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Context matters in NGO–government contracting for health service delivery: a case study from Pakistan

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Contracting non-governmental organizations (NGOs) for health service provision is gaining increasing importance in low- and middle-income countries. However, the role of the wider context in influencing the effectiveness of contracting is not well studied and is of relevance given that contracting has produced mixed results so far. This paper applies a policy analysis approach to examine the influence of policy and political factors on contracting origin, design and implementation.

Evidence is drawn from a country case study of Pakistan involving extensive NGO contracting for human immunodeficiency virus (HIV) prevention services supported by international donor agencies. A multilevel study was conducted using 84 in-depth interviews, 22 semi-structured interviews, document review and direct observation to examine the national policy design, provincial management of contracting and local contract implementation.

There were three main findings. First, contracting origin and implementation was an inherently political process affected by the wider policy context. Although in Pakistan a combination of situational events successfully managed to introduce extensive and sophisticated contracting, it ran into difficulties during implementation due to ownership and capacity issues within government. Second, wide-scale contracting was mis-matched with the capacity of local NGOs, which resulted in sub-optimal contract implementation challenging the reliance on market simulation through contracting. Third, we found that contracting can have unintended knock-on effects on both providers and purchasers. As a result of public sector contracts, NGOs became more distanced from their grounded attributes. Effects on government purchasers were more unpredictable, with greater identification with contracting in supportive governance contexts and further distancing in unsupportive contexts.

A careful approach is needed in government contracting of NGOs, taking into account acceptance of contracting NGOs, local NGO capacities and potential distancing of NGOs from their traditional attributes under contracts. Political factors and knock-on effects are likely to be heightened in the sudden and aggressive use of contracting in unprepared settings.

Keywords Contracting, context, government, NGOs

KEY MESSAGES

- Contracting origin and implementation is an inherently political process affected by the wider policy context.
- Aggressive contracting in an unprepared context can be affected by poor ownership and institutional capacity constraints within government.
- Wide-scale contracting may not match with local NGO capacity, requiring caution against undue reliance on unknown markets.
- Contracting can result in unintended knocks-on effects on both providers and purchasers; NGOs can move away from their grounded attributes, while the effect on government purchasers varies by governance context.

Introduction

Contracting out of primary health care (PHC) and preventive health services is being implemented with international donor assistance in an increasing number of developing countries, including Cambodia, Guatemala, Senegal, Costa Rica, Nicaragua, Afghanistan, Pakistan, Bangladesh and India (Perrot 2006). Recent cases of contracting have involved non-governmental organizations (NGOs) rather than individual for-profit private providers. The term NGO is commonly used for the non-profit sector credited with better access to disadvantaged populations and responsiveness of interventions (ICPD 1994; Fowler 2002). Available evidence has demonstrated uneven results of contracting, with improvement seen in service utilization, but the effect of contracting on quality, equity and cost aspects of service delivery remains questionable (England 2004; Loevinsohn and Harding 2005; Liu *et al*. 2008). Given the mixed results of contracting, there is a need for in-depth evidence on how contextual factors can facilitate or hinder contracting.

The influence of the wider context has been recognized and incorporated in theoretical frameworks on contracting (Liu *et al*. 2007). Supporting evidence from country case studies shows that the type of contracts and incentives can affect contracting (Palmer 2000) and that the public sector in low- and middle-income countries (LMICs) frequently does not have the capacity to write and monitor performance-based contracts (Broomberg and Mills 1998; Palmer and Mills 2005; Siddiqi *et al*. 2006). Contextual evidence, however, is thin on other areas such as political aspects of contracting, market-related dynamics and knock-on effects on the health system as a result of contracting. These contextual concerns may be of particular relevance for NGO–government engagement. Contracting necessitates a shift within the public sector from direct service provision to a strategic purchasing centre (Taylor 2003), raising questions of political will. Contracting also demands a new role from non-profit providers as competitors, bidders and implementers of public sector contracts. This raises questions of NGOs' willingness and capacity to contract, and whether NGOs maintain their client-centred attributes under public sector contracting.

This paper attempts to add to the evidence on the role of the wider context on government–NGO contracting for health service delivery. Evidence is drawn from a case study of Pakistan where wide-scale contracting of NGOs for human immunodeficiency virus (HIV) prevention was initiated with donor support during the early to mid 2000s. Departing from the usual examination of contracting centred on achievement of stipulated targets, an iterative policy analysis approach is applied instead to probe the influence of policy and political aspects on contracting. Two main areas are explored: (1) what factors influenced the origin, design and implementation of contracting; (2) what were the consequences for contract performance and the knock-on effects?

Setting

Pakistan is a low-income highly populous country with a post-colonial health system model. HIV prevalence in Pakistan has traditionally been low but risk of spread remains high (WHO 2010a). International policy recommendations for countries with low levels of HIV infection emphasize preventive interventions in high-risk groups as the mainstay of the HIV response in order to curtail spread to the general population (UNAIDS 2005). After years of inaction, wide-scale contracting of NGOs for HIV prevention in risk groups was introduced in Pakistan from 2003 to 2008. This was supported by substantial multi-donor support and backing from high-ranking policy officials and followed closely upon initiation of similar donor-supported initiatives in India and Bangladesh. Contracting was on a radical scale, involving contracts for interventions within high-risk groups, awareness campaigns for the general population, capacity building of government purchasers, and monitoring and evaluation (Table 1). It formed a sharp departure from previous low-scale contracting interventions.

