support and administration.

5 Contracting costs were calculated by estimating the time BPHC personnel spent on each major stage of the contracting process. Costs were allocated at current prices to time spent on the bidding process, the actual costs of travel and accommodation, plus 5% of the total overhead costs for the period of the contracting process.
who used NGO run clinics were very poor. The poor were identified on the basis of a household survey, and categorised into one of three categories - poorest, poor, and well-off. Households were given referral slips according to their economic category. The very poor were either fully exempted from service charges or provided subsidized care.

Performance with respect to quality of care

75. All NGO run clinics were renovated, and had running water supply. Five out of six had an electricity connection.

Performance with respect to increased stakeholder participation

76. A Community Clinic Management Group was formed at each site. CCMGs were actively involved in the operation of the clinics, for example in preparing service delivery schedules, renovating and furnishing the CCs, finalising service charges for different socio-economic groups of clients, communicating with and raising funds from different stakeholders of the community, operating the bank account, participating in Union Parishad meetings, etc. Community and religious leaders also actively helped in promoting community clinic service delivery.

77. A rickshaw van committee and boatman committee was established to support transportation of emergency cases, especially obstetric care.

Performance with respect to linkages with government

78. The NGOs and members of CCMGs regularly met and maintained good relationship with various government officials like Civil Surgeon and Deputy Director – Family Planning (at the district level) and Upazila Health and Family Planning Officer, Upazila Family Planning Officer, Medical Officer – Maternal and Child Health (at the upazila level), etc. Government officials frequently visited the CCs to supervise and monitor progress.

2.3.2 The Urban Primary Health Care Project (UPHCP)

Background

79. Bangladesh’s urban poor suffer from the worse health status in the country. This is largely a result of higher rates of infectious diseases due to high population densities, poor ventilation and inadequate nutrition, together with low PHC coverage. For example, measles immunisation coverage for urban slum populations in Dhaka and Chittagong is 61%, compared to 92% among non-slum dwellers and 78% in rural areas. Government investment towards meeting health needs of urban poor has been low. Prior to the intervention, each major city had only a handful of government owned dispensaries; roughly half of which were run by MOHFW and half run by the city corporation. The main providers of health care in urban areas remain the for profit and non-for profit private providers.

Description of the Intervention

80. In recognition of the need to better serve the health needs of the urban poor, four city corporations in Bangladesh (Dhaka, Chittagong, Rajshahi and Kulna) with funding from the Asian Development Bank (ADB) have entered into partnership agreements with NGOs for the delivery of primary health care (PHC) in and around urban slum
areas. The project comprises four main elements: i) provision of PHC through partnership agreements; ii) strengthening the urban PHC infrastructure; iii) building capacity of the city corporations and their partners to manage, finance, plan and evaluate health care provision; and iv) support for project implementation and operations research. An overarching objective was to “introduce structural reforms designed to change the role of the government and alter the way it relates to the private sector, including non-government organisations (NGOs)” (ADB 1997)

81. The four cities were divided into 16 partnership areas each corresponding to between 250,000 and 400,000 population. Partnership agreements were awarded on a competitive basis in two phases. Services to be provided included: immunisation, micronutrient support, family planning, prenatal, obstetrical and post natal care, BCC, and management of childhood ailments and TB. Partners were required to provide services from purpose built maternity centres, primary health care centres (PHCC), and on an outreach basis. However, in those areas where health facilities had not yet been built, partners provided care from rented premises. UPHCP started in 1998, the first 8 partnership areas were put out to tender in September 1999, and contracts signed in May 2000. The second round of contracting took place in late 2001. The total population served is 4 million.

Contracting process

82. A special project implementation unit (PIU) located within Dhaka City Corporation was responsible for managing the contracting process. Tenders were open to any private health provider with prior experience in Bangladesh, such as NGOs, for profit private sector groups or provider associations. The city corporations themselves were also permitted to participate in the bid. To be eligible to bid, NGOs were required to be registered with the NGO Affairs Bureau, while groups of private practitioners were required to be legally incorporated and either to be members of the Bangladesh Medical Association or the Bangladesh Private Practitioners Association.

83. Contractors were selected on the basis of quality of technical proposals and on the bid price. The evaluation committee first scored technical proposals using pre-agreed evaluation criteria. Financial proposals were only opened for those bidders with a sound technical proposal. The final score comprised both a technical and financial score. Bidders were encouraged to incorporate a cost recovery strategy in order to keep cost down but also for purposes of financial sustainability. During both tender rounds, the evaluation committee comprised members from the local government division, donor representatives (ADB, UNFPA, WHO) and the private sector (ICDDR,B).

84. During the first tendering round a total of 44 proposals were received, and 9 partnership agreement contracts awarded. Of these, eight contracts went to seven NGOs and one was awarded to the Chittagong City Health Department (CCHD) (representing a form of internal contract). The cost per beneficiary per year of winning bids averaged $0.64 (ranging between $0.42 to $0.98). The similar price per beneficiary of CCHD with contracted NGOs provided a natural control site, enabling performance to be compared between a contract with a private provider and one with a public provider. During the second tendering round, all seven contracts were awarded to NGOs.

85. Contracts specified the types of services to be provided, as well as coverage targets to be reached. They did not specify how the services should be delivered, thus allowing scope for innovation. A baseline survey was undertaken in all partnership areas prior to awarding contracts. Contracts emphasised meeting health needs of the
poor. They also included an element of performance related pay. Partners were to be given a bonus payment if set targets were reached. Medicines had to be purchased from one of six pre-selected pharmaceutical companies who had won competitive bids.

**Monitoring and evaluation**

86. Responsibility for monitoring contract implementation is shared between the following three parties:

- A contracted private firm (Mitra and Associates in collaboration with John Hopkins University)
- The PIU
- City corporation zonal health officers

87. Mitra and Associates are responsible for undertaking a mid and end term household and facility surveys, as well as for regular project monitoring. For on-going project monitoring, they have devised a special tool “the integrated supervisory instrument” or ISO aimed at capturing and analysing data on programme management, service coverage, quality, and record keeping. Scores are assigned for each of these programmes elements, and the total used to assign partners into one of four performance categories (excellent, very good, fair and poor).

**Performance:**

- **With respect to service availability**

88. Mid way into the project, it was noted that contracted NGOs faired better than the Chittagong City Corporation (CCC) in terms of range of services they provided and with respect to certain aspects of quality of care (see table 4). This was despite having similar levels of resources.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>NGO PAAs (%)</th>
<th>CCC PAA (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of health centres providing immunization</td>
<td>98</td>
<td>36</td>
</tr>
<tr>
<td>% of health centres providing &gt; 1 family planning method</td>
<td>100</td>
<td>19</td>
</tr>
<tr>
<td>% of health centres providing laboratory (haemoglobin) tests</td>
<td>63</td>
<td>18</td>
</tr>
<tr>
<td>% of prescriptions provided with a specific diagnosis</td>
<td>93</td>
<td>63</td>
</tr>
<tr>
<td>% of clients saying that waiting times were acceptable</td>
<td>75</td>
<td>63</td>
</tr>
</tbody>
</table>

Source Loevensohn and Harding (2004)
(Includes only first round PAAs)

- **With respect to ISO scores**

89. The supervisory monitoring report from Mitra and Associates (2003) noted that five PAAs had attained excellence, eight were performing well and two were in the Good category, only one in the Fair category and none in Poor category. Overall all partners had improved since the last round of monitoring, when none were in the excellent category. Of the three agreements with the Chittagong City Corporation, one scored Very Good, a second Good, and the third Fair. The same monitoring report shows that half of the partners were not able to reach even 50% of their cost recovery targets, indicating that target may have been ambitious.
- With respect to service coverage

90. Table 5 shows performance of all 16 PAAs with respect to uptake of select PHC services in the partnership areas as indicated by a household survey. It compares service utilisation rates achieved at mid term with those prior to the intervention (baseline survey).

<table>
<thead>
<tr>
<th>PAA</th>
<th>% pregnant women who received at least one ANC</th>
<th>% of deliveries attended by trained personnel</th>
<th>% of children fully immunised before 1 year of age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (Mid Term)</td>
<td>Baseline (Mid Term)</td>
<td>Baseline (Mid Term)</td>
</tr>
<tr>
<td>Dhaka</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAA1</td>
<td>65.4 (89.1)</td>
<td>49.7 (63.8)</td>
<td>57.4 (59.4)</td>
</tr>
<tr>
<td>PAA2</td>
<td>89.1 (92.8)</td>
<td>72 (86.1)</td>
<td>61.9 (74.1)</td>
</tr>
<tr>
<td>PAA3</td>
<td>73.2 (89.9)</td>
<td>48.7 (71.2)</td>
<td>47.8 (54.6)</td>
</tr>
<tr>
<td>PAA 4A</td>
<td>80.3 (82.9)</td>
<td>56.6 (63.9)</td>
<td>64.3 (61.3)</td>
</tr>
<tr>
<td>PAA 4B</td>
<td>80.3 (68.8)</td>
<td>56.6 (57.9)</td>
<td>64.3 (69.1)</td>
</tr>
<tr>
<td>PAA 5</td>
<td>64.1 (85.3)</td>
<td>46.7 (63.2)</td>
<td>46.4 (60.6)</td>
</tr>
<tr>
<td>PAA 6</td>
<td>80.9 (83.0)</td>
<td>65.3 (74.4)</td>
<td>73.0 (72.0)</td>
</tr>
<tr>
<td>PAA 7</td>
<td>71.9 (78.2)</td>
<td>39.5 (49.6)</td>
<td>50.1 (54.6)</td>
</tr>
<tr>
<td>PAA 8</td>
<td>70.8 (85.7)</td>
<td>47.8 (57.1)</td>
<td>62.6 (64.4)</td>
</tr>
<tr>
<td>PAA 9 and 10</td>
<td>61.7 (54.5)</td>
<td>39.3 (49.4)</td>
<td>52.6 (74.7)</td>
</tr>
<tr>
<td>Chittagong</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAA 11</td>
<td>47.7 (76.9)</td>
<td>28.3 (41.6)</td>
<td>63.0 (71.5)</td>
</tr>
<tr>
<td>PAA 12</td>
<td>63.9 (80.7)</td>
<td>36.4 (40.7)</td>
<td>58.5 (63.1)</td>
</tr>
<tr>
<td>PAA 13</td>
<td>-- (74.0)</td>
<td>-- (41.7)</td>
<td>-- (64.0)</td>
</tr>
<tr>
<td>Kulna</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAA 14</td>
<td>69.5 (65.2)</td>
<td>43.1 (50.4)</td>
<td>65.1 (64.7)</td>
</tr>
<tr>
<td>PAA 15</td>
<td>74.8 (77.2)</td>
<td>48.5 (61.8)</td>
<td>67.3 (74.8)</td>
</tr>
<tr>
<td>Rajshahi</td>
<td>72.5 (71.8)</td>
<td></td>
<td>66.4 (73.2)</td>
</tr>
<tr>
<td>PAA 16</td>
<td>64.9 (68.6)</td>
<td>47.0 (59.7)</td>
<td>54.1 (73.6)</td>
</tr>
</tbody>
</table>

Source: mid term household survey (Mitra and Associates 2003)

91. With few exceptions, coverage levels have increased for ANC, skilled delivery and immunisation in partnership areas. The CCC appears to have performed as well as NGO partnerships (although one of the three areas has no baseline data thus making a full comparison difficult). It should be pointed out that not all this increase can be attributed to the partnership agreements. The mid term household survey notes that for antenatal care, private doctors and health facilities (other than NGOs) appeared as the major source of care, followed by public health facilities. Around one in ten of mothers interviewed reported they received ANC from UPCHP supported PAA NGO clinic. Broader BCC messages imparted by partners may have also led to an increased uptake of services from non-partner providers.
- With respect to cost

92. The competitive bidding process appears to have kept prices low. Cost per beneficiary per year in partnership areas averaged $0.64. This is 35% lower than that estimated during project design. The cost compares favourably with current spend of about $2.00 per capita on PHC by the Ministry of Health and Family Welfare (largely targeted at rural areas). However, it should be stressed that the costs are not strictly comparable since a large number of the catchments population in urban project sites probably make use of other private providers.

93. There appears to have been sufficient competition during the tender. A total of 44 bids were received for 9 contracts. No contracts were awarded to private providers, suggesting NGOs may have won on the basis of lower costs. One of the partner NGOs interviewed mentioned that the bidding process imposed considerable pressure on bidders to keep costs unrealistically low, i.e. implying that cost mattered more than quality. Cost recovery levels in the bids averaged 15% of total programme cost compared to 11.3% among unsuccessful bidders, suggesting cost recovery was not a strong consideration in bid evaluation.

- With respect to reaching the poor

94. Although UPHCP emphasised meeting the needs of the urban poor, none of the monitoring instruments disaggregated service use by socio-economic status. It is therefore difficult to determine whether the partnerships have disproportionately benefited the poor. However, the fact that health facilities were located close to slums, and outreach services provided within the slums suggests a broad brush targeting approach has been adopted. None of the partners appear to have further differentiated the poor on the basis of whether they are the extreme poor or moderately poor.

95. The mid term review noted that roughly 60%-80% of the beneficiaries are poor, and that on average about 20% of patients received free medicines.

Other issues related to contracting performance:

- Payment of contractors

96. Some partners complained of delays in fund disbursement early in contract implementation. However, payments now appear to be made fairly promptly. To date no performance bonuses have been given. PIU reported that they do intend to give 5 to 6 NGOs an additional 30 lakhs each (over and above the contract price) as a result of good performance (measured in terms of numbers of patients seen, scope of services provided, and level of cost recovery).

- Supply of drugs and commodities

97. The mid term review notes that some partners encountered problems in drug procurement because some pre-qualified suppliers were interested only in supplying drugs in large amounts. Also that the quality of furniture procured from pre-qualified contractors was of poor quality.

- Degree of innovation

98. Contracts specified service targets to be reached but not the process for reaching them. As a result, some partners have developed innovative strategies for reaching
the urban poor. For example, one of the partners provides outreach care to women working in garment factories. Workers and their employers contribute to a health card, which entitles the worker to a fixed package of PHC. The same partner also runs a school health programme.

