

MEASURING COUNTRY OWNERSHIP AND ITS RELATIONSHIP TO HEALTH  
OUTCOMES: THE CASE OF LIBERIA

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## ABSTRACT

Stephanie Watson-Grant: Measuring Country Ownership and its relationship to Health Outcomes: The case of Liberia  
(Under the direction of Sandra B. Greene)

The concept of country ownership, in the international development aid context is not a new one; it is an essential international development aid component. The structure of development aid assumes a relationship between donor and recipient with the intention of creating goods or services to improve the socio-economic situation in a recipient country. But while country ownership's value is assumed to be beneficial, country ownership's effect is unknown. There is no universally accepted definition, and secondly, no systematic measurement of the concept has been developed.

The study aims are: 1) develop a measure of country ownership test if the performance based financing (PBF) system implemented by the Ministry of Health and Social Welfare, and supported by the US Government, can be referred to as 'country owned'; 2) assess if health outcomes have improved in Liberia; 3) determine intervening variables that could test a connection between country ownership and health outcomes; and 4) develop a plan for change.

This study used a mixed methods approach, first the concept of country ownership was defined, and then country ownership of the PBF system in Liberia was measured. Second, secondary data analysis was done to determine if health outcomes have improved. Third, a qualitative assessment was done to suggest intervening variables that could be used to detect a connection between country owned PBF process and improved health outcomes. Therefore, the methodological approach is aligned to the aims of the study.

The study's key findings are the PBF scheme in Liberia can be referred to as being country owned; health outcomes examined have not improved and variables for detecting a connection between a country-owned PBF scheme and health outcomes are already being measured within the context of the country ownership of the PBF scheme, so essentially there are no intervening variables.

The plan for change includes specific policy recommendations to improve the ownership of the PBF process for Liberian donors and recipients. The recommendations are grounded in the leadership principle of power and influence, which examines power relationships and processes of influence towards achieving effective outcomes and is framed around Kotter's Steps for Transformational Change.

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## LIST OF ABBREVIATIONS

BPHS	Basic Package of Health Services
CHSWT	County Health and Social Welfare Team
CDC	Centers for Disease Control and Prevention
CPC	Carolina Population Center
DFID	United Kingdom's Department for International Development
DRC	Democratic Republic of Congo
EPHS	Essential Package of Health Services
FARA	Fixed Amount Reimbursement Agreement
GHI	Global Health Initiative
HMIS	Health Management Information System
IRC	International Rescue Committee
IMF	International Monetary Fund
LQAS	Lot Quality Assurance Sampling
MOHSW	Ministry of Health and Social Welfare, Republic of Liberia
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
OECD	Organization of Economic Cooperation and Development
PBC	Performance Based Contracting
PBF	Performance Based Financing
PRISM	Performance of Routine Information System Management
UNC	University of North Carolina at Chapel Hill
UNICEF	United Nations Children Fund

UNHCR	United Nations Refugee Agency
USA	United States of America
USAID	United States Agency for International Development
USG	United States of America Government

## CHAPTER 1: OVERVIEW AND INTRODUCTION

### Study Aims

**Objective:** The concept of country ownership, in the context of international development aid is not a new one; in fact it is an essential component of international development aid. The annual provision of billions of dollars in aid by developed countries to developing countries assumes the products and processes that a donor provides are priorities for developing countries; that they will participate in the implementation of the initiative; and maintain and sustain the products and processes after the donor countries have discontinued their support. The structure of development aid further assumes that with the interest and participation of the recipient country, 'owning' an aid funded initiative will lead to more successful outcomes. Recipients will make decisions and take necessary steps, beyond what is detailed in program documents, in order to ensure successful outcomes.

This relationship between donor and recipient is the context of country ownership; the transfer of funds from donor to recipient; the interplay of power, capacity, accountability, and responsibility between donor and recipient; with the intention of creating goods or services to improve the socio-economic situation in a recipient country. But while the value of country ownership is assumed to be beneficial, the effect of country ownership is unknown. There is no

universally accepted definition, and secondly, no systematic measurement of the concept has been developed.

The primary objective of this study is to develop a definition of country ownership and measure it in a developing country within the context of a distinct aid funded program. Lofa County in Liberia was selected as the geographical focus of the study and the health sector performance based contracting has been chosen as the aid funded program. A secondary objective was to determine what intervening variables<sup>1</sup> would best demonstrate a connection between country-owned performance based contracting and health outcomes.

There were four aims to this research:

**Aim 1: Develop a measure of country ownership.** The idea of country ownership is multi-dimensional, intricate, and complex; therefore an over-simplified, prosaic definition is woefully inadequate in describing it. The measurement of country ownership is divided in two parts.

*Part A:* Through a systematic literature review, predominant themes that writers and practitioners use to describe the concept have been identified. These themes are the basis for the measurement of the concept.

*Part B:* A parallel exercise (to this study) is underway, implemented by the MEASURE Evaluation Project of the Carolina Population Center. They are developing a tool to measure country ownership of monitoring and evaluation (M&E) systems. The Country Ownership of M&E Systems Measurement tool was adapted and used in Liberia to test if the performance

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<sup>1</sup> Intervening variables stand between independent and dependent variables and mitigates the effects of the independent variable on the dependent variable. (Creswell, 2009)

based contracting system implemented by the Ministry of Health and Social Welfare, and supported by the US Government, can be referred to as ‘country owned’.

**Aim 2: Assess if health outcomes have improved in Liberia.** A literature review was done to provide evidence that an association between performance based contracting and health outcomes has been found in other country contexts. This association led to a rational expectation that the performance based contracting system in Liberia led to improved health outcomes. Therefore, four health outcomes were examined before and after the introduction of performance based contracting, so as to determine if the health outcomes improved. These data were extracted from secondary data sources, the Liberia Health Information System and the Lofa County Lot Quality Assurance Sampling Survey.

**Aim 3: Determine intervening variables that could test a connection between country ownership and health outcomes.** Based on results from aims 1 and 2, aim 3 explored what intervening variables future researchers may consider if they wanted to explore a connection between country ownership of Performance Based Contracting and health outcomes. Qualitative methods, that is, key informant interviews, were used.

**Aim 4: Develop a plan for change.** The plan for change includes specific policy recommendations to improve the ownership of the performance-based contracting process for Liberian donors and recipients. The recommendations are grounded in the leadership principle of power and influence, which examines power relationships and processes of influence towards achieving effective outcomes and is framed around Kotter’s Steps for Transformational Change.

**Proposal Contribution and Significance:** This research project contributes to a growing discourse on country ownership in the context of development aid. Its significance is that it attempts to measure this concept using performance based contracting process, which has not

been done previously. This project also sought to document testable intervening variables for connecting the country ownership of the performance-based contracting to health outcomes.

Therefore, this research sought to raise the issue of country ownership from merely theoretical to more concrete.

## **Research question**

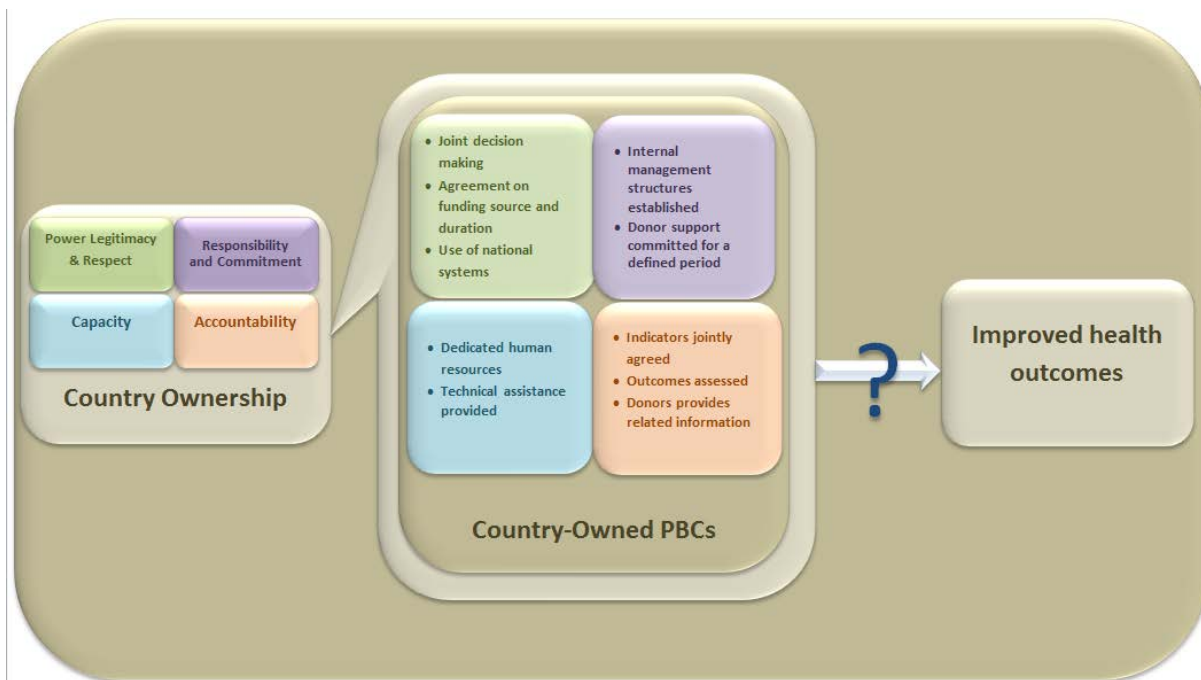
How can country ownership be measured and what relationship might it have with health outcomes?

## **Conceptual Model**

The model underpinning this research activity is that country ownership of the PBC process in Liberia is identified by looking at issues of:

1. Power, legitimacy and respect (i.e. joint decision making, agreement on source of funding, level of funding and duration of funding), and that national systems are used in the delivery of the PBC process;
2. Responsibility and commitment (i.e. that internal leadership and management structures are established and that donor support is known and committed for a defined period of time);
3. Capacity; that there are competent human resources dedicated to the PBC process and where there are gaps identified, there is a plan to fill those gaps and that technical assistance is provided in the interim;
4. Accountability (i.e. that health outcome indicators are jointly agreed, outcomes are periodically assessed and that donors provide timely information to recipients on changes in the donor funding environment that may impact the success of this initiative).





**Figure 1 - Study Conceptual Model**

The model further assumes that these country ownership issues contribute to improved health outcomes. However, this connection of a country-owned PBC process to improved health outcomes is untested and therefore unknown. This study will explore intervening variables for such a connection.

### **Methodological Approach**

This research project used a mixed methods approach; the quantitative methods supported the qualitative methods. It used sequential explorative strategy; first the concept of country ownership was defined, then country ownership of the performance based contracting system in Liberia was measured. Second, secondary data analysis was done to determine if health outcomes have improved. Third, a qualitative assessment was done to suggest intervening variables that could be used to detect a connection between country owned performance based contracting process and improved health outcomes. Therefore, the methodological approach is aligned to the aims of the study.

## **Delimitation**

The main limitation is that only one country, Liberia, and one county in Liberia, Lofa, was examined. This limitation means that the findings from the study are applicable only to Lofa County in Liberia. However, this study may have methodological implications that extend far beyond this limited context.

## **Introduction**

### **Country Ownership and International Development Assistance**

International development aid is a multi-billion dollar industry. It is estimated that in 2011, \$133 billion (US) was made available for development assistance, from twenty-three (23) countries (Organization for Economic Cooperation and Development, 2012). Other sources of aid, e.g. charities and foundations, have further expanded this industry well beyond the assistance of the major donor governments. International development aid exists because some countries cannot independently provide goods and services for their citizens. Whether this assistance is motivated by politically defined self-interest or altruism, richer countries have created a system designed to provide needed goods and services, while achieving or protecting their own interests.

One of the major assumptions central to international development is that once a donor provides resources to build infrastructure or systems then the recipient country will take these systems, maintain and sustain them as their own. However, there are many extant forces that serve to complicate this assumption. It assumes recipients and donors are agreed on what is provided, that there are appropriate resources in recipient countries to receive and sustain what is provided, and that what is provided is appropriate for filling the assessed gap.

There has always been the idea of ‘country ownership’ in development aid. The provision of funding, goods and services was not sufficient to ensure sustainable capacities, structures, process and outcomes in developing countries. There are active collaborative roles that both recipient and donor must play in the process for the outcome to be successful.

The World Bank and the International Monetary Fund (IMF) tried to foster country ownership through conditionalities attached to their financing mechanisms. Twinning the

provision of financing with what external experts defined as best for a particular country not only stigmatized the idea of country ownership in the 1980s and 1990s, it also created confusion about whether it was an economic or political concept or both (Best, 2007). Further, the solutions to development issues came from external experts and there was limited contribution from developing countries in resolving their developmental challenges. As the development approaches of the World Bank and IMF failed to yield the expected developmental outcomes at the close of the twentieth century, the concept of country ownership had limited mention in development discourse.

Then on March 2, 2005, approximately ninety-one (91) countries gathered in Paris, to discuss the way international development aid is delivered and managed. These countries represented both the donor and development aid recipient communities. This meeting not only reignited the concept of country ownership but de-stigmatized it. Participants committed to harmonized development strategies; to use and improve country level systems, where appropriate; and to deliver and manage aid to meet development objectives (OECD, 2005&2008).

In 2009, the Obama administration launched the Global Health Initiative (GHI), an integrated approach to unify the United States Government's (USG) international health investments (US State Department, 2009). Country ownership is one of the seven (7) principles that guide the GHI. Discussions have therefore begun, within and among USG assisted health activities of how to assess the contribution that country ownership, as a policy principle, makes to improved health outcomes.

One of the challenges with this assessment is that country ownership is not easily defined. As there are many parts to international health financing and the delivery of health

services in recipient countries, there are also many dimensions or component parts of country ownership. The challenge becomes even more acute when viewing it from the perspective of recipient countries that vary in their development status, governance systems and access to funding; and the perspectives of the donors with their differing interests, outcomes, systems and levels of resources. Although there has been considerable discussion on the issue of country ownership and the value of the principle is assumed, there has been no comprehensive definition of the concept, or testing of the idea that its existence has a positive influence on an outcome of interest.

Country ownership is once again at the forefront of development policy because in this era of donor economic crises and shrinking development funding, the need to objectively know if and when countries are transitioning to sustainable country systems and processes is vital.

## **Study Site: Liberia**

### *Rationale for selecting Study Site*

In September 2011, the United States Agency for International Development (USAID) in Liberia executed a \$42M grant agreement with the Ministry of Health and Social Welfare (MOHSW) focused mainly on performance-based contracting for the delivery of health services. Previously, a large health project, Rebuilding Basic Health Services (RBHS), implemented by John Snow Inc. (JSI) had been charged with managing contracts to non-government organizations (NGO) who deliver health services at the facility and community levels. The objective of this grant is to transition the management of Liberian health services away from external development partners to the Liberian government.

Lofa County in Liberia provides a good test subject for measuring country ownership and determining intervening variables that could test a relationship between a country-owned PBC system and health outcomes. Firstly, the MOHSW PBC system is newly implemented in Lofa County, having been awarded in December 2011; secondly, the post-conflict setting has meant heavy donor investment and involvement in rebuilding national systems; thirdly, there is a data available to determine if health outcomes have improved since the start of the PBC process.

### *Background*

Liberia is located on the West Coast of Africa, with Guinea to the North, Cote d'Ivoire to the East, Sierra Leone to the West, and the Atlantic Ocean to the South. It is a small country, comparable to the size of the state of Tennessee in the United States of America (USA).



**Figure 2 – Map of Liberia**

Independent since 1847, Liberia was engulfed in a 14-year civil war that began in 1989 and ended in 2003. In 2008, Liberia's population was estimated at 3.5 million people (LISGIS, 2009). The population is divided almost equally between the male and female and has a density of 93 persons per square mile of land (LISGIS et al, 2008). Approximately 61 percent of the

population is below the age of 35 and the annual population growth rate is 2.1 percent, with the total population of Liberia expected to double the 2008 number in 33 years (i.e. by 2041) if this observed annual growth rate continues (LISGIS, 2009).

Education is still a challenge and remains weak in Liberia. The literacy rate is estimated to be 58.1 percent (for age 15 and older), with more literate males (63.3 percent) than females (53 percent). The gross enrollment ratio (GER)<sup>2</sup> varies at different levels of education (UNESCO, 2010).

Liberia is a very poor country with a market-based economy. For a few years in the 1970s, Liberia's per capita income was equivalent to that of Japan (GlobalSecurity.org). But currently, Liberia is ranked by the World Bank among the very poorest countries in the world (World Bank, 2010). Before 1990, the country focused on curative and tertiary health care that was concentrated in cities and away from the largely preventable health issues that the country faced. Some key effects were high infant, child, and maternal mortality, and a low life expectancy (Bureau of Statistics, 1986).

