

IMPLEMENTING PERFORMANCE-BASED GRANTS FOR IMPROVED NGO PERFORMANCE IN BANGLADESH

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Despite significant achievements, remaining health systems weaknesses and inequitable use of quality health services persist in Bangladesh. To effectively serve its population of approximately 160 million and to fill gaps in the public health system, the government of Bangladesh has embraced a multisectoral health system—specifically through promoting the role of nongovernmental organizations (NGOs) in service delivery. Since the 1970s, Pathfinder International has implemented various projects with Bangladeshi NGOs, building their capacity to deliver high-quality, and equitable services. In 2012, Pathfinder began implementation of the NGO Health Service Delivery Project—a five-year, USAID- and DFID-funded project that aims to strengthen NGO capacity to deliver high-quality family planning and reproductive, maternal, newborn, and child health services to the country’s poor and underserved populations. Complementary to capacity building activities, and to catalyze improved NGO performance, Pathfinder implemented performance-based grants. This technical brief explores performance-based grants implementation and offers insights on the use of pay-for-performance mechanisms at the NGO level in Bangladesh.



CONTEXT

Since Bangladesh's independence in 1971, the country has achieved remarkable improvements in health outcomes. For example, by 2015, Bangladesh had surpassed its Millennium Development Goal to reduce the mortality rate of children under five by two-thirds, and had reduced its maternal mortality ratio from 574 deaths per 100,000 live births in 1990 to 194 deaths per 100,000 live births in 2015.¹ This progress is, however, somewhat paradoxical as nearly half of Bangladesh's population lives in poverty, and the public health system is often described as insufficient to meet the needs of the eighth most populous country in the world.² Though health systems vary from country to country, all require a robust financing mechanism, a well-trained and paid workforce, well-maintained facilities and equipment, and reliable information on which to base decisions.³ Total health expenditure in Bangladesh, as a percentage of GDP, is low, at 3.7 percent, and the limited health workforce is inequitably distributed.⁴ In 2011, the World Health Organization estimated only 0.356 physicians per 1,000 population in Bangladesh,^a with providers concentrated in urban areas despite approximately 77 percent of the population living in rural areas.⁵

Gaps in the health system are further reflected in inequities in the use of health services. Between 2011 and 2014, 63.9 percent of women between the ages of 15 and 49 who had a live birth in the three years preceding the 2014 Demographic and Health Survey received any antenatal care (ANC) by a trained medical provider.

Of women who had a live birth in the three years preceding the survey living in urban areas, 78.8 percent received ANC by a trained medical provider, compared to 58.6 percent of women living in rural areas. Further, 90 percent of women in the highest wealth quintile received ANC by a trained medical provider, compared to 35.6 percent of women in the lowest wealth quintile.⁶ This trend of inequitable use by residence and income status is evident in other indicators, such as unmet need for contraception, institutional deliveries, basic vaccinations for children, children under five with acute respiratory infection symptoms who sought treatment from a health professional and facility, and food security.

Research posits that private sector participation in the Bangladeshi health care system may positively impact beneficiaries,⁷ and data from the 2014 Bangladesh Demographic and Health Survey suggests that private sector facilities are an established component of Bangladeshi service delivery. In 2014, 52 percent of women who had a live birth in the three years preceding the survey received ANC services from a private facility, 36 percent of women received ANC from public facilities, and 11 percent received ANC from nongovernmental organization (NGO) facilities.^b Shortly after the country's independence, the Bangladesh NGO sector began to thrive. Today, Bangladesh is home to some of the world's largest NGOs.⁸ To necessarily compensate for gaps in the health system, the government of Bangladesh engages the private sector in health service delivery—including NGOs.