**Explanation of performance (BPHC and UPHCP)**

99. It is clear from the above evidence on performance that positive incentives inherent in contracting have been reaped by both BPHC and UPHCP. For example, the emphasis on achievement of outputs and outcomes, together with rigorous and objective monitoring has resulted in increased coverage of high quality ESP/PHC services among the poor. It could be argued that it is the special dedication and motivation of the NGO sector rather than the contracting instrument per se that has resulted in the good performance. However, the fact that the Chittagong City Corporation (under the UPHCP case) has also performed well negates this hypothesis. CCC did appear to be under performing during the early stages of the contract. However, the mid term household survey suggests that it has managed to make up the lost ground. Anecdotal evidence however does suggest that the CCC has not performed as well as the NGO partners (personal communication with project officials), suggesting that ideological and motivational factors may play a role.

100. Competition does appear to have driven down costs, while at the same time maintaining quality (sufficient numbers of NGOs participated in the different tendering processes to create adequate competition). Cost of services provided by BPHC and UPHCP partners compare favourably with those in government. This data refutes the claim made by government that NGOs perform well because they are better resourced than government. However, some caution should be exercised in reaching this conclusion since it is unclear whether NGO and government costs are directly comparable. For example, both should include overhead management and monitoring costs. No contracts were awarded to private providers (under UPHCP project), suggesting that NGOs and government bodies may have a price advantage over the for profit sector.

101. Under the same contracting arrangements in UPHCP, the NGO partners appear to have innovated considerably more than the CCC with respect to modes of service delivery and programmes. It is not possible to comment on whether this has resulted in better impact. Also intuitively one would assume NGOs are better at facilitating community involvement in project implementation and management (all partners have established local committees in partnership areas for broad oversight of the programme). This was especially successful in the community clinic management intervention.

102. Although none of the contracts outlined specific targets for reaching the poor, all contracted NGOs were successful in reaching the poorest. They comprised about a third of all clients of BPHC NGOs. NGO contracting has also successfully gone to scale – coverage populations under both UPHCP and BPHC are substantial.

103. All examples of NGO contracting were undertaken with special funds (i.e. loan or grant money), and with special institutional arrangements for undertaking contracting (a project implementation unit in the case of UPHCP, and an independent implementing agency in the case of BPHC). Whether the same result would have been achieved with government resources and more direct involvement of government in the contracting process remains to be seen. However, the examples do provide valuable lessons for government. For example, as seen in UPCHP case, participation of multiple stakeholders on the tendering committee minimises the scope
for corrupt practices to take place. Similarly, monitoring of contract compliance is best undertaken by a specialised agency.

104. The type of capacity that contracting requires depends very much on the model of contracting that is adopted. For example, capacity requirements would be significant if government were to undertake contracting directly, including selection of contractees, drawing up contracts, and monitoring of contract compliance. However, if government were to select an implementing agency to take on these roles on its behalf then capacity requirements would be more limited. In this case capacity would be needed to select the implementing agency, and to have broad oversight of the contracting process. The latter model appears to be the more favoured one in the emerging successor sector programme (HNPSP).

105. Capacity development objectives of projects also need to be grounded in the institutional context as well as relate to long-term objectives for contracting. In the case, of UPHCP the long-term objective was unclear. Although capacity development of the city corporation (particularly zonal health officials) was a central objective of the project, it was not clear whether capacity was being developed with the intention of institutionalising the contracting process within the city corporation at the end of the project. Very few of the capacity development objectives were in reality fulfilled during the project.

3. CONCLUSION AND RECOMMENDATIONS

106. This review clearly indicates the need for greater public engagement with NSPs if key health related MDGs are to be met in Bangladesh. The non-state sector is the largest provider of health care. Close to 70% of all health contacts are with NSPs, of which over half are with un-qualified providers. The poor usually consult these providers first, and typically only seek care elsewhere when they do not get better. Un-qualified providers are providing services that directly relate to IMR and MMR, such as treatment for diarrhoea, ARI, malaria, and abortion. However, the quality of care is widely perceived to be poor. The NGO sector has grown considerably over the last decade and is taking on an increasingly important role in health care provision. It has many advantages over public sector, including a willingness to serve in remote areas, and able to target and reach the poor, facilitate community participation in health care planning and management, and address health needs of special client groups, such as sex workers and men who have sex with men.

107. The review suggests that SWAs, with their sector wide perspective, provide an effective forum for promoting dialogue between government and NSPs. While participation of NSPs was fairly good during the design of the HPSP, it did not become a regular feature of the annual performance reviews. In their absence, donors appear to have advocated on behalf of NSPs (particularly with respect to NGOs) during policy dialogue sessions.

108. Although they are the largest single health care provider, no attempt is currently being made to regulate un-qualified practitioners (either by government or civil society). The main reasons for this appear to be professional vested interests and a lack of awareness on choice of available regulatory instruments (such as consumer information, training and accreditation, establishment of referral links etc). The World Bank private sector assessment study showed that findings from such studies provide a useful basis for engaging in policy dialogue with government on this issue. Demand side financing shows promise as an alternative regulatory tool for the
qualified sector. Competition among NSPs together with the accreditation process should lead to improved quality of care. However, DSF does demand considerable institutional capacity from government, and it remains to be seen whether this intervention can be successfully scaled up.

109. The two contracting out examples examined were extremely successful. Although conducted with donor funds, they have been useful in demonstrating the benefits of contracting to government, as well as how best to undertake contracting. The UPHCP example suggests that for profit providers are not able to compete with NGOs on a price basis. Government has shown an increasing interest in this policy instrument. Based on the positive experience of the community clinic pilot, GoB intends to contract out a further 350 community clinics to NGOs. This interest notwithstanding, the popular perception among government officials’ remains that NGOs are more expensive and that government could do as well given the same level of resources. There is an urgent need for better data on comparative costs of provision and quality of care in NSPs and government programmes to support or refute this claim. Government officials also expressed concern with weak governance and oversight of the non-profit sector. The studies highlight the importance of addressing capacity requirements for contracting. Donor funded efforts often mention the need to strengthen government capacity to take on new roles (e.g. contracting), however this aspect is often not well addressed in project design.
REFERENCES


Org-Marg Quest Ltd (2000), “Survey on Village Doctors in Brahmanpara”, funded under the public private partnerships project of The British Council and NICARE.


1. INTRODUCTION

1. There are a variety of forms of provision of primary education in Bangladesh, ranging from formal schooling provided by the private sector, communities, faith-based organisations, NGOs and government, to non-formal primary education (NFPE) predominantly provided by NGOs (see Table 1).

2. The 1972 Constitution of Bangladesh committed the state to provide ‘a uniform, mass-oriented and universal system of education and extending free and compulsory education to all children to such a stage as may be determined by law’ (Article 17, cited in Unterhalter et al 2003). Following this commitment, all schools were nationalised in 1973 including those established and supported by communities. The government took over the control of managing primary schools in 1974. Although the commitment to uniform, mass-oriented, free and compulsory education remains, during the 1980s it was recognised that this could be achieved through different forms of service delivery, paving the way for the establishment of Registered Non-Government Schools (RNGPS). Immediately prior to the 1990 World Conference on Education for All at Jomtien, the government introduced the Compulsory Education Act declaring its intention to make primary schooling compulsory in certain parts of the country unless their was a valid reason (such as work) preventing children from attending (Unterhalter et al 2003). This became effective throughout the country in 1993. As a complement to this objective, the government also declared its intention of achieving Education for All by 2000, a date which has since been extended to bring all school aged children into school within the shortest possible time (PMED 2000).

3. As Table 1 indicates, most children are enrolled in Government Primary Schools (GPS), although there are also a sizeable number (approximately one-quarter of enrolment) in Registered Non-Government Primary Schools (RNGPS). Despite problems with obtaining accurate education data are evident (with variations in whether NGO provision is included), sources generally report high levels of gross enrolment rate (ranging from around 90-120%), with an estimated net enrolment rate of 80% (Ahmed 2004). Those most likely not to be in school are from poor households, although enrolment amongst the poor is still relatively high for both boys and girls (Table 2). While Ministry of Education data do not include NGO NFPE programmes, a recent estimate of enrolment in these centres indicates that it caters for around 1.3 million children, comprising around seven percent of total enrolment (CAMPE 2004). Of these, 60 percent are enrolled in the BRAC primary education programme with BRAC also sub-contracting some NFPE programmes to smaller, local NGOs (BRAC nd).

6 The terminology for NGO provision is important and contentious. Some NGOs now prefer to refer to avoid the term ‘non-formal’ as this is often associated with second-rate education. In addition, their programmes follow the same basic curriculum as government schools so they prefer to be called ‘NGO schools’. However, in Bangladesh, there is another category of formal schools which the government handed to NGOs (notably BRAC) to run. For purposes of clarity, we use the term NFPE to refer to the alternative education provided by NGOs to differentiate from the schooling offered by GPSs and RNGPSs.
Table 1: Number and size of schools, 2001

<table>
<thead>
<tr>
<th></th>
<th>schools</th>
<th>teachers</th>
<th>students</th>
<th>% girls</th>
<th>% enrol.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPS</td>
<td>37671</td>
<td>162090</td>
<td>10830742</td>
<td>49.5%</td>
<td>57.2%</td>
</tr>
<tr>
<td>RNGPS</td>
<td>19428</td>
<td>77233</td>
<td>4163873</td>
<td>49.3%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Community</td>
<td>3268</td>
<td>9162</td>
<td>490456</td>
<td>48.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>High madrasah attache d ebtedaye madrasah</td>
<td>3843</td>
<td>14855</td>
<td>417383</td>
<td>44.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Ebtedaye madrasah</td>
<td>3843</td>
<td>15052</td>
<td>364196</td>
<td>50.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>2477</td>
<td>15052</td>
<td>364196</td>
<td>50.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>High school attached primary section</td>
<td>1576</td>
<td>10515</td>
<td>337543</td>
<td>38.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>NGPS</td>
<td>1971</td>
<td>7888</td>
<td>299345</td>
<td>48.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Satellite</td>
<td>4095</td>
<td>7224</td>
<td>276348</td>
<td>48.1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>NGO primary school</td>
<td>170</td>
<td>676</td>
<td>28864</td>
<td>47.5%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Experimental</td>
<td>53</td>
<td>255</td>
<td>11513</td>
<td>46.9%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Source: PMED 2002

* total enrolment includes those in NFPE (7.1%).

4. The data suggest that most children have access to some form of basic education, with an increase in enrolment (together with a closing of the gender gap) noticeable over the 1990s. The expansion has partly been achieved through the establishment of RNGPS. However, there is general concern that the improvements in access have been achieved at the expense of quality (see, for example, World Bank 2002b; CAMPE 2001). Furthermore, there is also broad agreement for the need ‘to improve management and accountability, reduce corruption and waste, and de-politicize the education system’ World Bank 2002a: 47).

5. Despite gains in enrolment as well as efforts in NFE, there appears to have been more limited change in the literacy rate, with half of the population aged 11 years old and above classified as non-literate, which is a continued cause for concern (CAMPE 2002). This might be partly due to a time lag in the effect of expansion (as younger age groups have higher literacy rates), but might also be because literacy gained is not sustained.

Table 2: Gross enrolment rates by expenditure quintile and poverty status, 2000

<table>
<thead>
<tr>
<th></th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>82</td>
<td>88</td>
<td>85</td>
</tr>
<tr>
<td>Non-poor</td>
<td>100</td>
<td>101</td>
<td>101</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>93</td>
<td>91</td>
</tr>
</tbody>
</table>

Source: World Bank, 2002

6. The two case studies chosen for the study present examples of non-state provision ostensibly driven by communities and local NGOs. These would appear to provide good examples of innovative practice. Indeed, the NGO NFPE is a widely-cited example internationally and has been adopted in other countries including in SSA. The apparently community-driven RNGPS provide a potential example of fostering local accountability through school-based management. The motivations behind these innovations and, importantly, the relations between the non-state providers and government, are likely to have important lessons for other countries.

7. Given the relative importance of RNGPS in providing schooling opportunities to poor children, Case Study 1 explores the support provided by communities and
government to these schools. The second case study examines the relationship between government and NGOs in provision of primary education to the most marginalised. It focuses on issues of contracting and registration of NGOs, as well as policy dialogue between NGOs and government.

8. The work for this paper was constrained by timing, with our short visit occurring soon after severe flooding which meant that some key informants were involved in flood relief at the time of the visit. In addition, unrest following grenade attacks meant that planned appointments with smaller NGOs had to be cancelled. This placed limitations on the case studies that could be investigated. Even so, we were fortunate in meeting with a range of important stakeholders from both the government and NGOs (see Appendix 1), and were also able to benefit from materials available (see Appendix 2).

2. CASE STUDY 1: GOVERNMENT SUPPORT TO REGISTERED NON-GOVERNMENT PRIMARY SCHOOLS

2.1 Overview and selection of case study

9. The case study examines the relationship between government and RGNPS, in particular with respect to facilitation through financial support to schools. RNGPS became established since the change in policy towards nationalisation in the 1980s and, in some respects, resemble schools in existence before nationalisation in 1973.

10. Registration of non-government primary schools is based on legislation in the Bangladesh Registration of Private schools Ordinance 1962, amended by the Registration of Private Schools Ordinance of 1989 (see Appendix 3). After completing the process of registration, RNGPS receive government support through both supply- and demand-side interventions, including:

- Construction and maintenance of school buildings
- Training of teachers at Primary Teacher Institutes
- Payment of 90% of teacher salaries
- Provision of free textbooks
- Inclusion of eligible students in the government’s primary education stipend programme targeted at poor students (see Appendix 4 for eligibility criteria and selection procedures).

11. Once registered, these non-government schools share similarities with GPS in terms of support received indicating blurring of boundaries between state and non-state with respect to financing. The main difference between the types of schools relates to their governance –management of RNGPS is decentralised to the school level (for example teacher recruitment being made by the School Management Committee), while management of GPS is highly centralised (recruitment of teachers undertaken by the Ministry).

12. Officials in the Primary Education Directorate reported that almost all applications for registering non-government schools reaching the Ministry eventually gain approval, although it is possible that some are turned down by the Division before they reach the final stage (otherwise it would be possible to envisage a situation where considerably more schools than required were established). Although there are criteria for establishing a school, it was reported that in practice these have been adopted flexibly until recently. Currently there has been a slowdown in the establishment of new schools - at the last meeting, one quarter of applications were
approved (approximately 100 out of 400). Reasons given for the slowdown include the view that sufficient school places are now available (although class size is still quite large), and so the criteria are beginning to be adhered to more strictly. An alternative explanation is related to the political pressure being exerted by strike action of the Non-Government Primary Teachers’ Association demanding that the schools and their jobs are nationalised, so that teachers in these schools receive the same benefits as those in government schools. Nationalisation is being resisted by the government, no doubt partly due to the financial implications. This is potentially discouraging the government from registering new schools.