The war, which ended in 2003, worsened the health situation in Liberia and caused substantial setbacks. The country's infrastructure collapsed and the government was unable to provide basic services. One key example is of the 293 public health facilities operating before the war, 242 were non-functional at the end of the war because buildings were destroyed and equipment and supplies looted (Kruk, 2010). Doctors, nurses and other health workers fled the country, leaving 30 physicians to attend to a population of 3 million (Kruk, 2010).

There have been improvements over the last eight years in the health sector and this progress has resulted in changes that can be seen in key health indicators, e.g. the infant

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<sup>2</sup> Gross Enrollment Ratio (GER) is the number of pupils enrolled in a given level of education regardless of age expressed as a percentage of the population in the theoretical age group for that level of education.

mortality rate dropped from 117 to 72 deaths per 1000 live births, and under-5 mortality also dropped from 194 to 111 deaths per 1000 live births (World Bank, 2010). However, there remain significant challenges to the health sector and health outcomes continue to perform below required standards.

### *Performance Based Contracting in Liberia*

In 2006, the Government of Liberia developed a National Health Policy and a National Health Plan. The National Health Plan (2007 – 2011) prioritized a Basic Package of Health Services (BPHS) and decentralization of management, and implementation of programs to the 15 counties. To support the implementation of the health policy and plan, a Health Sector Pool Fund was established in 2008 and currently has four main contributing donors: The United Nations Children Fund (UNICEF), the United Nations Refugee Agency (UNHCR), the United Kingdom’s Department for International Development (DFID) and Irish Aid (Hughes, 2012).

Further, the MOHSW initiated performance-based financing (PBF) for health service delivery throughout the country funded by the Health Sector Pool Fund. The 2008 Policy on Contracting aims to maintain and improve access to, and quality of, the MOHSW-approved BPHS package. Moreover, it aims to “leverage partner capacity to prepare the County Health Teams to resume management of health facilities and the workforce” (MOHSW, 2007). The MOHSW views the contracting of NGOs as a means to facilitate the transition from relief to development by improving the management of, and collaboration with, the County Health and Social Welfare Teams (CHSWTs), which are responsible for managing health services in their respective counties. The capacity of CHSWTs is to be developed, in part, through the PBCs with the NGOs (MOHSW, 2007).



The United States Agency for International Development (USAID) in Liberia is funding a similar PBC process with the objective of transitioning the rebuilding of US government funded health services to the Liberian government. The PBC process is part of an up to \$42 million (US) Fixed Amount Reimbursement Agreement (FARA) to support the implementation of the Ministry of Health and Social Welfare's National Health Policy and Plan 2011-2021. USAID has committed funding until June 2015.

Under the 'Procurement of Preventative and Curative Health Services and Commodities' section of the FARA, the MOHSW will assume the management of PBCs with NGOs implementing the Essential Package of Health Services (EPHS) in Lofa, Bong and Nimba counties. Therefore, this section replaced a previous arrangement where support to service delivery was provided through a US-based Cooperating Agency, John Snow Inc. This new arrangement, directly with the MOHSW, is part of USAID's Forward initiative that seeks to strengthen country partner capabilities towards the achievement and sustainability of national systems (Hughes, 2012).

The Health Sector PBF system has three models; 1) contracts between the MOHSW and a CHSWT; 2) contracts between the MOHSW and NGO or civil society organizations; and 3) a performance agreement between an implementing partner and a health facility (MOHSW, 2012). These models can have different approaches. For example, the MOHSW to NGO/CSO could be based on management contracting, that is the contractor provides only management services over government funds or contracting out, that is where the contracted partners have complete authority and autonomy to use resources to provide health services (MOHSW, 2012).

The MOHSW refers to their national scheme as PBF, since it includes PBC models as well as PBF models. They define the difference as; PBCs are contracts with NGOs “with payment depending on achievement of a performance measure that includes coverage targets and quality norms for a set of services. The contrast with PBF is that the latter concentrates on agreements with providers” (MOHSW, 2012). For the purposes of this study, PBF will be used to describe the model in Lofa and the system in general.

The PBF model in Bomi is an example of the MOHSW contracting with a CHSWT and the Lofa model is an example of a PBC with MOHSW contracting with an NGO based on the management services approach. There is little model differentiation by funder, i.e. both the USAID and Pool Funds have supported the implementation the ‘contracting in’ model, that is, the MOHSW contracting with a CHSWT. This model is implemented in Bomi (Pool Fund supported) and Bong (USAID supported) counties.

The PBF intervention in Lofa County is implemented through International Rescue Committee (IRC) which successfully won a competitive bid issued by the Government of Liberia’s procurement process. IRC is responsible for implementing the EPHS in 42 of the 48 clinics in Lofa County. The EPHS “includes all elements of the Basic Package of Health Services (maternal, child and newborn health, communicable diseases, reproductive and adolescent health, mental health and emergency care), as well as a phased-expansion to include non-communicable diseases, essential child nutrition, neglected tropical diseases, environmental and occupation health, school health, eye health and prison health” (MOHSW, 2012).

The performance targets are agreed upon and set by the MOHSW and IRC in Lofa County. According to the MOHSW Performance Based Financing Manual, after the targets are agreed upon by the MOHSW, IRC and the Lofa County Health and Social Welfare Team, IRC

sets a target with health facilities according to catchment population of the health facility, historical performance, geographical constraints; and ensures that each facility equitably contributes to the agreed target (MOHSW, 2012).

There is a verification process at community, health facility and county levels. This verification process at the health facility and county levels is the responsibility of the PBF Steering Committee and is conducted once per quarter. The county contracts an external entity to conduct the community verification. The MOHSW then conducts a counter verification of administrative indicators to ensure the integrity of the results and hires a party external to the MOHSW to conduct the counter verification of the facility indicators.

90% of the contract amount is paid to IRC with a 10% bonus paid when the targets are met and/or exceeded. This 10% is disbursed to the facility with the “recommendation... [that] up to 65% of the earned bonus ...be used for staff motivation, while accounting for certain criteria such as: base salary, responsibility, years of experience, absenteeism from work, etc. The remaining 35% of the earned bonus can then be used for innovative activities that are likely to improve the performance towards achieving a set goal” (MOHSW, 2012).

The transition to country managed health services will see Liberian management of PBF, which, it is hoped will lead to improved monitoring and evaluation of health outcomes and results. The idea with the implementation of PBF is that greater recipient country management of EPHS will mean a greater sense of responsibility for health service delivery. This greater sense of responsibility will mean programs are implemented and quickly adjusted, which will contribute to improvements in health outcomes.

PBF assumes that twinning remuneration and incentives to performance will improve performance. PBF is seen as an objective means of assessing the performance of partners,

holding them accountable for the services they deliver with payment as the ‘carrot’ or the ‘stick’.

But what is being touted as a country owned process may be missing critical elements or dimensions. This gap could hinder full transition to the sustained delivery of health services by Liberians and improved or maintained health outcomes.

## **CHAPTER 2: AIM 1 - DEVELOP A MEASUREMENT APPROACH TO COUNTRY OWNERSHIP**

### **Introduction**

The purpose of this chapter is to develop a measure of country ownership and assess if the performance based financing system in Lofa County, Liberia can be referred to as country owned.

### **Part A: Define country ownership - Methods**

The key concept examined in this literature review was *Country ownership*. This phrase is one that has relied on intuitive interpretation that is, it is more recognizable than definable. It assumes that there is a development financing arrangement between a donor and a recipient country and conjures up pictures of accountability, country leadership, decision making by country officials, participation in development processes by government and civil society actors, and hopes of sustained programs and systems.

But the dimensions are not defined and agreed. This literature review will provide the basis for defining the dimensions or parameters of country ownership.

### *Search Strategy*

The dimensions of country ownership are taken from several disciplines including, but not limited to; Political Science, Economics, International Political Economy and Health.

Therefore the search for literature on country ownership was divided into three parts and two tiers.

In December 2011, a general search using the term ‘country ownership’ was used in the University of North Carolina at Chapel Hill’s (UNC’s) ‘*E-Research Tools*’, which provided access to over 350 databases and collections including *PubMed*, *Web of Science*, *JSTOR Arts & Sciences Collection* and *Wiley InterScience Journals*.

Next, a search of gray literature (lectures, conference material, technical reports, policy papers and speeches) of the term ‘country ownership’ was done using the *Google* search engine. Third, the articles used for a literature review on country ownership recently conducted by ICF International for a Centers for Disease Control and Prevention (CDC) project, was reviewed.

A second tier search was conducted; from the appropriate material found using all three search engines, the reference pages were searched to ascertain additional literature.

### *Criteria for Selection*

All publications **included** in the first tier search were selected using the following criteria:

- Scholarly publications including peer reviewed journals (*UNC E-research tools and Google*)
- Published after June 2005
- Published in English
- Journal articles and gray literature must provide a definition or description of ‘country ownership’

For the second tier search, the literature must have included a definition or description of ‘country ownership’. Beyond this there are no limiting criteria.

Literature was **excluded** if:

- The discussion of country ownership was not within the context of development supported initiatives and development funding
- The discussion was of a domestic nature within a donor country e.g. country ownership of health reform in the US
- The discussion was within the private sector and multinational corporations with holdings in developing countries

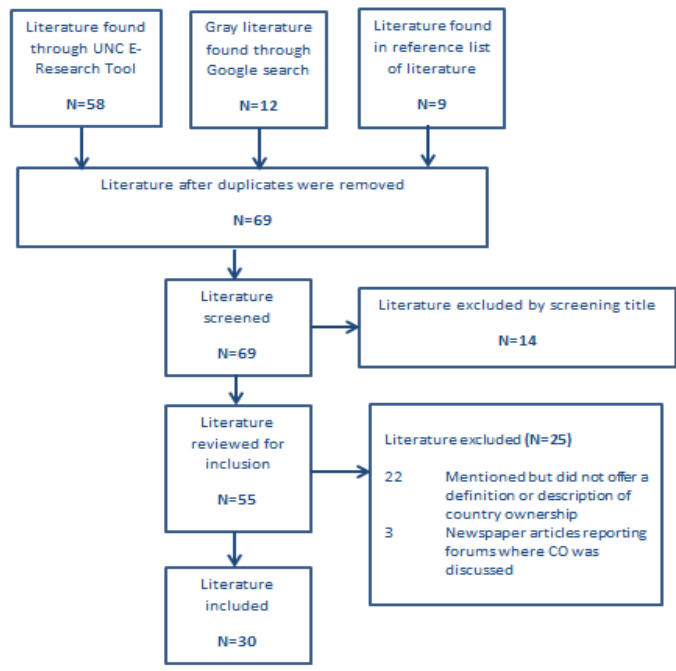
### *Process for Reviewing Literature*

Articles were reviewed first looking for the search term ('country ownership') in the title of the articles or literature. In most cases, appropriate literature did not have abstracts and therefore the entire article was read to find a description or definition of the dimensions of country ownership.

## **Literature Review Findings**

### *Overview*

The search was conducted from January to April 2012. 69 distinct articles were found using the UNC E-Research Tool, Google and ICF Literature Review.



**Figure 3 - Country Ownership Literature inclusion Process**

The titles of 69 pieces of literature were screened and 14 of those excluded. The 55 pieces of literature remaining were reviewed and 25 excluded because they mentioned, but did not offer a definition or description of country ownership, and were newspaper articles reporting forums where country ownership was discussed. Therefore, 30 articles met the inclusion criteria for ‘country ownership’.

*Key Assumption*

In all of the literature reviewed, the authors write of country ownership within the setting of development or foreign aid. Therefore, there is a key assumption that underpins all the dimensions of country ownership. It is only within the context of development aid, development cooperation and the donor-recipient relationship does this concept of ‘country ownership’ live.



This setting consists of the transfer of funds from a developed country or multilateral organization to a developing country for the purpose of rebuilding, strengthening or maintaining systems in those developing countries.

The idea of development aid came to prominence at the end of World War II with the US Government's 'Marshall Plan' or European Economic Recovery Program as it was officially known. The 'Marshall Plan's' main purpose was to rebuild Europe after the devastation of World War II and do so in a way that engendered cooperation and reconciliation (Fuhrer, 1996).

After the success of this Plan, the US Government expanded its assistance beyond European countries into Africa, Asia and Latin America. Neutral nations were promised rapid industrialization, akin to that of Europe, in exchange for Cold War allegiance and development funding (Easterly, 2010). The initial 'Marshall's Plan' recipient countries in Europe and the US formed what was to become the Organization of Economic Cooperation and Development (OECD), presently the largest collective of donor countries (Fuhrer, 1996)<sup>3</sup>.

Currently, aid provided by foreign sources continues to be the primary avenue through which strategic and emergency development initiatives are funded and implemented in many developing countries. Developing countries experience inherent vulnerabilities: natural disasters for which there are little or no resources for recovery; political instability stemming from civil and international wars; inability to compete on the world market because of the size of their markets or the lack of diversification of national production.

These vulnerabilities result in weak national systems that tend to be incapable of independently addressing the needs of its citizens.

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<sup>3</sup> In addition, some donor countries formed their own international development agencies. Even though the British Department for International Development was not established until 1997, the modern era of British development aid began in 1960 with a white paper discussing how economic development will lift poor nations out of poverty; USAID was established in 1961; and Canadian International Development Agency was established in 1968.

Donor countries are motivated to contribute to the improvement of developing countries because of humanitarian and utilitarian reasons. In response to the abject poverty being experienced by some countries, donors believe that there are common problems and therefore common solutions. This belief in turn engenders a sense of responsibility and solidarity. Donor countries are also motivated by self-interest and foreign policy imperatives, as instability and poverty are seen to be of strategic importance and therefore present increased security concerns for the developed donor countries (Besson, 2009).

Sustained development in much of the world, through development aid, failed to have the same blanket effect as it did in Europe in the same number of years. Moyo (2009) discusses the eras of aid as beginning with the newly formed Bretton Woods institutions (World Bank and International Monetary Fund) in the 1940s; to the era of nation building and industrialization in the 1960s; to the time of aid as an instrument of poverty reduction and political alignment in the 1970s; to aid as a tool of stabilization and structural adjustment in the 1980s; to aid as a means of bolstering democracy and governance in the 1990's; to the current era of aid as the main solution of all development issues.

Throughout these eras of development, the issue of ownership has come to matter. In development aid programming, all contingencies and eventualities cannot be foreseen, therefore remedies for these contingencies cannot be written into the program documents. When a program is 'owned' by a country, decisions can be made quickly and favorably for the success of the program, necessary local resources will be allocated and there will be domestic support for the sustainability of the program (Khan, 2001; Johnson, 2005; Goldberg, 2012).

Four (4) dominant themes of country ownership were found from this literature review using template analysis approach. This approach identifies key words that are then grouped and coded into themes (King, 2004). They are discussed below.

**Country ownership:**

- Involves recipient governments having the **right, power** and **legitimacy** to set priorities and make decisions that are **respected** by the donors;
- Involves **commitment** by political stakeholders to take **responsibility** for aid funded programs that address an identified need;
- Includes stakeholders in recipient countries (government, NGOs and civil society) having the **capacity to sustain** initiatives and programs;
- Consists of recipient governments, political actors and donors being **accountable** to both each other and their citizens, for programs, systems and strategies.

*Power and Legitimacy and Respect*

The concept of country ownership is inherently a political concept (Besson, 2009; Booth, 2011). In development aid there is a donor-recipient relationship which Khan (2001) discusses in the context of a principal-agent relationship. This relationship is governed by a power dynamic where the donor's power is seen as constructive (power to act) and the recipient's power is seen as controlling (power over a player or a process) (Hyden, 2008). Humanitarian and utilitarian motives mean the donor relies on the recipient to accomplish pre-determined objectives (Khan, 2001), and the recipient receives resources which it is unable to provide for itself.

Therefore, Besson (2009) argues that both the donor and the recipient should exercise the power to define the development and decision-making processes, prioritizing interests and determining how initiatives will be implemented and in what direction the development will move. However, this power relationship is not equal, the social and political interests of both parties are often different and power moves towards the source of resources, or as Carlos Diaz-Alejandro, prominent Columbia University professor of Economics, is quoted as saying, ‘if you ask for a gift, you must listen to your patron’ (Khan, 2001).

The Paris and Accra Declarations call on donors to commit to respect and support country ownership. This support assumes that the donor will respect the direction of the recipient country (de Renzio, 2008), listen to the priorities of governments, assist governments to achieve those priorities, and allow governments to make mistakes (Whitfield, 2009). Within this flexibility and innovation, donors must also be willing to withdraw aid when the direction and processes are inconsistent with what the donor is willing to support (Whitfield, 2009). Best (2007) refers to this approach as ‘political pluralism’, the idea that there is more than one way to achieve development, that people should have ‘the opportunity to debate those alternatives’ and that the one best solution does not have to be determined by the donor.

