



A Contract Too Far?

Will Performance-Based Contracting (Really) Work in Southern Sudan?

BY LINDSAY MORGAN, a Tanzania-based policy analyst and writer

Juba

There was a map of Southern Sudan on the wall behind his desk. The lines demarcating the boundaries between states were drawn in clear black ink against the smooth ivory paper. Near the bottom, Juba, the capital, was nothing more than a solid black dot.

I had arrived the day before with a few reports about Sudan in my suitcase and a few ideas in my mind of the story I would write. Touchdown and lumber across the tarmac in the glare of the midday sun; shuffle through the sweaty crush of immigration; then down a dusty road cut with craters, past slopes of mud huts and charcoal fires, to my pre-fabricated hotel. Internet is out so I can't confirm interviews. Drop heavily to sleep. Early morning departure, but we're lost and running late. By the time I arrive at the small compound of the international NGO whose country director I have come to interview, I'm exhausted.

From inside his spare, cement office, sunlight flooding in through the room's single wood-framed window, I take out my notepad and pen and ask: Do you think performance-based contracting can work in Southern Sudan?

He smiles. "On paper it's so easy. When you get here, it's not."

Past and Present

"I know of no other place on the face of the earth that is as chronically underdeveloped as Southern Sudan."

—Michaleen Richer, Field Officer, USAID/OFDA. Richer has worked in Sudan for more than twenty years, as well as in Somalia, Rwanda, and Burundi.

Sudan is the largest country in Africa, stretching out in a great yawn from the deserts that border Egypt in the north to the swamp lands of Uganda to the south. The Nile River snakes down the middle, separating east from west.

Under British/Egyptian occupation, the south of Sudan, an area home to about 12 million people who speak over one hundred languages, was economically and politically marginalized. The two long civil wars that followed independence shattered what meager social services and economic and physical infrastructure were left.

In January 2005, the Government of Sudan and the Southern Sudan-based Sudan People's Liberation Movement (SPLM) signed the Comprehensive Peace Agreement (CPA), which ended the war—which by then had killed an estimated 1-2 million people and displaced another four million—and made the country's ten southern-most states semi-

Photo: Ame Hosi, World Bank



autonomous.¹ Since then, Southern Sudan's "baby government" (as one billboard in Juba refers to it), donors, and NGOs have been trying to deliver basic services and build, almost from scratch, health and education systems, and a government.

Progress has been slow. "When we came in there was nothing to re-build or re-invigorate," says Charles Lerman, USAID health lead for Southern Sudan. "There was just nothing."

Health Status, Infrastructure, and Financing

"Sudan is the unhealthiest place on the planet...really at the point of infancy." –Donor representative

Sometimes it is easy to forget how sick the country is. On the one hand, Southern Sudan's deprivation is well known. Just glance at the reports, news articles and advocacy campaigns that paint the country in utterly tragic terms.

But step out onto the street and a different picture emerges. The markets are bustling, motorbikes are tut-tutting along with passengers on their backs, giggly children with backpacks are walking to school, and money transfer companies, as ubiquitous as roadside banana sellers, are opening their doors for business.

Juba is a boom town. Like a California gold rush, young men and women—desperate, adventurous, brave—are flocking to the capital in droves from Kenya, Uganda, Ethiopia, with nothing except the clothes on their back, and eking out a living.² There is a vibrancy and strength to the streets. But there is another reality. Take a walk through Tomling area, near Hai Jalaba—down a narrow dirt labyrinth, past mud huts. A middle aged woman is lying in the dirt moaning; a man without a leg is limping with a cane along the crater road. Nearby, at a dilapidated clinic, a baby lays in his mother's arms, feverish with malaria. And these are the lucky ones. They live in Juba where there *are* clinics.

Southern Sudan has some of the worst health indicators in the world. Malnutrition is widespread, vaccination rates are low, and tropical diseases account for a considerable proportion of the total burden of disease. Malaria is a leading cause of death in children under age five but only about 12 percent of households have at least one insecticide treated bed net. Infectious disease epidemics are common. The availability of clean water is extremely limited. Only 40 percent of women receive antenatal care at least once during pregnancy, and only 10 percent of deliveries are attended by skilled personnel

(compared to 70 and 49 percent, respectively, for Sudan as a whole). The maternal mortality ratio is a staggering 2,037 deaths per 100,000 live births. These indicators are all better in the North.

