Contracting of Tuberculosis Services in Bangladesh:

Assessment Report

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MESSAGE

I am delighted to learn that the Health Economics Unit (HEU) of the Health Services Division, Ministry of Health and Family Welfare, in collaboration with the Health Systems for Tuberculosis (HS4TB) Project funded by the United States Agency for International Development (USAID), has conducted this comprehensive assessment on the opportunities and challenges for contracting of TB services in Bangladesh.

Bangladesh's health sector has been recognized globally for its achievements, especially for the public health indicators. It has been implementing the National Tuberculosis Control Program (NTP) as part of the Health Population and Nutrition Sector Program and has made significant progress over the past decade. It has increased the case detection rate remarkably and has achieved a 94% treatment success rate. The success is mainly due to government leadership, an increased focus of the current government on health issues, and support from development partners, especially the Global Fund and USAID.

The NTP is an example of partnership where a large number of nongovernmental organizations are involved under Global Fund financing. This type of collaborative arrangement with government stewardship has improved the efficiency of the program in terms of access and quality. The government has kept increasing the allocation to the NTP and is very keen to achieve the global targets.

We are aware that Bangladesh is fast approaching economic graduation under the able leadership of the current government. The economic transition will come with growing responsibilities for the government for funding and managing development programs, including the NTP.

We aspire for a self-reliant, sustainable, and resilient NTP for Bangladesh. At the same time, we need to ensure high-quality and cost-efficient TB services. We appreciate the valuable technical assistance from USAID and other development partners in the smooth transition of the NTP from being donor-supported to a domestically-funded and managed TB program.

Because our resources are limited, we need to ensure the best use of all available resources. Contracting should be used as a means for the optimum realization of value for money. I believe this is the right time for the NTP's stakeholders to prepare for participation in the future TB program through contracting to improve access, efficiency, and quality of services.

This Assessment Report will help guide us toward a cost-efficient, high-quality, sustainable TB program. I appreciate the leadership of the HEU in conducting the Assessment. I would also like to thank the USAID HS4TB Project for supporting the HEU in conducting the Assessment.

Joy Bangla
Joy Bangabandhu
Long live Bangladesh

Zahid Maleque, MP

Lokman Hossain Mia
Senior Secretary
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MESSAGE

A substantial component of healthcare management involves the acquisition of medical equipment, medicine, medical logistics, and health services. Under the existing management, institutions under the Health Services Division have implemented procurement and supply chains according to government regulations. In this case, nongovernmental organizations (NGOs) are involved in managing several health services, including the National Tuberculosis Control Program. They receive financial assistance directly from development partners and do not need to follow the country's procurement system. Government institutions also do not follow the public procurement process in securing NGOs' services when funded by development partners. Nevertheless, services provided by NGOs are widely appreciated.

To make healthcare efficient, quick, and universal, some services can be managed by a third party through various processes. This is an issue that requires investigation. On the other hand, the general capacity of private service providers and NGOs needs to be assessed. Initiating contracting in TB service delivery will develop a process for the health sector and its implementation will make healthcare more efficient.

It was within this context that I learned that the Health Economics Unit of the Health Services Division, with the support of the US Agency for International Development (USAID), conducted an assessment with the help of the USAID-funded Health Systems for Tuberculosis Project, which aimed to assign the delivery of healthcare services to third parties through contracts. This assessment has helped identify a way forward for contracting of healthcare services.

Bangladesh's achievements in various health indicators are recognized worldwide. Under the dynamic leadership of Honorable Prime Minister Sheikh Hasina, implementation of the National Tuberculosis Control Program as part of the Health Population and Nutrition Sector Program has been a great success. The contributions of the Global Fund, USAID, and other development partners are undeniable.

The role of NGOs also deserves praise. If development partners withdraw their support, the question is whether NGOs will continue to play their role. Will they continue to engage with the NTP? If so, in what process?

This assessment examined how nongovernment entities can be engaged under existing rules and regulations, what services can be contracted, whether the private sector is prepared with expected capacity, what the social or political response might be, etc.

I think now is the right time to address these challenges and to find the right path for universal healthcare to continue.

This assessment activity is timely. I welcome the next steps.

Lokman Hossain Mia

Prof. Dr. Abul Bashar Mohammad Khurshid Alam
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MESSAGE

There have been remarkable developments in the health sector in Bangladesh, including in the National Tuberculosis Control Program (NTP), over the past few decades, under the able leadership of the government. Despite significant progress, Bangladesh is still one of the 30 high TB-burden countries in the world. The country therefore warrants special attention and needs to undertake innovative measures to control TB. Sustainable Development Goal 3 includes the target of ending TB by 2030, among other goals. This is undoubtedly a daunting task because the COVID-19 pandemic has reversed various hard-earned achievements in the health sector. It has become imperative to redouble our efforts and increase investment to expand access to treatment for this killer disease. Moreover, multipronged initiatives and new approaches to reach TB patients are required.

Within this backdrop, the Health Systems for Tuberculosis (HS4TB) Project, funded by the US Agency for International Development (USAID), conducted this contracting assessment, led by the Health Economics Unit (HEU), in collaboration with NTP. The goal of the assessment was to identify reforms and capacity development support needed to introduce contracting/strategic purchasing in health service delivery, initially in TB service delivery, supporting the continuity of the TB program after the Global Fund transitions out.

The assessment report contains very useful information and recommendations, based on interviews with the most important stakeholders, and a review of existing rules, regulations, government circulars, and research findings. The report also contains recommendations based on the practical constraints confronted by the persons/organizations concerned with health service delivery.

With the future graduation of Bangladesh to middle-income status, there needs to be enhanced budget for the NTP to carry out its programs without interruption and in the context of the gradual withdrawal of funds by development partners. During the first-ever United Nations General Assembly High-Level Meeting on Tuberculosis in 2018, more investment and more partnership were among the most important priorities. In Bangladesh, more investment and the allocation of more government funds are needed, which requires an appropriate health financing strategy. Engaging more partners (e.g., nongovernmental organizations and civil society organizations) through contracting, along with the NTP's current implementing partners, will bring synergy in TB control. These ideas are echoed in different parts of the assessment report.

It is my firm conviction that the recommendations in the assessment report will help sustain the momentum of ongoing TB control activities. The report's findings and recommendations may further help improve TB control services in the country and help Bangladesh achieve different national and international goals in TB control.

I thank USAID, HEU, NTP, and all concerned stakeholders for their unwavering support in conducting the assessment and preparing this important report.

Prof. Dr. Abul Bashar Mohammad Khurshid Alam

Dr. Md. Khurshid Alam
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MESSAGE

The National Tuberculosis Control Program (NTP) in Bangladesh has a long history, and there have been challenges and successes over the years. It has adopted different strategies and programs based on needs and global initiatives and innovations. In the recent past, it has achieved significant success in terms of the case detection rate (81%) and treatment success rate (96.39%). The Government of Bangladesh, together with its partners from the public and private sectors, is committed to further intensify TB control activity to sustain the success achieved and to achieve the TB control targets in the World Health Organization (WHO) End TB Strategy.

Currently, a major part of the NTP in Bangladesh is supported by the Global Fund. The NTP has successfully contracted several nongovernmental organizations using Global Fund money and its contracting framework. This experience could be further used by the NTP and by the overall health sector because contracting will be cost-effective and beneficial. The current National Strategic Plan for Tuberculosis Control (2020–2025) has aligned its targets with the WHO End TB Strategy and plans to intensify the public-private mix approach to address the challenges of case detection and treatment, among other priorities.

The Health System for Tuberculosis Project, funded by the US Agency for International Development, has extensively examined the existing environment for contracting in the health sector, especially for TB services. A comprehensive assessment was carried out by the project, with NTP professionals working closely on the assessment. I believe the findings of the assessment report, and its recommendations will guide us to look for a sustainable pathway for the TB response program by using domestic funds in the near future. The assessment has created a new window to look for a sustainable and efficient health financing and governance system in Bangladesh.

I appreciate the work and would like to thank all who were involved in this process.

Dr. Md. Khurshid Alam

Dr. Mohd. Shahadt Hossain Mahmud
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FOREWORDS

The health sector in Bangladesh has made significant progress, including increasing access to services and working to achieve health targets, such as immunization coverage; reducing maternal and child mortality; and controlling communicable diseases. The sector is now moving toward universal health coverage to further improve quality of care and financial protection. This requires groundbreaking, innovative approaches in different components of health systems, including health financing. Further combining the efforts of the public, private, and nongovernment sectors in healthcare is also needed to increase economies of scale and to create synergies to achieve national goals.

The Health Economics Unit (HEU) of the Health Services Division, Ministry of Health and Family Welfare has been working to improve financing governance to increase resources in health, improve efficiency in the use of public resources, and advance equity. It has been implementing the Health Care Financing Strategy (2012–2032), which was designed to expand financial coverage to the whole population. The HEU is now reviewing the strategy to make necessary adjustments in light of the current situation in Bangladesh.

The Health Care Financing Strategy and many other key policy documents, such as the Eighth Five-Year Plan (2020–2025) (which is the national development plan), include provisions for the procurement of healthcare services from nongovernment entities to increase coverage and to improve efficiency and equity. However, such procurement has not yet been put into practice, mainly due to the non-availability of operational instruments, including a clear strategy and appropriate legal mechanisms. The Health Systems for Tuberculosis (HS4TB) Project, funded by the US Agency for International Development, provided an opportunity for the conduct of a comprehensive assessment, examining current practices for procurement/contracting in Bangladesh; reviewing to what extent the policy, legal, human resource capacity, and cultural contexts allow the process to be applied in the health system; and identifying potential next steps for the efficient use of contracting.

In addition to policy directives for procuring health services (through contracting), there are other immediate imperatives for adopting measures for contracting, especially for the National Tuberculosis Control Program. Recent successes in tuberculosis detection and treatment are largely due to government leadership in combining the efforts of nongovernmental organizations, which have been contracted with funding from the Global Fund. Because Global Fund financing is transitioning out, we need to sustain the momentum by replacing these external funds with government funding and a government process for procurement.

This assessment report was prepared through an extensive desk review, key informant interviews, and a consultative process with stakeholders under the guidance of a Steering Committee set up in the HEU. The assessment appropriately focused on four interrelated areas: review of the legal and policy environment; capacity of the health sector to introduce and manage contracting; capacity of nongovernmental organizations, civil society organizations, and the private sector to compete for and implement contracts; and the political economy for contracting health services in the current culture of direct government provisioning. The HS4TB team, comprising consultants who are very familiar with

the context and systems, worked with the working groups and the Steering Committee. After multiple consultations and reviews, the Steering Committee has finally accepted the assessment report and its recommendations. The report includes specific recommendations in each of the four areas of review and suggests a road map for implementation of the recommendations in a phased manner.

On behalf of the HEU, I personally appreciate the broader team for successfully completing the assessment, which I feel is a depiction of the real-world situation and an illustration of a future practical approach to this issue. I strongly believe that contracting will be a milestone in the history of healthcare reform in our country and will benefit the National Tuberculosis Control Program in the immediate term and the whole health sector in the near future.

Dr. Mohd. Shahadt Hossain Mahmud

ACKNOWLEDGMENTS

The Ministry of Health and Family Welfare (MOHFW), specifically the Health Economics Unit (HEU) and the National Tuberculosis Control Program (NTP), would like to thank and extend their great appreciation to all members of the Steering Committee for their contributions to the Contracting Assessment and this report. The MOHFW also extends its appreciation to all stakeholders who participated in the key informant interviews, which provided valuable context and insight that informed and enriched the development of each recommendation.

In addition, the MOHFW thanks the US Agency for International Development (USAID) and its partner, Health Systems for Tuberculosis (HS4TB), led by Management Sciences for Health, for their financial and technical assistance in the implementation of this assessment. The MOHFW appreciates the contributions of Sk Nazmul Huda, Md. Ashadul Islam, Md. Faruque Hossain, Quazi AKM Mohiul Islam, Elise Lang, and Zina Jarrah of HS4TB; and William Wells of USAID. All played key roles in the development and implementation of the assessment and the review of the report.

Acronyms

ACC	Anti-Corruption Commission
ADB	Asian Development Bank
BREB	Bangladesh Rural Electrification Board
BWDB	Bangladesh Water Development Board
CHW	community health worker
CMSD	Central Medical Stores Depot
CPTU	Central Procurement Technical Unit
CSO	civil society organization
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DIMAPP	Digitalization of Implementation Monitoring and Procurement Project
DP	development partner
e-GP	Electronic Government Procurement [system]
ESP	essential service package
FDRA	Foreign Donation (Voluntary Activities) Regulations Act 2016
FY	fiscal year
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
HCFS	Health Care Financing Strategy (2012–2032)
HED	Health Engineering Department
HEU	Health Economics Unit
HPNSP	Health, Population, and Nutrition Sector Program
HR	human resource
HS4TB	Health Systems for Tuberculosis
HSD	Health Services Division
IMED	Implementation, Monitoring and Evaluation Division [Ministry of Planning]
INGO	international nongovernmental organization
IT	information technology
KII	key informant interview
LGED	Local Government Engineering Department
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MOLG	Ministry of Local Government, Rural Development and Cooperatives
MOP	Ministry of Planning
MOU	memorandum of understanding
NGO	nongovernmental organization
NGOAB	NGO Affairs Bureau
NIKDU	National Institute of Kidney Diseases & Urology
NSP	National Strategic Plan
NTP	National Tuberculosis Control Program
OP	operational plan
OSTEM	One Stage Two Envelope Method
OTM	Open Tendering Method
PE	procuring entity

PFM	public financial management
PP2041	Perspective Plan 2041
PPA	Public Procurement Act 2006
PPM	public-private mix
PPP	public-private partnership
PPR	Public Procurement Rules 2008
PPS	public procurement system
PSSM	procurement, storage, and supply management
SC	Steering Committee
SDG	Sustainable Development Goal
SEM	Social Enterprise Model
SPD	standard procurement document
STD	standard tender document
SWAp	sector-wide planning approach
TB	tuberculosis
UHC	universal health coverage
UPHCSDP	Urban Primary Health Care Services Delivery Project
USAID	US Agency for International Development
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The NTP in Bangladesh has achieved considerable success over the past few decades due to strong government leadership in the engagement of public, private, and nongovernmental organization (NGO) providers and development partners (DPs) in the program response. To achieve the tuberculosis (TB) targets set in the National Strategic Plan (NSP) 2020–2025, the NTP needs to continue to implement key strategies, such as maintaining the role of NGOs. This will require sustainable financing and some policy changes.

Contracting clinical and non-clinical TB services to NGOs/civil society organizations (CSOs) is a key strategy to achieve the country's TB control goals. However, this arrangement has occurred under Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) systems and funding since 2003. Such contracting does not follow the government's financial and contracting systems. As Bangladesh continues to experience a period of rapid economic growth, it is transitioning away from dependence on external aid for health. This transition requires adequate planning and preparedness to avert disruptions in service delivery that could arise without adequate systems in place as the country assumes more direct financial and programmatic responsibility for its health programs.

This assessment was undertaken to understand the regulatory and policy environment, and the capacity issues for introducing contracting of clinical and non-clinical services to NGOs/CSOs/private sector entities through the public procurement system (PPS) with government funding. The goal of the assessment was to explore the adequacy of the current legal, regulatory, and policy environment to support contracting of TB services; the current landscape of contracting with NGOs/CSOs/private sector; the institutional capacity of the MOHFW, NGOs, CSOs, and the private sector for contracting; and political economy considerations and potential political barriers to contracting.

The assessment was conducted under the guidance and leadership of a Steering Committee (SC) that was established and headed by the HEU at the MOHFW, with the USAID-funded HS4TB project staff primarily serving a role in the data collection and analysis.

Key Findings

Bangladesh has been trying to move toward universal health coverage (UHC). Critical policy documents, such as the Eighth Five-Year Plan (2020–2025) and the Health Care Financing Strategy (2012–2032) include a role for increased involvement of nongovernment sectors and government procurement of health services. Bangladesh has a robust legal and regulatory framework that guides procurement, which is based on the Public Procurement Act (PPA) 2006 and Public Procurement Rules (PPR) 2008. However, the current legal regulatory framework provides a narrow opportunity for contracting health services to nongovernment entities (NGOs/CSOs). The PPA and PPR focus on procurement of goods and works; they need to be further developed to include provisions for the procurement of physical services and contracting NGOs/CSOs for health services. Under the legal framework, NGOs/CSOs are not eligible to be tenderers in the PPS because they are not listed in the definition of a tenderer in the PPA and PPR. Even if they were considered eligible, NGOs and CSOs do not meet the current qualifications to enter into an agreement for the procurement of services because they do not belong to a trade/professional organization, do not have previous contracting experience with the government, and may struggle to show liquid assets and lines of credit.

Contracting TB services will require including health services in the definition of physical services because it falls under the procurement category of "physical services." Although procurement of physical services is permitted, the relevant legal framework (instrument), including a standard tender document (STD) to

guide the contractual mechanism, does not exist as a whole; therefore, these types of procurements are happening on a very small scale. There is no STD or other procurement guideline specifically for the health sector or for TB services, and without this, the execution of a health-related service contract would be difficult.

Bangladesh has widespread and varied experiences contracting with the private sector to provide technical assistance, goods, works, support services for research and training, and such support services as logistics, information technology, human resource support, and analytics, but not health services. Health sector NGOs and CSOs have experience being contracted to provide health services using DP funding (e.g., World Bank [WB], USAID Foreign, Commonwealth & Development Office, GFATM). However, because these contracts are executed following DP regulations, the NGOs and CSOs have no exposure to or experience working through the government's public procurement process.

In addition, the health sector, in general, faces capacity gaps to appropriately design, negotiate, implement, and monitor contracts. Most of the contractual processes are conducted manually, with limited administrative, financial, or programmatic systems in place to allow the MOHFW to monitor and use data generated by the contractor. Although an electronic platform, referred to as e-GP (Electronic Government Procurement), exists for procurement, the platform provides support to procure only goods and works, not physical services. Moreover, the health sector has limited capacity to use this platform for procuring goods and works.

Contracting health services is a politically sensitive policy decision that should be approached carefully to ensure political buy-in and public acceptability. For contracting to succeed, political agreement at the highest level of government should be obtained and sufficient capacity built. The Government of Bangladesh (GOB) has been pursuing private sector-led economic growth and promoting the nongovernment and private sectors for socioeconomic development. Contracting health services is included in policy documents in some form, but there is no explicit strategy for its implementation in any health program. Historically, health services have been a government responsibility, and the public health system is designed to deliver services directly. Introducing contracting-out requires shifting the perspectives of policy makers and health managers, and ensuring alignment with government strategies. The government is aware of the GFATM transition but has not yet initiated any significant steps to manage and address the transition—especially the financial and programmatic effects on the NTP.

Priority Recommendations

The analysis led to a series of recommendations to improve the enabling environment for contracting TB services to NGOs and CSOs through government channels. The following is a list of priority recommendations. The complete set of recommendations can be found in the full report below. The recommendations are categorized by topic area explored in this report: (L) – legal and regulatory; (N) – NGO capacity; (M) – MOHFW capacity; and (P) policy buy-in.

Recommendation 1 (M). The HEU at the MOHFW and the NTP conduct an analysis to support the decision-making process for which TB services to contract and where, including fiscal space projections with scenarios for decreased donor funding, and the strengths and experiences of the government and NGO sectors relative to TB clinical and non-clinical services.

Recommendation 2 (P). In collaboration with the NTP, the HEU develops a set of advocacy materials on the rationale and expected benefits of contracting of health services, in general, and of

clinical and non-clinical TB services specifically, including policy briefs targeting different levels of the government.

Recommendation 3 (P). The HEU develops a detailed stakeholder engagement plan, based on the initial stakeholder analysis and recommendations, to manage each player based on their power, interest, and probable position on whether to contract health services. (**Annex 8** provides more detail.)[1]

Recommendation 4 (P). The HEU, with the Directorate General of Health Services (DGHS), conducts advocacy and sensitization meetings, seminars, conferences, networking, and strategic engagement on contracting health services across key stakeholders and change agents in the MOHFW, Ministry of Finance (MOF), Ministry of Planning (MOP), NGOs, CSOs, and professional associations.

Recommendation 5 (P). The HEU develops and obtains high-level endorsement from the MOHFW on a position paper that demonstrates the clear commitment of the GOB to pursue contracting and contracting of selected health services and link this reform to key national priorities laid out in the Eighth Five-Year Plan (2020–2025).

Recommendation 6 (L). The HEU mobilizes the Central Procurement Technical Unit (CPTU) to identify a focal point to facilitate communication and required changes in the PPA, PPR, and other legal instruments.

Recommendation 7 (L). In collaboration with the CPTU, the HEU proposes specific amendments to the legal and regulatory framework, including the PPA 2006, PPR 2008, and Delegation of Financial Powers, to incorporate the necessary provisions for contracting health services to CSOs, NGOs, and the private sector. They include: (1) amendments to allow NGOs and CSOs to be tenderers in government procurement processes; (2) amending the qualifications and/or creating new qualifications for being a tenderer that are more appropriate and in line with NGO and CSO business models; (3) including health services in the definition of physical services; (4) creating a required STD for physical services, especially health-related services; and (5) defining the authority for the procurement of physical services in the Delegation of Financial Powers.

Recommendation 8 (P). The HEU uses the policy briefs (Recommendation 2) and Roadmap (Recommendation 9) to engage MOHFW decision makers to include contracting in key MOHFW policy documents, such as Operational Plans (OPs), Next Sector Program, National Healthcare Financing Strategy, and National Strategic Plan for TB Control.

Recommendation 9 (M). For effective planning, implementation, management, monitoring, and evaluation, the HEU and NTP lead the development and implementation of a Roadmap and action plan for government-led and financed contracting of TB services. The plan can include activities for the review and strengthening of procurement systems; training and refresher training; and the development of laws, policies, strategies, tools, guidelines, etc. The HEU and NTP also coordinate with the GFATM on its transition readiness planning for the TB program.

Recommendation 10 (P). In view of the trend of decreasing donor funding and increasing funding gaps, the HEU works closely with the Program Management and Monitoring Unit of the MOHFW, the NTP, MOF, and MOP to mobilize domestic resources for the TB program within the government's fiscal space.

[1] Note: This Annex may be removed before sharing widely because the stakeholder analysis and recommended actions may contain some sensitive information.

