Health Economics Unit
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STUDY TO DEFINE SCOPES, OPPORTUNITIES, CHALLENGES, AND WAY FORWARD FOR DEVELOPING A STAKEHOLDER COORDINATION STRATEGY TOWARDS HARMONIZING GO/NGO COLLABORATION IN THE HEALTH SECTOR

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ACRONYMS

ABCN	Area Based Community Nutrition
BADAS	Diabetic Association of Bangladesh
BAVS	Bangladesh Association for Voluntary Sterlisation
BDHS	Bangladesh Demographic and Health Survey
BINP	Bangladesh Integrated Nutrition Project
CBNC	Community-Based Nutrition Component
CES	Coverage Evaluation Survey
CS	Civil Surgeon
DC	Deputy Commissioner
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Service
EPI	Expanded Programme for Immunisation
ESP	Essential Service Package
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
GMP	Growth Monitoring and Promotion
GNSPU	Gender, NGO, and Stakeholder Participation Unit
GoB	Government of Bangladesh
HEU	Health Economic Unit
HPNSP	Health, Population, Nutrition Sector Programme
HPSP	Health and Population Sector Programme
HSD	Health Services Division
IMED	Implementation Monitoring and Evaluation Division
IPHN	Institute of Public Health Nutrition
KII	Key Informant Interview
LGD	Local Government Division
MOHFW	Ministry of Health and Family Welfare
MOLGDR&C	Ministry of Local Government, Rural Development and Cooperatives
MOSW	Ministry of Social Welfare
MOU	Memorandum of Understanding
MOWCA	Ministry of Women and Children Affairs
NGO	Non Government Organisation
NGOAB	NGO Affairs Bureau
NHCSDP	NGO Health Care Service Delivery Project
NNP	National Nutrition Programme
NNS	National Nutrition Service
NOC	No Objection Certificate
NTP	National TB Programme
PHC	Primary Healthcare
PLW	Pregnant and Lactating Women
PMIS	Project Management Information System
PMO	Prime Minister's Office
PPP	Public Private Partnership
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SWAp	Sector Wide Approach Programme
UHFPO	Upazila Health and Family Planning Officer
UH&FWC	Upazila Health and Family Welfare Centre
UNO	Upazila Nirbahi Officer
UPHCP	Urban Primary Health Care Project
UPHSDP	Urban Primary Healthcare Service Delivery Project

EXECUTIVE SUMMARY

Introduction

Bangladesh is one of the most densely populated countries in the world. Bangladesh has shown remarkable improvement in the economy; a 6 percent economic growth rate over the past decade and remarkable improvement in human development. A satisfactory economic growth has been seen in the past four decades, poverty rate dropped to 20.5 percent in 2019 from 24.5 percent in 2016. According to the constitutions of Bangladesh, improving the public health service is one of the government's key duties. To reach that goal, GoB has established a widespread healthcare structure in the public and private health sectors all over the country. Over the past decades, Bangladesh has made a remarkable development in the health, population and nutrition sector (HPN) particularly in life expectancy, maternal death, immunization coverage under 5 child mortality, infant mortality and communicable disease control.

Like other lower-middle and middle income countries, the health system of Bangladesh has four key actors-government, Private players, donor agencies and non-governmental organizations (NGOs). In order to improve healthcare services, after the government and private sector NGOs are playing as "third sector" of health providers of Bangladesh. NGOs are working as a channel of donor agencies for funding, and it has been seen that a significant portion of total health expenditure was managed by NGOs in Bangladesh. To meet the goals of the SDGs, provide universal health care coverage, and alleviate identified gaps, NGOs have assumed responsibility of ensuring the last-mile reach of healthcare services. Therefore, coordination between the Government and NGOs is needed to enhancing the capacity by reducing duplications. Consequently, partnerships between the Government and NGOs in the areas of financing, planning, service delivery, capacity building, and monitoring and evaluation are crucial to producing desirable results. In the domain of the health sector, GO-NGO partnership has become a repetitive practice in Bangladesh. GoB has understood the essentiality of GO-NGO partnership and government repeated the significance of the GO-NGO collaboration in different Five-Year-Plan. Now it is the high time to understand the opportunities and challenges of GO-NGO partnership. The Gender, NGO, and Stakeholder Participation Unit (GNSPU) of MoHFW is responsible for developing a GO-NGO coordination strategy in the health sector. Exploratory studies, surveys, and research is needed to identify the scopes and challenges of the GO-NGO collaboration and to develop the strategy.

Overall Goal of the Study

The goal of the study was to define various aspects of scopes, opportunities, and challenges that need to be considered for preparing a collaboration strategy; and to recommend a way forward for harmonious synergy between MOHFW and GO/INGO in the health sector in the country.

Methodology

The study was followed a mixed-methods approach with parallel combination, in which primary and secondary data collection, analysis has been done in parallel and results compared and interpreted in a combination. After the inception activities a comprehensive desk review of secondary literature has been conducted on the theme of health system and GO-NGO collaboration. Besides the documents of government and international agencies, online database such as Google Scholar, PubMed and, Trip Database were used for searching relevant documents. A series of search terms such as 'GO-NGO collaboration', 'NGOs in health sector', 'NGOs in Development Sector', 'Role of NGOs in Health Systems Strengthening', 'GO-NGO Collaboration in developed countries' and 'GO-NGO collaboration in developing countries' were used to search literature in online database. Key informant Interview (KII) a tool of research methodology were used to collect primary data for this study. A total of 17 KII were conducted using a semi-structured checklist with key policymakers and influencers from both government and non-government organizations. Through a framework analysis method, the transcribed

interviews analysed and interpreted. Two workshop has been organized with the potential stakeholders engaged in the delivery of healthcare services, national level of NGO healthcare workers and GO health policy makers. A total 51 stakeholders were participated in these two workshop. Feedback from both the consultative workshops have been used in developing this report.

Global and Regional Evidences of GO-NGO Collaboration in Health

To learn about the scopes and challenges of the GO-NGO collaboration this study identified some crucial global and regional projects that followed the GO-NGO collaboration approach in health. Global and regional case studies from Ghana, Peru, Malawi, Togo, Ethiopia, India, Pakistan and Afghanistan have been taken into account in this study to understand the scopes, challenges and contextual factors of the Go-NGO collaborations. Study have taken some key lessons from the analysis of global and regional case studies related to GO-NGO collaborations. The study found that all types of collaboration, such as contractual service delivery model, patronage, or network representation- both GO and NGO added a significant value and created synergy in generating positive outcomes on health systems and health service delivery. There were value additions not only to the outcome of the partnership but also on institutional capacities of the participating GO-NGO partners. Being interdependent and equal ownership in the partnership is the key driving force to the sustainability of the collaboration. partnership require complementarity among its partners for effectiveness and sustainability. For the sustenance of GO-NGO collaboration, politicians and bureaucracy should be convinced to develop explicit policy and support the implementation. Formal partnerships based on specific MOUs, designated roles and responsibilities increase accountability for each stakeholder involved, while there is a lack of trust in informal cooperation. Clear communication and information dissemination among partners is another key aspect of effective collaboration, and absence of such create the mistrust, which has been viewed as a common problem for GO-NGO collaborations. Openness in communication and sharing of all information is essential to ensure transparency and reduce suspicion among partners.

Evidence and lessons learnt from GO-NGO collaboration in health sector of Bangladesh

During the last two decades a large number of NGOs have been involved in providing basic health services, including participation in most of the components of Primary Healthcare. There was significant involvement of development partners and NGOs for the development of every Health and Population Sector Programme (HPSP). This study found that a large number of health programs have run under the GO-NGO partnership modality. Collaboration between the government and NGOs in TB, maternal and child health and family planning, extended Programme of Immunization, leprosy elimination and nutritional programmes are examples which has been effective and efficient. CARE-Bangladesh's reproductive health project, BRAC's health and development programmes, and the leprosy control programmes of Health, Education and Economic Development (HEED) are among successful implementations of GO-NGO collaborations. In the desk review, some challenging model of partnership were also seen such as Nutrition Programme and Urban Primary Healthcare Project of Bangladesh.

The desk review identified some of the regulatory instruments that govern the GO-NGO partnerships and detailed them in the report. These regulatory acts are Foreign Donations (Voluntary Activities) Regulation Act, 2016; The Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961 (Ordinance XLVI, 1961); The Societies Registration Act 1860; The Trust Act 1882; The Companies Act 1994; and The Waqf Ordinance 1962.

Possible Opportunities for GO-NGO Collaboration

- To ensure the government's commitment to universal health coverage, there can be a partnership between MOHFW and the local NGOs to provide primary healthcare services in hard-to-reach areas. This can be a contract-out model under which government can pay for the services, or, alternatively, special projects can be designed and the implementation can be done through technical collaboration among government, development partners and NGOs.

- If there is no significant change in the existing legal and policy framework, the responsibility of primary healthcare in urban areas can continue to be with LGD. Notwithstanding, NGOs should have more flexibility and their participation in the decision-making should be increased, and along with that, the government should encourage NGOs to come up with PPP model in setting up hospitals in urban slam or high densely urban areas.
- Unutilised government healthcare facilities can be contracted out to the willing NGOs while government would pay for the services, NGOs would ensure human resources, equipment and other facilities to operationalise the facilities. For ensuring 24/7 service delivery, under-utilized GO facilities such as UH&FWC can be utilized by a unique GO-NGO partnership while NGOs will provide a health workforce, and the government will provide money for the services.
- For proper use of valuable hospital equipment government can consider the contract-in of equipment services from competent NGOs.
- The government has already taken ancillary service providers from the private sector through a contractual model, and NGOs and civil society can be involved with this contractual model for smooth management. Already there is are proven model of NGO and civil society led ancillary service provision in Bangladesh, known as "Chaugaccha Model" and "Jhenaidaha Model".

Challenges in GO-NGO Collaboration in Health Sector of Bangladesh

Almost all the key stakeholders of the government in the KII indicated the duplication and overlapping efforts as a key challenges. It has been seen that similar activities are doing GO and NGO stakeholders in the particular geographical areas. These duplications and overlapping of efforts may create a waste of resources and may also cause health services not being reached to particular demographic groups due to the shortage of resources. Inadequate involvement of government is another common issue raised by almost all the government officials of the workshops. Government officials should be involved in the design process of their projects; otherwise, duplication of efforts of the GO and NGOs may not be prevented. Although NGOs involve government in most of their projects at implementation level, there is very limited monitoring from government on the project activities. On the contrary, government projects are being monitored by IMED but this entity does not monitor NGO's programme. According to the government respondent, NGOs tend to have a special relationship with the media to exacerbate the actual success of projects, where the government often does not get the justified credit since the government offices do not have the communication skills.

Respondents from NGOs revealed that operational flexibility has to compromise when they work with the government. Moreover, they have to complete a number of documents and to go a number of government offices to get the approval which is time consuming and shorten the project duration. According to them, the Foreign Donation act of 2016 had imposed more restriction to the NGO operation and limited the flexibility to a significant extent. Another challenge is the political interference particularly in the implementation level, especially political leaders and local government representative pressurize in the recruitment of field level workers. NGO representatives reported that fund flow from the donor agencies has been decreased for the last few years. The economic crisis of the donor crisis, changes in priorities and becoming a middle income country were the main reasons for the decrease of the fund flow. Frequent turnover of the government officials is one of the significant reasons for slowing down the project's progress as newly appointed officials are often unaware of the issues and the NGOs have to take additional efforts to sensitize them.

Recommended Mechanisms in GO-NGO Collaboration

- Non-contractual Technical Collaboration is based upon similarities in vision, values and mutual respect where NGO supports the government in areas in which its vision, objectives and activities are in line with those of government. As there is no contract between GO and NGO, no transaction is involved between the parties, albeit an MOU can be signed.
- Contractual collaboration is based on a formal agreement between the government and NGO partners for a specified period to perform a specific service or provide a particular product. Since there is a legal agreement between both parties, a transaction is involved. The Contract-

out refers to the government delegating the responsibility of managing certain services or facilities to NGOs in exchange for service charges/fees. The Contract-in refers to the uptake of any services of NGOs into government systems or facilities in return for service charges or fees.

- Partnership is a form of collaboration where financial as well as non-financial involvement can be seen from both the parties, although may be at a different extent, to jointly achieve a greater goal. In this collaboration both GO and NGO invest money where ownership of both parties is created, and accountability is ensured. PPP projects are the best examples of partnership.

Recommended Actions for Address Challenges in GO-NGO Collaboration

- A Project Management Information System (PMIS) can be developed with a dashboard to reduce the duplication of efforts and support the rapid approval of future projects. This database would consist of all the approved NGO and GO-NGO projects in the health sector.
- The openness of information is essential to build trust and ensure transparency between the two parties. Information regarding the relevant GO-NGO collaboration projects should be open and publicly available, including the economic data. All the information regarding progress, financial data, and results of the periodic evaluation may also be published on the websites of the NGOs and relevant government stakeholders.
- As most of the NGO stakeholders mentioned, present approval of development projects was quite complex and time-consuming, so it is necessary to speed up getting the project's approval. Once the PMIS is operational, the NGOs or the GO-NGO collaborating stakeholders can be asked to upload the project design/proposal into the PMIS. A detailed modality has been described in the report regarding increasing the pace and reducing the complexity of project approval.
- In order to create ownership, better monitoring and improvement of the implementation, all the implementation level stakeholders such as district/upazila administration, health and FP officials, other relevant government officials, local government representatives, development partner, civil society representatives and media should have involvement with the projects. All the GO-NGO collaboration projects should have a mechanism and budget to engage and sensitize all levels of stakeholders.

Conclusion

To avoid the duplication of efforts creating a waste of money and to ensure universal health coverage within the limited resource, it is high time to establish the GO-NGO collaboration in the domain of public health. To move further towards the common goal, it is essential to understand the opportunities and challenges that lies under GO-NGO collaboration. A number of recommendations regarding the opportunities and addressing the challenges of GO-NGO collaboration and possible mechanism of GO-NGO collaboration have been furnished in the report. There are opportunities for further research to implement the recommendations made in the report.

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1. INTRODUCTION

1.1 Context

Bangladesh, with a population density of 1,265 persons per square kilometre, is the most densely populated large country in the world. It is one of the lower-middleincome countries with per capita income of USD 1,855.74. In the past four decades, undergone significant socio-economic transition, for instance, poverty rate reduced from 56.7% in 1992 to 24.3% in 2017. Healthcare has been one of the top-most priorities of the Government of Bangladesh (GoB). The Constitution of Bangladesh identifies raising the level of nutrition and the improvement of public health as one of the primary duties of the government. To implement the mandate of the constitution, the GoB has established extensive healthcare infrastructure in the public and private sectors. Due to the rigorous efforts taken by the GoB, it has achieved impressive improvements in population health status by achieving the fourth Millennium Development Goal (MDG-4) of reducing child death. Also, it has rapidly improved other key indicators, including maternal death, immunisation coverage, and survival from some infectious diseases, including malaria, tuberculosis, and diarrhoea. Its under-5 mortality rate of 29 per 1,000 live births and maternal mortality rate of 169 per 100,000 live births are lower than those of many lower-middle and middle-income countries.

The health system of Bangladesh has four key actors- government, private players, donor agencies, and non-governmental organisations (NGOs). The government or public sector is the first key actor, which by the constitution is responsible not only for policy and regulation but for provision of comprehensive health services, including financing and employment of health staff. To complement the government's efforts to provide basic health services, the private sector and NGOs have established a network of facilities to provide health and family planning services. The private sector consists of the formal sector which provides both western and traditional (Unani and Ayurvedic) services through a range of facilities from hospitals to clinics, laboratories and drug stores; and the informal sector, which consists mainly of untrained providers of western, homoeopathic and traditional medicine. In order to enhance coverage of healthcare services, a vibrant and large NGO sector has emerged as "third sector" of health providers in Bangladesh. The role of NGOs is growing as donors are channelling significant and increasing amounts of funding directly to them. In 2007, 9% of total health expenditure was managed by NGOs, up from 6% in 1997.

Though it is the responsibility of the government to provide universal healthcare coverage ensuring accessibility, affordability, and acceptability, often governments especially those of developing countries cannot fulfil such responsibility owing to large public health agenda and finite resources. To bridge such gaps, NGOs have assumed responsibility of ensuring the last-mile reach of healthcare services, especially those relating to nutrition, and mother and child health. Lack of coordination between governments and NGOs result in duplication of efforts and inefficiencies, while robust collaboration augments the effectiveness of the efforts by bringing synergies. Therefore, partnerships between the Government and NGOs in the areas of financing, planning, service delivery, capacity building, and monitoring and evaluation are crucial to producing desirable results.

In the health sector domain, the GO-NGO partnership has become a recurrent practice in Bangladesh. Owing to its own incapacity to perform this country wide task alone, the government extends different responsibilities related to health, nutrition, and family planning to NGOs. In its Fifth, Sixth, Seventh, even in the recent Eighth Five-year Plan, the government recapitulated the significance of the GO-NGO collaboration in health care, family planning and reproductive health. Such collaboration is essential at the grassroots level, especially for rendering basic health services, spreading health education, motivating contraceptive users, and so on. Therefore, we define GO-NGO Collaboration in health as any initiative where any government organization works together with NGO/s to fulfil their common goals for improving health while sharing resources, risks, and responsibilities. To move further towards the common goal, it is essential to understand the opportunities and challenges that lies under GO-NGO

collaboration. It is also necessary to map out the way forward in purpose to create a mutually facilitative strategy which will ultimately allow harmonisation between such collaboration.