In Pakistan the public sector delivers health services directly through an expansive infrastructure of 10 000 primary health care outlets and hospitals (WHO 2010b). Constitutionally, health care provision has primarily been the responsibility of the provincial Departments of Health, with the federal Ministry of Health (MOH) responsible for formulation of national health policies and implementation of vertical programmes. The latter include nine programmes, with the National acquired immune deficiency syndrome (AIDS) Control Program (NACP) being one of the youngest vertical programmes. As a result of steady proliferation in vertical programmes, the MOH has come to play a centralized role in practice (Green *et al*. 1997). Very recently, devolution of the MOH to provinces has been approved, heightening concerns around capacity at sub-national levels for new governance measures such as contracting-out of services (Nishtar and Mehboob 2011).

Table 1 Key features of HIV contracting

	Key features
Scale of contracting	
Total contracts	29 risk group tenders, 4 provinces
Examined contracts	16 tenders: Sindh (7) Punjab (9); 3 bidding rounds
	Female sex workers: 4 contracts, 16 500 population. Male sex workers: 3 contracts, 9500 population. Injecting drug users: 7 contracts, 17 000 population. Prisoners: 2 contracts, 21 900 population.
Contract design	Detailed service package: population mapping, awareness building, behavioural change communication, condom distribution, voluntary counselling & testing (VCT), primary health care & sexually transmitted infection (STI) services, enabling environment, empowerment activities.
	Defined targets: levels of condom use, safe needle exchange, knowledge and attitude, VCT utilization, STI treatment rates.
	Financial releases tied to quarterly outputs.
Contracting process	Open market competition.
	Quality- and cost-based selection.
	Multi-tiered seven-stage contracting process.
	Detailed contracting guidelines based on international practices.
Government management	Lack of independent purchasing agency.
	Authority, financial powers, tendering, awarding and oversight responsibility with government.

Methods

For the purpose of this research the term 'policy' was interpreted as a purposive set of actions followed by the government in dealing with a problem or a matter of concern (Anderson 1975). Political factors were defined as those explaining the gap between technical decision-making and implementation, and what actually happens in practice (Walt 1994).

The framework to guide data collection and analysis was based on Walt's policy analysis model involving process, actors and context (Walt and Gilson 1994), additionally supplemented with key contracting-related features from economic literature (Table 2). For policy process, Kingdon's (1984) policy stages were adapted and processes examined at four levels: contracting origin and design formulation, grounding at sub-national level, the contracting process and contract implementation. Actors were taken as stakeholders wielding power or being affected by contracting (Brugha and Varvazovsky 2000). Contextual factors identified from contracting literature included contexts related to the contractual market, the service being contracted (HIV prevention services) and the institutional context for contracting (Hodgson 1988; Walsh 1997; Mills 1998), while other background factors identified during the course of data collection were included inductively.

Our study was multilevel. The policy process for the entire contracting initiative was examined at the national level. Implementation experience was examined at the provincial and local levels, confined to contracts for high-risk groups. These were the most prioritized contracts and also the most numerous. The provinces included were Sindh and Punjab, together accounting for the majority of contracts; the other two provinces (North West Frontier Province and Balochistan) were not included due to a delayed start to contracting.

Eighty-four in-depth interviews and 22 semi-structured interviews were conducted between 2004 and 2006, involving policy makers, donors, public sector implementers, bidding and non-bidding NGOs, contracted NGOs, experts, third party monitors and capacity-building firms (Table 2). Interviewee participation was voluntary, informed consent was taken and identity was anonymized for confidentiality. Interviews were supplemented by qualitative research tools of document review, media analysis and direct field observations for in-depth exploration, as well as secondary data on contract performance from third party assessments. Interview transcripts and observation notes were imported into the Nudist 6 software for coding while collected documents were reviewed manually. Data generated from all sources were triangulated and linked thematically to identify key findings. The following analysis draws upon data from the entire range of research instruments.

Results

Wider policy context for contracting

A timid backdrop for public–private partnerships

Prior to the HIV contracting initiative, no major effort had been made by government to harness the capacity of the private health sector, including NGOs. Although the private sector existed in parallel with the government sector, serving nearly 70% of the population (Federal Bureau of Statistics 2009), information on the activities and resources of the private health sector was scanty. Supportive systems for public–private partnerships (PPPs) within the MOH were weak. Organizationally there was also no entity within the MOH to co-ordinate and regulate the extensive private health sector, record information on its activities, or provide standard setting and monitoring. Although a separate ministry, the Ministry of Social Welfare, provided an umbrella body for all not-for-profit providers, its