During the wars, the public health system was virtually inoperative: most infrastructure and civil institutions were destroyed. United Nations (UN) agencies and non-governmental and faith-based organizations (NGOs/FBOs) were the main providers of health services. Their focus was on meeting the immediate, basic needs of the population, but their reach was limited. One assessment estimates that before the signing of the CPA, only three surgeons provided services to the whole of the South in three hospitals located in the main towns of Juba, Malakal and Wau.³ There was one doctor for every half a million people. Facilities were usually inadequately staffed and lacked drugs, supplies and equipment.

Following the peace agreement, four main financial channels emerged to support the health sector: the budget of the Ministry of Health of the Government of Southern Sudan (MOH-GOSS); multilateral donors such as the United Nations; bilateral donors; and various pooled funds.

GOSS funding for health was modest and has been declining, from about 8 percent of GDP in 2005 to about 4 percent in 2008.⁴ But overall, funds for health have been sizable. The Multi-Donor Trust Fund's (MDTF) Umbrella Program for Health Sector Development (UPHSD) and the Basic Services Fund (BSF) have together committed more than US \$243 million since 2006.⁵ Bilateral funding to NGOs, FBOs and the UN system was estimated to be a whopping US\$427.9 million for FY08 alone.⁶ Compare this to 2006, when total health spending was estimated at US\$ 130 million.⁷

Sluggish Progress Post-CPA

Into this context, the Umbrella Program for Health Sector Development (UPHSD) was born with the aim of improving access to the basic package of health services (BPHS) by 50 percent within three years and building the capacity of the central and state Ministries of Health (MOH) and County Health Departments. Launched in January 2005, three international NGOs—Norwegian Peoples Aid, IMA World Health, and HLSP/Mott MacDonald Limited—were contracted as Lead Agencies (LAs).

But implementation was slow. The procurement process for delivery of the BPHS dragged on for over two years and service delivery did not commence until 2009, and only in four states. A

requirement that NGOs provide bank guarantees for 20 percent advance payments before mobilizing also caused delays.

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Further complicating things, the MOH did not receive training in grant management. “They bit off more than they could chew and didn’t understand at all the complexity of contracts in Southern Sudan, and so they couldn’t use the money,” says a former GOSS official, now serving as an advisor to a bilateral institution. “They should have started by cleaning up the government contracting system. It was shortsightedness on the Bank side.”

MOH officials tried to exert control, not by focusing on outcomes, but by controlling the process and scrutinizing documentation, including the contracts and indicators, which were vague, broad and subjective. There was no methodology to track progress.

By the time phase I drew to a close, only 43 percent of the US\$ 16.6 million allocated for service delivery had been disbursed. The UPHSD, and the MDTF generally, had garnered a reputation as a colossal failure.

They were not alone. Other programs also saw disappointing results. Five years post-CPA, access to health services remains extraordinarily low: only 25-30 percent of the population of Southern Sudan is estimated to be covered.⁸ Health infrastructure also remains in a shambles. Many areas have less than one health worker per 1,000 people, and many health facilities are either deteriorated or housed in temporary structures with little equipment, no water or power supply.⁹

Moreover, financing for health has been inequitable. According to the GOSS Ministry of Finance, 21 counties (27 percent of the total) receive no external financing for primary health care, while several counties receive funding from multiple sources. Much of the funding is concentrated on supporting vertical programs.

There is also a strong sense that the NGOs delivering health services have not been held accountable for results. “In Sudan you have a situation where NGOs are getting funding from donors and not necessarily delivering because the situation is so bad, people sort of get away with

it,” says one NGO representative. “This has bred a lack of accountability and acceptance of poor performance.”¹⁰

Performance-based Contracting in Southern Sudan

During a three-day workshop in Juba in early November 2009, representatives from the World Bank, MOH-GOSS and Lead Agencies met to discuss phase II of the UPHSD. Making the contracts “performance-based” was proposed as a means to spur dialogue between the LAs and the MOH, and hence increase accountability, while also heightening the pressure for, and focus on, results.