INTRODUCTION AND COUNTRY CONTEXT

Bangladesh has achieved considerable economic growth in the past decade, with the gross domestic product (GDP) increasing by 6 percent[2] per year, on average, placing the country in the lower-middle income bracket and on a fast track to reach upper-middle income status. With the resulting poverty reduction and improvements in health outcomes, Bangladesh is embarking on a transition away from dependence on external aid for health services, including for tuberculosis (TB). As the country assumes more direct financial and programmatic responsibility for its health programs, the Government of Bangladesh (GOB) needs to adequately plan for and prepare to mobilize sufficient resources (financial, human, and medical) to sustain the significant gains already made and scale the TB response to reach Bangladesh's goals.

Nongovernmental organizations (NGOs) and civil society organizations (CSOs) play an important role in the national TB response, providing most of the supportive staffing for the national TB program. NGO staff carry out a variety of roles, from serving as extra lab staff, to community health workers (CHWs), to active case finding personnel at the community level. However, these NGO services are financed through contracts from the US Agency for International Development (USAID) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). To ensure that the national TB response is uninterrupted as the country transitions away from external funding, the GOB needs a way to start issuing and managing similar contracts to NGOs, CSOs and other private sector organizations. The purpose of this report is to examine the legal and regulatory barriers for the GOB to contract TB services to NGOs, examine the capacity of the GOB and NGOs to execute and manage contractual agreements, and explore the political economy around contracting-out health services.

Summary of Economic, Health, and TB-Related Outcomes

Before the COVID-19 pandemic, Bangladesh was among the five fastest growing economies in the world, with GDP growth reaching 8.2 percent in 2019 (figure 1).[3] Despite being one of the poorest nations in the world at its independence, Bangladesh's GDP per capita grew fifteen-fold between 1971 and 2019, from USD133.5 to USD1,954 (constant USD). The country's poverty rate dropped from 44.2 percent in 1991 to 14.8 percent in 2016, resulting in more than 23 million people being lifted out of poverty.

[2] The World Bank. GDP growth (annual %) – Bangladesh, 1961–2020. Washington, DC: The World Bank Group; 2022. Available from https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=BD.
[3] Hussain Z, Mahmood SA, Khan NS, et al. Bangladesh development update: Towards regulatory predictability. Washington, DC: The World Bank Group; 2019.

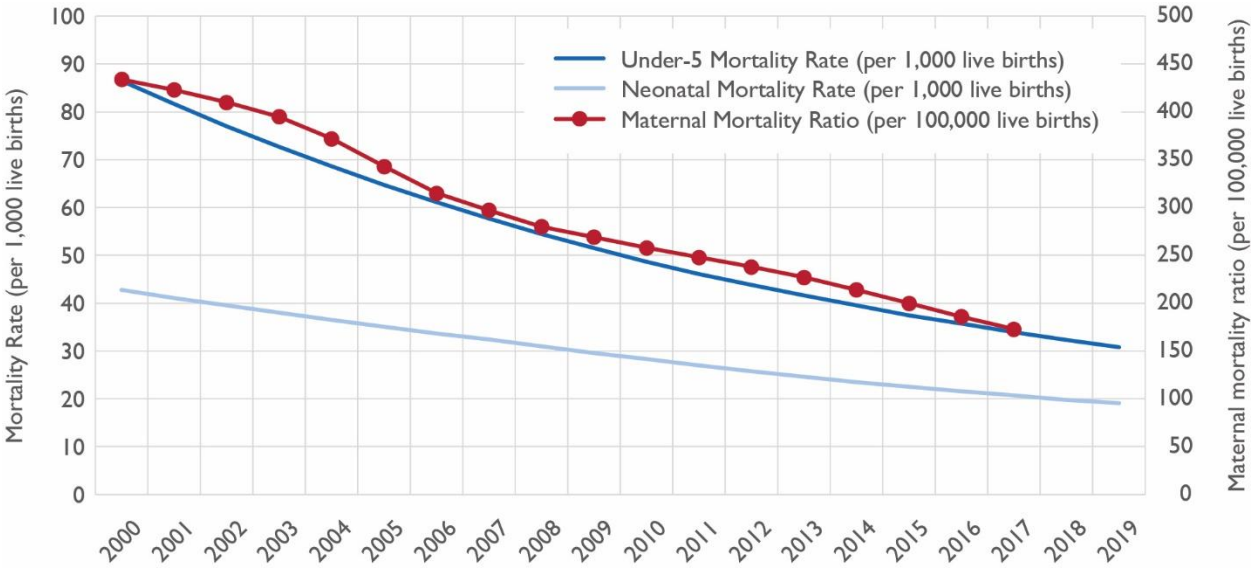
Figure 1. GDP growth and GDP per capita, 2009–2020[4]

Continued economic growth remains a key national priority. Bangladesh's Vision 2041, introduced in the 2021–2041 Perspective Plan (PP2041), aims to eradicate extreme poverty, achieve upper-middle income status by 2030, and high-income status by 2041. However, like other countries, Bangladesh faces the daunting challenge of fully recovering from the COVID-19 pandemic, which has constrained economic activities and reversed some of the gains achieved in the past decade. The COVID-19 pandemic decelerated economic growth in 2020 (although growth is forecasted to have increased by 5 percent in 2021 and to increase by 7.5 percent in 2022).[5] The pace of poverty reduction slowed down, exports declined, and inequality increased across several dimensions. Bangladesh also needs to address several challenges, including creating employment opportunities; increasing human capital and developing a skilled labor force; making infrastructure more efficient; and creating a policy environment that attracts private investments.

Concurrent with Bangladesh's economic growth have been significant improvements in human development and health outcomes. Life expectancy increased steadily from 46.6 years at birth in 1971 to 72.6 by 2019 (compared with the South Asian average of 69.6 years).[6] Bangladesh is making strides toward achieving health-related Sustainable Development Goals (SDGs), especially in the case of under-five mortality (currently at 30 deaths per 1,000 against a target of 25); neonatal mortality (currently at 19 deaths per 1,000 against a target of 12); and maternal mortality (currently at 173 deaths per 100,000 live births against a target of 140) (figure 2).

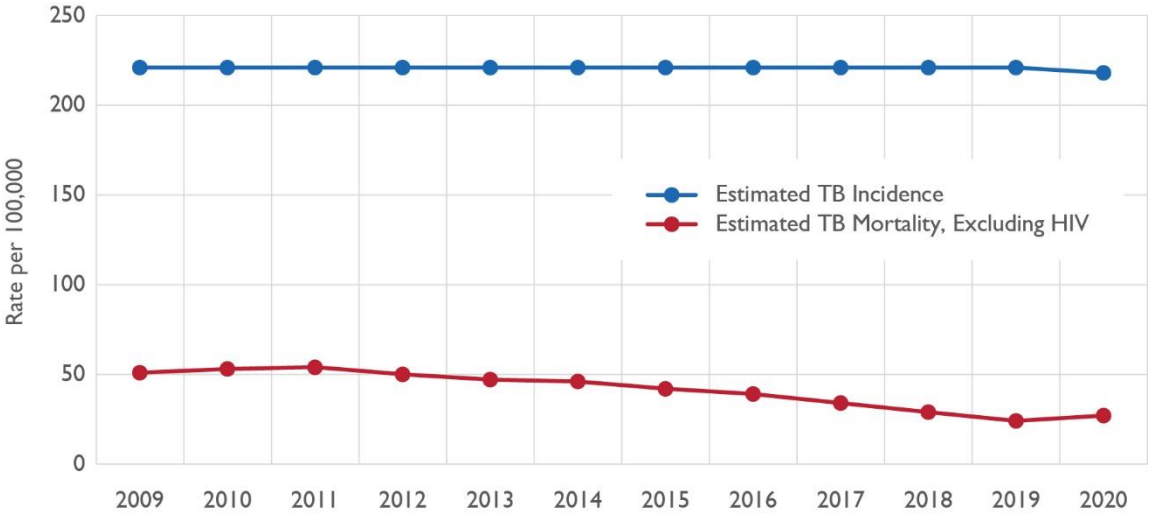
Figure 2. Bangladesh's progress on health-related SDGs, 2000–2019[7]

[4] The World Bank. GDP growth (annual %) – Bangladesh, 1961–2020. Washington, DC: The World Bank Group; 2022. Available from https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=BD.
[5] International Monetary Fund. World economic outlook: Managing divergent recoveries, April 2021. Washington, DC: International Monetary Fund; 2022. Available from https://www.imf.org/en/Publications/WEO/Issues/2021/03/23/world-economic-outlook-april-2021.
[6] The World Bank. Data: Bangladesh. Washington, DC: The World Bank Group; 2022. Available from https://data.worldbank.org/country/bangladesh.
[7] The World Bank. World development indicators. Washington, DC: The World Bank Group; 2022. Available from https://datatopics.worldbank.org/world-development-indicators/.



Despite the overall improvements in health outcomes, Bangladesh remains one of the world's highest burden countries for TB, with an estimated 360,000 people contracting TB and 44,000 TB-related deaths per year.[8] The estimated TB incidence currently stands at 218 cases per 100,000 (figure 3).

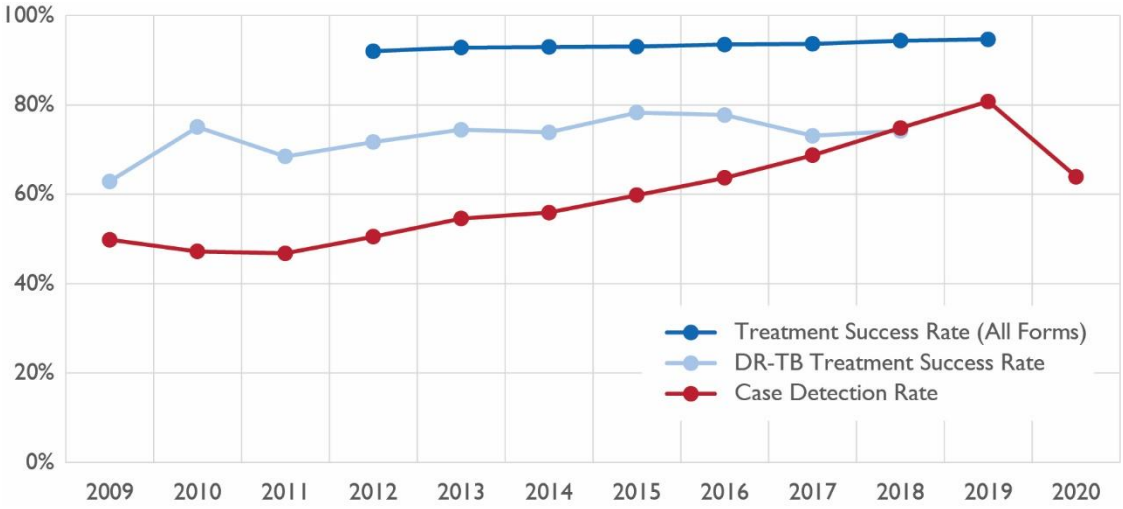
Figure 3. Estimated TB incidence and TB mortality rate per 100,000, 2009–2020[9]



However, the TB treatment success rate remains high, at more than 90 percent. Although the case detection rate fell in 2020, largely due to the COVID-19 pandemic, it had increased steadily from less than 50 percent in 2012 to 81 percent in 2019 (figure 4).

Figure 4. TB treatment success rate and case detection rate, 2009–2020[10]

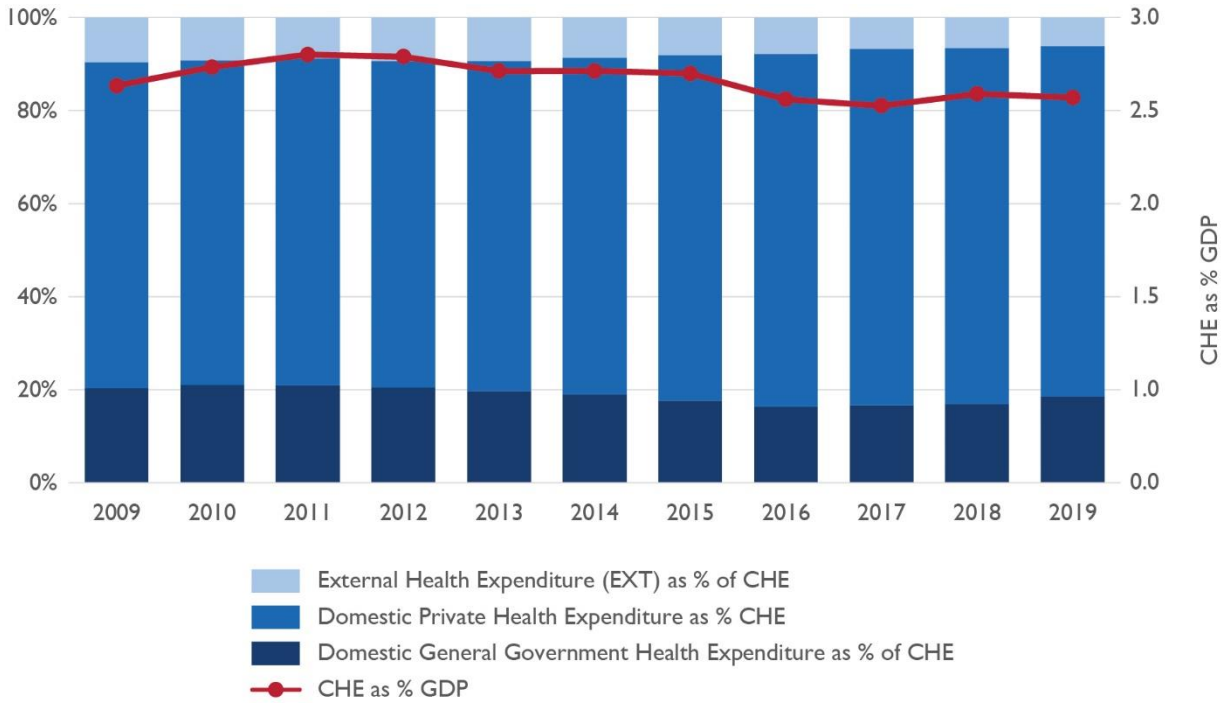
[8] World Health Organization (WHO). Global tuberculosis report 2021. Geneva: WHO; 2021. Available from https://www.who.int/teams/global-tuberculosis-programme/data.
[9] Ibid.
[10] World Health Organization (WHO). Global tuberculosis report 2021. Geneva: WHO; 2021. Available from https://www.who.int/teams/global-tuberculosis-programme/data.



Health spending in Bangladesh has remained relatively constant in the past decade, averaging 2.4 percent of GDP and representing USD37 per capita in 2015.[11] Private health expenditure, primarily consisting of out-of-pocket payments (67 percent), comprises the vast majority of spending on health, at 76.6 percent of current health expenditures. This is followed by government sources, at 16.7 percent of the total, and external sources cover the remaining 7.0 percent.[12] Government allocation to health is low, at 5.42 percent of the national budget and less than 1 percent of GDP in fiscal year (FY) 2021–2022 (figure 5).[13]

[11] Mustafa A, Rahman A, Hossain N, et al. Bangladesh national health accounts 1997–2015 (BNHA-V). Dhaka: Health Economics Unit, Health Services Division, Ministry of Health and Family Welfare; 2018.
[12] Ibid.
13 Ministry of Finance (MOF). Bangladesh national budget 2021–2022. Dhaka: MOF; 2021.

Figure 5. Current health expenditure (CHE), by source, and as a percentage of GDP, 2009–2019[14]



Bangladesh has a pluralistic health system encompassing the government, private sector, NGOs, and donors. By constitutional mandate, the government sets health policy and regulation, and is responsible for the provision of comprehensive health services, including financing and employing health staff.[15] The public sector health-delivery landscape is comprised of 53 District Hospitals, 425 Upazila Health Complexes, 1,469 Union Health and Family Welfare Centers, and 12,248 community clinics at the ward level.[16] The provision of urban primary healthcare falls under the purview of the Ministry of Local Government, Rural Development and Cooperatives (MOLG). The MOLG manages the Urban Primary Health Care Services Delivery Project (UPHCSDP), which is funded by a GOB grant and an Asian Development Bank (ADB) loan. In partnership with NGOs, the project provides health services to the urban poor in all seven city corporations and five municipalities in the country.

According to the most recent Bangladesh National Health Accounts 1997–2015, three types of providers account for most health provision: 41 percent of expenditure occurs at drug outlets and medical goods retailers; 30 percent at hospitals; and 15 percent at ambulatory healthcare providers.[17] Private providers and NGOs have steadily become a larger source of health service provision over the past several decades, rising from 28.9 percent of all hospital expenditures in 1997 to 70.4 percent by 2012.[18]

The NGO sector has emerged as a critical sector for health service delivery, with a dynamic landscape of nearly 2,500 registered NGOs working in the population, health, and nutrition sector. NGOs are especially active in the provision of health promotion and prevention activities. Last, the informal

[14] World Health Organization (WHO). Global health expenditure database. Geneva: WHO; 2022. Available from https://apps.who.int/nha/database.
[15] World Health Organization (WHO). Bangladesh health system review. Manila: WHO Regional Office for the Western Pacific; 2015. Available from https://apps.who.int/iris/handle/10665/208214.
[16] Ibid.
[17] Mustafa A, Rahman A, Hossain N, et al. Bangladesh national health accounts 1997–2015 (BNHA-V). Dhaka: Health Economics Unit, Health Services Division, Ministry of Health and Family Welfare; 2018.
[18] Ibid.

sector plays an important role in service provision, especially as a key source of healthcare to the urban poor in Bangladesh, although nationally representative data on the informal sector are lacking.[19]

The Ministry of Health and Family Welfare (MOHFW) has implemented a sector-wide planning approach (SWAp) since 1998. The current program, under the 4th Health Population and Nutrition Sector program (2017–2022), aims to move progressively toward universal health coverage (UHC) by improving governance and stewardship, and strengthening health systems to provide high quality and equitably accessible health services. Challenges to achieving UHC remain, especially relating to the country's rapidly shifting demographic and epidemiologic profile, environmental changes, and the incidence of emergencies and outbreaks. Bangladesh also faces an acute shortage of health professionals. The public sector suffers from absenteeism, and an improper skill mix and deployment of human resources for health. In addition to these challenges, Bangladesh continues to contribute humanitarian services, including the provision of healthcare, to more than one million forcefully displaced Myanmar nationals who have fled ethnic cleansing in Myanmar since August 2017.

The Health Care Financing Strategy (HCFS) 2012–2032 cites three broad categories of challenges relating to financing in the health sector: (1) inadequate health financing; (2) inequity in health financing and utilization of health services; and (3) inefficient use of existing resources. [20] In response to these challenges, the HCFS outlines three key areas for reform. The first is to generate more resources for health through an increase in the amount and efficiency of the government's budget allocation, and by designing and implementing a compulsory Social Health Protection Scheme targeting the poor and informal sector living below the poverty line, and progressively extending coverage to the remaining population by 2032.

The second reform is to enhance the efficiency of resource allocation and utilization through needs-based local-level budgeting and planning; deconcentration of budget and rationalization of expenditure control; development of financial management capacity at all levels of the health sector; and scaling up innovative provider payment mechanisms, such as results-based financing.

Last, the HCFS proposes strengthening national capacity—both individual and institutional capacity—in the public, private, and NGO sectors. This entails developing the capacity to design and implement the Social Health Protection Scheme; strengthening financial management and accountability in the public sector; improving monitoring and evaluation; and introducing mechanisms to increase the availability of human resources for health. The HCFS also highlights the need to maximize the complementary role of NGOs and the private sector through contracting and public-private partnership (PPP).[21]

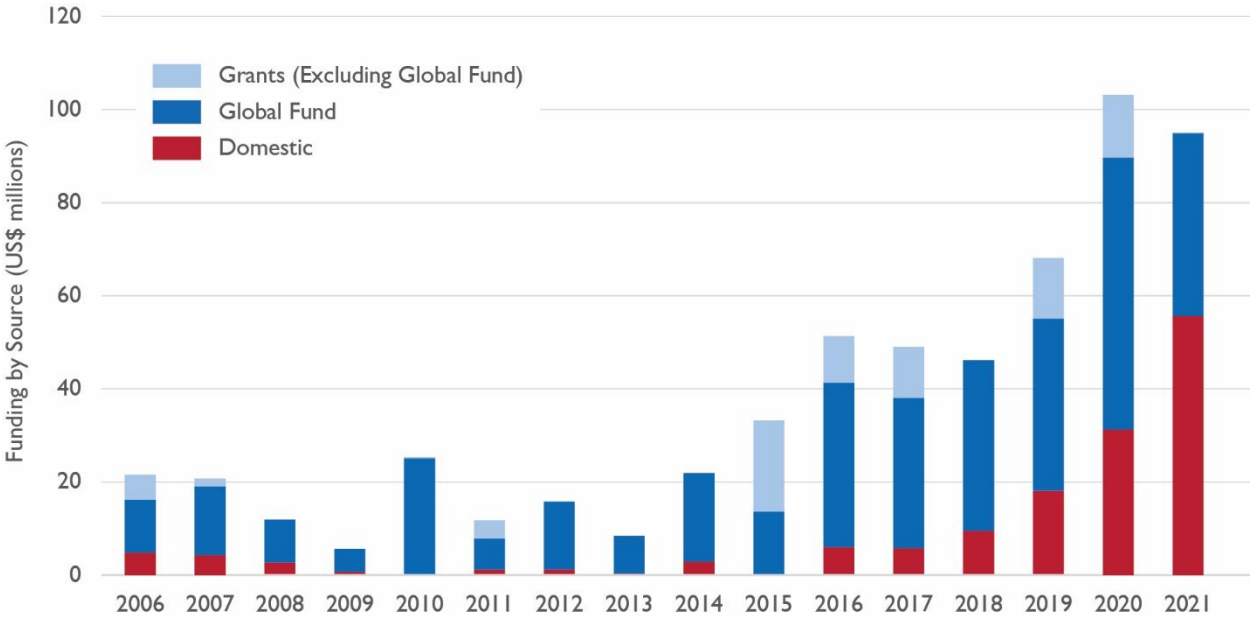
Status of Transition and Sustainability of the National TB Program

The national TB program is highly dependent on external funding in Bangladesh, especially when compared with the breakdown in overall spending on health shown in figure 5. In 2017, of the total estimated USD89.2 million spent on TB, 53.9 percent came from development assistance, 25.2 percent

[19] Ahmed SM, Hossain AM, Chowdhury MR. Informal sector providers in Bangladesh: how equipped are they to provide rational health care? Health Policy Plan. 2009 Nov; 24(6) 467–478.
[20] Health Economics Unit, Ministry of Health and Family Welfare. Expanding social protection for health: Towards universal coverage. Health care financing strategy 2012–2032. Dhaka: Health Economics Unit, Ministry of Health and Family Welfare; 2012. Available from https://socialprotection.gov.bd/wp-content/uploads/2017/03/HCF-Strategy-Bd-2012-2032.pdf.
[21] Note that the HCFS is currently under review.

from government spending, and 20.5 percent from out-of-pocket spending.[22] The national government TB budget for 2021 amounted to USD157 million, of which 35 percent was funded by domestic sources, 25 percent by international sources, and the remaining 39 percent remained unfunded.[23] This represents a change to previous years, where external funding sources considerably outweighed domestic funding (figure 6). This increase in domestic funding for TB is partly a reflection of the GOB buying first-line TB drugs that in previous years were procured with GFATM funding.