Table 2 Overview of methodology

Policy stages	Examined areas	Research tools
Origin of contracting *(National level)*	Scope of contracting, instigators, underlying rationale, and formulation processes PPP context, HIV context, NGO market	Document review: programming documents on contracting; policy documents on PPP; HIV background documents; donor country assistance strategies; survey reports on NGOs In-depth interviews of 84 stakeholders: 23 government officials; 9 international agencies; 36 NGOs; 3 technical assistance & evaluation firms; 9 experts Bidding lists Contracting rules and guidelines 16 tenders
Transfer to sub-national level *(National & provincial levels)*	Purchaser body, fund flows, institutional systems Experience and positioning for NGOs and contracts Capacity-building measures	
Contracting process *(Provincial level)*	Tendering, bidding and contract awarding process NGO competition and NGO motivations to contract Informal actor alliances	
Contract implementation *(Local level)*	Contractor characteristics, service programming and priorities, client involvement, administrative issues, monitoring, supportive environment, ease of implementation Contractual outputs Unintended impacts	Semi-structured interviews of 22 contractors Direct observation at 4 contracted sites Review of assessment reports of implemented contracts In-depth stakeholder interviews

contact with NGOs was confined to the initial registration; follow up was non-existent and links with the MOH were absent. Moreover, there was no separation between strategic planning and service delivery functions within the MOH and provincial Departments of Health, blunting ability for out-of-the-box solutions (Nishtar 2010). With weak information and lack of supporting organizational structures, the PPP area remained nebulous, lacking in clear-cut thinking:

> *''Everybody uses their own wisdom to interpret, accept or reject PPPs. There is no thinking on PPP policy so far.''* (Interview: 4/84)

The traditional mindset in government circles was of direct service provision, with preference for incentivizing and granting greater control to public sector managers rather than out-sourcing. The PPP area was generally regarded as donor turf by government, with little demand for purchasing services from NGOs:

> *''These NGO sector projects are approved on a case to case basis. It's the donors who exert pressure on us for PPPs, the demand is driven either directly by donors or by NGOs who exert pressure through donors.''* (Interview: 18/84)

Profiling of PPPs by international donors during the 1990s and 2000s had resulted in vague mention of PPPs in National Health Policy documents of successive governments (MOH 1997; 2001), the Five Year Development Plans of the National Planning Commissions (Government of Pakistan 1999) and Poverty Reduction Strategy Papers (IMF 2004). However, there was little follow up in terms of defining a clear-cut strategy and commitment of public sector funds for PPPs (World Bank 2010). PPP projects depended on donor funds earmarked within sizeable donor-assisted projects in the 1990s such as the Social Action Program, Family Health Project, Women's Health Project and National Trust for Population Welfare (Shakeel 2002). However, they were slow to be implemented, suffering from vague direction and limited interest from government (Batley 2006). Moreover, PPPs usually involved provision of grants to NGOs for community mobilization or awareness campaigns rather than performance-based contracting for service delivery. The only significant example of public-sector-funded contracting at the time was out-sourcing the management of Basic Health Units in Punjab province (Loevinsohn *et al*. 2009), but this involved contracting-in to another government ministry. This came about through support from the Chief Minister of Punjab and provincial elites rather than being initiated as a strategy of the Health Department.

HIV prevention was particularly reliant on NGOs for reaching out to high-risk groups. The few instances of contracts in the HIV area were funded through small grants occasionally provided by UN agencies (World Bank 2001a). These involved one-off screening and awareness-raising activities rather than concerted prevention and STI services (Khan and Hyder 2001). Contracts loosely defined the scope of work and there was usually no provision for monitoring.

In summary, at the time of formulation of the HIV contracting initiative, policy positioning on PPPs was weak, supporting regulatory and legal frameworks were non-existent, and there was little historical experience of service delivery contracts.

HIV/AIDS prevention: low policy priority, stigmatized context and weak expertise

HIV/AIDS was a low health priority in Pakistan in the early 2000s. There were only 1579 HIV and 202 AIDS cases (UNAIDS and MOH 2000), consistent with low infection levels seen in regional neighbours such as Iran, United Arab Emirates, Afghanistan and Bangladesh (United Nations 2004). However, risky practices of unsafe sex and needle sharing were widespread, with female sex workers (FSWs), men who have sex with men (MSM) and injecting drug users (IDUs) forming the

major risk groups (MOH 2002). Cultural taboos on open discussion of sexual practices as well as punitive legislation prohibiting substance abuse and extra-marital sex made it difficult to access high-risk groups (Government of Pakistan 1997; Saeed 2002). Risk groups mainly operated underground, were often denied care by health providers and were frequently extorted by police for money and sex:

> *''We cannot even openly acknowledge that in Pakistan there are FSWs. There are so many legal hurdles . . . The problem does not stop at condom promotion; these (risk groups) have links with criminal gangs and police, both of whom exploit them for earning money and sex.''* (Interview: 80/84)

Although detection of the first HIV case in 1987 sparked a high level of political attention (Lynn 1994), HIV subsequently slipped from the policy agenda. Apart from the vertical AIDS Control Program there was little involvement of government officials, hospitals and primary care outlets in HIV control. Although a sizeable family planning programme existed, it targeted married females and missed out groups at risk of HIV (World Bank 2001a). HIV tended to be perceived as a disease associated with foreigners that had taken little root in Pakistan. Handling of HIV cases was overlooked in medical training. The Pakistan Medical Association had a strong focus on more prevalent hepatitis B and C infections rather than HIV:

> *''. . . not everybody is convinced . . . (the) Minister says 'our issue is hepatitis'. In medical graduates the awareness is very poor. The DOH in the provinces says our issues are diarrhoea, malaria; this is a donors' agenda.''* (Interview: 47/84)

The National AIDS Control Program (NACP) remained non-functional until the mid-1990s due to a lack of funds. Even after becoming operational, activities were few and lacked a clear strategic direction, with preference for blood safety measures rather than engagement with risk groups (UNAIDS and MOH 2000). Provincial units, with the exception of Sindh, also remained largely inactive. The Sindh AIDS Control Program (SACP) had evolved from an issue-based pioneering network called the Karachi HIV Working Group on HIV/AIDS in the mid-1990s. There was exposure to NGOs and academics, early identification of risk group interventions and development of a stable leadership over the years (Khan and Hyder 2001). Some cases of contracting NGOs for HIV prevention were initiated by SACP but remained small-scale due to insufficient funds and weak technical support.

Until the early 2000s, donor funding constituted only 20% of total HIV-related spending (World Bank 2001a). Activities were diffuse, involving awareness building in the general population rather than concerted service delivery. Nevertheless, by the end of 1999, a re-activated UNAIDS had co-ordinated the development of a National Strategic Framework for HIV/AIDS setting out strong engagement with NGOs for targeted service delivery in risk groups. The National Framework, however, remained un-operational as a series of political events led to suspension of donor aid, while low government priority led to non-commitment of public sector funds for its implementation.

An uneven NGO market

NGOs are internationally recommended providers for reaching out to stigmatized groups for HIV control, developing innovative strategies and providing client-centred services (UNAIDS 2005). In practice, the NGO market is often pluralistic and not all NGOs may possess such attributes.

In Pakistan around 200–220 NGOs were listed with UNAIDS, but experts estimated that only around 12–30 were active, with only 3–4 having in-depth experience in the area of HIV prevention (UNAIDS 2004). The local NGO sector for HIV prevention was considered by donors and experts alike as being in its infancy. It comprised an extremely pluralistic group described as a *''mixed bag, at best a pickle''* (Interview: 11/84), but there was little in-depth work with risk groups:

> *''The second 'P' (of PPPs) is a problem . . . There is not a lot known, probably a dozen NGOs are working. NGOs in theory can reach high-risk groups . . . in reality it's practically a question mark.''* (Interview: 13/84)

The majority of NGOs involved with HIV prevention were small, from diverse backgrounds, had differing ideologies and were best known for their identification with the HIV issue. Activities typically involved one-off awareness-raising talks and seminars, medical camps and screening projects, and provision of charitable services such as clothes distribution and free medical treatment amongst risk groups (Interact Worldwide 2004). Few had experience of bidding and managing contracts.

A few national reproductive health NGOs were just beginning to move into HIV work in response to growing calls by international agencies, and were known for their professional organizational set-up and relatively wide-ranging projects. However, most had superficial experience in this field, relating to awareness raising in the general population or conducting small-scale research. Only 3–4 reproductive health NGOs had expanded to include HIV services (Greenstar Social Marketing 2002).

Another sub-group of NGOs were the 'IDU' NGOs. These were historically and ideologically a separate group, due to their association with IDUs and a work focus on detoxification and demand reduction rather than HIV-related harm reduction practices. IDU NGOs had developed over time in response to international funding for drug abuse and narcotics control in the 1980s and early 1990s. They comprised 5–6 large- to medium-sized NGOs (Azariah and Bokhari 2004; UNAIDS 2004). However, coverage fell well short of the estimated 60 000 IDUs in the country and expansion to HIV-related harm reduction practices, such as safe needle exchange and condom promotion, was still recent and at odds with the older demand reduction focus (Interviews: 64/84; 77/84; 9/84).

For all three sub-groups of NGOs, the provision of HIV services was a new area:

> *''Service delivery in HIV is not a clear area for us, for anyone; it's charting new waters''* (Interview: 79/84)

Management skills for contracting were also unevenly developed. This provided a poor market-base for contracting.

Opening the window for contracting: policy instigation and design

In Pakistan, public sector funding of the health sector has been low, estimated at less than 1% of gross domestic product (GDP), and is mainly consumed in operating existing government services (WHO 2010b). New health initiatives have often relied on donor assistance. Donor aid during the 1990s waned due to a series of political events that included the Soviet pullout from Afghanistan in 1994, subsequent nuclear proliferation sanctions in 1998 and finally the military coup in Pakistan in 1999 (World Bank 2001b; Ali 2004; US State Department 2007). A near freeze on donor aid blunted progress, in particular, on policies low on the government agenda, such as PPPs and HIV/AIDS.