The Gender, NGO, and Stakeholder Participation Unit (GNSPU) of MoHFW has responsibility for initiatives to develop a GO-NGO coordination strategy in the health sector. It comprises explorative studies, surveys, research to identify potential scopes, opportunities and challenges in collaboration in the health sector. In this context, the GNSPU engaged ARK Foundation to undertake a study on GO-NGO collaboration in the health sector.

1.2 Goal and Objectives of the Study

The goal of the study was to define various aspects of scopes, opportunities, and challenges that need to be considered for preparing a collaboration strategy; and to recommend a way forward for harmonious synergy between MOHFW and GO/INGO in the health sector in the country.

Objectives of the study were:

i. To identify key policy-level stakeholders for government and NGOs in the health sector
ii. To provide an evidence base for the effectiveness of NGO collaboration strategy in global, regional, and local health sectors
iii. To define potential scopes, opportunities, and challenges in developing an NGO collaboration strategy in health

1.3 Methodology

The study was a mixed-method study, using both primary and secondary data. A combination of desk review, key informant interviews (KII) and stakeholder/consultative workshops was used for the collection of relevant information to accomplish desired objectives. Different aspects of the methodology are detailed in the subsequent sections.

1.3.1 Inception Phase Activities

Upon being delegated with the responsibility to conduct the study, the ARK Foundation team drafted the methodology, list of key respondents, tools and a work plan. An inception report containing these was developed and submitted to HEU. The work plan, tools and other aspects of the methodology was finalised in a workshop with GNSP, HEU on 27th January, 2021.

1.3.2 Desk Review

Nature of the assignment involved a comprehensive review of secondary literature including documents and reports published by various departments of GoB, national and international development agencies and NGOs, and academic and research institutions on the themes of health systems and GO-NGO collaboration. The desk review involved collecting, organising, and synthesising available information on GO-NGO collaboration, especially in the health sector. Online databases such as Google Scholar, PubMed and, Trip Database were used for searching relevant documents. During the desk review, we got an understanding of the needs, priorities, and trends in health systems of Bangladesh and identify the gaps.

The review process consisted of three distinct stages: literature search, data extraction and synthesis. We identified a series of key search terms to be used in the review process, which were broadly grouped into the following themes: 'GO-NGO Collaboration', 'NGOs in Health Sector', 'NGOs in Development Sector', 'Role of NGOs in Health Systems Strengthening', 'GO-NGO Collaboration in developed countries' and 'GO-NGO collaboration in developing countries'. A list of the documents that we reviewed for the study are attached with the report in reference section of this document and also included in annexure 1.

1.3.3 Primary Data Collection and Analysis

KII was the principle method of collection of primary data in this study. We conducted 17 interviews with key policymakers and influencers from both government and non-government organizations. The interviews were audio-recorded with the prior consent of the respondents. A semi-structure question guide was used for interviews, shown in annexure 2. All the interviews were transcribed. Due to the huge volume of the transcripts, not all transcribed interviews could be attached to this report. An electronic version the transcriptions were shared with the Director General of HEU and his team. We analysed the transcribed data through the framework analysis method. The list of the participants in the interviews is attached to the report in annexure 3.

1.3.4 Consultative Workshops

We organized a consultative workshop with potential stakeholders engaged in the delivery of healthcare services in Cox's Bazar to get an understanding of the collaboration between public institutions and NGOs at the local level. There were a total of 25 participants in the workshop from different organizations who shared their experience and specific feedback on GO-NGO collaboration. The workshop was held on 01 April, 2021

Another consultative workshop was arranged with the stakeholders involved with national level NGO healthcare, and GO health policy makers at Dhaka on 21 June, 2021. A total of 26 stakeholders participated the workshop. The preliminary findings of the study were presented in the workshop and group exercise was conducted to get the feedback of the audience on the stakeholders of GO-NGO collaboration in health, potential opportunities and key challenges. Feedback from both the consultative workshops have been used in developing this report.

2. GLOBAL AND REGIONAL EVIDENCES OF GO-NGO COLLABORATION IN HEALTH

2.1 GO-NGO Collaborations in Public Health: Global Evidences

2.1.1 Case Studies of GO-NGO Collaborations in Ghana

Government of Ghana adopted the Primary Health Care (PHC) strategy as means for achieving "Health for All" back in 1974. However, chronic economic recessions restraints the resource allocations for public health, hindering this broad goal. Situation got worsen with prevalence parasitic and infectious diseases, malnutrition and emergence of non-communicable diseases. In addition, there was a regional disparity in the provision of quality healthcare, favouring more to the urban population and those living in southern part of the country.

As a mitigation strategy, government adopted five-year Medium-Term Health Strategies (MTHSs) since 1997. Decentralisation and integration in service delivery and management were among the key aspects of these strategies. As part of decentralisation, government modified the relevant policies relating to organisational relationships within health sector, and fostering recognition of partnerships and collaborations with NGOs and civil society for service provision, as means of achieving national health goals (Hushie, 2016). Notable of among the successful collaborations in previously underserved regions and rural areas included:

- the Catholic Relief Services (CRS) - Ghana Health Service (GHS) under Ministry of Health (to reduce under-five and maternal mortality);
- GAC – West Africa AIDS Foundation (WAAF) to combat Human Immunodefiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS;
- Alliance for Reproductive Health Rights (ARHR)-GHS (to increase access to women's sexual and reproductive health services);
- GHS-Sightsavers (to increase access to eye care services); and
- BasicNeeds- GHS (to increase access to mental health services)

Hushie identified several factors behind such effective GO-NGO collaboration, including: 1) developing new relationships by adopting and implementing health needs-based approaches and evidence-based interventions; 2) commitment to mobilise internal and external resources and support for effective programming; 3) using MOUs to formalise expectations for collaborative relationships as well as respective project roles and responsibilities; 4) making programme planning and implementation a collaborative process by involving project partners and key stakeholders from start-up to the end; 5) ensuring monitoring and evaluation is a continuous process to identify programme needs and issues and to engage in continuous programme improvement; 6) using decentralised organisational and administrative structures and existing country systems to promote local ownership and sustainability of programmes; and 7) sharing of accurate and timely information among partners, stakeholders, donors and the public to ensure more effective programme outcomes (Hushie, 2016).

Hushie, however, identified several challenges in GO-NGO collaborations in health sector, including difficulty of synchronising each other's work programmes; high staff turnover rate among CSOs; lack of transparency and mutual suspicion among partners' financial contributions, delays caused by cumbersome government bureaucratic procedures; government's inability to keep set programme targets, timelines or deadlines; NGOs' eagerness about timelines to demonstrate programme effectiveness to donors; and broader health systems' challenges, such as shortage and inequities in the distribution of human resources and ill-equipped health facilities (Hushie, 2016). Issaka and Issaka further identified some other challenges in such collaboration, particularly for local NGOs, which included with weak technical and financial capacities of local NGOs and poor organisation of NGO front (Issaka & Issaka, 2016). Issaka and Issaka emphasised on ensuring accountability, monitoring

and obtaining feedback of various programmes at operational level and developing specific guidelines for NGOs in resource mobilisation.

2.1.2 Case of CONAMUSA in Peru

The National Multisectoral Coordination in Health (CONAMUSA) is a coordinating body made up of representatives of the Government of Peru, bilateral and multilateral international cooperation, civil society and organizations of people directly affected by HIV / AIDS, Tuberculosis and Malaria in the country. Purpose of developing this body was to promote and build consensus, develop messages and concepts shared by all sectors, close the gap between public and private, and complement and strengthen what governments work on the prevention of HIV / AIDS, Tuberculosis and Malaria. It was created in 2002 in response to feedback on Peru's first proposal to GFATM, which cited the lack of a multi-sector coordinating body as a major reason for not receiving fund. Such a body has been considered to be unprecedented in Peru, creating new opportunities for cross-sector dialogue and activities (Cáceres, et al., 2010).

According to Buffardi, Cabello and Garcia, CONAMUSA has been extremely productive in terms of financial and policy outcomes (Buffardi, Cabello, & Garcia, 2012). The group has secured nearly US $140 million in GFATM funding, an amount second only to Haiti in all of Latin America. CONAMUSA members guided the creation of national multi-sector strategic plans for HIV and other sexually transmitted infections (STIs) (2007-2011), and TB (2010-2019). One of the most notable achievements is expanded access to HIV treatment: four years into the group's tenure, the Peruvian government began its program of free, universal access to highly active antiretroviral therapy (HAART).

The case of CONAMUSA provides evidence that broadening participation can expand access to decision-making processes and health care, particularly for stigmatized populations. At the same time, configuring representative and balanced participation of multi-sector coalitions is complex and poses disproportionate costs of time and potential role conflict for civil society members. The CONAMUSA case also offers two key lessons for groups aiming to expand participation: the importance of institutionalizing participation mechanisms and health policy reforms, and the influence of civil society mobilization.

To foster the division of power, CONAMUSA modified its organizational structure to include a Vice Chair, revised membership eligibility to protect against conflicts of interest, and created electoral systems for civil society. The institutionalization of these mechanisms to balance leadership and select representatives ensures that the group's commitment to inclusive participation endures beyond the involvement of specific individuals. Similarly, the creation of multiyear strategic plans for HIV and other STIs, and TB, and the passage of legislation guaranteeing access to treatment, codifies CONAMUSA's work into national health policy that will last beyond the tenure of a single administration.

The case of CONAMUSA highlights the importance of mobilization in terms of facilitating civil society involvement in multi-sector groups, as shown by the difference between active PLWHA and lesbian, gay, bisexual, and transgendered (LGBT) movements and the more dispersed, less organized communities of people living with TB and malaria. Groups that are well organized to articulate their interests have been able to influence both the structure and the agenda of CONAMUSA by advocating for specific policy changes, greater leadership opportunities, and greater representation.

It is important to note that in the case of CONAMUSA, these organizational strategies arose within the context of an enormous external financial incentive, sustained economic growth, and the support of the six Ministers of Health who have served during the group's tenure. In addition, while CONAMUSA's agenda and structure have been driven by the members themselves, the opportunity for cross-sector decision-making would not likely have existed without the donor requirement. This observation suggests that the engagement of more powerful actors-government in the case of CONAMUSA-may

require strong external incentives. Moving forward, one of CONAMUSA's greatest challenges will be sustaining the group when external funding declines (Buffardi, Cabello, & Garcia, 2012).

2.1.3 Public Private Partnerships in the Health Sector in Malawi

Healthcare delivery in Malawi is provided by both the public and private sectors, by government, private-for-profit services, and non-profit organisations like faith-based organisations and other NGOs. While there are various forms of Public Private Engagement (PPE) in Malawi, including social marketing, contracting out, public-private mix in health related sectors, the government partnership with private-not–for-profit Christian Health Association of Malawi (CHAM) is the only PPP where government and private sector co-operate in health service delivery (Tobias, 2020).

The PPP between government and CHAM is on service provision and is implemented through Service Level Agreement (SLA) between local councils through District Health Office (DHO) and CHAM health facilities in the respective district. The SLAs have evolved over the years. Their scope of coverage has expanded from maternal and child health, to now cover all the essential health package interventions and additional services such as for injury from road traffic accidents. They have also expanded in number to a current figure of 146 facilities. The management of the framework has improved with establishment of SLA Management Unit. SLAs have been effective in improving service utilisation and in cost effectiveness supporting progress towards universal healthcare coverage, with some evidence of value for money.

The equity gain in this PPP arises in CHAMs status as a not-for–profit provider that services mostly rural areas where the majority of the population lives and where poverty is high. SLAs help to enhance this by ensuring that services are free at point of care to support access, and by ensuring that the services are those at in Malawi's EHP and provided to an agreed standard, through both a central and local level contracts.

However the SLAs also face challenges such as delayed payment by government to CHAM, cost escalation, and insecure government funding that undermine their performance and these potential gains. Cost escalation has arisen due to CHAM purchasing medicines from private suppliers when the Central Medical Stores Trust runs out of stock. Other challenges found included lack of transparency, poor communication, inadequate human and material resources and lack of systems to monitor performance of the SLAs (Tobias, 2020).

2.1.4 GO-NGO Partnerships for Prevention and Treatment of HIV/AIDS and Malaria in the Maritime Region of Togo

A key finding concerning the health partnerships is that, while those between international NGOs and Togo's government were quite well-structured, those between local/national NGOs and the regime were mostly informal and unstructured (Aleyao, 2016). Another primary conclusion is that the government and national and international NGOS have collaborated to address HIV/AIDS and malaria for a fairly long time. Regime responsibilities in these collaborations included facilities and program funding in addition to implementation and oversight of the laws governing all NGOs. Typically, government partners coordinated partnership programs while collaborating non-governmental organizations implemented projects and delivered services, including public education campaigns. Some NGO organization personnel also trained care providers and provided pass-through funding for delimited activities.

Another characteristic of the partnership was the involvement of GO-NGO partners in decision making. While it has been observed that both GO-NGO partners are involved in decision making concerning the reach and character of service provision, however, it is not the same in case of local NGOs, who felt less involved in the process (Aleyao, 2016). Government officials' adoption of top down decision styles created particular difficulties for national and local NGOs, which was not found to be a difficulty for international NGOs. Trust among participants was found to be quite low, due to poor communication

and the unstructured (and therefore somewhat unpredictable) character of the relationships within them, especially those between national NGOs and government agencies. Low levels of trust also resulted, on occasion, from a lack of public actor transparency and/or perceived corruption.

Aleyao recommended several policy recommendations to address the challenges in the GO-NGO partnership in health in Togo, including the following:

- Formalization of all GO-NGO partnerships for health service delivery
- Promotion of effective communication and dissemination of information among GO-NGO partners
- Stakeholder engagement in cross-sector partnership decision making
- Making adequate funds available for partnership activities
- Coordination of partnership activities from government partners
- Building mutual trust amongst partners

2.1.5 Multi-stakeholder partnerships (MSPs) for health service delivery in Ethiopia

AMREF Health Africa (African Medical and Research Foundation), an international health development organization decided to initiate a specific program named Reproductive, Maternal, Neonatal and Child Health Care (RMNCH) to the region studied with objectives to improve sexual and reproductive, maternal, neonatal and child health status of the people in the project's area. The program that initiated in 2014 became the main focal area in the North Shewa Zone. A combined approach was taken toward maternal and child health care, affiliating this with Sexual and Reproductive Health (SRH). Activities included: bolstering the functional level of health facilities; developing the capacity of the health system and health workers especially at district level; and mobilizing community demand and ownership over maternal and child health care interventions. Apart from AMREF, the project included both state and non-state actors with an important role for regional government institutions.

One of the key aspects of the partnership was the interdependency of the organisations involved in the collaboration mainly due to the fact that all actors included in the partnership introduced resources and specific competencies that can be a certain value to other actors (Amare & Steen, 2018). For example, as the Family Guidance Association (FGA) had more in reproductive health service provisions with extensive health facilities and model clinics, could contribute in connection to reproductive health activities. TAYA, a local NGO, had good experience in youth-related works, so it focused on youth focus intervention services. AMREF, as a lead NGO, primarily focused on resource mobilization, negotiating with donors and to bring international experience.

Another key aspect of the partnership was interaction through negotiation. In the AMREF-RMNCH project, the actor's interaction at local level was more structured by negotiation as compared to regional and federal level. Concerning institutional framework, formal agreements and action plans framed the interaction of the actors in the MSP through establishing roles and procedures. The stakeholders also utilized informal agreements in forming the institutional setting. Beyond contract stipulation, actors carried out their responsibilities through dialogue and good relationships. Regular interaction provided the stakeholder with scopes to use their own ideas, resources and capabilities rather than receiving order through the chain of command. As a result, the actors could maintain the characteristic of self regulation. However, the MSP was not able to maintain its self-regulation completely as it entailed a complex interaction between state and non–state institutions in a certain environment. The state actors regulated the partnership in the operating environment.

2.2 Regional Evidences of GO-NGO Collaboration in Health

2.2.1 Contracting-out of Reproductive and Child Health (RCH) through Mother NGO Scheme in India:

In connection with the ICPD Cairo Conference and in agreement to the Ninth Five Year Plan (1997-2002) the Ministry of Health and Family Welfare started the RCH programme in 1997 with the aim to provide integrated health and family welfare services to cover the felt needs for health care for women and children. In the same year, the Ministry initiated the Mother NGO (MNGO) scheme under the RCH programme in which selected NGOs were identified and designated as MNGOs. These NGOs were allocated grants to bolster RCH services in selected districts and MNGOs in turn provided grants to smaller NGOs called Field NGOs (FNGOs) to reinforce the services at the grass-root levels and uphold the goals/objectives of the RCH programme. The Government of India also built Regional Resource Centers (RRCs) with financial assistance from the UNFPA to render technical and programmatic support towards capacity building of MNGOs.

The objectives of the MNGO scheme, are to improve RCH indicators in the under-served and unserved areas, with specific focus on Mother & Child Health, Family Planning, Immunization, Institutional Delivery, RTI/STI and adolescent reproductive health care. The overall approach shifted from a project to a programme mode (from one-year cycle to 3-5 year cycle).