Figure 6. Funding of national TB budget, by source, USD millions, 2006–2021[24]



External funding for TB is largely provided by the GFATM and, to a lesser extent, by USAID. A substantial proportion of these funds are channeled through NGOs and CSOs. USAID's budget for TB in Bangladesh for FY2021 was USD16.1 million.[25] The GFATM allocated USD115.8 million to TB for the 2020–2022 period (representing 72.9 percent of the total country allocation).[26] Based on a longstanding role for multiple organizations in the TB response in Bangladesh, 64 percent of the GFATM grant amount is implemented through international NGOs (INGOs).[27] The largest of the INGO implementers is BRAC, which was established in Bangladesh in 1972 and operates in all 64 districts of the country. Other large NGOs that participate in the TB response include the Damien Foundation Bangladesh, Heed Bangladesh, icddr,b, Rangpur Dinajpur Rural Service, and Interactive Research and Development Bangladesh. As the country transitions from donor funding, the GOB

[22] Institute for Health Metrics and Evaluation (IHME). Financing global health 2019: Tracking health spending in a time of crisis. Seattle, WA: IHME; 2020.
[23] World Health Organization (WHO). Global tuberculosis report 2021. Geneva: WHO; 2021. Available from https://www.who.int/teams/global-tuberculosis-programme/data.
[24] Ibid.
[25] US Agency for International Development (USAID). Bangladesh tuberculosis roadmap overview, fiscal year 2021. Washington, DC: USAID; 2021. Available from https://www.usaid.gov/global-health/health-areas/tuberculosis/resources/news-and-updates/global-accelerator-end-tb/tb-roadmaps/bangladesh.
[26] The Global Fund. Financials. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2022. Available from https://www.theglobalfund.org/en/financials/.
[27] The Global Fund. Audit of Global Fund grants in Bangladesh. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2017. Available from https://www.theglobalfund.org/en/oig/updates/2017-12-22-audit-of-global-fund-grants-in-bangladesh/.

will need to adjust its role in financing and purchasing TB services to be able to leverage the existing network and reach of the INGOs to be able to sustain and scale the TB response.

Rationale for Contracting of TB Services

Global evidence suggests that forming stable, meaningful partnerships between the government and NGOs/CSOs can improve a country's ability to respond to diseases, such as TB.[28] Contracting reforms in the public sector are usually motivated by a desire to reduce government spending and improve efficiency in the face of increasing healthcare costs,[29] and to take advantage of different relative skill sets in government and the private sector. NGOs, CSOs, and the private sector are often better equipped to provide certain essential services in a manner that is more effective and efficient than the government—especially for disease areas that infrequently receive domestic support—and in targeting marginalized and neglected populations.[30] As more and more low- and middle-income countries engage in contracting, growing evidence suggests that contracting health services can result in better outcomes than government provision,[31] especially when formal, well-designed contracts target specific government capacity issues while reducing duplication of services.[32,33]

The critical need for governments to engage NGOs and CSOs to meet national TB targets has been well-documented and advocated by the global community for decades.[34] Approximately 80 percent of TB services at the subdistrict level in Bangladesh are provided by NGOs/CSOs, and a substantial proportion of missed TB cases (43 percent of all estimated cases in 2015) were diagnosed and/or treated by NGOs/CSOs. NGOs/CSOs are essential to the TB response; however, their services are largely financed through GFATM contracts. As the GOB reduces its dependence on external funding, it will need a way to contract with NGOs/CSOs to sustain the gains made in TB and continue to scale up and address gaps in the national response. Many countries, including Bangladesh, contract with the private sector for support services, such as construction work, hospital food, and laundry services. With this experience as a base, the GOB can build on the existing contracting framework to contract with NGOs/CSOs and improve the sustainability of the TB response.

Based on the recent achievements in TB detection and treatment, the National Tuberculosis Control Program (NTP) has been striving to achieve the End TB Strategy milestones for 2025 (75 percent reduction of TB deaths and 50 percent reduction of TB incidence) and the targets for 2035 (95 percent

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[28] The Global Fund. Social contracting diagnostic tool for HIV, TB and malaria programs. Guidance note for use of tool for HIV and TB programs. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2017.
[29] Skipworth H, Delbufalo E, Mena C. Logistics and procurement outsourcing in the healthcare sector: A comparative analysis. European Management Journal. 2020 Jun; 38(3): 518–532.
[30] Open Society Foundations, The United Nations Development Programme, and The Global Fund to Fight AIDS, Tuberculosis and Malaria. A global consultation on social contracting: Working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society, meeting report. 2017, Oct 5–6; New York, NY. Available from http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf.
[31] Loevinsohn B, Harding A. Buying results? Contracting for health service delivery in developing countries. Lancet. 2005 Aug 20-26;366(9486):676-81.
[32] Bustreo F, Harding A, Axelsson H. Can developing countries achieve adequate improvements in child health outcomes without engaging the private sector? Bull World Health Organ. 2003;81(12):886–95.
[33] Mills A, Brugha R, Hanson K, et al. What can be done about the private health sector in low-income countries? Bull World Health Organ. 2002;80(4):325–30.
[34] World Health Organization (WHO). Engaging private health care providers in TB care and prevention: a landscape analysis, second edition. Geneva: WHO; 2021.

reduction of TB deaths and 90 percent reduction of TB incidence).[35] Achieving these objectives and maintaining momentum through a transition from donor funding will require implementing strategies to extend the government's engagement with NGOs/CSOs/private sector considering their significant involvement in the TB response.

External funding for TB will likely decrease as Bangladesh's economic status continues to improve. A transition process is needed for the ongoing delivery of TB-related services currently provided by NGOs and CSOs. It is very likely that the services of such NGOs and CSOs will remain important in the national TB response. Therefore, the GOB needs to develop a government-led mechanism to contract these organizations and to provide a sustainable financing channel for these services, while also establishing a mechanism by which government can steer the overall TB response.

The delivery of TB services—both clinical and non-clinical—presents a useful "test case" for the GOB to conduct contracting with NGOs and CSOs for the first time in the health sector. Developing the capacity to contract, including the requisite legal and regulatory framework to appropriately cover the provision of health-related services, will serve a useful strategy to strengthen the overall capability of the public sector. The recommendations in this report, while proposed through the lens of providing TB services, are relevant to contracting health services generally and will strengthen the country's overall public health financing.

Definition of Key Terms

For the purposes of this assessment, the definition of a few key terms is important. In relation to health, the World Health Organization (WHO) defines the private sector as "the individuals and organizations that are neither owned nor directly controlled by governments and are involved in provision of health services. It can be classified into subcategories as for profit and not for profit, formal and informal, domestic and international."[36] As outlined in this definition, this includes private sector organizations that are providing not just direct health care services, but also health-related services in a wide range of other areas, such as supply chain and connectivity.

The World Bank (WB) defines CSOs as "the wide array of non-governmental and not for profit organizations that have a presence in public life, express the interests and values of their members and others, based on ethical, cultural, political, scientific, religious or philanthropic considerations."[37] NGOs are more broadly defined as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services or undertake community development."[38] The main difference between these two terms is that CSOs are primarily organizations that exist to benefit their members directly. According to the Foreign Donation Regulation Act 2016, "NGO means any organization registered by the NGO Affairs' Bureau (NGOAB)

[35] National TB Control Program (NTP), Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh. National strategic plan for TB control 2021–2025. Dhaka: NTP; 2020. Available from https://www.ntp.gov.bd/wp-content/uploads/2022/03/Clear_FINAL_NSP-Bangladesh-2021-2025.pdf.
[36] Klinton J. The private health sector: An operational definition. Geneva: World Health Organization; 2020. Available from https://cdn.who.int/media/docs/default-source/health-system-governance/private-health-sector-an-operational-definition.pdf?sfvrsn=5864e1f0_2&download=true.
[37] The World Bank. Civil society. Washington, DC: The World Bank Group; 2022. Available from https://www.worldbank.org/en/about/partners/civil-society/overview.
[38] Malena C. Working with NGOs: A practical guide to operational collaboration between the World Bank and nongovernmental organizations. Washington, DC: The World Bank; 2012.

to conduct voluntary activities inside Bangladesh and any organization or NGO registered under prevalent law of any foreign country, which is also registered under this Act."[39]

Outsourcing in the public sector refers to "the act of a public organization transferring internal activities or services and decision-making to external suppliers through long-term contracts or agreements."[40]

Contracting is defined as "the process by which government resources are used to fund entities which are not part of government (called here civil society organizations, or CSOs) to provide health services which the government has a responsibility to provide, in order to assure the health of its citizenry."[41]

Note that this assessment considers the potential contracting of services to not just CSOs but also larger NGOs and both for-profit and not-for-profit private entities. Moreover, the assessment includes a consideration of contracting not just clinical health services but also non-clinical services more indirectly related to a functioning TB program (such as TB-related information technology [IT] support).

METHODOLOGY

The assessment was conducted under the guidance and leadership of a Steering Committee (SC) established and headed by the Health Economics Unit (HEU) at the MOHFW. (**Annex 1** provides information on the composition of the SC and its terms of reference.) The HS4TB project served the primary role in data collection and analysis. The HEU undertook the leadership role in shaping and guiding the overall process, engaging stakeholders, maintaining oversight throughout the assessment, and participating in some of the key informant interviews (KIIs). A more complete description of the methodology, including the KII templates, is available on request.[42]

Using desk reviews and KIIs, this assessment investigated the following areas: (1) the ecosystem for contracting, including laws, regulations, policies, and operational guidelines; (2) the landscape of NGOs, CSOs, and other private sector entities and their experience and capacity in contracting with the government; (3) the capacity of the NTP/MOHFW for contracting; and (4) the political economy of government contracting.

Recommendations from this assessment will feed into the development of a Roadmap with an action plan to address the policy and enabling environment challenges, and to design and implement a pilot for contracting of TB services. As stated in the previous section of this document, TB will serve as a "test case" for contracting health services. The recommendations from this assessment and experiences from a future pilot will help inform the health financing agenda in Bangladesh as a whole.

Desk Review

The assessment began with a desk review of the peer-reviewed and grey literature, using search terms developed for each topic area. The online search of major databases was supplemented by the

[39] Government of Bangladesh. Foreign donations (voluntary activities) regulation act 2016. Available from https://www.icnl.org/wp-content/uploads/Bangladesh_FDVA.pdf.
[40] Ghatari AR, Rostamy AAA, Hosseini A. Designing a generic model for outsourcing process in public sector: Evidence of Iran. Management Decision. 2008 May;46(4):521–538.
[41] United Nations Development Programme (UNDP). Guidance note for the analysis of NGO social contracting mechanisms: The experience of Europe and Central Asia. New York: UNDP; 2019.
[42] Health Systems for Tuberculosis. Outsourcing and social contracting in Bangladesh: Framework for assessment and planning for transition from external to domestic funding. Medford, MA: Management Sciences for Health; 2021.

knowledge and expertise of the HS4TB Bangladesh team, which proposed specific documents for review, such as the laws, circulars, and regulatory documents related to contracting. As part of the desk review for the landscaping of NGOs, CSOs, and private entities that have contracted with the government, the team also collected hard copies of contract documents because they were not available in digital format.

The desk review informed the assessment questions and the development of the KII questionnaires, drawing on the global literature documenting transition readiness, best practices in conducting contracting, and country experiences. Documents identified in the desk review were organized in a summary table indicating which assessment areas were addressed and noting any relevant findings or conclusions that could be applied in the data analysis.

Key Informant Interviews

The team conducted 58 interviews with key informants over the course of one month, covering questions across the four assessment areas. (**Annex 2** provides the list of key informants). Interviews were conducted in person in Bangla and were not recorded to ensure that informants were comfortable expressing their honest opinions freely. Handwritten notes were taken by the interviewer and/or an assistant, then translated into English and converted to digital format to enable sharing and review across the team.

Two sets of interview instruments were developed: one for stakeholders in government and a second for NGOs, CSOs, development partners (DPs), and academia. Both instruments had four separate modules with questions about each of the four assessment areas. As the list of key informants was drawn up, each individual interviewee was assigned modules to which they were expected to respond, based on their position and area of expertise.

Data Analysis

After each interview, the interviewer summarized the key points and themes of the interview, indicating which assessment questions were addressed and highlighting any interesting or surprising opinions; new information gathered; or validation of an existing understanding. These summaries were then compiled on a weekly basis to synthesize the findings and begin organizing recommendations by thematic area. The responses across all interviewees to each question in the KII instrument were compiled into a single master document. Findings from the desk reviews were applied to supplement the recommendations from the KIIs.

Findings

The findings from the assessment are described in the following sections starting with the legal and regulatory environment, then the contracting capacity of NGOs, CSOs and other private sector organizations, then the capacity of the government to manage contracting of health services and lastly key informant perspectives on the political economy for contracting.

Mapping the Legal, Regulatory, and Policy Environment

The primary objective of this area of the assessment was to collect and evaluate public laws, policies, regulations, circulars, and guidelines relevant to contracting in Bangladesh, and to identify any legal or regulatory barriers to contracting health-related services, specifically TB-related services. A secondary objective was to review key MOHFW policy documents and strategic plans, and to identify opportunities to align the recommendations of the legal and regulatory assessment for contracting

with national policy goals. This section starts with a brief review of the contracting landscape, then examines the policy environment, before reviewing the legal and regulatory landscape for contracting.

NGOs and Government Interface in the Health Sector

Several NGOs have been working in Bangladesh's health sector and collaborating with the government to implement national health programs and achieve the sector's goals. Recent progress in the health sector has been possible due to collaboration and partnerships among stakeholders, with the NGOs as major actors. NGOs' work in public health includes such areas as TB, immunization, health education, nutrition, maternal and child health, reproductive health, and family planning. Although some NGOs receive government funds as grants and align their activities with national programs, their programs are mainly funded directly by donors. In most cases, NGOs submit proposals for development work and negotiate funding with international donors. Once an NGO receives a commitment from a funding agency, the proposal passes through an approval process in the NGOAB, which also requires approval from the MOHFW. The MOHFW looks at the utility of the proposed activities and their complementarity with the government program, and tries to ensure oversight by the local (district/sub-district) health authority. The NGO implements the program with oversight by local health management, but its main compliance remains with the funding organization.

In some cases, NGOs become part of government-led health programs, and the government agrees with DPs to involve NGOs as implementers of the program. In this modality, donor funds are allocated to NGOs for work defined in the agreement. The public procurement framework (Public Procurement Act 2006 [PPA 2006] and Public Procurement Rules 2008 [PPR 2008]) allows the DPs' procurement guidelines to be followed when the procurement is funded by a DP. The WB-financed Bangladesh Integrated Nutrition Project and the ADB-funded Urban Primary Health Care Service Delivery Project are examples of this type of NGO engagement, where the whole package of services is contracted out following the donors' guidelines for contracting/procurement. As it relates to TB, under the GFATM-funded program, NGOs are aligned with the overall plan and oversight of the NTP, but are contracted by an NGO Principal Recipient (BRAC), overseen by the Country Coordinating Mechanism, and follow GFATM rules and regulations for contracting and sub-contracting.

Contracting out health services to NGOs using only government funding has not happened because NGOs are not able to participate in the government's PPS based on the existing PPA 2006 and PPR 2008. The NGOs' characteristics do not qualify them for competitive bidding under this law and the regulations. Moreover, detailed procedures for procuring health-related services are not yet developed, which bars the implementation of health service-related contracting with NGOs. This is further explained in the next sections.

Health and TB Policy Environment for Contracting

Contracting to the private sector has long been an important intervention of the GOB. There is increasing recognition that the health sector, in particular, would benefit from engagement with nongovernment actors for health service delivery. This section presents a summary of the key policy documents. A detailed description of the documents can be found in **Annex 3**.

The National Health Policy 2011. The National Health Policy outlines three primary aims: to ensure accessibility of primary healthcare and emergency care for all; to ensure and extend coverage of quality healthcare services for all based on equity; and to increase community demand for healthcare with consideration of rights and dignity. To achieve these objectives, the plan highlights the need for coordination among healthcare-related organizations (e.g., the MOHFW and NGOs). Although the

document emphasizes the need for collaboration with the NGO and private sectors, there is no statement relating specifically to the mechanism for this collaboration, such as procurement of NGO or private sector services through contracting.

National Strategic Plan. In 2015, the five-year National Strategic Plan (NSP) for TB Control (2015–2020) defined an ambitious goal to reduce the prevalence of all forms of TB by at least 10 percent by 2020 and by 5 percent annually thereafter; increase annual detection rates of TB; and maintain a treatment success rate of at least 90 percent for all forms of TB. The NSP acknowledges that these goals cannot be achieved by the public sector alone and that public-private mix (PPM) is an essential strategy for the NTP. The following is highlighted in Objective 4 of the NSP: to "strengthen the engagement of all public and private care providers." There is also a strategic intervention that stresses the need to strengthen engagement of private providers in TB diagnosis.

The current NSP (2021–2025) cites "widespread acceptance of private providers as one of the important target groups for outreach and referral of presumptive cases" and notes that PPM models are working well. The experience of the Social Enterprise Model (SEM), in which screening centers manage referrals from surrounding providers, is highlighted. The GOB developed a NSP on PPM in Tuberculosis (2016–2020) that lays out detailed interventions to engage with the private sector. However, the NSP does not mention contracting TB services to NGOs as a specific strategy for moving financial support from DPs for the private sector (as is the case with SEM) to the GOB.

Although numerous policy documents emphasize the importance of engaging with the private sector for TB control, the interventions proposed primarily relate to engaging with individual providers to shape their service delivery, (e.g., through training the private sector to ensure compliance with international treatment standards, developing referral programs, improving adherence to case notification requirements, and enhancing monitoring and evaluation of the private sector). Therefore, the NSP does not generally address the functioning of entire NGOs or other private sector organizations (which are currently maintained through donor-supported contracts). There is no current policy relating to government-led contracting of TB services to the private sector.

Health Care Financing Strategy (2012–2032). The HCFS (2012–2032) has a provision for purchasing individual clinical services and setting up an autonomous entity for purchasing broader organizational services. The strategy is being revised to make it more practical, and a Health Protection Act is being drafted to provide the legal foundation for such an organization.

The Eighth Five-Year Plan (2020–2025). The Eighth Five-Year Plan (2020–2025)—Bangladesh's National Development Plan developed by the National Planning Commission—represents the first phase of Bangladesh's PP2041. It emphasizes the important role of the private sector in delivering high-quality health services and increasing the efficiency of the healthcare system. The Plan includes objectives on increasing access to quality health services and improving equity along with financial protection to achieve UHC by 2030. The Health, Population and Nutrition (HPN) strategy in the Plan states:

1) "Exploring various innovative approaches (e.g., purchasing services to offset inadequate service provision to disadvantaged groups) for improving service delivery particularly for hard-to-reach areas."
2) "Increasing access to and utilization of quality services by adopting a more inclusive approach to engaging the private sector for ESP [essential service package] delivery, public-private partnership and NGOs."

3) "Building and strengthening linkages with NGOs will be an approach to complement government efforts in increasing access of the poor, the disadvantaged and the hard-to-reach populations to HPN services."

The main modality of engaging the private sector/NGOs in service delivery is mentioned as contracting; however, this is not discussed in detail in the Eighth Five-Year Plan. The Plan emphasizes the need to establish laws and rules; to formulate new policies; and to update existing policies to achieve improved governance, equity, and inclusiveness.

The National Perspective Plan of Bangladesh (2021–2041). This document outlines the country's "Vision 2041" to achieve high-income status in the next two decades. The Plan articulates the government's plan and goals for transitioning from a lower-middle income country by 2031 and to a high-income country by 2041 under WB classification. According to the Plan, there must be a rapid transformational shift over the next two decades in various sectors, including health. The Plan cites NGOs and CSOs as the "third state," after politicians and the bureaucracy, and targets that by 2041 "all CSOs will be mature high-quality broad-based operations with some as international best practices and all will be institutionalized under normal regulatory and business practices." However, the Plan does not include detail on how private entities will be engaged or how achieving the vision relates to contracting to the private sector.

The review of these strategic documents revealed that engagement of NGOs and other nongovernment entities in the provision of health services is a policy priority of the government because it plans to expand access to and improve the quality of healthcare. Because the government has been trying to move toward UHC, it may further devise a cost-effective way to expand services to cover the entire population. For that reason, major planning documents set forth plans or intentions to procure health services from NGOs and the private sector. However, contracting-out health services to NGOs with government funding is not explicitly planned in any document. The process for designing, costing, implementing, and monitoring contracting-out health services to NGOs needs to be made explicit in the MOHFW's Operational Plans (OPs) so that it can be taken forward. The MOHFW also needs to develop detailed guidelines on the procurement process that are aligned with the relevant laws, regulations, and policies to aid implementation.

Lessons from global experience: Macedonia[43]

Following the end of GFATM support, Macedonia passed the National HIV Strategy for 2017–2021, which outlined a contracting mechanism and allocated more than half of the annual HIV prevention program budget to civil society-led interventions, with a focus on key populations. There is high-level political commitment from the Prime Minister's Office and the Ministry of Health to support NGO-delivered services for HIV. As of October 2017, the Ministry of Health had signed contracts with 13 NGOs.