2.2 Nature of providers affected

13. As noted, RNGPSs comprise a significant proportion of primary provision, although the intention is that each school operates at the local level, run by a School Management Committee (SMC). They primarily serve relatively poor areas, with a recent study indicating that a larger proportion of those enrolled in RNGPSs are from households below the national poverty line, compared with those in GPSs:

‘RNG schools in Bangladesh...serve the equity objective as they cater more to poorer families than public schools because they are community-based and not really profit-driven’ (ADB 2003a: 28).

14. However, a closer investigation of these schools raises questions about the extent to which they are improving equity in primary schooling opportunities particularly given the lower quality of these schools. For example qualifications of teachers and physical facilities are worse in RNGPS compared with GPS (ADB 2003a; CAMPE 2001; PMED 2000). Despite this, studies indicate that the achievement of basic competencies, which is low overall, are higher on average in RNGPS than in GPS (Figure 1. See also ADB 2003a and CAMPE 2000). The reasons for this require further investigation. Despite this, a higher proportion of those in Class V in GPS than in RNGPS were found to take the Class V scholarship examination (17 percent and 14 percent, respectively. The government expects 20 percent of students enrolled in Class V to take the exam) (CAMPE 1999). It is also evident that achievement is considerably higher in NFPE than formal schools in rural areas, an issue that will be returned to in Case Study 2.

Figure 1: Basic education competencies by school type (percentage)

Source: CAMPE 1999
15. Given that one criterion for registering a school is that there is no other school within 2km (see Appendix 3), the schools do not compete directly with GPSs or other types of schools. RNGPS have some similarities with government schools. They follow the same curriculum and receive financial support. In principle, neither GPS nor RNGPS should charge fees given the government’s commitment to free and compulsory primary schooling. In practice admission/readmission and examination fees are charged, since funding for running costs are not provided by the government. Almost half of households have reported that they had to make ‘donations’ as a form of bribery to help ensure enrolment of their children (Transparency International Bangladesh 1997, cited in Duncan et al 2002). According to recent studies, households spend in total around $14 on average per student. In both types of schools expenditure on books and stationery is the greatest cost – estimated to be around half of total private expenditure. In principle, textbooks are provided by the government, but in practice studies have shown that parents often have to buy these (ADB 2003a; CAMPE2001; World Bank 2003).

16. As the second Primary Education Development Plan (PEDPII) notes, Bangladesh has one of the largest and lowest cost primary education systems in the world, with an annual public cost per student estimated at US$13 – i.e. parents are spending as much per primary school pupil as the government. As the document indicates, this is partly achieved at the expense of quality with large pupil: teacher ratios, low teacher salaries, and minimal spending on learning materials. The significant proportion of children in RNGPS reduces the average cost per student further, at an even greater cost to quality in these schools, as well as a transfer of some of the responsibility for financing of education to communities. Moreover, students in RNGPS are more likely to have to pay for private tuition (see below).

17. RNGPS schools are in principle established and owned by communities, who are expected to support the schools until they are registered, a process which should take approximately four years (see Appendix 3). Prior to full registration, there is a period of temporary registration which allows them to operate legally, although without government support. During the time of temporary registration, it is likely that the schools will operate in sub-standard facilities, and teachers may not be paid regularly as their pay is dependent on contributions from the community. However, the anticipation of receiving near-full support from the government is considered worth the wait. After registration schools are officially recognised and continue to operate legally. School Management Committees continue to play a central role in managing the schools, including with respect to recruiting and monitoring teachers. The community is also expected to provide financial support to schools, including topping up teacher salaries (90% of which is paid by the government).

18. The motivation for establishing RNGPS is usually neither profit nor ideological, but rather to provide employment opportunities for teachers as well as political support for MPs. However, in some cases, local philanthropists may also be involved in establishing schools to support out-of-school children in their home area, in particular by donating land on which to build a school. The ‘community’ establishing the school often consists of unemployed youth hoping to benefit from employment in the school who make contact with a community leader (elected or social). The community leader is usually responsible for putting in the application to the Deputy Director of the Division. Although the community is supposed to initiate the establishment of a non-government school through a demand-driven process, it appears, that the initiative often does not come from parents in the community who want a school to which to send their children, even though they are potentially beneficiaries as enrolment has increased simultaneous as the increase in schools in the 1990s.
19. In principle, the School Management Committee should comprise of 11 members, four of whom should be elected by guardians of students. The duration of the SMC should be for two years. Duties include assisting in development work; ensuring enrolment of all school-aged children; monitoring the activities related to classroom teaching, school management, attendance of teachers and students; recommendation of appointments of head, assistant head and other staff which have to be approved by the Thana Education Committee; take all decisions regarding leave/discipline of the head, assistant head and staff (major punishment requires the approval of the Thana Education Committee); supervise the works of repair, new construction of school buildings and repair of furniture etc; assist in the procurement and distribution of textbooks and learning materials; ensure regular and timely attendance of teachers and take measures against those breaking rules. However, SMCs often operate sub-optimally, with evidence that some schools falsify records of meetings taking place (CAMPE 1999).

2.3 Explicit and technical case for intervention

20. Despite commitments to achieving free and compulsory primary schooling for all, the number of government schools and teachers in these schools remained more-or-less stagnant over the 1990s - the number of teachers increased very slightly from 160,098 to 162,090 between 1991 and 2001 (DPE 2002). Thus, expansion could only be achieved either through larger class size in GPS (which was already high) and/or expansion of the system through RNGPS. The growing importance of RNGPS has been in part a response to state failure to provide schooling opportunities for all children, leaving a gap in provision. This has been filled by the non-state sector, rather than as a result of a planned strategy of increasing non-state provision.

21. In principle, given the government’s commitment to uniform free and compulsory primary schooling for all, its support to RNGPS is seen as it fulfilling its responsibility to ensuring uniform and equitable access, regardless of the type of school children are attending (PMED 2003). This is considered important given the government’s inability to provide sufficient school places in its own schools where less than two-thirds of children are enrolled.

2.4 Performance of the intervention

22. Given that, as noted, children attending RNGPS are likely to be from poorer households, government support has allowed these children to have access to schooling. Further support to children from poor households in these schools is also provided through the stipend programme which does not discriminate by the type of school children attend. As such, it is contributing to providing educational opportunities to the poor, although not as part of an explicit pro-poor intervention.

23. The operation of RNGPS is dependent on the effectiveness of SMCs which have considerable authority in the running of the schools. In principle, this ensures local accountability. However, in practice these committees do not appear to be operating as envisaged. Although most schools report having an SMC, in practice some of these are inactive (CAMPE 1999). Other studies have also found that committees only arrange occasional meetings, do not have ‘committed membership, and are generally considered ineffective’ (Tietjen 2003: 15).

7 The CAMPE studies include information on frequency of meetings and number of members, but do not examine the type of decisions made at these meetings, who makes the decisions etc.
24. As noted, members of the community involved in establishing the school are those seeking work, so that appointment of teachers occurs as a result of local patronage rather than following procedures of recruitment through SMCs which in turn should be approved by the Thana Committee. There are various reports that establishment of schools and teacher appointments are politically motivated. An example was given of an MP’s business card mentioning that he was responsible for establishing 350 RNGPS! In addition, the head teacher often has considerable control in school management, while community members have limited involvement. Thus, although concerns about patronage are raised with respect to government schools in which teacher appointments are made centrally, it appears that similar problems arise through the local appointment of teachers. Teachers in RNGPS are often less qualified than their counterparts in GPS. A cause for concern was raised during interviews that teachers in RNGPS have more problems in coping with teaching, which is apparent as those entering Primary Teacher Training Institutes often struggle with the training. This suggests that the local process of recruitment is not identifying those most suitable to teaching.

25. Given that stipends are also allocated by SMCs (in principle based on criteria set centrally), this also offers opportunities for misallocation. It was estimated that only 25 percent of the allocations for the Food for Education (FFE) programme actually reached households, with indications that problems of leakage worsened over time (World Bank 2002). In order to address this, FFE was changed to a Primary Education Stipend Programme although problems of ‘ghost students’ are still apparent (Tietjen 2003). This, as other studies, does not distinguish between different types of schools so it is not possible to know whether the problems are the same in both GPS and RNGPS. However, given issues in composition of SMCs in RNGPS discussed above, it is likely that the problems will be as evident, if not more so, in RNGPS.

26. Furthermore, although teachers in RNGPS would otherwise be unemployed and are often behind the establishment of these schools, there is apparent dissatisfaction amongst teachers in these schools. This is no doubt related to the lower salaries they receive compared to their counterparts in government schools. While the intention is that the community will provide resources to make up the difference in salaries for teachers in RNGPS (given that government provides 90% of the salary and fees are officially not permitted, so resources are not supposed to be raised directly from parents of children in school), the community often does not make up the difference in salaries as anticipated. The communities in which RNGPS are located are often relatively poor, implying that poorer households are expected to contribute directly towards the costs of education than some of those in better-off areas. In addition, RNGPS teachers are not eligible to other benefits that teachers in government schools are entitled to, for example house rent. A recent survey indicates that the salaries received by teachers in RNGPS is just one-third of that of teachers in GPS and that teachers in RNGPS are also less likely to receive their salary regularly (Table 3) (see also World Bank 2003). As a result, the Association of Teachers in Non-Government Schools has been calling for RNGPS to be nationalised so they would receive the same benefits as GPS, with members of the Association going on hunger strike over the past year.

27. Moreover, the inability of communities to top up teacher salaries in RNGPS as intended results in teachers getting involved in other income-earning activities in order to support themselves and their families. A recent study indicates, for example, that teachers in RNGPS are more likely to be engaged in private tuition (Table 3). These figures are likely to be an underestimate. CAMPE (2001) estimates, for example, that 23 percent of students in GPS and 16 percent in RNGPS spend money...
on private tuition. Studies have indicated that, where teachers provide private tuition, they are likely to hold back parts of the curriculum during normal teaching hours in order to ensure that private tuition is paid for, and give students involved in private tuition preferential treatment (World Bank 2003; World Bank 2002a; Hossain et al 2002). Given that children in RNGPS are, on average, from poorer households, this means either that poorer households are paying for their children’s education, or that they are being deprived of a proper education because they are not receiving full tuition in schools and cannot afford to pay for it privately. Thus, although these schools may be increasing access, the allocation of government resources may be inequitable. On the one hand, government support of RNGPS is laudable as it is ensuring the spread of schooling to areas previously deprived. On the other hand, concern is expressed by some of those interviewed that the system is potentially allowing the government to provide education on the cheap by spending less on teachers in RNGPS.

Table 3: Income sources for teachers in GPS and RNGPS

<table>
<thead>
<tr>
<th>Source: Ahmed 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly salary (Taka)</td>
</tr>
<tr>
<td>% teachers receiving salary regularly</td>
</tr>
<tr>
<td>% teachers involved in private tuition</td>
</tr>
<tr>
<td>% income from teaching</td>
</tr>
<tr>
<td>School salary</td>
</tr>
<tr>
<td>Private tuition</td>
</tr>
</tbody>
</table>

28. There is no planned strategy in PEDPII for RNGPS. It is not clear whether the demand-driven strategy for school construction through RNGPS has resulted in schools where they are most needed. However, it is possible that this is contributing to ‘the disparity in geographical coverage characterised by over-supply of schooling in Dhaka and under supply in remote rural areas’ which is a barrier to equitable provision (DFID 2000: 19). Once a school is registered, the government is supposed to take over responsibility for buildings. The first phase of the government programme to support RNGPS took place between 1992-96 during which, out of 19,658 schools, 8,505 were constructed/repairsed at a cost of Tk3900m. The second phase of the programme aimed to reconstruct and renovate approximately 11,000 registered schools including 1,000 schools in the low-lying areas. The project includes construction of latrines, installation of tube wells, and supply of furniture where necessary. The development of approximately 15 remaining schools could not be undertaken due to land disputes, registration and subvention problems. The deadline for completion continues to be extended as the work remains unfinished. There is concern that the quality of infrastructure of RNGPS remains sub-standard, with evidence of schools housed in dilapidated buildings which are in worse condition than GPS.

29. Furthermore, although RNGPS are supposed to be treated in the same way as GPS with respect to government inspection, evidence suggests that RNGPS are less likely to be inspected (Ahmed 2004; PSPMP 2001, cited in PMED 2003). Much of the inspection time in these schools is reported to be spent filling in the ‘Primary School Inspection Form’ (PMED 2003).

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8 The Planning Department in reported that it has been undertaking a school-mapping exercise but the results of this are not known, and there is also no information on whether RNGPS are included.
30. In summary, while the government system is highly centralised, management of RNGPS is highly decentralised, with control in the hands of SMCs. However, given that communities are dominated by local leaders, decentralisation does not result in greater accountability to clients in practice. School-based management has not resulted in increased voice of the poor in decision-making. While teachers in RNGPS are unionised, their demands through direct action for nationalisation of schools has not had any effect. If anything, this could backfire as it was reported that one of the reasons for slowdown of government approval of non-government schools recently is due to concern that they might be forced to nationalise schools which would place financial pressure on them.

31. The combination of the government’s centralised approach and ineffectiveness of SMCs is reported to result in inappropriate use of resources:

‘Accountability and incentive mechanisms and checks and balances for teachers and administrators are extremely weak. The Government’s centralized administration and the lack of involvement of communities also handicap the efficiency and effectiveness of resources devoted to education...Even where SMCs are established, local elites often dominate, leaving little room for real representation by parents and objective community members’ (World Bank 2003: 59).

32. The World Bank Public Expenditure Review concludes from this that ‘real authority over teacher appointments and school budgets should be put in the hands of local school boards or management committees while ensuring that they are genuinely representative of the local communities’ (World Bank 2003: 59). Given the problems noted above concerning SMCs, this recommendation should be treated with caution - the possibility of ensuring genuine representation of local communities is likely to remain a challenge. Before placing more control in the hands of local communities, the analysis here supports the proposal also made in the Public Expenditure Review that there is a need for a critical evaluation of SMCs, as it is not apparent that they are necessarily operating in the interests of poor and marginalised groups.