In 2002 a number of factors combined to open up donor assistance for PPPs and HIV/AIDS. A key factor was the favourable geo-political shift towards Pakistan. A deliberate process of 'liberal modernization' was started by the new military regime. This involved induction of economists in senior policy positions and basing reforms on market entrepreneurship and apolitical governance (Talbot 2002; Hoodbhoy 2004). The moves drew positive recognition from major development partners such as the World Bank (World Bank 2001b). Moreover, the emergence of Pakistan in 2001 as a key US ally in the war on terror over-rode earlier international concerns, resulting in heavy donor investment (World Bank 2001b; USAID 2002; USAID 2003). The opening up of development funding in Pakistan also coincided with renewed international interest in both HIV and contracting. By the early 2000s, international interest in HIV/AIDS had grown tremendously, fed by reversals in development indicators in Africa. This resulted in widespread donor-funded contracting initiatives for HIV prevention in neighbouring India and Bangladesh (World Bank 2001a). At the same time, growing disenchantment of international donors with Pakistan's weak government health care delivery and the vacuum provided by the conclusion of the multi-donor supported Social Action Program led to a search for new and bold ways of service provision. The HIV contracting initiative dove-tailed with both these imperatives and the UNAIDS-co-ordinated National Strategic Framework provided a ready platform for moving ahead.

Lobbying of government by international donors was done at the highest level at the Ministry of Finance. Acceptance of the economic implications of HIV, aspirations of the new regime for positive recognition in the international community and need for foreign aid led to ready and tacit approval. This effectively over-rode prior hesitations of the MOH and smoothed the process with the National Planning Commission and provincial governments:

> *''The main considerations (for government) were the potential economic damage of HIV, its profile in the international policy agenda, and having a positive country image.''* (Interview: 3/84)

The new initiative led to an increase in the national funding allocation for HIV control from US$2.5 million to nearly US$10 million per annum between 2002 and 2003 (MOH 2002). Donors accounted for more than 80% of funding (WHO 2003) with major funds provided by the World Bank, UK Department for International Development (DFID), United States Agency for International Development (USAID), European Commission (EC) and the Canadian International Development Agency (CIDA).

A subsequent re-shuffling of the National AIDS Control Program provided a new and energetic leadership closely aligned to contracting for HIV prevention. Design of contracting was largely confined to a tight policy circle of donors, the NACP and consultants:

> *''Policy is decided by a few people. We pick up the people and work with them . . . at least you are over the first hurdle.''* (Interview: 4/85)

The new initiative relied on NGO contracting for all components and had four distinctive features (Table 1). First, contracting out was conceived on an extensive scale involving large volume contracts and several bidding rounds. Second, emphasis was on performance-oriented contracts, with particular emphasis in terms of targets on low cost public health measures. Third, reliance was placed on market forces to draw potential contenders into the HIV area through elaborate contracting processes patterned on international practices. Lastly, the public sector, despite inexperience in contracting, had a central role as managers of the contracting process.

Implementation dynamics

Problematic grounding at sub-national levels

Provincial grounding of contracting was problematic due to issues with ownership as well as institutional capacity. Constitutionally, authority for planning, financing and implementing health initiatives rested with the provinces. The detailed design of contracting was assisted by donor guidelines, consultants and the NACP. Although provinces were consulted during design, most felt by-passed and felt forced to buy into the contracting. They also had low identification with the HIV focus. Moreover, there were fears of extensive out-sourcing to NGOs. Most provincial government officials in the government hierarchy, aside from the handful involved with the AIDS Control Program, had little prior involvement with NGOs. Doubts were expressed over the credibility of NGOs and resentment about the close links of NGOs with international donors:

> *''There has been a mushrooming of NGOs, most have little capacity, mainly the show of a few people . . . There is little accountability, NGOs are in direct contact with donors.''* (Interview: 24/84)

Implementers also feared political pressures for the award of tenders and being suspected of personal motivations in contract disbursements:

> *''There are many fears and doubts . . . if we (government officials) contract out services to an NGO we will be branded with personal motivations and connections.''* (Interview: 24/84)

Implementers also pointed to lower prevalence of HIV in comparison with other diseases, and acknowledged unease in dealing with taboo risky practices associated with HIV. This

further diminished interest in HIV services contracting and highlighted the perception that it is a top down agenda:

> *''HIV contracting is donor driven not demand driven . . . we were not involved in formulation of this program, this is a vertical program.''* (Interview: 14/84)

Purchasing committees were set up in the provinces to oversee contracting. Lacking an independent autonomous status, they were dependent on multi-tiered public sector approvals. Purchasing committees comprised senior government officials with little representation from NGOs, experts and international agencies. This weakened transparency and confined contracting experience to logistics procurement, civil works and feasibility studies usually practiced in the public sector, and which usually decided on the cheapest tender.

Capacity-building measures including training workshops, assistance by a capacity-building firm and provision of output-based financial systems were built into the contracting programme, but were poorly absorbed due to rigid overarching public sector rules as well as low enthusiasm for modern contracting.

Dynamics of the contracting process

The contracting process was carried out along modern lines, using performance-based contracts, multiple rounds of competitive tendering, and cost and quality evaluation of bids.

