

**Performance-Based Contracting for Health services in Haiti: Process,  
Progress, and Impacts**

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**by John Pollock**

Management Sciences for Health  
Haiti Health Systems 2004 Project  
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## **Performance-Based Contracting for Health services in Haiti: Process, Progress, and Impacts**

John Pollock, Management Sciences for Health

Inputs from: Paul Auxila, Uder Antoine, Bernateau Desmangeles, Pierre Despagne, Pasquale Farese, Florence Guillaume, and Chantale Lamarre

### **1) Introduction**

The HS2004 project was initiated in 1996 with funding from USAID in a context where adequate health services were not available to many people in Haiti and where services that were available were being provided primarily by NGOs. The services were subsidized by an array of donors with funds being transferred directly to NGO's on what was fundamentally a cost-reimbursement basis. Well-known political and resource constraints had minimized the ability of the Ministry of Public Health and Population (MSPP) to be effective.

The numerous NGOs in Haiti had been able to provide enough services through this mechanism to have a positive impact on major health indicators over the previous several years. Their work had, for example, already significantly lowered infant mortality rates. But the services were erratic in quality and had wide variations in cost from NGO to NGO.

USAID had recognized that their system for transferring resources was not being as effective as it could be in providing access to quality services and wanted to shift to a system that would reward impact rather than activities. The HS2004 Project was designed to consolidate the USAID investment in health (combining a number of previous project activities) and to establish a basis for activity that focused on performance and impact.

### **Goals, Roles, and Players**

Management Science for Health, (MSH) proposed an approach for working with these NGOs as contracting partners (not as grantees) and accepted responsibility for achieving program results entirely through the work of these NGO partners. At the outset, there were 15 NGO's that had been supported by

#### **The HS2004 Project strategic objective is "Healthier Families of Desired Size."**

Program goals are for increased use of quality child survival services, increased use of quality reproductive health services, and reduced transmission of selected infectious diseases (including HIV/AIDS and TB).

The project currently works with a network of 30 service delivery NGOs in addition to actively coordinating with the MSPP at the central and departmental level. Work is supported in all 9 departments.

By the end of the Project (now scheduled for March 2005) nearly \$100,000,000 will have been allocated to meeting these goals.

USAID and a continuation of this support without interruption was the start-up priority. Whatever the new system would be, current levels of service provision could not be allowed to collapse.

## 2) Design of contracting and incentive scheme

The entire HS2004 project is 'performance-based' MSH is responsible for outputs, not for activities. Each NGO partner has a negotiated subcontract with the goals and program boundaries well-defined. At project start-up, there was no choice but to contract with the initial 15 NGOs on a pure cost-reimbursement basis (delays in the federal award process had used up all of the transition period in the design). MSH established these instruments for an initial period of 3 months in order to maintain service levels while working with the NGOs to develop a more appropriate system.

The problems with the cost-reimbursement system were clear. With all expenditures reimbursed, there was no real incentive for efficiency or to improve management and operational systems. With no contractual link to results, there was weak incentive for improved quality or expansion of service coverage. (Its worth noting here that these organizations were and are mission driven. There was and is an internal drive within each NGO for providing essential services. The use of the word 'weak' is intended to recognize both the central importance of these NGO missions and the fact that there was little pressure to innovate and expand).

Early steps in the process included establishing a Preferred Package of Services that each NGO would be responsible for delivering, negotiating work plans and budgets with each NGO that clearly defined their roles and obligations, and setting up monitoring systems for tracking service delivery and quality and for management and financial accountability. The Project has been interested in

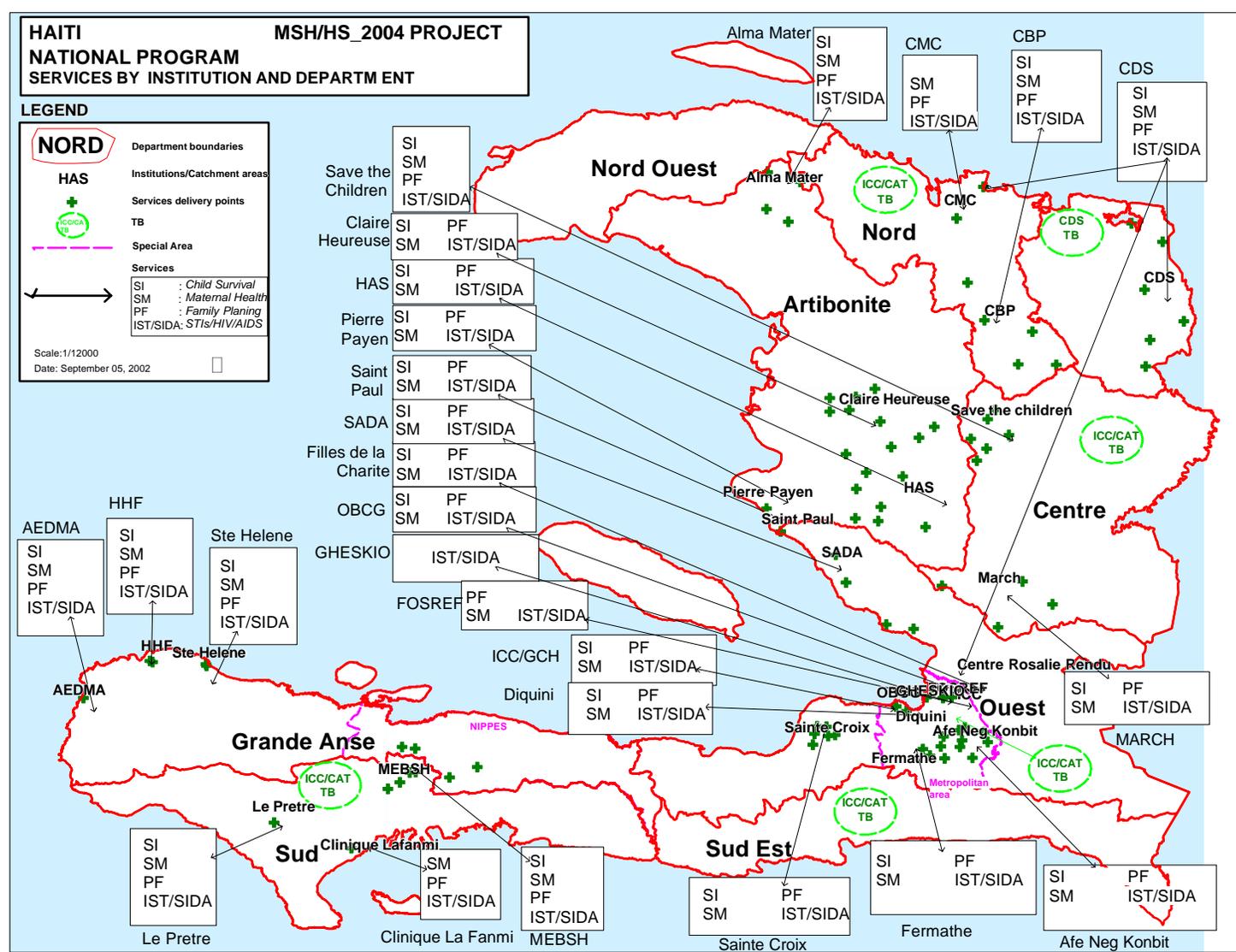
A population based survey performed in 1997 found wide ranges in the performance of indicators established by the HS-2004 project. For example:

- Some NGOs achieved contraceptive prevalence rates of 25%, while others achieved less than 7%.
- Some NGOs succeeded in providing a minimum of 2 prenatal visits to 43% of pregnant women in their regions, while others only reached 21% of this important target group.
- One NGO succeeded in ensuring that a trained attendant attended 87% of births, while a worse performing NGO only succeeded in attending 53%.
- Vaccination coverage varied widely with the worse performer only reaching 7% of the target population and a good performer reached 70%.
- One NGO made sure that 80% of women knew how to prepare ORT, while another only educated 44%.

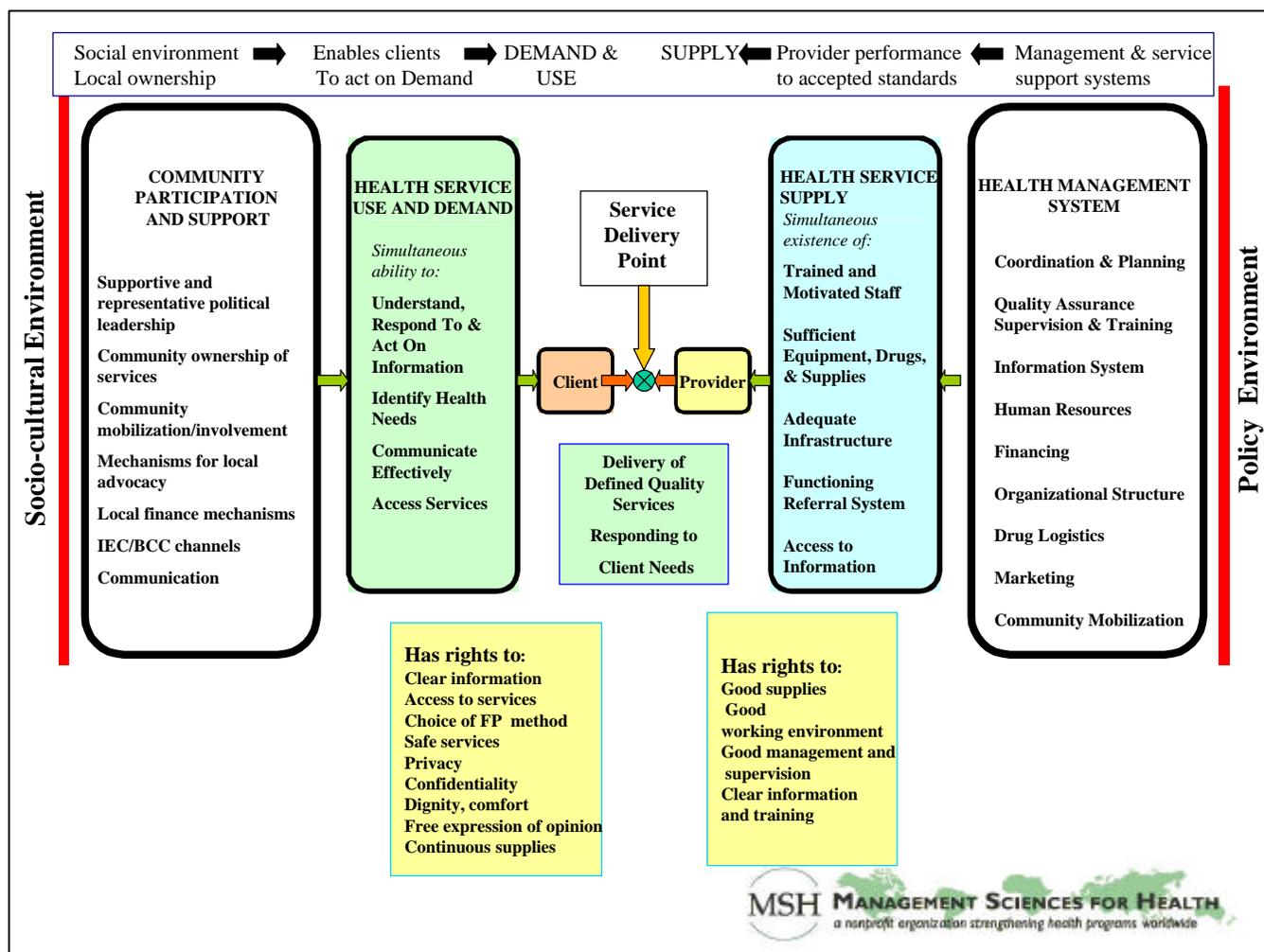
This wide range in a sample of indicators was in no way correlated with costs incurred per visit (rough estimates of average costs per visit based on performance data ranged from \$1.35 to \$51.93). Some NGOs with high estimated average costs per visit were relatively poor performers, while other low cost NGOs achieved more impressive performance targets. While it is clear that conditions differ among regions of Haiti, it is not likely that wide differences can be explained by conditions that are completely outside of the control of health care providers. It is also clear that an NGO with high average costs per visit and poor performance indicators is not efficient.\*

and has supported the organizational development of its NGO partners, but only in relation to achieving its goals and promoting sustainable systems for service delivery. Technical assistance has been provided to NGO staff in both management and technical services areas and tools have been introduced to enable NGO managers and service delivery staff to plan and monitor their own work for efficiency and impact (CORE, MOST, SD&MA).<sup>1</sup> The HS2004 Network (a name the NGOs have given themselves) has increased from the initial 15 to 30. This change has included the departure of some NGOs from the network (support is not continued where impact is not achieved) and the addition of new partners that have come forward with strong proposals.