Concurrently, recipient countries must have the power to ‘exert meaningful control over their decisions and actions’ (Best, 2007). That is, they must have authority. Since ownership is a political concept, then in the context of this era of aid effectiveness, the recipient must be the legitimate voice of the country, and for whom national development is a key objective (Besson, 2009; Booth, 2011). The recipient must have the right to set its own development agenda and develop strategies and programs to meet the objectives of that agenda (Ghebreyesus, 2010; Roderson, 2005). Without this legitimacy, governments will be unable to engender and sustain

support and may have to resort to other forms of power such as force or coercion, which may achieve a ‘modest degree of implementation in the face of sabotage, indifference, nonparticipation, and minimum effort and compliance from the general population, despite large expenditure of resources’ (Johnson, 2005).

The issue of legitimacy in this power dynamic is twofold. Legitimacy (perceived or actual) in a recipient country acts as internal social control as the citizens of the country believe that the government acts without coercion (Johnson, 2005); and external assurance that development goals negotiated with donors will be met (Best, 2007). On the part of the donor, there must be the perception that the expertise behind negotiated programs is legitimate, or as Best argues ‘its authority is perceived to be justified’ (Best, 2007). Also, there must be the perception that the donor is providing objective solutions to problems that the country is seeking to resolve (Best, 2007).

In the context of country ownership, the power that both donor and recipient possess in this relationship is tempered by a partnership arrangement. In this partnership, the donor’s power serves to enable the objectives of the recipient, not treat them as the ‘means’ or the ‘instrument’ to achieve development results (Volker, 2011). This relationship in turn meets the objectives of the donor as these objectives are aligned to that of the recipients (Hyden, 2008).

### *Commitment and Responsibility*

The value of the Paris and Accra Declarations was the idea of ‘commitment’. The term was used over thirty times in the documents to denote the obligation placed on donors and recipient alike to the process of aid effectiveness. The Declarations called the donors to respect and strengthen country leadership and obliged recipients to develop and implement their own national strategies in response to identified and prioritized national needs (OECD, 2005 & 2008).

Castel-Branco (2008) argues that there is a natural link between commitment, leadership and control. He argues that ownership in its purest sense includes the recipient formulating development agendas free from the influence of the donor and the donor financing that agenda, even if the policy preferences are not aligned. Castel-Branco (2008) admits that this purist perspective is ‘unrealistic’, and argues that the other end of the spectrum is undesirable as well. What he does advocate for is emphasis on the substance rather than the form of the ownership; that there should be recipient country commitment to, leadership of and control over the development goals, programs and processes to reach those goals. In this way, ‘ownership reinforces commitment, and commitment in turn yields results and assures long term sustainability’ (Ghebreyesus, 2010).

With this commitment or right of agenda setting, comes a responsibility. Johnson (2005) argues that if a country has the right to insist on deciding its own development agenda without coercion, then it is also obliged to take full responsibility for what comes of the policies and programs that are implemented. In other words, recipients take responsibility to ‘do or fail to do’ (Molund, 2000). They take responsibility for setting the agenda, designing the programs, engaging the partners, managing the overall process and accounting for results (Buiter, 2007; Health Systems 20/20, 2012).

This idea of responsibility implies a level of control. Whitfield (2009) introduces an idea of ‘ownership as control’. She argues that control can be assessed by observing ‘what proportion of the implemented policy agenda was decided by the government; what proportion resulted from a compromise between recipient and donor; and what proportion was accepted reluctantly as a necessary price to pay for accessing financial aid’ (Whitfield, 2009). Whether or not ownership as control is achievable is dependent on the donor-recipient relationship.

Molund (2000) presents a legal definition of ownership as right of use, control and transfer. He argues that in addition to these objective criteria, there are also subjective criteria of necessary ‘attitudes, feelings and opinions’. Boughton (2002) argues that though the ‘state of mind’ and ‘internal commitment’ of the national stakeholders is important, and inferences can be drawn from observed behavior, there is no way to directly observe this commitment and evidence would be incomplete. While not dismissing these more subjective concepts, he suggests more practical signs of commitment can be found in greater control given by the donors to recipients over the development agenda in a relationship of trust and empowerment.

### *Capacity*

If a recipient is to lead the determination of their policy direction, gain and sustain the trust of their donors, and take responsibility for processes and outcomes; and if donors are to achieve their development goals, then there must be the recipient capacity to do so (Best, 2007). The recipient ‘should have the institutional capacity to develop strategies and operational plans, coordinate and align the activities of key stakeholders, implement programs or delegate their implementation to others and provide oversight and hold implementers accountable’ (Health Systems 20/20, 2012).

Capacity is a complex notion; it includes multiple stakeholders, multiple dimensions and multiple levels. For simplicity, capacity can be said to ‘represents the potential for using resources effectively and maintaining gains in performance with gradually reduced levels of external support’ (LaFond et al, 2003). This definition presents the idea of existing capacity and a capacity gap that need to be resolved, and it assumes an internal process that is enhanced or accelerated by an external source (Goldberg, 2012).

A 'capacity dilemma' is at play in the donor recipient-relationship (Best, 2007). Recipients who possess the required level of capacity to engage in true ownership are least likely to need donor assistance and the recipients for whom leadership, power, authority, and engendering respect will be a challenge are the ones most in need of donor assistance and for whom ownership of programs and initiatives would be most beneficial (Best, 2007).

Within this capacity dimension of country ownership, there is a role for donors in recognizing the existing capacity and its capability, working with recipients to identify areas for improvement or strengthening and integration of donor supported capacity and programs with institutional structures and processes (Atun, 2009; de Renzio, 2008)). Donors themselves grapple with capacity issues as structural limitations, such as staff turnover and lack of delegation from respective headquarters, or the way they deploy their resources, constrain attempts at contributing to capacity development (Wood, 2008). But, it is also important for the donor to recognize that capacity building requires substantial investment, more than the usual five years, from a sustained source (InterAction, 2011; Mas de Xaxas, 2007).

Further, Sridhar (2009) argues that donors should assist recipients to find sustainable solutions to their identified needs and resist developing parallel systems that weaken and neglect already inadequate systems, in other words, the expediency of 'quick wins' must be replaced by 'long-term priority setting and planning' (Sridhar, 2009).

Recipients continue to be challenged by both real and perceived capacity constraints and the tension between dedicated systems to address the demands of ownership while needing to integrate or 'mainstream' vertical programming in existing systems (Wood, Kabell, Sagasti, & Muwanga, 2008). Therefore, recipients must be flexible in adjusting their national and sub-



national structures, and be open to alliances and partnerships from civil society and the private sector, and be inclusive in planning and oversight processes (Atun, 2009; Mas de Xaxas, 2007).

Hauck et al (2011) argues that capacity building and ownership are cyclical, self-perpetuating elements. Ownership is integral to creating capable systems, organizations and individuals that are in a constant state of interaction; and this capacity in turn strengthens commitment and responsibility for outcomes, both central tenets of ownership.

### *Accountability*

Accountability is based on a power dynamic where an agent reports to a principal on his/her activities and there are consequences for non-compliance. Easterly (2010) and Sridhar (2009) point out that in this dynamic, those with power are not accountable to those with less power.

The Paris and Accra Declarations use the term mutual accountability to describe the joint obligation that both the recipient and the donor share in this development process. This contemporary view of mutual accountability, assumes a more equal balance of power. It is an agreement between recipients and donors, manifested in a sound accountability mechanism, including results-based frameworks 'premised on clear outcome targets that must be defined and agreed to the outset' (Ghebreyesus, 2010).

Monitoring and evaluation of programs and initiatives and results frameworks have become a primary focus of accountability structure and the foundation on which other accountability activities have been based (Wood, 2008).

In the area of health, donors and recipients need to place less emphasis on indicator reporting and more emphasis on coherent systems of data collection, analysis and use. Greater investment is needed in demographic surveillance and civil registration systems that also

addresses chronic, non-communicable diseases while integrating disease-specific initiatives in national health systems. Donors and recipients alike should appreciate that monitoring and evaluation goes beyond counting, and investments of time and resources are needed to determine causes of morbidity and mortality and the effects of programs in a developing country setting (Boerma , 2007; Sridhar, 2009).

Additionally, Booth (2011) and InterAction (2011) believe the donor should provide information on their plans, programs and aid flows to all partners in country. Further, recipients must be open to sharing their national budgets as they relate to counterpart funding for development initiatives, therefore there is an enhanced parliamentary role in developing and accounting for strategies and budgets (Wood, 2008).

There is an increased demand to account for external funding and the results that funding is intended to produce (Boerma, 2007). The challenge of mutual accountability is to ensure that the accountability mechanisms implemented in the recipient country serve the purposes of that country and not just external accountability (Holzscheiter, 2012). Not only governments but civil society and other non-governmental actors are involved in these accountability structures, so that accountability and ownership are ‘mutually reinforcing values’ (Germain, 2011; Wright, 2008).

## **Discussion**

The objective of this literature review was to define the dimensions of country ownership. The results presented ideas on country ownership which coalesce around four themes, in short, power, legitimacy and respect; commitment and responsibility; capacity and accountability. The themes are discussed below.

The literature reviewed in this section demonstrates that country ownership is both an essential component in the development process as well as a constructed outcome. The idea of

country ownership, expressed as it should be not as it is, seeks after optimal behaviors and conditions in a donor-recipient relationship. This literature review does not seek to conclude that the donor-recipient relationship is a positive or negative one. The question is; what are the norms, behaviors, and inputs that will allow for the achievement of successful and perhaps sustainable development outcomes, without questioning the virtues of the relationship or value of development aid. It has long been believed that country ownership is critical for a successful development result. Nonetheless, each theme identified has inherent challenges that make the concept of country ownership complex.

First, once the idea of power is introduced, intrinsic in that dynamic will be the ‘powerful’ and the ‘less powerful’ or the ‘powerless’. And certainly once a discussion of a donor recipient relationship is broached, this dichotomy of power is even more pronounced. How then does the issue of a more balanced share of power in this relationship become practice? Is it realistic to expect that there will be power sharing in a relationship defined by power? But can ownership be said to exist if the recipient does not exercise power over the process?

- **Is it realistic to expect that there will be power sharing in a relationship defined by power?**
- **This new paradigm recognizes the power of donors but also the right of legitimate recipients and attempts to define the parameters for engagement in this relationship.**

Can a recipient ‘own’ an initiative if they are not the legitimate representative of the target constituency? Is there country ownership if the donor does not demonstrate respect for recipient leadership, priorities and systems?

The answers to these questions are the crux of the concept of country ownership. To seek greater aid effectiveness and more sustainable outcomes, donors and recipients alike, through the Paris and Accra Declarations are articulating a new paradigm of development, in short, a new relationship. This new paradigm recognizes the power of donors but also the right of legitimate recipients and attempts to define the parameters for engagement in their relationship.

While Easterly (2010) and Buiters,( 2007) question whether a ‘ruler’ can represent a heterogeneous population with ‘conflicting views and interest,’ including the poor of the country; and Moyo (2009) points to the donors as the constituents of the recipients in contemporary aid relationships; these arguments do not negate the current political practice of an elected leader of a country being the legitimate spokesperson for its citizens. And that spokesperson has authority over the policies and programs that are implemented in order to improve the status of the citizens he/she leads, despite the source of funding.

- **Not all development processes and products need to be sustainably ‘owned’**
- **Commitment and responsibility are not static concepts but dynamic and appropriate to the initiative**
- **Some capacity may be needed for ownership to thrive as well as the ownership process may engender capacity development**

Second, Johnson (2005) argues that recipients must have a vision for the country that the donors 'buy into' and that they must be responsible for the successful or failed outcomes of development processes and products.

As there are many development products and processes that can be 'owned', so too can there be many levels or layers of ownership. A recipient may only be interested in a given product. Does the recipient also have to own the process of developing this product? For example, if a country is interested in a Demographic and Health Study does it need to commit to and take responsibility for the process when there is no comparable capacity to oversee and manage the process? When there is no notion if there will be a need for this study to be repeated or if it will be a single activity? Can the recipient trust the partner to undertake the process but commit to using or 'owning' the results from the study?

These questions point to the idea that not all development processes and products need to be sustainably 'owned', perhaps some processes and products need only to be owned for a point in time and no more. Therefore, commitment and responsibility are not static concepts but dynamic and appropriate to the initiative. As Molund (2000) argues, "the strength of ownership depends on two types of circumstances; what the actors want and what they, under prevailing circumstances, can do or believe they can do, their desires, preferences, or priorities, on the one hand, and their actual and presumed capacities on the other".

Which leads to the third challenge; the capacity involved in ownership depends on the product being owned and necessary inputs into the process. For example, a process may involve the recipient having the capacity to assess the situation in a country and develop a vision for change; lead and negotiate the terms of the aid package; have the technical capacity to manage and implement an initiative and the ability to funnel the results, if necessary, back into the

national processes. Or an initiative may simply require the will and commitment of the recipient, while the donor builds capacity for future implementation by the recipient. Therefore, some capacity may be needed for ownership to thrive as well as the ownership process may engender capacity development. As Goldberg et al (2012) argues, “All organizations must already have some level of capacity as a pre-condition to effectively build more capacity”.

But capacity is not one-sided. The capacity of donors is important in three ways; first the donor must have the ability to scan the national environment and twin its global objectives with national priorities in a way that is helpful and not disruptive or distortive of national goals (Sridhar, 2009); second the donor must be able to provide the resources needed to accomplish what it has agreed with the recipient to undertake; and third, the donor must have the ability to deliver those resources through adequately staffed offices and appropriate procurement systems that are not neglectful of national development processes (Sridhar, 2009).

- **It is clear that the idea of accountability is wrapped up in power dynamics and whereas the donor has the means of ensuring accountability from recipients, the recipients do not have such means.**
- **Donors have broadly instituted accountability mechanisms and recipients have complied with those mechanisms.**
- **The authors do not dispute the importance of power, legitimacy and respect; commitment and responsibility; capacity and accountability; rather they argue the practicality of engendering or seeking after these dimensions within the current donor recipient environment.**
- **A theme missing from the systematic search of literature was that of financial transition.**
- **Conceivably, the reason for this absence is explained by the notable absence of donor policy papers from this review.**

Therefore, 'successful country-owned capacity building projects echo the importance of inclusiveness in the planning process and excellent working relationships between partner/donor organizations that produce true partnerships' (Goldberg, 2012).

Finally, the authors talk about accountability; recipients being accountable to donors, recipients being accountable to their citizens, donors being accountable to recipients and also to their citizens. It is clear that the idea of accountability is wrapped up in power dynamics and, whereas the donor has the means of ensuring accountability from recipients, the recipients do not have such means. Therefore, usually missing from the donor recipient accountability process is information from the donor (Wood, 2008).

It may be argued that accountability is a western concept that has little meaning for other cultures. In other words, others cultures may believe that they do not need to be accountable for a gift or for something which is now theirs. Nonetheless, even if this perspective is held by many, donors have broadly instituted accountability mechanisms and recipients have complied with those mechanisms.

Despite these challenges, country ownership is a theme that endures in the context of development aid. There is a logical, and almost inextricable, link between country ownership, development financing, technical assistance and successful outcomes of initiatives. The authors do not dispute the importance of power, legitimacy and respect; commitment and responsibility; capacity and accountability; rather they argue for practicality of engendering or seeking these dimensions within the current donor recipient environment. This debate, important and cautionary in nature, does not, however, diminish the importance of these dimensions.

A theme missing from the systematic search of the literature was that of financial transition. None of the authors mentioned the long term ability of recipients to provide products

or processes for themselves, independent of donor assistance. This neglect is quite a notable absence in the discussion as this idea of financial transition is the very essence of development aid; that a donor provides resources to a country now, domestic resources and systems are built and there is no longer any need for donor assistance. This objective is the epitome of the Chinese proverb '*Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime*'. And it is rooted in the ideology of self-determination (Goldberg, 2012).

In fall 2012, the US Government made public their Global Health Initiative Interagency Paper on Country Ownership. The paper does mention financial transition and does so in the context of strengthening local capacity to eventually assume financial responsibility over health initiatives. The paper acknowledges that the pace of this transition is dependent on the stage of development of the country.

Nonetheless, the absence of a discussion of financial transition in the literature found from the systematic search perhaps indicates that the authors wish to insert some realism in this modular concept, may be after 60 years of development aid, they have enough examples to demonstrate the development aid is an on-going concern rather than a means to an end. Perhaps they discussed the idea of country ownership within the context of contemporary international political economy where structural and systemic challenges conspire for developing countries to remain 'un-developed' (with a few notable exceptions). Or perhaps they delimited their discussions to that of donor recipient relationship where the predominant source of funding is the donor.