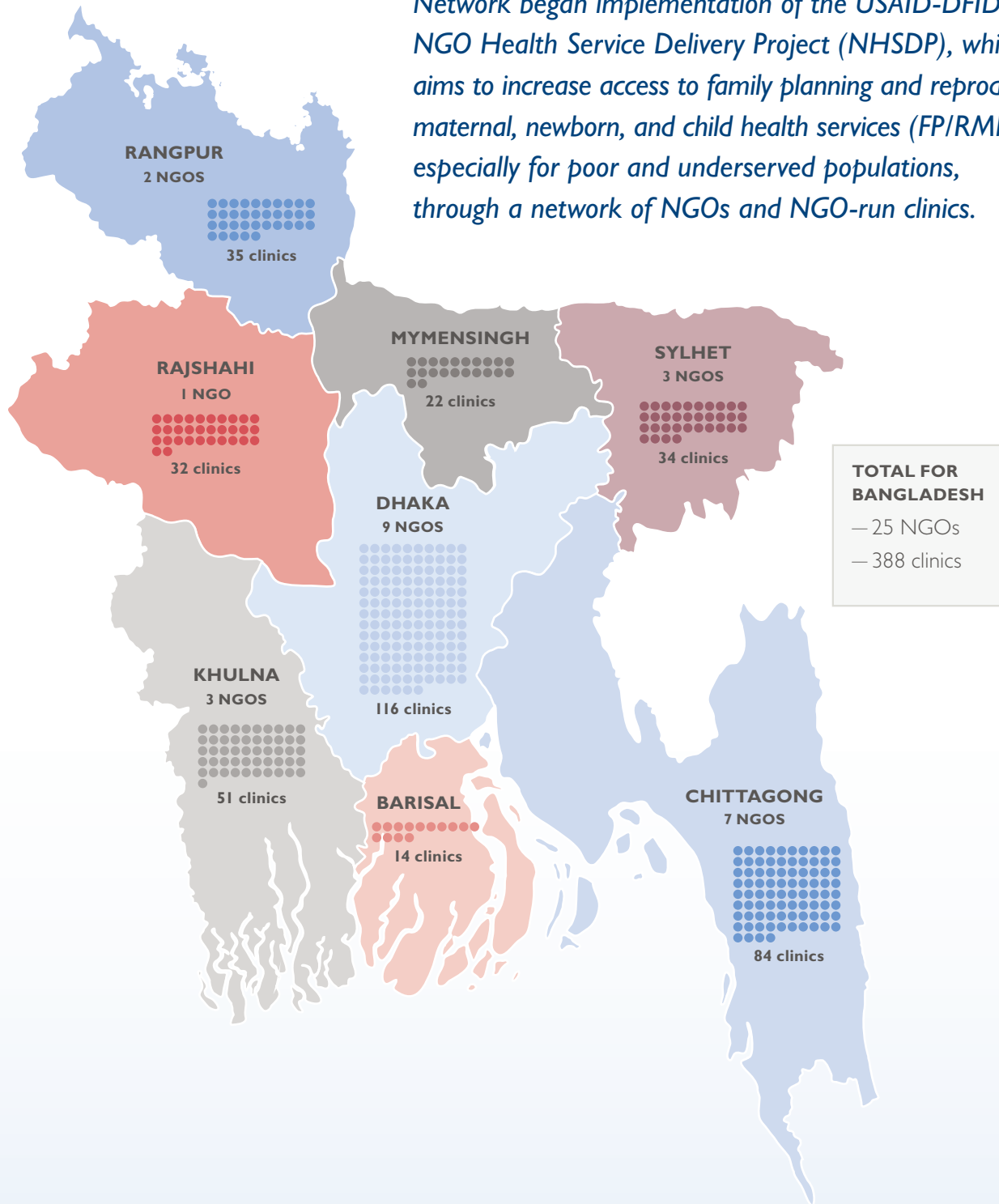
Since the 1970s, Pathfinder has been working with local partners in Bangladesh to harness the potential of Bangladeshi NGOs to improve health outcomes and reduce inequities. In 2012, USAID, Pathfinder, and the Surjer Hashi NGO Network^c began implementation of the USAID-DFID NGO Health Service Delivery Project (NHSDP), which aims to increase access to a package of essential family planning (FP), and reproductive, maternal, newborn, and child health services (RMNCH),^d especially for poor and underserved populations, through a strong network of NGOs and NGO-run static and satellite clinics.