In practice, both bidders and purchasers found the tendering and awarding process to be complex. Most NGOs with some links to HIV applied for contracts, but strong contenders were few due to lack of in-depth HIV experience. The large number of contracts further thinned out promising contenders (Sindh AIDS Control Program 2003; Punjab AIDS Control Program 2004; Sindh AIDS Control Program 2004). With the exception of a few more-experienced NGOs, submitted bids were generally sub-optimal, with contenders either adept at proposal writing but lacking HIV insights or having some programmatic exposure but poor skills to write and cost proposals. As commented by government purchasers:

> *''Most (NGOs) did not have links with high-risk groups. Some big NGOs had very good paperwork but very little on the ground. The understanding of HIV within NGOs was very poor.''* (Interview: 19/84)

Government purchasers faced difficulty in tendering and award of contracts due to insufficient insight into the NGO market and weak skills in cost and quality assessment. Capacity gaps were aggravated by the large volume and scope of contracts. With little time to spare for contracting from other routine duties, the bid evaluation process was often a hurried exercise despite elaborate performance assessment criteria:

> *''Each contract requires at least 3 days (to assess) – there is all the explaining to do from the Secretary downwards. What with transfers and everything, we start again with every new person. A target of 10 contracts in a year means 30 whole days in a year! Is he (Secretary of Health) going to give me that sort of time?''* (Interview: 31/84)

Contract finalization involved superficial reading of the technical content of contracts due to mutual inexperience of the government and NGOs with HIV prevention. This subsequently bred confusion during contract implementation over actual service delivery responsibilities, and led to complaints of an inadequate budget.

Asides from capacity gaps, contracting was also affected by several delays due to lengthy paper work and time lags in obtaining multi-layered approvals. Rent-seeking pressures and preference for familiar organizations were reported in the award of contracts. Transparency issues related to NGOs also arose, with the overstatement of attributes and less than transparent bidding alliances. Despite tight oversight rules, there were at least two instances where the award of contracts was controversial.

Engaging purchasers and contractors were also mutually wary of each other. Many government purchasers harboured suspicions of NGOs' motives, accountability and delivery. Holding NGOs accountable was considered a cumbersome task and there was concern about whether NGOs would be amenable to work with a hierarchical government system:

> *''We don't have mechanisms here for tracking the accountability of contracted NGOs and we don't want to get involved with lengthy litigations in court. Then again we (government) would always want the upper hand . . . this creates tensions with NGOs.''* (Interview: 18/84)

Conversely, NGOs voiced fears of political likes and dislikes and rent-seeking practices within the public sector. While this was not a deterrent for most NGOs to bid, with only a couple of prominent NGOs not bidding, most NGOs approached contracting with caution:

> *''NGO partnership at present is a forced agenda. Apart from Dr.__ we have had bad relations with the government from the beginning. As for transparency, whether the provincial governments have the will for it that too is uncertain.''* (Interview: 69/84)

In practice, capacity gaps, delays and occasional transparency issues and mutual wariness between NGOs and government purchasers kept contracting from being as technically smooth an exercise as envisaged.

Contract implementation and knock-on effects

Responsiveness of HIV contracts

Implemented contracts, except for a few cases, were interpreted narrowly and service coverage mostly fell below expected targets (SOSEC 2007; Khan 2008).

A comprehensive service package was stipulated in contracts (Table 1), comprising both public health measures as well as client empowerment and rehabilitative measures considered internationally as necessary for the uptake of HIV interventions (UNAIDS 2005). In practice, contractual delivery tended to focus on quantitative outputs specified in the contract and linked to financial releases. Services were confined largely to HIV testing, condom provision and safe needle exchange, with less progress in areas of more intensive and innovative activities of behavioural change, social support and client empowerment:

''The understanding of HIV within NGOs was very poor. Take the example of this so-called large NGO__. I visited their field office in the red light area. The staff tells me that the main objective of their HIV program is to test and report positive FSWs.'' (Interview: 19/84)

Even for core public health interventions, in most contracts there were instances of inappropriate programming in terms of service location and timings, and non-standardized care (NACP 2005). Moreover, the risk groups served were usually passive service recipients, uninvolved in the programming of services, which raised questions of innovation and responsiveness (DFID 2005). Overlooking of empowerment and behavioural change measures was felt by experts to blunt the impact on the risky behaviour of clients:

''Client position remains the same whether government providing or NGO providing.'' (Interview: 46/84)

Contracts were assessed periodically by a third party firm. However, overall oversight on contracts and financial payments was provided by government purchasers. Government monitoring usually relied on site visits and NGO reports. Technical assessment and feedback to NGOs was constrained due to inexperience in HIV best-practice measures and low use of field-based information. Moreover, time-consuming processes for financial releases, well beyond the control of government purchasers, considerably delayed contractual payments and slowed the pace of implementation. Substantial time of both contractors and purchasers was consumed in dealing with financial delays, further detracting attention from technical concerns of contract implementation:

''Payments are made by reimbursements but we have been reimbursed only 20% of our spending so far. Now we have lost our financial resources and have given a SOS to the government! . . . This is what I have come for today, just trying to get releases.'' (Interview 67/84)

NGOs working with IDUs were able to overcome some of the handicaps facing contract implementation. With hindsight from smaller projects in the past and a work culture of involving former IDUs in service delivery, these NGOs successfully lobbied for a wider package for IDUs, incorporating both clinical and rehabilitative elements. They also negotiated for advance financial approvals for quick contract implementation. Consequently, IDU contracts had a broader service range including shaving, tea and chat facilities, wound care, curative services, detoxification and better technical programming, and were quicker to get off the ground with service provision (NACP 2005). Coverage rates (66–75%) were higher compared with FSW, MSM and prisoners' contracts (9–15%), with the latter contracts being particularly affected by both technical gaps and delays (SOSEC 2007; Khan 2008).