Evaluation of the scheme identified numerous challenges to implement it in all states in India, including delay and uncertainty of funding and contract renewal, lack of partnership orientation in the scheme, lack of trust among the key stakeholders, capacity constrain in the district and state health system, weak monitoring system, procedural delays and multiple points of authority and reporting relationships (Bhat, Maheshwari, & Saha, 2007). It was also observed that the capacity of field NGOs to deliver in the programme is constrained due to non-availability of financial and human resources. The scheme demands a strong leadership at local levels and ownership from the state health system. This can be achieved through effective decentralisation, flexibility in decision-making and creating adequate accountability systems. Regional Resource Centres has to play an important role in coordination between state/district RCH society and the NGOs and strengthening their capacities. The central government instead of focusing on micro-management of the scheme at state level should focus on developing and strengthening the enabling environment and capacity of various stakeholders to implement the scheme. Also, they need to address various systemic issues including development of accountable and performance oriented system, ensuring financial autonomy and decentralisation, delegation of authority, building trust and accountability in the system, effective integration, continuity of the scheme and fostering true sense of partnership between the state and non-state sector.

2.2.2 Karuna Trust Model in India: Management of primary health care centres (PHC)

In 1996, the Karnataka State Government handed over the management of Gumballi PHC to the Karuna Trust, a public charitable trust, as a unique and pioneering example of Public-Private Partnership in health care. This was done in the context that only 20 percent of the rural population were getting quality primary healthcare services that is available 24 hours, accessible and affordable, whereas state governments had healthcare infrastructure but could not operationalise those. Partnering with the Government and taking over the complete management of non-performing and remote primary health centres in tribal areas was the basis for this model, which later shifted its focus in serving only tribal people to all rural people in the vicinity of the PHCs in rural areas. Starting in Karnataka, the Trust at present manages 71 PHCs in seven states of India (Karuna Trust, 2020). Comprehensive Primary Health Care with innovative initiatives of integrating vision centres, mainstreaming traditional medicine, community mental health, telemedicine, emergency medical services, management of communication disorders, mobile dental care along with enabling 24x7 services are the key differentiators in the health services offered by this model. This model is currently being included under

National Rural Health Mission (NRHM) and state governments like the Government of Arunachal Pradesh are practicing it with other NGOs as well.

As per this model, the state governments handover physical and infrastructure of PHCs or Community Health Centres (CHC) to the selected NGO, along with existing equipment for a specific period of time, in which, the maintenance of such infrastructure becomes the responsibility of the NGO. The NGO is also responsible to engage appropriate number of health workforce to keep the PHCs/CHCs operational for 24 hours. A formal Memorandum of Understanding (MOU) is signed under which government pays for the services of the NGO for keeping the infrastructure operational and provision of services to the target rural people. To ensure the 24 hours operation, all staff of the NGO are required to stay within the PHC premises as per the MOU (Department of Health and Family Welfare , 2021).

One of the effectiveness of this model was reduction of parallel practices of primary healthcare provision, which they NGOs were doing in those areas under donor funding, something which was getting difficult for them with the gradual shrinking of development funding in India (Nair, 2008). The NGOs realized that managing 'micro- level interventions' and establishing parallelfacilities would only solve the problem of poor services to some extent and scaling upto larger levels itself was restricted due to resource limitations. The NGOs thereforefelt that it was more prudent to utilize the vast but inefficiently used government infrastructure to upscale and improve services and also bring the state and the community together on to a common platform and thus started work with the state in the PHC (Nair, 2008). Within the Department of Health and Family Welfare (DH&FW) of state governments, the understanding of the purpose of partnership was mixed, with most of the officials at the state level viewed the partnership as a matter of convenience and a policy imperative which would be sustained in the future (Nair, 2008). According to them, within the model, the NGOs could easily recruit competent health workforce and ensure their retention for provision of quality services. However, there were others who were convinced that the partnership with the NGOs was the result of 'political pressures' and the outcomes were not impressive (Nair, 2008). Besides, most of the NGO managed PHCs focused largely on the curative aspects and did not adequately plan and implement the National Programme. The fact that the NGOs were trained by the Government as part of the partnership was interpreted to imply that the Government was more qualified and hence there was no relevance in handing over PHCs to NGOs.

In practice the dynamics of the relationship between the NGO and DH&FW could be reflected at two levels - more positive at the state level, while a mixture of acceptance and reluctance at operational level. At the state level there was general willingness of decision makers to continue with the experiment as a potential strategy for managing remote PHCs. On the other hand at the district and taulaka levels, there was a range of reactions from perceptible reluctance to placid acceptance or active support (Nair, 2008). While, some saw it as an unnecessary intrusion by an agency that is allegedly unable to perform better than the government, others were informed enough to appreciate the advantages that the NGO offer. There were also a few who simply accept it as one of the many projects of the government which need to be implemented according to the rules.

The relationship between the NGOs and the DH&FW was informed and cordial at the level of the state but generated a mixed response at the implementation level. It was a relationship that was clearly pushed by the NGOs in the initial stages and well accepted at the policy making level. However, the tensions at the operational level and almost single focus on the PHC, limited its impact, although it has been successful as a model of an efficient PHC responding tocommunity needs.

2.2.3 Government's partnership with PRSP, the Health sector case in Pakistan

For many years, Pakistan has had a wide network of Basic Health Units (BHU) spread across the country, but their utilization by the population in rural and peri-urban areas remained low. Since late 1990s, in an attempt to improve the utilization and performance of these public primary healthcare facilities, the government started contracting out of these BHUs to NGOs. In 1999, 3 BHUs were

initially contracted out to Punjab Rural Support Programme (PRSP), an NGO, more specifically, a government-owned QUANGO (Quasi-Autonomous NGO). Under the partnership, the entire government budget for running the BHUs was transferred to PRSP. The model was observed to be particularly desirable because under it the government continued to take the responsibility of the financial cost of running the BHUs but transferred the government annual budget for those BHUs to the NGO and also gave it complete freedom to utilize the budget as it deemed fit (Bano, 2018). The government provisioned budget covered the salaries of all the staff at the BHUs and paid for medicines and all other running costs. The only financial cost for the NGO was the salaries of the management staff; it employed five or six employees in each district to manage the program.

Studies demonstrated that PRSP was able to record dramatic improvements in performance: the problem of staff absenteeism disappeared, patient turnout increased, government-supplied medicines which in the past always seemed to be out of stock were now available, and all these improvements were recorded within the existing budget (World Bank, 2006). However, this case was able only to render technical solutions, which did improve provision of services but without bringing about any systematic change in the working of the relevant government agencies. Consequently, the betterment in service delivery in this case was only temporary, with no evidence of long-term sustainability. Later studies found that contracting of the BHU management did not have any effect on health care use generally in the population (Malik, Poel, & Doorslaer, 2017).

PRSP has had limited influence on the government's standard operating practices regarding running the BHUs. The model failed to win over the health bureaucracy, which actively resisted the program from its very start, and in 2008, the Chief Minister of Punjab actually announced that PRSP was to return the management of the BHUs back to the Ministry of Health. The follow-up fieldwork in 2016 showed that due to the change of government after the 2008 elections, PRSP was able to manage an extension of the BHU management contracts. However, the replication of the model to other districts has been very slow, and to date, the health bureaucracy is being reluctant in formal adoption of this model (Bano, 2018).

Bano identified several factors for the PRSP model not being replicated widely across the country, as described below:

- The technical expertise assumed the form of managerial practices would yield improved service, and did not focus on the actual health service delivery improvement in the form of more service providers, quality service providers, improved technology, etc.
- The partnership was based from the beginning on a formal contract, however, the contract was not a very specialized document, or very stringent in laying down the duties and restrictions.
- The project persisted despite active resistance from the bureaucracy, owing to the continued backing of political leaders, which was partly due to chance. The bureaucracy, which lost control over the BHUs' budget, had, however, showed firm resistance to this model, thereby hindering its formal adoption by the ministry.
- Collaborations negotiated through political pressures assisted PRSP to by-pass lower-level government officials, rather than trying to engage with them and make them change their way of working.

2.2.4 Contracting-out Basic and Primary Health Service (BPHS) Delivery in Afghanistan

In December 2001, a new democratic government was established in Afghanistan with international support. The new government inherited extreme disorder in the health sector. No policies were in place to guide the delivery of services and there was a notable lack of coordination among the many actors working on health. The health sector was characterized by the absence of infrastructure, lack of capacity in the public sector, the shortage of health human resources, and inconsistency in the quality of services being delivered (Waldman & Newbrander, 2014). May 2002, the Ministry of Public Health (MoPH) established a Basic Package of Health Services (BPHS) with technical support from donors and international organizations. The BPHS was designed to ensure equitable access to a core set of health services in remote and underserved populations. In recognition of the extent of its problems, the Afghan health sector adopted a new paradigm for operations. While health care services were regarded previously as a state responsibility, in 2002 the MoPH and its development partners decided to contract-out (CO) delivery of vital health care services to non-state providers (NSPs) (Hansen, et al., 2008). The MoPH launched BPHS implementation in 2003 with financial support from the United States Agency for International Development (USAID), the World Bank (WB), the European Union (EU) and others in the international community. 31 of 34 provinces were contracted with NSPs and were supported by different donors. As a result, different contracting mechanisms were established to implement the standardized and unified BPHS across the country. The MoPH served as the steward and owner of the program. The program's impact was evident in increased health services coverage (defined in terms of having a health facility within walking distance), from 9% in 2002 to 67% in 2015, and improvements in health systems performance indicators including maternal and child health (Akseer, et al., 2016). As a result of the CO, access to and utilisation of primary health care services in rural areas increased dramatically because the number of BPHS facilities more than doubled; supply of essential medicines increased; and the health information system became more functional (Newbrander, Ickx, Feroz, & Stanekzai, 2014).

While some contextual factors facilitated the CO (e.g. MoPH leadership, NSP innovation and community participation), harsh geography, political interference and insecurity in some provinces had negative effects. Contractual factors, such as effective input and output management, guided health service delivery. Institutional factors were important; management capacity of contracted NSPs affects their ability to deliver outcomes. Effective human resources and pharmaceutical management were notable elements that contributed to the successful delivery of the BPHS (Salehi, Saljuqi, Akseer, Rao, & Coe, 2018).

Another success factor of the model was the explicit policy of MoPH to collaborate with NGOs, which ensured bureaucratic support at policy, as well as implementation level, and helped the NGOs effectively carry out their activities (Siddiqi, Masud, & Sabri , 2006). Moreover, there were specific performance monitoring indicators for NGOs, and their payment was tied to the achievements of these indicators. There were third party monitoring to ensure the NGOs achieve their set performance indicator before release of payment.

2.3 Key Lessons Learnt from Global and Regional Evidences

i. **Value Addition**: Overall, the introduction of NGOs into a GO-NGO partnership adds value and creates synergy in generating positive outcome on health systems and health service delivery. It was seen in all type of collaboration, be it may be a contractual service delivery models (case of Karuna Trust India, BHU Pakistan, BPHS Afghanistan), patronage (GHS partnerships in Ghana) or network representations (the case of CONAMUSA Peru) - both GO and NGO partners added significant value to the partnership. From reviewing the case studies, it was observed that in the effective collaborations, the GO partners contributed with legitimacy and institutional support, facilitative regulatory mechanism, resource channeling and resource allocations and access to public infrastructure, whereas, the NGO partners contributed with management specialisation, client/beneficiary-centric low price and quality service design,

funding, expertise and community mobilisation. There were value additions not only to the outcome of the partnership, i.e. improvement of health systems and health service delivery, but also on institutional capacities of the participating GO-NGO partners. For government, the partnerships brought in fulfillment of its mandate of improved healthcare for unserved and underserved people, expansion of service network to previously hard-to-reach geographical locations and efficiency in resource utilisation. For NGO partners, there were enhanced image among the community and in front of donor communities, increased competitive advantages in competing with other NGOs for fund securing, influence in national agenda, high visibility and credibility and shared risk. So effective GO-NGO partnership in health seems to be a "win-win" situation for the participating partners.

ii. **Complementarity and Interdependence in Partnership**: In general, partnership require complementarity among its partners for effectiveness and sustainability. When a partner complements an expertise or skill of the other partner - they become interdependent and assume equal ownership and responsibility in the partnership, which is an important driving force for the sustenance of any collaboration. Identification of partnership opportunity, thus, largely depends on identification of "lacks" in partners' capacities and addressing those with self-organisational strengths and expertise. The case studies of Ghana, the MSP in Ethiopia and Karuna Trust Model can be exemplified here for complementarity, whereas such complementarity in capacity and value addition was not seen as universal in the MNGO scheme of India, resulting in additional efforts from government to build capacities of even some of the MNGOs (Bhat, Maheshwari, & Saha, 2007).

iii. **Buy in from Policy Makers as well as from Bureaucracy**: A critical aspect for GO stakeholders in GO-NGO partnership is the involvement of politicians as policy makers and bureaucracy as implementer. For effective GO-NGO partnership, buy-in from both this wings of GO is needed into the partnership concept. If the example of Pakistan is considered here, getting political popularity was one of the major motivation for designing the model, and there were not enough efforts to convince the bureaucracy. As a result, there was non-cooperation, even resistance from the bureaucracy, resulting in the project not being scaled up into larger areas, in spite of its apparent successes. On the contrary, the similar model of contract-out of government facility in Afghanistan had blessings from both policy makers and bureaucrats, with both being convinced regarding the necessities of the model for expansion of primary healthcare at rural areas. As a result, there was a explicit policy developed by the policy makers, with specific role of bureaucracy to support the implementation, which the NGOs got during their service delivery.

iv. **Formal vis-à-vis informal partnership:** From the global and regional evidences, two type of partnership can be visible. For example, the GO-NGO partnership in case of Togo was found to be informal, not a written contract or MOU, and more of an "Agreement in Principle", which, later, found to be creating lack of trust and active mistrust among partners, and even, a dearth of commitment from the partners (Aleyao, 2016). Similarly, in the case of PRSP, Pakistan the partnership was based from the beginning on a formal contract, however, the contract was not a very specialized document, or very stringent in laying down the duties and restrictions of each partner. On the other hand, the partnership in Karuna Trust model was developed based on specific MOU, designating role and responsibility of both the government and the NGO partners. This formal nature of partnership increases the accountability for each stakeholder involved. However, having said so, the formality also depend on the nature of the partnership. While the Pakistan, India and Afghanistan model of partnership was based on service delivery, the CONAMUSA case of Peru was more of a network representation, and may not require a formal contract or agreement among the stakeholders.

v. **Importance of Communications:** Clear communication and information dissemination among partners is another key aspect of effective collaboration, and absence of such create the mistrust, which has been viewed as a common problem for GO-NGO collaborations (Aleyao, 2016). The case study of Togo showed that government officials did not readily share significant information with their local/national NGO partners. Similar issue was also found to be in MNGO scheme in India. In both cases, the government partners viewed the NGO counterparts more of a "contractor" rather than partner in the collaboration, which may caused the reluctance of GO stakeholders not sharing information or only sharing information on "need-to-know" basis. Lack of openness in communications and limited information share also create lack of transparency and mutual suspicion among partners' financial contributions, which was seen in the case of Ghana partnerships (Issaka & Issaka, 2016).

3. GO-NGO COLLABORATION IN HEALTH SECTOR OF BANGLADESH: CONTEXT, EVIDENCES AND LESSONS LEARNT

3.1 GO-NGO Collaboration in Bangladesh: Historical Context and Overview

In the then East Pakistan, organized voluntary development activities were carried out by various Christian Missionaries, foreign funded research organization like Cholera Hospital at Matlab/ ICDDR,B and some private philanthropy. The Missionaries used to run some schools and hospitals mostly for the poor and disadvantaged family members. Mentionable private philanthropic activities were carried out by Kumudini Welfare Trust in areas of health and education. Although all these activities were small compared to dominant Govt. institutional activities, public perception about the qualities, dedication and commitment was very high.

During the Liberation War in 1971, International NGOs became very active to provide succor to the refugees and war affected people. The sprouting of initial health related activities in organized way was with the establishment of a field hospital for the injured and serious war-victims. After the war, INGOs and newly registered local NGOs like BRAC and Ganashasthya Kendra were mostly involved in relief and rehabilitation activities including medical aid to address the urgent needs of the refugees and other war-affected people.

In the middle of 70s, with the funding from development partners, NGOs initiated activities in the fields of promotive, preventative, curative, and rehabilitative health care and also towards the promotion of family planning services. Initially, major involvement was from the international NGOs, however, very soon, the participation of national and local NGOs also began in the health and family planning sector. Some NGOs carried out their own, independent programmes while many others collaborated with the government in strengthening as well as in implementing government programmes. Government-NGO collaboration emerged and expanded in the 1970s and 1980s on national programmes relating to tuberculosis, leprosy, immunization, family planning and nutrition.

During the mid-1990s, development partners became increasingly enthusiastic in involving NGOs in providing basic health services. There has been an increasing effort to involve NGOs in policy dialogue, programme formulation and implementation. There was significant involvement of development partners and NGOs for the development of first Sector Wide Approach Programme (SWAp) in Bangladesh, known as Health and Population Sector Programme (HPSP), which continued throughout the first four SWAps and expected to be in place for the design of the upcoming fifth SWAp. Notable contributions were from NGOs and civil society organisations in formulation of National Health Policy, 2011, National Population Policy, 2015 and National Nutrition Policy, 2015, in the form of advisory services, technical assistances and participation in multi-stakeholder dialogues and platforms (MOHFW, 2017). The 4th SWAP, i.e. 4th Health, Population and Nutrition Sector Programme (4th HPNSP) included multiple collaborations with NGOs in the areas of maternal health, child health, reproductive health, adolescent health, communicable disease control, non-communicable disease control and family planning.

