In Schematics: Cambodia Performance-Based Contracting of Non-Government Organizations

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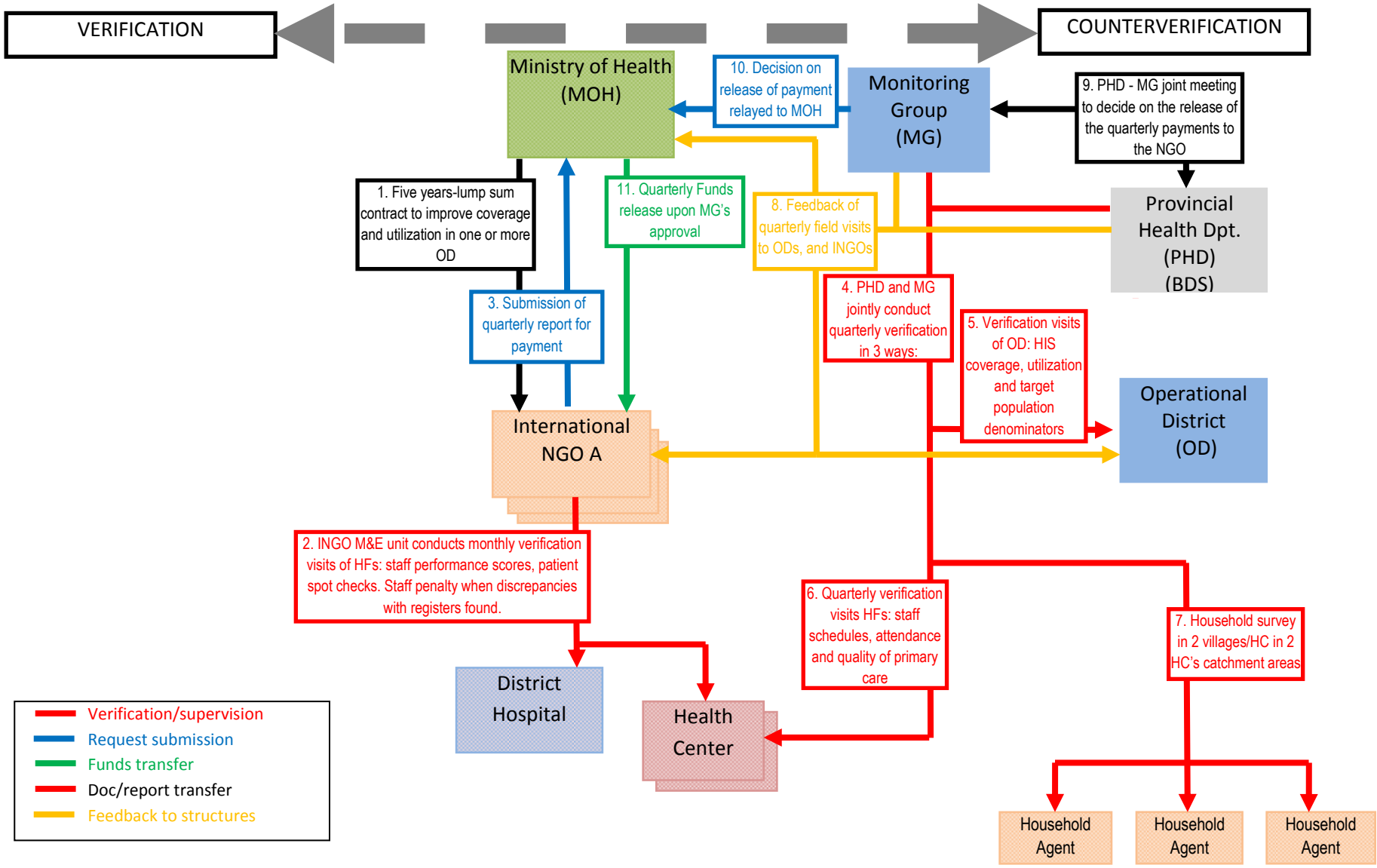
In 1999, Cambodia's Ministry of Health (MOH) first contracted with non-governmental organizations (NGOs) to provide health services in selected health Operational Districts (ODs) under the Basic Health Services Project, which was funded by the Asian Development Bank (ADB). The success of this first effort led to the incorporation of NGO contracting into the successor project—the Health Sector Support Project 2003-09—which was jointly funded by ADB, The World Bank, DFID, and UNFPA. A total of eleven ODs were contracted out to seven international NGOs based on competitive bids received from local and international NGOs based in Cambodia from 2004 to early 2009. Currently a new system for internal contracting is being developed with contracting of designated ODs and Provincial Referral Hospitals, including contracting out external technical verification audits.

This schematic illustrates the previous performance-based contracting (PBC) scheme with five-year contracts to NGOs. Each contract stipulated OD coverage and utilization rates that were expected to be achieved by the contract's end for a range of reproductive, maternal, newborn and child health indicators. Financial penalties were envisioned for those contractors who failed to achieve their targets. Based on contract targets, each NGO contractor introduced either staff-based or health facility-based performance incentive schemes in their respective ODs to motivate low-paid staff to perform key tasks that would contribute toward achievement of stipulated targets.

Verification arrangements were established at MOH level (central and provincial) and NGO level. A first level of verification was established by NGO contractors at health facility level through monthly verification visits. Wherever discrepancies in registers were noticed, the contracted NGO applied appropriate penalties to facility staff. Each NGO had strong incentives to keep costs down through intensive monitoring because of the lump sum nature of the contract. At the central level, a high-level Monitoring Group (MG) was set up. Quarterly field visits by a combined MG-provincial MOH team were conducted to each OD to verify coverage and utilization figures from the Health Information System (HIS). In addition, household surveys were conducted in two villages each in the catchment areas of two health centers. Health centers were also visited to examine staff schedules, assess attendance, and observe the quality of care provided. Results were presented to the MG at the next quarterly meeting for decision making on the release of funds. The schematic walks through the different steps taken in the Cambodia PBC model in relation to contracting, verification and payment while highlighting the different actors involved in the process. Further descriptive information can be found in *Verification at a Glance*, by editors: Joseph F. Naimoli and Petra Vergeer at: http://www.rbfhealth.org/rbfhealth/library/doc/309/verification-glance

A final evaluation of contracting in Cambodia, which relied on individual household surveys in each of the 11 ODs in the first quarter of 2009, found substantial agreement with HIS figures and confirmed that verification arrangements had been successful.

CAMBODIA



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