Political spin-offs on providers and purchasers

The sudden opening up of multiple contracts led to both beneficial and detrimental impacts on NGO working. NGOs appreciated the push towards adopting more professional and output-based practices for securing and implementing contracts. At the same time they regretted that identification with clients had been supplanted by commitment to contracts:

''NGO culture before was typified by motivation, few funds and loose operations . . . now there are more professional (practices) and funds but less commitment.'' (Interview: 48/84)

Less attention was given by NGOs to areas such as client empowerment and behavioural change that demanded their innovative and client-centred skills, than to areas with quantifiable clinical targets. Moreover, confronted with multiple contracts, the overriding emphasis shifted to the securing of contracts. In some instances experience was overstated and less than transparent bidding alliances were forged. More commonly, competition for contracts led to politicking and infighting amongst NGOs, undermining issue-based networking for HIV:

''Competition is cut throat, everyone thinks that I should keep the knowledge to myself otherwise someone else will take the project. This happens where work is mainly for funds.'' (Interview: 63/84)

Occupied with successive rounds of bidding, many NGOs expressed frustration in finding themselves left with less time for programming and implementation of secured contracts.

Contracting also had knock-on effects on government purchasers, albeit the consequences differed in the two provinces. The Sindh AIDS Control Program (SACP), as mentioned earlier, was more developed due to past management of small grants to NGOs. Better HIV-related expertise and knowledge of NGOs provided a technical edge in tendering, monitoring and technical feedback to NGOs during monitoring. Moreover, the familiar interface provided by SACP to NGOs was noted by NGOs to provide a facilitatory interface during the management of contracting. However, the political pressures for procurement prompted the departure of the entire core leadership from the SACP for other jobs:

''There are a lot of pressures . . . when we got to know that this program is coming we all decided to get out (of the HIV Program).'' (Interview: 33/84)

A subsequent series of politically motivated transfers in SACP failed to provide a stable leadership and further eroded contracting capacity in Sindh. In contrast, in Punjab the AIDS Control Program (PACP) lacked staff and had little exposure to NGO working to begin with. Political pressures were more controlled in Punjab, allowing development of a stable PACP leadership. The new leadership succeeded in speeding up government administrative processes related to the award of contracts and to performance payments, but lack of experience in HIV and NGOs blunted technical management of tendering and performance-based monitoring.

Discussion

This paper has attempted to add to existing evidence on factors that support or hinder contracting for health service delivery

between government and NGOs. A broad policy analysis lens was used forming a departure from studies that tend to focus on the contract implementation level. We found that contract design, incentives and formal controls for contracting are themselves products of the wider policy context that must be unpicked to explain success or failure of contracting (Figure 1). The following three main findings emerge from our study.

First, we confirm that contracting is affected by the wider policy context as found in contracting reviews (Mills and Broomberg 1998; Liu *et al*. 2007), but additionally we bring to light issues related to the policy process of contracting which has been less well probed. In Pakistan, a combination of situational events successfully introduced extensive and sophisticated contracting but ran into difficulties during implementation. Against a backdrop of lukewarm political support, development partners particularly influenced the instigation and design of contracting and drew in support of policy elites, thereby underlining the role of stakeholders other than purchasers and providers in shaping contracting. Subsequent grounding at sub-national level remained problematic due to both ownership and capacity issues. Low political ownership by implementers is of concern given that there are instances of extensive donor-supported contracting in LMICs as seen in Afghanistan and Cambodia (Soeters and Griffiths 2003; Sabri *et al*. 2007). This raises issues of sub-optimal implementation, as evidenced in Pakistan, as well as questions of sustainability. The issue of institutional capacity gaps for performance-based contracting has already been highlighted in a number of Asian and African countries (Bennett and Mills 1998; Siddiqi *et al*. 2006; Bhat 2007), but our findings also show that external assistance for tight designing of contracts and contracting process is insufficient. Larger institutional issues of bureaucratic delays, indifference to use of modern contracting methods and poor experiential knowledge of NGOs make the public sector poorly conducive for management of contracting. Our findings also highlight a relational aspect of capacity, that of mutual wariness between NGOs and government at all stages of contracting. Its importance, as already evidenced in the case of traditional loose contracts (Palmer and Mills 2005), is also relevant to performance-based contracting which cannot be deemed as a neutral and technocratic process. Given these capacity constraints, the presence of an independent purchasing agency for contracting as emphasized by best practice guidelines (England 2004) is needed both for technical management of contracting as well as for provision of a facilitatory and neutral interface with NGOs.