The involvement of NGOs in the implementation of large donor funded health projects has demonstrated a significant increase in recent years. The HPSP, UPHCP, HIV/AIDS prevention and Care and Tuberculosis Control are a few major examples of these projects, where special project mechanisms were developed for the involvement of NGOs in the implementation process (Alam, Whose Public Action? Analysing Inter-sectoral Collaboration for Service Delivery, Country Review, 2007). In its seventh, and recent eigth Five-year Plan, the government recapitulated the significance of the GO-NGO collaboration in health care and birth control. As per experts, such collaboration is

essential at the grassroots level, especially for rendering basic health services, spreading health education, motivating contraceptive users, and so on (Haque, 2004).

Collaboration between the government and NGOs in TB, maternal and child health and family planning, extended Programme of Immunization, leprosy elimination and nutritional programmes are examples which has been effective and efficient. CARE-Bangladesh's reproductive health project, BRAC's health and development programmes, and the leprosy control programmes of Health, Education and Economic Development (HEED) are among successful implementations of GO-NGO collaborations.

One particular area of GO-NGO partnership is evident in the actualization of community-based nutrition in rural Bangladesh where malnutrition is a serious health problem. More specifically, the implementation of the Bangladesh Integrated Nutrition Project (BINP) (supported by the World Bank and the UNICEF) has engaged partnership between the government, the community, and NGOs (Ahmed, 2000). The successor of BINP, known as National Nutrition Services (NNS) continued collaboration with NGO, although through a special modality, known as "Multi-sectoral collaboration for nutrition" (NNS, 2017). This is discussed further in later sections. Similar GO–NGO partnership can be observed in urban health care for the underprivileged people living in slums (Haque, 2004). Local governments have experience of working with NGOs in determining sites for setting up of community clinics, social mobilizations and sanitation programmes.

During the last two decades a large number of NGOs have been involved in providing basic health services, including participation in most of the components of PHC. Within the early 2000 the number of NGOS involved in the Health sector was significant. The World Bank's 2006 survey identified 149 NGOs involved in health and nutrition, although it found that five large NGOs dominated the sector (World Bank, 2006).

3.2 Existing Regulatory Instruments Governing GO-NGO Partnership in Bangladesh

Foreign Donations (Voluntary Activities) Regulation Act, 2016

On October 5, 2016, Bangladesh's Parliament passed a new law, titled, the Foreign Donations (Voluntary Activities) Regulation Law 2016, which regulates the work and activities of foreign-funded NGOs. The new law repealed the Foreign Donations (Voluntary Activities) Regulation Ordinance, 1978 and the Foreign Contributions (Regulation) Ordinance, 1982. The act empowers NGO Affairs Bureau (NGOAB), under Prime Minister's Office (PMO), to inspect, monitor and assess NGO activities. The act stipulates that no NGO can undertake or conduct any voluntary activity funded by foreign donations without the approval of the NGO Affairs Bureau. If any individual wants to undertake voluntary activity and conduct it, then he or she would not require any registration for taking donations, rather he or she would have to take approval from the Bureau. Besides, if any NGO or individual passes any indecent or discriminatory comments against the constitution or any constitutional organization or conducts any anti-state activity or finances any terrorist and militant activity or patronises, or gets involves in children and women trafficking, engages in arms and drug smuggling, then it would be considered as an offense as per the existing law of the country. As per the Bill, no individual or NGO would be able to take foreign donations without approval of a specific project while the activity of that individual and NGO would have to be limited within the scope of project. With the passage of the Bill, it would empower the NGOAB to cancel the license of NGOs for violations of the law and irregularities. It is mentioned in the Bill that any NGO would get registration for 10 years for conducting its activity subject to the opinion of the Ministry of Home Affairs and the Ministry of Finance. But in cases of violation of any law, the registration could be cancelled or suspended. According to the Act, NGOs receiving foreign funding must register with the NGO Affairs Bureau, submit to inspections by it regularly and seek the Bureau's approval for all planned activities before receiving the donations.

The Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961 (Ordinance XLVI, 1961)

An organisation, association or undertaking established for the purpose of rendering welfare services and depending on public subscriptions or government aids is regarded as a voluntary social welfare agency. Such agencies are required to be registered under the Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961. All formal as well as informal organizations established to provide welfare services for children, youth, women, family, physically or mentally handicapped, family planning, recreation, civic responsibility, released prisoners, juvenile delinquents, socially handicapped, beggars and the destitute, patients, the aged or infirm, social work, or co-ordination of social welfare agencies must be registered according to the provisions of this ordinance. However, registration is not applicable for, art, science, culture, environment and other non-profit organizations of similar disciplines under this ordinance. All non-profit organizations which have been registered under this ordinance will be administered by the Social Welfare Department of the Ministry of Social Welfare and this department has the right to suspend or dissolve an organization which is involved in unlawful activities and without any exception, no judicial appeal will be permitted against the decision of the Social Welfare Department under this Ordinance. Where a non-profit agency is dissolved by the authority, the government may order a bank or person who holds money, securities or other assets on behalf of the agency not to part with it without the permission of the government; to appoint a competent person to institute and defend suits on behalf of the agency and to take such action as and when necessary. The government may also order the transfer of any money, securities and assets of the affected agency to another agency with similar objectives after discharging all debts and liabilities of the agency concerned. Such decisions may be appealed, but the decision on appeal is final as it may be reviewed in court. It is noted that most non-profit organizations are registered under this Ordinance.

The Societies Registration Act 1860

The most commonly used legal enactment governing philanthropic activities in Bangladesh is the Societies Registration Act 1860 adopted during the British colonial period. The Act lays down the parameters for the formation, management and control of societies. Section 20 of the Societies Registration Act 1860 provides that societies that may be formed and registered include a wide range of organisations, such as, charitable societies and societies established for the promotion of science, literature and fine arts; societies for the foundation and the maintenance of libraries, public museums and collections of natural history, mechanical inventions and philosophical enlightenment. A great majority of non-profit organisations in Bangladesh are formed and registered under this act because of its wide scope and flexibility to permit a broad range of activities. Seven or more persons associated in any literary, scientific, charitable purpose or any other similar purposes may apply to the Registrar of Joint Stock Companies to form a society by subscribing to its memorandum of association, accompanied by the society's rules and regulations. There must be a formal governing body, constituted under the law, which is responsible for the management of the affairs of the society, in accordance with the rules and regulations attached therewith. Societies must hold annual general meetings except where their rules allow otherwise. Special meeting may be convened to consider a change in a society's purpose. These changes require a three-fifths vote. Societies established under the Societies Registration Act automatically acquire legal status and can enforce their rules against the members to hold bank accounts under the society's name, and can sue and be sued in legal proceedings. Since it is a non-profit organization, a society's members are barred from gaining a pecuniary benefit from the society. If a member misappropriates the society's money he shall be subjected to a criminal prosecution. From the above discussion it is seen that the Societies Act states the requirement of an annual meeting of the executive members of the society only but the Act is silent on the annual accounts. Besides, there are no provisions for fines, penalties, or involuntary dissolution should the commission of any misdeed in the society is encountered to redress the issue.

The Trust Act 1882

The Trust Act provides legitimacy to charities by setting up a trust for the benefit of children, for public good, or for religious purpose. Many non-profit organisations prefer to establish the trust under the Trust Act 1882 because it affords relatively greater flexibility in terms of status, registration and management. Usually an organisation creates a trust through a trust deed specifying the intention of the author of the trust. Certainty of words in unambiguous terms indicating intention, subject matter and specific objective are required for the creation of a valid trust. By registration of the trust deed the concerned organisation can start functioning. A trust may be created for any lawful purpose which is not prohibited by law or does not defeat the provision of any law or is not fraudulent or does not injure any person or property of another person or is not considered by any court as immoral or opposed to public policy. A trust created for unlawful purposes is automatically rendered void. Where a trust has two purposes, where one is lawful while the other is unlawful, the whole purposes shall be void if the two purposes cannot be distinctly separated. A trustee cannot deal with a trust property for his or her own profit or for any other purpose not connected with an express purpose of the trust. A trustee is not entitled to remuneration in the absence of an express provision in the trust deed or the consent of the beneficiary or the order of the court. A trust created under the Trust Act 1882 may be extinguished when its purpose is fulfilled or when its purpose becomes unlawful or when the fulfilment of its purpose becomes impossible to implement on account of destruction of the trust property or a revocable trust is expressly revoked.

The management of a trust is undertaken by a Board of Trustees. It is the main duty of a Board of Trustee to protect the trust property and enhance it to its maximum benefit. The trust deed defines the composition and functions of the board. A trustee who has accepted the trust cannot afterwards renounce it except with the permission of the court or with the consent of the beneficiary, or by virtue of a specific provision in the trust deed. Whenever any trustee disclaims a trust or remains absent from Bangladesh for a continuous period of six months; leaves the country for good or is declared insolvent; or is otherwise incapable, unfit or dies or the trust is extinguished or trust duties prescribed by the trust deed are completed but not giving any benefit to the trust, the office of the trustee will be deemed to be vacated and new trustees may be appointed. A trustee is bound to obey the lawful direction of the author of the trust faithfully. However he or she will not be obliged to obey any direction that would be impracticable, illegal or manifestly injurious to the beneficiaries where there is more than one beneficiary, the trustee must be impartial and cannot cause any discrepancy. A trustee is bound to maintain clear accounts of the trust property. On request by the beneficiary the trustee shall furnish him with detailed information on the amount and state of the trust property. Any trustee without instituting a suit may seek the opinion and the direction of the civil court in respect of the management of the trust property wherein the trustee shall act upon the advice or direction of the civil court. Where the trustee commits a breach of trust he is liable to make good any loss he incurs to the trust property or the beneficiary. From the above discussions, it is seen that a trust may be wound up if the purpose of the trust becomes illegal and a competent court may give order to a trustee to fulfil a duty or remove a trustee on the basis of the application of the beneficiary. The Act has also stated that each non-profit organization must maintain clear accounts but charitable status rules are unclear here, hence, the status of the charitable trust and their tax system should be made distinctively clear.

The Companies Act 1994

Companies are primarily concerned with the business and the Companies Act regulates their activities. But the companies Act 1994 contains provisions that permit registration of nonprofit companies provided that they conform to the rules and regulations of a company with limited liability. An association will be incorporated as a non-profit company when it obtains a license from the government under Section 28 of the Companies Act. The government will grant license when it appears that the association will promote commerce, art, science, religion, charity or any other useful objectives and it

will apply its profits or income to promote its objectives without paying any dividend to its members. These types of welfare oriented companies may be incorporated as companies limited by guarantee.

To form a non-profit company a Memorandum of Association and Articles of Association should be prepared. The Memorandum of Association contains conditions limiting the activities of the company which are not generally alterable without the approval of the High Court. The Articles of Association provide the rules for regulating the affairs of the company, which are easily alterable.

After completion of the documentation it is submitted to the Registrar of the Joint Stock Companies which is under the control of the Ministry of Commerce. If the Registrar is satisfied that the requirements of the Companies Act have been complied with he will grant registration and if he refuses registration, he shall communicate the grounds of refusal and the applicant may appeal to the government whose decision is final by virtue of the fact that the government may at any time cancel the license granted to an organisation which then ceases to enjoy the exemptions and privileges granted under Section 28 of the Companies Act. However, before a license is cancelled, the government shall notify the association expressing the grounds for such decision and shall give an opportunity to the organization to defend itself.

Besides cancellation of the license, non-profit companies may be wound up either by the court or voluntarily without the intervention of the court or voluntarily subject to the supervision of the court. If a company is wound up, its assets are converted into money and shall be used to settle its debts. After satisfying the creditors, the balance is returned to the shareholders. If the company fails or becomes unable to pay its debts or fails to file the statutory report, or adopts a special resolution to the effect that the company would be wound up by the court which will then effectively wind up the company. Where there is an extraordinary resolution to wind up a company, a notice must be given in the official gazette as well as in the newspaper. A voluntary winding up of the company may be initiated either by its members or by its creditors.

A non-profit organisation if registered as a company becomes a corporate body and is governed by the Companies Act. But its distinguishing feature is that it is a philanthropic body committed to non-profit work of charity and accordingly enjoys certain privileges. It may hold property, enter into contracts, and can sue and be sued in the name of the organisation. The management of a non-profit company rests on the Board of Directors. The distribution of power between the Board of Directors and the members are usually specified in the Articles of Association which can be easily amended from time to time in a Board of Directors' meeting. The Board of Directors cannot give any undue facility or advantage to any director. A director cannot hold any office of profit except with the consent of the company in a general meeting. Without consent of the Board of Directors, a director cannot enter into any contract for sale, purchase or disposal of the company's goods.

The *Waqf* Ordinance 1962

Like the English concept of trust, an institution of *waqf* is noticed in the Muslim Law which is enforced in Bangladesh. An owner of a property, both movable and immovable, can settle his property for the use of beneficiaries in perpetuity. The owner by a declaration in an instrument can create a *waqf*. The property so settled is known as the *waqf* property and the person who creates the *waqf* is known as a waqif.

The *waqf* is administered by a trustee who is known as a mutawalli in accordance with the conditions of the *waqf* instrument. The *Waqf*s Ordinance 1962 requires all *waqf*s to be registered at the office of the Administrator of *Waqf* through an application filed by the Mutawallis of the *waqf* property. On receipt of the application, the Administrator shall proceed to register the *waqf* property after which, the Administrator maintains its detailed information in his register, including the deeds, the name of the mutawalli, and the rules of succession to the office of mutawalli.

The 1962 Ordinance does not have any provision for dissolution of the *waqf* since it involves a permanent dedication of a property. But the ordinance empowers the *Waqf* Administrator to take over and assume the administration, control and management of any *waqf* property when it is noticed that the objectives of the *waqf* are not being carried out properly in the spirit of its intended purposes and in the occurrence of this event, the Administrator or the waqif can access the court and seek its directives in this regard.

3.3 Evidences of GO-NGO Collaborations in Health Sector of Bangladesh

3.3.1 National TB Programme (NTP)

The overall objective of the National Tuberculosis Programme was to reduce the transmission of TB until it is no longer a public health problem. The immediate goals were to increase the cure rate of sputum smear-positive cases to 85%, and to increase case detection to 70% of the estimated incidence. Internationally recognized DOTS was initiated in 1993 but limited capacity and quality remained a huge barrier . Lack of physical infrastructure and properly trained health and laboratory personnel were the main obstacles. Even though the DTS population coverage was nominally 95%, the estimated case detection rate was only 32%. In reality, only half of the population truly had access to DOTS programme, which explains the large difference in population coverage and case detection rate. Following the International guidelines, the Bangladesh NTP was mainly clinic-based. One research conducted in 1997 found that only one bed was available per 500 TB cases (Chowdhury, Chowdhury, Islam, Islam, & Vaugh, 1997). The lowest level health facilities providing TB care were Upazila health complexes. Most of the facilities lacked skilled staff equipment and drugs, especially in rural areas.

To address the challenges, Government of Bangladesh (GOB) signed MOU with six NGOs. The main objective of the Memorandum was to outline specific tasks for the government and partner NGOs in the delivery of DOTS in defined areas. Area of collaboration included setting up policy; implementation; case finding and case holding; training; drug supply ; monitory and supervision; behavioral change communication . The government's role was constructing national policies and strategies supporting collaboration, setting up national TB guidelines and protocols, providing equipment and lab supply, supplying training materials and training the trainers , ensuring central procurement of drug supply, conducting national campaigns and coordinating the overall programme. The NGOs actively took part in utilizing its resources in specific areas. Their contribution involved diagnosis, treatment, follow up; late patient tracing; local storage and distribution and local campaigns.

In 2003, NGOs provided services to 259 upazilas (56% of all upazilas) and in four metropolitan cities in collaboration with the government. In supporting the NTP, the role of NGOs were vital in TB service delivery, management support, operations research and social mobilization. The NTP provisioned treatment protocols, policy guidelines, logistic supplies (drugs, reagents and equipment) and training, while NGOs provided supervised treatment at the community level, promoted active case finding and raised awareness about TB among the general population. The increase of coverage and detection rate shows that the collaboration with NGO led to gradual and steady improvement in key areas of TB control. It was also effective in enhancing the technical capacity of staff and maintaining the standard quality. TB treatment coverage increased to 81 percent in 2019; deaths among TB/HIV-negative patients decreased to 24 per 100,000 in 2019; and a high treatment success rate (TSR) of more than 90 percent for drug-susceptible TB (DS-TB) cases has been maintained (WHO, 2020).

External reviews conducted to assess the collaboration, recognized GO-NGO collaboration in Bangladesh identified NTP as a major success. The reviews pointed out that the government's commitment to TB control was evident, while NGOs have increased the coverage, quality and sustainability of their services by utilizing their resources to provide standardized treatment to TB patients, particularly in remote, rural areas. Internal evaluations were also carried out by the NTP and the partner NGOs. Common learnings suggested that the collaboration was effective in increasing coverage; NGOs were instrumental in increasing awareness; unified reporting system ensured full

account of programmatic performance, autonomy in deciding operational strategy within the NTP guideline ensured both independence and accountability.

3.3.2 Expanded Programme of Immunization (EPI)

The Expanded Programme of Immunization (EPI) comprising vaccination against six diseases: neonatal tetanus, polio, diphtheria, measles, tuberculosis and pertussis, was globally launched in 1974 and was formally initiated in Bangladesh on April 7, 1979. In 1985, GOB started a phase-wise process of EPI intensification through partnership with NGOs. The government and donors realized that mobilization of both effective consumer's demand and resources to provide immunization are two key elements in achieving a rapid and sustainable increase in immunization coverage. The past observation showed that although the government health sector was good in supplying information and inputs but their performance in creating the demand for immunization was not satisfactory. On the other hand NGOs had good previous performance in creating demand among people through mobilization. Therefore, it was felt that by engaging NGOs in the EPI program of the government an effective functioning of both demand and supply sides of the program would be viable.