An important feature of the Project is that the NGOs are brought together as partners for purposes of planning and information exchange. Information from the monitoring system on NGO performance (both cost-efficiency and service data) are shared across the Network. NGO managers not only work with their own budget and service delivery systems, but are also able to understand where they are performing well in relation to others and where improvements may be needed. Regular Network meetings encourage sharing of strategies that both succeed and fail in the challenging Haitian environment. The network effect enables NGOs to support each other.



The context for providing health services in any environment is complicated and includes many factors that operate at once. MSH uses a Fully-Functional Service Delivery Point concept to model the array of systems, social, and policy elements that must be considered in designing any program intervention.



In working with the NGOs to expand capacity and broaden impact, the need to address all of these factors is emphasized. Since all projects are finite in scope and time, MSH adopted an approach that focused entirely on local ownership and promotion of sustainable practices. Through the first several years of work on the Project, NGO contracts were managed on a dual system. Contracts were negotiated around performance goals, but payments were still based on cost-reimbursement. This meant that within each reporting period, the cost-reimbursement process operated with its known lack of incentive for efficiency and innovation. The main leverage for improved efficiency and impact came at contract renegotiation points. At these points, individual NGO efficiency and impact data were used in confirming NGOs for continued participation in HS2004 and then included in the process of determination of what the scope, goals, and budget would be for each continuing NGO.

Progress was being made, but there was an opportunity emerging to add a new set of elements that had the promise of creating stronger incentives within NGOs for efficiency and expansion of coverage that could also have the impact of creating a market pressure for quality and access. The project team identified the three top performing NGOs and worked with them to design a revision to the contracting mechanism that enhanced the focus on HS2004 objectives and also responded to needs perceived by the NGO managers. Each of these NGOs had already established strength in capacity areas such as financial management, strategic planning, human resource management, patient flow, drug & commodity management, etc.

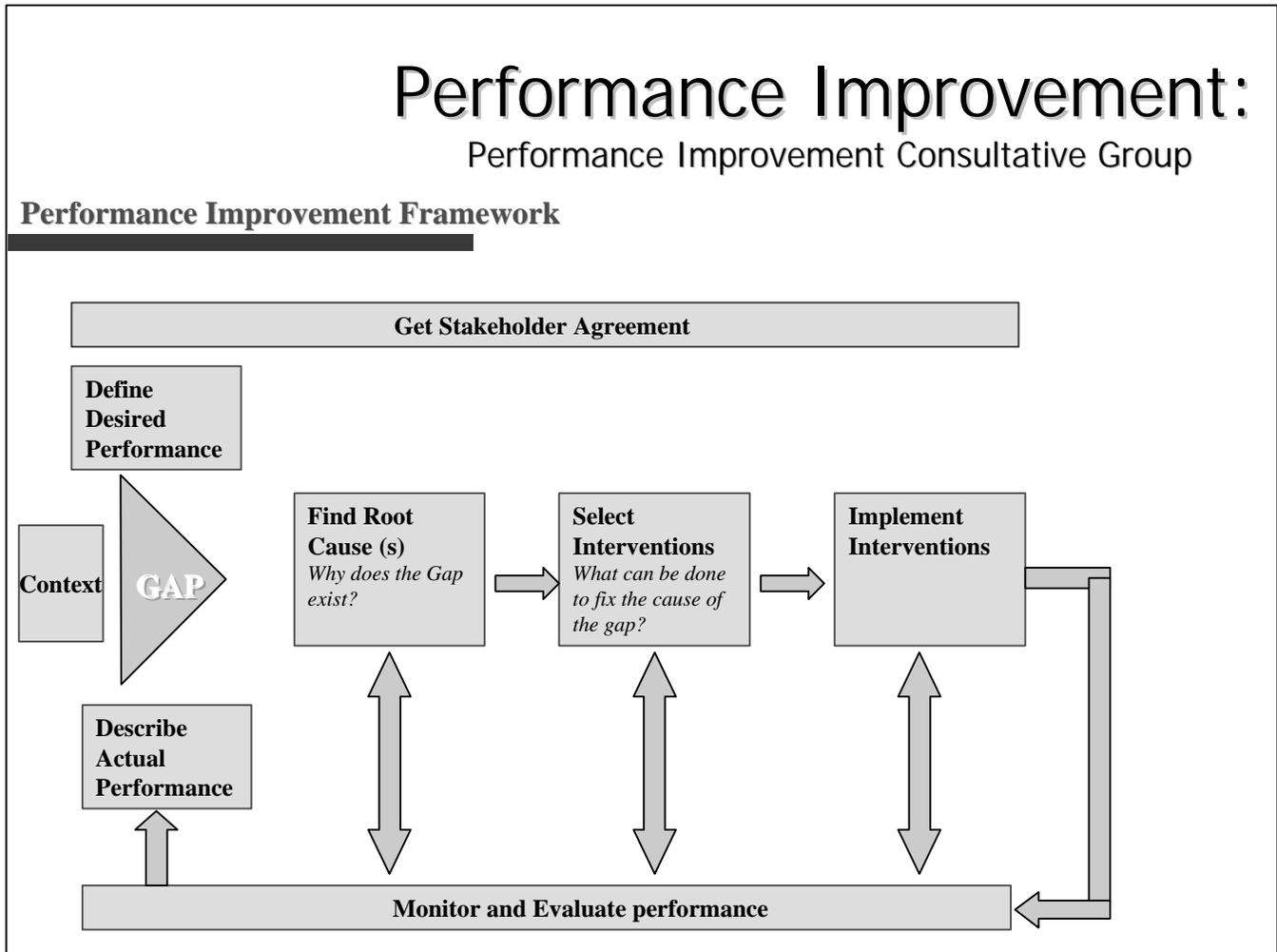
The new mechanism, the Performance-Based Contracting Program, included specific accountability for service delivery goals and, while maintaining the safety net of cost-reimbursement, added elements of both financial risk and incentive. Each NGO negotiated and agreed to the specific subcontract indicators and performance targets. Each also accepted a major new element in the financial contract. For whatever the projected budget requirement was for the coming period, the NGO was required to meet the agreed performance goals but could only be reimbursed 95% of the projected budget. The risk was the loss of 5% of the projected budget if goals were not met. The incentive was that, if all goals were met, there would be an additional performance incentive payment to the NGO of 5% of the projected budget. These NGOs saw an immediate need to 'do more for less' by planning to meet 100% of the goals with 95% of the financial resources. But they also saw the potential for gaining through the performance incentive not only the 5% at risk, but also another 5% beyond the '100%' boundary...all of which would be available for discretionary allocation by the NGO. Failure to meet any individual target results in a reduction of the potential incentive payment according to a pre-specified formula agreed upon with each NGO.