Second, we found that undue reliance should not be placed on market simulation through contracting. Presence of an ample market has been underscored as a key pre-requisite for contracting (Walsh 1997). So far, large-scale contracting in Cambodia, Rwanda and Afghanistan has largely relied on international NGOs rather than local NGOs, and capacity of local NGOs has been questioned at least in Afghanistan and Guatemala (Soeters and Griffiths 2003; La Forgia *et al*. 2005; Palmer *et al*. 2006; Soeters *et al*. 2006). However, not much is known about local NGO 'markets' for contracting. Our findings, covering 36 bidding and non-bidding NGOs, show that sudden and aggressive contracting in Pakistan led to forced market creation among local NGOs, with many lacking either service expertise in HIV or management capacity for bid development, tendering and implementation. Implemented contracts were thereby affected by quality and service interpretation issues,

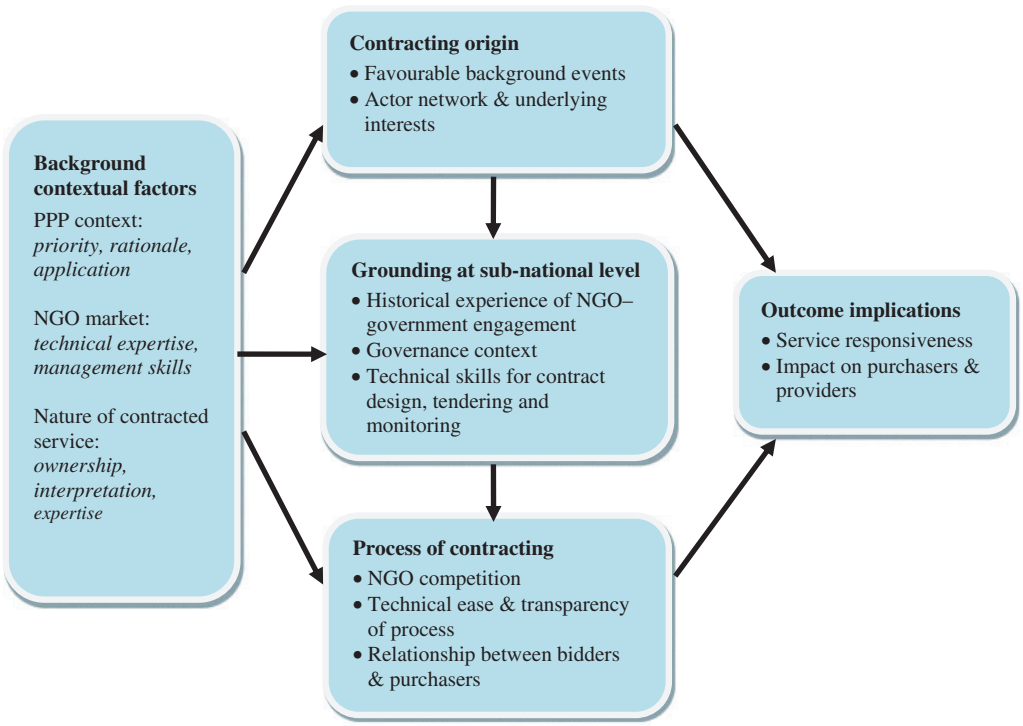

Figure 1 Factors influencing contractual engagement between NGOs and government

with the handful of NGOs who had gradually acquired experience through prior projects demonstrating superiority here. Our study underscores that in contexts where NGO capacities are untested, contracting should be approached more incrementally, with fewer and smaller contracts to allow market testing and development of capacity.

Third, following an iterative process of inquiry we found that contracting can result in knock-on effects on both providers and purchasers. There has been concern about the potential impacts of contracting and PPPs beyond immediate health targets on the larger health system (Bennet and Fairbank 2003; Buse and Harmer 2007), but this is an area that has been less well examined. NGOs are widely promoted for contracting based on their client-centred attributes; however, we found that these attributes are put to the test under public sector contracts. As a result of aggressive contracting, NGOs became more adept at writing and bidding for contracts, but shifted to behaving like for-profit providers driven by an emphasis on securing contracts. This bred inter-NGO factionalism, adoption of less transparent bidding practices and undermined attention to responsive service delivery. An underdeveloped NGO sector for HIV in Pakistan presumably heightened the vulnerability to knock-on effects; however, the commercialization of NGOs as a consequence of wide-scale contracting needs to be cautioned against even in more robust NGO market settings. Knock-on effects on purchasers were also seen but were less predictable, being linked to the provincial governance context. Weaker governance in one province heightened capacity gaps and apprehensions about contracting, while a more supportive governance context in another province led to greater identification with contracting and smoother implementation. This again points to consideration of institutional context prior to introduction of contracting.

In Pakistan, contracting has since been expanded to the out-sourcing of 2391 Basic Health Units across 127 districts (Government of Pakistan 2010). However, consideration of contextual factors has not featured in this expansion of contracting and it is uncertain whether it has played a role in donor-supported contracting in LMICs generally. We argue that mere reliance on external assistance for contract design, tendering and monitoring, and on market simulation through contracts, is insufficient for successful contracting. Both governments and donors need a measured strategy taking into account the local context for contracting—in particular, political willingness, technical and relational aspects of government capacity, availability of an NGO market, and potential for distancing of NGOs from their grounded attributes under contracts.

Conclusion

Contracting origin and implementation is likely to be an inherently political process which may not always bed down with local ownership and capacities, can result in knock-on effects and is unlikely to be addressed by quick fix measures. Political factors and knock-on effects are likely to be heightened in the sudden and aggressive use of contracting in unprepared settings. An incremental approach to contracting to build in political ownership, use of an independent management agency to side-step overarching public sector capacity issues, and market testing of NGOs are recommended.

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Conflict of interest

None declared.

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