Legal and Regulatory Environment

Bangladesh's Procurement System

Bangladesh has a robust regulatory environment covering the public procurement of goods, works, and services. (Box 1 provides definitions of key procurement terms.) The procurement process is governed by a single legal framework comprising the PPA 2006 and secondary legislation in the PPR

[43] Nechosina O, Semeryk O, Nitsoy A, et al. Social contracting in Ukraine: Sustainability of non-medical HIV services. Washington, DC: Palladium, Health Policy Plus; 2019.

2008. These documents define the process; the institutional arrangement, including the provision of a nodal policy unit responsible for ensuring the proper implementation of the procurement rules and regulations (see below); standard procurement documents (SPDs); and a functional complaint redress system with an independent appeal mechanism to oversee the implementation of the rules and regulations and the development of capacity in the government. The Central Procurement Technical Unit (CPTU), under the Implementation, Monitoring and Evaluation Division (IMED) of the Ministry of Planning (MOP), is the nodal procurement policy unit and has a widely used, freely accessible, and regularly updated website providing all procurement-related information, policies, and functional documents. The CPTU has been working to regulate the implementation of the legal framework, monitor public procurement management in the country, and develop the public procurement capacity of government offices. The fundamentals of the public procurement system (PPS) are that it: is decentralized so that any office having administrative and financial power can initiate a procurement process; is a single uniform system for the whole country; standardizes performance; promotes competition with a systematic complaint and appeal mechanism; and the CPTU ensures that the regulations are followed. The CPTU has already transformed all national processes for procurement of goods and works into an electronic system by establishing a central portal called e-GP (Electronic Government Procurement). This transformation is taking place gradually. This central e-portal has not yet covered the procurement of intellectual or physical services.

Box 1. Definition of key procurement terms (PPA 2006)

- ***Procurement:*** The purchasing or hiring or acquisition of goods and related services, the execution of Works and physical services and the performance of Intellectual and Professional Services by any contractual means.
- ***Procuring entity:*** A procuring entity having administrative and financial powers to undertake procurement of goods, works or services using public funds (e.g., NTP, District Hospital).

Types of procurements:

- ***Goods:*** Raw materials, products, and equipment and objects in solid, liquid, or gaseous form, electricity, and related services if the value of such services does not exceed that of the goods themselves (e.g., medical equipment, raw materials, drugs).
- ***Works:*** All works associated with the construction, reconstruction, site preparation, demolition, repair, maintenance, or renovation of railways, roads, highways, or a building, an infrastructure or structure, or an installation of any construction work relating to excavation, installation of equipment and materials, decoration, as well as the physical services ancillary to works, if the value of those services does not exceed that of the works themselves (e.g., construction of a hospital building).
- ***Intellectual and professional services:*** Regarding services to be performed by consultants with advisory, design, supervision, or transfer of a know-how nature (e.g., consultancy for software development).
- ***Physical services (or non-intellectual services):*** The following services with measurable outputs: (a) the supply of goods or execution of works relating to the operation and maintenance of facilities or plant, surveys, exploratory drilling, or (b) individual service-oriented contracts regarding security services, catering services, geological services, or third-party services (e.g. ambulance services, clinical services, public health services); (c) appointment of pre-shipment inspection agent, clearing and forwarding agent, transportation of goods, hiring transport, appointment of transportation contractor for transportation of goods or insurance

risk; or (d) other services specified by the government, from time to time, under the purview of the law.

The current procurement structure was developed through a gradual reform process that began in 2002 with recommendations proposed by a Country Procurement Assessment Report, supported by the WB and the ADB. The reforms included a significant capacity development program that trained more than 37,000 stakeholders between 2008 to 2019, comprising focal persons on procurement activities from all government ministries, including the MOHFW, and officials from the audit office, the Anti-Corruption Commission (ACC), the judiciary, journalists, and tenderers; and the development of the comprehensive online electronic government procurement portal (i.e., the e-GP). As of FY2019, 1,325 of 1,362 public organizations in Bangladesh and 65,559 bidders had been registered in the e-GP system. Bangladesh spent an estimated USD24 billion on public procurement in FY2019, representing 45.2 percent of the annual budget, 8 percent of the GDP, and 85 percent of the Annual Development Program[44] budget.[45] In that year, 62 percent of public procurements were processed through the e-GP system.

The procurement methods for goods and works include the Open Tendering Method (OTM), One Stage Two Envelope Method (OSTEM), Limited Tendering Method, Two Stage Tendering Method, Request for Quotation Method, and Direct Procurement Method (box 2). The processes for solicitation/advertisement, contract awarding, and contract implementation are well structured in existing tools for procurement of goods, works, and intellectual services. The procurement methods are used for procurement of goods and works across the government, including the MOHFW. Among these methods, OTM is the most preferred and followed (at around 80 percent of contracts) for procurement. OTM is the highest competitive method that allows all principles of public procurement (e.g., transparency, accountability, nondiscrimination, free and fair treatment, integrity).

There are currently no procurement methods for physical services specified in the PPA or PPR. At present, the methods for procuring goods are followed for procuring physical services (e.g., cleaning, catering, security services, event management). If contracting health services is added as a physical service, the procurement would likely follow similar methods as those for goods.

The procurement methods for individual and professional services are given in box 3.

Box 2. Procurement methods for goods and works[46]

[44] The Annual Development Program is an organized list of projects and annual allocations for them in various sectors.
[45] World Bank. Assessment of Bangladesh public procurement system. Washington, DC: World Bank; 2020. Available from https://openknowledge.worldbank.org/handle/10986/33882.
[46] Based on the PPR 2008. Central Procurement Technical Unit (CPTU), Implementation Monitoring and Evaluation Division, Ministry of Planning. The Public Procurement Rules 2008. Dhaka: CPTU; 2008.

Open Tendering Method: Often known as open competitive bidding, open competition, or open solicitation, this method focuses on the process of open competition and minimizes discrimination for procuring goods and works at the lowest evaluative price.

One Stage Two Envelope Method: System of having bidders submit two sealed envelopes simultaneously. One envelope contains the technical proposal and the other contains the price proposal, and they are submitted together in a single outer envelope.

Limited Tendering Method: A limited noncompetitive procurement process that is limited to only a few qualified potential bidders.

Two Stage Tendering Method: A method allowing the early offer of a contract in the first stage before reaching a final submission in the second stage.

Request for Quotation Method: Also known as an invitation for bid, this method is for procurement of readily off-the-shelf goods and low value simple works invited subject to financial limitations.

Direct Procurement Method: A process of purchasing goods and works by the entity that is sourcing without pursuing competition; only one bidder is invited to submit an offer.

Box 3. Procurement methods for intellectual and professional services[47]

Quality and Cost-Based Selection: A method of selection following two steps—technical and financial evaluations—to find providers who can be contracted at the lowest cost with the best quality. Short-listed consultants compete on the basis of quality and cost.

Fixed Budget Selection Method: Simple and specific services with a fixed budget.

Least Cost Selection Method: Standard or routine nature where the cost of the service is within the prescribed price limit.

Individual Consultant Selection Method: Qualified individual expert.

Methods based on consultant's qualification: Very small high-quality assignments for which preparation and evaluation of a competitive proposal is not justified.

Community-based service selection method: Overall knowledge of community needs, local issues, and community participation are paramount.

Single-source selection method: Continuation of ongoing or just completed, low-value, speedy selection in emergency situations, rare experience/qualification, or other urgent need (catastrophic event).

Design contest: Technical excellence and innovation are of prime considerations.

Considerations for Contracting Health-Related Services

Although the existing regulatory framework broadly covers public procurement, various weaknesses exist in the system, especially in procuring physical services, which includes health-related services.

[47] Based on the PPR 2008. CPTU, Implementation Monitoring and Evaluation Division, Ministry of Planning. The Public Procurement Rules 2008. Dhaka: CPTU; 2008.

Table 1 presents a summary of key legislative and regulatory documents, and their strengths and weaknesses with respect to contracting out services to NGOs, CSOs, and the private sector. A detailed description and review of these documents can be found in **Annex 3**.

The PPS is gradually evolving to meet and adjust to ever-increasing needs. The PPA 2006 and PPR 2008 have classified goods and services into the following categories for procurement purposes (see box 1):

- Goods and related services
- Works and physical services
- Intellectual and professional services
- Physical services

In the PPA 2006, "goods" means raw materials; produced goods and machinery; solid, liquid, or gaseous goods; electricity; produced computer software (off-the-shelf) and other IT or similar software; and goods-related services (provided the value of those services does not exceed that of the goods themselves). "Goods-related service" means a service linked to the supply of a goods contract.

However, with the increasing need for procurement of physical services, PPA 2006 added physical services to the list of categories in 2016, defined as:

- (Ka) Linked to the supply of goods or execution of works relating to the operation and maintenance of facilities or plants, surveys, and exploratory drilling.
- (Kha) Individual service-oriented contract regarding security services, catering services, geological services, or third-party services.
- (Ga) Appointment of pre-shipment inspection agent and clearing and forwarding agent, transportation of goods, hiring transport, appointment of transportation contractor for transportation of goods or insurance risk.
- (Gha) Other specified by the government, from time to time, under the purview of the law.

Because the primary focus of the PPA and PPR was originally on the procurement of goods, works, and intellectual and professional services, the government has focused on developing the provisions and other instruments (e.g., standard tender document [STD]/SPD) needed for their procurement. Because physical services are new to the list of procurement types and the demand for their procurement is not exceedingly high, these methods and instruments have not been yet developed for physical services. Procedures and instruments (STD/SPD, etc.) have been developed only for procurement of human resource (HR) support (such as security guard or cleaner), because these services are in demand.

Contracting of physical services is also not addressed in the Delegation of Financial Powers.[48] The Delegation of Financial Powers, enforced by the Ministry of Finance (MOF), provides the authority to approve procurement contracts for goods, works, and intellectual services. Because physical services are not widely procured, the authority to approve physical service procurements is not yet assigned or reflected in the Delegation of Financial Powers. As such, a revision of the Delegation of Financial Powers will be required to incorporate the authority for procurement of physical services to facilitate contracting of physical services across sectors.

The procurement of physical services (as well as international and intellectual services) has likewise not been integrated in the e-GP system. Procurement is still conducted manually, making it challenging

[48] Notifying the officers of Government Departments for exercising the powers at various levels.

to effectively manage and monitor it in an efficient and transparent way. The procurement process is gradually being transformed into a digital system, and because the necessary rules, regulations, and procedural tools are not yet in place for physical services, procurement of physical services has not yet been introduced in the e-GP system.

Another key issue is that the selection of awards for physical services is based on a technical and financial offer in a single bid (as per the single available STD). In this process, the bidders first qualify in a technical evaluation, and among the technically qualified bidders, the lowest financial offer gets the award. Although the technical evaluation process decides whether the bidders meet minimum criteria and qualifying marks, it does not include any structured scoring system and quality assessment; therefore, in many cases, the most competent bidder is not selected (in the opinion of several key informants). Therefore, the government is considering introducing evaluation based on life cycle costing instead of lowest financial offer. Life cycle costing evaluation is a relatively better evaluation method than financial offer-based evaluation because it considers long-term overall economic value.

Contracting health services (including TB services) should fall under the category of physical services; however, they are not listed as a type of physical service in the PPA. Because the government has never had an explicit policy to contract health and, specifically, TB services, they have not yet been added to the list of physical service categories in the PPA and the government has not requested the CPTU to develop STDs for procurement of health/TB services. In the revision of the PPA, the list of physical service categories should be revised to explicitly include contracting for health/TB services. (The government already procures drugs, equipment, and other inputs for health services delivery because they fall under the procurement category of "goods.")

Lessons from global experience: Mexico[49]

In Mexico, the government transitioned GFATM activities before its support ended in 2014, which helped ensure the continuation of services. Government officials recognized the critical role of civil society in the HIV response and created an enabling legal environment, with provisions in several laws that specifically support the participation of civil society in contracting, including the general law on health and the law on public administration. There is transparency in the contracting process, including the preparation of budgets with funding amounts, with an electronic contracting and reporting system, and tenders awarded based on a public call for proposals.

[49] Open Society Foundations, The United Nations Development Programme, and The Global Fund to Fight AIDS, Tuberculosis and Malaria. A global consultation on social contracting: Working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society, meeting report. 2017, Oct 5–6; New York, NY. Available from http://shifthivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf.

Table 1. Summary of strengths and weaknesses in key legal and regulatory documents as they relate to health sector-related contracting

Document (Law, Policy, Regulation, Circular)	Purpose of the Document	Strengths	Weaknesses	Reform Required
Public Procurement Act 2006 and Public Procurement Rules 2008	Primary and secondary legislation providing procedures to be followed for ensuring transparency and accountability in the procurement of goods, works, and services using public funds and ensuring equitable treatment and free and fair competition among all persons wishing to participate in such procurement.	Previously, PPA 2006 included the procurement of non-intellectual services (i.e., services other than intellectual and professional) but this was integrated with goods (as related services) and with works (as physical services), without defining non-intellectual services independently. Through an amendment in 2015, "physical services" were defined in the law and rules as an independent category of procurement, strengthening the law in processing overall non-intellectual services (physical services).	A detailed procedure for procurement of physical services and associated STDs is still missing. STDs are not available to use specifically for health sector service contracting under this procurement category (physical services). NGOs and CSOs are not included in the definition of a tenderer and, therefore, are not able to participate in the public procurement process.	Develop detailed provisions and procedures for the procurement of physical services. Develop separate STDs to guide the contracting of health services, including TB. Make necessary adjustments to regulatory framework to allow NGOs/CSOs to be eligible as tenderers, including modifying the definition of a tenderer and either adjusting existing criteria or developing alternatives that

Document (Law, Policy, Regulation, Circular)	Purpose of the Document	Strengths	Weaknesses	Reform Required
				facilitate NGO/CSO participation.
Delegation of Financial Powers (issued by Finance Division)	The orders regarding the delegation of financial authorities issued by the government from time to time relating to the conduct of public procurement or sub-delegation of financial powers under such delegation.	Some specific physical services are included in the Delegation of Financial Powers document.	Financial power has been provided only for a few physical services, like catering, ambulance, transportation, event management, repair and maintenance, plumbing, woodwork, etc.	Finance Division assigns financial power for large-scale physical service procurements, including health services.
Policy on Procurement of Services through Contracting (issued by Finance Division)	Circular issued for the purpose of specifying the procedure for paying salary and other benefits for procurement of human resources and other services through contracting.	Hospital services are included in the list of services for contracting.	Creates some opportunity for contracting but conflicting instructions with the PPA and PPR (see Annex 3).	Amend policy to align with the PPA/PPR.
Circular of Economic Relations Division for enhancement of the mobility of project implementation	Defines the up-front preparation for processing a procurement before approval of the project to minimize the time for project implementation.	The Circular has given very useful direction to minimize the time of procurement and project implementation.	The Economic Relations Division is not the proper authority to issue this circular and that is why its application is not seen very often.	Because procurement and project approval is under the purview of the MOP, this circular should be issued by the MOP.

Document (Law, Policy, Regulation, Circular)	Purpose of the Document	Strengths	Weaknesses	Reform Required
Public-Private Partnership Act 2015	To provide the legal framework for the creation of a PPP by involving private sector participation.	Creates a robust general policy on the PPP regulatory environment. The health sector can apply PPP modalities to support the implementation of development projects.	PPP development is a lengthy process. It is mainly focused on infrastructure (power, road, bridge, port, etc.) Small procurements (like for TB services) are difficult to procure through this mechanism.	None. Only big projects related to health infrastructure can be considered for procurement under this law.
Arbitration Act 2001	Law relating to international commercial arbitration, recognition, and enforcement of foreign arbitral award and other arbitrations.	Serves as a tool for dispute settlement after failure to resolve the dispute through the process of amicable settlement and adjudication.	If agreed by the parties, the Act can also be applied in the case of proceedings in other countries; however, this is not well known to stakeholders.	Needs more clarity on the role of arbitration in resolving disputes in an international procurement contract.
Public Financial Management (PFM) Strategy (2016–2021) and PFM Action Plan (2018–2023)	Strategy and action plan to carry out reform to improve fiscal discipline, financial reporting, and greater transparency and accountability in selected government agencies.	Indication of needed public procurement reform to strengthen the CPTU as it becomes a Public Procurement Authority. This is an opportunity to integrate the reforms needed to procure physical services, with broader health sector reforms in procurement management being undertaken by the GOB.	Action plan does not clearly specify the procurement issues needing reform, except the restructuring of the CPTU into an authority.	Additional procurement-related reforms should be included in these documents.

Regulation of NGOs and CSOs

By nature, NGOs are non-profit and cannot engage in profit-making ventures, restricting their eligibility to participate in the public procurement process in Bangladesh because the rules that govern NGOs do not allow them to engage in business. There is no single/uniform law and authority for establishing, regulating, and monitoring NGOs in the country. Different laws have been promulgated at different times, most of which cover provisions for: receiving funds upfront (directly as donation/grants from donors and the government); engaging in voluntary/non-profit activities in different sectors; and ensuring financial discipline. Contracting is a business venture, which can include making a profit; however, none of the laws related to NGOs allow them to participate in such activities.

Societies Registration Act No. XXI. In 1860, the then Provincial Government of Bengal promulgated the Societies Registration Act No. XXI to improve the legal position of societies for the promotion of literature, science, or the fine arts, for diffusion of knowledge, or for charitable purposes.

The First Ordinance No. XLVI of 1961. It was promulgated on December 2, 1961. It made registration mandatory for all NGOs working in what was then East Pakistan and made the Director of Social Welfare responsible for ensuring registration.

The Foreign Donations (Voluntary Activities) Regulation Ordinance 1978. The ordinance was promulgated on November 15, 1978 to regulate the receipt and expenditure of foreign donations for voluntary activities.

The Foreign Donations (Voluntary Activities) Regulation Rules. The rules were promulgated on December 12, 1978, requiring all NGOs intending to receive foreign funds to be registered under specified prescribed rules.

The Foreign Contributions (Regulations) Ordinance enacted on September 6, 1982 reiterated that no individual representing NGOs or the organizations themselves would be allowed to give or receive any foreign contribution without prior permission from the state. The government amended the Foreign Donations (Voluntary Activities) Regulation Ordinance 1978 at different times (1990 and 2016) to improve the regulation of foreign funds.

NGO Registration Mechanisms

An NGO can be registered in three ways: with the NGOAB under the Prime Minister`s Office; with the Department of Social Services under the Ministry of Social Welfare; or with the Joint Stock Companies and Firms under the Ministry of Commerce. For NGOs to receive foreign financial support or donations, they must be registered with the NGOAB. The foreign funding that NGOs receive is then controlled under the Foreign Donation (Voluntary Activities) Regulations Act 2016 (FDRA). NGOs must comply with the stipulations of the FDRA, which include requiring a certification of incorporation in the country of origin; a Constitution of the NGO; and submission of activities reports and OPs. NGOs must comply with the legal framework associated with NGOAB registration to receive donor funding. They do not have some of the commercial processes that are evaluated under the PPR 2008 (see table 2) and, therefore, cannot meet the eligibility and qualification requirements for participating in the public procurement process.

The rules and regulations that regulate NGOs (box 5) and the overall purpose of NGOs are different from those required for a tenderer in the government procurement system. Table 2 outlines the criteria that tenderers must meet to be eligible to participate in the public procurement process for all types of procurement. The legal stipulations that limit NGOs' ability to participate in business-related ventures also bar them from being able to meet all eligibility criteria. Therefore, if NGOs are going to be engaged as contractors for health services, the relevant provisions in the PPR reform need to be changed.

Box 5. Laws related to NGOS

Laws related to NGOs

- The Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961
- The Foreign Donations (Voluntary Activities) Regulation Rules, 1978
- The Microfinance Regulatory Law, 2006
- The Foreign Contributions (Regulation) Ordinance 1982
- The Society Registration Act, 1860
- The Trust Act 1882
- The Companies Act 1994
- The Waqf Ordinance 1962
- The Mussalman Waqf Validating Act 1913
- Other Acts governing the Non-Profit or Voluntary Social Welfare and Charitable organizations are the Charitable Endowments Act 1890, Charitable and Religious Trust Act 1920, Co-Operative Societies Ordinance 1984, Income Tax Ordinance 1984, and Value Added Tax
- Foreign Donation (Voluntary Activities) Regulations Act 2016

Eligibility of NGOs for Competitive Bidding

As stated in the PPA and PPR, the person who participates in the tendering process to execute works, supply goods, and provide services is defined as the "Tenderer." A person means and includes an individual, body of individuals, sole proprietorship, partnership, company, association, or cooperative society that wishes to participate in procurement proceedings. NGOs and CSOs are not explicitly included, but they are also not explicitly excluded in this definition and do not fall under the government's legal definition of a tenderer.

In addition to NGOs not being legally considered a tenderer, there are mandatory requirements for a tenderer (eligibility criteria and qualifications) to participate in tender proceedings for supplying goods or services, most of which are very difficult for an NGO to fulfill.

Table 2. Mandatory requirements for a tenderer for all types of procurement (eligibility and qualification criteria as defined in the PPR 2008)

Sl	Eligibility Criteria in the PPR 2008	Enablers or Barriers for NGO/CSOs
1	Tenderers shall have the legal capacity to enter into the Contract under the Applicable law.	**Barrier:** NGO/CSO are not included in the definition of a "Tenderer."

Sl	Eligibility Criteria in the PPR 2008	Enablers or Barriers for NGO/CSOs
2	Tenderers shall be enrolled in the relevant professional or trade organizations registered in Bangladesh.	**Barrier:** The evidence of this enrollment is usually the trade license in Bangladesh. NGOs/CSOs currently do not have a trade license to work as a supplier because they are not allowed to engage in trade/business.
3	Tenderers shall have fulfilled their obligations to pay VAT, taxes, and social security contributions under the provisions of laws and regulations of the country of its origin.	**Enabler:** NGOs are already required to pay these contributions.
4	A Tenderer shall not have a conflict of interest.	**Enabler:** NGOs must comply with this criterion.
5	Tenderers in their own names or other names or also in the case of its Persons in different names shall not be under a declaration of ineligibility for corrupt, fraudulent, collusive, or coercive practices.	**Enabler:** NGOs should fulfill these criteria, must comply with this criterion.
6	Tenderers are not restrained or barred from participating in Public Procurement on grounds of poor performance in the past under any Contract.	**Enabler:** NGOs must comply with this criterion.
7	Tenderers shall not be insolvent, be in receivership, be bankrupt, be in the process of bankruptcy, not be temporarily barred from undertaking business, and shall not be the subject of legal proceedings for any of the foregoing.	**Barrier:** NGOs are not at all involved in business. According to the FDRA 2016, NGOs are strictly non-profit. They are not allowed to undertake any profit-making venture.
	Qualification Criteria	**Enablers or Barriers for NGO/CSOs**
8	A minimum number of years of general experience	**Barrier:** Without involvement in government contracting in the past, it is unclear how the NGOs will demonstrate their general experience.
9	Specific experience similar to the proposed Works, in at least a number of contract(s), each with a minimum value over the period, as specified.	**Barrier:** Many NGOs have no contracting experience with the government. Government may accept NGOs experience of contracting with government under DPs' funding as their contracting experience in this definition. However, very few NGOs have such experience.