By building the capacity of NGOs to deliver high-quality services, NHSDP aims to strengthen NGOs as an essential pillar of the Bangladeshi public health system. Pay-for-performance mechanisms, which link specific outcomes to reward, became popular in the 1990s and have since been implemented in high-, middle-, and low-income countries.⁹ Research suggests that such mechanisms can improve performance, particularly at the individual level and in the private sector.¹⁰ However, there is less known about the implementation of such mechanisms at the organization level, and about how motivations in the private and public sectors differ—which determines how a pay-for-performance mechanism is structured and implemented.¹¹ In 2013, to complement capacity building activities and to improve NGO performance, NHSDP implemented a performance-based grant (PBG) mechanism as part of its approach to fund the operations of NGO-owned and operated clinics.

(a) The WHO recommends 2.3 physicians, nurses, and midwives per 1,000 population (http://www.who.int/hrh/workforce_mdgs/en/) (b) Though the Bangladesh Demographic and Health Survey distinguishes between the private sector and NGOs, for the purposes of this publication, the private sector comprises private not-for-profit organizations (including NGOs) and private for-profit organizations. (c) Surjer Hashi, or Smiling Sun, is a network of 25 NGOs and 388 clinics that serve more than 22 million people across Bangladesh. At project start, the network consisted of 26 NGOs, however, during project implementation, two NGOs left the network and their clinics were transferred to remaining NGOs, and one new NGO was added to the network. Pathfinder and USAID have been working with this network since 1997. (d) The five components of this essential services package are: long-acting and permanent methods of contraception, maternal health, nutrition, newborn and child health, and treatment for acute respiratory infections.

FIGURE 1: MAP OF COVERAGE OF NHSDP NGOS AND CLINICS*

In 2012, USAID, Pathfinder, and the Surjer Hashi NGO Network began implementation of the USAID-DFID NGO Health Service Delivery Project (NHSDP), which aims to increase access to family planning and reproductive, maternal, newborn, and child health services (FP/RMNCH), especially for poor and underserved populations, through a network of NGOs and NGO-run clinics.



* Some NGOs operate clinics in multiple divisions.

STRATEGY

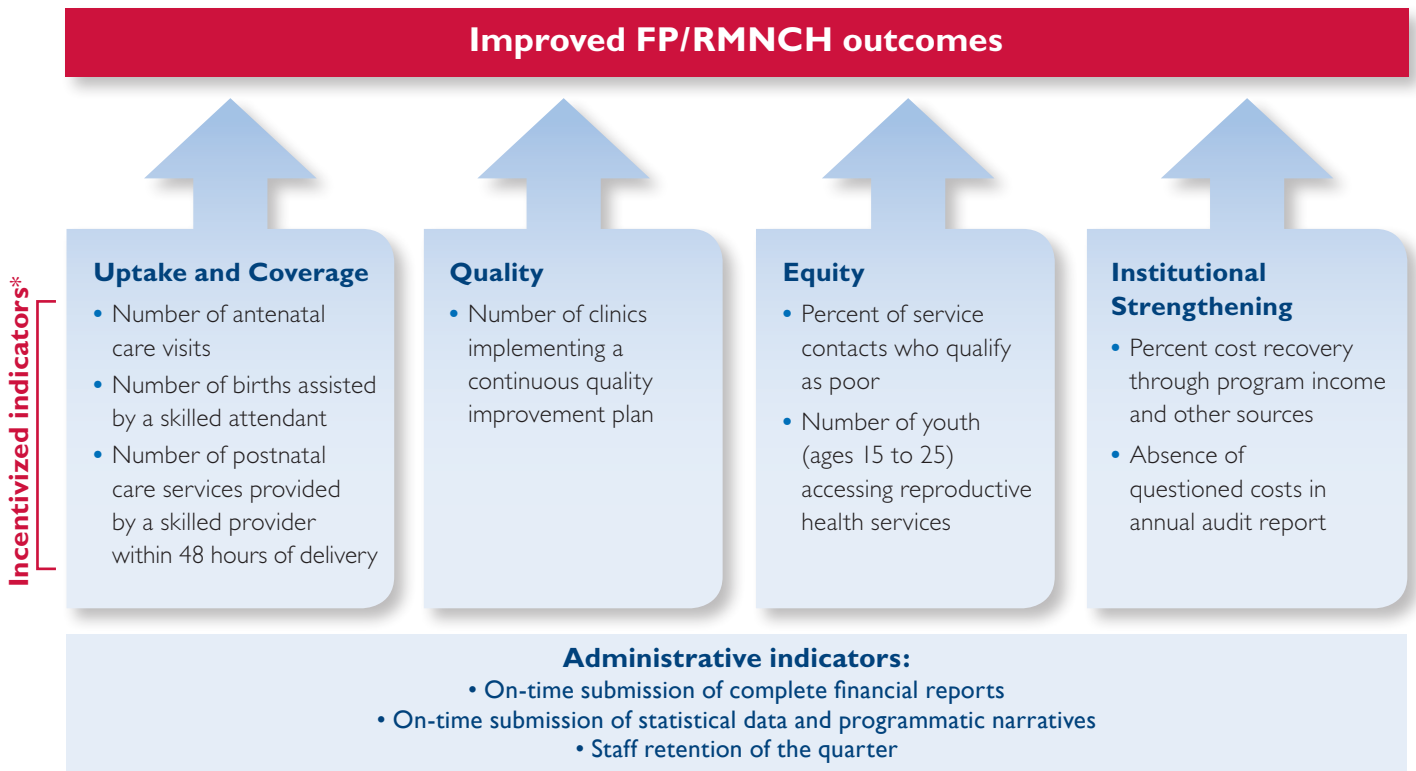
To move NGOs toward local ownership and sustainability without compromising provision of quality services to poor and underserved populations, NHSDP strategically ties PBGs to four dimensions of NGO performance: service uptake and coverage, quality, equity, and institutional strengthening (see Figure 2). NGOs increase service coverage of underserved populations through mapping exercises, and expansion of essential FP/RMNCH services via static, satellite, and mobile clinics. To generate demand for services, the project deploys behavior change, community mobilization, and social marketing initiatives. As service quality is a necessary prerequisite for demand generation, the project ensures high quality by reinforcing quality standards at every service delivery level and through

