Dash across with street with a plastic bag over my head, a shield from sheets of rain.
—Phew, I say in the car to Wilson, my driver-for-hire. It’s pouring!
—Dat true, he says. Dat a true ting. How da deh?

It caught me off guard at first: an accent that is vaguely American, inner city. Kinda Creole. Partly pidgin. Words that are round and choppy. Tough like the streets, cool like a bass guitar.

A friend conducting a survey in Liberia has questions translated from English, into, well, English, Liberian style. She asks the cohort (mostly rough and tumble ex-fighters): how many boy child do you have in your whole life (i.e., how many male children do you have total, not just with your wife)? Do you think you like to hold your heart always when trouble comes to you (i.e., are you patient when something frustrates you)? When things are rough can you sometimes hustle (i.e., steal) from people?

—And what do you do when the hustle gets rough?

Ghosts

The hustle has been rough for a long time in Liberia. Indeed, rough is too pale a word to describe what Liberians have been through. Fourteen years of civil war tore the country apart, shattered the economy, and left many severely traumatized. Per capita GDP declined by 87 percent between 1980 and 2005; in 2009, more than half of the population lived on less than US$1 a day and about 80 percent were unemployed.

And the repercussions of sustained violence, of years of persistent, gnawing threat, appear as cracks, shockwaves. They come out unexpectedly, like a car backfiring: impacted rage, stress, fear.

In the car one morning, on our way to a health clinic, I ask James, a Liberian doctor who lived in Monrovia before, during and now after the war: What was it like to be here in those days?

He shakes his head and half smiles, looking down at the floor: “We fought for food,” he says. Then his phone chirps and he takes it out of his pocket and types a message.

I look out the window, into the spit of morning rain. We pass by charred skeletal buildings, an abandoned hospital, some ramshackle houses built atop the jagged black rocks that jut up out of the ground all over this city, like gigantic claws.

The old presidential office speaks of grander days: a wide, elegant half-moon driveway, a towering building on the edge of the sea. But it has been empty since a fire broke out inside soon after President Sirleaf took office. Now it stands rusting, derelict, some people say haunted—by evil spirits maybe or simply the past.

A few minutes down the road, James begins again suddenly: “Wars were fought on these streets.” I turn to face him. He is staring out the window too, but not at anything in particular—just past everything, at some secret thing I can’t see. “We fought for food.”

1 Lindsay Morgan is a policy analyst and freelance writer based in Dar es Salaam. She would like to thank Rick Brennan, Momolu Sirleaf and Yah Zolia, among many others, for their help.
Progress Since War’s End...But a Long Way to Go

Liberia has made astonishing progress since hostilities ended. Under the watch of the Sirleaf government backed by a UN peacekeeping operation, the country is enjoying a period of steadily improving peace and stability. Power was restored to the capital, massive amounts of debt have been forgiven, and the economy is recovering, thanks to investments in physical infrastructure, hefty sums of donor aid and a gradual improvement in security.

Health status is also gradually improving. The infant mortality rate, for instance, decreased from 117 per 1,000 live births in 1999 to 71 in 2007, and the under-five mortality rate from 194 to 110.

But Liberia still has a long way to go. The maternal mortality ratio—994 deaths per 100,000 live births—remains one of the worst in the world. Only about 46 percent of births are attended by a skilled health worker, life expectancy at birth is about 44 years, and only about 39 percent of children 12-23 months are fully vaccinated.

And there are many other health sector woes: deteriorated infrastructure and a tremendous shortage of skilled workers. Health care delivery is fragmented and uneven, with the distribution of trained health workers heavily skewed in favor of urban areas. The Health Management Information System (HMIS) and drug supply chain, though improving, are rudimentary.

Health spending stands at about 6.46 percent of GDP; per capita health expenditure was about $29 in 2008, a fairly large amount relative to many other sub-Saharan African countries. Donors, however, provide the largest source of financing—nearly 50 percent—followed by private out-of-pocket expenditure, which accounts for about 29-35 percent. Though the MOHSW has worked hard to lead the recovery process, it remains heavily dependent, financially and technically, on foreign support. About 75 percent of health services, for example, are provided by aid organizations.