Another feature of the program is that participating NGOs can access financial resources (up to the 95% committed) as they perceive need rather than on the basis of monthly or quarterly tranches. This flexibility is designed to allow changes in plan and strategic investments that can enhance performance but which might be hampered in a more highly regulated system for resource flows.

Since the first year of the Performance-Based Contracting program, the participation has increased from the initial 3 NGOs to a total of 9 for the work in 2002. (A 10<sup>th</sup> NGO had participated in the second year, but withdrew). This participation represents 1/3 of the HS2004 Network NGOs, but covers 1/2 of the population to which Network health services are delivered.

The Performance Improvement model, adapted from the work of the International Society for Performance Improvement, was introduced to the Network NGOs in 2000 to provide a clear process that managers could use within their organizations to identify performance gaps and their causes and then act to improve performance. The model itself is simple enough to grasp. In the context of this program, each NGO begins with an agreed assessment of the current status of its service delivery program and works with the HS 2004 team to establish goals. The monitoring of progress begins early and is used to gather information that has helped organizations to identify causes of problems and inefficiencies as well as to identify areas of high impact. When problems are understood, it is easier to design and implement changes to remedy them. When areas of strength are clearly outlined, it is easier to build on and replicate their characteristics. The continuation of the monitoring process leads naturally to active evaluation by the NGO staff themselves. When a potential for failing to meet incentive targets becomes clear, individual staff members of the NGOs have information that enables them to consider changes in

approach. The NGO managers are able to consider alterations to systems, reallocation of resources, or fundamental strategy changes.



Indicators in the initial year were entirely focused on service delivery. For the 2002 cycle, elements related to management systems and coordination were added. The indicator targets are negotiated based on results of the previous year (or current status), capacity of the NGO, and needs and institutional goals of the NGO. All NGOs in the HS2004 Network report monitoring data on a routine basis and participate in a periodic process of evaluation, the Service Delivery & Management Assessment Protocol (SD&MA). The SD&MA validates these data and assesses the performance of each program across all points of the preferred package of services and links this performance to an assessment of the essential management support systems noted in the FFSDP.

Current health services indicators include:

- % children under 1 year fully vaccinated
- % pregnant women receiving 3 prenatal visits
- % births followed by postnatal care home visit
- % utilization of family planning services
- % FP method users not re-supplied (=2 mo.)

Current management systems indicators include:

- Putting in place an improved system for supervision
- Establishing a performance management system
- Reinforcing the organization of dispensary services
- Establishing human resources management function
- Improving inventory systems

### 3) Results to date:

The results have been generally positive and fit into two categories. The first category is on the delivery of health services. These figures reflect the impact of the P-B C program on service access and quality. Its important to note that the targets are estimates and that the Project has been open to reviewing targets if it seems that they had been based on incorrect assumptions or reporting of data. To date, no NGO has asked to lower targets, even in a few cases where late information had indicated that the assumptions were high and it seemed that the targets might not be met. The table below shows the success rate (as a percentage of the target incentive for each of the three years of the program) for each participating NGO. It does not represent individual indicator results.

#### P-B C periods

HS 2004 Phases	Phase I	Transition	Phase II		
Performance periods	P. 1 - Pilot	P. 2	P. 3	P. 4 – Extension of P. 3	P. 5
Dates	Nov. 1999 - March 2000	April – Sept. 2000	Oct. 2000 – Sept. 2001	Oct. – Dec. 2001	Jan. – Dec. 2002
Time extent	5 months	6 months	12 months	3 months	12 months
Nb. Of NGOs	3	3	7	6	9

#### Achievements of NGOs in Performance-Based Contracting Program Serving 1,194,008

NGO	Population Served	Percent of Incentive Earned (achievement of All Targets)					Indicator change during P-B C partic. and Years in program		
		P. 1	P. 2	P. 3	P. 4	P. 5	Immunization	3 prenatal visits	Years
1	167,374	70	85	90	100	70	49.2 to 78.0	49.3 to 41	3
2	323,513	80	85	70	100	60	39.7 to 81.0	32 to 63	3
3	55,983	40	75	90	90	20	34.7 to 69	18 to 38	3
4	127,706			80	100	55	37 to 65	17 to 27	2
5	144,905			70	90	10	73 to 84	38 to 78	2
6	125,207			80	81	80	54 to 83	25 to 67	2
7	126,700			10			NA	27 to 25	1 (not ctd)
8	NA					48	NA	NA	1
9	59,620					78	50 to 88	44 to 47	1
10	63,000					48	78 to 77	36 to 36	1

Non- PB-C NGOs serve 1,312,207 ( Total population served by HS2004 network 2,506,215)

The project target for immunization was 63% for 2000, 70% for 2001, and 80% for 2002  
The project target for 3 pre-natal visits was 47% for 2000, 55% for 2001, and 65% for 2002.

Reports from individual NGO managers have indicated high satisfaction with the program and observed that the processes of monitoring, identifying problems that could impede performance, and devising actions have had a positive impact on motivation. An apparently low 'success' rate in 2002 (the percent of the possible award target that was earned in period 5) represents, in some part, the difficulty of meeting increased expectations taken on by continuing NGOs that had already made the most readily identified adaptations. But this result is also linked to central system problems with commodity distribution in Haiti during 2002 that were not directly in the control of NGOs but which resulted in unavailability of essential vaccines and family planning supplies when and where they were needed. The factor was not a basis for lowering expectations, but did cause NGOs to come up with tactics to improve their own abilities to secure supplies in an environment where the central systems were failing.

The second category relates to changes in the organizations that targeted cost-effectiveness, but have also had impacts on the development of these organizations in several areas. Capacity for strategic planning has increased, demand for and effective use of M&E for performance enhancement has developed, improved systems for supervision and human resource management have been established, and awareness of the potential of incentive systems for promoting innovation and impact has increased.