Government is the principal actor in EPI partnership. Other than providing policy guidelines by the central government, local government plays a crucial role in designing the need-based local level plans and programs, and in coordinating all the partners at the local level which is the key strength of the program. GOB purchases EPI vaccines with its own currency and provides the vaccines and other logistics e.g. syringes, safety boxes, refrigerators, record report forms to all related NGOs free of cost. Thus the government delivers vaccine, human resources, infrastructure, logistics and cold chain.

NGOs have bolstered the immunization program throughout the country through providing training for vaccinators, managers and communicators, providing immunization services in areas where government services cannot extend easily, providing many of the communication materials and activities which have largely assisted program expansion, and mobilizing local talent and resources for the program. Three NGOs namely, BRAC, CARE and RDRS provided extensive support to the EPI, each assuming responsibility for certain selected upazilas.

Quality assurance is conducted jointly by the government and NGOs. Government through continuous supervision ensures quality and NGOs themselves maintain quality of services. NGOs spread information and develop community awareness. The local government also plays role in mobilizing the community through providing communication materials.

EPI is one of the most successful public health interventions in Bangladesh, and has contributed significantly to reducing mortality and morbidity from vaccine-preventable diseases (Sarker, Sarker, Doulah, & Bari, 2015). As per the latest Coverage Evaluation Survey (CES), the valid full vaccination coverage by the age of 12 months was 83.9% (EPI, 2020). The service delivery mechanism of EPI throughout the country has been used as the role model and a platform to deliver other interventions.

The EPI program is a remarkable example of use of cooperative task performance strategies. From the start, a planned effort was made on the part of those cooperating together to clearly delineate the roles each member would undertake. Formal line of communication and informal lines of communication both were utilized as cooperative communication strategy. Informal lines of communication happened in Bangladesh immunization program where meetings of those involved in this project focused in developing good working relationships at the personal level between the government and NGO workers. The partners agreed that efforts should be made to develop a harmonious working atmosphere through fostering better relationships among the workers involved.

NGOs concentrated on creating a largescale awareness for immunization services through motivation and campaigns. While doing this, NGOs also helped the government in preparing a list of children and mothers to be immunized. NGOs trained mothers on a purely voluntary basis to encourage them to get their children immunized. Furthermore, the NGOs motivated upazila chairman, union parishad

chairman and members of local level clubs, village defense parties, rural doctors, local unemployed youths, religious and community leaders. They were engaged in increasing the scale of community involvement and motivating communities on a continuous basis.

Regular communication among the partners grew a strong sense of ownership among them. Each partner (both the service providers and the recipients) received rewards for his/ her performance. 'As providers', NGOs and field workers, and 'as recipients' mothers of children who conducted the whole vaccination, were given awards for their performance. As a result, a good sense of competition grew amongst the partners. The performance award was distributed by the Deputy Commissioner, which again, worked as an additional motivation to the implementation of the program from all sides.

EPI had a strong functioning monitoring system. Although in the beginning, supervision and monitoring were weak but gradually, in course of time, it was systematized. Government officials, donor agencies and NGOs all worked to ensure that the program was being supervised regularly. Upazila officials and elected representatives of the union parishads (union councils) frequently visited the vaccination sites regularly and showed great interest in immunization. An efficient monitoring system was on place. The record of vaccination is maintained on a daily tally sheet at vaccination sessions and compiled in a monthly reporting form. NGOs through continuous monitoring diminished wastage of resources and secured timely arrival of vaccine from the centre.

3.3.3 Nutrition Programme - A Challenging Model of Partnership

Before the introduction of NNS, blended into regular responsibilities of Institute of Public Health Nutrition (IPHN) in 2011 in the 3rd SWAp, as the process of covering all the population in the country, nutrition-specific interventions of MOHFW used to be carried out as development project, and used to be implemented in selected geographical areas. In the initial phase it was known as Bangladesh Integrated Nutrition Programme (BINP) (1995- 2002) and in the later phase it was called the National Nutrition Programme (NNP) (2002-2010). BINP happened to be the first large-scale multi sectoral project on nutrition in Bangladesh, which was implemented through partnership with NGOs and the community. National Nutrition Programme (NNP) also inspired partnership with NGOs and the community as BINP did but the program outcome is not that satisfactory.

The BINP consisted of three components: 1) national nutrition activities including institutional development, IEC, and monitoring and evaluation; 2) Community-Based Nutrition (CBN) and (3) Intersectoral nutrition programme development, supporting schemes such as home gardening and poultry rearing. The Community-Based Nutrition Component (CBNC) was the central component of the project which included monthly growth monitoring and promotion (GMP) for children under two years of age and pregnant and lactating women (PLW), supplementary feeding of malnourished PLW and growth-faltered children under 2 years of age and nutrition education for pregnant women, mothers of children under two, and adolescent girls. The components of NNP stayed the same as BINP. Only the name of CBN changed as Area Based Community Nutrition (ABCN). Like BINP, ABCN was the main focus of NNP, which was implemented by NGOs.

NNP was conducted through government and NGO partnership. Planning, financing and logistics were the key responsibilities of government. The main sources of financial or technical assistance for the NNP were the GOB, the World Bank, Canadian CIDA and Netherlands Government. GOB also set up policy guidelines and other large-scale assistance and worked as the coordinating partner of the programme. GOB also played a central role in providing training (training of trainers of NGOs) and quality assurance. Similar to EPI, local government took a coordinative and managerial role in nutrition.

NGOs were delegated with the responsibility of a number of upazilas. GOB signed contracts with a small number of "lead" NGOs who may, in some upazilas or parts of upazilas, in turn associated a "smaller" partner NGOs to provide ABCN activities. Under the contract, the activities, mode of

payment, period of time for the work were specified. NGOs recruited only the Upazila Nutrition Manager (head of the nutrition programme) and 13 field supervisors whose salary was provided by the government. NGOs were also delegated the responsibility of GMP, training and advocacy, along with community mobilisation.

The programme did not achieve significant success. In 1996-97 the rate of stunted children under five was 55 percent, which dropped considerably to 45 percent in 1999-2000 but in 2004 the rate of decline (43%) was rather slow (Osman, 2008). The number of underweight children was reduced to 48 percent in 1999-2000 from 56 percent in 1996-97 though in 2004 the rate remained at the same level. The programme could only be extended to 105 of the 464 upazilas. Several evaluations showed that BINP, (a US$ 60 million project) and NNP (a $US 92 million project) couldn't succeed to produce an overall satisfactory impact on the level of nutrition of the people of Bangladesh. Later, in third SWAp, the entire implementation was taken up by government as an operational plan under 3rd SWAp, as NNS, delegating IPHN, an entity under Directorate General of Health Services (DGHS) with the responsibility of planning, stewardship and governance. The field structure of DGHS and Directorate General of Family Planning (DGFP) was made responsible to implement the nutrition specific (and some nutrition-sensitive) interventions at field level. Collaboration with NGOs are kept as one of the key activities of NNS, however, currently, GOB is not under any contractual obligations with any NGO for implementation of any nutrition interventions under NNS.

Partnership in nutrition programs couldn't generate a significant output. Some programmatic weaknesses as well as inefficiencies of the partners were the factors behind the poor outcome of partnership (Osman, 2008), some of which are narrated below:

i. Disruption of programme from 2002 to 2004, resulting flow of fund and creating dissatisfaction among NGOs as well as among community partners.
ii. Frequent change of program directions created uneasiness among partner NGOs.
iii. Change in payment procedure in NNP, which was perceived as complicated by the NGOs
iv. Complicated/lengthy procedure of renewing contracts with NGOs
v. Lack of managerial efficiency from government at both the central and local level
vi. Limited support from local level health and FP officials to NNP, as they did not own the programme
vii. Ineffective monitoring and supervision of NGO performance
viii. Inappropriate selection of NGOs
ix. Over dominance of government, leaving limited ownership and flexibility for the NGO partners

3.3.4 Four Phases of Urban Primary Healthcare Project in Bangladesh

By policy, the responsibility of primary healthcare at urban areas is the responsibility of Local Government Division (LGD) under Ministry of Local Government, Rural Development and Cooperatives (MOLGDR&C), and hence, MOHFW does not have its primary healthcare provision structure in urban areas. To fill up the gap of service provision without having its own health workforce, donors and LGD came up with the design of a project in which the primary healthcare services for the urban population would be provided by the contracted NGOs. The Urban Primary Health Care Project (UPHCP) was developed, financed, and implemented by the Government of Bangladesh (with financial and technical support from Asian Development Bank and other development partners) in 1998. The project had a design of contracting primary health care services to NGOs to improve and support urban health across Bangladesh amidst the growing urban population and increasing difficulties in unaided access to health care of the urban poor. UPHCP started in 1998 and covered the city corporations of Dhaka, Chittagong, Khulna, and Rajshahi and demonstrated increased maternal and child health care utilization with improved equity among the poorest half of the population. The Second Urban Primary

Health Care Project (UPHCP-II) (2005-2012), which is evaluated in this study, expanded coverage to include two additional city corporations, Barisal and Sylhet, and five municipalities, namely Bogra, Comilla, Sirajganj, Madhabdi, and Savar. The third phase project known as the Urban Primary Health Care Services Delivery Project (UPHCSDP) (2012-2018) covered 10 city corporations and four municipalities (more urban areas compared to the first two phases), and the ongoing fourth phase (UPHCSDP-II) (2018-2023) covers 12 city corporations and 13 municipalities (more urban areas than the first three phases).

The UPHCP-II modality of contracting primary health care services to NGOs follows the first phase's design. UPHCP-II financed 24 project areas, each covering 200,000 to 300,000 people, and established comprehensive reproductive health care centers (CRHCC) that provide emergency obstetric care, newborn care, and other specialized services. At least one PHC center catering to 30,000 to 50,000 people, and at least one satellite or mini-clinic per 10,000 people was established in each project. Currently, 24 CRHCC, 161 PHC centers, 24 voluntary counseling and confidential testing centers for HIV/AIDS, and 24 primary eye care centers were established. A set of health care services under UPHCP-II, called the essential services package plus, included immunization and growth monitoring of children; micronutrient support for malnutrition; family planning; prenatal, obstetric and postnatal care with special attention to prevent eclampsia; sexually transmitted infections, and HIV/AIDS; other reproductive health; and child health services. The project also included systematic case management of pneumonia and diarrhea in children; health education; sanitation, safe water and waste disposal; case management and services dealing with tuberculosis, leprosy, malaria, filarial and visceral leishmaniasis; and management of emergency cases.

Different stakeholders had different important roles in building the relationship: donors provided money and encouraged the participation of NGOs, whereas the government provided mechanisms for implementation through relevant government departments and agencies. The relationship of NGOs with government in UPHCP was shaped through a process of contact, consultation, dialogue and workshops. However, in practice, the previous contacts and consultation did not contribute much to creating better understanding in the implementation of the project by NGOs. As is the case with many such projects in Bangladesh, UPHCP was mainly a donor-driven government initiative.

By the early 2000s, there were alterations and uncertainties around the flow of external funds and aid modalities by donors. The rise of 'budget support' approaches accommodated a more direct approach by donors to working with the government and less direct funding of NGOs by donors. Funding that NGOs would have hitherto expected to receive directly from donors was increasingly being channeled through government, indirectly giving government greater control. Anticipating a further squeeze of direct donor funding, many NGOs in Bangladesh therefore found that it was prudent to undertake at least some government projects, even though this meant winning their funding through the unconventional routes of competitive bidding and contractual agreements.

NGOs were selected through a competitive bidding process based on some predefined criteria. There were formal agreements with the selected NGOs. The agreement was all inclusive and complete, inscribing the inputs the contractors were to make, the nature and type of activities that the NGOs would provide, and how they would relate to the client, along with payment modalities. As per Alam, this contracting process was viewed by the NGOs as barrier to creating relations with government, with a built-in assumption that the relationship was one of profit (Alam, 211). There were also issues with payment delays, during which, NGOs had to continue provision of services to sustain their reputation among the community people. NGOs also complained that government did not consider them as partners, rather contracted service providers, which reduced their (NGOs') involvement in decision making and strategy formulation, and eventually, decrease in ownership (Alam, 2011).

3.3.5 Family Planning (FP) Programme in Bangladesh

There has been progress in other FP indicators in Bangladesh. The population growth rate has now been reduced to 1.32% in 2019 from 1.37% in 2015 (BBS (a), 2020). There has also been reduction in dropout rates and unmet needs which stood at 37% and 12% respectively (BDHS 2017-18). The proportion of women of reproductive age (Age 15- 49 years) who have their need for FP satisfied with modern method has increased to 77.4% (BBS (b), 2020) from 72.6%. Antenatal care rate has increased from 31.2% in 2014 to 47% in 2018 and post-natal care has also increased from 33.9% in 2014 to 52.1% in 2018 (BDHS 2017-18). Household data of about one crore population had been collected and stored through the Population Registration System (PRS). Some of the mentionable FP activities are popularization of long acting permanent methods and increasing the use of contraceptives, providing clinical contraception and maternal, child and reproductive health services, BCC for awareness raising, etc.

Bangladesh Family Planning Program evolved through a series of development phases that took place during the last 52 years. Family planning efforts in this country began in the early 1950s with voluntary efforts of a group of social and medical workers. Categorical FP program emerged during 1965-95 with the objective to control population growth as a strategy of economic development. Since the beginning of the first SWAp, family planning was one of the two priority component of the SWAp delivery. However, the government upon review, decided in January 2003 to reestablish separate organisational structures and authority for health and family planning as they existed before July 1998. Accordingly, separate operational plans were design for family planning efforts in the second SWAp (2003 to 2010) and directorates under DGFP were given responsibilities to implement those.

NGOs were involved with the policy, as well as, field level activities of FP programme from the very beginning in the form of supporting policy formulation, capacity development, expansion of FP services in rural areas and hard-to-reach areas, including the clinical contraception services, and community awareness and community mobilisation. Although there are specific contract-out agreement with some NGOs, overall, the GO-NGO collaboration in FP programme is governed by the relevant policies and guidelines (e.g. National Population Policy, 2015; National Guidelines for Menstrual Regulations, respective Operational Plans, etc.). By policy, all the logistics required for FP programme are procured by government, i.e. DGFP, however, the responsibility to distribute those are jointly carried out by field structure of DGFP, as well as different NGO FP programmes working in different areas of Bangladesh. The distribution reports are uploaded into DGFP's own Management Information System (MIS) and the entire distribution process coordinated and monitored by DGFP officials, namely, Upazila Family Planning Officer (UFPO) at upazila level and Deputy Director (DD) - FP at district level. Also, by policy, NGOs can refer the patients to DGFP's clinical facilities in case of complicated cases in RH and clinical contraception services. NGOs also play a vital role in awareness creation and community mobilisation. Although they do it through their separate individual programmes, however, the uniformity of information is ensured through the communication strategy in RH and FP. Hence, the modality of collaboration between GO-NGO stakeholders is more informal. However, having said so, there are specific agreements of DGFP with NGOs. For example, a significant allocation of DGFP is made to Bangladesh Association of Voluntary Sterlisation (BAVS) for clinical contraception service delivery, particularly, long term and permanent methods. DGFP is in the process of contract out of clinical contraception services to Marie Stopes Bangladesh (MSB) in a few hard-to-reach areas. In addition, quite a number of NGOs are working with LGD under the UPHCSDP and USAID and DFID funded NGO Health Care Service Delivery Project (NHCSDP) as FP service providers under contractual modality.

3.3.6 Special Grants from MOHFW

Every year, MOHFW, provides special grants to a number of NGOs, to participate in different public health related interventions in their respective areas. There are two types of grants are allocated. The smaller grants, varying from BDT 50,000 to BDT 100,000 in a year is distributed among smaller, local

level NGOs. In 2020-21, it has been decided that a total of 682 NGOs[1] all around the country would receive this grant, with the condition that the NGOs would spend the money to any interventions relevant to health, population and nutrition, which would be monitored by the respective Civil Surgeons (CS). However, in reality, the amount is so insignificant that it is not possible to implement any meaningful interventions. Virtually, there has been no monitoring of these funds till date in MOHFW. So the effectiveness of this fund is not very clearly known.

The other type of grant provided from MOHFW is quite significant in size and are distributed among some of the large NGOs including BAVS, FPAB, Diabetic Association of Bangladesh (BADAS), TMSS, CRP, Bangladesh Breastfeeding Foundation (BBF) and Non-government run institutes including Dhaka Shishu Hospital, Chattogram Ma o Shishu Hospital, Ahsania Mission Cancer Hospital, OGSB Hospital, etc (Sabur & Abdullah, 2016). Most grant recipient NGOs are based in Dhaka city and so also urban area than rural, which, according to Sabur and Abdullah, goes against the principle of equity (Sabur & Abdullah, 2016). Sabur and Abdullah also found that the amount varies significantly for the NGOs every year, without any systematic evaluation or performance assessment. At the same time, some of the NGOs receive grants every year, although there were addition and deletion of names in the list. It was also found that NGOs receiving grants from MOHFW also received grants from other ministries in the same year for similar purposes.