The Lure of Performance-based Contracting

It is a familiar recital. And in countries such as Liberia, that are rebuilding after years, even decades, of war, performance-based contracting (PBC)—wherein contracts are signed between a financing agent and an implementing agent (often an NGO) “with payment depending on achievement of a performance measure that may include coverage targets and quality norms for a set of services”—is increasingly viewed as a way to motivate the health workforce; focus attention on (and provide demonstrable evidence of) measurable results; strengthen information systems; build local capacity to manage and deliver health services; and, of course, improve health outcomes.

The hopes are rich: can tweaking contracts so that targets are tied to an incentive, whether a bonus or a penalty, accomplish such a laundry list of good things? The success of schemes—which are sprouting up like wildflowers in springtime—has varied. In Haiti, NGOs under performance-based payment contracts have exhibited consistently better results than their counterparts. In Afghanistan, contracting itself helped to expand service delivery rapidly and the PBC model outperformed other schemes, but the differences were relatively small (improvements in Afghanistan were also fueled by a huge increase in health funding levels, which has helped to rapidly expand health service delivery in other countries, such as post-conflict Mozambique where there was no contracting). In the DRC, progress with PBC has been more muted. South Sudan is off to a slow start as well, but a pilot in Somaliland has shown positive results.

While the evidence may be far from conclusive, experiences are on average positive enough to spur other countries to give it a try.

Enter Liberia. In 2009, the Rebuilding Basic Health Services (RBHS) project launched a PBC scheme, which contracts NGOs to manage and support Ministry of Health and Social Welfare (MOHSWSW) health facilities and to help build the capacity of County Health Teams (CHT). Less than a year later, the MOHSWSW embarked on its own PBC scheme, contracting both a County Health Team and several NGOs.

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2 Liberia Demographic and Health Survey 2007, Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International Inc.

3 A census carried out in 2009 reports a total of almost 9,000 health workers, of whom 5,461 have technical skills. This total corresponds to roughly twice the number considered as active in 2006. Available data suggest that gross overstaffing is commonplace among many cadres of health workers, even if often invisible because of widespread absenteeism. The personnel of many hospitals, for instance, largely exceed their respective number of beds. There are close to 550 health facilities in Liberia (according to a personal communication with the MOHSWSW Director of M&E). According to the 2010 MOHSWSWMOHSSWSW Accreditation Survey there are 330 public clinics, 30 health centers and 18 hospitals.


6 Counties in Liberia are the equivalent of Districts.
This brief describes the overall design of the schemes, and lessons learned from the first year of implementation.  

The RBHS Scheme: How It Works

In November 2008, Rebuilding Basic Health Services (RBHS) was launched with the goal of increasing access to basic health services and strengthening the decentralized management of the health system. A five-year, $62 million USAID-supported program (a very large amount, for a slice—about one-fifth—of the health services provided in a country as small as Liberia), RBHS is being implemented by JSI Research & Training Institute, Inc. (JSI) and its partners JHPIEGO, the Johns Hopkins University Center for Communication Programs, and Management Sciences for Health.

The service delivery component of RBHS is being implemented through performance-based contracts with five NGOs (Africare, EQUIP, International Rescue Committee, MERCI (Medical Emergency Relief Cooperation International), and Medical Teams International), which provide management support to over 100 health facilities in seven counties. Contracting is a pillar of the MOHSWSW health sector recovery plan, viewed as a means to facilitate the transition from relief to development by improving the management of, and collaboration with, the CHTs.

A request for proposals was issued in February 2009, and contracts were signed in July 2009. For nearly everyone involved—from the RBHS management team, to the NGOs, MOHSW officials and health workers—it is their first experience with PBC.

Selection of Indicators and Targets

Twelve performance indicators were selected in year one; five were added and several were tweaked in year two. Indicators relate to service delivery (for example, the number of children under one year old who are fully immunized) and to administrative and management practices (for example, the number of facilities submitting a timely, accurate and complete HMIS report to the CHT during the quarter).