2.5 Capacity to perform interventions

33. There is a clear incentive for non-government schools to register, given the financial benefits they receive (even if these are less than GPS). In RNGPS, considerable power is given to SMCs, in terms of teacher recruitment and, as with GPS, selection of students for the stipend programme. This appears to be a laudable example of involving the community in school management. However, it raises questions about the appointment of the SMCs and their capacity to perform the tasks assigned to them. There is general concern of weak capacity and experience of SMCs in both GPS and RNGPS. Although some training has been provided to SMCs in relation to the stipend programme, the content appeared to focus on their responsibilities rather than actual approaches and techniques of selection etc. Although schools have information on background criteria (see Appendix 4), they do not have guidance on how to identify and select pupils from poorest households, for example. ‘At best, selection decisions will be made on the basis of their [SMC and head teacher] knowledge of the community. At worst, they will be made out of self-interest’ (Tietjen 2003: 16). There is general scepticism of the ability of SMCs to carry out the tasks assigned to them, which could result in ‘deliberate or unintended biases and distortions.’ A 2001 study by Transparency International found SMCs and head teachers complicit in favouring local elites (to which members of SMC often belong) and the non-poor in school admission and enrolment in the FFE programme, or extracting some form of payment for inclusion. Given the weak capacity of SMCs and
lack of clear procedures of holding them to account, they are also susceptible to outside pressure from other influential members of the community.

34. DFID’s Effective Schools through Enhanced Education Management (ESTEEM) programme has been providing support and training to SMCs, focusing on GPS, even though these have more limited decision-making power than in RNGPS. The reason for the focus on GPS is due to the vast numbers of schools requiring training. Given that this programme is coming to an end, it would be beneficial to evaluate its success in strengthening SMCs in carrying out their responsibilities, and consider whether it is appropriate to replicate a similar form of training for RNGPS.

35. As noted, RNGPS are less likely to be inspected than GPS. District and sub-district primary education offices are expected to monitor and supervise both GPS and RNGPS by making regular visits. However, there are no systematic mechanisms for supervising RNGPS (ADB 2003a). Capacity to monitor through supervision and inspection is hampered by insufficient resources for transport which results in more remote schools (which are more likely to be RNGPS) being visited less frequently. In addition, where choices have to be made about inspection due to limited numbers of inspectors, they will choose to inspect ‘their own’ GPS first. As the ADB report proposes, there is a need for frameworks for monitoring performance in RNGPS which should be developed in dialogue with private providers ‘to build mutual trust and ensure their cooperation’, and to ensure continuous ‘cooperative monitoring’ (ADB 2003a: 31).

36. Even though RNGPS operate in similar ways to GPS and, if anything, provide access to children from poorer households, external agency support is more likely to be directed at GPS. This is the case with respect to DFID ESTEEM programme, as well as ADB and World Bank support to primary schooling (ADB 2003a; World Bank 1999), although one of the recommendations of the recent ADB evaluation was to extend its support to RNGPS.

37. Support to construction of RNGPS raises a question of whether the demand-driven process of construction is more effective than government decisions based on a school mapping exercise, particularly given the nature by which decisions for establishing a school at the local level are being made in practice. According to PEDPII, in order to reduce class size from 73 to 56 students per class, on average, and allow single shift teaching in 80 percent of classrooms would require 86,000 classrooms to be built between 2003-2008. While PEDPII proposes a physical audit at Upazila level to determine the magnitude of required construction requirements, it is noticeable that there is no discussion of whether the proposed expansion should occur through the RNGPS or GPS systems. Given that most of the growth occurring over the 1990s has occurred as a result of the expansion of RNGPS, the effectiveness and desirability of this requires attention.

38. Indeed, there is very little mention of RNGPS in PEDPII in general, other than with respect to providing students in these schools with textbooks (as in GPS). It is perhaps not coincidental that there was no representation of RNGPS in preparation for the PEDPII (there is no representative body, other than the Non-government Teachers’ Association which is campaigning for the nationalisation of RNGPS). PEDPII does propose strengthening the involvement of communities and SMCs in schooling without discussing the different roles and responsibilities of SMCs in RNGPS compared with GPS, and how this might influence the possibilities for their involvement. Experience from RNGPS would be informative regarding the possibilities for increasing community involvement in the ways proposed in both GPS and RNGPS, taking into consideration their capacity and domination by local elites.
CASE STUDY 2: GOVERNMENT CONTRACTING AND REGISTERING OF NGOS INVOLVED IN EDUCATION DELIVERY

3.1 Overview and selection of case study

39. This case study examines the relationship between government and NGOs involved in service delivery of education to marginalised groups. NGO primary education programmes began in 1972, although the vast majority (525 out of 564) began after 1992 (CAMPE 2004). The vast majority of NGOs run other programmes along with education – most commonly microfinance (only five specialise in education alone). As such, issues of NGO-GO relations are usually cross-sectoral, rather than specific to education. This case study looks mainly at those issues that are relevant to education in particular, while noting some of the broader issues (see, for example White 1999; Zaman 2003 for a discussion of relevant cross-sectoral issues). An important difference between education programmes and microfinance, for example, is that while the latter can be self-sustaining, the former are dependent on external resources.

40. Given its influence, both in service delivery as well as in contracting out to smaller NGOs, the case study will focus in particular on the role of BRAC. About half of the NGO budget on education is spent by BRAC, with 88% of the NGO education budget accounted for by 10% of NGOs (with an education budget of at least TK3 million per annum), and 84% by the top 5% (with a budget of Tk5 million per annum) (CAMPE 2004). Most NGO NFPE programmes are funded directly by external donors, although the relationship is mediated by the government through registration of NGOs. NGOs receiving foreign funds are expected to register with the government’s NGO Affairs Bureau (NGOAB), established in 1990. The majority of NGOs with NFPE programmes (i.e. those not receiving foreign funds) are registered with the Directorate of Social Welfare (89 percent), while 44 percent are registered with the NGO Affairs Bureau.

41. NGOs are selected by donors in a number of ways which are briefly indicated below:

- **Sole source selection:** When the services to be delivered require specialized knowledge and/or adequate administrative back up to ensure success, based on information and past record, a donor might select a particular NGO, which they feel is capable of implementing the programme. The selected NGO then approaches the NGOAB for approval.

- **Sort listing of NGOs:** which have the capability to deliver services is prepared by the donor, based on information about their past record or through advertisement, and approval obtained from the NGOAB either on the initiative of the donor or through the efforts of the beneficiary NGO.

- **Joint committees:** Selection is made by committees comprising representatives of both the donor and the government.

- **Contracting by large NGOs:** Large NGOs (such as BRAC) are contracted mainly on a sole source basis and are provided with funds by the donor for implementation of programmes by smaller and mainly local NGOs (usually registered with the Directorate of Social Welfare), through a selection process agreed upon beforehand, which is both transparent and acceptable. The large NGO, after selecting the smaller NGOs then approaches the NGOAB for approval.

42. There has been some previous experience of donors contracting through the government. Following the 1990 World Conference on Education for All at Jomtien, the government launched the Integrated NFE Programme (INFEP), covering all non-formal education components (including primary), although this was relatively small. In 1995, the
Directorate of Non-Formal Education (DNFE) was created out of INFEP with responsibility for initiating, coordinating and monitoring NFE programmes, including contracting of programmes to NGOs. With respect to NFPE, it was responsible for two projects for 6-14 year olds, offering a 2-year course aimed at providing grade III level of proficiency, encouraging transfer to mainstream primary (PMED 2000). However, the Directorate was dissolved in 2003, and the Department of Primary Education has taken over its responsibilities. Activities associated with the DNFE have been severely scaled down, so that it is no longer involved in NFPE programmes. The case study will explore registration and monitoring of NGOs by government. It also looks at the role played by the Campaign for Popular Education (CAMPE), an umbrella association of NGOs established in 1990 to foster cooperation between NGOs working in education, the government and civil society.

3.2 Nature of providers affected

43. NGO NFPE programmes serve the most hard-to-reach parts of the population (with a particular focus on girls) and are usually specifically designed to be pro-poor. There is estimated to be at least 1.3 million children enrolled in NFPE, comprising around seven percent of total enrolment (see Table 1). Given that these children are mainly enrolled in earlier grades, an even greater proportion of children will be following NGO programmes at that stage.

44. Each NFPE operates on a small scale in a local area. Provided the NGO running the centre is registered with the government, it operates legally. One of the motivations of NGO involvement in NFPE is related to a small (but growing) educated urban elite which has a strong commitment to modern education for the masses for instrumental reasons (i.e. to transform behaviour and attitudes of the poor in ways which are likely to have broader benefits) (Hossain et al 2002).

45. The BRAC primary education programme started in 1985 includes two-thirds of those enrolled in NGO NFPE programmes (80,000 children, 65 percent of whom are female). It currently runs a four-year cycle with a pupil: teacher ratio of 33:1 (considerably lower than for government schools), covering 456 Thanas. In addition, BRAC sub-contracts to 630 smaller NGOs, running 10,830 centres, which received financial as well as technical support (BRAC nd). As a result, BRAC runs a virtual monopoly in provision of NFPE. Given its size and influence, it receives support from donors through sole source selection so does not have to compete for funding. Proshika has the second largest NFPE programme, starting in 1993. A total of 17,800 children are enrolled in NFPE programmes (13 percent of the total) (CAMPE 2004). However, the number of children enrolled is reported to have declined significantly in recent years and has recently been de-registered meaning that it cannot access foreign funds, the implications of which are discussed below.

46. As illustrated in Figure 1, children in NFPE perform better, on average, in basic competencies than their counterparts in formal schools. Part of their success is attributed to providing learning centres close to homes, involvement of the local community in management of the centres, and recruiting teachers (mainly female) locally who therefore have a commitment and understanding of the local environment and are themselves part of the community. These teachers are often under-qualified (and receive considerably lower salaries than teachers in government schools). Teachers in centres run by larger NGOs such as BRAC receive on-going training and close monitoring by the NGO which provide the opportunity of piloting innovative approaches on a small scale. They also benefit from small class size by design, as they do not accept more than 30 students on to the programme for a particular cohort. This is a luxury that government schools cannot afford as it is achieved by the low salaries of teachers involved in NFPE programmes. It
is often claimed that NGO programmes are more cost-effective than government provision, although the full costs of the programme (including training and monitoring) are often not known. BRAC has its own research and monitoring department, which keeps a close track on the progress of their programmes and has carried out a number of studies to assess their performance (see for example, Nath et al 1999; Chowdhury et al 2002; Nath 2002).

47. Despite this success, the persistence of a low literacy rate implies that more needs to be done to ensure the programmes provide sustained literacy. Concern is also expressed that, despite their successes, NGOs have had little effect on levels of poverty and, despite their size, coverage remains limited (Ahmad nd).

3.3 Explicit and technical case for intervention

48. In principle, NGOs and government see NFPE programmes as a complement to government provision, with the aim of filling the gap (both in terms of quantity and quality) (BRAC nd; Cummings et al 2004). From the government’s perspective, NGOs are an important instrument in showing their publicly-stated commitment to Education for All (Miwa 2003), which is of particular importance for donors.

49. In practice, there is limited relationship between NGOs involved in NFPE and government other than through registration which mainly relates to control of foreign funds. This implies that the programmes are pro-poor independent of government, rather than due to any direct attempts by government to promote a pro-poor agenda through registration/registration, policy dialogue or facilitation. Unlike RNGPS, NGO NFPE centres do not obtain financial support from government, other than free textbooks which have been provided since 2003. The lack of ‘facilitation’ by government could help to explain the reported success of the programmes reaching the poor as they have been able to operate relatively free of government interference. Based on problems encountered through the experience of sub-contracting through the DNFE, bilateral donors and larger NGOs prefer funding to be independent of the government while recognising that the government has a coordinating role to play. Initially, some of the well-resourced NGOs felt it would be beneficial to subcontract from government, both because this would enable them to influence policy from within, and also to have access to alternative sources of funding which would be more sustainable than government funding (Miwa 2003). However, difficulties included efficiency and transparency of procedures which tended to stifle innovation and reduce flexibility and responsiveness to local needs. Some NGOs also felt uncomfortable with competitive bidding as it was felt that this encouraged a ‘business approach’ to education, which could result in NGOs understating their financing needs, for example (Cummings et al 2004). In addition, sub-contracting through DNFE has been criticised in relation to the selection of NGOs, some of which were ‘briefcase’ NGOs, established with the aim of obtaining funds rather than for the purpose of NFPE. This was possible as NGOs can ask ‘experts’ to prepare a professional proposal even if they do not have a substantive service to offer (Miwa 2003).

50. While preferring not be sub-contracted by government, the better-resourced NGOs see the benefit of linking up with government to influence formal education policy (Miwa 2003). CAMPE has played an important role in this regard. Policy dialogue has mainly been driven by NGOs concerned about the quality of formal primary education rather than by government.
3.4 Performance of the intervention

51. As mentioned, NGOs obtaining foreign funds have to be registered with the NGOAB. In principle, the NGOAB is responsible for registering, monitoring, and overseeing the activities of the NGOs. Other important functions include:

- Approval of projects and fund release
- Auditing and scrutinizing reports of the NGOs
- Evaluation and inspection of activities
- Liaison with donors and NGOs.

52. The NGOAB provides a ‘one-stop shop’ for NGOs, with the aim of cutting down on the bureaucracy. For example, if an NGO is involved in multi-sectoral activities, the NGO bureau will liaise with the ministries on their behalf. The NGOAB sends applications to appropriate focal points in sectoral ministries who pass it on to the appropriate officer within the Ministry. Ministries are given 21 days to send comments, after which if no response is obtained, it is assumed that they approve – approximately half of applications do not receive comments from the Ministry, and only a few are turned down (usually on the grounds of duplication with activities already being undertaken by the government, implying that competition between government and NGO activities is not encouraged). The NGOAB is also responsible for receiving and checking audit and performance reports (sectoral ministries are not involved in this), as well as inspection of NGOs. In practice, this is most likely to involve visits to NGO offices, rather than monitoring of the programmes themselves. It appears that this inspection takes up a large amount of the effort of the small bureau, which could be due to the possibility of rent-seeking when visiting offices. On the other hand, there are only two auditors for all NGOs registered, with around 2000 audit reports. As a result, the auditors only focus where their attention has been drawn to potential malpractice of an NGO (as has happened recently with PROSHIKA and Transparency International, both of which were de-registered, although Transparency International has subsequently been re-registered). In general, their role is procedural rather than influential and, as mentioned, does not relate to the government promoting a pro-poor agenda.