Duration of grant were found to be varying from 0 year to 44 years, with no fixed duration for the awardees to receive grant. Same organization started soon after independence and continued till the time of assessment (Sabur & Abdullah, 2016). Others found to receive for 32 and 25 years. Monitoring and supervision of the awardees organizations suffered from systematic approach. Periodical visits of the MOHFW officials were done. However, the field level machineries of the MOHFW were not routinely involved. Concerned CS/Deputy Director-Family Planning or Upazila Health and Family Planning Officer/Upazila Family Planning Officer were not routinely copied with the quarterly allotment letter (Sabur & Abdullah, 2016). Awardees were required to submit audit and activity reports along with the lists of services provided free or at reduced costs, trainings and researches conducted. However meticulous reviews of the submitted reports were not found to be possible due to capacity constraints of the respective departments (Sabur & Abdullah, 2016).

[1] Office order from HSD, MOHFW, 17 June, 2021

4. CHALLENGES, OPPORTUNITIES AND STAKEHOLDERS IN GO-NGO COLLABORATION IN HEALTH

4.1 Important Stakeholders and Their Role in GO-NGO Collaboration

From the field findings and analysis, we identified the key stakeholders in GO-NGO collaboration and their roles. Important stakeholders and their role in GO-NGO collaboration at present is shown in the table below.

Table 1: Stakeholders and their Roles in GO-NGO Collaboration in Health Sector

Stakeholder	Specific Roles
HEU, MOHFW	• Recommend specific strategies with action plans for GO-NGO collaboration • Recommend specific collaboration mechanism • Recommend a monitoring mechanism to review progress of GO-NGO collaboration projects • Identify opportunities and review alternative options • Involve project design as expert • Review final design on behalf of MOHFW • Develop knowledge pieces and articles on successful GO-NGO collaboration project experiences
Planning Wing, MOHFW	• Conduct feasibilities of the proposed project (non-PPP) • Review options for funding and recommend funding (in case GO funding is involved) • Liaison with NGOAB to expedite the approval process, if required, in applicable cases • Monitoring of the progress of the project
PPP Cell, MOHFW	• Conduct feasibilities of the proposed project (PPP projects) • Review options for funding and recommend funding (in case GO funding is involved) • Liaison with NGOAB to expedite the approval process, if required, in applicable cases • Monitoring of the progress of the project
NGOAB	• Ensure due diligence of the collaborating NGO • Review the funding source (in case foreign fund) and provide NOC in funding • Provide NOC for project design after review • Other activities as per 2016 act
DGHS	• Identify potential collaboration opportunities and recommend to planning wing/PPP cell for feasibility • Participate in designing of the project, including specific activities, implementation plan and budget • Ensure duplication of efforts and resources in designing the project • Coordinate with other stakeholders at national and implementation level for smooth implementation of the project • Monitoring of the progress of the project and take corrective actions, jointly with NGO partners • Ensure open and free communications with the NGO partners to avoid any mistrust and ensure transparency • Regular dissemination of the progress of the project to encourage other entities to collaborate, including NGOs and development partners

Stakeholder	Specific Roles
Ministry of Social Welfare (MoSW), Ministry of Women and Children Affairs (MoWCA), Local Government Division (LGD)	• Review opportunities for collaborating with NGOs • Participate in project design in case appropriate collaboration opportunities are identified with NGOs • Allocate funding from own fund, if available, in case of appropriate projects • Liaison with development partners for sourcing funds
DC and CS (district level); UNO and UHFPO (upazila level)	• Provide initial feedback and input in the project idea and project design • Provide NOC and other supports required by the NGO for implementation of the project • Regular monitoring of the project progress through own field force • Periodic visit to project sites and discussion with the beneficiaries and project staff • Regular reporting to own line management and supervising authority regarding the progress of the GO-NGO collaboration project • Sensitise local government representatives and civil society regarding the importance of project and seeking their support
Professional bodies (e.g. Bangladesh Medical and Dental Council (BMDC))	• Assist MOHFW (DGHS, HEU, PPP Cell, Planning Wing and other relevant agencies) in identifying scope of collaboration • Support MOHFW, as technical experts, in reviewing project designs • Monitor the progress of the implementation of GO-NGO collaboration projects
NGOs	• Develop project idea through need assessment in collaboration with DGHS, Planning Wing, HEU, PPP Cell and other entities under MOHFW and other ministries • Collect field information from target districts and upazilas through discussion with the DC, CS, UNO and UHFPO • Get feedback from field administration (DC, CS, UNO and UHFPO) regarding the project idea and possible implementation mechanism • Collaborate with the respective ministries and entities under the ministries for possible sources of fund • Liaison with development partners/donors for the fund • Design the project incorporating appropriate GO stakeholders from national and implementation level, along with theory of change, results framework and realistic implementation plan • Develop a realistic budget and collaborate with relevant GO stakeholders to identify possible fund sources • Submit the project to NGOAB (in applicable cases) or PPP Cell for approval • Implement the project after getting approval and fund release as per the action plan • Regular update the field administration regarding the progress of the project activities, financial management, benefits to the beneficiaries and other aspects • Collaborate with sponsoring ministry for periodic evaluation through third party/IMED • Periodic dissemination of project outcomes and lessons learnt to relevant GO-NGO stakeholders, in collaboration with HEU or other relevant entities
Academies and research entities	• Support HEU in strategies with action plans for GO-NGO collaboration and recommend specific collaboration mechanism • Identify specific GO-NGO collaboration project opportunities • Assist MOHFW in reviewing project design • Assist in developing monitoring mechanism

Stakeholder	Specific Roles
Local elected representatives and local civil society representatives	• Participate in the project design phase and provide feedback on local context, requirements and possible solutions • Provide support to the implementing NGO and GO officials for effective implementation of project activities • Monitoring the progress of project and provide feedback to DC, CS, UNO or UHFPO in case of any discrepancies or grievances
Electronic and print media	• Disseminate potential GO-NGO collaboration for information of the interested NGOs and civil society organisations • Periodically review the progress of the GO-NGO collaboration project • Wider dissemination of the achievements of the projects/weaknesses of the projects for lessons learning

4.2 Possible Opportunities for GO-NGO Collaboration

4.2.1 Expansion of Primary Healthcare at Hard-to-Reach Areas and Difficult-to-Reach Demography

As per 8th FYP, government is committed towards universal health coverage. However, there are pockets of geographic locations in which, historically, the coverage of government healthcare services is weak due to a number of physical, social and cultural factors. Some of these areas include the island chars, haor areas, former enclaves, tea gardens, hill tract districts, etc. There can be partnership between MOHFW and the local NGOs in these areas for provision of primary healthcare services among the population. It can be assumed that some of the local NGOs may not lack the appropriate institutional capacity. In those cases, a model similar to MNGO Scheme of India can be applied under which some of the larger NGOs can be given the role for monitoring, supervision and capacity development of these smaller local NGOs. This can be a contract-out model under which government can pay for the services, or, alternatively, if development partners are interested, special projects can be designed and the implementation can be done through technical collaboration among government, development partners and NGOs. In addition, there are some demographic population groups that are difficult to reach through conventional public health network. Some of these group include the *Bede*, floating population in urban areas, transgender, sex workers, etc. A similar model can be followed in this regard to reach out these people through NGOs already having some connection with them. The following services can be expanded under this scope:

- Vaccination, deworming, vitamin A and iron supplementation, etc.
- ANC and PNC services, including counseling of mothers, checkup and referral to hospitals in case of complications
- Reproductive health and family planning services, particularly for adolescents and young women and newly married couples
- Counseling regarding healthcare and nutrition, including dietary diversity, handwashing, child faeces management, adverse impacts of junk food, importance of nutritious food, food safety, breastfeeding, complementary feeding, personal and menstrual hygiene, first aid, etc.
- Checkup for vital symptoms, including blood pressure, glucose, heart/pulse rate, weight, height, etc.
- Limited curative care
- Referral linkage to secondary and tertiary hospitals

4.2.2 Urban Health

Unless there is a major change in the prevailing legislative and policy framework, the responsibility of primary healthcare in urban areas would continues to be with LGD. Hence, government would continue to utilise the contract-out modality of primary healthcare through NGOs. However, present modalities need to be reviewed so that NGOs can have more flexibility and ownership and their participation can be increased in decision making. Along with contract-out, government may encourage NGOs to come to PPP arrangements in establishing hospitals and other healthcare facilities near slums and similar high density urban localities in which 24/7 ESP+ services would be provided.

4.2.3 Utilisation of Unutilised and Under-utilised GO Facilities

Quite a number of healthcare facilities, particularly the 10-bed and 20-bed hospitals are unutilized all around the country, predominantly due to a number of reasons, including lack of recruited human resources from MOHFW, limited equipment supply, lack of utility and other support services and remoteness of the facility. These facilities can be contracted out to the willing NGOs following the Karuna Trust model of India or the BHU contract out model of Afghanistan. While government would pay for the services, NGOs would ensure human resources, equipment and other facilities to operationalise the facilities. This model would be appropriate to the facilities for which there has been no HR allocation from the ministries. In addition, there are other 10 and 20 bed hospitals in which very few number of human resources are deployed, but without a full workforce and other operational supports, these facilities are not quite functional. Apart from these, the present Union Health and Family Welfare Centres (UH&FWC) located in remote areas often cannot provide 24/7 service delivery due to the limited number of workforce deployed. In case of such under-utilised GO facilities, special partnership can be arranged in which the NGOs would provide additional health workforce, for which, government would provide funding.

4.2.4 Provision of Hospital Equipment Services

Ensuring biomedical and high-tech equipment services is a challenge in government facilities. Due to the procurement inefficiencies, often the equipment are reached at hospitals at the end of their warranty period. For a number of equipment, the required technical persons are not recruited in the hospitals, leaving those equipment idle. Maintenance is also an issue, which cause under-utilisation of valuable hospital equipment. To address this situation, government can consider the contract-in of equipment services from competent NGOs. Under this modality, government would only pay for the equipment services, whereas, the contracting NGO would ensure availability, installation, operation and maintenance of the equipment. This can also be operated under a PPP model, similar to the present PPP project at NIKDU

4.2.5 Ensure Ancillary Hospital Services

Ancillary services include cleaning, housekeeping, transportation, food and relevant support activities that hospitals and healthcare facilities require for smooth operation. These are as important as the provision of healthcare services. At present, government, due to the shortage of ancillary service providers, have already taken the approach in outsourcing these services from private sector service providers through a contractual model. NGOs and civil society can be involved in this regard. Already there is are proven model of NGO and civil society led ancillary service provision in Bangladesh, known as “Chaugaccha Model” and “Jhenaidaha Model” in which the local government representatives, NGOs and civil society arranged security, cleaning and a few other ancillary services for hospital. This model can be applied in other areas also in which NGOs can be approached to support hospital ancillary services from its different projects.

4.2.6 Community Awareness Raising on Healthy Lifestyle and Physical Activities

Bangladesh is facing a transition in disease burden, shifting towards more to non-communicable diseases like cardiovascular diseases, diabetes, kidney diseases and cancer, predominantly due to issues

like smoking, obesity resulting from limited physical activities and consuming processed and junk foods. To address this, government has taken the initiative of promotion of healthy lifestyle, which includes promotion of locally available nutritious food, performing exercise and other physical activities, negative promotion of smoking and tobacco intake, etc. NGOs, due to their extensive expertise and experience in community mobilisation and awareness raising, can be part of this approach. Government can encourage each NGOs working in public health sector, to incorporate common messages on healthy lifestyle into their Social and Behavioural Change Communication (SBCC) tools and activities. At the same time, NGOs conduct a number of courtyard sessions and community based programmes. Messages regarding healthy lifestyle, particularly the harmful impact of junk food on obesity and resulting diseases can be promoted in these sessions.

4.3 Challenges in GO-NGO Collaboration in Health Sector of Bangladesh - Perspective of Government

4.3.1 Duplication and overlapping of Efforts

Almost all the key respondents in the KIIs and those in the consultative workshops indicated the duplication and overlapping of efforts as a key challenge. The duplication was expressed in terms of doing the same or similar activities by both GO and NGO stakeholders, even by several NGO stakeholders and/or implementing similar activities in the same geographical areas.

Duplication or overlapping of efforts was seen having impact on health service coverage and quality. Due to the finite, and in many cases, limited resource allocation in government and development projects, duplication of efforts may create waste of resources, which could have, otherwise, spent in other geographical areas. Duplication of efforts may also cause health service not being reached to a particular demographic groups due to shortage of resources.

NGOs predominantly rely on development partners for funding, and development partners have specific focus and interest in terms of geography and demography and areas of activity. Hence, several NGOs implement projects funded by different development partners, having similar agenda and focused area are implemented in a specific area. For example, in spite of having eight upazilas in Cox's Bazar district, development partners work on RH, FP, MNCAH and relevant areas in Ukhiya and Teknaf due to the influx of refugees. Hence, there are multiple projects implemented by NGOs, in addition to regular programmes of government, whereas, such NGO-run projects are quite insignificant in number and fund-size for other six upazilas in the same district.

"I would say they should be involved. When a NGO plan their projects and decide their working area, if the DC or UNO gets involved here and NGOs have to take permission from them then we can avoid the cases of duplication easily"

A senior official from HEU

"....we have felt that govt. is already working on that type of projects so NGO does not need to repeat same work and it will only cause duplication"

A senior official from PPP Cell, MOHFW

"If you go to my working area, you will find at least three/four NGOs doing almost same activities, whereas in XXX [mentioning the name of a remote area], you won't find anyone"

A field level officials from MOHFW in a consultation workshop

4.3.2 Inadequate Involvement of Government in NGO Project Designs

Inadequate involvement of government is another common issue raised by almost all the government officials. They informed that NGOs design their projects in collaboration with their respective development partners (donors), but they do not consult with or involve the government officials from policy level, even from implementation level in the design process. As a matter of fact, some of the respondents identified this as another reason for duplication of efforts.

As per the present policy, NGOs would submit their project design to NGOAB for approval. As NGOAB, would forward the project to respective ministries (in this case, MOHFW), for review and based on the feedback of that respective ministry, would approve the project. This is one of the mechanisms in which government could be involved at the design phase of the projects. However, as per the order from PMO, respective ministries would have to provide their feedback (after review of the project) within fifteen days, after which it would be considered that the respective ministry does not have any objections, and NGOAB would give the No Objection Certificate (NOC) to the project. According to the respondents from HEU, due to the lack of human resources within the unit, it is not possible for the unit to provide feedback, on behalf of the MOHFW. At the same time, according to them, the request for sending feedback comes to them (HEU) at the last moment, in which the unit cannot provide feedback and NGOAB provides NOC to the project without the response from MOHFW.

Another mechanism for government to be involved at the design phase would be through district and upazila level officers from administration and health, i.e. Deputy Commissioner (DC) and CS, respectively at district level and Upazila Nirbahi Officer (UNO) and Upazila Health and Family Planning Officer (UHFPO). The field level government officials respondent that they are not involved at the design phase of the project by the NGOs and are only informed after the project is approved from NGOAB.

"When I was UNO, I gave report or endorsed on the performance of NGOs. I have seen many were doing really good even and talking with respective officers I used to give certificate but to be honest the real involvement (of government officers with NGO projects) did not take place yet. If we want to do so then we have to ensure their (government officers) involvement in all the stages (of NGO projects) starting from the planning level"

A senior official from NGOAB

4.3.3 Inadequate Monitoring and Oversight of the Projects of NGO

Government respondents mentioned that although NGOs involve government in most of their projects at implementation level, there is very limited monitoring from government on these activities. Whereas government programmes are being monitored regularly by Implementation Monitoring and Evaluation Division (IMED) under Ministry of Planning, this entity does not monitors NGO implemented programmes. NGOs have separate evaluation system through their own, or by the respective donors or through third party evaluation. However, government is not involved with this evaluation process. NGOs also have their own monitoring system, however, government is also not involved with that system. By policy, DC at district level and UNO at upazila level are responsible for monitoring of all NGOs at their respective jurisdictions. However, due to excessive workload they cannot physically monitor or visit NGO projects. Although the NGOs report to the DC and UNO regarding their progress in the respective projects, however, these are hardly reviewed by the district and upazila administration due to shortage of human resources, particularly those having expertise in monitoring. In the monthly coordination meeting, NGOs present their progress report, however, government respondents mentioned that there are so many other important issues are discussed in these meetings that there are hardly any time or attention given to the progress of the NGO activities.

"We are providing clearance for the projects however, we are not being able to monitor. In the NOC that we provide we include a condition for them to report to us time to time with their work progress. However, in majority of the cases such progress report is not provided"

A senior official from MOHFW

4.3.4 Unjustified Media Coverage and Credit

Government respondents mentioned that the NGOs are very strong in communications and have special relationship with the media. As a result, they tend to exaggerate their project success in the media and in front of their donors. Sometimes they even misreport their progress and coverage and report inflated results. On the other hand, government often do not gets the justified credit, since the government offices do not have the communication skills.

"NGO support reaches to the place where they have better media coverage or transportation and remote areas thus stay out of these help"

A senior official from HEU

4.3.5 Lack of Clarity in Fund Management

Government stakeholders opined that the NGOs are not always clear and transparent in their fund management and often spend more than required in terms of their own operational and management cost. Government stakeholders also informed that majority of the fund the NGO would bring in are spent for consultants, human resources, day-to-day expenditure and other relevant operational and management cost, which should have gone for the intervention cost for betterment of the beneficiaries. According to them, after initial approval, NGOs do not provide the accurate report on fund management, or submit the report near project completion - at a time when government cannot intervene. As mentioned earlier, due to the shortage of human resources of government at implementation level (i.e. at district and upazila level) and due to their excessive workload, there is virtually no monitoring of fund management of the development projects of NGOs at field level. As per the government stakeholders, the Foreign Donation Act, 2016 was introduced predominantly to address such issues and would result in better transparency and accountability in NGO operation.