Establishing baselines and setting targets is the foundation for any PBC scheme. Reward or penalty is determined and performance judged by these targets, yet their selection is often fraught. Post-conflict countries, by their very nature, are information-weak. Figures are often disputed, and disagreements not addressed at the outset can have a corrosive effect on PBC’s smooth implementation.

In the RBHS scheme, NGOs were asked to propose baselines and targets. Where they could not establish baselines, JSI made the determination and targets were negotiated. In the end, baselines and targets were imperfect, since they relied on patchy health facility data, the 2007 Demographic and Health Survey (DHS), and in some cases, averages for regional data. This, along with differences of interpretation of indicator definitions, contributed, say some NGOs, to their failure to meet some targets in year one.

In year two, RBHS staff and NGOs worked together in essentially the same way to determine targets, but with better baseline data, and more clearly defined indicators. And critically, despite year one hiccups, the process by which indicators were selected and targets determined was deemed fair by everyone involved. “They [JSI] were good about it,” said the head of one of the contracted NGOs. “They were not trying to set us up for failure.”

Incentives: Carrots and Sticks

In year one, service delivery indicators were linked to a potential 6 percent annual bonus while administrative and management indicators were (and still are) linked to a potential quarterly penalty.

JSI senior management and NGOs agree that providing a bonus annually was not sufficient to motivate front-line staff. Chris

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7 The latter focuses on the RBHS experience, for which there is more information to draw on.

8 105 facilities in year one, 112 in year two.

9 Contracting has been central to Liberian health policy for decades: the act that established the Ministry of Health in 1971 stipulated that the Ministry would provide services by contracting private providers. The YEAR contracting policy states that the aim is to “leverage partner capacity to prepare the County Health Teams to resume management of health facilities and the workforce... The Government of Liberia is the provider of last resort.” “The county level shall be responsible for health service delivery, while the central level will focus on policies, resource mobilization and allocation, aggregate planning, standard setting and regulation.” The policy document recognizes that a number of services can be delivered in a more cost effective manager is they are out-sourced, and describes a desire for a “small but efficient government in Liberia.

10 Implementing partners also report on over one hundred other indicators not directly linked to incentives, most of which are routinely collected through the HMIS. They are reported to monitor progress of the health services which are considered for NGOs contract extension and allow RBHS to monitor for any potential perverse effects by incentivizing some indicators over others. For more on how indicators were selected see: Petra Vergeer, Deirdre Rogers, Richard Brennan, Shirl Sarcar, “Identifying Indicators for Performance-Based Contracting (PBC) is Key: The Case of Liberia,” World Bank, June 2010.

11 Partners used their own household surveys, facilities’ historical data, and the 2007 Demographic and Health Survey (DHS) to establish baselines.
Seubert, Country Representative for Africare, illustrates the problem: “I presented the PBC system to senior staff at facilities at a meeting in December [2009]. When I told them about the bonus they cheered and clapped. But since it was Christmas, we also gave them each 25kg of rice—and they were much more excited about that than a month’s pay one year later.” In year two, the bonus will be paid each quarter.

The contracts allow relative flexibility on how bonuses are spent but they are meant to reach frontline staff at facilities and CHTs and are subject to the approval of RBHS. Cash is preferred, but to comply with USAID regulations, implementing partners are considering a range of other incentives, from scratch cards for air time and housing and schooling allowances, to generators and lab coats.

The “stick”—quarterly penalties for not meeting targets—is a powerful incentive for implementing partners. Having a portion of their annual budgets hinge on things not entirely in their control was described as a “gamble” by one NGO representative. “If you lose that, what gets cut? You can’t stop repairing your cars,” he said. But, “we can voice our concerns, which mitigates the risk.”