53. Given the process of a ‘one-stop shop’ NGOs do not register directly with the Ministry of Education. This has distinct advantages of cutting down red-tape, but means that there appears to be no government or independent monitoring of the NFPE programmes themselves to assess the standard of education offered. It also means that the Ministry has no control over the use of funds (Cummings et al 2004). Neither the NGOAB nor the MOE has a database which provides information on NGOs involved in NFPE which would enable the Ministry to keep track of its scale and geographical coverage. NPAII notes, for example, that the lack of a composite national database in the MOE means that those enrolled in NFPE programmes are not adequately counted, and information is not known on how many children in the project areas remain excluded, or the numbers who transfer to the formal system is not known (PMED 2000). The initiative for establishing a database of this kind has been undertaken by CAMPE on behalf of the NGOs themselves (CAMPE 2004). In addition, there is no national level coordination or synthesisization of materials developed for NFPE programmes by different agencies, and curricula/syllabus have not been standardised. This could be advantageous in terms of allowing for flexibility, provided they are of an acceptable standard.

54. As mentioned, there is evidence to show that NFPE programmes perform at least as well as FPE in general, but these are mainly undertaken by monitoring departments in NGOs themselves (notably BRAC). These do not tend to investigate effectiveness of different NGOs, so some of the smaller ones remain unmonitored. As NPAII reports, independent
studies suggest that while achievement is similar to formal schools, on average, participants still only achieve the lowest level of competence at best. It also notes that NGOs implementing NFPE report very low dropout rates in their programmes (of around 4%), but this is artificial as dropouts are quickly replaced to maintain the number of participants at around 30 per centre. Furthermore, some NGOs do not have local presence and only limited contact with the community, resulting in variation in performance between NGOs. The report, therefore, proposes a need for setting standards and improved supervision of implementing NGOs, which would mean going beyond the formal registration process.

55. In addition, since some of the larger NGOs sub-contract to smaller NGOs, these local NGOs obtain foreign funds indirectly and so do not have to register with the NGOAB. As mentioned, there is evidence to suggest that some smaller NGOs may be ‘briefcase’ ones. BRAC is reported to be unique in having a good monitoring process to follow up on the NGOs to which they sub-contract. However, even BRAC is unable to keep fully on top of these NGOs. An example was given by an interviewee of an evaluation which uncovered examples of local NGOs obtaining funding from more than one source for the same activity, including from BRAC, and that BRAC was unaware of this. In addition, the criteria for selecting partners for BRAC’s Education Support Programme (BRAC nd) does not include any criteria to illustrate their capacity in relation to NFPE. It appears, therefore, that there is little information of the performance of some of the smaller NGOs and the registration process is not taking account of this. Overall, at present, it appears that there is considerable disparity between different kinds of NGO provision, but limited quality control, and no means of assessing the situation overall (Cummings et al 2004).

56. In principle, there is the opportunity for stronger accountability in NFPE programmes given that they are operating at a local level with teachers from the community itself. Close monitoring by both the community and NGO is reported to be one of the elements of success. In practice, NGOs which are dependent on foreign funds are probably more accountable to their donors than to the government of Bangladesh.

‘In reality the state is unable to control NGOs. The NGOs often work against the directions and decisions of the state. Weak administration on the one hand and strong national and international backing on the other encourages some NGOs to defy the state and work according to their own whims’ (Ahmad nd).

57. This raises important questions regarding responsibilities for ensuring a pro-poor agenda.

58. Although NGOs have been involved in education for 20 years, there is no coordinated strategy between the government and NGOs. Transfer between NFPE and FPE has been occurring for larger NGOs such as BRAC, so students could transfer from BRAC centres to formal secondary schools (with over 90 percent of students reported to transfer from its programmes to the formal system), but not for some smaller NGOs. BRAC’s success is partly due to its size and influence which has enabled it to build a relatively strong relationship with the government allowing for transfer to take place on an informal basis, although students from BRAC centres often face problems once they enrol due to the different style of teaching in the formal sector (Nath 2002). In general, the average length of NFPE programmes is three years, with around 20 percent two years or less. It cannot be expected that children would achieve sustainable basic literacy and numeracy in this limited time so, unless the aim of the programmes is for transfer to the formal system, their intention is not clear. It is reported that the government is addressing the issue of transfer by establishing a set of core competencies which can be tested regardless of the type of education a child follows (Zaha 2004).
59. In addition, despite the long experience of NGOs ‘filling the gap’ and agreement by NGOs and government that their role should not be permanent, there is no evidence of a planned exit strategy. Rather, it appears that NGOs will continue to play an important role for the foreseeable future as they receive further support through the recently agreed World Bank ‘Reaching out of School Children’ programme. The more recent development of BRAC acting as a sub-contractor of education services suggests that, rather than having a planned strategy of withdrawal, there is seen to be a need for NFPE for the foreseeable future. Indeed, the NPAII proposes increasing coverage of NFBE to 33 percent in 2015. This increase is proposed simultaneous with an increase in the GER from 97 percent to 110 percent, implying that all children (including some overage) would have access to primary schooling (PMED 2000). It is, therefore, not clear why there would be a need for expansion in NFPE. On the other hand, obstacles of transfer between NFPE and FPE are noted as enrolment increases and puts pressure on the already overstretched primary system, implying that further expansion of the NFPE system is likely to increase tensions.

60. With respect to policy dialogue, CAMPE reported that, while NGOs were involved in dialogue related to the development of the Primary Education Development Programme (PEDPII), their proposals for including NFPE within the plan were not taken into account. Perhaps indicative of the peripheral role NFPE plays within the government, PEDPII does not include NFPE. Alternatively, the recent World Bank ‘Reaching Out-of-School Children’ project which focuses support on NGO NFPE programmes suggests that the omission prevents the dilution of the government’s key focus on FPE, justifying its establishment of a separate $50 million project to support NFPE. An additional reason for this could be to avoid including funds for NFPE within the PEDPII given the problems of subcontracting experienced under DFNE, as discussed above, but rather to bypass the government system.

61. One area of contention between CAMPE and the government relates to the provision of stipends. CAMPE’s view is that the money would be better allocated to improving the quality of schooling (including through reducing class size), rather than providing incentives. It points out that one of the reasons for the success of NFPE programmes is due to their flexibility and that they have better attendance than government schools even though they do not provide stipends. CAMPE suggests government schools could learn lessons from this. However, students in NFPE programmes usually receive pencils and stationery free (unlike in government schools), so have other forms of incentive. Interestingly, an important aspect of the World Bank’s new ‘Reaching Out of School Children’ programme is the provision of stipends to children enrolled in NFPE.

3.5 Capacity to perform interventions

62. Clearly, BRAC has been extremely successful in delivering NFPE to marginalised groups. As noted, this has been achieved with limited government involvement. BRAC has an impressive, well-functioning administration and is seen to be a ‘state within a state’, providing a parallel system to education provided by the government. As has also been argued, Bangladesh can be seen as ‘a weak state in a strong society’ (White 1999: 319). As such, BRAC’s capacity to perform its role is probably stronger than the state’s ability to regulate it. BRAC’s impressive offices and facilities are clearly far superior to those available to government officials, an issue that could be a cause for tension between government and BRAC (Miwa 2003).

63. Since part of the success of the BRAC programmes is thanks to its own monitoring, it would appear that the system of self-regulation is working effectively without a need for additional state regulation. However, there is a danger of extrapolating from BRAC’s success to other NGOs which might not have the same support mechanisms (particularly
smaller ones, although even Proshika does not have as effective a monitoring system as BRAC), about which there is more limited information. This is one reason for the development of the Education Support Programme, through which BRAC aims to build the capacity of smaller NGOs (BRAC nd). In this case, in principle smaller NGOs are monitored and regulated by BRAC which in turn is accountable to external donors. Although this might not happen to the extent intended (see Box 1), these NGOs receive considerably more monitoring from BRAC than the government.

**Box 1: Monitoring of NGOs sub-contracted by BRAC**

Program Organizers (POs) of partner NGOs are supposed to visit a school at least twice a week. ESP TSSs also visit partner NGOs and their schools (30% at the minimum) usually once a month and provide feedback on the progress of the project activities and suggest measures to improve the quality of the program. During their visit, the TSSs [Technical Support Specialists] develop a monitoring report in a standard format titled "Monitoring Of NFPE Undertaken By Partner Organisations" contains 35 items to be ranked on a five-point rating scale. Monitoring is also carried out in a number of other ways. These include: (1) Thorough monitoring of the programme by ESP Monitors, (2) regular monitoring of the program by the BRAC Monitoring Department (since May 2003), (3) visits to partner NGOs and their schools by the ESP Regional Managers and Program Coordinator, (4) assessment of student achievements in ESP schools by BRAC's Research and Evaluation Department (RED) on alternate years since 1995, and (5) auditing the program by BRAC's Audit Department.

**Extract from BRAC (nd)**

64. BRAC’s capacity to provide NFPE is heavily dependent on external donor funds. Given its size and influence, White (1999: 321) suggests ‘the scale of some donor commitments to BRAC mean that a break down in the relationship would be as much a disaster for the donor as it would be for BRAC itself’. However, as the recent experience of Proshika indicates, the relations between NGOs and donors, mediated by the government may not be as strong as BRAC’s. Proshika has been de-registered due to reported to the NGOAB resulting in a freeze on external funds (DFID, for example, is not currently supporting Proshika), it is likely that the programme will have to close down in the next year as it is entirely dependent on donor funds. This indicates the fragility of NGO programmes which are dependent on donor funding which might be withdrawn either due to changing donor priorities or for other reasons (as in this case). UCEP is an example of a smaller NGO which focuses almost exclusively on education, particularly for children and adolescents.

65. Scaling up has been successfully occurring within the NGO sector with limited government interference or involvement. Unlike RNGPS, NGO NFPE centres do not obtain financial support from government, other than free textbooks which have been provided since 2003. In principle, NGO programmes should follow the government curriculum although usually adopt it flexibly to suit the learning needs of children. The provision of textbooks might help to support smaller NGOs which are unable to develop their own materials, but larger NGOs such as BRAC and PROSHIKA have designed their own materials to suit their programmes. Thus, provided NGOs can choose whether to adopt government textbooks their free provision would be advantageous, but if their use is imposed this is likely to stifle innovation evident in NGOs, which is the reason for their success. The lack of government facilitation could be part of the explanation for their ability to perform effectively, as it has also meant that the government is not in a position to get involved in their activities.

66. This could partly be attributed to the power associated with larger NGOs (notably BRAC) due to the donor resources to which they have access. As long as donors continue to provide support to NGOs, these programmes are likely to continue. On the other hand, it can also be attributed to the lack of a planned strategy for government to expand provision of formal schooling (whether through GPS or RNGPS) to under-served areas.
This is notable by the absence of inclusion of NFPE in PEDPII, indicating that this will continue to be seen as a separate programme (to be supported independently by the World Bank ROSC project). One explanation for this put forward is that the government has little incentive to develop its system in marginalised areas which have limited political clout (Hossain et al. 2002). As such, the continued and expanded involvement of NGOs could be seen as permitting government complacency. The continuation of the NFPE programme is further ensured as a centre only caters for one cohort of around 30 students at a time – a new cohort is not enrolled until the existing one has completed the three to four year cycle, thus those children becoming of primary school age cannot join the NFPE centre until they are overage for the formal system.

4. CONCLUSIONS AND POLICY RECOMMENDATIONS

67. The paper has noted the important role played by both RNGPS and NGOs in achieving the education MDG in Bangladesh. However, while they have both encouraged increased access, there is a danger that a dual or triple tier system is being created – even though those attending NFPE appear to perform better than those in FPE, they are still often considered as a second-chance option.

68. RNGPS appear to offer the opportunity for school-based management, enabling accountability at the local level. However, indications suggest that they are not operating effectively at present, with local elites dominating at the expense of genuine community involvement and, in practice, are a way to achieve education on the cheap. There are very few studies that have been undertaken focusing on RNGPS – most studies either only refer to GPS or, where RNGPS are also included, do not differentiate adequately between the different types of school. It is proposed that a study is undertaken to explore in more detail the functioning of SMCs in both RNGPS and GPS, to investigate ways to overcome identified problems. It is possible that lessons could be drawn from the work undertaken by DFID’s ESTEEM programme which focused on providing support and training to SMCs in GPS. Given that decision-making powers are greater in RNGPS there is an even greater imperative to strengthen these, which could in turn have lessons for reforming SMCs in GPS.

69. There is also concern that reliance on community involvement in RNGPS can result in demands on communities in poorer communities which already lack capacity:

‘First, in the face of considerable regional inequalities in resource mobilization potential, while school-level management can effectively be decentralized, local financing cannot be the exclusive source of educational support. Government action may still be needed at the national or regional level in providing resources, setting standards, developing curricula and assessing learning. Second, relying on decentralization to improve the management of education presupposes that families and communities will be sufficiently empowered to participate effectively, to influence policy formulation through democratic processes, and to prevent elite capture and corruption’ (World Bank 2002: 48).

70. Thus, while important lessons could be drawn from the experience of school-based management in these schools for GPS, it might be more appropriate to level the playing field in terms of the support provided by the government between RNGPS and GPS to ensure uniform access to schooling of reasonable quality for all children, as intended. Local government could play an important mediating role in relation to this.

71. Although NGOs are seen as filling a gap in provision, it is likely that they will continue to have a role to play for the foreseeable future. Given their experience with innovative
approaches of working in hard-to-reach areas, it would be beneficial to involve them more explicitly in policy dialogue. At the same time, it would be appropriate to ensure that there is a clearly planned strategy for NGO involvement in education, agreed jointly by government and the NGOs themselves.

72. In terms of registration of NGOs, the one-stop-shop provided by the NGO Affairs Bureau is laudable. However, at present the involvement of education stakeholders in the process of registration and monitoring is marginal. It is proposed that a broad-based, democratically-elected forum, including the government’s NGO Affairs Bureau, representatives from the Ministry of Education as well as a representative network of NGOs, such as CAMPE, should be jointly responsible for registering and monitoring of new NGOs. Coordination for this could remain with the NGO Affairs Bureau to maintain the principle of a one-stop shop. This supports the recommendation of the World Bank’s Public Expenditure Review that a formal mechanism should be put in place to monitor policy implementation, including NGOs, the private sector, donors and government officials (World Bank 2003).