Sl	Eligibility Criteria in the PPR 2008	Enablers or Barriers for NGO/CSOs
10	The average annual construction turnover/production capacity	**Barrier:** Not applicable to health sector contracting.
11	Availability of minimum liquid assets or credit line(s) or working capital, net of other contractual commitments of the amount, as specified.	**Barrier:** NGOs are, by definition, non-profit organizations so they will typically struggle to show sufficient liquid assets/lines of credit/working capital, and/or such requirements may themselves put the organization in financial trouble.
12	The Minimum Supply and/or Production Capacity, as specified	**Barrier:** Because they have not yet participated in a tender previously, NGOs will not be able to show supply and/or production capacity.

For intellectual and professional services procurement, the PPR 2008 framework allows for a method of "Selection of Social Services Organization," which provides a procurement entity the opportunity to procure intellectual services from NGOs, community service organizations,[50] or from any other non-profit organization. In relation to this provision, two STDs are included in the list of required STDs, named as PS1 and PS2; however, they are still being developed by the CPTU to guide this type of procurement process. As a result, no procurement of intellectual services by the GOB from NGOs or CSOs has taken place.

Summary of Legal and Regulatory Findings

There are opportunities to align contracting with critical MOHFW policies, such as the HCFS (2012–2032), the Eighth Five-Year Plan (2020–2025), and the Perspective Plan (2021–2041). Although Bangladesh has a robust legal and regulatory framework guiding procurement, detailed in the PPA 2006 and PPR 2008, the current environment creates very limited opportunities for contracting of physical services, which includes health services, among others. Contracting and procurement are completely guided by the provisions of the PPA/PPR and the regulations still lack at least some of the detailed provisions and procedures needed to procure physical services. Although amendments have been made to the PPA/PPR, especially in relation to adding specific definitions on the procurement of physical services, the STDs are not yet developed for the contracting of health services. In addition, physical services are not included in the e-GP system because the STD and other instruments have not yet been developed.

NGOs and CSOs are not eligible to be "Tenderers" and to participate in the procurement of goods, works, and physical services because they do not meet the eligibility and qualification criteria set out in the PPA and PPR. The PPR framework only allows NGOs to participate in the procurement of intellectual services/ professional services (e.g., research, study, preparation of development plans), not in the procurement of physical (non-intellectual) services. But even within this intellectual/professional services

[50] Central Procurement Technical Unit (CPTU), Implementation Monitoring and Evaluation Division, Ministry of Planning. The Public Procurement Rules 2008. Dhaka: CPTU; 2008.

category, the relevant STD has not yet been developed; therefore, NGOs/CSOs are not currently able to participate in related procurements.

The need for legal and regulatory changes to support government contracting of TB services is extensive and could take years to complete. They include:

- Changes in PPA, PPR, and MOF circulars on contracting to allow NGOs to be able to meet the criteria to qualify as a tenderer in the PPS (this may require developing specific rules, regulations, and criteria appropriate to the legal definition of NGOs) and to include health services under the definition of physical services.
- Development of STDs for the procurement of physical services and of health-related services, specifically.
- Revision of the Delegation of Financial Powers
- Integration of physical services in the e-GP platform

NGO, CSO, and Private Sector Landscape Mapping for Service Delivery and Contracting Experience and Capacity

This part of the assessment summarizes the service delivery landscape; identifies the major NGOs, CSOs, and private sector service providers that support health-related (and specifically TB-related) activities in Bangladesh; presents information on existing practical contracting experiences; and describes the capacity of these organizations to engage in contracting with the government.

CSO, NGO, and Private Sector Landscape

The total number of CSOs operating in Bangladesh is 250,000, of which nearly 2,500 are registered with the NGOAB.[51] Several NGOs have been working in the health sector, providing services like prevention/screening, diagnostics, treatment, research and training, technical assistance, and support services, such as logistics, IT, HR support, and analytics through either memorandums of understanding (MOUs) with the government or under DP contracts. There are 26 NGOs working as collaborating partners of the NTP. Some of the largest partners in the TB response are the Ashar Alo Society, BRAC, Damien Foundation, HEED Bangladesh, icddr,b, International Organization for Migration, LAMB Hospital, LEPRA Bangladesh, National Anti-Tuberculosis Association of Bangladesh, NGO Health Service Delivery Project, PIME Sisters, Rangpur Dinajpur Rural Service, Salvation Army, The Leprosy Mission Bangladesh, and the UPHCSDP.[52] These organizations receive funding from the GFATM.

NGOs often receive funds from the GOB in the form of grants for other purposes. Every year, the MOHFW sets aside lump-sum allocations in the form of grants for different NGOs, in consideration of their substantial contributions to the health sector. This is done to encourage the NGOs to implement health and family planning-related activities. The process is carried out through an MOU, not a competitive

[51] United States Agency for International Development, Bureau for Democracy, Conflict and Humanitarian Assistance, Center of Excellence on Democracy, Human Rights and Governance. 2019 civil society organization sustainability index for Asia, 6th Edition. Washington, DC: FHI 360; 2020.
[52] National Tuberculosis Control Program (NTP), Directorate General of Health Service. Tuberculosis control in Bangladesh. Annual Report. Dhaka: NTP; 2015.

bidding process, such as contracting-out. Experience managing these grants cannot be equated to participating in and managing a contract.

Many NGOs have considerable infrastructure and many trained field workers at the grassroots level. For example, partner NGOs of the Smiling Sun clinic network have their own infrastructure to provide primary care services. Marie Stopes Society operates several clinics in small towns and in Dhaka. Kumudini Hospital is a large 750-bed tertiary care center with an advanced laboratory run by an NGO. Ad-din, an NGO, operates more than 10 large hospitals in Dhaka, Khulna, Kushtia, and Jashore, and has a primary healthcare delivery system integrated with a microcredit program. There are many missionary hospitals with good service delivery infrastructure, some of which (such as LAMB Hospital) have their own community outreach systems.

The GOB has procured various goods and services (not in the form of physical services), especially for logistics and supply, dialysis, and COVID-19-related services, from many private entities. For example, SANDOR Dialysis Services Pvt. Ltd. is providing dialysis services. Beximco Pharmaceuticals Ltd, Himalaya Trading Company, JMI Syringes & Medical Devices Ltd. etc. are providing logistics and supply services (mainly IT, HR support, and analytics) to the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) and other entities. During the early stages of the COVID-19 pandemic, the government contracted some private hospitals,[53] such as Holy Family Red Crescent Hospital and Anwer Khan Modern Hospital, to provide COVID-19-related services and agreed to pay a negotiated amount of money to them under an MOU.

A profile of organizations that are receiving GFATM funds, and additional organizations that are not currently contracted but could potentially provide services in the future, are detailed in **Annex 4**.

Contracting Experiences

A review of health-related contracts collected for this assessment can be found in **Annex 5**. Due to confidentiality concerns, few documents were available for review; this also reflects the rarity of direct government contracting for health services. Indeed, three of the five contracts were for procuring commodities, not services; two of them were solely donor-funded; one was a concession for dialysis; and one was for making a TV commercial. The review did not identify contracts of the type of greatest interest for this assessment (i.e., the provision of various packages of health services).

By contrast, a substantial number of NGOs/CSOs have been working and involved in partnerships with the government to implement many initiatives—and some NGOs have gained considerable contracting experience this way—but this is all through donor-funded projects. Such NGOs are not able to participate in the government procurement process due to the legal constraints presented above. The majority of the CSOs/NGOs' contracting experience is limited to highly experienced NGOs with an established presence in specific geographic locations and to projects implemented with DP funding. Several DP-funded contracted health projects have been found to be well-performing. The most well-documented of them is the UPHCSDP, which improved the health status of populations in the project areas when compared with

[53] Note that there are no real substantial chains of private hospitals in Bangladesh, although there are private hospitals/diagnostic centers with branches in big cities, (e.g., Islami Bank Hospital, Ad-din, Labaid, Ibn Sina, Popular. Ad-din has 54 clinics for outpatients; Surjer Hashi has 134 clinics/primary healthcare centers; Marie Stopes Clinic Society operates small clinics).

non-project areas.[54] Improvements in coverage among the poorest 50 percent of the population were greater in the NGO-run area and the cost per service delivered was 47 percent lower in the NGO area.[55]

However, it should also be noted that contracting-out can be a costly process with respect to human resources, involving multiple principals and agents, compared with direct public provision. The beneficial impact of the UPHCSDP is well-documented, but scaling it up with domestic funding would be difficult and would require institutionalizing accountability mechanisms, including improving citizen participation.[56] Others have noted the need for legal and regulatory reform in the urban health system to engage both state and non-state actors and allow for GOB contracting of NGOs for health services.[57]

Another well-performing initiative is the partnership through which Bangladesh has achieved near universal coverage of immunization. The successful outcomes of the partnership have been attributed to strong commitment at all levels of government; the smooth flow of resources; active involvement of local government; training; strong supervision and monitoring; and clear communication among the partners.[58]

As to DP-funded contracting, it is difficult to discern the capacity of the NGOs/CSOs based only on the evaluations of the various projects. Contradictory results are seen in various evaluations on the outcomes and results of the contracts. Some studies of donor-funded projects that are contracted-out to NGOs indicate that strong commitment among parties, availability of resources, and defined roles and responsibilities of all parties were behind the successful PPPs. Some studies showed that lack of commitment from the government, poor monitoring and supervision, and failure to select appropriate partners were responsible for the failure to achieve the desired outcome.[59]

Key informants noted that the contracting experience of NGOs, in general, with donor funding points to a lack of competition in the bidding process. Large and experienced NGOs are usually awarded donor-funded contracts, whereas new NGOs are unlikely to win awards, and smaller NGOs are not fully or accurately aware of the procurement process. Although respondents noted that government-NGO collaboration can effectively improve access to and quality of TB and other healthcare services, existing rules and regulations do not permit the procurement of physical/non-intellectual services, as discussed above, and there is a lack of mutual trust. NGOs fear exposing themselves to bureaucracy, and the government faces difficulty in choosing partners from among the available NGOs working in the health sector. There is also the absence of a legal framework for contracting to NGOs/CSOs with government funding.[60]

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[54] Albis MLF, Bhadra SK, Chin B. Impact evaluation of contracting primary health care services in urban Bangladesh. BMC Health Services Research. 2019 Nov 21; 19, 854.

[55] Heard A, Nath DK, Loevinsohn B. Contracting urban primary healthcare services in Bangladesh – effect on use, efficiency, equity and quality of care. Trop Med Int Health. 2013 Jul;18(7):861–70.

[56] Ahmad A. Provision of primary healthcare services in urban areas of Bangladesh – the case of Urban Primary Health Care Project. Lund, Sweden: Department of Economics, Lund University; 2007. Available from https://project.nek.lu.se/publications/workpap/Papers/WP07_9.pdf.

[57] Shafique S, Bhattacharyya DS, Anwar I, et al. Right to health and social justice in Bangladesh: Ethical dilemmas and obligations of state and non-state actors to ensure health for urban poor. BMC Medical Ethics. 2018 Jun 15; 19, 46.

[58] Sajani TT, Alo K, Aktaruzzaman S. Public private partnership (PPP) in health sector of Bangladesh. Anwer Khan Modern Medical College Journal. 2014 May; 5(1).

[59] Osman FA. Public-private partnership in health service delivery: Lessons from Bangladesh. 2008. Retrieved September 19, 2021, from https://www.semanticscholar.org/paper/Public-Private-Partnership-in-Health-Service-%3A-From-Osman/1dd8719bcd0805ba1ed2a5521ba185d8e2383743.

[60] Ullah ANZ, Newell JN, Ahmed JU, et al. Government-NGO collaboration: The case of tuberculosis control in Bangladesh. Health Policy Plan. 2006 Mar;21(2):143–55.

Although, in principle, the tender document details the payment modality that is accepted by both parties, the practice does not always follow accordingly. Regarding the contracting of HR support (cleaners, security, etc.) to private contractors by government hospitals, there are reports of irregularities in implementation, especially in payments to the contracted staff. The Particular Conditions of Contract and General Condition of Contract include the conditions of the contract, and have a section on payment that the contractors do not always abide by. As a result, the government has been taking extra measures to ensure payment to contracted personnel. If there are any disputes, the government and the concerned entities try to resolve them amicably. In many cases, the employees hired through contracting-out mechanisms do not receive their full pay, despite stipulations requiring the contracting entity to show the government the bank statement indicating that the salary was paid in the previous month to receive pay for the following month's salary.

CSO/NGO Capacity Assessment

NGOs are not able to contract with the government to provide health services and, therefore, no NGOs have this direct contracting experience with the government. However, many large NGOs have significant experience and capacity to manage donor-funded contracts (e.g., NGOs under the NTP funded by the GFATM). The KIIs revealed that smaller NGOs often suffer from a lack of financial and technical capacity and may not be able to participate in tenders with DPs. Key informants also expressed concern about competition, saying that it is difficult for new or smaller NGOs to get contracts because large NGOs that have experience executing donor-funded contracts are often selected. Rules and regulations need to be developed to help promote capacity development and to help smaller or newer NGOs gain contracting (or at least subcontracting) experience.

Many CSOs and NGOs lack the necessary HR capacity for contracting even if the laws are updated to permit them to participate in government-funded contracting. Only larger NGOs have legal experts available who can understand the contracting requirements. Even these organizations may face difficulties because few have tax/VAT experts. Many of the CSOs and NGOs do not have staff with adequate training on the government procurement system.

The financial resilience of NGOs and CSOs is another area of concern. Working capital is required for contract implementation, and depending on the size of the contract, this may represent a significant proportion of the overall revenue of the organization. Private companies under contract with the government often obtain loans from commercial banks, but this is not always an option for smaller NGOs and CSOs without a strong credit history.

Lessons from global experience: Ukraine[61]

In Ukraine, the government has used contracting as a key strategy to ensure sustainability of non-medical HIV services as part of the transition from GFATM to domestic public funding. Ukraine has a strong legal and regulatory framework that allows local authorities the responsibility to undertake the different stages of contracting (needs assessment, planning, financing, and procuring services). Despite having a regulatory environment conducive to contracting, it was due to the strong and persistent advocacy of CSOs, which were able to adequately demonstrate their capacity to provide services, that the Government of Ukraine pursued contracting.

Summary of NGO Capacity Findings

Bangladesh has a widespread and varied private and nongovernment health sector, providing everything from prevention/screening, diagnostics, treatment, research and training, technical assistance, and support services, such as logistics, IT, HR support, and analytics. There are several well-documented examples of contracting health services with donor funding (albeit with mixed results in the available literature), such as the UPHCSDP. There are no NGOs and CSOs with experience contracting with the GOB for health-related services. Although some, especially larger and well-known NGOs, have experience providing health services under donor-funded contracts, the general capacity of the NGO and CSO sector to potentially undertake government contracting in the future is weak, especially among smaller and less-experienced organizations that do not have the benefit of a long history of providing services in the country and are not well known by the government.

Assessment of MOHFW Capacity for Contracting

The primary objective for this assessment area was to examine contracting capacity in the government, in general, and specifically in the MOHFW, including its strengths and weaknesses, and any specific capacity building needs.

Capacity of Government and MOHFW

Findings from KIIs suggest that the capacity of the government in contracting-out is gradually increasing; however, not in case of physical or non-intellectual services because these services are not usually contracted-out, as discussed above in the legal and regulatory section. The performance of the contracting entities depends considerably on the leadership qualities of the procuring entity (PE). Due to challenges in specific capacity areas in the government, numerous non-health related contracts, like for cleaning services, security services, and waste management services at different institutions under the MOHFW, have encountered performance issues and been subject to complaints.

Capacity to conduct contracting varies considerably across ministries and departments in the GOB. Seventy-two percent of all public procurement in Bangladesh relates to the country's development program, implemented by the following sectoral agencies: Local Government Engineering Department (LGED), under the Local Government Ministry Roads and Highways Department; Roads and Highways Department, under Ministry of Roads and Bridges; Bangladesh Water Development Board (BWDB), under

[61] Nechosina O, Semeryk O, Nitsoy A, et al. Social contracting in Ukraine: Sustainability of non-medical HIV services. Washington, DC: Palladium, Health Policy Plus; 2019.

the Ministry of Water Resources Bangladesh; Rural Electrification Board (BREB), under the Ministry of Power, Energy and Mineral Resources; Central Medical Stores Depot (CMSD), under the MOHFW; Education Engineering Department under the Ministry of Education; Department of Public Health Engineering under the MOLG; Public Works Department under the Ministry of Housing and Works; and Bangladesh Power Development Board under the Ministry of Power, Energy and Mineral Resources.

The highest capacity and best performance in contracting has been through the leading ministries for procurement and contracting: the LGED, the BWDB, and the BREB. Their experience is well recognized in contracting and procurement, with large-scale procurements managed centrally, and smaller ones administered at the district or sub-district level. These procurements are primarily between the government and private for-profit entities. For all procurements, OTM is the preferred method and alternative methods need justification; 80 percent of goods and works contracts were processed through an OTM in FY2019.[62]

In general, all government agencies are encouraged to use the e-GP platform for the procurement of goods and works, with annual benchmarks for the proportion of procurements that should flow through the e-GP system. However, the MOHFW is a low volume user of the e-GP system and conducts most of its procurement manually. Approximately 40 percent of the MOHFW budget goes toward procurement, primarily consisting of medicines and equipment, followed by training and other services (research, study, audit, and intellectual services). Most of the procurement in the MOHFW is conducted by the Health Engineering Department (HED) and the CMSD. The HED procures infrastructure-related services, such as health-related construction of up to 200-bed hospitals. The CMSD procures medical equipment and medicines. There are known issues with long delays to process contracts, with many surpassing the timelines stipulated in the tender document.

Procurement-related issues in the MOHFW are addressed by the procurement sections under the development wing of the MOHFW. The sections under this wing are not always staffed by officials who have background and experience in procurement functions. The officials are not regularly updated and oriented on the procurement practices. Frequent transfers of officials further challenge the capacity of the MOHFW to adequately staff these procurement sections with qualified personnel.

There is also a need for the MOHFW to engage NGOs already experienced in providing healthcare services, especially TB. The MOHFW will need to develop a mechanism to engage these NGOs through the NTP even after the withdrawal of donor funding. Although cleaning and security services[63] are contracted at some health facilities (e.g., National Institute of Neuroscience and Hospital), the MOHFW needs to find out which medical services (physical services, like diagnostic facilities that provide GeneXpert and sputum smear testing, and X-ray screening) could be contracted. However, contracting of medical services may face opposition from some entities, such as professional associations. Quality control and monitoring of potentially contracted services are other important areas in which MOHFW needs strengthening.

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[62] World Bank. Assessment of Bangladesh public procurement system. Washington, DC: World Bank; 2020. Available from https://openknowledge.worldbank.org/handle/10986/33882.

[63] These services are currently contracted with private organizations and, therefore, do not face the same legal constraints as contracting NGOs. In addition, given the small size of the contracts, they fit under the threshold that would require special processes for the delegation of financial power. Last, the procurement entity uses the one STD that is already developed for physical services to guide the procurement process.

There are various existing committees and offices in the government that provide overall economic and financial discipline and oversight, and also provide guidance and advice to the MOHFW on procurement issues. They are: the Public Accounting Committee of Parliament (oversight); other Cabinet Committee for Government Purchase (the highest authority for approval of procurement proposals); the Cabinet Committee for Economic Affairs (the highest authority for approval of procurement methods in emergency/natural disasters/urgent case/any special circumstances); the ACC (oversight); Comptroller and Auditor General's Office (audit); and the CPTU (regulatory).

MOHFW Capacity Gaps

There are several specific areas where the MOHFW lacks adequate capacity required to manage the procurement process. As noted above, the MOHFW lags behind most ministries in using the e-GP procurement system (although it is gradually adopting it) because it is only available for certain types of procurements. There are many different units in the MOHFW that are conducting procurements, but with limited capacity. In developing contracts, the MOHFW does not have strong capacity in the specification of performance metrics and the development of indicators to assess contracting services or products.

For performance measurement, the MOHFW has a standard contract monitoring system that is paper-based. Performance is verified through monthly meetings and annual performance reviews. However, there are no administrative, financial, or programmatic systems in place to allow the MOHFW to use data generated by the contractor. Additional HR challenges and MOHFW capacity gaps were highlighted by the key informants (box 6).

Box 6. Responses from KIIs: What do you perceive to be the capacity, strengths, and weaknesses of the MOHFW in supporting the contracting process?

- "The Ministry of Health has acquired some expertise in purchasing security services or cleaning services. There is no experience related to other services."
- "The Ministry of Health has the capacity to make contracting decisions. But there are examples of complaints voiced by the contracted organization that are not properly addressed."
- "The Ministry has the capacity to assess the need and invite tenders. But buying healthcare is different from buying other services/goods."
- "The work pace slows down due to frequent turnover of government employees. Many people delay making decisions because they don't clearly understand the various agreements, especially those related to bill payment."
- "There are many weaknesses in the agreements signed between the contracted organization and government organization due to lack of knowledge by the responsible government officials."

Although the MOHFW has capable human resources, they are not trained sufficiently to design and implement contracting. They lack the requisite skills to accurately assess the services needed, to engage in negotiation, or to determine the costs of services and products. As a result, value for money in procurement by the MOHFW is not always ensured.

Following the procurement training conducted by the CPTU and other organizations, MOHFW officials have not been as efficient and proactive as expected. Currently the training is disorganized, includes all personnel, and is not targeted to any specific government unit/ministry. Findings from the KIIs indicate that the impact of the training is barely reflected in the overall performance of officials due to frequent transfers, attrition, and improper placement. Most key informants also mentioned a challenge related to the mindset of government officials: they are usually busy and overloaded, and consequently have little time to devote to procurement/contracting-related matters.