Benjamin Loevinsohn, Lead Public Health Specialist and Health Cluster Leader at the World Bank, who helped design Afghanistan’s performance-based contracting scheme, played a key role introducing and designing the UPHSD program.¹¹ Says Loevinsohn: “Making it performance-based means there are clear indicators that are measured regularly and the results or lack of results have consequences. This is the minimum, and this wasn’t happening under phase I.”

“The most important thing is to establish a dialogue,” says Kamil Mohammed, World Bank Task Team Leader for PBC. “It is really missing from this country.”

Noriko Oe, former assistant to the health team lead at the Bank’s Juba office, agrees: “It’s an opportunity to introduce a little bit of accountability. It’s a baby step to get people thinking about results.”

How It Works

An initial list of indicators and targets, based on experiences primarily in Afghanistan and Rwanda, was proposed to stakeholders during the 2009 workshop. They were discussed and modified by the lead agencies, MOH, and the Bank.

A baseline was established for targets based on the 2006 Sudan Household Health Survey (SHHS).¹² Lead agencies were then given the opportunity to modify targets, in consultation with the government and the Bank, based on their analyses of their catchment areas, which they conducted during phase I. The MOH-GOSS, with technical assistance from the World Bank, determined the targets based on the 2006 SHHS and the LA’s reports. It was an imperfect system for establishing targets, but it worked.

Table 1: Indicators of Success for the Lead Agency Contract

Indicator	Baseline ¹	Approximate Target ²	Means for Data Collection
% children 12 to 23 months old who received DPT3/measles vaccine before the age of 12 months	67.5%	85%	A, B, C ¹
% children under 5 sleeping under an ITN the night before the survey	9.4% ³	35%	B, C
Vitamin A coverage: among children 6-59 months % receiving it in the last 6 months	65.6%	80%	A, B, C
Antenatal care from skilled providers %, among women giving birth in the last 2 years	27.5%	40%	A, B, C
Skilled birth attendance* in a health facility.	15.2%	25%	A, B, C
Family planning – Contraceptive** prevalence rate for modern methods.	1.6%	7%	B, C
Treatment of diarrhea, ARI, malaria – out-patient visits among <5 per capita	NA		A, B, C
Underweight (Weight for age < -2 SD)	NA	TBD	A, B, C
HMIS strengthening - % of health facilities submitting new, standardized HMIS monthly reports within one month of the reporting month	NA	60%	A, D, E D, E
Strengthen supervision - % of health facilities with structured supervision visit within a month before the supervisory visit (using quantified supervisory checklist [QSC])	NA (likely 0%)	50%	D, E
Staffing - % of PHCUs with at least one male and female trained health worker (CHW or higher)	NA	60%	D, E
Drug supply: % of facilities having 10 essential drugs*** at the time of supervisory visit.	NA	80%	D, E
Knowledge of health workers in managing important ailments as judged by clinical vignettes	NA	40%	D, E

¹ A=HMIS, B=LQAS, C=national household survey, D=health facility survey, E=QCS

² Baseline data is from the 2006 SHHS for Central Equatoria unless otherwise stated. NA = Not available

³ Targets should be seen as approximate rather than exact given the limits of precision in measurement of these indicators and uncertainties about the actual baselines at the beginning of the contract. What is important is statistically and programmatically significant changes in these parameters.

⁴ The only relevant indicator from the SHHS 2006 is percent of households with at least one ITN.



Each quarter, Lead Agencies submit reports to the MOH-GOSS, documenting progress on targets, along with a one-page financial statement (in phase I, they submitted quarterly invoices with receipts and technical reports about procurement and training). The reports are checked against HMIS data, which are (in theory) submitted each month by facilities. LA reports are also checked against a health facility survey carried out with technical assistance from the Liverpool Associates in Tropical Health (LATH). The MOH-GOSS has also initiated monthly review meeting with LAs, representatives of state MOHs, World Bank and others partners.

LAs are paid every six months; 70 percent of the payment is made upon submission of the report, while 30 percent is withheld until results are considered and verified by the MOH-GOSS. If targets are not met, the MOH has thirty days to discuss bottleneck and how to overcome them with the LAs.