- **The dual role for the donor and the recipient make the term ‘country ownership’ a misnomer.**
- **Though it suffers from some inaccuracy, the terminology is useful in its distinctiveness and notoriety.**

Conceivably, the reason for this absence is explained by the dearth of donor policy papers. Aside from a published article, Atun & Kazatchkine, (2009), coauthored by Michel Kazatchkine, Executive Director of the Global Fund for AIDS, Tuberculosis and Malaria, the donor voice, captured in their policy documents, is missing from this review. If the donors have written on this subject, they have not shared these writings publicly, except for the case of US Government Interagency Paper. For other donors, perhaps, this lack of writing, or lack of access to documentation, points to a global alignment of thought and ideas around country ownership and financial transition.

Interestingly, the US Government Interagency Paper defines and discusses country ownership as a one-sided concept. They include aspects of the dimensions discussed in this review, but articulate these dimensions as roles, responsibilities and purview of recipients. They discuss the role of the US Government as ‘promoting’, ‘accelerating’ and ‘enhancing’ country ownership. While these are important advocacy activities, the paper is silent on the duality of responsibility as has been discussed in this review.

This dual role for the donor and the recipient make the term ‘country ownership’ a misnomer. Power has to be shared; the perception of legitimacy and the attitude of respect have

to be held by both donor and recipient; commitment, responsibility, capacity and accountability are mutual. Therefore, a more accurate concept label would be ‘ownership’ rather than ‘country ownership’. So, though the concept label suffers from some inaccuracy, the terminology is useful in its distinctiveness and notoriety.

### **Limitations of Literature Review**

There are two main limitations of this review.

First, the perspective of major donors in the form of policy, other papers, and transcripts of speeches or conference presentations is limited. It is unclear whether this limitation is due to a lack of public access to these documents or whether there is inadequate individual donor material on the issue of country ownership. Further, it is unclear if the documents and comments coming from such forums as the Paris and Accra High Level meetings are the agreed and aligned voice of the donors and therefore there is no need for individual perspectives. Perhaps the inclusion criterion for this review was too narrow to capture these additional sources. Whatever the case, the policy perspectives of the major donor countries and organizations is limited.

Second, the use of UNC’s E-Research Tool may have excluded eligible articles because the list of resources that the database searches fluctuates. Initial searches on Google Scholar, however, found the same or similar articles to that of the E-Research Tool. Both validated the result of the search using the UNC E-Research Tool and negated the use of Google Scholar as a value added search method.

Additionally, the authors of the literature reviewed were drawn from different backgrounds, differing expertise, expressing differing attitudes and beliefs about the concept of country ownership; from idealistic to cynical. While one could argue that the absence of a core expert opinion is a weakness of the literature selected and therefore this review, one would also

argue that the range of opinions and voices added legitimacy and authenticity to a notion that is the purview of more than just experts.

### **Implications for further study**

Now that dimensions for country ownership have been identified, the next step is to apply them to a developing country context where a donor recipient relationship exists.

### **Study Design - Part B: Measurement of Country Ownership**

#### *Definitions*

The definitions used in this part of the research are the same as were arrived at through the literature review:

*Country ownership* is defined as:

1. Recipient governments having the right, **power** and **legitimacy** to set priorities and make decisions that are **respected** by the donors;
2. **Commitment** by political stakeholders to take **responsibility** for aid funded programs that address an identified need;
3. Recipient stakeholders (government, NGOs and civil society) and donors have the **capacity** to sustain initiatives and programs;
4. Recipient governments, political actors and donors being **accountable** to each other and their citizens, for programs, systems and strategies.

A tool for measuring country ownership of M&E systems is being developed and validated by the MEASURE Evaluation Project of the Carolina Population Center. This tool will be adapted to measure country ownership of health sector PBF scheme in Lofa County, Liberia. Some key differences include:

- The original tool is focused on HIV M&E systems while the adapted tool is focused on PBF scheme. Therefore, the content and focus is different. For example, the original tool includes statements relating to an AIDS Authority while the adapted tool includes statements related to the PBF Steering Committee.
- The original tool includes a statement aimed at determining if a country engages in international partnerships for greater impact on the domestic HIV epidemic, while the adapted tool does not include this international aspect as the impact of this specific application of PBF will likely be felt only in Liberia.
- The original tool refers to data from different sources (facilities, community or civil society and private sector); the adapted tool refers to data from one source, the HMIS.

A Likert-type scale of ‘strongly agree’ to ‘strongly disagree’ is used for responses to questions or statements for the first two dimensions (power, legitimacy and respect and commitment and responsibility); and a mix of ‘completely’ to ‘not at all’ and ‘strongly agree’ to ‘strongly disagree’ for the remaining two dimensions, (capacity and accountability) (*see Appendix 2*).

The original version of the tool uses a dashboard that aggregates the proportion of responses and displays this aggregation to give a pictorial representation of the level of country ownership of an M&E system. This dashboard feature is also used to summarize the level of country ownership of the PBC system.

## **Respondents**

In March and April 2013, the tool was administered to 13 key informants in face-to-face interviews. The idea was that data be collected from a minimum of 10 respondents per

dimension. Since not all respondents could provide answers to statements in each dimension, a total of 13 respondents were needed to achieve the minimum 10 respondents per dimension.

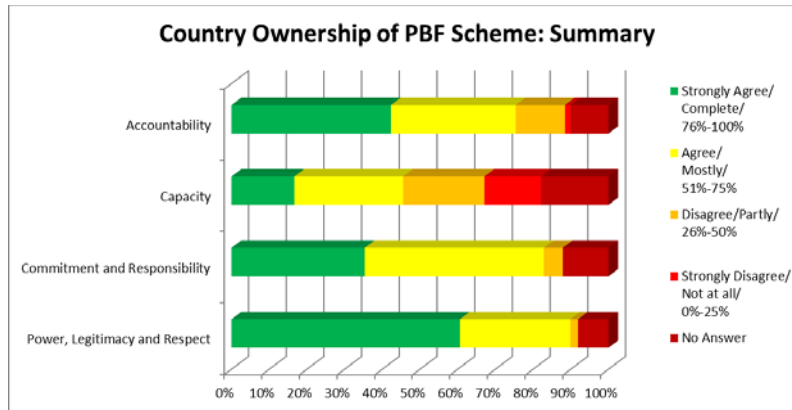
These key informants were drawn from the MOHSW in Liberia, USAID Mission in Liberia; from the Lofa County Health and Social Welfare Team (CHSWT), International Rescue Committee (IRC) and selected health facilities in Lofa County.

The selection of the key informants was based on their knowledge and involvement in the health sector PBF at the national and county level and involvement through the United States Agency for International Development (USAID), the PBF funder of interest. The number of respondents reflects the small group of persons with detailed knowledge of the initiation, functioning and vision for the PBF scheme in Liberia. Three deputy and assistant Ministers of Health represent three health departments in the MOHSW; that is Planning, Administration and Health Services. Therefore, even though the majority of respondents were from the MOHSW, the selection was deliberate to include a wide cross section of views from the MOHSW. The selection of the facility officers was done to include the impressions of different facilities in different health districts in Lofa County in this study.

## **Findings**

The study design outlined a decision rule that the PBF process was considered country owned if 51% or more of positive (i.e. 'strongly agreed', 'agreed', 'completely' and 'mostly') responses are achieved in the Power, Legitimacy and Respect and Commitment and Responsibility dimensions. In this application, 90% and 83% of positive responses were achieved in the Power, Legitimacy and Respect and Commitment and Responsibility dimensions; therefore PBF scheme in Lofa County, Liberia can be said to be country owned.

In every country ownership dimension, there were statements that respondents selected ‘no answer’ as the response category. While this category was designed to cover instances when a respondent may have been uncomfortable giving a positive or negative reply to selected statements; in all instances ‘no answer’ reflected that the respondent did not have sufficient information to give their impression of the statement.

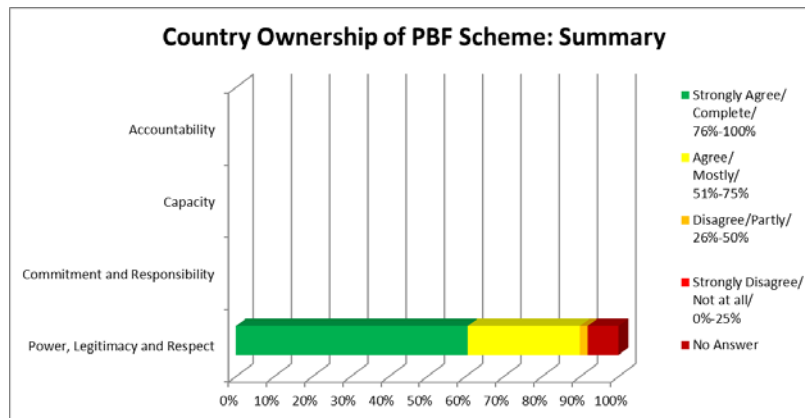


**Figure 4 - Summary of Country Ownership of the PBF Scheme**

*Power, Legitimacy and Respect*

With 90% positive responses, 67% of which were ‘strongly agree’, respondents believed that the PBF had a program and budget negotiation process that was balanced between USAID and the MOHSW, that there is monitoring of the PBF process and that there is a structure in place to manage the PBF process. For only one statement was there two ‘no answer’ responses, the statement was ‘USAID and the MOHSW participated in decision making about allocation of resources for the PBF scheme’. One of the respondents is a county level actor and was not close to the negotiation process and the other was a USAID respondent who was not posted in country during the initial PBF scheme negotiation. For seven of the nine statements in the power, legitimacy and respect dimension, different respondents selected the ‘no answer’ response. The two statements which had no ‘no answer’ responses, which also had only positive responses

were; ‘USAID participated in the last PBF scheme review hosted by the MOHSW’ and ‘there is a PBF coordinating Unit’.



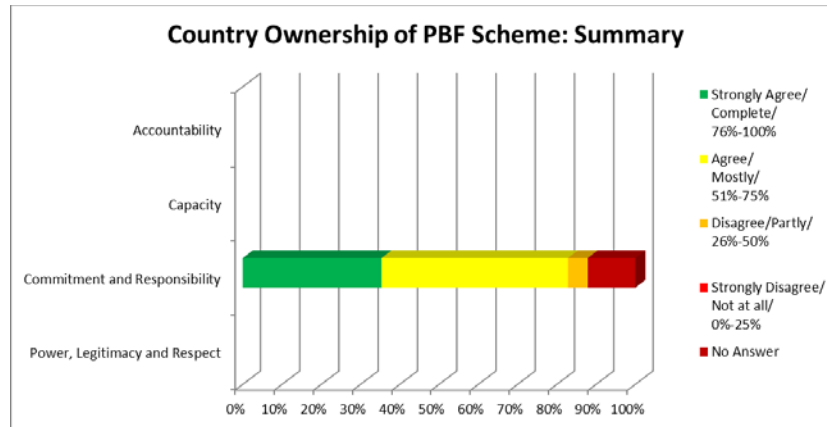
**Figure 5 – Summary of the Power, Legitimacy and Respect Dimension**

For two statements in this dimension were negative responses selected. One respondent disagreed that the PBF scheme is aligned to the national health strategy; S/he reasoned that the health strategy and the PBF scheme are not aligned because the scheme is being tested to see if it achieves its objective of improving the performance of the health sector. If the objective is achieved then the PBF scheme and the health strategy will be more closely aligned. The only other disagreement was with the statement ‘USAID made changes in its programming strategies in order to effectively support the PBF processes. The respondent argued that his/her response hinged on the word ‘effectively’. S/he argued that because of USAID’s regulations of not co-mingling funds, a separate PBF scheme was set up parallel to the existing scheme funded by the Pool Fund. To effectively support the PBF scheme, there should be one approach, one system, s/he argues.

*Commitment and Responsibility*

The majority of responses (83%) were positive. Respondents had the impressions that there was good strategic and operational planning process and there were known governance

structures and processes in place to operationalize the PBF process at the central and county levels. For one statement, ‘An organizational chart or similar document defines lines of authority and accountability for the PBF in Lofa County’ nearly half the respondents either did not know if an organizational chart existed or disagreed that one was developed.



**Figure 6 – Summary of the Commitment and Responsibility Dimension**

There were five statements that respondents selected ‘no answer’, two of the statements by more than one respondent. These were ‘The PBF Coordinating Unit's work plans have elements that can be mapped directly to elements of the National Health Strategic Plan’; ‘the work plan defines technical and/or cost sharing responsibilities for USAID, MOHSW and other partners’; ‘IRC and CHSWT have specific plans that are linked to the PBF Operational Plan’; ‘The PBF Coordinating Unit has institutionalized a set of standards for the PBF scheme that conforms to accepted practice’; and ‘An organizational chart or similar document defines lines of authority and accountability for the PBF in Lofa County’. The later statement had the most ‘no answer’ responses.

Of the five different statements that respondents selected ‘disagree’ for, one respondent disagreed with four statements; ‘An organizational chart or similar document defines lines of

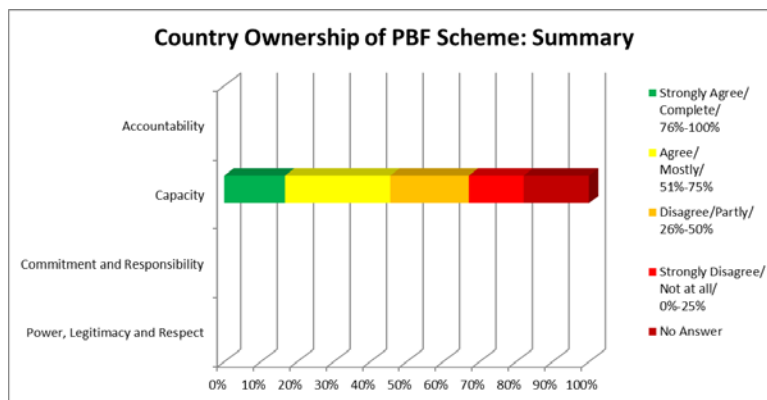


authority and accountability for the PBF in Lofa County’; ‘There are identified leadership structures at the national and county levels with the authority for planning, implementing and managing the PBF scheme’; ‘Managers at all levels are held accountable for results’; and ‘Coordination between partners is functioning to ensure the successful implementation of the PBF scheme’.

Similarly, there was also one respondent who accounted for five of the twelve ‘no answer’ responses selected. He agreed with the four remaining statements in the dimension.

*Capacity*

The capacity dimension had the greater divergence in views among the respondents. Less than half of the responses were positive and there was very little agreement among the respondents regarding existing human capacity, capacity building, physical capacity and leadership and management of capacity processes.



**Figure 7– Summary of the Capacity Dimension**

One respondent selected 16 of the 36 ‘no answer’ responses categories in this dimension. For the other two statements to which he responded, he selected ‘strongly disagree’. For eight of

the statements, the majority of the responses were positives; for seven statements the majority of the responses were negative.

The majority of the respondents agreed that there was an acceptable rate of staff turnover at the national level; they agreed that human capacity to manage the PBF scheme is being built through routine supervision and/or on-the-job training and mentorship; they agreed that the knowledge, skills and competences were documented; agreed that the PBF unit had adequate capacity in core functions; agreed that there was a capacity development plan; agreed that external technical support is not required on an ongoing basis to fulfill routine tasks related to implementing the PBF scheme which is usually the responsibility of government; agreed necessary equipment and supplies were available; and agreed that PBF uses structure processes for planning and managing change.

The majority disagreed that PBF related posts are permanent government posts (i.e. establishment posts that are reflected in the entity's official organizational structure and budget) - whether filled or vacant posts; disagreed that there are adequate PBF posts at the county level; disagreed that human capacity was being built through local colleges, universities and/or technical schools in Liberia; disagreed that there is a national database or register of who is receiving necessary training to avoid duplication and assure complementarity; disagreed that there was basic ICT infrastructure at the central and county levels; disagreed that policies and programs are in place to transition the PBF scheme to government only financing; and disagreed that the government had a specific budget line item for the proper functioning of PBF units.

There was ambivalence among the respondents about whether the PBF Coordinating Unit has well-established systems for HR planning and management of HR resources and procedures

to support current and anticipated levels of staff; and whether there was an acceptable rate of staff turnover at the county level.

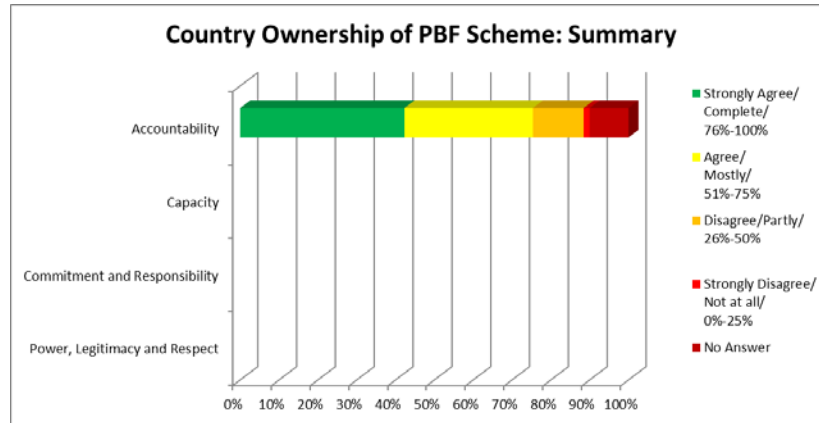
If the 'no answer' responses were positive or negative, it is unknown if it would affect the positive, negative and/or ambivalence impressions of the respondents because of the number of possible combinations this change could produce.