stressing service integration, youth-friendliness, non-discrimination and non-stigmatization of poor people, and emphasis on women- and girl-centered approaches. To reach poor populations and adolescents and youth—particularly young couples who are beginning childrearing—the project utilizes behavior change and community mobilization strategies to address norms around early marriage and childbearing, as well as gender-based violence. In order to bring NGOs closer to long-term sustainability, the project strengthens NGO capacity by providing tailored technical assistance on leadership, governance, administrative systems, financial planning, and human resources through a range of methodologies, including training, mentorship and coaching, and cross-NGO learning opportunities.

IMPLEMENTATION

In the first nine months of NHSDP implementation, the project collaborated with NGOs to identify capacity building priorities and benchmarks, and initiated activities to expand access to quality services (such as community mapping, strengthening of community groups designed to connect community members with satellite clinics, and clinical trainings for providers) and promote improved healthy behaviors (such as training of community health workers on interpersonal communication and information dissemination). During this time, NHSDP financed NGOs through standard cost-reimbursable grants and established a foundation and design for the PBG mechanism. Namely, the NHSDP team collaborated with USAID to select a set of

FIGURE 2: STRATEGY FOR IMPROVED NGO PERFORMANCE: INDICATORS INCENTIVIZED THROUGH PERFORMANCE-BASED GRANTS



* Indicators for performance-based grants have evolved over the course of implementation to match project priorities and in response to feedback from NGOs.

incentivized indicators that best emphasized project focus areas. These indicators form the basis of the PBG mechanism, in that high performance in those focus areas would result in financial incentives paid to the NGOs. Following design of the mechanism, preparation for PBGs included releasing a request for applications from NGOs to participate in the PBG mechanism,^e establishing a technical committee to review applications, an orientation to the indicators and terms and conditions of PBGs, and a negotiation process in which NHSDP and NGO staff discussed budgets and negotiated performance targets. USAID approved the issuance of all 26 PBGs, and implementation of PBGs began in October 2013 (Year 2 of NHSDP).

Incentives are paid to NGOs annually based on performance against eight performance indicators (for a list of indicators, see Figure 2). For every target met, NGOs receive a bonus payment equal to 1 percent of their total annual budget. If all 8 targets are achieved, NGOs receive an additional 2 percent bonus, so the total reward is 10 percent of their total annual budget. In addition, the project identified three administrative indicators. For each administrative target not met, the NGO is penalized by 1 percent of its quarterly funding from NHSDP. Thusly, the NHSDP PBG mechanism uses a “carrot and stick” approach. The project supports NGO capacity to reach these performance targets through a range of methodologies—including training, remote and onsite mentorship and coaching, and opportunities for cross-network learning. These methodologies target NGO capacity related to leadership, governance, and management; grants management and financial reporting; and staff retention.