There is no language in the contracts stating that the agencies will not receive the 30 percent—in essence, the 30 percent is probably *not* at risk. Rather, withholding a portion of the funds is meant to force government review of NGO performance, hence building government capacity to manage the health system while enhancing NGO accountability. “The 30 percent makes for at least a quarterly in-depth discussion about results,” says Loevinsohn. (Lead Agencies are concerned, however, about having 30 percent of their funding hinge on the MOH having the capacity and motivation to review their performance and pay them in a timely manner, particularly given that there is no penalty if the MOH does not do this.)

Phase two of the U.S. Agency for International Development’s (USAID) Sudan Health Transformation Project (SHTP), also evolved

into a performance-based contracting scheme, but rather than withhold funds, it offers implementing partners the opportunity to receive an additional 6 percent of the overall quarterly budget if they meet targets on a random subset of indicators.¹

Phase II of the MDTF is slated to run through December 31, 2011, with a budget of \$63 million, down from a previously estimated \$165 million, with no contribution from the GOSS. In addition to making the contracts performance-based, two other key changes were made: LAs are no longer required to guarantee 20 percent of the contract value, and NGOs can now manage their own procurement for anything worth \$250,000 or less.

The Messy Realities of Implementation

Implementing PBC has proved difficult. Both the UPHSD and USAID programs have been beset with delays. Because it took time for the various players to reach a shared understanding of PBC and for design details to be hammered out, contracts between the MOH and LAs for phase II of the UPHSD were not signed until April 2010. Six months into a two-year program, things are just getting started.

Similarly, while USAID’s PBC scheme officially launched in November 2009, some of the contracts between Management Sciences for Health (MSH), which is managing implementation, and implementing partners were not signed until February 2010. Said one NGO official involved: “We are assuming a loss of the six percent in the first quarter and probably in the second quarter.” As other country experience has shown, unpredictable delays at the outset can be de-motivating, and can squander goodwill between players.²

Another obstacle is a lack of communication, or miscommunication, between partners. In both PBC schemes there are several layers of institutions, each with their own mandate, constraints, and understanding of the program. In the MDTF scheme, there has been confusion among lead agencies about the overall management structure of the program. In an interview, one lead agency representative asked who they are supposed to report to at the MOH, and said they were waiting on their contracts with subs to be reviewed by the MOH/Bank. When I asked a Bank representative about this, I was told the sub-contracts need not be approved, and that he thought the lead agencies understood this.

There are also disconnects in the USAID scheme. For example, the number of indicators linked to the performance incentive has been reduced from 50 to 16 following concerns from implementing

partners (although they must still report on all 50). But targets have not been modified despite repeated requests (implementing partners had little role determining targets). USAID officials point to the former, saying that partners' concerns have been addressed; the partners point to the latter and say that they have not.

“There is a misconception with performance-based financing,” says the Southern Sudan head of one NGO, “that just adding an incentive will fix the problem.”

But sometimes the problems are the mundane realities of getting people to talk to each other. The discrepancy between planning and implementation is greater than is generally assumed.



Photo: Anne Hehl, World Bank

“The question is what can performance-based contracting do about any of this?”

Constraints to Good Performance

Most agree that PBC is a good idea—in theory—but there are many concerns and questions about its viability in the uniquely challenging context of Southern Sudan. Many concerns center on the question: how can even a small portion of NGO funding hinge on meeting targets that may be unrealistic, given the many negative externalities that affect health service providers' ability to perform?

NGOs delivering health services in Southern Sudan face many constraints. Simple access is one: over 70 percent of the population lives in remote, rural areas, and the logistics of ensuring that staff, drugs and other supplies reach them can be impossible over torn up dirt roads, which cut off vast swaths of the country during the rainy season. Security is another. Five years after the end of the war, NGOs must still be prepared to move staff at a moment's notice. In August 2010, Medecins Sans Frontier suspended operations in Jonglei state after staff were attacked in three separate incidents.