Data Collection and Verification of Results
Implementing partners have thirty days from the end of each quarter to submit reports to JSI, and they are generally paid 3-4 weeks after submission. 12

All providers are required to report through the HMIS, but RBHS has established additional mechanisms to verify performance including random facility visits by independent monitors (three randomly selected health facilities per NGO per county each quarter) to cross check reports against facilities records.

“One of the biggest benefits [of PBC] is the focus on data to drive your program and the data validation process,” says EQUIP’s Justin Pendarvis. By scrutinizing data, EQUIP found instances where some facilities’ good performance was not being captured due to poor record keeping. 13 “It keeps everyone accountable because you know someone is going to check.”

Start-up
Shortly after contracts were signed, RBHS held an orientation for stakeholders in which the basics about PBC were explained. But thorough sensitization of health workers—the intended beneficiaries of bonuses—was never done systematically. 14 At least one NGO attempted uniform sensitization, developing a one-pager explaining the scheme, which was distributed to health facility staff. But overall, education was haphazard.

RBHS Results, Year One 15

RBHS and its partners documented solid results during the first year of PBC implementation. Some of the main achievements include:

- 81 percent increase in facility-based deliveries;
- 52 percent increase in couple-years of family planning protection; and
- 134 percent increase in pregnant women receiving a second dose of intermittent preventive treatment of malaria (IPT2).

Almost 110,000 children were treated for malaria, averting an estimated 2,167 deaths. And the number of individuals tested for HIV exceeded targets by almost a factor of four. There was also progress in program management—99 percent of health workers were paid on time by the end of year one and 94 percent of HMIS reports were submitted to the MOHSW on time.

Overall, partners met 63 percent of administrative targets, which translated into an average penalty of 1.85 percent per NGO—a solid performance considering that targets increased steadily each quarter. And partners met 52 percent of the annual performance targets, resulting in an average bonus of 3.1 percent. Of the seven annual indicators, at least one NGO met its target

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12 This includes a narrative report, explaining progress against targets; exported DHIS data; data sheets from facilities; a financial report (to justify expenses; no receipts are required); an invoice; and various attachments, such as meeting minutes or supportive supervision reports.
13 For example, the IPT2 indicator reflects the imperative for women to take two doses during pregnancy to prevent malaria. But even when facilities were giving women the second dose, they did not always register it in the ledger. Sometimes, they only marked the second dose on the women’s cards or they marked it as an ante natal visit. So PBC became an opportunity to improve the facility’s score by improving data collection.
14 From Bank indicators report to providers was found to be especially important in the case of management contracting in Cambodia: “To bring about change it is essential that incentives be directed to the service provider and/or beneficiary level. This trickling down of incentives
15 This information was obtained in a personal communication from Rick Brennan, Chief of Party for Rebuilding Basic Health Services, 14 November 2010.
for each, and for five of the indicators three or more NGOs met their targets.

Given the challenges of start up, RBHS management were slow to penalize and quick to reward in year one. Implementing partners, for example, were not penalized for drug stock outs, since, due to ordering and procurement delays, drugs were not delivered to partners until June 2010. "Developing new systems and processes to support performance-based contracting was always going to have growing pains," says Rick Brennan, RBHS Chief of Party. "We did not want to unfairly penalize our partners for failing to meet a target because of confusion over definitions or because of factors beyond their control. We erred on the side of being lenient when determining whether to impose a penalty, especially during the first three quarters."

The Ministry of Health & Social Welfare Scheme

In November 2009, the MOHSW signed its first two performance-based contracts, one with Bomi County, and another with the faith-based organization Pentecostal Mission Union (PMU), which together covered 37 facilities. Six additional contracts with four international NGOs (African Humanitarian Action, IRC, Merlin, and Save the Children UK) were signed in April 2010—covering 87 facilities in six counties.  

The Ministry’s commitment to PBC is strong. Yah Zolia, the new Director of the Monitoring and Evaluation Unit recalls her experience with health facilities that are paid bonuses to be open on the weekends. "So you go there and they are open," she says. Momolu Sirleaf, the Director of the External Aid Coordination Unit, is also a champion: “If you give people a bonus to deliver more babies,” he says, “they will go out into the community and mobilize.”