Community Service Provider providing door-to-door counseling, Bangladesh

PHOTO: Quamrul Abeedin

This assistance is typically provided to NGO project directors, finance and administration managers, and management and information systems officers—who are then supported to cascade that learning throughout their organizations to ensure that all staff benefit from relevant efforts.

To monitor each grant, NHSDP employs: management information system routine reports, supportive supervision and monitoring visits, and a third party data quality assurance process to validate all submitted performance-based grant data prior to payment. In addition to—and to complement—quantitative data collected, Pathfinder conducted semi-structured interviews and focus group discussions with clinic and NGO staff, with the aim of better understanding how and why PBGs impact NGO and clinic performance. Specifically, interviews focused on initial perceptions of PBGs, what has been done well and what could be improved in PBG implementation, and any positive or negative changes in management and service delivery caused

by PBGs. Convenience sampling was used to identify 19 staff from 7 different clinics in Dhaka and Chittagong, and 36 staff from 10 different NGOs in Dhaka and Chittagong to participate in these interviews. Interviews were conducted in March 2016. Select quotes have been used in this publication to better illustrate findings.

On an annual basis, NHSDP assessed PBG indicators, alongside NGO performance in other areas, to ensure indicators were appropriately calibrated and were continuing to incentivize desired behavior. Indicators were revised based on these assessments, NGO input, and evolving project priorities. Additionally, in Year 2, the contract was modified and DFID was added as a donor. This modification resulted in a significant increase in targets for certain performance payments, and thus increased the challenge NGOs faced to meet their targets. At the time of this writing, NHSDP is in its fourth year of implementation and its third year of PBG implementation.

(e) To be eligible, NGOs must be: registered Bangladeshi local NGOs with an NGO Affairs Bureau and Social Welfare Registration; principally located in Bangladesh; current Surjer Hashi Network NGO; strongly linked to community in which implementation is proposed; and must have a constitution and financial management system.

FINDINGS

Quantitative and qualitative findings suggest that performance-based grants contributed to improvements from a systems, service delivery, and engagement perspective.^f With regard to systems improvements, the administrative indicators and the potential to incur a penalty if these indicators were not met, contributed to on-time and more accurate monthly reports from NGOs. During the first nine months of NHSDP implementation, an average of 3.8 NGOs (out of 26) submitted monthly reports on time. In the first and second years of PBG implementation, all NGO reports were submitted on time. The project has also seen significant improvement in the quality of the