The need to track progress toward targets led to a general strengthening of the internal need for and valuing of M&E systems. The service data were collected with a view toward monitoring efficient use of resources and program impact. In some cases, this has been the first time that service data have had an internal use in program planning and system innovation.

- NGO number 2 was alerted to the likelihood in 2002 of failure to achieve the immunization target, one that they had effectively met in the first two years in the program. The main reason for the problem was known, but the managers recognized that they could and should consider their options for improving on what looked to be a dismal outcome (an actual reduction in coverage seemed to be inevitable). They worked with service staff to identify points where staff limitations had prevented full program implementation and moved some staff to enhance efforts. They sought (and gained) access to vaccines being held in central warehouses or available through other sources than had been used in the past and so improved their supplies. In the end, this effort dramatically changed the result. Immunization coverage went up over the previous period rather than dropping off. The target, however, was missed by a narrow margin. While the staff members were disappointed in missing that element of the incentive payment, the experience galvanized both management and service staff to include an element of 'innovation planning' in their regular work. A planning workshop has been organized by this NGO (taking place this week) to review the experience in 2002 and to design actions and changes to assure success in the current year.

The use of the incentive payments themselves has had an impact on internal management processes. NGOs working in this program have found a number of ways to pass the incentives along to individual staff members as a way in reinforcing individual and team motivation.

- One NGO has chosen to pass most of the incentives along to staff in the form of individual awards at the end of the year. In order to avoid internal conflict, all staff members were eligible to receive these awards, not only those working on HS 2004-funded program elements. A base amount was allocated to each individual, while groups (no attempt was made to single out individuals) that had made particularly important contributions were given larger awards along with recognition for their

effectiveness. The awards were significant (averaging at the equivalent of more than a month's salary).

While solid management systems were required for inclusion in the P-B C program, the evolution of the internal management and support systems of these NGOs has been impacted by the program. All Network NGOs are assessed on both their service delivery records and management system functions. In the third year of the P-B C program, specific indicators were agreed on with each participating NGO relating to these systems (establishing or improving supervision systems, for example). These changes are altering the way the NGOs undertake planning and financial and human resource management.

Eight NGOs had the putting in place of an improved system for supervision as a target indicator in 2002. The incentive for this indicator was divided into three components 1) Most of the NGOs successfully developed new protocols for supportive supervision of service delivery staff. 2) They also established a clear calendar for supervision visits and those visits have taken place. 3) The third step in putting in place an effective supervision system, the documentation of results through individual performance reports has been more complicated to achieve. Only 2 of the 8 NGOs with an improved supervision system as a target indicator were successful in this component.

- One NGO Identified a flawed supervision system. Community health workers (CHWs) were not getting any useful support or supervision since they reported to higher level staff who were rarely in direct contact. The solution was to train auxiliary nurses, who were in regular, direct contact, to supervise the CHWs.
- One large NGO found that their senior clinical staff were upholding clinical standards, but not adhering to good management practices for resource management. The solution was for the Directors to meet with the nurses and physicians to engage them in the concept of running the organization as both a service delivery (mission driven) NGO...and also as a 'business'...with cost recovery and resource conservation as goals along with delivery of services. Training in specific management systems and principles was provided.
- One NGO discovered that there was a serious problem with the collection of user fees. Because of a misunderstanding in the purpose of the 'exoneration program', fees were often being waived for the wrong people (20-30% of clients were exonerated...but often those exonerated were able to pay the fees and the poorest clients did not access needed services because they were being charged)... A new system was devised for managing this program and staff were given training in both how to manage it and why the guidelines were important. With the new system in operation, those who can pay do so (increasing clinic income) while those who cannot are more regularly exonerated. In the end, more services were delivered at a lower cost.

#### **4) Lessons learned**

Focusing contractual requirements on results rather than on processes allows a program to maintain progress toward strategic goals. This focus promotes the collection and use of performance data, scanning the environment for changes that will impact the program, and revising plans and strategies accordingly (and in a timely way). Participating organizations

become partners in the drive for impact on shared targets rather than simply being recipients of resources.

Incentive options can be designed to promote ownership (by partner organizations and their individual staff members) in working toward goals. These incentives generate motivation to both track and understand the reasons for progress (or the lack thereof) and can promote innovation in strategies and systems.

The potential for the Incentive payment is as powerful as the incentive payment itself. Even in cases where an indicator target has been missed (and no incentive, therefore, is received) the NGOs have used the experience as an investment in improvement.

Since internal system and strategy changes are 'self-developed' and then specifically rewarded when they are effective, these changes may be better sustained by NGOs after the end of the project period.

Indicators and targets need to match both project goals and participating NGO priorities and needs. There is the potential for an indicator that is selected to represent a range of important areas of activity to distort overall program efforts (causing relative lessening of effort in areas not being assessed as incentive indicators).

The sharing of performance and impact data is a powerful influence on how the market for services operates. In the context of an incentive program aimed at improving access, quality, and efficiency, the competitive pressure positively impacts the establishment of accepted standards.

### **Possible Role of The GPOBA Trust Fund**

The potential for the Global Partnership on Output-Based Aid is significant in the context of health service delivery in Haiti. The specific case just presented is not really a pilot, since the HS2004 Project is now supporting service delivery to nearly half of the population of Haiti. There are two factors in the current situation that may represent opportunities for GPOBA.

- 1) Until now, the Government of Haiti (through the MSPP) has been a close collaborator, but not a direct participant in HS2004. In the past few months there have been major changes that have brought MSPP and HS2004 and other units of Management Sciences for Health together in the joint planning of programs and activities relating to HIV/AIDS (and PMTCT and VCT), TB control, and the management of essential drug logistics. At the same time, new funds are becoming available through the GFATM to support provision of services in HIV/AIDS. It may be worth exploring whether the GPOBA could support a program of adapting the HS004 P-B C program for use in direct connection with MSPP service provision and GFATM-funded initiatives.
- 2) The work with the NGO network has already been proven successful (all original HS2004 Project targets have already been achieved). The incentive system of the PB-C program has been cost-effective and has been embraced by participating NGOs. These NGOs have

already expressed an interest in marketing the approach to other donors (it is widely accepted that Haiti is not going to have adequate internal resources to cover health service delivery for some years to come). HS2004 will end its technical program in 18 months (all projects come to an end). The GPOBA could consider approaches to supporting the continuation and expansion of the P-B C system within the network through assisting and coordinating with continued efforts financed by USAID and programs funded by other donors to include these elements (and to agree on common indicators and targets) or by directly supporting the continuation of the monitoring system and incentive schemes where other program funds are not available.