Good performance also depends on a sufficient number of motivated health staff, and a reliable supply of essential drugs. Currently, the majority of health workers in Southern Sudan are considered employees of the GOSS, and their remuneration is, in theory, the responsibility of the MOH, though in practice, many (about one-third) are financed by NGOs. According to many GOSS officials, this is a stop-gap measure, intended to be phased out over the coming years. But where NGOs have ceased paying health worker salaries, GOSS payments have been irregular, unpredictable, and in some cases NGOs have had to restart payments in order for services to continue.³

Drug procurement is also controlled by the central government. The procurement process is lengthy, and there is no drug storage site in Juba large enough to house large orders. Once drugs arrive, delivering them to state MOHs and county health departments is difficult. Lack of capacity and expertise within the GOSS to manage drug procurement has led to major stock shortages throughout the country. At one point, an estimated 40 percent of facilities in the country faced stock outs, while the drugs sat in Juba storehouse for four months. An NGO official just returned from Unity State reported in June 2010 that facilities there had received no drugs for nine months. That same month, a health facility director in Juba reported receiving no drugs from the central pipeline since December 2009, despite the fact that they are supposed to receive supplies every three months.

“The question is,” says Steve Moore of the Malaria Consortium, “what can performance-based contracting do about any of this?”

Without the ability to pay health workers and procure drugs, and given logistical and security constraints, NGOs' ability to deliver services and meet targets is complicated. Yet contracts are short and performance is measured each quarter. Eighteen- to 24-month contracts offer barely enough time to get started, some feel, let alone establish and monitor complex programs. "Six months ago I was sold," says one bilateral representative. "Now I'm questioning it [PBC] more, not in terms of whether we should do it, but measurement. It should be over the long term, not on a quarterly basis."

Another question raised by stakeholders is how credible baselines can be established when health data in Southern Sudan is less than reliable. "Some NGOs are skeptical," says an NGO representative, "that the results will be contested because of disagreements about the baseline—it's a forever argument."

Others worry that disagreements over baselines will either encourage organizations to come up with bogus figures or demotivate them, if they believe targets are unrealistic. "If you're going to have a contract," says the country director of an international NGO, "you better be sure you can measure it."

*"Things change for the worse so quickly.
They change for the better more slowly
— but they can."*

—Bono

What Does Performance Even Mean?

Add to this complex picture confusion surrounding the word "performance," and among some, irritation at the focus on terminology. Economists at the World Bank tend to define performance the same way they define "result": as outputs or outcomes, or both.⁴ Making something "performance-based" implies financial reward or penalty for achieving or not achieving some definition of results or performance.

But many NGOs establish best practices based on lessons learned, and share these in various forums. And some, such as the Basic Services Fund, base contracts with implementing agencies on targets. NGOs are measured against progress on these targets and risk not having their contracts renewed if they perform badly. This may be different from how the World Bank defines performance, but to many, it counts.

"There's an arrogance," says one NGO official, "in saying that increasing or decreasing the amount NGOs get within a contract, as opposed to not renewing contracts if they don't perform, is the only thing that qualifies as performance-based."

Too Long In Exile

One morning, a taxi driver named Linda picked me up at my hotel in Juba Town. She was a large bear of a woman, gregarious and friendly, and as she hurtled down the road, she said she moved to Juba from Kenya four years ago. I asked her why she had come. "Greener pastures," she said.

There is much to be hopeful about in Southern Sudan. Aerial bombardments of civilians have ceased; a government has been formed; oil revenue is being shared; civil servants are being paid. These are not small accomplishments.

And there is a striking consensus among stakeholders that, despite setbacks, progress is possible in the health sector, but a move from emergency response to long-term development is necessary. "We need to start thinking in the long term, and planning for it," says a Sudanese advisor to USAID. "We have to get out of this emergency mentality of: just let us get this done until this emergency passes."

Kamil Mohammed agrees: "We should help them [the government] deliver services themselves. We're not going to be here forever."

The UPHSD PBC scheme is an effort to focus explicitly on results, and work with, not around, the government. Working with the government is intended to help them build up capacity to deliver services to their citizens, which is what everyone wants. It is a slow and painful process, but this does not mean it is the wrong thing to do.

As one USAID official says, "The MDTF has a reputation for not achieving results but I'm not sure the model is wrong."

"It [PBC] can happen here," says Kate Foster, Director Program Development and Advocacy at Save the Children's Southern Sudan office. "We have the space and willingness to do development work and the earlier you start the more sustainable it is."