"…often they show that they have done certain programs to justify their annual expenditure but in reality they do not do"

A senior official from MOHFW

4.4 Challenges in GO-NGO Collaboration in Health Sector of Bangladesh - Perspective of NGOs

4.4.1 Rigidity and Overregulation from Bureaucracy

NGO representatives thought that one of the major strengths in their operation was flexibility, which get compromised when they work with government. According to them, they are overrun with regulations with not only their fund flow and financial management, but also in their operation. According to them, NGOs would have to go to a number government entities and complete quite significant documentation for approval of projects, which sometimes delay the whole process, shorten the project duration and result in unutilisation of valuable donor funds. They also informed that often they design projects based on secondary information, and identify difference in situation or change in situation when the project is in implementation at field level, however, cannot change the modalities of the project as it would require approval from the respective government departments. According to them, the Foreign Donation act of 2016 had imposed more restriction to the NGO operation and limited the flexibility to a significant extent.

"…the government system simply does not allow the NGO to implement their work quickly"

An NGO Representative

"…any successful partnership there should be flexibility. If you set some strict rules for both parties to follow then neither may progress with their work"

An NGO Representative

4.4.2 Interference at Field Levels by Different Interest Groups

Another challenge reported by the NGO respondents was the political interference, particularly at the implementation level, i.e. district and upazila, from the local political leaders and local government representatives. NGO respondents admitted that in general they would receive support from the political leaders and local government representatives, however, in cases, they would receive pressure from them in terms of recruitment of field level workers. At times, they reported that the local political leaders would force the selection of specific locations or demographic group to gain political popularity.

4.4.3 Decreased Fund Flow

NGOs in Bangladesh predominantly depend on the development partners and donors for their funding. They reported that there has been a gradual decrease in fund flow into development initiative from the development partners for the last few years. Reasons for the decreased fund flow included the economic crisis in the respective donor country, change in priorities, and new and emerging issues resulting diversion of funding. The graduation of Bangladesh into a middle income country was also identified as a reason for decreased fund flow by the NGOs. They informed that DFID, one of the largest donors in public health sector in Bangladesh got merged with the Foreign Commonwealth Development Office (FCDO) of UK and the funding has been stopped into new project from this entity. Even some of the UN agencies' fund have been reduced due to their shift in priority from Bangladesh to other countries. As a result, there has been reduced NGO projects in public health area, and increased competition among them to secure donor funding. Considering government as a potential source of funding, majority of the NGOs responded that it would be difficult to work with government unless the formalities and restrictions are relaxed and a more flexible approach is taken by the government.

4.4.4 Frequent Turnover of Government Officials

Respondents from NGOs in public health responded that a series of activities on awareness and sensitisation on the particular issue has always been incorporated in all development projects designed by them. Accordingly, they conduct the awareness activities to sensitise the respective government officials at central, regional and field level. However, as per the norm, there is a frequent change in government officials, particularly at the field level. The newly appointed officials are often unaware of the issues and the NGOs have to take additional efforts to sensitise them. Sometimes, the progress of the project gets slowed down due to the change in government officials advising and supporting it.

4.5 Challenges in GO-NGO Collaboration - from Analytical Perspective

Similar to some of the global and regional evidences, limited information flow and communications could be visible between the government and NGO stakeholders in public health sector of Bangladesh. Respondents from both sides were providing opinion, which were based on speculation rather than experience. Moreover, it seemed that both parties had limited information on the systems, procedures and operations of the other party in management of development interventions. Very limited scope was found to be for a free-flow of information between the GO-NGO stakeholders in the prevailing operational mechanisms. Because of the limited communications, knowledge and information, the degree of mutual respect and trust regarding the counterpart was found to be less than expected for an

effective GO-NGO collaboration. Each parties seemed to be more confident regarding his/her own system and hesitant regarding the capacity of the counterpart's system. A tendency of generalisation from one unpleasant or unsuccessful experience to the entire GO/NGO system was seen among the respondents, which may also contribute to the lack of trust and mutual respect.

As both the parties have limited knowledge about the others' competency other than some generic ideas, the issue of potential value addition from complementarity was also seen quite limited among the respondents. While each side were aware of their own limitations, they were not fully aware on the complementarity that could brought in by stakeholders from other side in creating synergy to design a more effective solution for increasing healthcare network coverage or improving quality. Very few collaboration opportunities came from unprompted responses, indicating the GO-NGO collaboration was also may not be something that the respondents from both the parties would consider in general. Also, while asking some of the effective GO-NGO collaborations in the country, majority (apart from few senior level officials) could not cite some of the examples, again, evidence that the idea of the scope of GO-NGO collaboration is still probably at the basic stage among the relevant stakeholders. So a significant level of sensitisation and awareness creation may required for both parties to enable them thinking strategically in forming effective GO-NGO partnerships and collaborations.

Sensitisation may also required to modify the mindset and working principles of both the stakeholders, as it seemed to be set in two extreme directions for the parties involved. While government was found to be considering longer timeframe of implementation, with wider coverage at low cost through, predominantly, existing and time-tested solutions, NGOs were found to be looking for innovations, piloting at a smaller scale within smaller extent and for a specific time period. A practice of trade-off in strategic thinking may be required from both the parties in this regard to think identify collaboration opportunities in which both GO-NGO stakeholders can bring in their strengths and address respective weaknesses.

4.6 SWOT Analysis of GO-NGO Collaboration

A Strength, Weakness, Opportunity and Threat (SWOT) analysis was done based on the feedback from respondents of KIIs and stakeholder consultation workshops. The analysis is shown in table below.

Table 2: SWOT Analysis of GO-NGO Collaboration for Health in Bangladesh

Strengths	**Weaknesses**
• Enhance coverage of service and improve accessibility for citizens, particularly poor people • Creates demand for services among poor and disadvantaged population • Ensures utilization of knowledge and abilities of collaborating agencies • Provides opportunity for rapid expansion of PHC. • Improves institutional capacity of government and NGOs from sharing of technology and information • Collaboration around areas of excellence between GOB and NGOs improves quality • Gives GOB and NGOs access to each other's expertise and resources	• Difficult to choose partners because of diversity and abundance of NGOs in the health sector in Bangladesh • Uncertainty in sustenance of NGOs due to their reliance on foreign funds • Local level and smaller NGOs being afraid of complexity due to government bureaucracy • Lack of trust between GO and NGO • Lack of uniformity in standard or quality of care among the NGOs in healthcare • Culture of blaming GO-NGO partners each other for collaboration not being effective

Opportunities	**Threats**
• Current 4th HPNSP already have provisions and budgetary allocations for collaboration with NGOs • 8th FYP emphasis on GO-NGO collaboration in all sectors, including health • Preexisting successful models of GO-NGO collaborations in health in Bangladesh (e.g. EPI, FP) • Increased interest and advocacy from development community in GO-NGO collaboration • Emerging diseases and global health issues like COVID requires multi-sectoral initiatives and opens more opportunities for GO-NGO collaboration	• Potential competition among NGOs for the same pot of money - may result in competent yet relatively expensive NGOs not getting part into collaboration • Gradual decrease in development fund into Bangladesh threatening survival of NGOs • Slow progress in implementation of health sector reforms may delay successful GO-NGO collaborations • Gradual over-controlling of government (e.g. Taxation) may hinder flexibility of NGOs

5. RECOMMENDED MECHANISMS AND WAY FORWARD IN GO-NGO COLLABORATION

5.1 Possible GO-NGO Mechanisms

5.1.1 Non-contractual Technical Collaboration

This is a form of collaboration based upon similarities in vision, values and mutual respect. Under this collaboration, the NGO supports the government in areas in which its vision, objectives and activities are in line with those of government. The support can be in the form of advisory services, technical assistances, capacity building and monitoring and evaluation. The collaboration may not be based upon any contract, so there would be no transaction involved between the parties, although there can be signing of MOU. Working on a shared value is crucial for the success of this kind of collaboration, as the involvement of partners could be governed by their organisational mandate and/or willingness to bring in a greater change in the system for betterment of the target population. Some of the possible scope of non-contractual technical collaboration may include:

- Participate as technical advisors in technical committees, working groups or network consultations in development of health related strategies, policies and action plans (e.g. involvement of leading NGOs as Thematic Group members for development of the upcoming 5th Health, Population and Nutrition Sector Programme)
- Involve as members of entities to monitor and supervise government activities (e.g. participate in the Upazila Nutrition Coordination Committee as members)
- Capacity development of government officials by NGOs with own expertise and/or from any existing development project (e.g. Capacity development initiatives of RHSTEPS) or vice-versa

Advantages:

- Involves limited or no cost
- Significant number of organisations with relevant expertise can be involved
- Rapid deployment is possible
- Particularly useful for development of strategies, policies and action plans
- Government is already accustomed to this modality in the form of thematic groups, local consultative groups, technical groups, etc.

Disadvantages:

- Limited accountability and ownership of the partners involved
- Only applicable for a narrow spectrum of opportunities
- Not applicable for implementation type projects, e.g. expansion of curative and preventive healthcare
- Only effective for a short time period

5.1.2 Contractual Collaboration

These are collaborations based upon formal agreements between government and NGO partners for a particular time, for performance of a particular service or delivery of a particular product and in-return to a particular amount of money. This collaboration involves transaction, typically cash flow from government to the NGOs. There are two major type of contractual collaborations:

1. **Contract-out:** Delegation of the responsibilities to perform some of the services or management of some of the facilities from government to the NGOs in return of service

charge/fees. E.g. Contract-out of unutilised health facilities, contract to conduct clinical contraception services at hard-to-reach areas, etc.

2. **Contract-in**: Uptake of any services of NGOs into government system or facilities in return of service charge or fees. E.g. contract-in training support from NGOs, contract-in maintenance support of infrastructure, etc.

Advantages:

- Rapid expansion of government services can be possible, particularly at the hard-to-reach areas and difficult-to-reach demographic groups
- Can be complementary to government efforts
- Possible to improve existing government services, e.g. make health facilities operational for 24/7
- Better accountability of the NGOs can be ensured due to formal contract through modalities, for example, performance-based fund disbursement
- Performance monitoring is easy
- Quick result is possible after completion of procurement

Disadvantages:

- Success of collaboration depends on fund availability to government
- Limited ownership of NGOs on the project and its outcomes
- Delay in payment may result in disruption of services
- Imbalance power dynamics, inclining more towards the fund provider, resulting limited interest to improve for the fund receiver

5.1.3 Partnership

In this type of collaboration, there are financial as well as non-financial involvement from both the parties, although may be at a different extent, to jointly achieve a greater goal. Typically, both the partners invest money either on a separate entity or on a common pot from which the expenditure of the collaboration activities are met, although transaction between the parties may also exist. PPP projects are the best examples of partnership. Shared risk is the corner stone in partnership. That is why the ownership and accountability is the highest for the collaborating entities among all the proposed collaboration models. This is the ideal collaboration mechanism in terms of creating synergy and ensuring sustainability of benefits. Investments in partnership may not always be in cash, but can be in the forms of land, infrastructure, reputation, influence or anything in kind that is important for sustaining the partnership.

Advantage:

- Long term projects can be implemented
- More ownership and accountability from both the parties involved
- A broad spectrum of health care related can be resolved, including infrastructure, equipment, preventive and curative service delivery, hospital service improvement, etc.
- Government can involve its influence, reputation, existing infrastructure and other resources as alternative to cash/money and vice-versa - so not necessary both parties require to infuse cash
- GO-NGO relationship becomes more sustainable and collaborative
- Power dynamics in relation is more balanced
- Shared risk enables both GO-NGO partners being more involved and serious with the collaboration

Disadvantages:

- Can take several years from design to implementation, i.e. lengthy period to reap the benefits
- Not many successful examples of such partnership in health sector of Bangladesh
- Limited number of NGOs with the financing capacities to invest large amount

A comparison among the three proposed models of collaboration is shown in the table below.

Table 3: Comparison among Proposed Models of GO-NGO Collaboration

Area of Comparison	Technical Collaboration	Contractual Collaboration	Partnership
Transaction	Does not involve	Transaction is the basis of collaboration	Typically transaction between partners does not happen, rather both parties invest on a common project/area
Need for a shared value and common goal	Essential	Not necessary required	Essential
Ownership	Limited	Limited for contracted NGOs	High ownership from both parties
Accountability	Limited or no accountability	Only during the contract period	Significant accountability to each other, to the investors and, in cases, to the beneficiaries
Duration of collaboration	Short	Short to medium	Typically long term
Shared risk	Not involved	Not involved	Shared risk is the core concept

5.2 Recommended Actions for Address Challenges in GO-NGO Collaboration

5.2.1 Development of a Database of NGO and GO-NGO Projects

To increase awareness of the development projects in a specific location or one a particular issue, to avoid duplication of efforts, and to assist in quick approval of future projects, a Project Management Information System (PMIS) can be developed with a dashboard. This would be a database with all the approved NGO and/or GO-NGO projects in health sector. The dashboard would have options to search for and browse through the projects in terms of - specific NGOs, specific locations, specific theme of project (e.g. RH, FP, Nutrition, Non-communicable disease, etc.), time period, etc. There can be several interfaces with separate degrees of authority to get access into the database. The PMIS should have automated query system if it matches with certain parameters. For example, if a NGO wants to develop a project for "XXX" upazila, the PMIS should automatically show the existing projects on same topic being implemented in that upazila so that the NGO can either change the location or identify a collaborative mechanism to work with the existing projects. All the relevant stakeholders discussed in the previous chapter should have the accessibility into the PMIS. The existing infrastructure of DHIS2 of DGHS can be used as the backbone of this PMIS, however, DHIS2 is already burdened with a number of software and databases, making it quite slow in recent times. So, HEU can either think of collaborating with DGHS to improve the DHIS2 infrastructure and upload the PMIS into that system or develop a different information infrastructure for the PMIS. However, if there are other database with similar features, then instead of duplicating or adding a new database the existed database can be refined more to include the recommended feature. This will reduce the time to implement the recommendation.

5.2.2 Ensuring Openness in Information to Ensure Trust and Transparency

To ensure trust and transparency, information regarding the relevant GO-NGO collaboration projects should be open and publicly accessible, including the progress of the project and the financial information. In this regard, these information can be published in the relevant websites of the NGOs and relevant government stakeholders (e.g. HSD, DGHS, etc.) so that anyone can review the progress, including financial management, fund disbursement status, number of beneficiaries, geographical

coverage, etc. At the same time, such projects should have periodic evaluations, either from third party evaluators or by IMED. The results should also be uploaded regularly in the website of the respective stakeholders. In addition, sensitization workshops in forms of dissemination, sharing experiences, etc. should be held between relevant ministries, departments of GO and NGOs where the focus would be on sharing positive learning experience of collaboration, strategies implied to overcome challenges in such collaboration and how such collaboration have impacts on people's lives. This will encourage GO and NGOs to come up with more ideas for collaboration and will show the competency of partners.

5.2.3 Increasing Pace and Reducing Complexity of Project Approval

Present approval of development projects was found to be quite complex and time consuming. This process can be simplified and fasten up through use of technology. Once the PMIS is operational, the NGOs or the GO-NGO collaborating stakeholders can be asked to upload the project design/proposal into the PMIS. Short fields for the project design to upload essential project information can be created, which the respective stakeholders can fill-up. Some of these fields may include project location, theme, coverage, budget, etc. Once uploaded, a unique ID will be generated against the project and the descriptions will be automatically sent to NGOAB and respective ministries and departments. There would be specific authorisation fields, which the respective stakeholders can access using their own passwords. They can provide their feedback and approval into the PMIS using those authorisation fields and passwords. The present clause of 15 days for approval can be kept, i.e. if any stakeholder does not provide approval/feedback within 15 days, the PMIS will consider that stakeholder to be in-line and thereby authorised the project. Once the required number of authorisation is received from required number of stakeholders, another automated message will go to NGOAB or the relevant approval body, asking for approval of the project, with a copy to the respective GO-NGO stakeholders to follow up. The entire process will be faster than the present system, and will save time for reaching the documents from one entity to another, and by parallel review from different authorising entities. However, at initial stage, full phase of online approval might not be feasible for the transition. In such case a mix of online and physical approval system can be taken place. The requirement of documents and description can be submitted online. After submission an automated generated date will be provided to the project for physical visits and meetings with the stakeholders.

5.2.4 Engaging Local Stakeholders

Involvement of implementation level stakeholders, including the district/upazila administration, health and FP officials, other government officials, local government representatives, development partners civil society representatives and media is very important for increased ownership, better monitoring and supervision and improvement in overall implementation. To ensure this, all the GO-NGO collaboration projects should have specific components/mechanisms and budget to engage the local stakeholders. Some of the mechanisms may include periodic meetings of project with the local stakeholders, visit of local stakeholders to the project sites and/or publications of articles/news in local media. Concerning issues need to be raised in the local level monthly coordination meetings and supports need to be sought from local stakeholders to resolve those issues. A local level project advisory committee can be formed taking into participation from local administration, government officials, local government representatives, civil society and community people to monitor progress and resolve critical issues in project implementation.