### *Accountability*

Though not as many positive responses as the Power, Legitimacy and Respect, and Commitment and Responsibility dimensions; three quarters of the responses for the accountability dimension were positive.

Respondents had positive impressions of the existing national guidelines and standards, that there was information flow and feedback in the PBF scheme and that donor accountability and electronic capture and storage of information was functional. For all but one instance in this dimension, the majority of respondents positively agreed with the statements. Respondents were divided on whether or not staff who submit reports consistently get feedback.

The selection of the 'strongly disagree' category came from two respondents who strongly disagreed that 'National guidelines exist that document the procedures for recording, collecting, collating and reporting PBF scheme monitoring data' and that 'Partners share funding levels and staffing information in a timely manner'.



**Figure 8– Summary of the Accountability Dimension**

Two respondents contributed the majority of the ‘no answer’ responses. Between the two respondents, the two statements that they provided a response other than ‘no answer’ were, ‘Facilities and partners delivering the same services use standardized data collection and reporting forms’ and ‘During previous data auditing visits, all source documents (e.g. completed forms) have been available for auditing purposes’. They chose positive responses for both statements.

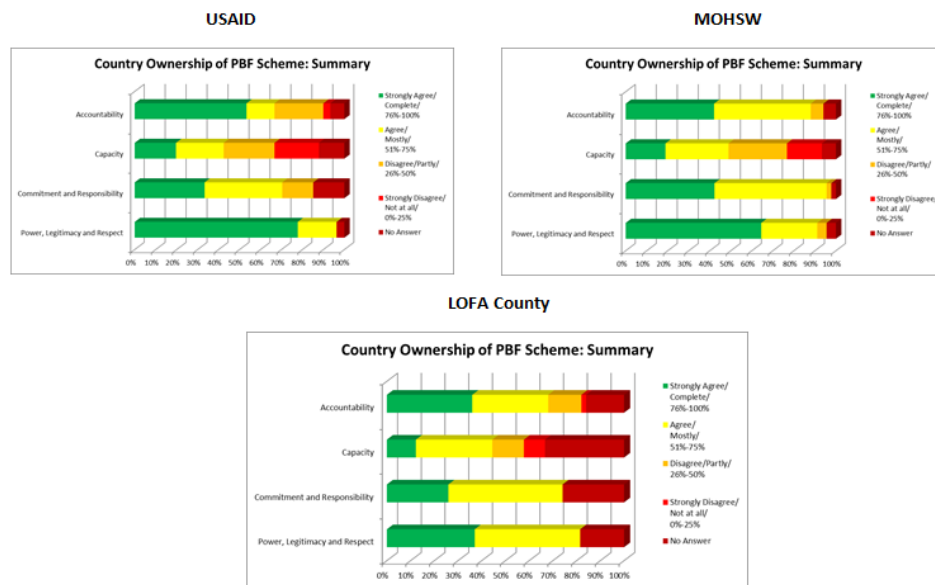
*Result by type of Respondent*

Three types of respondents were included in this study; USAID, the MOHSW and County level actors.

The decision rule of 51% of positive responses in the Power, Legitimacy and Respect and Commitment and Responsibility dimensions was also assessed by respondent type. Each of three types of respondents interviewed also selected responses that met the decision rule. Therefore, each respondent type independently concluded that PBF scheme could be referred to as being country owned.

Results varied when looking at the dimension level:

- *Power, Legitimacy and Respect* - USAID had a more positive impression of the priority setting power sharing between them and the MOHSW, than did the MOHSW and the County Level actors. Interestingly, the county level actors had a more positive impression of the priority setting power sharing than did the MOHSW. Only one respondent, from the MOHSW group, selected a negative response to one statement for this dimension.



**Figure 9– Comparison of the impressions of the three groups of respondents**

- *Commitment and Responsibility* - Almost all of the MOHSW’s responses were positive (95%), indicating that the MOHSW had a very positive impression of the commitment by the MOHSW to take responsibility for the PBF scheme. USAID and the County were less positive; the county selected marginally more positive responses (75%) than did USAID (70%).
- *Capacity* – None of the respondent groups selected above 50% positive responses. USAID had the most positive responses of the three types of respondents (45%); the

MOHSW and the County were similarly positive (39% and 34%). However, the MOHSW and USAID selected similar numbers of negative responses (45% and 43%). The County did not select many negative responses for this dimension (22%) but a third of their responses were from the ‘no answer’ category.

- *Accountability* – This dimension followed the pattern of all the ‘no answer’ responses for all respondents. That is, the further removed from the MOHSW the respondents were, the less positive their impression of how accountable the programs, systems and strategies are. The negative responses followed the pattern of the country versus external respondents. The MOHSW (6%) and the County (16%) selected less negative responses than did USAID (26%).

## **Discussion**

The level of knowledge of the PBF, reflected in the ‘no answer’ responses did not affect the overall assessment of country ownership based on the decision rule. The ‘no answer’ responses accounted for 8% of the Power, Legitimacy and Respect responses and 12% of the Commitment and Responsibility responses. Therefore, even if the 8% and 12% of ‘no answer’ responses were negative responses (‘disagree’ or ‘strongly disagree’), the positive responses (‘agree’ and ‘strongly agree’) were already more than 50%.

The only dimension where greater knowledge of the PBF may have made a difference if the responses were positive is the Capacity dimension. The positive responses accounted for 46% of answers and ‘no answer’, 18%.

Nonetheless, the level of knowledge of the PBF system is a key finding. Respondents had more responses to statements relating to relationship elements between USAID and the MOHSW and less responses to statements related to the MOHSW’s capacity to implement the PBF.

Interestingly, the respondents selected more negative response categories related to capacity statements and less negative response categories related to power, legitimacy and respect statements.

Even though there were some MOHSW respondents who selected ‘no answer’ for some of the statements in the tool, it seemed the further removed from the MOHSW the respondents were, the more likely they were to have gaps in their knowledge of the PBF scheme. Therefore, the county level actors seemed to have the most gaps in information about the PBF scheme compared with the MOHSW and USAID.

The impression of the PBF scheme seemed to be a function of the type of actor. The in country actors (MOHSW and County level actors) had a more positive impression of the country ownership PBF scheme than the external actors (USAID). Likewise, the in country actors had a less negative impression than did the external actors.

### **Limitations**

This study has found that the PBF scheme in Lofa County is country owned, but this conclusion is not without caveats. The responses are a mix of what exists or may have occurred with development and the function of the PBF scheme in Lofa County and the impressions of the respondents. Therefore, the measurement approach acknowledges that subjective impressions are important for ownership. As Boughton (2002) argues, these subjective impressions are important to establish the ‘state of mind’ or ‘internal commitment’ to the aid funded initiative of interest, in this case, the PBF scheme.

Accepting that subjective impressions are critical, the tool mixes subjective and objective judgments to promote a systematic understanding of country ownership. Therefore, there is the expectation that there will be differences in how national and international actors interviewed

view the ownership of the PBF scheme in Lofa County. Is it surprising that USAID thought better of the power sharing than the MOHSW? Is it surprising the MOHSW thought better of their commitment to and responsibility for the PBF scheme than the donors?

The second caution relates to one of the inherent disadvantages of using Likert scales, that is social desirability bias. Given the focus on performance based financing in Liberia, respondents may have felt the need to portray their responses in a more favorable light, rather than expressing their honest reactions. Conducting the interviews individually with respondents giving reasons why they selected the response category they did, was an attempt to temper this bias.

The third caution is based on the validity of the measure. The country ownership measurement approach implemented in Liberia was consistent with the Program Evaluation Standards of utility, feasibility, propriety and accuracy as developed by the Joint Committee on Standards for Educational Evaluations.(Joint Committee on Standards for Educational Evaluations, 2013).

Even so, does the collection of statements in the tool give a valid description of dimensions of country ownership? Does the tool have the right mix of statements? Are there any statements that are superfluous? A factor analysis of the statements and responses in the tool could answer some of these questions. However, that analysis is outside the scope of this study.

The conclusion that the PBF scheme is country owned is based on a predetermined decision rule that 51% of positive responses should be achieved in two dimensions. Was this decision sound? The Power, Legitimacy and Respect, and Commitment and Responsibility dimensions are necessary features of country ownership, without these dimensions there could be in-country capacity to implement and systems for feedback but no country ownership.



The withdrawal of the donor's support and the absence of national leadership governance processes and structures would likely mean the failure of the initiative; indication that the initiative was not owned by the donor and/or host country, but the converse is not true. If there was limited capacity and feedback systems, but there was donor support and national governance, capacity and feedback systems could be built over time. Therefore, it is the relationships and the demonstrations of commitment that support the capacity and feedback systems that are critical to country ownership.

Measuring country ownership of the PBF scheme in Lofa County provides an indication of the importance of relationships and demonstrations of commitment. Although there are significant gaps in the human, physical and long term capacity to implement the scheme, and some gaps in the accountability structures; there seems to be a healthy relationship between USAID and the MOHSW and commitment on the part of the MOHSW to implement the scheme over the long run. The challenge will be having all levels of the system and actors therein, capable of sustainably implementing the scheme. This challenge will be explored further in the Plan for Change.

Finally, this measurement approach is more descriptive than prescriptive. Therefore, its value is in the conversations that emerge, and the actions that are taken as a result. One could argue that objective confirmation of the impressions of the respondents would add a level of detachment to the subjective nature of the measurement approach, but does this objectivity add value? If the respondents are the ones most intimate with the program or initiative of interest, and if these respondents are expressing their subjective impressions, among them lays collective objectivity.

Therefore, perhaps, what is missing from this application is that opportunity for collective confirmation of impressions and the opportunity to discuss remedies to the gaps being highlighted. For example, since there was ambivalence about whether there the PBF Coordinating Unit has well established systems for HR planning and management, bringing key stakeholders together to agree on what the status of the HR and planning systems is would be the first step to improving the systems that currently exist or building these systems where they do. This opportunity for collective confirmation of impressions will be explored in the Plan for Change.

## **CHAPTER 3: AIM 2 - ASSESS IF HEALTH OUTCOMES HAVE IMPROVED IN LIBERIA**

### **Introduction**

The purpose of this chapter is to first provide evidence of an association between PBCs and health outcomes. The chapter, therefore, offers a rational expectation that this association can be found in Liberia. Second, four health outcomes from Lofa County in Liberia will be examined, before and after the introduction of the PBF scheme to determine if the outcomes have improved. The findings and discussion in this chapter, with the previous chapter's findings that the PBF scheme in Lofa County is country owned, together add to the exploration of the connection of country ownership and health outcomes.

### **Literature Review**

A literature review was undertaken from January to April 2012 to find evidence that PBCs can lead to improved health outcomes. The first key concept examined in this literature review was *Performance Based Contracting*. PBC is an objective means of assessing the performance of a partner with whom there is an agreement to produce or deliver a defined product or service. It is usually done through the execution of an agreement with a deliverable and remuneration (or disincentive) clearly defined for achieving (or not achieving) the deliverable. Examples include targeted payments, conditional cash transfers and contracting out

health services. The term PBC will be used to represent other like terms, e.g. performance based financing, pay for performance and performance based payment.

The second key concept examined was *health outcomes*. Health outcomes focus on changes in knowledge, practice, and service coverage for particular aspects of health. One example is, women who use a modern method of family planning.

#### *Search Strategy and Criteria for Selection*

A similar search strategy was used for this literature review as was done with ‘country ownership’. First, a general search ‘performance based contracting’ or ‘performance based financing’ was used in the UNC’s ‘*E-Research Tools*’ and an independent search of Wiley Online Library was done.

Publications were **included** if they were:

- Scholarly publications including peer reviewed journals
- Published after June 2005
- Published in English
- Provided evidence on the efficacy of PBCs
- Referred to development aid supported initiatives

Literature was **excluded** if the PBC was of a general nature and not specific to health.

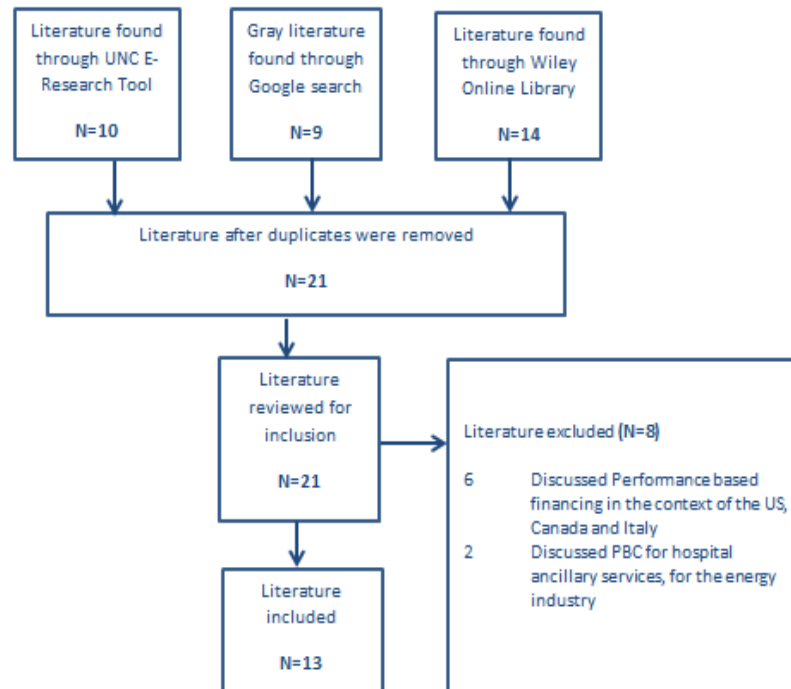
#### *Process for Reviewing Literature*

Articles were reviewed first looking for the search terms (‘performance based contracting’ or ‘performance based financing’) in the title of the articles or literature. Abstracts of studies were the second point of review before reading the entire article. Where there are no abstracts the entire article was reviewed.

## Literature Review Findings

### Overview

The search, using two key terms in the UNC *E-Research Tool*, Google and Wiley Online Library; yielded 21 distinct articles.



**Figure 10 – PBC Literature Inclusion Process**

Eight articles were excluded because they discussed performance based financing in the context of hospital ancillary services and the energy industry in the US, Canada and Italy.

Therefore, 13 met the inclusion criteria for PBC and were used to discuss the efficacy of PBCs.

These included three published studies, three systematic reviews, and seven other articles. Two

of the three studies are included in one of the systematic reviews; resulting in a total of 13

distinct studies included in this review. These articles discuss PBC in the context of fourteen

countries<sup>4</sup>. Eldridge's review (2009), offers results of the implementation of the PBC process without details of the study or assessment method.

### *Study Designs*

The methods used for these studies were randomized control trials (Philippines, Rwanda and Cambodia); controlled before-after (Rwanda, Democratic Republic of Congo (DRC), Burundi, Tanzania, Zambia, Bolivia); and interrupted times series (Pakistan, China, Vietnam, Rwanda) (Basinga, 2011;Lagarde, 2009; Rusa et al., 2009; Soeters, 2011; Witter, 2012).

The data analysis method was detailed for only one study. Basinga (2011) reports using multivariate regression, with a difference-in-difference model “in which an individual's income is regressed against a dummy variable, indicating whether the facility received P4P [payment for performance] that year, facility-fixed effect, a year indicator, and a series of individual and household characteristics”.

### *Unit of Analysis*

In 11 of the 13 studies, the units of analysis were facilities. The exceptions were in Vietnam and China where the units of analysis were physicians and pharmacists. In a Rwanda study; a household survey was also conducted to complement the facility data (Basinga, 2011).

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<sup>4</sup> Countries covered in the material are: Rwanda, Democratic Republic of Congo, Bolivia, Pakistan, Cambodia, Vietnam, China, Uganda, Tanzania, Burundi, the Philippines, Haiti, Afghanistan and Uganda.

### **Health Outcomes assessed in studies**

#### *Pre-natal care*

- 4+ antenatal visits during pregnancy
- Number of prenatal care visits in first trimester
- Institutional deliveries
- Delivery attended by qualified provider
- Tetanus vaccine during pregnancy visit

#### *Family Planning*

- Total family planning consultations – total women protected at the end of the month
- Woman in household uses modern family planning

#### *Child Health*

- Children less than 12 months and less than 59 months receiving growth monitoring consultations
- Vitamin A supplementation

#### *HIV&AIDS*

- Heard about HIV and AIDS
- Voluntary Counseling and Testing per population

#### *Malaria Prevention*

- Household with at least one bed net

#### *Sanitation*

- Household has latrine in reasonable condition

### *PBC Interventions*

The PBC interventions included in the studies were mainly of two types; targeted payment e.g. ‘payment for reaching a certain level of coverage, which can be defined in absolute

terms or relative to a starting point' (Witter, 2012); and conditional cash transfer, i.e. transfer of funds contingent on defined output.