Currently, the only contracting-out of TB-related services is conducted centrally through the GFATM, (i.e., there is no contracting of TB services using GOB funding or systems). The MOF and three NGOs (BRAC, Save the Children, and icddr,b) are the Principal Recipients for all GFATM grants. (For TB, BRAC is the only nongovernment Principal Recipient, and in this role, it administers the subcontracts of the other NGOs that receive GFATM funds for TB.) The MOHFW implements the government grants on behalf of the MOF through national programs for the three diseases. The Bangladesh Country Coordinating Mechanism provides regular oversight of the grants to support the achievement of program targets. There is no government-led procurement, although the NTP line director signs off on the final contract document with the GFATM. For the subcontracting of NGOs for TB under BRAC, the standard GFATM procurement process is followed. The GFATM Office of the Inspector General monitors the contracts stringently and, as a result, has uncovered multiple instances of fraud and corruption perpetrated by various NGOs and the NTP.[64]

Summary of MOHFW Capacity Findings

Contracting-out is used extensively in the Bangladesh TB program with DP funding; therefore, useful packages of services are already well known and have clearly associated results. However, this contracting is conducted entirely following GFATM systems. There are no MOHFW contracting systems or specific capacity in this area that would prepare the MOHFW to take up such contracting processes. The MOHFW faces capacity gaps in contracting training and systems; officials lack key skills required to appropriately design, negotiate, implement, and monitor contracts; and many of the contracting processes are conducted manually, with limited administrative, financial, or programmatic systems in place to allow the MOHFW to monitor and use data generated by the contractor.

Political Economy Analysis

The objectives of this component of the assessment were to understand the political barriers and enabling factors to contracting health services; assess the power, interest, and position of different stakeholders with regard to contracting; and identify threats, opportunities, and strategies to address barriers and engage stakeholders toward the political acceptability of contracting health services.

[64] The Global Fund. Investigation in Bangladesh. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2018. Available from https://www.theglobalfund.org/en/oig/updates/2018-01-19-investigation-in-bangladesh/.

Political Context

Constitutionally, Bangladesh is a parliamentary democracy. Although it has experienced disruptions in the political and democratic process at various points in its history, including a long military dictatorial rule, it has been functioning as a democracy since 1991.

The current government was elected for its third consecutive term in 2019 with a supermajority of 301 out of 350 seats in the country's unicameral parliament. The popular perception, as widely confirmed by the KIIs, is that the ruling party will remain the dominant force in politics for the next several years because it has a strong network of patronage, strengthened over its three consecutive terms in office, which will further enable the party to shape the political landscape. The ruling party introduced several important health reforms, notably, the implementation of a SWAp for planning; setting up community clinics at the grassroots level on a population basis; and development and roll-out of an ESP.

Public procurement through contracting has increased steadily since the adoption of privatization as an economic policy reform in 1976.[65] With the advent of COVID-19, the government has increased its partnership with the private sector to address the procurement of equipment, treatments, and vaccines, placing health in a high position on the policy agenda. The HCFS (2012–2032) has a provision for purchasing services and for setting up an autonomous government purchasing organization. The Strategy is being revised to make it more practical, and a Health Protection Act is being drafted to give the legal foundation for such an organization.

Political Barriers and Enabling Factors for Contracting Health Services

The assessment of political economy was primarily conducted through KIIs and supplemented by a review of the literature to identify barriers and capture lessons learned from previous experiences with procurement in Bangladesh. Several key themes emerged.

Public Perception of Contracting

Procurement in the health sector remains very sensitive, and public perception about procurement and contracting are not positive due to allegations. Media reports reflect some irregularities in the health sector's procurements at different times, which negatively impact the public perception. Parliamentary committees (such as the Standing Committee on Health and Public Accounts Committee) are also very critical about procurement issues, citing hundreds of audit objections. These perceptions and concerns about potential challenges for the government to conduct contracting-out effectively and transparently were affirmed by several informants (box 7).

[65] Islam MR. Public procurement and contracting in Bangladesh: An analysis of the perceptions of civil servants. Journal of Public Procurement. 2007; 7(3): 381–398.

Box 7. Responses from KIIs: What are potential political barriers to contracting?

- "It has already been mentioned that the issue of tender management has always been executed under political and administrative pressure. It has an impact on tender bidding and negotiation. Transparency becomes disrupted."
- "Effort is needed to change the mindset of the highest level of the government. In a centralized system of government, the top level gets what it wants. If the mindset of the top level changes, contracting will increase, the existing system will change accordingly."

In general, and despite these reservations, the public is less concerned about who provides health services, and more concerned about the availability and quality of services. The primary expectations relate to the presence of providers, good behavior, availability of medicines, and discipline. Respondents also highlighted accountability as a critical element to improve public perception but noted that if contracting-out does not improve quality and access to services, the initiative could backfire.

The MOHFW has been trying to address the issues/problems with procurement in various ways, including taking legal and disciplinary measures against the persons involved in malpractice and wrongdoing, organizing training to improve the knowledge and skills of officials who have procurement responsibilities, moving toward greater use of the e-GP, and accessing technical support from DPs and the CPTU for improved procurement functioning.

Under the health sector program, there are two OPs (one is for the DGHS and the other is for the DGFP) that deal with procurement issues in this sector. They include activities to improve efficiency in planning and managing procurement and the supply chain, including capacity building activities.

Under the previous sector program, all procurement conducted with the pooled fund (the fund organized by several DPs, including the WB, USAID, Foreign, Commonwealth & Development Office, etc.) required the review and approval of the WB country and headquarters offices.

Several officials faced legal and disciplinary procedures for their alleged involvement in procurement malfeasance. Some private suppliers are blacklisted because the ACC found their involvement in malfeasance.

All these initiatives and actions have contributed to improving the situation; however, more time and efforts are required to streamline all procurement issues. The mid-term review report of the sector program suggests some measures, including restructuring and strengthening the capacity of the CMSD and scaling up the e-GP.

Political Environment and Acceptability of Contracting

Contracting is as much a political matter, shaped by those in power who determine health policies and oversee their implementation, as it is a technical matter requiring specific technical expertise.[66] As such, consideration of the political environment for contracting is extremely important. At present, the key

[66] Agyepong IA, Adjei S. Public social policy development and implementation: A case study of the Ghana National Health Insurance scheme. Health Policy Plan. 2008 Mar;23(2):150–60.

informants suggested that there is support in Bangladesh for contracting arrangements with private providers, with a view to making publicly-funded services more accountable, transparent, and efficient.

Most of the informants believe that the current political environment is favorable to more engagement of nongovernment entities in the health sector because the government has actively pursued a private sector-led development policy. The newly adopted Eighth Five-Year Plan (2020–2025) includes provisions for buying services from the private sector. Although different groups close to the political establishment will have an interest in being involved in contracting, the government would need to ensure a win-win situation for all (purchaser, providers, and beneficiaries). On the question of whether the policy of contracting could be reversed after any political change, respondents unanimously said that a reversal would be highly unlikely.

The experience of contracting out via the UPHCSDP in Bangladesh has been well documented and has demonstrated the importance of considering political economy. Factors contributing to the success of these types of initiatives require among others: ensuring government ownership; adapting and integrating contracting provisions in health systems; developing local capacity; setting up an appropriate legal framework; and developing contracting-out modalities that are adaptable and responsive to a changing context.[67] The health sector can build on this experience by applying lessons from this procurement process to the reform of the country's legal and regulatory framework for procurement (box 8).

Box 8. Procurement in the UPHCSDP

The UPHCSDP contracts with NGOs to provide primary healthcare services. The National Project Director of the UPHCSDP works in the Local Government Division of the MOLG. The Local Government Division is the PE and the Director's team completed the whole procurement process with ADB supervision. Because the method for procuring physical services (which includes clinical health services) has not yet been developed, the UPHCSDP used the procurement method for goods. The ADB's procurement guideline was followed, which is allowed under the PPR 2008 (Section 3). ADB prepared a master bidding document applying the OSTEM and using evaluation criteria similar to the Quality and Cost Based Selection method of intellectual services. The quality to cost ratio was 80:20.

Methods of Contracting (government to government, government to private, open tendering) and Services to Be Contracted

Although most key informants acknowledged that open and competitive bidding processes were best in principle, many of the government respondents (PEs) favored procurement from other government entities (i.e., insourcing) as the preferred method of contracting, citing that this would be the least risky option, without raising issues of competition and complaints surrounding the procurement process. This reflects an important mental attitude of government personnel, who favor the status quo and try to avoid

[67] Islam R, Hossain S, Bashar F, et al. Contracting-out urban primary health care in Bangladesh: A qualitative exploration of implementation processes and experience. Int J Equity Health. 2018 Oct 5;17(1):93.

the steps required for processing a competitive bid. There was also consensus that the procurement method would depend on the type of service to be contracted. In terms of the services to be contracted, key informants felt that contracting should be iterative, starting with support services, like ambulance services and diagnostics. Once successful, contracting could be further expanded to core services, such as public health programs like TB.

Apart from proper deployment and capacity issues, sometimes the procurement personnel become subject to undue pressure and harassment for their services. Such personnel need some sort of protection so that they do not become subject to pressure and harassment for the services they do in good faith.

System Readiness and Capacity

Although this issue has been addressed in other components of this assessment, the lack of government capacity in contracting was a theme that came out in all interviews. Key informants underscored the need for improved system readiness, including the development of simplified rules, regulations, and STDs; a detailed work manual for contracting; a clearly defined responsibility and protection mechanism[68]; and true government (MOHFW) ownership and engagement, with necessary support from concerned government departments, such as finance, audit, and planning.

Political Buy-In at the Highest Level

Given Bangladesh's very centralized system, most respondents felt that the successful introduction of a new contracting policy would require agreement and political buy-in from the highest level of government.

Role of the NGOs and CSOs

The critical role of NGOs and CSOs was emphasized by all informants, pointing to the successful experiences of large organizations, such as BRAC, in delivering health services. However, some informants expressed concerns about the ability of NGOs and civil society to maintain neutrality in the face of increased politicization, which could cast doubt on the transparency and legitimacy of the contracting process.

Summary of Political Economy Analysis Findings

Contracting health services is a politically sensitive policy decision that should be approached carefully to ensure political buy-in and public acceptability. Although the current political environment appears to be favorable to contracting, considering the sensitivity around contracting, decisions about contracting methods and the types of services to contract should be carefully considered based on Bangladesh's specific needs. For contracting to succeed, political agreement at the highest level of government should be obtained, and sufficient capacity built. A negative outcome early in the contracting process could effectively backfire and render the reform politically non-viable.

[68] Protection of the person for unintended/inadvertent mistakes or errors, and work done in good faith, and from undue pressure and harassment for following rules, regulations, and procedures.

RECOMMENDATIONS

Based on the findings of the analysis, there are several actions needed to create an enabling environment for contracting TB services to NGOs/CSOs through the government public procurement process. The following recommendations include priority action steps that are needed. A comprehensive Roadmap with sub-activities, roles and responsibilities, and a timeline will be developed with the GOB as an operational tool to advance this agenda.

The recommendations are categorized by topic area: (L) – legal and regulatory; (N) – NGO capacity; (M) – MOHFW capacity; and (P) – policy buy-in.

Immediate Priority Recommendations

This section presents the immediate priority recommendations based on the analysis. Recommendations for further support and actions specific to each topic area are listed further below. The recommendations are generally discussed in sequential order; however, many can be acted on simultaneously. Detailed sub-activities and a timeline will be developed as part of an action plan.

Recommendation 1 (M). The HEU at the MOHFW and the NTP conduct an analysis to support the decision-making process for which TB services to contract and where, including fiscal space projections with scenarios for decreased donor funding, and the strengths and experiences of the government and NGO sectors relative to TB clinical and non-clinical services.

Recommendation 2 (P). In collaboration with the NTP, the HEU develops a set of advocacy materials on the rationale and expected benefits of of contracting of health services, in general, and of clinical and non-clinical TB services specifically, including policy briefs targeting different levels of the government.

Recommendation 3 (P). The HEU develops a detailed stakeholder engagement plan, based on the initial stakeholder analysis and recommendations, to manage each player based on their power, interest, and probable position on whether to contract health services. (**Annex 8** provides more detail.)[69]

Recommendation 4 (P). The HEU, with DGHS, conducts advocacy and sensitization meetings, seminars, conferences, networking, and strategic engagement on contracting health services across key stakeholders and change agents in the MOHFW, MOF, MOP, NGOs, CSOs, and professional associations.

Recommendation 5 (P). The HEU develops and obtains high-level endorsement from the MOHFW on a position paper that demonstrates the clear commitment of the GOB to pursue contracting of selected health services and link this reform to key national priorities laid out in the Eighth Five-Year Plan (2020–2025).

Recommendation 6 (L). The HEU mobilizes the CPTU to identify a focal point to facilitate communication and required changes in the PPA, PPR, and other legal instruments.

Recommendation 7 (L). In collaboration with the CPTU, the HEU proposes specific amendments to the legal and regulatory framework, including the PPA 2006, PPR 2008, and Delegation of Financial Powers, to incorporate the necessary provisions for contracting health services to CSOs, NGOs, and the private

[69] Note: This Annex may be removed before sharing widely because the stakeholder analysis and recommended actions may contain some sensitive information.

sector. They include: (1) amendments to allow NGOs and CSOs to be tenderers in the government procurement processes; (2) amending the qualifications and/or creating new qualifications for being a tenderer that are more appropriate and in line with NGO and CSO business models; (3) including health services in the definition of physical services; (4) creating an STD for physical services, especially health-related services; and (5) defining the authority on the procurement of physical services under the Delegation of Financial Powers.

Recommendation 8 (P). The HEU uses the policy briefs (Recommendation 2) and Roadmap (Recommendation 9) to engage MOHFW decision makers to include contracting in key MOHFW policy documents, such as OPs, Next Sector Program, National Healthcare Financing Strategy, and National Strategic Plan for TB Control.

Recommendation 9 (M). For effective planning, implementation, management, monitoring, and evaluation, the HEU and NTP lead the development and implementation of a Roadmap and action plan for government-led and financed contracting of TB services. The plan can include activities for the review and strengthening of procurement systems; training and refresher training; and the development of laws, policies, strategies, tools, guidelines, etc. The HEU and NTP also coordinate with the GFATM on its transition readiness planning for the TB program.

Recommendation 10 (P). In view of the trend of decreasing donor funding and increasing funding gaps, the HEU works closely with the Program Management and Monitoring Unit of the MOHFW, the NTP, MOF, and MOP to mobilize domestic resources for the TB program within the government's fiscal space.

Additional Recommendations: Enhancing the Legal and Regulatory Environment Toward Contracting of Health Services

Recommendation 11 (L). The HEU creates a strategy to introduce and monitor the revisions to the legal and regulatory framework [Recommendation 7], including mapping the specific sequence of approvals required and suggested processes to obtain approvals from the Legislative Division of the Ministry of Law, Justice and Parliamentary Affairs.

Recommendation 12 (L). As the legal and regulatory framework is revised, the HEU, in close collaboration with the CPTU, develops a comprehensive guidance document on the legal and regulatory requirements for contracting health services, targeting the MOHFW and implementing agencies, which discusses eligibility criteria, performance evaluation, selection process, etc.

Recommendation 13 (L). The CPTU incorporates "physical services" in the e-GP platform to digitally manage public procurements.

Additional Recommendations: Building the Capacity of NGOs and CSOs to Enter Into Contracting Arrangements with the Government

Recommendation 14 (N). In collaboration with the NTP and CPTU, the HEU develops and implements a capacity needs assessment of NGOs and CSOs, beginning with the NTP's implementing partners, to identify specific areas requiring additional capacity building to engage in contracting with the government, including all steps in the public procurement process.

Recommendation 15 (N). With support from the NTP, the HEU defines and receives the MOHFW's endorsement on a clear scope of work for NGOs, CSOs, and private organizations in the provision of clinical and non-clinical TB services (based on the results of Recommendation 1), and ensures that MOHFW policy documents reflect this scope of work.

Recommendation 16 (N). The HEU reviews, revises, and disseminates existing training modules on governance, tax/VAT policy, public procurement management, contract management, etc. for NGOs/CSOs/private sector to build their capacity for government contracting to be tenderers.

Additional Recommendations: Building MOHFW Capacity to Conduct Contracting

Recommendation 17 (M). The HEU and NTP develop a detailed design for a pilot to contract clinical and non-clinical TB services to NGOs, CSOs, or strategic alliances, including details on the specific health services to contract out and the geographic areas and populations to be reached (based on the results of Recommendation 1).

Recommendation 18 (M). The HEU proposes and creates a plan for the creation of a new Procurement Unit at the DGHS to support, oversee, and monitor the procurement of all procuring entities under the DGHS, including the NTP.

Recommendation 19 (M). In collaboration with the CPTU, the HEU conducts a training needs assessment and creates a comprehensive training plan on the procurement of health services, specifically targeting NTP and health sector personnel. The HEU then develops or modifies existing training materials and organizes a training for NTP and DGHS personnel to develop their capacity to design, negotiate, implement, and monitor contracts, including use of the e-GP system.

Recommendation 20 (M). The HEU develops appropriately designed performance indicators to monitor and evaluate the performance of NGOs and CSOs in undertaking contracts, drawing on best practices from well-performing procuring entities in the GOB, and global experiences in contracting.

Recommendation 21 (M). The HEU and NTP implement piloting of contracting of TB services through the government procurement system, holding monthly and quarterly monitoring meetings to review data, discuss bottlenecks, and adjust approaches.

Recommendation 22 (M). To strengthen existing institutional arrangements for contracting, the HEU, in collaboration with the CPTU, forms a dedicated team (committee/working group) with a specific terms of reference, scope of work, goals, deliverables, and milestones, with relevant stakeholders to share challenges and best practices at different levels of the MOHFW: high-level officials, mid-level health managers and line directors, and field-level health managers at the divisional and district levels.

Additional Recommendations: Engaging with Stakeholders to Promote Political Acceptability and Buy-In for Contracting Health Services

Recommendation 23 (P). The HEU communicates with and creates dialogue among key policymakers of the MOHFW, the Prime Minister's Office, the MOF, and public and private providers to continue to advocate for contracting, keep them informed of progress in developing reforms to implement contracting for TB services, and to understand and mitigate concerns of various interest groups and stakeholders.

ANNEX 1. STEERING COMMITTEE COMPOSITION AND TERMS OF REFERENCE

Based on the history of TB program implementation in Bangladesh, there is a need to assess and plan for contracting for elements of the TB response. This effort is implemented in Bangladesh under the leadership of the Health Economics Unit of the Health Services Division, Ministry of Health and Family Welfare, in collaboration with the National TB Control Program, and is supported by the USAID-funded Health Systems for Tuberculosis (HS4TB) Project, led by Management Sciences for Health.

The Project aims to support the strengthening of Bangladesh's financing and governance systems by developing feasible mechanisms for competitive contracting to improve efficiency and health outcomes. The Project will review the legal and regulatory environment and existing practices and capacities for contracting and will develop an Action Plan for implementation.

A Steering Committee with the following composition and Terms of Reference is hereby constituted for implementation of the Project:

Composition of the Steering Committee

1	Director General, Health Economics Unit	Chair
2	Joint Secretary, Public Health /WHO*	Member
3	Director (MBDC), and Line Director, TB & Leprosy Control	Member
4	Director (Planning), Directorate of Health Services	Member
5	Representative from USAID	Member
6	Director (Research), HEU, and Focal Point for HS4TB Project	Member Secretary

*GOB official, does not indicate affiliation with WHO

Terms of Reference

- The Steering Committee will support and guide the project team in implementing the activities of the project.
- It will periodically review and monitor the progress of the activities and ensure the relevance and quality of the work.
- It will facilitate the project team in networking with the wider stakeholders and organize the required approval of different outputs by the competent authority.
- The Committee will meet at least once per month.
- It may co-opt any person it deems necessary for the interest of the project implementation as an additional Member.

ANNEX 2. LIST OF KEY INFORMANTS AND RELEVANT MAPPING AREAS

	Organization / Agency of each key informant	Legal & Regulatory	NGO/CSO Landscape	Govt Capacity	Political Economy
1	MOHFW				•
2	MOHFW	•	•		•
3	MOHFW, Health Services Division (HSD)	•		•	•
4	Cabinet Division	•			
5	MOHFW, HSD			•	
6	Ministry of Finance	•		•	•
7	MOHFW		•		•
8	Ministry of Planning	•	•	•	•
9	CPTU	•	•		
10	DGHS	•		•	
11	DGHS HIV/AIDS Program		•	•	
12	DGHS	•	•		•
13	National Institute of Neurosciences	•	•	•	•
14	National Institute of Kidney Diseases		•	•	
15	Sandor Dialysis Private provider to NIKDU)		•	•	
16	Asian Development Bank, Dhaka		•		
17	World Bank, Dhaka		•	•	•
18	UNAIDS		•	•	
19	Global Fund and Bangladesh Coordination Mechanism (BCCM)	•	•		

20	DGFP	●			
21	DGFP		●		
22	Ministry of Local Government, Rural Development and Cooperatives, Local Government Division		●		
23	Ministry of Primary and Mass Education		●		
24	Program Management and Monitoring Unit, MOHFW				●
25	Academia				●
26	Academia				●
27	NGO BRAC	●	●	●	●
28	NGO Damien Foundation		●	●	
29	ARK Foundation			●	

ANNEX 3. DESCRIPTION OF KEY LEGAL, REGULATORY, AND POLICY DOCUMENTS RELATING TO PROCUREMENT

Public Procurement Act 2006 and Public Procurement Rules 2008

These two acts are the principal legal instruments for managing public procurement. Initially, following the study, the government initiated massive reforms for the first time and created a regulatory framework through the formulation of Public Procurement Regulation 2003, through the establishment of the Central Procurement Technical Unit (CPTU) under the Ministry of Planning, and a capacity-building program for government officials. Treated as the foundation of reform, the Public Procurement Regulation 2003 was later removed and replaced by the Public Procurement Act 2006 and Public Procurement Rules 2008, which made the legal framework more enforceable. The regulatory framework is fully authorized to carry out public procurement management as a uniform system for the whole government. The procurement of physical services and the procurement of services through contracting were not a focus of the legal framework initially.