\*A summary of the early results of this work were presented in "Performance Based Payment to Improve Impact: Evidence from Haiti," Rena Eichler, Paul Auxila, John Pollock, and published by the World Bank with the IFC in Contracting for Public Services: Output-Based Aid and Its Applications. A copy of a model HS2004 sub-contact is attached (and also available through the World Bank web site "Sample Contract Provisions for Performance-Based Payment

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<sup>1</sup> *CORE* (Cost/Revenue analysis tool) was developed by MSH to facilitate organization financial analysis and planning. *MOST* (Management, Organization, and Sustainability Tool) was developed by MSH as a procedure for self- evaluation of the management capacity of an organization. Both can be accesses through the Electronic Health Managers Toolkit link at: [www.msh.org](http://www.msh.org). *SD& MA* (the Service Delivery & Management Assessment Protocol) was developed in Haiti as an M&E tool to link the assessment of delivery of clinical services with the effectiveness of the management systems that support them. It is being translated into English for publication and will soon be available for dissemination and use elsewhere.

# HS2004 Project: Haiti 1996- 2004

## USAID/Haiti's Strategic Objective – 3: Healthier Families of Desired Size

*IR 1: Increased use of quality  
child survival services*

*IR 2: Increased use of quality  
reproductive health services*

*IR 3: Reduced transmission  
of selected infectious diseases*



**MANAGEMENT SCIENCES FOR HEALTH**

*a nonprofit organization strengthening health programs worldwide*



# What does MSH DO?

## What is a project?

Context

Goals

Resources

Collaboration

Plans & Programs

Monitoring & Evaluation

Results



# What does MSH DO?

What do we do When we do it ?

Who ?

does What?

Why?

How?

with Whom?

How will we be effective?

How do we know we did it?

MSH is working with a network of 30 local, service-delivery NGOs to implement the HS2004 project.

The broad project goal is to provide efficient and high quality primary health care services to the people of Haiti.

# MSH/HS\_2004

## SERVICES OFFERTS PAR INSTITUTION ET DEPARTEMENT

### LEGENDE

**NORD**

Departement boundaries

HAS

Institutions



Services delivery points

Services



SI :

SM:

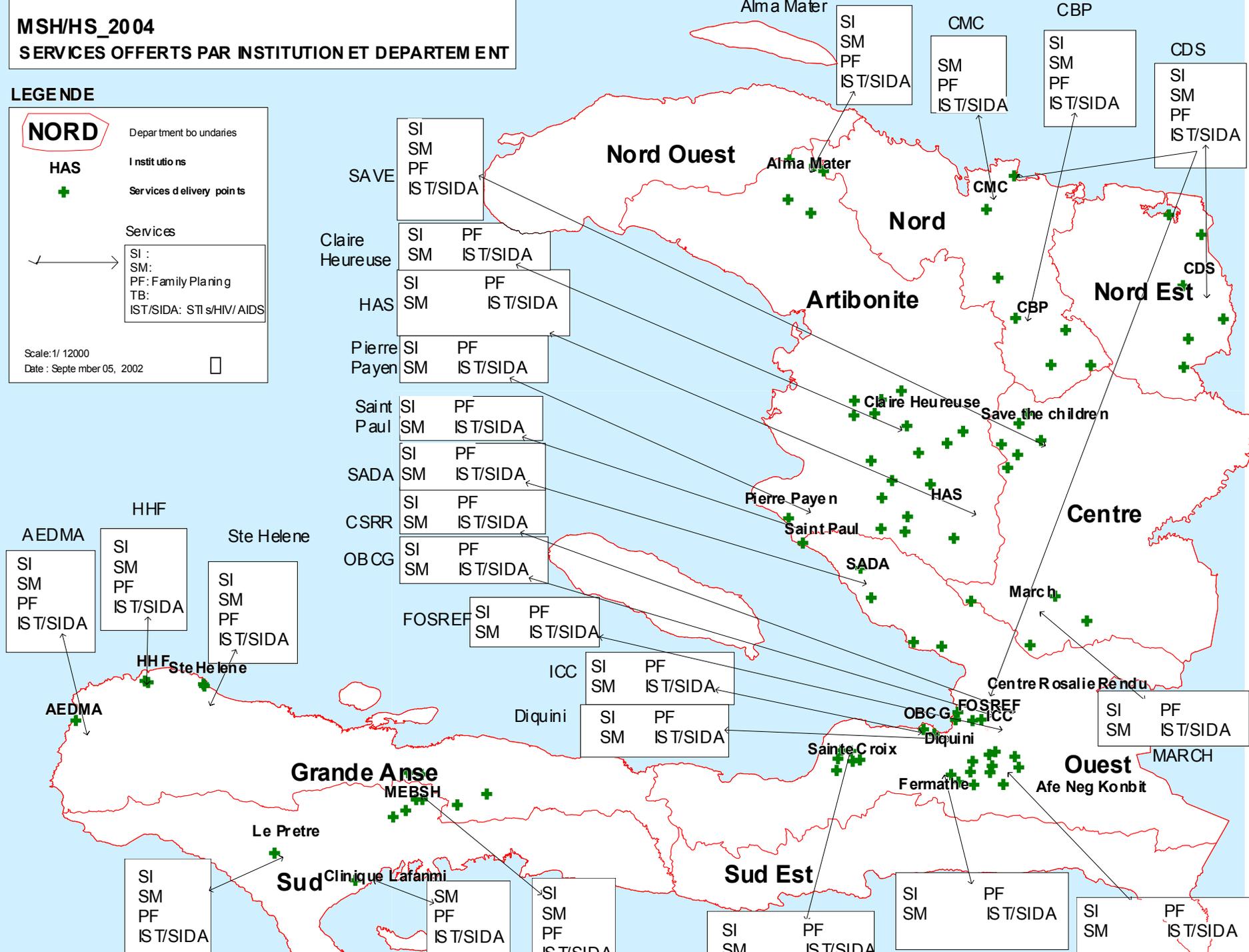
PF: Family Planning

TB:

IST/SIDA: STI s/HIV/ AIDS

Scale: 1/ 12000

Date : September 05, 2002



The HS-2004 resource base will total \$100,000,000 by the time it ends

Phase I was designed to work with both the public & private sectors.