The MOHSW scheme has benefitted from the experience of RBHS, and indeed, the schemes are similar. In the MOHSW scheme, there are 15 performance indicators, down from about 24 when the program began. RBHS and the MOHSW have worked to harmonize their indicators: they are nearly identical. Target setting was a challenge. The MOHSW relied on HMIS and DHS data, negotiated targets with NGOs, and agreed to revise as the program was implemented.

Incentives consist of a potential quarterly penalty for underperformance on some indicators and a potential annual bonus of up to five percent of the contract value for achievement of others. As with RBHS, the bonus is meant to be filtered down to the facilities, and is subject to Ministry approval, but frontline workers have not been systematically sensitized about the program they are meant to be motivated by.

Implementing partners submit quarterly reports to the MOHSW and the CHT summarizing progress made on the performance indicators, and are monitored by the MOHSW and CHTs through random facility visits, interviews with facility staff, health facility assessments, and regular meetings with the MOHSW technical team at the CHT level with contracted organizations.

As with RBHS, there is a sense among NGOs contracted with the MOHSW that PBC is a good thing. Says Merlin Country Director Lawrence Oduma: “this country has been running on an emergency mode for so long, and many external agencies are yet to transform to development. Merlin saw PBC as a means to do so.”

But along with enthusiasm, there is a strong sense of confusion. Contracts were signed without many details in place, and there are many aspects of the program—terms of payment, duration, validation tools, even a mechanism for awarding bonuses—that remain unclear.

The Risk PBC Poses for Implementers

“Were we looking at it today,” said one NGO representative contracted under the RBHS scheme, “our senior management may not go for it.” Most NGOs operate under cooperative grant agreements, wherein they agree to accomplish certain objectives and are paid based on the things they do to try to accomplish those goals, such vehicles that were purchased, meetings held, people hired.

16 Contracts will run through June 2012, and are funded through the Pool Fund, to which the U.K. Department for International Development (DfID) was the first contributor in April 2008. Irish Aid, Unicef and UNHCR subsequently also contributed.

17 As an example, the circumstances under which the penalty or reward will come into play are fuzzy. According to the contract with Bomi County: "This performance bonus will be awarded based on progress made towards the agreed targets. Conversely, up to five percent (5%) of actual expenditure against the obligated Contract amount will be deducted for under performance on the agreed targets." What "progress made" and "under performance" mean is not clear. An INGO representative concurred: “There’s a lot that’s not clear right now.”

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They are paid for inputs and “effort” but not necessarily for accomplishments. Payment, in this kind of an agreement, could be withheld if they do not perform but it rarely is, as most of the time NGOs can prove they made an effort.

“With PBC you have to perform or you’re not paid,” he went on. “We’re used to getting advance funding, operating off of that and then requesting the next installment. With PBC we were given some ‘seed money’ when we produced our plan of work but we used it quickly and then we were on our own. This creates a cash flow problem for NGOs. Local NGOs could never do this. Say you do all the work and then don’t ‘perform’? This is a risky environment in Liberia, one we can’t control.”

Capacity Building: A Tricky Task

“The purpose of RBHS,” says Teferi Beyene, RBHS Project Director for Medical Teams International, “is to help the ministry decentralize and manage health services. But still, there is a gap.”

Or as Merlin’s Lawrence Oduma says, “There is a significant disconnect between the MOHSW and CHTs in terms of capacity. There are some very good technocrats in Monrovia, and they set good policies, but the CHTs need help planning ahead, managing supplies and human resources and finances.”

County Health Teams are typically staffed with 10-14 people who are generally not well paid. Over the course of a year, the County Medical Officer may change (in Bong County, Africare worked with four CMOs in year one of the RBHS scheme), and each time there is a change of staff, new relationships must be built and the contracts explained.

CHTs are also in the process of sorting out their role in a health sector defined by the amorphous transition from emergency relief to long-term development. “The CHT has to tell you how they want you to build their capacity and they have lots of other things to do,” says Dave Waines, Country Director for EQUIP Liberia.