Eldridge (2009) discusses four models of performance based financing; donor to government e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria; within the public sector e.g. in Brazil the central government provided funds to municipalities to increase specific services; Government/donor to non-state actors e.g. contracting services to NGOs; and non-state provider to health facility or health care worker e.g. NGO supporting a health facility.

### **Evidence of the efficacy of PBCs – Improved health outcomes**

Of the 13 studies, nine, covering six countries<sup>5</sup>, assessed the effect of PBCs on health outcomes. In the Rwandan studies, increases in institutional deliveries and child growth monitoring or preventative visits were found in the intervention or case health centers compared with the control centers (Basinga, 2011; Rusa, 2009; Soeters, 2011). In the DRC, for persons who heard about HIV, improvements in health services utilization, malaria prevention and vaccination for children less than 12 months showed significant results in case districts (Soeters, 2011). In Cambodia, vitamin A supplementation for children was found to have a greater increase in case (42%) than the comparison group (23%) (Lagarde, 2009).

In Bolivia, there was a 24% increase in deliveries attended by health personnel in case districts compared to a 14% increase in qualified provider attended births in comparison districts (Lagarde, 2009). In Tanzania and Zambia, increases in antenatal care, HIV voluntary counseling

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<sup>5</sup> Countries where PBC effect on health outcomes was assessed are: Rwanda, Democratic Republic of Congo, Burundi, Cambodia, Zambia and Tanzania.



and testing and institutional deliveries in intervention facilities were similar to or worse than control facilities (Witter, 2012).

In Haiti, ‘performance based contracting was credited with increasing immunization coverage’ from 42% to 74% in children aged 12-24 months and increasing oral rehydration salt usage’ (Eldridge, 2009).

### **Evidence of the efficacy of PBCs – Other results**

The implementation of PBCs had other results. In Rwanda, there was an estimated increase of 0.157 standard deviations in prenatal quality (Basinga, 2011); in the DRC, perceptions of availability of drugs improved in case districts and declined in control districts over time, and revenue from users increased by 25% in case districts and fell by 43% in control districts (Soeters, 2011). In Cambodia, there was a 29% increase in the use of public facilities in the case group compared to in 8% increase in the comparison group during the study period (Lagarde, 2009).

In Bolivia, in the first phase of the health contracting process, duration of hospital stay and bed occupancy rates decreased by 16.2% and 22.3% respectively. In the second phase, the trend was reversed and there was an increase in the duration of hospital stay (8.3%) and bed occupancy rates (23%) (Lagarde, 2009).

Patient satisfaction varied across countries and studies; improvements were noted in the Philippines and DRC, no change noted in Tanzania and deterioration noted in Burundi (Witter, 2012). In Uganda, no improvements were found with the intervention group, and the control group ‘out-performed those receiving performance based payments on several indicators’ (Eldridge, 2009).

## **Biases and Limitations**

The studies were found to be at high risk for bias (Witter, 2012). For many of the studies there were no baseline data, the control areas had different characteristics than the intervention areas, control sites were chosen retrospectively; the reliability of the outcome indicator was questionable (Witter, 2012), and the ‘clusters chosen were limited to enable the randomization process to be successful’ (Lagarde, 2009). In Rwanda, Burundi and the DRC, the researchers were involved in the design of the intervention (Witter, 2012). For the Pakistan study, the information provided was too limited to make an assessment of confounders (Lagarde, 2009). In Cambodia, even though there were improvements in health outcomes and health service utilization, payments were linked to process indicators such as attendance at work and punctuality, and not to health outcomes (Eldridge, 2009).

Further, there were contextual factors that affected the studies. In a number of countries, a policy change coincided with the study period. In Rwanda, the government started a national compulsory community health insurance and decentralized the health sector during PBC implementation, and user fees were reduced by the health center (Basinga, 2011; Rusa, 2009). Since the study did not isolate the effect of reduced user fees and the community health insurance, then it is not possible to attribute the growth in the use of services in the Rusa (2009) study to the implementation of the PBC. Further, some governments doubled the funding available to provinces for PBCs during the study period (Witter, 2012). The Tanzanian study was confounded by the abolition of user fees as well as national campaigns that may have increased utilization numbers (Witter, 2012).

In Bolivia, a national insurance scheme was implemented during two phases of the hospital contracting; therefore the performance of one phase is not comparable to the second

phase. In the DRC, the facilities used in the studies did not have similar characteristics at baseline. Since support to the facilities varied by donor and level of investment, there were clear baseline differences that affected the detection of the effect of PBCs (Witter, 2012).

In Haiti, the effect of other supports (e.g. donor technical assistance, capacity building and NGO support) was not isolated from the PBC results. Eldridge posits that the service delivery improvements, especially immunization coverage for 12-24 months was so ‘dramatic’ that it could not be explained by the payment of bonuses (Eldridge, 2009).

- **Enthusiasm for PBCs is ‘unsubstantiated’**
- **PBCs produce side-effects such as inequity as a result of ‘cherry-picking’ clients’ in a facility and focusing on quantity rather than quality**
- **PBCs allow for decision making to be disaggregated to the facility level, forces attention on effectiveness of roles and responsibilities, increases accountability and can improve efficiency including addressing geographical inequities**
- **Instead of searching for proof of whether PBCs work or not, we should instead draw on useful lessons from experiences**
- **PBCs provide a framework for thinking through some of the issues related to institutional strengthening, tangible results, human resource development and sustainability**

In Cambodia, around the time of the implementation of PBCs, the Asian Development Bank granted a loan to the Ministry of Health and an international NGO increased the number of physicians available. These effects were not controlled for during analysis of the impact of the PBCs (Eldridge, 2009).

## **Discussion**

Even though the literature presents evidence that links PBCs to improved health outcomes, authors are divided on the issue of attributing success to PBCs (Canavan, 2008). Ireland (2011) argues that the enthusiasm for PBCs is ‘unsubstantiated’ and proponents make “grand claims about its achievements and potential...with very little evidence to support these claims”. The opponents argue that it is inefficient because of the increased management burden it places on a country and that the one source of credible evidence, Rwanda, is not replicable in other settings. Finally, they argue that there is a risk of the PBCs producing side-effects such as inequity as a result of ‘cherry-picking’ clients’ in a facility and focusing on quantity rather than quality in health service delivery; thus emphasizing financial gain and numbers rather than patient-centered care (Ireland, 2011).

The proponents argue that the history of public health is littered with health initiatives that are not underpinned by evidence, but which are rendered no less important than those that are evidence based (Basinga, 2011). They suggest that PBCs should not only be seen as a provider performance inducement mechanism, but its potential for health system reform should not be overlooked (Meessen, 2011). PBCs allow for decision making to be disaggregated to the facility level, forces attention on effectiveness of roles and responsibilities, increases accountability and can improve efficiency including addressing geographical inequities (Meessen, 2011).

Further, the proponents argue that one of the strengths of PBCs is flexibility and that it can be a broad approach, with ‘incremental’ but “sensible steps to improving the health system” (Soeters, 2011). Therefore, instead of searching for proof of whether PBCs work or not, we should instead draw on useful lessons from previous experiences (Macq, 2011).

In many low income settings, governments contract out health services. This arrangement is especially true in fragile or post conflict states. These contracts serve the purpose of rapidly responding to the health demands of the country when a government does not have the requisite infrastructure or workforce to do so (Palmer, 2006). To transition the capacity for health service delivery over to governments, PBCs provide a framework for thinking through some of the issues related to institutional strengthening, tangible results, human resource development and sustainability (Canavan, 2008).

Despite the ongoing debate, in 2011, 20 African countries were in the process of implementing PBCs (Meessen, 2011). These data suggest that PBCs are currently seen as a viable means of delivering health services and achieving positive results in both service delivery and health status in low income settings.

### **Implications for further study**

PBCs provide a desirable test case for exploring country ownership’s impact on health outcomes because it assumes the use of national systems with recipient decision making disaggregated to the facility; funding agreed upon by the donor and recipient, usually supplied by the donor; the commitment of the recipient and donor to the terms of the PBC mechanism; existing specific contract, output and outcome management capacity with the recipient and capacity inputs where there are gaps identified; and PBC specific accountability structures and mechanisms by both the recipient and the donor.

Although articles discussing PBCs mentioned country ownership, none systematically measured or described the PBC process to conclude that they are country-owned. Nor was there any literature found that discussed a connection between country-owned PBC and health outcomes.

## **Study Design – Aim 2**

### *Definitions*

The definitions used in this research are the same as those used in the literature review:

***Performance Based Contracting*** - Performance based contracting is an objective means of assessing the performance of a partner with whom there is agreement to produce a defined product or service. It is usually done through the execution of an agreement with an output and remuneration clearly defined or articulated for achieving (or not) the deliverable.

***Health Outcomes*** – Health outcomes focus on changes in knowledge, practice, and service coverage for particular health program areas.

### *Sample and Measures*

The study examined four health outcome indicators:

- Percent of women of children aged less than 24 months whose deliveries were in a facility and was attended by a skilled birth attendant
- Percent of women of children aged less than 24 months who received 2 doses of intermittent preventive therapy (IPT) during their last pregnancy
- Percent of children under 1 year who received DPT3/pentavalent-3 vaccination
- Percent of women of children aged less than 24 months who completed 4+ antenatal visits during their last pregnancy

These four indicators, three of which are official Liberian PBF indicators, represent three health program areas that are delivered at the health facility level in Liberia. Assessing three health areas will provide an indication of whether any improvements are a function of specific areas of service delivery, or point to system wide improvements.

Data for the four selected indicators were drawn from two data sources; Lofa County Lot Quality Sampling Survey (LQAS) and the National Health Management Information System (HMIS).

The HMIS in Liberia is a national ‘information system, consisting of various sub-systems, specially designed for data collection, processing, reporting, and use of the information necessary for improving health service effectiveness and efficiency through better planning and management at all levels of health care delivery systems’ (Liberia MOHSW, 2008). The planned components are as follows:

Services	Determinants and Status	Resources [Information System (IS)]
• Health Services	• Vital Registration	• Human Resources IS
• Disease surveillance	• Rapid Assessment	• Physical Assets
• Operations Research	• Surveys	• Infrastructures IS
• Community based HIS	• Census	• Finance IS
		• Logistics and Supplies IS

In the HMIS, the numerators of the four indicators are counts recorded through the facility based IS at service delivery points and the denominator is an estimate of the population of interest based on the total population of the county.

The LQAS is a rapid assessment survey with a sample size of no less than 95 communities, implemented in seven USAID selected counties, one of which is Lofa County. Intended as a health outcome monitoring tool for the MOHSW and CHSWT, data are collected annually with the counties as primary sampling units. With a sample size of 95 communities, there is sufficient power to detect the desired changes from which local stakeholders can make programmatic decisions. In Lofa County, the sample size is 114. Six ‘lots’, comprising of a health district or groups of health districts, allow for a second level of analysis, useful primarily to program managers within each county. This analysis looks at whether the programs implemented in a distinct geographical area met predetermined targets set by stakeholders. The aggregation of no less than 19 sample points in each ‘lot’ or health district grouping allows for the calculation of point estimates and associated confidence intervals for an indicator at the level of the primary sampling unit, taking into account ‘lot’ population sizes.

To assess whether there has been an improvement in health outcomes, a ‘before and after’ comparison of the implementation of USAID supported PBC, as well as a trend analysis, was done using data as follows:

- 2010, 2011 and 2012 HMIS; and
- 2011, 2012, 2013 LQAS for Lofa County.

Indicators from the two sources are similar but not the same. The HMIS collects facility based data and the LQAS study collects community based data. Therefore, even though the indicators are similar, there are some differences that should be noted:



- HMIS data is facility based data, whereas LQAS is based on a sample survey;
- For the IPT and 4ANC indicators LQAS includes women who completed a pregnancy, whereas the HMIS may also include women who did not complete their pregnancy;
- For the Penta 3 indicator, LQAS includes a sample of children aged 12 – 23 months, whereas the HMIS includes an estimate of the under 12 months population in the county;

Indicators	Numerator		Denominator	
	HMIS	LQAS	HMIS	LQAS
Percent of women of children aged less than 24 months who completed 4+ antenatal visits during their last pregnancy	Number of women who made 4 and/or more than 4 visits to antenatal clinic in the last month	Mothers of children age 0-23 months who/received at least 4 antenatal care visits during the last pregnancy	Expected pregnancies (5% of the population of the county)	Mothers of children age 0-23 months
Percent of women of children aged less than 24 months who received 2 doses of intermittent preventive therapy (IPT) during their last pregnancy	Number of women who received second dose of IPT in last month	Mothers of children age 0-23 months who received second dose of IPT for malaria during pregnancy	Expected pregnancies (5% of the population of the county)	Mothers of children age 0-23 month
Percent of children under one year who received DPT3/Pentavalent 3 vaccination	Number of children aged between 12 and 23 months who received DPT3/ Pentavalent 3 vaccination before their first birthday	Children aged 12-23 months who received DPT3/Pentavalent 3 vaccination before their first birthday	Population of children under 12 months (3% of the population of the county)	Mothers of children aged 12-23 months
Percent of women of children aged less than 24 months whose deliveries were in a facility and was attended by a skilled birth attendant	Total deliveries in facility by skilled birth attendants	Mothers of children aged 0-23 months who gave birth in a facility and was attended by a skilled birth attendant	Expected deliveries (5% of the population of the county)	Mothers of children aged 0-23 months

**Figure 11 – Definitions of the Health Outcome Indicators**

For the SBA indicator, LQAS includes a sample of the mothers of children less than 24 months, whereas the HMIS includes an estimate of expected deliveries in the county.

Nonetheless, they both provide a more complete assessment of health outcomes than using one data source and provide strong evidence of the status of the selected health programs.

The study proposal discussed using the Liberia Demography Health Survey (DHS) to provide additional contextual information on the improvement in the selected health outcomes. However, the DHS data were not available to be included in this study.

## Data Analysis

In April 2013, estimates for the four indicators were calculated from counts and population estimates obtained from the HMIS for Lofa county. Using the national definitions for each indicator, estimates for 2010, 2011 and 2012 were calculated. Estimates were also calculated from the 2011, 2012 and 2013 LQAS surveys for Lofa County.

	HMIS					LQAS				
	2010		2012		p - value	2011		2013		p - value
	%	CI	%	CI		%	CI	%	CI	
Percent of women of children aged less than 24 months who completed 4+ antenatal visits during their last pregnancy	47	46-48	45	44-46	1.00	72	62-82	61	49-67	0.96
Percent of women of children aged less than 24 months who received 2 doses of intermittent preventive therapy (IPT) during their last pregnancy	82	81-82	82	82-83	0.08	71	61-81	65	56-75	0.83
Percent of children under one year who received DPT3/Pentavalent 3 vaccination	96	95-96	87	86-87	1.00	86	79-93	86	80-92	0.50
Percent of women of children aged less than 24 months whose deliveries were in a facility and was attended by a skilled birth attendant	37	36-38	56	55-57	<0.001	69	59-80	77	69-86	0.08

Figure 12– Health Outcome data from HMIS and LQAS

A one tailed z-test of estimates was performed to test if the 2012 estimate was greater than the 2010 estimate for each indicator in the HMIS; and if the 2013 estimate was greater than the 2011 estimate for the LQAS study. A p-value was then calculated from the z-score and significance assessed at an alpha ( $\alpha$ ) level of 0.05.

## Findings

Between 2010 and 2012, using the HMIS data, there seemed no increase in the coverage of the second dose of IPT among pregnant women, no increase in four or more ANC visits by pregnant women and no increase in the coverage of Penta 3 vaccinations for children less than 12 months. LQAS also found no increase in the IPT2 coverage, the four or more ANC visits and Penta 3 vaccinations between 2011 and 2013 studies.

Even though the calculated estimates for IPT2 and Penta 3 vaccinations and 4+ ANC visits suggested no improvement in the estimates from the pre-PBF years to post-PBF years; a z-test was done because there is difference in the denominator population in the HMIS for each year and because the LQAS drew its denominator population from a sample for both years. From the results of the z-test, there is not enough statistical evidence to suggest that the 2013 and 2012 estimates were greater than the 2011 and 2010 estimates. The p-values ranged from 0.08 to 1. The differences in point estimates were due to chance alone. Therefore the hypothesis was rejected.