73. In addition, the NPAII proposes the review and development of a framework and guidelines for curricula and syllabus for NFPE programmes, as well as establishment of a common system of assessment in competence in NFPE parallel to the government system, to ensure equivalent quality and transfer between the systems, to be undertaken by government in cooperation with NGOs and other stakeholders (PMED 2000).

74. Furthermore, an independent body, with representatives from both government and NGOs is needed to oversee the monitoring of programmes themselves, involving periodic field visits. This can draw on the experience of BRAC’s monitoring of its own programmes, as well as of sub-contracted NGOs through the Education Support Programme, but needs to extend to NGOs not included in this.

75. Coordination between NGOs, and between NGOs and government, would be assisted by further developing a national database of NGOs (as already established by CAMPE) with information of use both to government and other NGOs.

76. Finally, the experience of Bangladesh with respect to NSP in basic education to support the poor has much to offer. While they have not always been successful, important lessons can be drawn for other countries of some of the attempts to build partnerships between government and NGOs in education, as well as more generally.
APPENDIX 1: DOCUMENTS CONSULTED


Ahmad, Mokbul Morshed (nd) 'The state, laws and non-governmental organisations (NGOs) in Bangladesh' *International Journal of Not-for-Profit Law* Vol 3 No 3

Asian Development Bank (2003a) ‘Special evaluation study on the government and non-government provision of primary education in Bangladesh, Indonesia and Nepal’

Asian Development Bank (2003b) ‘Report and recommendation of the President to the Board of Directors on a proposed loan to the People’s Republic of Bangladesh for the second Primary Education Development Program (Sector Loan)’

BRAC (nd) BRAC’s Education Support Programme. Mimeo

CAMPE (1999) *Education Watch: Hope not Complacency* Dhaka: CAMPE


World Bank (1998) *Bangladesh. From Counting the Poor to making the Poor Count* Washington DC: World Bank


**APPENDIX 2: PEOPLE MET**

Tasneem Athar  
Deputy Director, CAMPE

Abdul Mazid Shah Akond  
Director, Policy and Operation, Directorate of Primary Education

Anjan Kumer Dev Roy  
Assistant Chief, Ministry of Primary and Mass Education

Khonder Ariful Islam  
Programme Manager, BRAC Education Programme

Md. Mizanur Rahman  
Director General, NGO Affairs Bureau

Proshika
APPENDIX 3: CONDITIONS FOR REGISTRATION

- The proposed school must be at least 2 km away from a recognized school. This distance is relaxed on account of communications difficulties or if the number of students is 150 or more.
- There has to be an approved Managing Committee.
- The school must be 4 teachers, of whom one must be a science teacher and two of them have to be female. The Head and Assistant teachers must have the approved academic qualifications. The conditions may be relaxed in the case of the Hill Districts.
- The school must have a minimum of 150 students, this requirement being relaxed in the case of marshy and very low lying flood prone areas.
- The school must be situated on at least .33 decimals of land and have a structure of the size 70x15 ft. The land must be registered in the name of the school. However in the case of city corporations this minimum requirement is .20 decimals. In the case of government and self-governing'autonomous organizations, the transfer of land is not necessary but the approval of the authority of the proposed site plan is required.
- Where a school is named after an individual, the organiser/initiator has to deposit Tk 3 lacs in a reserve fund to be operated by the Chair and Head teacher of the school. The interest of the fund can be spent.
- A savings account of Tk 5000 and a 5 year term deposit of Tk.10000 have to be provided.

In principle, the process of registration is as follows:
- An application for registration is made to the divisional deputy director, who sends inspectors to the school to see if they meet the criteria set. If they accept the application as genuine and approve it, the Division submits the application to the Primary Education Directorate which is responsible for making the final decision. A committee under the Chair of the DG, Primary Education and comprising members from the Ministry and Compulsory Primary Education wing will decide on the application within three months.
- An initial approval for three years will be given, during which period the government will not be bound to provide financial or other support. Within four years of the approval, the school authorities will have to ensure training of all untrained teachers.
- In the fifth year, after issue of temporary registration, and while confirming permanent registration status, various aspects will be considered such as the results of Class IV, as well student attendance and drop out, and the results of the National Scholarship examination. The school will not be provided financial grants or included in the MPO (which entitles it to teachers salary, grants etc) until it is registered permanently.
- The registration can be cancelled if the regulation in place is not followed.
- The evaluation form will have to be signed by the official conducting the evaluation.
- The application will have to be signed by the Chair of the committee. All information such as the population of the village in which the schools is situated along with the population of the neighbouring villages, the names of surrounding schools and number of students, will have to be provided.
- All information with regard to the manner of appointment of teachers, their qualifications will have to be provided.
- All documents relating to the general fund, term deposits, information and documents relating to the land, design etc will have to be provided. In the case of schools established in an individual's name, bank documents in support of such deposits will have to be provided.
APPENDIX 4: PRIMARY EDUCATION STIPEND PROGRAMME

Objectives of the programme:
- Increase in the enrolment of poor students and their attendance.
- Reduce dropouts
- Prevent child labour and support poverty alleviation
- Increase the standard of education

Eligible educational institutions:
- Government primary schools.
- Registered Non Government Primary Schools (RNGPS)
- Community schools
- Temporary RNGPS
- NGO schools established through government support
- Government recognized Ebtedie Madrashas

Definition of poor families.
- Poor widows
- Day labourer and poor professionals like fishermen, blacksmiths, cobblers, weavers etc
- Landless with an maximum land of .50 acre

Selection procedure:
- Initially the School Management Committee (SMC) identifies 40% of the poorest students which will the need the approval of the UpZilla (sub district) education officer.
- Every year the SMC will identify the poor students of class one along with the number of family members.
- In case of cancellation of a stipend, the next in order of priority will be awarded the stipend.

Conditions for receiving stipends:
- Must be eligible under the criterion indicated above.
- Must have an attendance of at least 85% and must have received at least an average of 40% marks in the annual examination of class 2 upwards
- At least 10% of the students of a school must have appeared in the Scholarship examination.
- The school must be holding the examinations in an orderly manner and the eligible students must have appeared in all the examinations, unless there was an acceptable cause.
- During inspection on any normal day, not effected by inclement weather, if it is found that the attendance rate is below 60%, the school will be suspended from being a part of the programme. The programme will restart on production of evidence of satisfactory performance.
- In case of madrasahas there has to be minimum of 100 students.

System of payment:
- All payments will be made every three months, to a bank account to be opened in a designated bank in favour of the mother, and in her absence in favour of the father or legal guardian. Where necessary the bank will establish a camp office to cover three schools.

Duties and role of Managing Committee/head teacher/officials.
- The head teacher is to ensure that all records of admission register, attendance register, examination register and other registers are maintained.
- Prepare the list of eligible students and maintain the register.
- Ensure that the profession of the parents are correctly recorded.
- Help the upzilla education officials to maintain the list of eligible students.
- Sensitize the students and parents that attendance of at least 85% and attainment of 40% marks at the minimum in the examinations are essential requirements for stipends.

**School management committee**
The school management committee (including involvement of female members/commissioners) will be responsible for preparing the list of eligible students as per the laid down criterion.
1 INTRODUCTION

1. Bangladesh provided a rich variety of case studies, and, although there are three cases listed here, examples are drawn from at least six different projects, organizations and activities.

1.1 General water supply situation

2. Bangladesh provides an example of the successful provision of water, especially in rural areas, with about 10 million tubewells, 80-90% privately owned, of which over two-thirds were drilled privately. Before the identification of naturally occurring arsenic in some aquifers, coverage was estimated to be 97%. Even regarding the water supplies with arsenic in them as “unsafe” only reduces coverage to about 60% - 80% of the population.

3. Much of the activity has been carried out by the small-scale private sector, drilling boreholes and installing cheap shallow tubewells, in an unregulated free market.

4. Not only is coverage high, but the service level is also significant, with tubewells often nearby (one per 70 people) for shallow aquifer areas. In coastal and deeper aquifers this falls to one per 200 to 300 people. There is a willingness to pay for enhanced quantity and convenience. The density of the population provides an economy of scale, with groups of households able to share single tubewells.

In the euphoria of the private sector-led approach to drinking water delivery, the issue of monitoring water quality was largely ignored in Bangladesh. Arsenic contamination has now raised the issue of institutionalising mechanisms to monitor water quality in the country

"Willingness to Pay for Arsenic-free, Safe Drinking Water in Bangladesh". (WSP, World Bank, BRAC, 2003)

5. In Dhaka, the coverage for water supply is about 65%.

Water resources

6. Part of the success has been due to the presence of shallow aquifers, deep enough to provide clean water but accessible with fairly simple and cheap drilling techniques. There are also significant surface water sources, but the regular flooding and lack of sanitation render these unsafe and unsuitable for water supply without treatment. 97% of the population rely on groundwater for drinking.

1.2 General sanitation situation

7. The level of sanitation coverage in Bangladesh is low, at 42% and is adversely affected by flooding. Recently the total sanitation experience has moved the subject onto the political and development agenda. This is covered in more detail in one of the case studies. Of this, one quarter are pour-flush and three-quarters pit latrines.
8. In the cities, there is limited piped sewerage, with coverage estimated at 30% in Dhaka with the remainder of the population relying on on-plot sanitation methods where they are available. Sanitation coverage, including the water borne system, is estimated at 72%.

1.3 Institutional Arrangements

9. In the Bangladesh water supply and sanitation sector, there exist two parallel systems of interventions: through the public sector and through private enterprise and NGOs. Public sector implements large projects in both rural and urban areas either from domestic resources or with the support of multilateral and bilateral agencies. In the implementation of these projects, the non-state providers have an insignificant role other than being contracted for software aspects. NGOs on the other hand, independently implement small projects all over the country with the financial assistance from bilateral donors and international NGOs. The NGOs have successfully developed effective models of service delivery mechanism for both urban and rural poor. The private sector has a more direct financial relationship with the users.

10. The responsibility of water supply in the 274 urban areas is shared between the Department of Public Health Engineering (DPHE) and Pourashavas (municipal areas), except in Dhaka (including Narayangong) and Chittagong, where the Water Supply and Sewerage Authorities operate. Only 100 Pourashavas have a piped water system. The DPHE also works with the Local Government Engineering Department (LGED) to plan and implement services. Most Pourashavas and Union Parishads have Water Supply and Sanitation Committees. In rural areas, the local community is responsible, with DPHE as the lead government agency, in developing capacity to support action.

Non-state providers

11. The range of non-state providers examined included large NGOs, large and small commercial enterprises and community-based organisations. Many of the large NGOs take an integrated approach, working across health, education and infrastructure sectors. There also appears to be a high amount of co-operation and communication between NGOs, with evidence of both sharing experiences and working together in an integrated fashion. A hierarchy of NGO activity was also apparent, with one NGO securing funding and engaging in policy discussions and the enabling environment, with more practical activity being sub-contracted to another NGO working as a partner.

12. Private sector involvement is apparent in the many small enterprises providing tubewell drilling, provision of handpumps and selling of slabs and rings to make latrines. Reportedly people have resorted to providing their own water supplies, due to the slow pace of bureaucracy, although the limited state action can be interpreted as “pump priming”, with training and awareness-raising by government resulting in increased demand which is then met by the private sector, supported by micro-finance. Government drilling has been highly influenced by political considerations, but the private sector followed a purer, demand responsive approach. This pattern is shown in the diagram below.
13. Drillers of deep boreholes are meant to be registered, which is reported to be not a difficult process. Smaller operations are neither taxed nor registered, with quality allegedly controlled by competition.

Dialogue

14. Relations between NGOs and government are sometimes coloured by traditional government attitudes (especially in the technical field) and government procedures, compared with the more responsive, participatory attitude of the NGOs and the even more demand responsive approach of the private sector. However relationships are reported to be friendly – for example the presence of NGOs on the secretariat for the government sponsored South Asian Conference on sanitation. The local branch of the Water Supply and Sanitation Collaborative Council is providing a forum for such dialogue, more so than the government NGO Bureau, which administers the registration of NGOs and facilitates foreign money exchange.

2 CASE STUDY 1: URBAN WATER SUPPLIES

15. Dhaka Water Supply and Sewerage Authority has the mandate to manage water supplies in the capital city. The water pumped from deep boreholes and treated, with capital works carried out by contractors. In contrast to this formal involvement of non-state providers, there is formal and informal water vending in the high-density peri-urban areas, sometimes from private deep tubewells or from on-selling of DWASA water, informally or formally (such as the DSK case below). Expensive water vending from illegal water connections was costing both DWASA and the poor money. By moving to a formal system, both parties benefit.

2.1 Contracting out of services

16. DWASA was launched in 1963 under the WASA Ordinance as a state owned enterprise with a mandate to provide potable water supply, sewage disposal and drainage of storm and wastewater for Dhaka city. DWASA services are divided into six geographical zones in Dhaka city. DWASA has 2,100 km of water lines including rehabilitated/replaced water lines, 190,000 water connections and over 1,000 standpipes in Dhaka city (DWASA Report Dec. 2001). There are some private supplies (e.g. boreholes supplying factories), but their licence prohibits them on-selling water to other parties.

17. Financially DWASA presents a very grim picture. It is not able to recover the cost for the services it renders. In order to improve the financial situation DWASA contracted out revenue billing and collection activities in two of its revenue zones (Mirpur and Gulshan) to private sector contractors. This was done in 1997 under the IDA guidelines.
in DWASA - IV project. After couple of years IDA withdrew from the project because of non-compliance to a number of project pre-conditions. Nonetheless, DWASA continued with the contracting and succeeded in improving revenue collection. Presently CBA (Combined Bargaining Association/Union) Co-operative of DWASA is functioning in 3 zones (Mirpur, Gulshan and Lalmatia) out of the six and DWASA is contemplating on contracting out all the six zones to CBA Cooperatives in near future.

18. Up to 50% of water is unaccounted for; high levels of leakage (25%) are coupled with many illegal connections – local political and social pressures make this difficult to police. Water is regarded as a free commodity and so public education is required to enhance its value (a local phrase states that something that is very cheap is “just like water”). Although the borehole production costs are currently low, the water table is falling and this will raise costs, hitting the poor first.