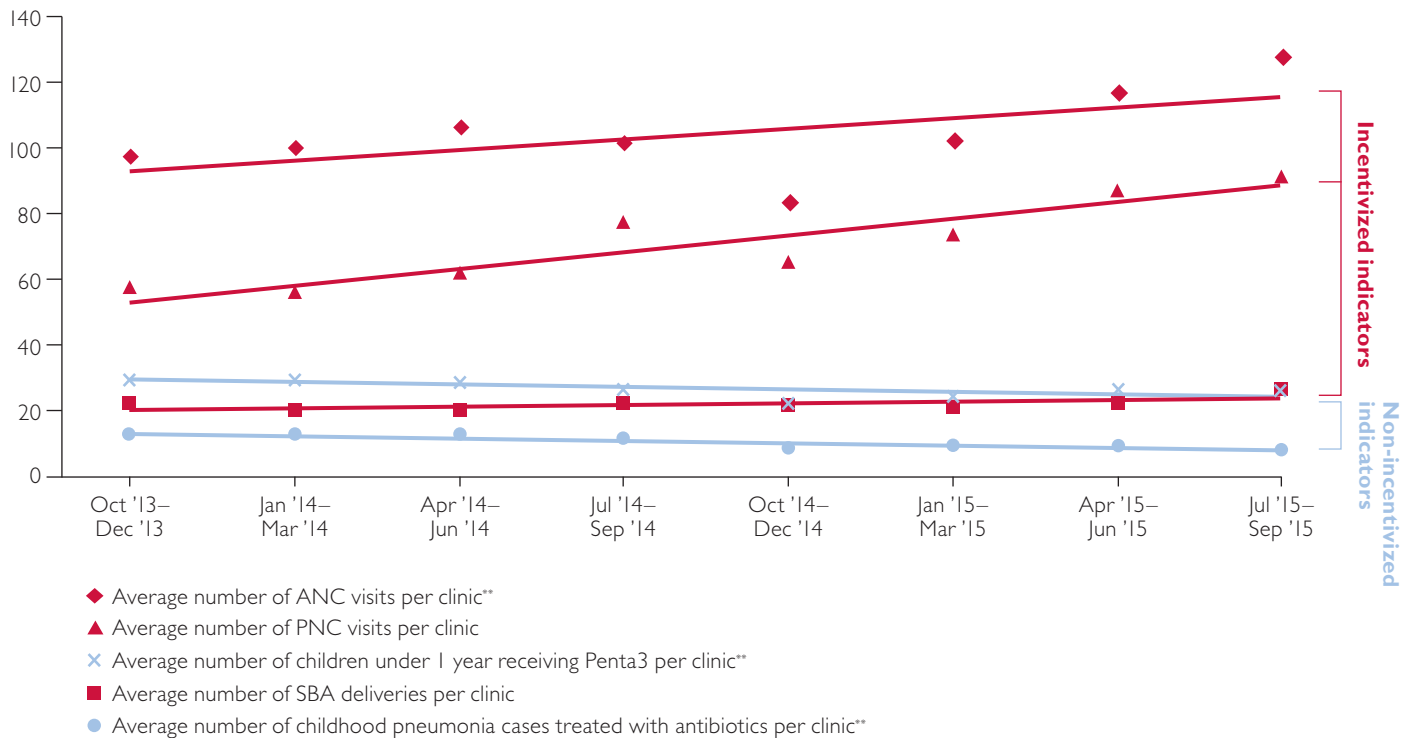
submitted reports, as the errors in submitted reports have decreased over time.

With regard to service delivery, all NGOs met at least one performance indicator target in Years 1 and 2 of PBG implementation, making them eligible for a performance payment. In the first year of PBG implementation, approximately USD 696,867 was paid to NGOs and in the second year, approximately USD 505,719 was paid.^g Illustrative of improved performance, the number of ANC visits provided by project-supported clinics increased from approximately 101,727 per month in NHSDP Year 1 to 134,712 per month in Year 3^h and the number of deliveries assisted by a skilled birth attendant increased from 1,963 per month in Year 1 to 2,868 per month in Year 3.

Further, the percent of services provided to those who qualify as poor increased from 35 percent in Year 1 to 42 percent in Year 3.ⁱ

When compared to non-incentivized indicators, data suggests incentivized indicators performed better. As depicted in Figure 3, the incentivized indicators (number of ANC visits, deliveries by a skilled birth attendant, and number of postnatal care [PNC] visits) increase more over time, while non-incentivized indicators (number of childhood pneumonia cases treated with antibiotics per clinic, and the number of children under one year old receiving Penta3 per clinic) appear to be stagnant or decreasing. These results suggest PBGs may contribute to further improved performance, when paired with other capacity building activities.

FIGURE 3: PERFORMANCE OF INCENTIVIZED VERSUS NON-INCENTIVIZED MATERNAL AND NEWBORN HEALTH INDICATORS IN YEARS 1 AND 2 OF PBG IMPLEMENTATION*



* Deliveries by skilled birth attendants' was not incentivized until Year 2 of PBG implementation.

** These numbers have been divided by 10 due to differences in scale and to facilitate viewing all indicators on the same graph.

(f) At the time of this writing, project data is available for Years 1 through 3 of NHSDP, and Years 1 and 2 of PBG implementation. (g) The project estimates that the modified indicators and increased targets led to decreased performance pay in PBG Year 2. (h) With the inclusion of DFID on the contract, the target for ANC visits increased significantly. (i) After Year 1 of PBG implementation, approximately 55 clinics were added to the project. Results here reflect improved performance from original project clinics only. The total reported data for Year 3 is slightly higher.