6. CONCLUSION

Vision 2041 of Bangladesh aims to reach Upper Middle-Income Country (UMIC) status by 2031, and High-Income Country (HIC) status around 2041. One of the crucial, yet, challenging prerequisites to do so is to extend universal health care to 75 percent of the population. Considering the pluralistic health system in the country relying on multisectoral involvement, there is no other alternatives to involve both public and private sector healthcare providers in a synchronous way. It is expected that this study would provide key inputs for HEU and other stakeholders in formulating a framework for effective GO-

NGO collaboration in healthcare, which would eventually facilitate the health system expanding to the target population with UHC.

From the similar experience in global and regional context, it is already a proven fact that effective GO-NGO collaboration adds value and creates synergy in generating positive outcome on health systems and health service delivery. Such a coordination offsets the gaps that both the GO-NGO stakeholders possess and enhances their individual effectiveness. However, higher level commitments and buy-ins are required for both the stakeholders for the collaboration to generate optimum effect. Both formal and informal relationships are needed based on an environment of transparency, accountability and free-flow of information. These are some of the key issues that should be considered while development of the collaboration strategy. Positive and negative lessons learned from the previous collaborative examples should also need to be considered.

A number of constraints lie ahead of the envisaged GO-NGO collaboration in Bangladesh's public health sector. The set of recommendations furnished in the document is expected to support the policymakers in including appropriate strategies to identify the constraints and devise action plans to address those. The collaborative mechanisms suggested also have respective advantages and challenges. The policymakers, while developing the strategy, should carefully analyse the trade-offs to maximise the benefits that each mechanism offers. It is quite understandable that one collaborative mechanism would probably not resolve all the issues, and hence, the intended strategy should incorporate an operationalising strategy, indicating suitability of specific mechanisms in respective context and situation. Consultation sessions and discussions with the relevant key stakeholders identified in this study, thus, would be quite important in that regard.

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ANNEXURE 1

Documents reviewed for the desk review

Type of Document	Author/s	Year of Publication	Country of origin	Title of the document	Context	Setting
Journal article	Dr. Bijoy Das	2019	India	GO-NGO partnership: A developmental approach for Health Sector in North East india		North East India
Journal article	A N Zafar Ullah, James N Newell, Jalal Uddin Ahmed, M K A Hyder, Akramul Islam	2006	Bangladesh	Government-NGO collaboration: the case of tuberculosis control in Bangladesh	Bangladesh	Bangladesh
Journal article	Iram Ejaz, Babar T Shaikh and Narjis Rizvi1	2011	Pakistan	NGOs and government partnership for health systems strengthening: A qualitative study presenting viewpoints of government, NGOs and donors in Pakistan	Regional	Pakistan
Conference Paper	Hiwot Amare, Trui Steen	June 2018		Multi-stakeholder partnerships (MSPs) for health service delivery in Ethiopia	Global	Ethiopia
Journal article	Olivia Biermann, Martin Eckhardt, Siw Carlfjord, Magnus Falk and Birger C. Forsberg	2016	Ecuador	Collaboration between non-governmental organizations and public services in health – a qualitative case study from rural Ecuador	Global	Ecuador
Journal article	JENNIFER M. BRINKERHOFF	2002	USA	Government–nonprofit partnership: a defining framework	Global	Brazil
Journal article	Bhuiyan Shafi Yasuhide Nakamur	2004	Japan	GO−NGO Partnership Challenges and Opportunities in the New Millennium: A Case Study of Reproductive Health Initiative in Bangladesh	Bangladesh	Bangladesh

Journal article	Ramesh Bhat Sunil Maheshwari Somen Saha	2007	India	Contracting-out of Reproductive and Child Health (RCH) through Mother NGO Scheme in India: Experiences and Implications	South Asia	India
Report	Kim Scriven		Bangladesh	Bangladesh: understanding humanitarian networks ALNAP Case Study		
Lecture	Ferdous Arfina Osman Ph.D	2008	Bangladesh	Public-Private Partnership in Health Service Delivery: Lessons from Bangladesh	Bangladesh	Bangladesh
	Tamgid Ahmed Chowdhury, Ashit Baran Das, Liton Chakraborty, and Munim Kumar Barai	2020	Bangladesh	NGOs for Development: Experience of Bangladesh	Bangladesh	Bangladesh
Journal Article	Mohammad Saifullah and Shaikh Mostak Ahammad	2008	Bangladesh	ACCOUNTABILITY OF NGO OPERATIONS IN BANGLADESH	Bangladesh	Bangladesh
Journal Article	M. Shamsul Haque	2004	Bangladesh	Governance based on partnership with NGOs: implications for development and empowerment in rural Bangladesh	Bangladesh	Bangladesh
Journal Article	N.M.Clark, E.A.Baker, A.Chawla and M.Maru	1993	England	Sustaining collaborative problem solving: strategies from a study in six Asian countries	Bangladesh, Asia	Bangladesh
Journal Article	Martin Hushie	2016		Public-non-governmental organisation partnerships for health: an exploratory study with case studies from recent Ghanaian experience	International	Ghana
Journal Article	Masooda Bano	2018	Pakistan	Partnerships and the Good-Governance Agenda: Improving Service Delivery Through State–NGO Collaborations	South Asia	Pakistan
	Anne L. Buffardi,	2012		Toward greater inclusion: lessons	Peru	Global

	Robinson Cabello; Patricia J. Garcia			from Peru in confronting challenges of multi-sector collaboration		
Country review	Professor S. M. Nurul Alam	2007		Whose Public Action? Analysing Inter-sectoral Collaboration for Service Delivery	Bangladesh	Bangladesh
Journal article	Jennifer M. Brinkerhoff	2003		Donor-Funded Government–NGO Partnership for Public Service Improvement: Cases from India and Pakistan	South Asia	India, Pakistan
Journal article	S. M. NURUL ALAM	2011		HEALTH SERVICE DELIVERY: THE STATE OF GOVERNMENT–NON-GOVERNMENT RELATIONS IN BANGLADESH	Bangladesh	Bangladesh
Country paper	Salehuddin Ahmed, Mohammad Rafi	1998		GO-NGO Relations: The BRAC Experience	Bangladesh	Bangladesh
Doctoral dissertation	Binioube Aleyao	2016		An Investigation of NGO-Government Partnerships for Prevention and Treatment of HIV/AIDS and Malaria in the Maritime Region of Togo	Global	Togo
Act	-	2016	Bangladesh	FOREIGN DONATIONS (VOLUNTARY ACTIVITIES) REGULATION ACT 2016	Bangladesh	Bangladesh

ANNEXURE 2 (DATA COLLECTION TOOLS)

Topic Guide for Public Stakeholders

Study Title: "*Study to Define Scopes, Opportunities, Challenges and Way Forward for Developing a Stakeholder Coordination Strategy towards Harmonising GO/NGO Collaboration in the Health Sector*"

SERIAL	QUESTION
OVERALL IDEA AND THOUGHTS	
1	How do you see GO-NGO collaboration for developing any sector?
2	How can such collaboration can contribute to health sector in Bangladesh?
3	What are the examples in the health sector of successful GO-NGO collaboration?
4	How can the public sector (and GoB) be benefitted (and harmed) for such collaboration?
POLICY AND GUIDELINES	
5	What policies and guidelines available in the country regarding GO-NGO collaboration?
6	What policies and guidelines should be introduced to enhance such collaboration?
7	What are the current priorities in the health sector in Bangladesh?
8	What are the things need to be considered before making any policy for GO-NGO Collaboration?
STAKEHOLDER COORDINATION	
9	Who are the major stakeholders for such collaboration (Public and Private) in Bangladesh and why?
10	Which are the leading NGOs and INGOs for healthcare service delivery in Bangladesh and how?
11	Currently, what strategies are taken for stakeholder coordination between GO and NGO?
12	Do you have any direct experience of such coordination? (where a GO and NGO worked together for a common goal related to health)
13	In your experience, what are the successful examples of GO-NGO collaboration for health in the country?
WAY FORWARD	
14	What are the prerequisites for a successful stakeholder coordination in health?
15	What are the (current and anticipated) challenges for successful stakeholder coordination in terms of GO-NGO collaboration?
16	What precautions need to be taken from public side for implementing such collaboration?
17	How can we ensure sustainability of such collaboration and coordination?
18	What will be your suggestions to the health ministry regarding GO-NGO collaboration?

Topic Guide for Private Stakeholders

Study Title: "*Study to Define Scopes, Opportunities, Challenges and Way Forward for Developing a Stakeholder Coordination Strategy towards Harmonising GO/NGO Collaboration in the Health Sector*"

SERIAL	QUESTION
OVERALL IDEA AND THOUGHTS	
1	How do you see GO-NGO collaboration for developing any sector?
2	How can such collaboration can contribute to health sector in Bangladesh?
3	What are the examples in the health sector of successful GO-NGO collaboration?
4	How can the NGO sector be benefitted (and harmed) for such collaboration?
POLICY AND GUIDELINES	
4	What policies and guidelines available in your organization regarding GO-NGO collaboration?
5	What policies and guidelines should be introduced (in private and public sector) to enhance such collaboration?
6	Which of the current priorities are in favor of the collaboration and which are not?
7	What are the things need to be considered before making any policy for GO-NGO Collaboration?
STAKEHOLDER COORDINATION	
8	Who are the major stakeholders for such collaboration (Public and Private) in Bangladesh and why?
9	Which are the leading NGOs and INGOs for healthcare service delivery in Bangladesh and how?
10	Currently, what strategies are taken for stakeholder coordination between GO and NGO?
11	Do you have any direct experience of such coordination? (where a GO and NGO worked together for a common goal related to health)
12	In your experience, what are the successful examples of GO-NGO collaboration for health in the country?
WAY FORWARD	
13	What are the prerequisites for a successful stakeholder coordination in health?
14	What are the (current and anticipated) challenges for successful stakeholder coordination in terms of GO-NGO collaboration?
15	What precautions need to be taken from private side for implementing such collaboration?
16	How can we ensure sustainability of such collaboration and coordination?
17	What will be your suggestions to the health ministry regarding GO-NGO collaboration?

ANNEXURE 3

Participant details for Interview

SN	Name	Designation	Organization
1	Saidur Rahman Khan	Programme Manager	GNSP, HEU, MOHFW
2	Md Mokhlesur Rahman	Director (Project-2) [Joint Secretary]	NGO Affairs Bureau, Prime Minister's Office
3	Shilu Ray	Assignment Officer-3 (Senior Assistant Secretary)	NGO Affairs Bureau, Prime Minister's Office
4	Saifullahil Azam	PPP Focal Point, Joint Secretary	HSD, MOHFW
5	Dr. Md. Aminul Hasan	Director	DGME, MOHFW
6	Md. Rashedul Islam	Director General	NGO Affairs Bureau, Prime Minister's Office
7	Md Shahadt Hossain	Director General	HEU, HSD, MOHFW
8	Mohammad Touhidul Islam	Health Financing Expert	Development Partner; Technical Organization
9	Dr. Mahfuza Rifat	Health Specialist	ThinkWell
10	Dr. Taufique Joarder	Health System Expert	
11	Mr. Ahasan Habib		NGOAF
12	Zobair Ahmed	Director	DORP
13	Iqbal Anwar	Health System Expert	
14	Anonna Rahman	Program Manager	WBB Trust
15	Dr. Esrat Jahan	Project coordinator	Handicap International
16	Dr. Mukhlesur Rahman	Assistant Director	Ahsania Mission
17	Shahnaj Sultana	Head of Programme	Centre for the Rehabilitation of the Paralysed (CRP)

Health Economics Unit
Health Services Division
Ministry of Health and Family Welfare

STUDY TO DEFINE SCOPES, OPPORTUNITIES, CHALLENGES, AND WAY FORWARD FOR DEVELOPING A STAKEHOLDER COORDINATION STRATEGY TOWARDS HARMONIZING GO/NGO COLLABORATION IN THE HEALTH SECTOR

Policy Matrix

31 October, 2021

ARK Foundation, Dhaka, Bangladesh

WAY FORWARD FOR EFFECTIVE GO-NGO COLLABORATION IN HEALTH

Policy Matrix

Recommendation	Major Activity (What to Do?)	Strategy (How to Do?)	Responsibility		Timeline	Resource		Objectively Verifiable Indicators				Means of Verification
			Lead	Support		HR	Finance	Inputs/processes	Output	Outcome	Impact	
Development of a database and dashboard of NGO and GO-NGO development projects (PMIS) in public health sector	• Find out existing databases, if any, under other relevant program • If any database exists, review and refine it to be more comprehensive for using it to enlist projects run by NGOs in health sector • If there is none, design and implement a development/pilot project on the database in health • Linking the databases with the implementing authority • Creating a dashboard to search for linking all projects by NGO, GO-NGO, Theme, Location, etc.	• Development of a data collection template • Share the template with relevant ministries for data • Hire an IT firm expert in dashboard development • Ensure timely completion of the dashboard • Create appropriate access authority and share passwords to relevant stakeholders • Upload the dashboard in HSD and ME&FWD website	HEU	HSD, ME&FWD, NGOAB, DGHS, DGFP, DGDA, MOSW, MOWCA, LGD, DPHE, DPs, relevant NGOs in public health sector	Short term (one to three years)	✓	✓	Workshops, discussion sessions, consultations, validation; contract with IT firm; activity monitoring of IT firm	PMIS and dashboard with relevant NGO, and GO-NGO projects in health created and uploaded	Mechanism established to identify competent NGOs, avoid duplication, focus on unserved areas	Enabling environment created for improved GO-NGO collaboration in health sector	Data entry template, Dashboard in PMIS, Uniform and one database with relevant information, in case of existed database, revised component but no duplication or added database

Recommendation	Major Activity (What to Do?)	Strategy (How to Do?)	Responsibility		Timeline	Resource		Objectively Verifiable Indicators				Means of Verification
			Lead	Support		HR	Finance	Inputs/processes	Output	Outcome	Impact	
Ensure openness and transparency in GO-NGO collaboration to create trust and mutual respect	• Ensure openness in information • Increase trust between collaboration partners	• Regular review of the progress of GO-NGO collaboration by third party or IMED • Activity monitoring of GO-NGO collaboration projects at field level • Regular financial audit for cost-effectiveness, transparency and internal control • Upload the aforementioned information in the dashboard or HSD and ME&FWD website and allow for public access of the information • Conduct sensitization workshops with relevant stakeholders to share positive outcomes of collaboration	HSD and ME&FWD	HEU, DGHS, DGFP, DGDA, NIPORT, MOPA (through DC and UNO), NGOAB, IMED, respective NGOs	Medium term (Three to five years)	✓	✓	Monitoring checklist, contract with IMED, contract with third party evaluators, contract with audit firm, review workshops, letter to system analyst to upload reports, designated group of people to organize workshops/meetings	Progress along with financial information of GO-NGO collaboration projects is publicly available, workshops conducted	Openness regarding design, implementation and performance of GO-NGO collaboration projects in Bangladesh, knowledge about competency of collaborators, knowledge about how the collaboration has impacted on the lives of beneficiaries		Evaluation reports, audit reports, field reports by DCs, Dashboard in PMIS, number of workshops and number of relevant stakeholders participated in the workshops

Recommendation	Major Activity (What to Do?)	Strategy (How to Do?)	Responsibility		Timeline	Resource		Objectively Verifiable Indicators				Means of Verification
			Lead	Support		HR	Finance	Inputs/processes	Output	Outcome	Impact	
Increasing pace and reducing complexity of approval of GO-NGO collaboration projects in health sector	• Develop a mix of online and physical project approval system, as appropriate • Enable system generated unique ID for project • Develop review and approval process for major parts of the project design (area, theme, budget, coverage, etc.) • Share the project's review and approval with relevant approval authorities • Auto generated date for physical visits to the project and meetings with relevant stakeholders • Receive approval from the authorities online	• Input of project information into PMIS • Sending project information to relevant authorities via PMIS • Approval of project by relevant authorities online by reviewing important information from the given template which will have short review section and approval • Follow up in case any important authority did not approve • Support via IT personnel in case any authority could not understand the approval process	NGOAB, HEU, Planning Wing, Planning Branch and PPP Cell of MOHFW	Respective GO department and specific NGO designing the project (uploading information)	Medium term (Three to five years)	✓	✓	No of Project information in PMIS, No of projects approved, time for project approval	IT-enabled project review and approval system is created using the PMIS	Ease of complexity and increased speed of approval for GO-NGO collaboration projects		Review of PMIS, reports generated by PMIS on approved and rejected projects

Recommendation	Major Activity (What to Do?)	Strategy (How to Do?)	Responsibility		Timeline	Resource		Objectively Verifiable Indicators				Means of Verification
			Lead	Support		HR	Finance	Inputs/processes	Output	Outcome	Impact	
Engaging local stakeholders in GO-NGO collaboration projects	• Involve local stakeholders, including local government representatives, development partners, civil society and community people in design, implementation and monitoring of GO-NGO collaboration projects	• Focus group discussions and key informant interviews during project design phase • Sensitisation and awareness campaigns upon project approval • Formation of citizen committees for monitoring and supporting project implementation • Capacity development of the citizen committees for monitoring and supporting project implementation	Respective GO department and implementing NGOs	DC, CS, UNO, UHFPO, DD-FP, UPO, and other upazila level official, DP	Medium term (Three to five years)	✓	✓	FGDs, Workshops, Campaigns, Capacity Building Programmes	Local stakeholders provided their feedback in project design, Citizen committees are formed to support implementation and monitoring of GO-NGO projects in health	Mechanism for engaging local stakeholders in design and monitoring of GO-NGO collaboration projects in health established		Minutes of FGDs, workshop, and sessions