There was an increase in the number of births at a facility being attended by a skilled birth attendant reported from both the HMIS and LQAS. However, for only the HMIS was the increase significant at an alpha level of 0.05 ( $p = <0.001$ ). For LQAS, the confidence intervals for the 2011 and 2013 estimates overlapped, therefore the true population estimate could have lay between the confident intervals for both years. Therefore, the increase in estimates for LQAS could be by chance, a function of the sample selection.

## Discussion and Conclusion

Despite the differences in how the indicators are calculated from both data sources and the differences in the estimates, for three of the four indicators there was no increase in coverage between the 2010 and 2013.

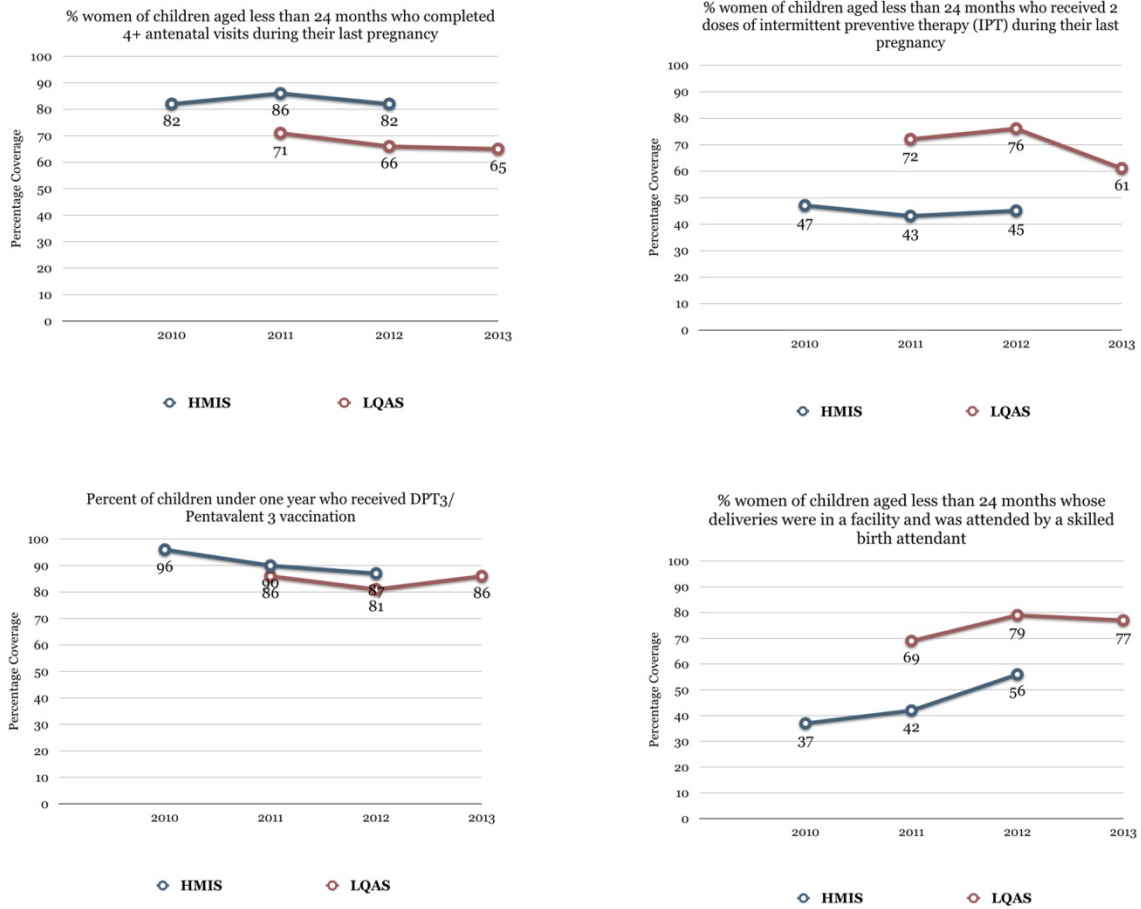


Figure 13 – Trend Graphs for Health Outcome data

These findings demonstrate that the trends in coverage of the three program areas; maternal health, child health and malaria are similar, signaling that the conditions for service delivery are similar.

The National Health Policy lays out a number of objectives for each of the program areas represented by the indicators in this study. Specifically, from 2011 to 2021, the MOHSW seeks to:

- Increase by 50 percent the number of skilled attendants at all levels of the health care delivery system
- Increase the use of Intermittent Preventive Treatment (IPT) among pregnant women in Liberia to 80 percent by 31 December 2010 and sustain this coverage level through 2021

The coverage of DPT/Penta 3 in children less than 12 months has a goal of a 16% absolute increase by 2021. There is no mention in the National Policy and Plan of a specific goal for antenatal visits for pregnant women. However, the objective of increasing the number of skilled attendants at all levels of the health care system assumes a focus on the antenatal visits for pregnant women.

Therefore, while there is an increase in the births attended by skilled birth attendants and not in the other program areas, it is not the result of policy focus. Rather, it could be argued that it is the result of how the services were incentivized and delivered.

### **Limitations**

There are two key limitations to the study methodology for Aim 2. First, there are data quality issues inherent in each of the data sources. For LQAS, recall bias could affect the responses. Although the study followed the standard protocol of selecting mothers of children aged less than 24 months for the ANC 4+ visits, IPT and skilled birth attendant indicators and women of children aged between 12 and 23 months for the DPT/Penta 3 indicator; there is still a chance that there was recall bias. Of note, recall bias was not an important factor in the method

for arriving at the DPT/Penta 3 indicator as the date of vaccination and the child's birth date was confirmed by a child health card in over 90% of respondents.

For the HMIS, a study conducted by the RBHS project in 2012 found that only 75% of complete reports were submitted in Lofa County in 2012 and data accuracy ranges from 38% in August 2011 to 46% in February 2012 (RBHS, 2012)<sup>6</sup>.

However, despite these data issues, data from both sources are largely trending similarly.

The second limitation is more of a caution in interpreting the data than a limitation of the study. There is a focus by the MOHSW on maternal and child health and malaria; therefore, there are resources that are being channeled to these programs. So there is the expectation of change in the coverage of services. However, there are behavioral elements inherent in many of the services represented by these indicators that are difficult to change in the short term. Women have to come to a health facility for their antenatal visits, to receive IPT doses and to be delivered by a skilled birth attendant. This circumstance is less the case with immunization, where there is a community outreach component. Therefore, caution should be taken when interpreting these data, as there is more than health facility service availability considered when estimating service coverage.

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<sup>6</sup> A Performance of Routine Information System Management (PRISM) Assessment was conducted in 2012. This assessment measures RHIS performance output, processes, and determinants as well as their relationships. RHIS processes have seven components that are crucial for strengthening the technical, behavioral and organizational components of any information system. The technical components consist of data collection, data transmission, data processing, data analysis, data display, data quality checking, and feedback. The behavioral factors consist of perception of information process vis-à-vis personal values and skills. Organizational components include organization structure, resources, procedures, support services, and culture to develop, manage, and improve RHIS processes. (RBHS, 2012)

## **CHAPTER 4: AIM 3 – DETERMINE INTERVENING VARIABLES THAT COULD TEST A CONNECTION BETWEEN COUNTRY-OWNED PBCS AND HEALTH OUTCOMES**

### **Introduction**

In chapters 2 and 3, this study found that PBF scheme in Lofa County, Liberia can be referred to country owned and most of the selected health outcomes in Lofa County have not improved between 2010 and 2013. The purpose of this chapter is to determine intervening variables that could be used if researchers wanted to test a connection between the country owned PBF scheme in Lofa County (independent variable) and the selected health outcomes (dependent variable). Therefore, this chapter is focused on hypothesis generating rather than hypothesis testing.

### **Respondents**

A second interview was conducted with seven of the 13 key informants interviewed in Aim 1. Six of the seven key informants were chosen by the researcher based on the least number of ‘no answer’ responses to the Country Ownership Tool, therefore, the researcher’s assessment of their ability to provide responses to the questions in the second interview. In the case of the USAID respondents, the researcher determined, based on responses in the first interview that two respondents would provide sufficient information for the second interview.

In the case of the county level actors, the selection of the respondent was based not on the number of ‘no answers’ but on convenience. The interviews for Aim 1 were conducted in Lofa County but after several scheduling attempts, a follow up visit to Lofa County was not possible. Therefore, the respondents residing in the county were not included in the Aim 3 interviews.

For the respondents interviewed, they were presented with the analysis of the health outcomes, shown the summary dashboard of their responses to the country ownership tool, and shown the aggregated summary from all key informants interviews. They were then asked questions to elicit their perception of how the country owned PBC system may be connected to the status of health outcomes.

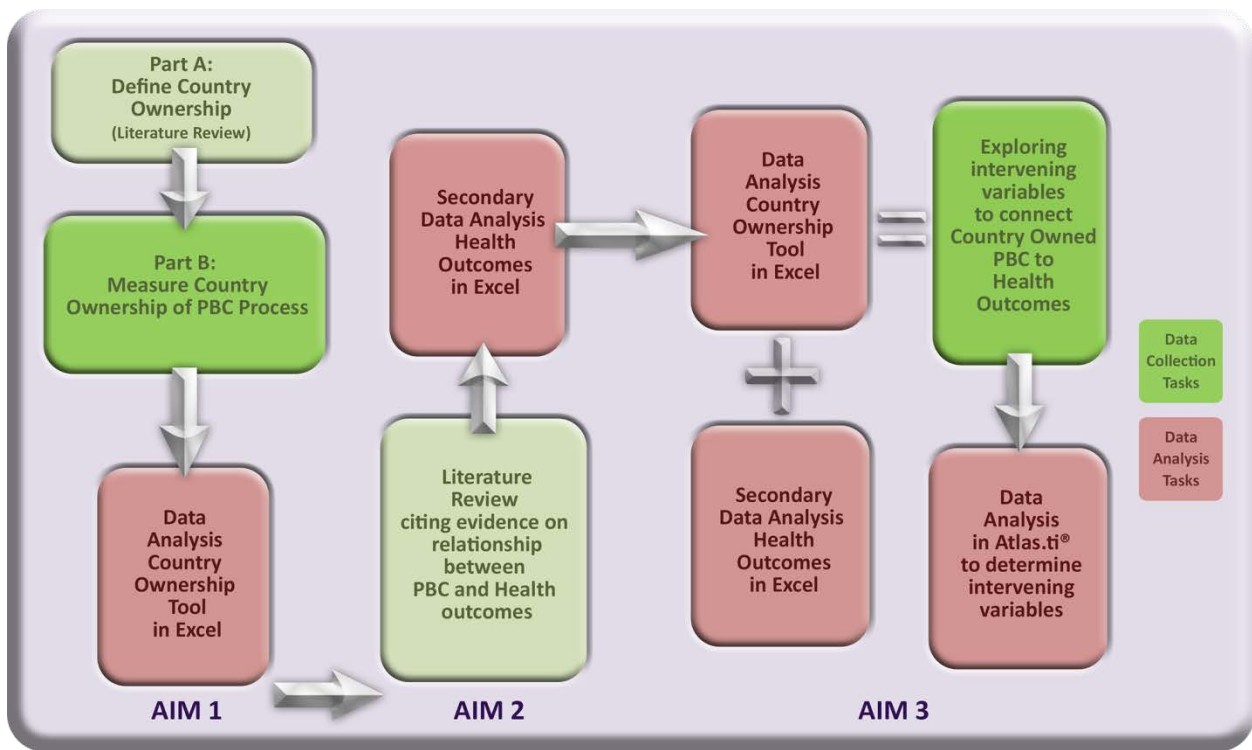


Figure 14 – Summary of Process of data collection and Analysis



## **Analysis Approach**

Each interview was electronically recorded. These audio records were then transcribed by the researcher using *Dragon Naturally Speaking* after each interview. From this transcription the researcher began to get a sense of the recurring themes from the interviews.

The transcripts were then uploaded to *Atlas.ti*; a qualitative data analysis software. The researcher read through all the transcripts and highlighted key sections. These key sections pertained to respondents' explanations of why many of health outcomes had not improved or how they thought the element included in the question influenced the health outcomes. These highlighted sections became 'quotes' in the program and the researcher added comments to the quotes to explain why the section was thought to be important. When comments started to be repeated and themes started to emerge from the highlighted sections, the researcher created a code.

When all transcripts were read and sections highlighted, the list of quotes and their accompanying comments were reread. The researcher created additional codes from recurring comments. Additionally, quotes and comments were grouped thematically. When grouping these themes, *Atlas.ti* automatically generated additional codes. Codes were reviewed and those with nuanced wording were merged e.g. 'Ministry of Health pre-financing', 'FARA' and 'pre-financing' were merged to one code. The quotes associated with each code were reread several times to see if they were coded appropriately. Shifts in code and quotes were done where applicable.

## Findings

The 16 codes that emerged were further grouped into three primary codes or themes; organization of the PBF scheme, finance and management.

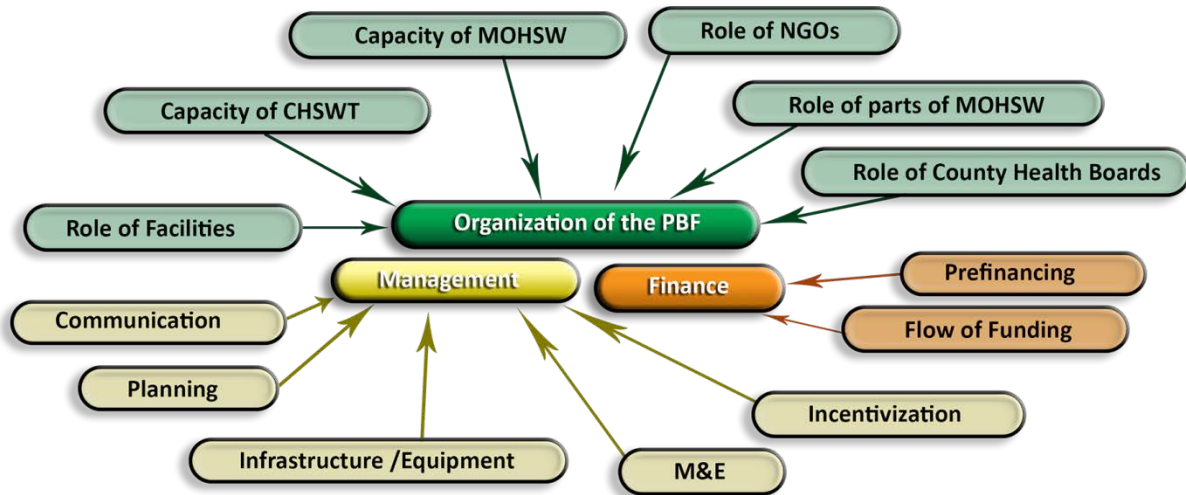


Figure 15 – Code Network diagram adapted from *Atlas.ti*

These three themes are further elaborated as follows:

### *Organization of the PBF*

The organization of the PBF scheme in Lofa County was a major theme of the interviews. How the scheme was organized, the roles of different actors and how they worked or were supposed to work together, and the existent capacity within the scheme were prominent features of the interviews. Responses indicated that the structure of the PBF in Lofa County was a function of the existing capacity within the County Health and Social Welfare Team. The structure seemed to be a compromise between cost and capacity.

「 The capacity of the counties is so weak that without the support of the NGOs, I don't think we would be able to maintain the outcomes. 」

NGOs were substituted for the gap in county level actors' skill, competence and knowledge to implement the PBF scheme. While acknowledging that there were inadequate and delayed training and orientation that would have increased knowledge about the scheme at the county level, the respondents cited a lack of oversight, communication and direction by the CHSWT as key gaps in the scheme in Lofa. Respondents related this absence of oversight both to the structure of and authorities within the PBF to the capacity within the Lofa CHSWT to manage the PBF scheme.

They mentioned that there was no provision of a decentralized structure at the county level in the financing of the scheme, therefore if there were dedicated persons at the county level who understood the scheme and who were tasked with PBF functions then the results could have been different. If this lack was a matter of cost, it was not noted by any of the respondents. The roles for different actors were a major point of discussion for the respondents. Not only their individual roles but also how they, together, should have an influence on the health outcomes. They cited the County Health Boards or Community Health Committees and how it was envisioned that they would provide a role as external verifiers of PBF data and how they could play a role in the community involvement in the PBF health programs. This role was not in place in Lofa at the time of this study.

The respondents also mentioned the role of the facilities and the facility workers as the key conduits of the PBF programs. It did not seem from the interviews that the health facility workers knew what their roles were in the scheme and in some cases perhaps were not even aware that there was a change in management from the RBHS management scheme to the MOHSW managed scheme.