Through the 2016 amendments to the provisions of Section 26 of the Public Procurement Act 2006 and Rule 2(43) of the Public Procurement Rules 2008, the updated framework now includes the areas of physical services/non-intellectual services/definition of contracting for applications. There is a significant difference between intellectual/professional services and non-intellectual services in processing procurements. Before 2016, the framework included the provision of standalone physical services with a very brief explanation in Rule 76(5) saying "a contract for physical services may be extended through the direct procurement method yearly or less than that period, if the contract is obtained through a competitive process and the procuring entity is satisfied with the contractor's services." Goods-producing services and physical services were integrated and given less importance, despite the fact that non-intellectual services make up a large part of the government's current procurement needs. Due to this lack of prioritization, no standard document or detailed procedure was developed for procuring these services. The area of physical services was included in the 2006 Act and the 2008 Rules, but without any details about the method for procuring the services, the evaluation process, the nature of the physical services, or the contractual arrangement to be used. The provisions for procurement of services from CSOs and NGOs were included in the Act and Rules with independent STDs. The health sector has specific needs for contracting contracts, which needed specific STDs. The 2016 amendments better defined and conveyed the importance of physical services and contracting; however, no steps were taken to develop detailed procedures in the Rules or to develop STDs for these services. Physical services are heavily used in the health sector, and many experts have agreed on the need to develop sector-specific STDs, especially for the health sector.

In the context of procurement, service contracting means the procurement of physical services. This type of service will mainly use performance-based/output-based specifications. The scope of physical services is very wide, so a single definition and procedure may not be sufficient to cover this kind of procurement.

The wide scope of procurement of physical or non-intellectual services, and their handover to a third party, has not always been recognized. Non-intellectual and professional services, such as catering, event management, and customs clearance, form a substantial subset of all government procurement. It is also necessary to follow a procurement process when contracting healthcare. The Public Procurement Act

and Rules do not provide a detailed procedure; however, it is possible to obtain the technical support of the CPTU to develop STDs, which are required to contract services in the health sector.

As stated in Schedule 1 of the Public Procurement Rule 2008, the following STDs related to procurement of physical services, NGOs, and CSOs are available on the CPTU`s website:

PS 1: Standard Request for Proposal for Selection of CSOs, National

PS2: Standard Request for Proposal (SRFP) for Selection of NGOs

PSN: Standard Request for Proposal for Procurement of Physical Services, National

All these STDs are mainly used for procurement of NGOs/CSOs/physical services through contracting. The PSN document is used for hiring personnel, part of which is regulated by a circular of the Finance Division of the Ministry of Finance.

Delegation of Financial Powers issued by the Finance Division

The Finance Division of the Ministry of Finance has delegated financial powers to the administrative ministries, or divisions; attached offices; offices at the field level; project directors; and autonomous bodies on financial matters. Under the rules of business of 1975 (issued in revised form in 1996), references to the Ministry of Finance are mandatory on all issues involving finances in specified areas. As a general rule, the ministries/divisions and their attached departments and autonomous organizations are free to incur expenditures within the budget allocations made by the Finance Division with the approval of Parliament.

The Delegation of Financial Powers made by the Finance Division falls into two broad categories: first, those relating to the non-development budget, and second, those relating to the development budget. This document specifies the level at which the procurement proposal will be approved. The level of approval authority for procurement is of great importance in this document. Authority streamlining varies across categories. Procurement by the non-development budget provides specific levels of authority from Cabinet Committee, Minister, Head of the Procuring Entity, Divisional Office Head, District Office Head, and Upazilla Office Head. Procurement by the development budget provides the levels of authority to approve from the Cabinet Committee, Minister, Head of the Procuring Entity, and Project Directors of category a, b, and c.

The Delegation of Financial Powers and the Public Procurement Act and Rules are complimentary to each other. After following the procurement process, the recommendation of the Tender Evaluation Committee must be approved by a level of approval authority. Section 8 of the Public Procurement Act 2006 and Rule 11 of the Public Procurement Rules 2008 define the level of approval authority based on the Delegation of Financial Powers.

Policy on Procurement of Services through Contracting

The Finance Division, Ministry of Finance, issued a notification on January 11, 2019 that defined contracting as a mode of procurement, and outlined the procedure for contracting many different types of services to third parties, NGOs, and private entities. The policy covers the following services:

- Security and guard
- Cleaning and gardening

- Transportation
- Electrical, mechanical, and woodwork
- Cooking and dining
- Hotel, mess room, club, sports, and common room
- Housekeeping, caretaking, and hospital services
- Lift maintenance, pump operating, generator operating, machine operating
- Project operating
- Air-conditioning machine installation and maintenance
- Post distribution
- Sanitary and plumbing works
- Any other type of service specified by the Finance Division

The objective of this policy is to ensure the most efficient use of resources to procure quality services in minimum time. In defining services, the notification mainly underlines the procurement of personnel to provide the above-mentioned services. Among others, these instructions also specify the hospital services to be procured in compliance with PPA/PPR.

In accordance with the policy, service providers receive commissions defined by the contract value. The service provider receives a specific /consolidated/fixed salary as defined by the Finance Division, based on their hours of work. The following qualification criteria are also specified in the policy:

1) The person shall have adequate physical capacity
2) The provider may be hired as an individual or as an organization
3) The number, category, and qualifications of the service provider must be approved by the government (meaning the Finance Division)
4) Age limit 18-60 years

These criteria reflect the contracting procedure for hiring personnel, and are widely used by all government procurement entities.

Circular of Economic Relations Division to Enhance the Mobility of Project Implementation

The Economic Relations Division, Ministry of Finance, issued the Circular for fund allocation and management policy for project formulation and preparation. According to the preamble, the objective of this Circular is to ensure the mobility of project implementation and changes to structure and procedure. The Circular was issued to provide direction and fund allocation for preparation of projects prior to the approval of Development Project Proposal/Technical Project Proposal.

Several steps are necessary for project preparation, approval, and implementation. Some of these steps require expenditures prior to the formal project approval and budget allocation. The Circular provides authority to the organizations/project implementation authority to receive budget allocation for making upfront expenditures. The Circular also provides provisions to initiate and complete certain tasks before the project launches, mainly under procurement. A checklist is also attached to the Circular, where all steps are detailed and must be completed before the project is approved. This initiative facilitates project preparation and implementation with increased mobility. It was used to satisfy DPs who criticized delays in project implementation.

Public-Private Partnership Act 2015

The Government of Bangladesh introduced provisions for public-private partnership (PPP) to the development procurement process through private-sector investment in government projects, and through promulgation of The Policy and Strategy of Public-Private Partnership to facilitate the development of public infrastructure and services vital for the people. Since then, the PPP program has been part of the government's vision for ensuring a more rapid and inclusive growth trajectory and for better meeting the need for enhanced high-quality public services in a fiscally sustainable manner.

Under the new policy, an autonomous institution—the PPP Authority—under the Prime Minister's Office, was established as the facilitator of PPP. A PPP Unit in the Finance Division, Ministry of Finance, was also established to foster an environment of fiscal responsibility and provide upfront support to the PPP initiative. At the same time, the Bangladesh Infrastructure Finance Fund Limited was created to extend equity and debt support to PPP projects and lead the catalytic role of financiers of PPP initiatives.

Subsequently, the government has promulgated the PPP Law, rules for technical assistance, financing, rules for viability gap financing, procurement guidelines for PPP projects, and the PPP through government to government partnership; and has created a robust PPP environment in the country. Since this PPP framework was operationalized, more than 100 projects have been approved in principle, including two projects that have been completed and five projects that are currently being implemented with significant visibility. One of the most important PPP modalities is procuring public services, including two dialysis centers at the National Institute of Kidney Diseases & Urology (NIKDU) and Chattagram Medical College Hospital. This initiative may be one of the more significant contracting initiatives in the health sector that is being implemented through the PPP process. Two other initiatives are also undertaken through feasibility studies: Development of Occupational Diseases Hospital, Medical College; and modernization of the Railway Hospital at the Central Railway Building in Chittagong, Medical College and Nursing Institute. The legal framework of PPP includes jurisdiction of all sectors, with no special provisions for health services contracting. Theoretically any health services can be managed through a PPP, if the private sector is the developer of the services.

The Company Act 1914

"Company" means a company formed and registered under this Act, or an existing company. This law frames the provisions for managing, operating, and forming a board of directors; and defines the functions, powers, etc. of the Board of Directors. Per the Public Procurement Act 2006, a company owned by the government, using public money for procurement, must follow the PPA 2006 and PPR 2008. Per the Company Act, the Board of Directors holds unlimited administrative and financial power over any company it manages. It is very important that the Public Procurement Rules 2008 specify the full power of the board to approve a public procurement proposal and specify that it need not follow the Delegation of Financial Powers of the Finance Division, Ministry of Finance. It creates a speedy environment to complete the public procurement approval process when a project is implemented by a company.

If a procuring entity is established as a company under the Company Act 1994, it has this power over the approval process. Under the Government of Bangladesh, several companies have been established under the Ministry of Power, Energy, and Mineral Resources, the Ministry of Finance, the Ministry of Defense, and the Ministry of Industries. (No government-owned companies have apparently been established under

the Ministry of Health and Family Welfare.) A publicly-owned company, while working as a procuring entity, can exercise its power to process the procurement of health services through contracting and strategic procurement.

The Public Moneys and Budget Management Act 2009

This Act covers the custody of public money; the deposit and withdrawal of money from a consolidated fund; the withdrawal of money from a public account of the Republic; the maintenance of a budget (including maintaining a sustainable budget deficit and public debt); the assurance of inter-generational equity; the improvement of macroeconomic stability; the establishment of accountability and transparency in budget preparation; and other related issues.

The Act provides general instructions and a legal foundation for developing a budget, covering the following aspects: custody of public money; deposit and withdrawal of money from the consolidated fund; deposit and withdrawal of money from the public accounts of the Republic; and other related issues.

The Act also covers the following areas:

- Consolidated Fund and the Public Account of the Republic
- Budget management
- Principal Accounting Officer and Executive Authority
- Borrowings and guarantees
- Financial misconduct

Although the Budget Management Act has no direct role in regulating public procurement management, the budget allocation specifically to the health sector is a factor in the procurement of services through contracting.

Arbitration Act 2001

When private partners are engaged in a public procurement contract, disputes may arise during implementation of the contract. The method of solving them depends on the legal provisions of the country. Arbitration is a swift and efficient means of dispute-solving and, therefore, facilitates implementing a strong PPS, whose sustainability depends on three pillars: efficiency, protection of public interest, and respect for the rule of law. This has an impact (to varying degrees, depending on the specific situation and/or the country's legal system) on both the public interest and the rights of the contract holders (private providers and/or public works executors) when the state does not comply with its obligations.

In a public procurement contract, in Bangladesh, when a dispute arises, the procuring entity and the contractor/supplier must use their best efforts to amicably settle any disputes arising out of, or in connection with, the contract or contract interpretation. If a dispute settlement fails to be reached through amicable means, the decision is referred to the Adjudicator, a person/institution appointed jointly by the parties per the provisions of the Public Procurement Act and Rules.

If the parties are unable to reach a settlement on the matter of disagreement, then either party may give notice to the other party of its intention to commence arbitration in accordance with the provisions of the clause of contract. Then the arbitration shall be conducted in accordance with the Arbitration Act (Act No 1 of 2001) of Bangladesh as at present in force and in the place specified in the contract.

The Arbitration Act 2001 is enacted relating to international commercial arbitration, recognition, and enforcement of foreign arbitral award and other arbitrations. Arbitration, as stated in the law, relates to disputes arising out of legal relationships, whether contractual or not, considered as commercial under the law in force in Bangladesh, and where at least one of the parties is (i) "An individual who is a national of, or habitually resident in, any country other than Bangladesh; or (ii) A body corporate which is incorporated in any country other than Bangladesh; (iii) A company or an association or a body of individuals whose central management and control is exercised in any country other than Bangladesh, or (iv) The Government of a foreign country."

According to section 3 of the Act, the Arbitration Act shall apply where the place of Arbitration is in Bangladesh; for large international procurements the arbitration site must be negotiated each time.

Powers of the Arbitrator(s), form of the Arbitration agreement, arbitrability of the dispute, composition of the arbitration tribunal, appointment of the arbitrators, jurisdiction of arbitration tribunals, and the conduct of arbitral proceedings are clearly stated in the sections of the Act. The parties are free to choose the place of arbitration, according to the Act. In most cases, the Arbitration Act 2001 is stated in the STDs/template of the contract in a very generic way, which is not sufficient for the parties to understand the procedures if they need to resort to arbitration.

PFM Strategy (2016–2021) and PMF Action Plan (2018–2023)

Public financial management (PFM) reform is considered a key component for improving governance and accountability in Bangladesh.

The key bottlenecks in public resource allocation, availability, and use for social service delivery include delays in budget releases and slow procurement processes that delay the provision of necessary goods and services. For example, it takes an average of 15–18 months for drugs to reach the Upazila Health Complex and below, whereas it should not take more than nine months to procure and distribute them. Inadequate audit follow-up and delayed resolution of audit queries affect aid disbursement and civil servants' terminal benefits.

In this context, the Government of Bangladesh has initiated reform programs, such as the Public Financial Management (PFM) Program to improve fiscal discipline, financial reporting, transparency, and accountability in selected government agencies. These reforms will contribute toward achieving Sustainable Development Goals and Upper Middle-Income Status by 2030. The World Bank provides credit support to implement the PFM Action Plan under this strategy. The Strategy was adopted by the Government for 2016–2021. Objective 3.2 of the Strategy pinpoints the upgrading of standards of public procurement when it states: "Adopt International Standard of Procurement Practice to facilitate service delivery and value for money." The Strategy has tackled the challenges of (among others) strengthening the role of the Central Procurement Technical Unit (CPTU), making the CPTU a regulatory authority, and transforming the Electronic Government Procurement (e-GP) operation into a business service provider mode.

To continue its previous efforts, Bangladesh is now working to modernize the PFM system, increase government efficiency, and encourage investment through the transformation of social and infrastructure projects. The Ministry of Finance has approved the PFM Action Plan (2018–2023) in conjunction with the implementation of the reform strategy (2016–2021). The PFM Strategy clearly sets out the key goals and

objectives of the PFM reforms and identifies priority reform actions. The action plan provides the road map of the priority actions with clear institutional responsibilities, cost-benefit analysis of sub-activities, and result indicators to monitor implementation progress. The PFM Action Plan includes strengthening the CPTU through restructuring it as part of the Public Procurement Authority to better institutionalize its operations. The government has already taken initiative and submitted a first-draft law to the Cabinet Division. This is the perfect time to address all the remaining issues, such as adding more specific guidance for procuring physical services, expanding the contracting of services (considering the health sector), including whole life cycle cost-based evaluation in tender evaluation, and applying economically-advantageous tender in public procurement proceedings in Bangladesh.

Under the PFM Action Plan, the Ministry of Finance, Finance Division, is responsible for strengthening the CPTU so that it can more effectively regulate public procurement in Bangladesh.

Eighth Five-Year Plan

The Eighth Five-Year Plan discusses NGOs and PPPs as significant and growing means of health service delivery. The Plan mentions that some well-established and institutionally strong NGOs are providing services as healthcare providers, innovators in diversifying modalities of service delivery, trainers of formal and informal health providers, researchers working on research and development, and catalysts/facilitators for demand creation and linking communities with health facilities. PPP is also being practiced in the health sector by the government as an approach for enhancing effective health service delivery. Bangladesh has already contracted kidney dialysis services at the NIKDU and Chattagram Medical Hospital through PPP. The Eighth Five-Year Plan includes the objective of improving implementation capacity by rationalizing procurement management.

Chapter 10 of the Eighth Five-Year Plan discusses Health, Population, and Nutrition (HPN). It summarizes the chronological performance of SWAp since 1998. This SWAp brings together the government, DPs, and other stakeholders in a single-sector policy and expenditure program. The first SWAp (HPSP, 1998–2003) focused on decentralizing health sector delivery in rural communities; the second SWAp (HNPSP, 2003–2011) focused on ensuring a user-centered, effective, efficient, equitable, and accountable high-quality HPN sector. The third SWAp (HPNSDP, 2011–2016) focused on strengthening the health services system and improving health and family planning services, and the ongoing fourth SWAp (HPNSP, 2017–2022) has taken a holistic approach focused on strengthening the MOHFW's governance and stewardship roles in HPN services, and emphasizing them in the public and private sectors. The fourth SWAp has also been aligned with the SDGs for achieving UHC.

The plan, under HPN strategies, has highlighted the increased quality and use of services by adopting a more inclusive approach to engaging the private sector of ESP delivery, PPPs, and NGOs.

The main modality of engaging private sector/NGOs in service delivery is contracting, although they are not discussed in the Five-Year Plan. But the Plan emphasizes the need for future activities to establish laws and rules, formulate new policies, and update existing policies for improved governance, equity, and inclusiveness.

Regarding urban healthcare, the plan states that new ways of involving partners, MOLG, NGOs, private sector providers, and others are needed. Capacity building may help determine the roles and accountabilities of different NGOs and the private sector in the diversity of urban health.

In many ways, the greatest emphasis has been placed on the legal and regulatory framework; however, these frameworks need to be combined with Health Services Division (HSD) partnering with NGOs and the private sector to strengthen existing regulatory mechanisms and create new ones.

Although the Plan mentions the indirect involvement of private organizations and NGOs in healthcare, it does not mention the procurement process for their involvement. It also does not discuss whether the proper procedures and legal provisions are in place in the government procurement process, or whether the capacity of the procuring entities is sufficient to implement this involvement. However, it has been established in the Eighth Five-Year Plan that private service providers and NGOs can have a wide range of involvement in the provision of health services.

National Health Policy 2011

The National Health Policy 2011 states that health services received from the government and the private sector need to be improved in terms of their volume and quality.

The policy has identified and highlighted the following weaknesses:

- Time-consuming procedures for the procurement of health services equipment, and other requirements
- Due to time-consuming procedures, the health budget is used improperly
- Supplies are not appropriate or obtained in a timely manner
- Budget for physical infrastructure and equipment maintenance and repair is not sufficient, and is also not expended fully or effectively
- Waste management in health services management, personal health, and security are not satisfactory

The objectives of the National Health Policy did not mention procurement issues, and nothing is highlighted about procuring services through contracting or strategic alliances.

Strategy 16 of the National Health Policy states that private entities and NGOs will be encouraged to play an increased and complementary role. However, it does not explain how the private sector and NGOs will be engaged in government health services. Although contracts and strategic alliances are related to procurement, regulatory guidance should still be given in the health policy.

Perspective Plan of Bangladesh 2021–2041

Bangladesh has prepared 'VISION 2041' for the accomplishment of its dream, the dream of the Father of the Nation, Bangabandhu Sheikh Mujibur Rahman – "a golden Bangladesh." It has developed a 20-year-long Perspective Plan to attain this goal and make vision 2041 a reality. This document was prepared by the General Economic Division, Bangladesh Planning Commission, Ministry of Planning, in March 2020. The plan was approved by the National Economic Council on February 25, 2020.

According to the Perspective Plan, its elements are designed to align with a rapid transformational shift over the next two decades in various healthcare-related sectors.

The strategy of PP 2041 for population, health, and nutrition states that the government will gradually increase public health spending to 2.0 percent of GDP by FY 2041. The major health policy includes

expanding healthcare service delivery, including health sector governance; improving the health information system; and improving the quality and quantity of health professionals. In line with the SDGs, the government is committed to achieving universal healthcare by 2030.

Chapter 12 elaborates on the strategic initiatives toward achieving goals. However, none of the chapters analyze the health sector in the context of the procurement process or obtaining services through contracting NGOs.

The document states that in Bangladesh, the NGOs/CSOs collectively comprise the third state, behind politicians and the bureaucracy. The NGO/CSO entities have stepped in to partially deliver the functions of the state. Available evidence suggests that, although the civil society movement in Bangladesh has had an impact on development at the micro-level, its impact at the macro level has been modest. Some institutional and policy issues will influence the direction that civil society takes in the future. A case for a unified legal framework exists, but one must be careful not to stifle innovation, creativity, and experimentation.

Recognizing the existence of CSOs, the Perspective Plan highlights that Bangladesh has done well by not putting a cap on the size and diversity of CSOs. These organizations have moved along the path of corporatization. For social institutions, the target for 2041 is that "all CSOs will be mature, high-quality, broad-based operations, with some of them initiating international best practices, and all will be institutionalized under normal regulatory and business practices" while milestones are given by gradual improvements.

Although the plan does not include a specific chapter on healthcare development or improvement, under the chapter HUMAN DEVELOPMENT THROUGH QUALITY EDUCATION AND HARNESSING THE DEMOGRAPHIC DIVIDEND, paragraph 5.2 Progress with Human Development under PP2021 states that evidence shows that considerable progress was made in the Population, Health and Nutrition (PHN) area during Perspective Plan 1.

The government's development interventions in the health sector have always been geared toward expanding health services, building the capacity of service providers, and improving quality of care. The establishment of community clinics nationwide is a flagship program of the government and is recognized globally as a model for providing low-cost primary healthcare services to grass-roots community populations. The community clinic-based service provision has increased the access of the poor (particularly women) to public health services and community participation.

5.5 PP2041 Strategy for Population Health and Nutrition paragraph highlights that the PP2021 strategy for PHN was to combine the public delivery system with the private sector. The focus of public PHN delivery was to serve the needs of the rural community, where private PHN service delivery at low cost is very limited. Much of the PHN public services were focused on simple, low-cost supplies delivered through rural clinics and health workers. This model was already tested with good outcomes since the early years of independence. In the urban areas, PHN services relied much more on private supplies at market cost. One of the major factors underlying the success of this model is the high demand for private healthcare and the large volume of private spending. The PP2041 will essentially continue this successful strategy of public-private partnership by promoting the private supply of health services for most of the population, while also enforcing accountability to promote quality service delivery and prevent willful negligence; and focusing on public supply to the rural communities, areas not served well by the private sector, and to the

urban poor; on mass communicable diseases; on health research and training based on a system of high quality public national hospitals; and on nutrition programs.