19. In the first round of contracting-out, two organisations were selected, the DWASA based CBA and a private sector operator. Performance targets were set by DWASA. However the private operator has not performed as satisfactorily as the CBA, perhaps due to factors such as:

- Better knowledge and experience of CBA staff
- Informal access by CBA staff to past billing records etc.
- High levels of leakage, known by DWASA staff but not by the new operator.
- Informal contacts with DWASA staff, leading to faster leak repairs, whilst the private operator had to go through the formal reporting system. Delays in leak repairs led to loss of revenue.
- Government support for the co-op as part of general civil service reform

20. The CBA funds all staff costs of employees and has in fact substantially increased the wages of inspectors from Tk 7000/month to Tk 12,000/month. Productivity rates have increased markedly. Strategy and progress is discussed by the CBA. Managerial aspects such as job descriptions, work plans and a unified working environment have boosted performance, in contrast to the lack of interest in the organisation’s role displayed by standard DWASA staff. The CBA have a new computerised billing system, paid for by results, with additional technical support bought in as required.

21. A regulator for the sector has been proposed but this was dropped by a Cabinet Committee, as the time was not right for full privatisation; the infrastructure requires improving first and public awareness raised. Tariff rises would be under the control of the private sector but the protests would be political.

2.2 Community water points

22. Dushtha Shasthya Kendra (DSK) is a non-governmental organization based in Dhaka. It started functioning in late 1980s with an integrated programme of primary health care, savings, credit and income generation in the slums of Dhaka city. In 1992 DSK took the initiative to provide water supply and sanitation facilities to the urban poor within an integrated program.

23. In 1992-94, DSK had successfully implemented two water points in the slums of Dhaka city. Based on the success of these two initiatives, the UNDP-World Bank Water Supply and Sanitation Program; the Swiss Agency for Development and Cooperation and Water Aid (funded by DFID) came forward to fund DSK in replicating the model in
other slum areas of the city in 1996. The water points are managed and paid for by the community themselves. In 2001 Water Aid formed a donors consortium to scale up the model through a programme which will support construction of a further 300 water points in the slums of Dhaka and Chittagong (also with NGO Forum and CWASA). The points serve between 35 and 100 people.

24. DSK has succeeded in convincing DWASA to provide basic service provisions to the poorest of the poor who lives in slums and squatters. As per DWASA Ordinance, water supply and sanitation facilities can only be provided to people who have legal tenure of occupancy. DSK organized and build capacity with the communities to operate, maintain and manage water supply facilities, so they understand cash flows and bills. DSK also run a micro credit scheme for the construction of pit latrines, with Tk 21 being paid over a year.

25. The community either pay a monthly fee (Tk 30) or Tk 1 per 30 litres (Tk 3.3/100l). This pays for the cost of the water (Tk 6/1000l – Tk 0.6/100l), a caretaker and some profit for investing, once the cost of the original construction has been paid back to DSK. 97% of bills are being paid. Some points did turn into an income generation activity for the committee, but greater community involvement is now reducing excess profits. The water points are managed by an all female committee of nine people carrying out the routine administration. They are supported by a mixed gender "advisory" committee with no formal management role but which provides a public face with more presence in relation to organised crime. DSK provide hygiene promotion staff to monitor the water points.

26. As land tenure is crucial to the water supply, communities are now being empowered to campaign for land rights. The majority of water points constructed have been demolished by subsequent slum clearance, significantly diminishing the actual impact of the interventions. Of the 102 water points constructed in Dhaka, only 20 -25 are currently working, six of which have been totally handed over to the community. 15 more physically exist but are not operating due to lack of water supply from DWASA (due to many illegal connections controlled by organised crime groups) or due to slum clearances.

27. The water points consist of a reservoir fitted with a handpump. Intermittent supplies and low pressures mean that the water fills the tank at night for use during the day. The concrete tanks are expensive (Tk 750,000) but cheaper plastic tanks did not work.

28. Water Aid has an advocacy programme to try and promote the right to water. The DWASA byelaw based on water supplies to households, not people. As a public service it does not provide for all the “public”. Without a legal holding number for a house, individuals cannot be billed. However DSK can now act as guarantor for the bills, allowing DWASA to provide a supply; CBOs also now have the legal right to a connection. The programme has also succeeded in reducing the connection fee from Tk 15, 000 to Tk 1, 000. This has required a change in the institutional culture and thinking in DWASA.

2.2 Water vending

29. A range of water vending activities occurs within Dhaka. WASA sell 1500l loads for Tk 125, (Tk 8.3/100l) delivered by a tanker. Private operators sell 1200-gallon loads for Tk 200 officially but actual prices tend to be Tk 600 (Tk 3.7/100l or Tk 11.1/100l). DSK buy 200l loads for Tk 20 that are sold from a bicycle for Tk 5 for 30l (Tk 10/100l sold for Tk 16.6/100l) or from a van (Tk 2 for 20l – Tk 10/100L).
3 CASE STUDY 2: TOTAL SANITATION

30. Sanitation coverage has not followed the success of water supply. Even with 100% subsidy, the effective coverage of sanitation was not increasing at a satisfactory rate, with householders using the latrines built for them as stores, or selling the rings and slabs to others, especially when the poor had a financial crisis. For example a 1962 project distributed 160,000 free slabs, ten years later only 30% were being used and these were often broken. Open defecation was still being practised. The standard approach was not working. In 1975 a pilot project sold subsidized latrines and here 60% were being used, but the government sector could not be expected to provide the capacity for complete coverage and the poor could not even afford the subsidized latrines. A new method had to be found to increase coverage.

31. The government line (through DPHE) was very hardware based, with a single option that did not take into account geology or culture. The NGOs had a better understanding of the situations on the ground, but are not a sustainable solution as their funding is so dependent on donors. The sanitation area is growing, with 30% of the ADP being allocated for sanitation, a figure likely to grow in the future, an initiative being driven by the Minister of Local Government.

3.1 Rural mobilization

32. A new technique was piloted by VERC (Village Education Resource Centre) taking an approach that did not rely on subsidies. Using participatory approaches, the whole community was informed of the practical health and environmental impact of poor sanitation and how the faeces of some people, e.g. the poor could affect the health of others e.g. the rich, so it is was an issue for the whole community and health benefits would not result unless open defecation was stopped completely. This motivated the rich, not only to provide their own latrines, but to support others, for example by providing land and simple materials to the landless so the poorest of the poor could also have access to a latrine. Children are encouraged to monitor progress, naming and shaming people who still defecate in the open. This message also filters into the surrounding areas. The declaration of an open-defecation free village is made by a local political officer putting up a public sign.

33. This approach is now being used by a variety of NGOs, such as PLAN International and is also influencing government policy. It does rely on local political support, but capacity can be lacking so local government cannot respond effectively to central initiatives. Often this results in budgets being spent on latrine construction rather than community mobilisation. The NGOs can move faster than government structures and can help train government staff so investment is made in human resources rather than inappropriate buildings. NGOs can provide co-ordination across government divisions and encourage political support. Government civil service is becoming more political (especially in health) and the changes in staff leads to a lack of sectoral experience and knowledge. NGOs can also work at very local levels, whilst government structures seem less effective below Upazila (sub-district) level.

34. Where hardware support is needed, this is provided through helping seed production units, providing moulds for small entrepreneurs to cast slabs or providing an initial batch of plastic pans to a tea shop for selling on, creating supply chains independent of the NGO. Subsidies for latrines are not provided – ideas and inspiration are given rather than cash, although provision does have to be made for the hard-core poor. Sanitation fairs allow people to see different latrines, not all of which are technically sound, but this encourages people to experiment and see there is not a single solution.
The five original designs have now expanded to 34, adapted to local conditions. About 80% of latrines are water seal and 20% simple pits, often offset using 3’ of pipe that is flushed before and after use. The government provided water seal is not always appropriate.

35. As with many NGOs, PLAN do not see this as a sectoral activity, but move on to improve water supplies, solid waste management and energy provision, as well as working on education, health, micro-finance and other development activities.

36. As an indication of the success of the approach, a community of 182 households managed to build 37 latrines to bring about 100% sanitation, motivated by an NGO and the Union officials, all at their own expense, using rings and slabs or home-made latrines. It has also been observed that people upgrade their facilities over time, once they have grown used to using latrines. Latrines included:

- Three rings, one slab, one pit cover offset latrine using 3’ of pipe costing T580.
- A simple latrine costing T90, using a plastic bag as the offset pipe next to a latrine costing T700.

37. Political support is growing, with the Minster writing to 4648 local government chairmen to support the approach. 20% of the total Union budget has been earmarked for sanitation only (not even including water). Up to 90% of this is still going on hardware (with some taken by other local government institutions), but the “no subsidy” approach does appear to be gaining ground (with exceptions for the very poor, such as widows or beggars). Successful programmes do appear to be less prone to corruption.

**Hardware provision**

38. The manufacture of sanitation hardware is a small-scale private-sector activity that is visible from the road as you travel out of Dhaka. As an example a small yard can be set up with a loan of 400,000T. Eight employees produce and sell between 3 and 10 sets of slabs and rings a day, depending on the season. Slabs cost Tk 200 and a ring Tk 100.

39. NGO Forum also operates as a sub-contractor under the National Sanitation Programme, with 935 production centres, beside 350 private sector operators. DPHE have 900 production centres at Upazila level; the NGOs are based at a more local level, where access to the sub-district centre is difficult. This is co-ordinated with DPHE to avoid overlap but also to provide indirect government support.

3.2 Urban sanitation

40. DSK is a non-governmental organization based in Dhaka. It started functioning in late 1980s with an integrated programme of primary health care, savings, credit and income generation in the slums of Dhaka city. In 1992 DSK took the initiative to provide water supply and sanitation facilities to the urban poor within an integrated programme.

41. DSK has successfully introduced Vacutug Mark 1 & 2 (mechanized latrine pit emptying device) in the slums and squatters of Dhaka city with the assistance of Water Aid Bangladesh. Most of the urban poor use pit latrines or septic tanks for their excreta disposal. If the pits or tanks are full they must either be emptied or abandoned. As the slums are densely populated having insufficient space, the only option is to empty the
pit or tanks in a hygienic and non-hazardous way. Introduction of Vacutug by DSK in 2001 has to some extent resolved the problems of sanitation environment of the slums.

It may be noted, that DWASA has given DSK permission to dispose the sludge into their sewerage lines at two points (a pumping station and a treatment works) for a fee of Tk 1000 a day. Unfortunately the distance to these points (especially in the city’s traffic\textsuperscript{9}) means that it is uneconomic to travel to these points and the material is dumped in storm sewers. This is illegal but recognised by the authorities. Many septic tanks and overhung latrines also empty into the storm drain. It is planned to build a treatment works in the slum.

42. The Vacutug consists of a 250’ hose connected to a 1900l tank and suction pump. The cost of the locally made tank and pump was Tk 250,000. This is capable of emptying a pit latrine in a single visit or a septic tank in three visits, at Tk 800 a visit, although discounts are available to the poor (Tk 150 for a pit, Tk 600 total for a septic tank). This is operated by a driver and two operators (paid on a daily basis). A third worker is required if the pit is far from the road, to aid communication. Sweepers (a euphemism for people work manually empty pit latrines) are given a 20% commission for bringing in custom, as is a tailor who owns a mobile phone and acts as a sales representative. Although the sweepers lose income for emptying the latrine, they get a reward for little effort. They normally charge Tk 10,000 for the two days it takes to empty a latrine (working with ten people, so Tk 500 per person a day). The Vacutug provides a quick and relatively smell-free service.

4 CASE STUDY 3: RURAL WATER SUPPLIES

43. The success in terms of rural water supply coverage in Bangladesh has been reduced in recent years by the presence of naturally occurring arsenic in some aquifers. In response, various options are being tried, from small-scale arsenic removal technologies, to the provision of piped water schemes. Because of the high level of service provided by individual tubewells, piped water systems have to provide an equivalent service, with taps at least at yard level, rather than community standposts. A reticulated\textsuperscript{10} water supply system requires a management approach based on the community, rather than the individual or neighbourhood focus that tubewells provide. One initiative is to harness the skills of the non-state sector to provide these services, based on people’s willingness to pay for arsenic-free, safe water.

44. One project to address this problem is being managed by the Social Development Foundation (SDF), which is a legally registered company, but falling under the management of the Ministry of Finance. It is financed by the World Bank and has government officials on its board, but is autonomous from government\textsuperscript{11}. It covers a range of development activities, including information and communication, community infrastructure works and health. The institutional arrangements are designed to free the project from unnecessary bureaucracy and delays.

45. Water takes about 10 crore Taka (including investors money) of SDF’s spending. 20-30 crore Taka is spent in other sectors. (i.e. £100,000 on water with £200,000 - £300,000 spent elsewhere). The pattern in other sectors is to use PRA to identify

\textsuperscript{9} This is made worse as the vehicle is unusual and often stopped by traffic police to check the documentation – which is not required due to its small size.

\textsuperscript{10} Reticulated – using a network of pipes

\textsuperscript{11} This organisation eludes definition, but could be termed a Quango – a quasi-autonomous non-governmental organisation.
community needs and then assist the community in providing roads, schools, social programmes and medical facilities.

4.1 Financing small piped systems

46. Government cannot expect to address the arsenic issue by itself. In an attempt to bring in a range of players to solve the problem (and provide skills, knowledge and resources as well), SDF is running a pilot scheme, letting concessions to build, operate and maintain water supply systems for 15 years. Funding is raised by SDF (40%), by the community (20%) and by the operator (40%). Banks and donors are also being encouraged to provide investment funding.

47. Both the private commercial sector and NGOs were eligible to bid for concessions. During the piloting of the approach, 12-15 organisations stated they were interested and, after initial screening (based on credit worthiness and experience), 12 were invited to submit expressions of interest, of which 10 were submitted. Eight organisations were selected to take part in the pilot scheme and six eventually signed a memorandum of understanding. Two (BRAC and NGO Forum) were not selected, as they could not provide venture capital up front.

48. The NGOs involved had the advantage of working at grassroots and recognizing the service delivery approach, whilst the medium and large private sector has not been so involved in “welfare” projects and not so interested in rural or social issues. Piloting the scheme with NGOs should allow the profitability to be demonstrated and encourage the involvement of the private sector. The NGOs selected also could draw on a loan from core funding whilst they design and develop their schemes.