Phase II was designed to work exclusively with the private sector.

**Both plans were changed!**

Social environment → Enables clients → DEMAND & USE ← SUPPLY ← Provider performance ← Management & service support systems

Local ownership → To act on Demand → USE ← SUPPLY ← to accepted standards ← support systems

Socio-cultural Environment

Policy Environment

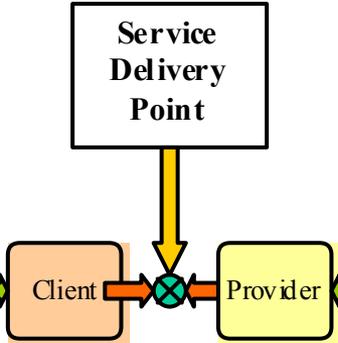
**COMMUNITY PARTICIPATION AND SUPPORT**

- Supportive and representative political leadership
- Community ownership of services
- Community mobilization/involvement
- Mechanisms for local advocacy
- Local finance mechanisms
- IEC/BCC channels
- Communication

**HEALTH SERVICE USE AND DEMAND**

*Simultaneous ability to:*

- Understand, Respond To & Act On Information
- Identify Health Needs
- Communicate Effectively
- Access Services



**Delivery of Defined Quality Services Responding to Client Needs**

**HEALTH SERVICE SUPPLY**

*Simultaneous existence of:*

- Trained and Motivated Staff
- Sufficient Equipment, Drugs, & Supplies
- Adequate Infrastructure
- Functioning Referral System
- Access to Information

**HEALTH MANAGEMENT SYSTEM**

- Coordination and Planning
- Quality Assurance Supervision & Training
- Information System
- Human Resources
- Financing
- Organizational Structure
- Drug Logistics
- Marketing
- Community Mobilization

**Has rights to:**

- Clear information
- Access to services
- Choice of FP method
- Safe services
- Privacy
- Confidentiality
- Dignity, comfort
- Free expression of opinion
- Continuous supplies

**Has rights to:**

- Good supplies
- Good working environment
- Good management and supervision
- Clear information and training



A primary strategy of HS2004 to improve performance by health institutions has been to hold them accountable for results.

Reimbursement is linked to achievement of explicitly defined indicators.

Performance-based contracting mechanism linking payments directly to results

NGOs that receive funds through HS-2004 are sub-contractors, not grantees, and have explicitly agreed to the terms and conditions in the contract.

Success requires strength in areas such as financial management, strategic planning, human resource management, patient flow, and drug and commodities management.



# What was wrong?

Identified problems with the cost-reimbursement system include:

- Weak incentives to become more efficient
- Weak incentives to improve management and operations.
- Since payment is not tied to results, cost based reimbursement contains weak incentives to expand coverage of services.
- The lack of a results orientation also implies weak incentives to improve clinical quality and quality as perceived by consumers.



# Erratic Outcomes

- Some NGOs achieved CPR of 25%, while others achieved less than 7%.
- Some NGOs succeeded in providing a minimum of 2 prenatal visits to 43% of pregnant women in their regions, while others only reached 21%.
- One NGO succeeded in ensuring that a trained attendant attended 87% of births, while a worse performing NGO only succeeded in attending 53%.
- Vaccination coverage varied widely with the worse performer only reaching 7% of the target population and a good performer reaching 70%.
- One NGO made sure that 80% of women knew how to prepare ORT, while another educated 44%.



# Inefficiency

This wide range in a sample of indicators was in no way correlated with costs incurred per visit.

Rough estimates of average costs per visit ranged from \$1.35 to \$51.93.

Some NGOs with high average costs per visit were relatively poor performers, while some low cost NGOs achieved more impressive performance targets.



# Network Process

The project makes it clear that focus for support is on efficient delivery of quality services.  
(HS2004 is not a prisoner to individual NGOs)

OD support and continuation of NGO contract requires progress to efficiency and impact (some NGOs have been dropped from the Network)

Performance Based system is subset of overall process (1st with 3 NGOs...with 10 on last round)

## The Performance -Based System

Each participating NGO (10 out of 30) has agreed to accept 95% of their target budget, which is issued to them at regular intervals.

The incentive (bonus) is 10% of the target budget if all targets are substantially met (resulting in an additional 5% over the target budget that can be allocated by the NGO on a discretionary basis)

## The Performance -Based System

Failure to meet individual targets results in a reduction of the incentive according to a pre-specified formula.

General failure would result in no incentive payment and would represent a significant penalty to the NGO (5% of projected operating costs)



# Indicators

The performance based financing model provides incentives for NGOs to deliver high quality services in a way that uses resources most efficiently.

To increase coverage of the population for essential services and to ensure that quality is adequate, indicators of coverage and quality were developed in conjunction with each participating NGO.



# Indicators

Current health services indicators include:

% children under 1 year fully vaccinated

% pregnant women receiving 3 prenatal visits

% births followed by postnatal care home visit

% utilization of family planning services

% FP method users not re-supplied

(for 2 months or more)



# Indicators

Current management systems indicators include:

Putting in place an improved system for supervision

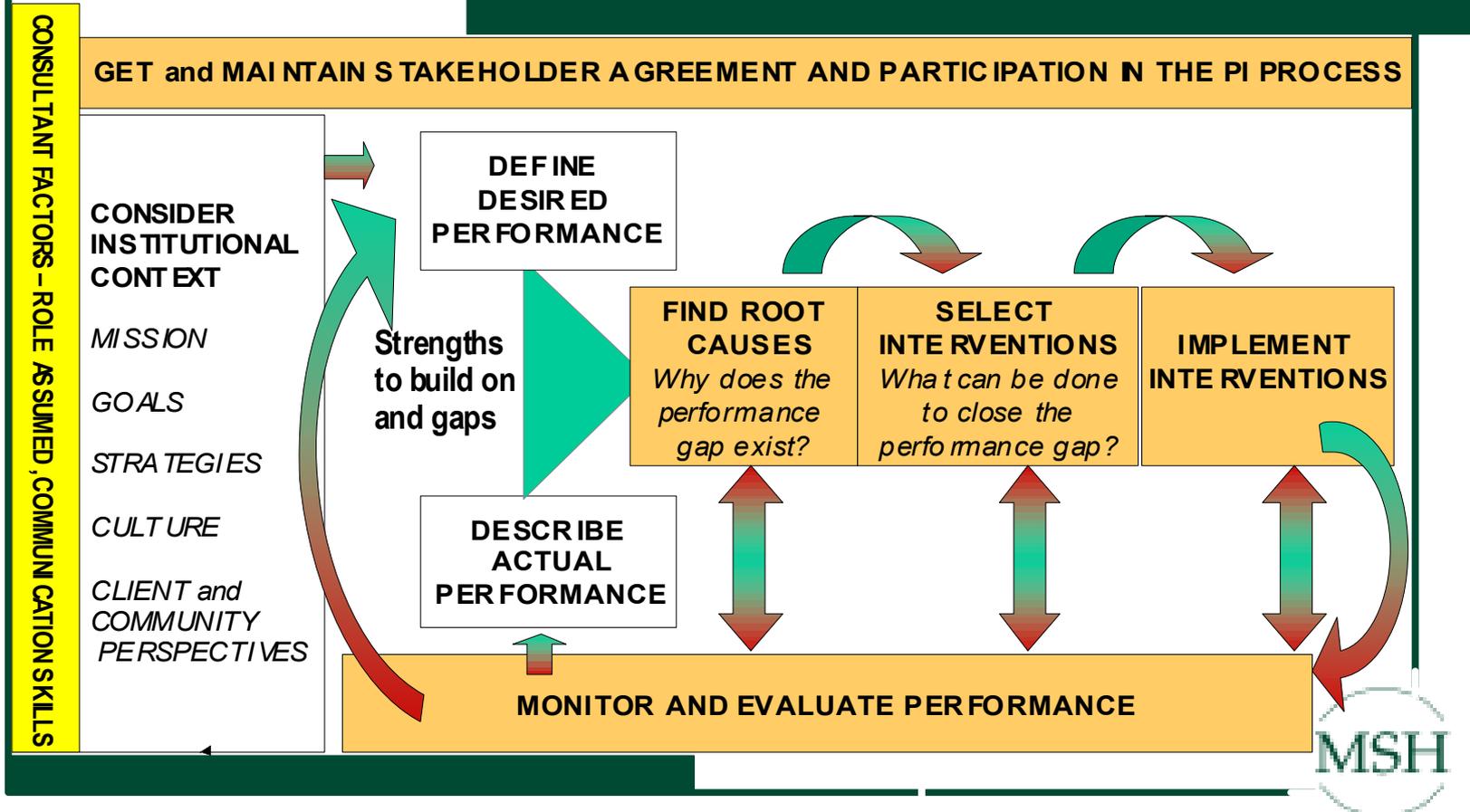
Establishing a performance management system

Reinforcing the organization of dispensary services

Establishing human resources management function

Improving inventory systems

# The Performance Improvement Process





# Sustainability

Improving institutional sustainability is one of the goals of HS-2004.

The project facilitated creation of an NGO network to enable NGOs to support each other.

Regular meetings encourage sharing of strategies that both succeed and fail in the challenging Haitian environment.



# Monitoring

There is a routine system for M&E that compiles NGO monthly service reports and shares these reports across the service delivery network.

Periodically, assessment teams made up of network NGO staff, Project team members, USAID staff, perform a review of the performance and quality of services provided by all partners (SD&MA all sites).



# Contracting Periods

HS 2004 Phases	Phase I	Transition	Phase II		
Performance periods	P. 1 - Pilot	P. 2	P. 3	P. 4 – Extension of P. 3	P. 5
Dates	Nov. 1999 - March 2000	April – Sept. 2000	Oct. 2000 – Sept. 2001	Oct. – Dec. 2001	Jan. – Dec. 2002
Time extent	5 months	6 months	12 months	3 months	12 months
Nb. Of NGOs	3	3	7	6	9



# Results

## Achievements of NGOs in Performance-Based Contracting Program Serving 1,194,008

NGO	Population Served	Percent of Incentive Earned (achievement of All Targets)					Indicator change during P-B C partic. and Years in program		
		P. 1	P. 2	P. 3	P. 4	P. 5	Immunization	3 prenatal visits	Years
1	167,374	70	85	90	100	70	49.2 to 78.0	49.3 to 41	3
2	323,513	80	85	70	100	60	39.7 to 81.0	32 to 63	3
3	55,983	40	75	90	90	20	34.7 to 69	18 to 38	3
4	127,706			80	100	55	37 to 65	17 to 27	2
5	144,905			70	90	10	73 to 84	38 to 78	2
6	125,207			80	81	80	54 to 83	25 to 67	2
7	126,700			10			NA	27 to 25	1 (not ctd)
8	NA					48	NA	NA	1
9	59,620					78	50 to 88	44 to 47	1
10	63,000					48	78 to 77	36 to 36	1

Non- PB-C NGOs serve 1,312,207  
2,506,215)

( Total population served by HS2004 network

The project target for immunization was 63% for 2000, 70% for 2001, and 80% for 2002  
The project target for 3 pre-natal visits was 47% for 2000, 55% for 2001, and 65% for

2002.

# Positive outcomes

NGOs focus on service goals rather than accounting. Plans are adapted to reality.

- Increased use of M&E for internal purposes
- Internal scrutiny of operations for efficiency. Budgets become policy instruments.
- Accountability has lead to innovation
- Innovations shared
- Improved results (Immunization for example)
- Change in market focus



# Problems

Some NGOs agreed to specific targets without full agreement of staff (process now amended)

The target indicators can get disproportionate attention in relation to the full package of services (some NGOs are moving to a 2-stage approach with incentive allocation)

Political pressures

How to make transition beyond 'Project'  
(other donors are being informed)



# Future

Participating NGO are marketing the approach to other donors and 'adopting internally'.

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# Potential Role for GPOBA

Explore support to adapting P-B C program for use in public sector and GFATM-funded initiatives.

Consider collaborating with other donors and agencies to support continuation and expansion of the P-B C system after the end of the HS 2004 Project.



# Potential Role for GPOBA

Explore possibility of collaboration with implementing agencies on programs elsewhere.

(the 'Partnership' function can be useful in enhancing the impact of other donor investments)