ANNEX 4. SUMMARY OF BASIC INFORMATION FOR NONGOVERNMENTAL ORGANIZATIONS PROVIDING HEALTH/TB SERVICES

Name of Organization	Type of Organization	Funding sources	Geographic scope of operation	Type of service provided	Healthcare services provided	Non-healthcare services
	• NGO • Not-for-profit • For-profit • Faith-based • Semi-government (i.e., research institute)		• National • Regional • District	• Healthcare • Non-healthcare • Both	• Prevention/screening • Diagnostic • Treatment • Social service • Workplace • Special groups (prisoners, diabetics) • Technical assistance • Support services (logistics, IT, HR support, analytics, etc.)	• IT • Logistics • HR • HIS/M&E
BRAC	NGO	Donor	• National • District	Both	• Prevention/screening • Treatment • Social service • Workplace • Special groups (prisoners) • Technical assistance • Support services (logistics)	• Logistics • Transport
Light House	Not-for profit	Donor	District	Healthcare	• Prevention/screening • Control • Diagnostic • Treatment • Social service	
Care Bangladesh	Not for profit	Donor	• National • Regional	Healthcare	• Prevention/screening • Treatment • Social service	
Nari Maitree	Not for profit	Donor	Regional	Healthcare	• TB treatment • Prevention • Primary healthcare service • Skill development	

Proshika	NGO	Donor	Regional District	Healthcare	• Training • Technical assistance • Advocacy	
HOPE Foundation	Not for profit	Donor	Regional	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
Gonoshasthay	Not for profit	Donor	• National • Regional	Both	• Prevention/screening • Diagnostic • Treatment • Social service • Workplace • Special groups (Dialysis) • Technical assistance • Support services	MIS
Marie Stopes	Not for profit	Donor	District	Healthcare	• Prevention/screening • Diagnostic • Treatment • Social service • Workplace • Special groups • Technical assistance	
Dhaka Ahsania Mission	NGO	Donor	• National • Regional • District	Healthcare	• Prevention/screening • Diagnostic • Treatment • Social service • Workplace • Special groups (Dialysis) • Technical assistance • Support services	
BAPSA	NGO/Research	Donor	Regional	Healthcare	• Prevention/screening • Diagnostic	

			District		• Treatment • Social service • Workplace • Special groups (TB) • Technical assistance • Support services	
PSTC	Not-for Profit	Donor	District	Healthcare	• Prevention/screening • Diagnostic • Treatment • Primary Healthcare • Social service • Workplace • Special groups • Technical assistance	
UTPS	Not-for profit	Donor	District	Healthcare	• Prevention/screening • Treatment • Primary Healthcare • Special groups	
Shimantik	NGO	Donor	National	Healthcare	• Prevention/screening • Diagnostic • Treatment • Primary Healthcare • Social service • Special groups	
PRISM	Not-for profit	Donor	District	Non-healthcare		Medical waste management (logistics, transport)
Padakhep Manabik Unnayan Kendra	Not-for profit	Donor	National	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	

Damien Foundation Bangladesh	Not-for profit	Donor	• Regional • District	Healthcare	• Prevention • Control • Diagnostic • Treatment • Training	
HEED Bangladesh	Not-for profit	Donor	District	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
Rangpur-Dinajpur Rural Service	NGO	Donor	Regional District	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
Ashar Alo	Not-for profit	Donor	National	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
Mukti	Not-for profit	Donor	Regional District	Healthcare	• Prevention/screening • Treatment • Social service	
RSF	NGO/For-profit	Donor	National	Healthcare	• Technical assistance • Support services	
SANDOR Dialysis Services Pvt. Ltd.	For-profit		District	Healthcare	• Treatment	
Red Crescent Hospital	For profit		District	Healthcare	• Prevention • Control • Diagnostic	

					• Treatment • Social service • Training	
Anwer Khan Modern Hospital	For profit		District	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
Surjer Hashi	NGO	Donor	National	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
SMC	NGO/For-profit	Donor	National	Both	• Prevention/screening • Treatment • Social service • Workplace • Special groups (prisoners) • Technical assistance • Support services (logistics)	Logistics/supply
ICDDRB	Research	Donor	International	Healthcare	• Prevention/screening • Treatment • Social service • Workplace • Special groups (prisoners) • Technical assistance • Training	
BADAS	NGO	Donor	National	Healthcare	• Prevention/screening • Treatment • Social service • Workplace • Special groups (Diabetic) • Technical assistance	

					• Training	
Asa	NGO	Donor	National	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training	
Shushilan	NGO	Donor	• National • Regional	Healthcare	• Prevention/screening • Treatment • Social service	
Lamb Hospital	NGO	Donor	Regional	Both	• Prevention • Control • Diagnostic • Treatment • Social service • Training • Technical assistance • Support services (MIS)	MIS
Bondhu Foundation	Not-for profit	Donor	National	Healthcare	• Awareness • Training	
ARK Foundation	Not-for profit	Donor	• Regional • District	Healthcare	• Awareness • Training • Prevention • Research	
SAJIDA Foundation	NGO	Donor	District	Healthcare	• Prevention • Control • Diagnostic • Treatment • Social service • Training • Technical assistance	

ANNEX 5. SUMMARY OF HEALTH-RELATED CONTRACTS REVIEWED

Contract title Name of organization	Date contract signed	Contract duration (start/end)	Total monetary value	Source of funding	Donor agency	Government contracting agency
Procurement of Maternal and Child Health Drugs Beximco Pharmaceuticals Ltd, DGFP	Apr 15, 2020	12 weeks from the date of contract signing	BDT 173 million	Donor	IDA	Logistics and Supply Unit Directorate General of Family Planning Ministry of Health and Family Welfare
Procurement of BP machine and stethoscope Himalaya Trading Company Dhaka DGFP	Jun 29, 2020	16 weeks from the date of opening LC	BDT 5.3 million	Donor	IDA	Logistics and Supply Unit Directorate General of Family Planning Ministry of Health and Family Welfare
13.8 million pieces AD syringe JMI Syringes & Medical Devices Ltd	Oct 7, 2020 (date of submission)	12 weeks	BDT 757 million	GoB (RPA)/Donor	IDA (RPA)	Logistics and Supply Unit/ FSD Directorate General of Family Planning Ministry of Health and Family Welfare
Concession agreement for two patient hemodialysis centers at NIKDU Dhaka and CMC Hospital Chattogram on PPP basis Sandor Medicaid Pvt Ltd, India	Jan 27, 2015	10 years	19500 dialysis /year BDT 53 million / year	GoB	GoB	NIKDU, DGHS, MOHFW
TV spot/TV commercial production on LAPM, MNH, Breastfeeding, five danger signs, three delays, birth planning telecasting in private TV channel Expressions	Dec 03, 2020 (submitted)	1 year	BDT 15 million	GoB	GoB	IEM, DGFP

ANNEX 6. SETTING UP A PROCUREMENT UNIT AT THE DGHS TO FACILITATE THE PROCUREMENT FUNCTION

Introduction

Contracting out is a purchasing function, and the GOB/MOHFW can only undertake it through the public procurement system (PPS). Many procurement functions are being carried out in the health sector following PPS; however, since procurement is a technical process and relatively difficult for the health managers, who are medical doctors by training, the entire health sector has been struggling with this process. Moreover, it is a decentralized function, and directors and managers at all levels are responsible for procurement of their respective goods and services. However, major procurements are done by the CMSD, other line directors (16), project directors (23), and directors of large hospitals / institutes (around 40).

Before the introduction of the sector-wide approach in the health sector, development activities were project-based and the project authorities were responsible for procurement under their project. Other than the development programs, managers of different organizational units (such as hospital directors) used to procure their goods and logistics. With the beginning of the GOB's Health, Population and Nutrition sector program in 1998, a centralized procurement arrangement was established and the CMSD was assigned to undertake the main procurement function of the sector for all the Operational Plans (OPs). Now, procurement under different OPs is undertaken by the CMSD on request from the line director. The line director can procure the goods and services planned under the OP, or they can request the CMSD director to procure them on their behalf. At present, there is no clear guideline about when it is appropriate for the line directors to procure vs. request CMSD, but in practice, for big and bulk procurements, line directors usually ask the CMSD to procure the items for them through a procurement plan. However, the main procurement item that CMSD procure is goods (e.g., drugs, equipment, and logistics). As mentioned earlier, other line directors also procure goods and intellectual services (consultancy, research, feasibility, etc.).

Initiatives to Improve Procurement Functions

Because procurement in the health sector is a sensitive issue, and there are a lot of discussions around it, the government as a whole and the MOHFW have taken several measures to address the challenges.

The MOHFW has been implementing activities to improve the capacity of the relevant professionals as part of improving financial management. Within the Health, Population and Nutrition Sector program, it has given a five-day training on public procurement to more than 500 health managers. It has also initiated activities for organizational change for improving procurement activities. Notably, among the 31 OPs of the 4th Health Population and Nutrition Sector Program (2017–2022), one OP under the DGHS and one under the DGFP are on procurement, storage, and supplies management of health services (PSSM-HS), and on procurement, storage, and supplies management of family planning services (PSSM-FP), which are mainly designed to improve the procurement and supply chain management functions under the DGHS and DGFP. (Note that this is again restricted to commodities and not to services procurement.) The director of the CMSD is also the line director of the PSSM-HS OP, where activities, such as the

reorganization (expansion) of the CMSD and its capacity improvement in its role as the central PSSM unit are included.

The CPTU, which is responsible for regulating the PPS across the government, is authorized to provide support through training and capacity building, to clarify and simplify the procurement process, and to arrange expert support to different sectors, including the health sector. The World Bank has been supporting the development of the PPS in the country for many years. The development of the current PPS has happened with World Bank support. The World Bank is currently providing support to fully develop the system and increase the capacity of the CPTU to manage it. As part of the World Bank's support to the current phase, the CPTU has set up six procurement cells to support 24 government offices, including the DGHS, under the Digitalization of Implementation Monitoring and Procurement Project (DIMAPP). The cell that covers the DGHS and other MOHFW offices is located at the DGFP building (a separate location). The CPTU provided an expert on electronic tendering and equipment, and the concerned office (DGHS or DGFP) is supposed to deploy three procurement-trained officials to the cell. The project will continue until 2024. The cell is not functioning well due to a lack of ownership and other issues. DGHS sources reported that the location of the cell was somewhat far away, and the expert was only available via telephone, which did not serve their purpose. The officials deputed to the cell (who were trained in procurement) were not very interested in working there and were frequently transferred. The DGHS faces continuous procurement issues, and needs a cell/unit fully equipped with skilled personnel to be available in the DGHS office.

It should be noted that having a procurement unit/cell at the DGHS would be a very different approach to that currently being taken under DIMAPP and would require high-level agreement and sign-off (see proposed steps below). It will not necessarily increase the government's contracting of clinical/public health services to NGOs. Rather, it will support any contracting initiatives by the government once the explicit policy on contracting is adopted and preparatory measures are completed (tools, STDs, guidelines, etc.). At present, the major issues around procurement in the health sector are related to procurement of goods (equipment, drugs, logistics, vehicles, etc.), whereas the procurement of intellectual services is a relatively minor topic (due to the low volume and low financial value of these procurements). The procurement of physical services, such as clinical and public health services, has not yet commenced (except for some support services – cleaning, catering, etc.).

Process for Setting Up the Unit

If the MOHFW decides to expand its procurement/contracting-out of services, especially healthcare services, a central unit at the DGHS will be justified.

The MOHFW has to agree with the DGHS's proposal to set up the unit to facilitate these procurements. The main objectives will be to:

- Support different units/programs under the DGHS in procurement, including NTP support to prepare procurement plans, tender document, specifications, costing, and other legal, technical, and management services
- Avoid the present issues with procurement
- Expand the contracting out of certain health-related services (as the Eighth Five-Year Pan, Health Financing Strategy, HS4TB, and other DPs are suggesting)

A proposal will be required with a justification (purpose, main functions, reporting line, etc.), draft organogram, number of positions, and job descriptions of all positions. There might be two approaches, depending on how quickly the unit needs to be set up, which are described below.

Quick and Interim Arrangement

If the DGHS and MOHFW agree, a unit can be set up (as per the proposal) with an office order (an official order with approval from the MOHFW) appropriating existing manpower. Some of the DGHS personnel trained in procurement might be posted there. The CPTU might be requested to provide some expert/training support. Experts can also be hired with DP support, or from the relevant OP allocations. The challenges will be office space, logistics, and selection of appropriate staff.

Regular Arrangement

The proposal for setting up the unit can be processed for government approval that involves the Ministry of Public Administration, Ministry of Finance, and Secretaries' Committee of Administrative Development. It will take six months to one year, depending on the MOHFW's level of interest and prioritization.

These two approaches can go together; however, their success (especially regarding the performance of the unit) will depend on the extent to which the DGHS and MOHFW prioritize it. Because procurement is a burning issue and can help improve the image of the sector (if it functions properly), these approaches have the potential to receive support.

CPTU's Role

The CPTU has been working to support the entire government and all relevant offices by developing instruments, organizing training, giving clarification, providing troubleshooting, etc. It has been working to build its own capacities in these areas as well. The CPTU can help develop the outline of the proposal for the unit, provide training for unit personnel, troubleshooting, etc. However, the CPTU cannot and will not be able to take on any of the procurement functions for the DGHS.

Other DPs working in this area can be sensitized to this organizational change/reform to garner their support for this initiative.

Issues to Be Considered

The MOHFW already has a plan to strengthen the CMSD (PSSM-HS OP) through reorganization and capacity improvement; however, the CMSD is only responsible for the procurement of goods not services. Discussions and assessments about reorganizing the DGHS have been happening for quite some time, so there is a natural entry point for this proposal for a procurement office within the DGHS.

Second, if, as proposed, TB services are the first services to be contracted, a procurement unit in the NTP will be more immediately useful, although the DGHS will also be eager to establish a procurement unit to address its ongoing challenges.

ANNEX 7. PROPOSED AMENDMENTS TO PPA 2006, PPR 2008, STDS, AND OTHER LAWS AND REGULATIONS PERTAINING TO CONTRACTING

(A) Amendment in Public Procurement Act 2006

1) Separate sections on non-consulting services/physical services to be incorporated
2) Procedure and method to be specified
3) If similar method is followed, performance/output-based specification describing the method
4) Scoring requirement for the evaluation criteria to be indicated in specific section
5) Inclusion of negotiation form and provision
6) NGO/CSO as tenderer, how can they participate?
7) Per eligibility criteria, how NGOs/CSOs were determined to be eligible tenderers

(B) Amendment in Public Procurement Rules 2008

1) Separate chapter in PPR for procurement of non-intellectual/physical services (as separate category from goods/physical services (works)/intellectual and professional services)
2) Strategy and methods to be followed – currently these are not clear
3) If similar methods are followed for services and goods – (e.g., specification, evaluation criteria, and negotiation) – they should be clearly described
4) How NGOs/CSOs emerged as tenderers to participate in the tendering process, complying with the eligibility and qualification criteria
5) Flow chart for procurement of physical services via different methods
6) Timeline for processing of procurements, from submission to contract signing, for physical services
7) Assessment of contract value threshold to follow the appropriate methods

(C) Standard Tender Document

1) Separate Standard Tendered Documents are to be prepared for NGO, CSO, and private service providers
2) Separate STD are to be prepared for different category of services
3) Separate STD are to be prepared based on different methods
4) Separate STD are to be prepared for the health sector, based on the nature of the services being procured
5) Scoring criteria to be incorporated as option in STD
6) Negotiation provision be allowed in STD for procurement of physical services

(D) Delegation of Financial Powers

1) Clear and detailed description of non-consulting services/physical services in the Delegation of Financial Powers
2) Financial delegation to be rationalized in line with the market and demand for physical services
3) Direct contracting to be provisioned as per market demand

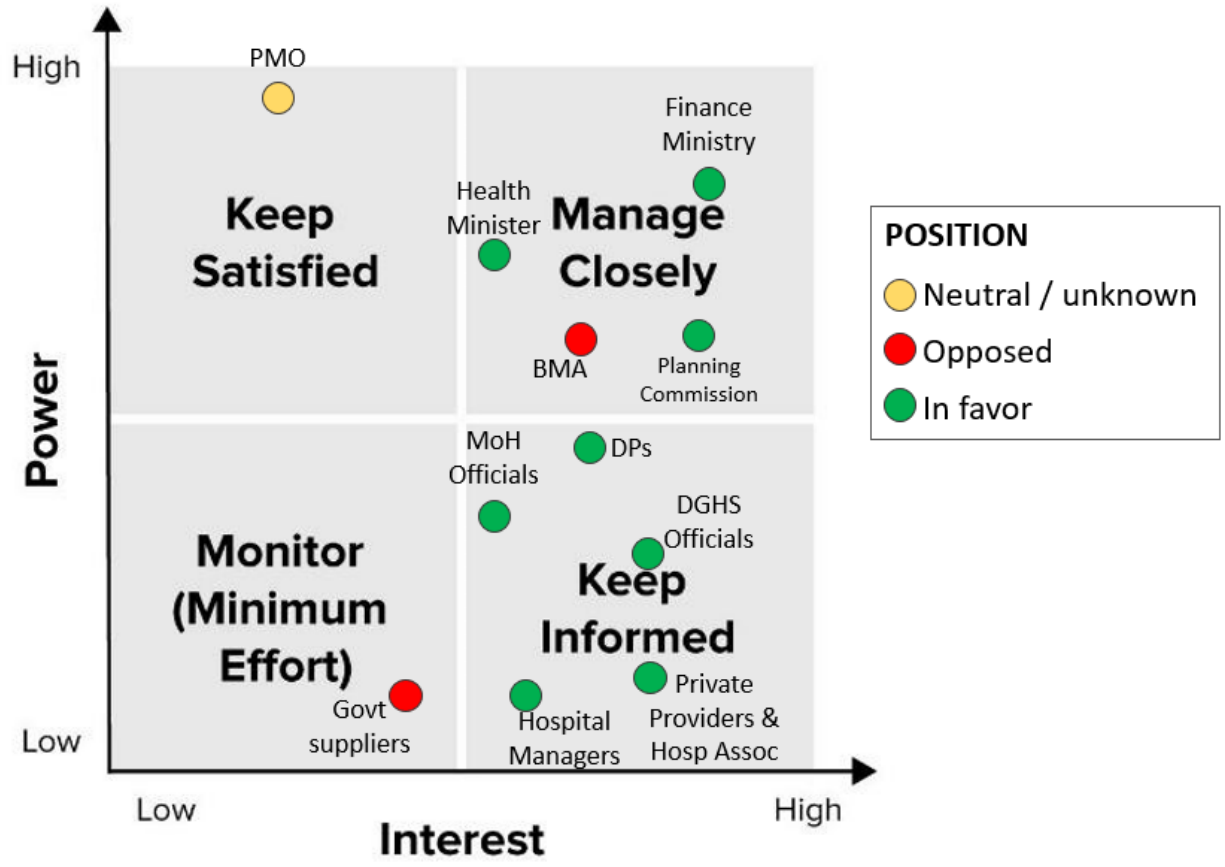
(E) Amendment of Circular no.01, dated 01/01/2019, for contracting services issued by Finance Division, Ministry of Finance

1) This circular is contrary to the procurement principle-against competitive ground, may be revisited

Necessary provision of this circular be shifted to Rules/STDs with framing in line with the principles of public procurement.

ANNEX 8. FINDINGS AND RECOMMENDATIONS FROM STAKEHOLDER ANALYSIS

A stakeholder assessment was conducted, first by identifying key players who could have an interest in contracting health services, and second by mapping their interest and power on a grid[70] to assess potential strategies to engage with each stakeholder.[71] The analysis was conducted to understand the perceptions, beliefs, behavior, and interest of the relevant actors.



The table below provides some brief information on the interest, level of influence, and methods for addressing each group of stakeholders.

[70] Bryson JM, Patton MQ, Bowman RA. Working with evaluation stakeholders: A rationale, step-wise approach and toolkit. Eval Program Plann. 2011 Feb;34(1):1–12.
[71] Ackermann F, Eden C. Strategic management of stakeholders: Theory and practice. Long Range Planning. 2011 Jun; 44(3): 179–196.

Stakeholders	Interest in Contracting	Level of Influence	In favor / against and main reason	Methods to address
Prime Minister's Office (PMO)	Moderate/not aware	Very high	Unknown	Positive engagement (a policy brief with evidence) • Examples of similar / neighboring countries
Health Minister	Moderate (high interest in diagnostics and maintenance; moderate in partnership in TB services)	High	In favor of selective services (government directly delivers core services for public image)	• Briefings • Showing evidence on comparative advantages • Reorienting on public perception
MOHFW Officials	Moderate with conditions on corruption control mechanism and capacity improvement; support from highest policy level	Moderate	In favor	• Designing health service scontracting instruments • Training for capacity improvement • Interactions between highest policymakers and Ministry officials • Interaction with non-government entities
DGHS Officials	High with conditions of capacity improvement, protection for lawful steps and increased authority, additional manpower	Low	In favor	• Training plan for capacity improvement • Assessment of workload and rationalization of work distribution • Proper protection mechanism in the contracting process
Finance Ministry	High with conditions of cost containment and quality improvement	High	In favor as very unsatisfied with current performance	• Costing exercise and rationalization process • Evidence generation • Regular engagement
Hospital managers	Very high with conditions of protection from unruly elements, increased authority on selection for quality	Low	In favor as task will be shifted, difficulties with government employees will be reduced	• Keep contracting at certain level (for example, district/division) • Capacity-building on contract formulation and management

Stakeholders	Interest in Contracting	Level of Influence	In favor / against and main reason	Methods to address
Planning Commission	High	High	In favor as it will be consistent with Eighth Five-Year Plan	
Bangladesh Medical Association (BMA)	High	High	Might worry about losing opportunities, or label it as privatizing government services	Phased actions: • Meeting with top leaders • Showing evidence and policy decisions from the highest level • Regular meetings and communication to dispel misconceptions • Identification of some 'reformers' within the organization and their integration into capacity development exercise
Development Partners	Moderate	High	In favor, as it is in their policy agenda, and they support increasing private sector engagement	• Discussion in the DP consortium meeting • Adoption as a policy agenda for change
Private practitioners and hospital associations	High - with caution about the behavior of government offices regarding contract management	Low	In favor as it will help expand their business	• Communication on service standards, process, and costs • Organization of capacity development initiatives • Review and simplification of the payment mechanism
NGOs/CSO/ private providers	High	Low	In favor	• Communication on service standards, process, and costs • Organization of capacity development initiatives • Establishment of proper prequalification/shortlisting standards
Government suppliers	Low	Low	Against (fear of losing business)	• Clear messaging that contracting will add to the existing supplies, not replace anything

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