Increased pride, accountability, and autonomy leading to locally developed solutions

All staff expressed feeling positively impacted by the PBGs because of the recognition, pride, and material goods the PBGs brought with them. As a clinic counselor and an NGO finance and administrative manager explain:

“There is a formal acknowledgment that the target was achieved and I feel proud.”

“All are committed to achieving the target and it’s not just in terms of the money. It’s also about ownership—the staff person feels a [sense of] accomplishment about what she did.”

The sense of “ownership” is reflected in interviews with staff from all levels. From NGO directors to clinic paramedics, staff demonstrated comprehension of and commitment to meeting their targeted performance. As one clinic paramedic states: “We are constantly monitoring [how] we are lagging behind and we are constantly thinking about what we still have to achieve.” Interestingly, this increased sense of ownership and commitment influenced clinic staff members, as local experts, to actively seek context-appropriate solutions to staff turnover and barriers to uptake or equity. For example, some clinics created a pool of candidates, composed of previous applicants for positions with high turnover, to expedite the hiring process should there be a new resignation. In addition, other clinics employ part-time doctors to meet level of effort targets. Further, clinic counselors and managers explain how they changed their practices to ensure they are meeting targets for service uptake:

“We are more proactive on follow-up visits for ANC and PNC. Previously, we waited for the clients to come. If a client came to the clinic, we provided her with the service.



New mother receiving counseling at Surjer Hashi Clinic, Bangladesh

PHOTO: Quamrul Abeedin

Now, we track the expectant mothers and do active follow-up to encourage them to come in for services like ANC and PNC.”

“We try to provide services in a way that will better satisfy the customers so that [our] customer base will increase.”

This finding suggests an ancillary benefit of pay-for-performance mechanisms may be locally developed modifications to service delivery and solutions to barriers to coverage. Further, such initiatives offer implementers an opportunity to work with incentive recipients to learn from these efforts to adapt and respond to contextual challenges in real time.

Prioritizing incentivized indicators increase staff direction and focus

Interviews revealed that, as expected, the incentives influence NGO and clinic staff to focus more on the indicators that were incentivized, compared with indicators that were not incentivized. Sometimes this had detrimental results. As one NGO monitoring officer shares: “Most staff are interested in increasing the numbers of the PBG targets and we’re losing some quality because of

that.” As such, there is a need for careful consideration when selecting which indicators to incentivize, and for built-in stakeholder feedback opportunities to identify when and how other indicators might be disincentivized and to mitigate potential negative impacts on performance and thus public health.

Intrinsic versus extrinsic incentives as motivators for improved performance

Though clinic and NGO staff both expressed being motivated by extrinsic incentives (such as money for material goods or salary) as well as intrinsic incentives (such as knowledge that one is contributing to social welfare), more clinic staff explicitly expressed intrinsic motivations when compared with NGO staff. For example, as one NGO project director offers: “Staff retention is increasing. Staff satisfaction is felt. When they received the bonus, they could buy a TV or other large purchase.” Performance payments appear to help with staff retention, suggesting extrinsic incentives may successfully motivate improved performance at the organization level in Bangladesh.

In contrast, one clinic counselor offers: "I think there is a benefit for the client. There is more emphasis on our key services and clients receive a benefit from that focus." A second counselor, in describing the benefit received from the PBGs, explains: "Our performance has increased and we are providing more services to the customers." The variety in acknowledged benefits suggests that PBGs have the potential to improve performance of staff motivated by both intrinsic and extrinsic drivers. In addition, future implementation of PBGs may consider the range of factors that motivate different individuals, with particular focus on job functions, to develop incentives that are meaningful and impactful.

CONCLUSION

Performance-based grants have never before been implemented at the organization level in Bangladesh. However, the experience of NHSDP thus far suggests that, when implemented at the organization level in tandem with capacity building activities, PBGs can successfully contribute to improved reporting, autonomy, accountability, focus, and engagement—thus contributing to improved

NGO performance. Performance improvement is a complex endeavor that requires understanding the differing motivations of individuals, groups, and organizations, as well as changing the behavior of individuals, groups, and organizations. Because of this complexity, NHSDP recognizes first, that PBGs may drive change, but are not directly or solely responsible for this change. Second, to understand how and why change occurs, implementers must apply flexible learning approaches that allow them to learn about and respond to drivers of performance and behavior change in real-time.

ENDNOTES

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