49. The successful organisations had to undertake feasibility studies, costing five to six lakh Taka (£5,000 -£6,000 approximately), which was reimbursed in arrears, but required to ensure an “investor” approach. SDF oversaw the studies and facilitated the process. The studies have been approved and are about to be reviewed by the World Bank, but the investors have mobilised resources, working with the communities and drilling trial holes.

4.2 Serving the consumer

50. As a condition of the SDF grant, the service must be provided to 100% of the community at a relatively high service level. The connection options are:

- 1, 2 or 3 taps inside the house;
- a tap in the house yard;
- a tap outside the house yard; or
- a tap shared with another household or close family.

51. This is to provide drinking water, with existing tubewells being used for washing and other uses. The water sources are deep groundwater (which may require iron removal) or (in one case) surface water (which requires treatment). There is some resistance to building simple water treatment works. Chlorination will be provided.
<table>
<thead>
<tr>
<th>Sponsor</th>
<th>No. of households to be served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gana Shathay Kendra (health organisation)</td>
<td>888</td>
</tr>
<tr>
<td>BURO Tangail (micro credit organisation)</td>
<td>570</td>
</tr>
<tr>
<td>HFSKS (house building and micro credit)</td>
<td>650</td>
</tr>
<tr>
<td>Brotee (NGO)</td>
<td>1137</td>
</tr>
<tr>
<td>MACCA (small NGO - micro credit, education, sanitation)</td>
<td>510</td>
</tr>
<tr>
<td>Mothers’ Society (women’s organisation)</td>
<td>678</td>
</tr>
</tbody>
</table>

52. Studies have been undertaken to see if people are willing and able to pay for different service levels, with explicit reference to vulnerable groups. There will be an open cross-subsidy, with tariffs ranging between 50 and 200 Taka, based on the service level. Householders have to sign an agreement with the provider and defaulters will be policed through community peer pressure and meetings. This will be tested to see if it is practical during the pilot stage, but is not envisaged to be a problem. SDF can arbitrate if the investor raises the tariffs.

53. The Local Authorities are aware of the process, but have no capacity or motivation to get involved beyond the legal aspects and political endorsement. SDF has been addressing the legal status of these schemes with relation to the pourashavas. DPHE is also observing the process as they have 70,000 villages requiring this level of service, but are constrained from innovative action by government rules. Scaling up this process will have to rely on decentralised structures rather than DPHE’s centralised operations.

54. The total cost of the project is 50 – 60 lakh (£50,000 - £60,000).

5 ANALYSIS

5.1 Relationships and political processes

*Policy*

55. Both NGO and private non-state provision is an accepted part of sector policy. How this is going to be put into practice is less clear, but pilot projects are being trialled to explore mechanisms.

56. The NGOs are trying to put the case for greater private sector involvement in the national strategy for the sector. NGOs are taking the lead in PPP approaches, rather than government. This is being discussed and some pilots are now being trialled prior to possible expansion. This follows on from the previous position 10 years ago when NGO activity was ignored but has now been accepted in the 1998 policy and NGOs treated as partners. Implementation mechanisms still need to be addressed. However even though NGOs have the (development partner led) blessing of Government, they can still be controlled by the Authorities on occasions and can only proceed with political support.

*Legislation*

57. Legislation did not seem to be an issue; even when NGO activities were “illegal” – such as dumping pit latrine waste into storm channels, this was accepted as a pragmatic solution rather than being actively regulated. However this same lack of enforcement also causes problems with issues of illegal connections to urban water supplies, which hampers the provision of water to legitimate customers.
Standards
58. The case of sanitation is a clear case of NGO services deviating from government standards. National policy documents do contain standard technical designs in great detail, rather than specifying performance standards. The NGO approach is to set people centred standards, such as latrines containing faeces effectively and not smelling or attracting flies, rather than specific dimensions and quantities of cement. Again the light regulatory touch does not adversely impact on NGO activities but does send a confusing message, especially to local government.

Regulatory and support systems
59. DPHE do not regulate the sector, but do collect coverage data. More active support is provided by some of the larger NGOs, such as WaterAid and NGO Forum.

60. Taking a different view, government actions through lack of a joined up approach, undermine both NGO and government actions, for example the approach to slum clearance conflicting with the programmes bringing water to the urban poor. Successful projects are reported to attract less obstruction by officials.

Agreements and understandings
61. Water Aid and other NGOs are engaging activity in developing the understanding of the issues by state actors and then formalising these perspectives in agreements.

5.2 Implementation of interventions

Regulation
62. There is no water regulator in the country. The WASA are autonomous and not regulated, let alone smaller service providers. Thus, from a watsan perspective rather than an NGO perspective, there is no controlling body. There is no regulation of drilling contractors except within the DWASA area, where a licensing system works. Politically as government is also an implementer, they cannot act as poacher and gamekeeper, and the time is still not ripe politically for government to withdraw totally from implementation.

Holding providers accountable to clients
63. Non-state providers seem to have closer relationships with their clients; NGOs taking a demand responsive approach and the private sector responding to market forces. Government admits it does not work effectively at a very local level, where NGOs and CBOs have a better knowledge of the situation.

Facilitating or supporting providers
64. One of the characteristics of NGO activity in Bangladesh is the multi-disciplinary nature of their activities. Whilst this is partly a development approach (e.g. based on holistic livelihoods), it is also a response to the funding streams, with a sector specialisation being too risky in terms of long-term funding. This does lead to a lack of expertise by some NGOs. However some umbrella NGOs, such as NGO Forum for Water Supply and Sanitation have been set up to complement government activities and support smaller NGOs – NGO Forum have 650 partners around the country which they support through training, resource centre, monitoring and evaluation, research and field activities. They also support the private sector, providing loans and training so they can produce the hardware that is being promoted by CBOs, raising awareness of sanitation issues.
65. NGO Forum report that they have no direct support from local government but do have their endorsement and local government is kept aware of the issues through Village Development Committees.

66. The government policy has now recognised the role of non-state providers and knows the sector needs to be upgraded to meet its potential, but the government is not sure how this can best be achieved. For example in the design and operation of rural piped water supplies there is a need for capacity development.

**Commissioning provision**

67. The Local Government Ministry has commissioned NGO Forum for social mobilization on sanitation in 20 sub-districts. DPHE hires local NGOs to provide the community work expertise that they lack. Government however does not have such a good system for using private sector organisations. Even where government commissions NGO activities, this is normally with donor money rather than state funds, with the Ministry providing contributions in kind (vehicles or office space). The rural piped water project is an experiment in more direct commissioning of providers, through a franchise approach rather than a direct contract.

6 EXPLANATION OF THE PERFORMANCE OF THE INTERVENTIONS

6.1 Impact of interested parties

68. Government does not take a high-profile role in service provision, but this is compensated for by high levels of activity in the NGO and private sectors, and also action by individuals at a local level. Individuals' interest in commissioning or campaigning for their water source or sanitation infrastructure seems to be the key factor in the successes seen here. Empowerment of communities unleashes resources in excess of anything that can be provided by state or non-state providers.

6.2 Capacity of control by policymakers

69. The capacity of control may not be high but that appears to be a positive decision, rather than a lack of resources. A laissez-faire approach appears to be adopted, with obvious signs of success. The only case were more control is required is the development of local government capacity to support (or not hinder) local activities and also for political action to address the problem of illegal connections in urban water supplies.

**Co-ordination by government**

70. One of the cases examined was the provision of water in Dhaka’s slums. Whilst the NGOs concerned had liaised with the parastatal DWASA and other local and national government departments, lack of a “joined up approach” had led to slums being cleared shortly after the construction of water points. A similar issue occurs in the rural sanitation sector, where sanitation is firmly on the political agenda and the Total Sanitation Approach being adopted widely, but local government capacity lagging behind and still considering discredited construction based approaches.

6.3 Capacity of control by clients

71. The clients do need support in developing their capacity; it is latent and often untapped. The example of empowerment and mobilisation in a Total Sanitation
Campaign shows how capacity development is the missing link and major barrier in many cases. A high level of willingness to pay for piped water shows how the clients can have clear expectations of the service they want. The control they exercise depends on the relationship with the supplier, with community/ demand driven relationships with NGOs and commercial relationships with the private sector seeming to be more open to influence than more centralised state approaches.

6.4 Capacity of intervening organization

72. Interventions supporting non-state provision take a laissez-faire attitude, so capacity to support inventions is not a great barrier to progress. Poverty and the capacity issues that stem from that (such as educational levels and physical resources) are more of a limiting factor in service provision than any state intervention.

73. The one area where capacity did appear to restrict progress was the failure of the private enterprise activity in DWASA operational activities, due partly due to the failure of the client (DWASA) to provide a level standard of service and information to the two different sub-contractors.

7 COMPARISON WITH GENERAL HYPOTHESES

Amount of research carried out into NSPs

74. Bangladesh does have a history of recording NSP action, especially the work carried out by WSP, WaterAid and other large NGOs. The level of NSP activity almost appears to be taken as standard within the country, only appearing unusual from the outside.

Ethical / ideological significance and political decisions.

75. The role of the entrepreneur and innovative NGO does seem to permeate society from the individual cycle rickshaw to well-managed NGOs. The fact that the full title of the Ministry of Local Government also refers to Co-operatives demonstrates the political significance of these actors.

76. The quasi-privatisation of parts of DWASA indicates the direction of government decision-making in this respect.

Blurring of boundaries

77. There is a blurring of boundaries between the NGO and private sector, with many NGO activities taking on the appearance of commercial activities (such as the latrine emptying), with the “charity” aspect being the piloting and development of capacity, rather than direct service provision. Between the state and non-state sector there is also blurring, with the piloting of the rural piped water schemes being a quasi-government activity and NGO support and funding coming from other NGOs rather than the state.

Economic/ social characteristics – nature of “clients” and “providers”

78. The economic and social profile of clients goes across the whole community. Urban water vending takes place on a formal, high volume basis for the more affluent members of society and also on a more informal, small-scale basis for the less well off. Rural sanitation mobilisation can result in a latrine costing Tk 700 being built next to a latrine costing TK 90, both as a result of the same approach. Non-state provision serves both rich and poor.
Recognition of NSPs as a basis of dialogue

79. There is a National Steering Committee for Watsan based in the Local Government Ministry. DPHE is a member of this committee, with NGO Forum as a representative of NGOs. This is where policy is discussed and working groups are based. DPHE and NGO Forum ran a joint consultation on the development of policy and are currently carrying out a similar process on the National Arsenic Policy, reaching to local groups through other development partners.

80. There is however no forum for the private sector; government does not have an organisation to have a dialogue with. At a local level however, local government can interact more successfully with civil society, including the private sector.

81. One NGO noted that they do not know how government departments work and what drives them, making engagement difficult.

Formal high quality or informal/ “not legal” provision

82. The hypothesis takes the stance that the informal sector provides a lower quality of service. Taking a technical approach, a Tk 700 latrine is a higher quality than a Tk 90 latrine, but in terms of performance specification, they both do the same job. “Quality” needs to be balanced with appropriateness and compared with no provision. A simple latrine is better than no latrine, rather than looking to an unachievable and inappropriate standard.

NSP grows in relation to state failure and state failure cannot regulate/ support NSP

83. The government maintains that many of the successes in the sector have been a result of piloting by the government and then handing over to non-state providers to scale up the activity; an example is the tubewell programme. Sanitation is allegedly following a similar pattern. Whether this is state failure or a sophisticated plan is not so clear!

Small/ informal = high cost low quality substitute for the poor

84. Whilst it is undoubtedly the case that the poor proportionately more for their water and proportionately have to make a larger investment in sanitation than their richer neighbours, this has to be placed within an assessment of being appropriate. Past sanitation programmes failed due to the use of inappropriate technical solutions. Quality should be judged by willingness to pay and fitness for use, rather than external assessments of quality using parameters that are not necessarily recognised by the client.

Regulation normally suppresses and marginalizes NSPs

Regulation governs entry not quality and accessibility

Regulation is difficult – especially if NSPs are not recognised

85. These three hypotheses cannot be tested due to the lack of active and obvious regulation.

Quality/ accessibility is best ensured through competition

86. There are two aspects to this. Yes competition exists, for example in the provision of sanitary hardware, but this has to be coupled with educating the client, so they can recognise the level of quality that they should select.
Community design is advocated but experience is scarce – needs sustained external facilitation.

87. This is one area where Bangladesh excels; the activities of “rural engineers” in designing and building appropriate low-cost sanitation solutions are of international importance. This does now appear to be moving towards a sustainable level, if the experience of tubewells and more formal sanitation hardware provision is to be followed.

Contracting out is efficient and effective but problems in (a) measuring service (b) multiple contracts (c) complex and long-term

88. There is limited experience of this, with the rural water schemes only being piloted. The DWASA project does appear to show successful and measurable improvements in service, but this is single contract with an organisation whose staff have extensive experience and knowledge of the service being provided.

Maintenance assumes political stability and neutrality – corruption requires independent pro-poor ideology

89. The level of maintenance needed for the rural services is small and seems to be in place. The urban schemes however do suffer more from the need for sustained political support; the failure of community water points is not in the hands of the implementing organisation, but requires government recognition and freedom from local organised crime groups.

7.1 Policy implications

90. From a global perspective, Bangladesh is very significant in terms of the provision of both water and sanitation services, and the role that non-state providers play in this, especially given its economic status. The sector is vibrant and is moving forward. Capacity development at a local government level is one specific area for development and sanitation funds should focus on this rather than construction activities. Putting power (often through education) into the hands of the client has been seen to be a powerful tool, both in the provision of technical services and addressing issues of corruption and illegal activities. Fostering a wide and varied entrepreneurial climate also seems to ensure that people (rich and poor) can meet their needs once they are aware of possible solutions.

91. The sector however does need to liaise with other government activities if progress is not to be wasted through opposing actions such as slum clearance. Regulation is also needed, as lack of a decent monitoring system lead to the arsenic crisis.

Recommendations

92. The recommendations of this study will be to learn from the Bangladesh experience. Whilst situations could be improved, especially with respect to capacity development, many of the easy policy decisions have been made. A national regulator is lacking; the regulatory role many not be crucial, but the monitoring, evaluating and dissemination of good practice is needed.
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