The key to success will be clear and constant lines of communications between players, and a willingness among program designers and managers to adjust as concerns are raised and lessons are learned.

References

- ¹ The interim national constitution established Sudan as one country with two systems. A Government of National Unity (GONU) administers North Sudan and also provides services normally the responsibility of a national government, such as defense and foreign affairs. The Government of Southern Sudan (GOSS) administers 10 states, some 90 counties, and other local governments, and has a cabinet of ministers separate from that of the GONU. The SPLM became a political party; it is the main constituent of the GOSS, including holding the presidency and 70 percent of seats in the legislature, and it gained about one-third of GONU positions.
- ² Part of Juba's "boom" is undoubtedly due to the economic distortions of the aid business, but the private sector is also helping to fuel Juba's economy. With investors from Uganda, Kenya, Ethiopia, and China flooding the capital, the service and construction industries are booming.
- ³ Health Performance Mapping: State Ministries of Health Southern Sudan, Liverpool Associates in Tropical Health, Liverpool, England, 2009, p. 6.
- ⁴ GOSS health spending per capita stood at US\$ 7 in 2008, well below Kenya (US\$28), Tanzania (US\$ 12), Uganda (US\$ 10) and Zambia US\$ 18. (See Health Performance Mapping: State Ministries of Health Southern Sudan, Liverpool Associates in Tropical Health, Liverpool, England, 2009.) Under the CPA, Khartoum agreed to transfer 48 percent of all oil revenues to the GOSS, but some GOSS officials say the transfers have been unpredictable and slow. And after a war that killed and displaced millions, some feel the most immediate and compelling need of the GOSS is to invest in security (nearly 50 percent of the GOSS budget is spent on the military according to the World Bank's 2007 Public Expenditure Review for Sudan) particularly when donor funds can substantially cover basic social services needs. Others disagree, arguing that it is a GOSS responsibility to contribute more fully to the basic services needs of its population.
- ⁵ The largest and most significant of the pooled mechanisms is the Multi-Donor Trust Fund-Southern Sudan (MDTF), administered by the World Bank. The Basic Services Fund (BSF) is another important mechanism. It was established by the U.K. Department for International Development, initially for a period of two years (though it has been extended several times) with a commitment of about US\$20 million.
- ⁶ Health Performance Mapping: State Ministries of Health Southern Sudan, Liverpool Associates in Tropical Health, Liverpool, England, 2009, p. 14.
- ⁷ JAM 2005, MOH/GOSS 2006d and World Bank 2007.
- ⁸ Southern Sudan Health System Assessment, USAID, July 2007, xiii and LATH assessment.
- ⁹ Health Performance Mapping: State Ministries of Health Southern Sudan, Liverpool Associates in Tropical Health, Liverpool, England, 2009, p. 25.
- ¹⁰ Interview with the director of program development for an international NGO involved in health service delivery in the south.
- ¹¹ For more information on PBC see [A Toolkit on Performance-Based Contracting for Health Services](#) and for more information on the different forms of RBF see [Rewards for Good Performance or Results: A Short Glossary of RBF](#).
- ¹² The 2006 SHHS, if not the gold standard for health statistics in southern Sudan, is the frequently cited source of, albeit, slightly out of date but generally credible information. The government conducted another household survey in 2010 but, at the time of this writing, the data were not yet available.
- ¹³ This system is still under review.
- ¹⁴ As was the case with a pilot RBF program in Uganda. See *Some Days Are Better Than Others*, Lindsay Morgan, World Bank, April 2010.
- ¹⁵ Public salary structures are on par with those in Northern Sudan, however, the lack of housing and other amenities has made it difficult to recruit and retain qualified staff. For the most part, NGOs compensate workers at a level unaffordable to the MOH, and also provide a range of non-financial incentives—professional development (e.g., training), housing, team building—to retain workers. These non-financial incentives have a powerful influence, often stronger than increasing monetary compensation. Taking on the current level of NGO compensation for health workers and programs generally—either through contracting directly or assuming them as MOH programs—will be fiscally challenging.
- ¹⁶ See Philip Musgrove, *Financial and Other Rewards For Good Performance or Results: An Essay and a Short Glossary On Concepts and Terms*, World Bank, June 2010.