Furthermore, “They don’t always want the advice,” says another NGO representative. CHT staff are sometimes averse to being “taught” in front of staff of the facilities they are supposed to, eventually, manage. Several NGOs also complain that for many CHTs, capacity building equals money: “for some people, if there is no monetary benefit they are not interested.”

“Personal, collaborative relationships with CHTs are key,” says Waines. “We’ve invested a lot. You won’t get anywhere if you’re butting heads.”

Implementation is Hard: How Do You Maintain Momentum and Goodwill?

The first year is a critical time in PBC, the time to experiment and correct. There are several attributes that have helped Liberia maintain an appetite for PBC, even as implementation has been bumpy.

Let’s start with leadership. “Liberia used to be a pariah, and they knew that. Now they’re a donor darling,” says a veteran health sector expert who has worked in numerous post-conflict countries. On a visit to Monrovia in 2010, he says he was concerned the MOHSW might have grown slovenly, wasted money on ostentatious offices and become aloof, self-important. “But their office is still falling apart!”

It is an odd compliment, but illustrative: the MOHSW leadership is widely respected among donors and development agencies in Monrovia. It is not unusual to hear them described as the strongest Ministry in Liberia, forward thinking, proactive, ambitious, and modest. It was the MOHSW, for example, that requested an assessment of their capacity to contract. And in order to demonstrate that donors could entrust them with their money, the MOHSW set up an office of fiscal management and, with assistance from DFID, contracted PriceWaterhouseCoopers to train local accountants. They also managed to avert a serious funding gap by convincing donors to maintain funding to the sector despite a planned withdrawal of humanitarian funding and delayed arrival of development funding.

“The MOHSW here has a strong vision.” says Brennan. “There was a lot of stakeholder buy in right at the beginning, and since then the MOHSW has proven itself to be credible and transparent. They’ve insisted that they lead the process, and they have engendered the trust of the donors.”

Another critical ingredient to the overall smooth functioning of PBC in Liberia is frequent communication between players and a willingness to listen and course correct on the part of program managers.

For example, according to one NGO representative, the RBHS independent monitors were at first reluctant to share reports with
partners, creating a sense of frustration among NGO frontline staff that could have grown. But RBHS responded by making it a priority to train monitors that it was okay to share information. “This is important,” says Africare’s Chris Seubert. “We’ve had relationships [with another partner] where people start to hide things, don’t trust each other. You need openness.”

RBHS and its partners also hold monthly meetings with partners to discuss challenges they are facing during implementation and possible solutions, as well as quarterly monitoring and evaluation meetings to review data and progress.

Open lines of communication and acknowledgment of mistakes generate goodwill and trust among the players, and have resulted in a sense in Liberia—among MOHSW officials, RBHS management, implementing partners and even health facility staff—that they are on the same side.

**Conclusion**

There are things that could have been done better in both PBC schemes. Ordering and procuring drugs took way too long; health workers ought to have been systematically sensitized at the outset, and indicators should have been more clearly defined. On the RBHS side, the process of drafting an RFP through to establishing baselines and targets was rushed—it is worth it to take time at the outset to get these details right.

On the MOHSW side, Benedict Harris, the Director of Policy, Planning and Health Financing would like to see a secretariat established in the Ministry specifically tasked to manage PBC, and several stakeholders agree that a formal assessment of the first year of implementation would be helpful.

But design and implementation issues are inevitable in any PBC scheme (indeed, they are inevitable in any development project anywhere) and can be corrected over time. The key to PBC’s long-term success is more fundamental: it requires strong and committed leadership; regular and frequent forums for communication between players; flexible and responsive management; and, perhaps most important, goodwill among partners. When the hustle gets rough—when implementation begins and the challenges cascade like a waterfall—these intangibles are the key to keep PBC moving forward.

Progress made in Liberia in the post-conflict period is a reason for optimism—but not of complacency. The hurdles ahead—for PBC and the health sector broadly—are higher than the ones just overcome.