( In my mind it is not clear whether an nurse at the facility...can translate how many people I see today or over a month, to know how that is contributing to my targets and therefore how I'm being paid...I don't know if the design fits with the level of competence. )

The respondents also discussed the role of other units or sections of the MOHSW. The respondents mentioned the seeming absence of a mandate by other units of the MOHSW to participate in the management of the PBF, therefore the PBF unit had to address issues that were outside of their immediate control. And because the PBF unit is not an autonomous entity in the MOHSW, it had no authority to marshal or direct the work of other units in order to address issues that affect the implementation of the PBF in Lofa.

( The PBF unit has been tasked with doing all of this...they have made a lot of effort to have units provide feedback to the NGOs...Getting the family health division, getting the national malaria control program and those other programs to look at the work plan and provide feedback...They have done what they could, a lot of it is outside of their control. )

### *Finance*

The respondents discussed the structure of the financing arrangement and how it could have influenced the health outcomes. They referred to it as a “complicated way of doing business” and a “fundamental problem”. The arrangement of having the MOHSW request funds from the Ministry of Finance (MOF), implement activities, reconcile expenditure and then have the MOF request a reimbursement from USAID was seen as a big influence on the status of the health outcomes. The keys issues surround the availability of funds from the MOF when the MOHSW need it and the difference between the funds advanced to the MOHSW and the amount reimbursed by USAID, should there be any challenges with program implementation.

The government feels that the ministry (of health) is receiving a lot of money from outside. We give them government money, then he wants EU money, then he wants FARA money. Use the money first and then come back. But the arrangement is not like that, they're not at the level of implementation, they don't understand issues that this money is supposed to go to contractors to do the work. So for them, they give you money then you go back for EU money and then you go back for FARA money, it's like you have a lot of money just keeping it somewhere. And you have to continue to explain to them each time your request for money. Then they say this guy is not serious.

All the respondents acknowledged that there were disruptive delays in the disbursement of funds from the MOF to the MOHSW. These disruptions had many consequences, delays in training and orientation; delays in implementation of the PBF Unit's work plan, service delivery and supervision visits, and staff salaries were not paid for two months. Therefore, the result was that performance was less than projected. But this had greater influences.

The impact of the lack of funding is a real one, you introduce this system and people can't rely on when they will get their bonuses when they've earned it. They're going to lose confidence in the system.

### *Management of the PBF*

In many cases, the respondents expressed their uncertainty on whether the structure or organization of the PBF scheme or the leadership or management was the greater influence on the health outcomes. They point to the fact that the NGO implementing health programs in Lofa was working in Lofa County before the start of the MOHSW PBF scheme in 2012. Therefore, since there was little change in the program implementation and significant changes in the management of that implementation, then respondents focused more on the management of the scheme than on implementation. They acknowledge that the change in management from the RBHS project to the MOHSW had an impact, and some cited that the management and supply of certain commodities such as those for IPT were now being supplied by the MOHSW where they were previously managed by the RBHS project. Decisions pertaining to the level of incentives,

what was incentivized, and how counter verification of PBF results were done, were also factors that the respondents cited as influencing the health outcomes.

Nonetheless, the respondents believed that planning was a factor in the status of the health outcomes.

{ You probably would've seen a greater decrease in a lot of the indicators if  
the planning wasn't as good as it was. }

The respondents note that the planning processes seemed out of 'sync' in the beginning, that there were many different processes going on at the same time by many different actors in the MOHSW. Information was 'scattered all over the place...and it was difficult to assess where you were and what you need to improve'.

{ They [the health facilities] didn't know about the transition target setting.  
The health facilities didn't set targets, the NGOs set the targets but the  
strategies to achieve those targets were not discussed with the health  
facilities. }

Therefore, the work plan, targets and the deliverables were initially less realistic than it should have been. However, respondents noted that this improved over time.

Communication was another key factor that respondents discussed. They noted that there were gaps in the information flow within the MOHSW, between the MOHSW and the CHSWT, between the NGO and the facilities and between the NGO and the CHSWT. Respondents agreed that this was an area that needed improvement.

Respondents commended the PBF scheme for the monitoring and evaluation systems that were implemented. Referring to it as 'one of the most valuable things', it was seen as going beyond tracking where the incentives go but also tracking the delivery of services.

Incentives were seen by the respondents as another factor that influenced the health outcomes. They questioned the lack of incentivized motivation for the rest of the MOHSW and the expectation that they be as responsive as the incentivized sections. They also mentioned that there were persons involved in the scheme who viewed the incentives not as a bonus but as part of their regular salary.

〔 To date, many of the end-use health workers have never fully understood the PBF. They knew they got bonuses or not but they never understood how it works and how they can ensure they get their bonuses. 〕

Finally, there was some ambivalence about the role of existing infrastructure in the status of the health outcomes. Respondents noted the condition of the roads, the lack of consistent internet and the absence of computer equipment as contributors to the status of the health outcomes. There were some respondents; however, who did not agree that infrastructure played a part in the status of the health outcomes. One respondent argued that there was little change in the physical infrastructure and therefore the influence on the lack of improvement in most of the health outcomes is not important. Another respondent argued that perhaps if the facilities had computers they would better be able to track their performance but this also depended on the facility workers ability to use the computers. One respondent noted ‘it is one thing to have a recording tool and another to know how to use it’.

## **Discussion**

Three themes have been distilled from the second interview. Simple but profound, the three themes and the sub-themes relate to establishing norms, organizing to implement and financing. In some senses, these three themes and sub-themes represent the influence of ‘how’

the PBF scheme is implemented. They speak to the influence of the manner in which norms, structures, processes were implemented.

The connection or relationship between these themes and country ownership is not linear, it is complex. Complex connections are characterized by:

- (1) a number of contributing factors,
- (2) recursive causality (e.g., A affects B, and B also affects A) and feedback loops,
- (3) nonlinear relationships,
- (4) multiple causal pathways through the contributing factors – some operating at the same time, and different ones operating in different contexts, and
- (5) Unpredictable emergence of some outcomes (Watson-Grant, 2012).

First, it is clear that there are many contributing factors and many relationship pathways operating at different times and in different contexts. That this scheme is being implemented in Liberia with its attending challenges of post conflict settings and that this study is being conducted less than two years after the start of the PBF scheme in Lofa country are influences not to be overlooked.

Second, all of these intervening variables are dependent on each other or have recursive causality. If structures and processes are not articulated and known and if these processes are not financed adequately then there is nothing to manage. If there are structures and processes in place but no financing, again management is moot. Financing a program that has no structure is also unlikely.

The recursive nature of the variables can also be seen because they are part of or closely related to the elements measured in country ownership. The country ownership dimensions include all the themes and some sub-themes found in this analysis.



As all the intervening variables are interacting together, so too is there a relationship between the dimensions of country ownership. Further many of these dimensions and variables are also relating to and supporting each other. Figure 19 maps the themes and sub-themes to specific elements in the country ownership dimension.

<b>Aim 3 themes</b>	<b>Elements in Country Ownership Dimensions</b>	<b>Country Ownership Dimension</b>
Capacity of CHSWT	There are an adequate number of PBF related posts at the county level	Capacity
	The knowledge, skills and competences for the PBF related posts are documented	
	There is an acceptable rate of staff turnover at the county level	
Capacity of MOHSW	The knowledge, skills and competences for the PBF related posts are documented	Capacity
	PBF Coordinating Unit has adequate capacity in core functions (e.g. Technical and monitoring)	
	Percentage of full time and/or part time government-level PBF related posts filled (people currently working)	
	There are an adequate number of PBF related posts at the county level	
	PBF related posts are permanent government posts (i.e. establishment posts that are reflected in the entity's official organizational structure and budget) - whether filled or vacant posts	
There is an acceptable rate of staff turnover at the national level		
Communication	There is an accurate and timely information flow between the PBF Coordinating Unit and partners	Accountability
Finance	USAID and MOHSW participated in decision-making about allocation of resources for the PBC scheme	Power, Legitimacy and Respect
	Policies programs and resources are in place to support capacity building in preparation for a transition to government-only financing and management	Capacity
	There are specific budget line items within the national budget to provide adequately for functioning PBF units	
Flow of funding	Financial resources/investments for PBF are monitored and reported	Accountability
Incentives	The work plan defines technical and/or cost sharing responsibilities for USAID, MOHSW	Commitment and Responsibility

Aim 3 themes	Elements in Country Ownership Dimensions	Country Ownership Dimension
	<p>and other partners</p> <p>IRC and CHSWT have specific plans that are linked to the PBF Operational Plan</p> <p>The PBF Coordinating Unit has institutionalized a set of standards for the PBF scheme that conforms to accepted practice</p>	
Infrastructure/Equipment	<p>There is basic ICT infrastructure (telephones, internet access and email) in place at the national and sub-national levels</p> <p>Necessary equipment and supplies (e.g. computers and stationery) are available for a functioning system</p>	Capacity
M&E	<p>National guidelines exist that document the procedures for recording, collecting, collating and reporting PBF scheme monitoring data</p> <p>National guidelines exist that provide instructions on how data quality should be maintained from the health information system(s)</p> <p>PBC indicators have been selected according to explicit criteria including usefulness, scientific soundness, reliability, representativeness, feasibility and accessibility</p> <p>Facilities and partners delivering the same services use standardized data collection and reporting forms</p> <p>Staff who submit reports consistently get feedback.</p> <p>There is an accurate and timely information flow between the PBF Coordinating Unit and partners</p> <p>During previous data auditing visits, all source documents (e.g. completed forms) have been available for auditing purposes</p> <p>Financial resources/investments for PBF are monitored and reported</p> <p>Database(s) for electronically capturing and storing data generated for/by the PBF system is functional</p>	Accountability
Management	<p>The PBF coordinating Unit is empowered to take action for making adjustments in PBC scheme implementation</p> <p>The PBF Coordinating Unit is empowered to convene meetings of committees, partners or CHWST</p> <p>IRC and CHSWT have specific plans that are linked to the PBF Operational Plan</p>	<p>Power, Legitimacy and Respect</p> <p>Commitment and Responsibility</p>

<b>Aim 3 themes</b>	<b>Elements in Country Ownership Dimensions</b>	<b>Country Ownership Dimension</b>
	<p>The PBF Coordinating Unit has institutionalized a set of standards for the PBF scheme that conforms to accepted practice</p> <p>The PBF Coordinating Unit has processes in place for quality assurance and management at national, county and facility levels.</p> <p>An organizational chart or similar document defines lines of authority and accountability for the PBF in Lofa County</p> <p>There are identified leadership structures at the national and subnational levels with the authority for planning, implementing and managing the PBF scheme</p> <p>Managers at all levels are held accountable for results</p> <p>Coordination between partners is functioning to ensure the successful implementation of the PBF scheme</p>	
Planning	<p>The PBF Coordinating Unit's work plans have elements that can be mapped directly to elements of the National Health Strategic Plan</p> <p>The work plan defines technical and/or cost sharing responsibilities for USAID, MOHSW and other partners</p>	Commitment and Responsibility
Role of county health boards	<p>An organizational chart or similar document defines lines of authority and accountability for the PBF in Lofa County</p> <p>There are identified leadership structures at the national and subnational levels with the authority for planning, implementing and managing the PBF scheme</p>	Commitment and Responsibility
Role of facilities		
Role of NGOs		
Role of parts of MOHSW		
Organization of the PBF	There is a PBC coordinating Unit	Power, Legitimacy and Respect
	An organizational chart or similar document defines lines of authority and accountability for the PBF in Lofa County	Commitment and Responsibility
	There are identified leadership structures at the national and subnational levels with the authority for planning, implementing and managing the PBF scheme	

**Figure 16 – Mapping of Country Ownership dimensions to themes from Aim 3**

In essence, there are no intervening variables. The complex nature of country ownership and what it means to have a country owned PBF scheme means that the variables for detecting a

connection between a country-owned PBF scheme and health outcomes are already being measured within the context of the country ownership of the PBF scheme.

The measurement approach mixed the concepts of ‘what’ the PBF scheme should include and the context in which this inclusion is determined, with ‘how’ the implementation is done. Invariably mixing what was previously described as the independent (country ownership of PBF scheme) and intervening variables (determined to be management, financing and organization) that act upon the dependent variable (health outcomes).

The definition of country ownership becomes critical in this discussion. The idea of country ownership asks what are the norms, behaviors, and inputs that will allow for the achievement of successful and perhaps sustainable development outcomes. As was previously argued, there is a logical, if not complex, and almost inextricable, link between country ownership, development financing, technical assistance and successful outcomes of initiatives.

Therefore, the job of the researcher is not to measure intervening variables in this link between country ownership and health outcomes. The focus instead is on measuring country ownership as directly influencing health outcomes. It is important to reiterate that it is unlikely these connections can be quantified with precision because the measurement of country ownership is qualitative. Therefore, it is inappropriate to discuss an association between the two variables or that one causes the other. The connection of country ownership of the PBF scheme to health outcomes will remain the collective opinions and impressions of those most familiar with the scheme and its results.

### **Limitations**

There are two key limitations with the study design of Aim 3. First, the timing of the study affected the results. The interviews were conducted 18 months after the official start of the

PBF in Lofa County. Challenges to smooth the transition from RBHS to the MOHSW were to be expected. Many of the management processes were new the MOHSW and certainly the financing model was one that provided great challenges to MOHSW and its partners. It is likely that if similar interviews were conducted three or more years into the implementation of the scheme, the responses would be different. But it may also be likely that the PBF scheme would be different as well.

The second limitation is that even though an inductive process of data analysis was used to arrive at what could have been the intervening variables, the questions provided a predetermined deductive frame. All but one of the questions sought responses to an idea that was pre-determined by the researcher based on likely connectors of country ownership to health outcomes. The only question that was aimed at giving respondents the opportunity to add any other factors they thought influenced the health outcomes tended to be, by the end of the interview, a summary and reiteration of their key points. However, this tends to be a flaw of inductive qualitative interviews in general.

## **CHAPTER 5: CLOSING THOUGHTS - MEASUREMENT OF COUNTRY OWNERSHIP AND ITS INFLUENCE ON HEALTH OUTCOMES**

From the previous chapters, it is clear that measuring country ownership and attempting to link it health outcomes, comes with challenges. These challenges ask two fundamental questions: is there value in measuring country ownership and what do we expect this ownership to do or affect?

Albert Einstein once said “Not everything that can be counted counts and not everything that counts can be counted”. This study establishes that country ownership ‘counts’ and that even though there remain questions, a credible attempt at ‘counting’ country ownership in Lofa County was undertaken. What does this attempt at accounting for country ownership tell us? It tells us five things.

First, it tells us measurement is possible. It is possible in very structured and clearly defined circumstances. The value of this exercise, of measuring country ownership, is the clarity of description and the limited measurement scope. Does this mean that where there is no clarity or limitation there can be no measurement? No it does not. As with any measurement activity, lack of clarity makes the exercise challenging. Researchers usually have to take a step back, discuss with stakeholders their objectives before the measurement activity can begin. It is no different with measuring country ownership.

Second, this measurement exercise unmistakably demonstrated the ‘capacity dilemma’ that came from the literature. The capacity to own the PBF scheme and how capacity is applied

to the PBF scheme to engender greater ownership is a multifaceted notion. What this capacity dilemma does as well is confirm the essential nature of all four dimensions of the country ownership. Capacity is needed for relationships, governance, communication and feedback and to implement the initiative. Further, relationships, governance, communication and feedback are all individually affecting capacity and as a collective. Therefore, when discussing capacity in the context of country ownership, it is important to see it as one of the dimensions of country ownership, while bearing in mind its role as facilitator of country ownership.

Third, the measurement of country ownership raises the question of the usefulness of the decision rule for determining country ownership. For study purposes, dichotomizing country ownership was done to provide a frame for the theory building exercise of determining intervening variables for linking country ownership of PBF scheme to selected health outcomes. But is dichotomizing country ownership into 'exists' or 'doesn't exist' useful for stakeholders to take action? Would it not be better to have a range or continuum where stakeholders can gauge progress and continue to refine their actions and interventions to improve health outcomes? It seems to be more suitable, in future, to describe an aid funded initiative as having different levels of country ownership and focus on actions to move stakeholders from one level to the next.

Fourth, the measurement approach assumed that only a small number of people knew enough about the PBF scheme to respond to the statements in the tool and to think through the nuances of how country ownership of the PBF scheme influences health outcomes. This assumption was correct. But should conclusions about institutional influences be drawn from small number of actors within each institution? If the actors are well positioned, know the initiative and can see many of the angles of how the initiative functions, why not? Who but the key stakeholders have the knowledge required to draw these conclusions? Are there other

perspectives that could be sought from others in the same institutions? Would these perspectives be an added value or more voices? For any health funded initiative such as a PBF scheme, there will be a small number of people who have detailed knowledge about the initiative. Their perspectives on institutional influences of country ownership are appropriate for drawing actionable conclusions.

Fifth, this measurement exercise tells us it is important to accept unsurprising findings. Certain ‘truths’ will hold; donors will believe they are participatory and recipients will believe the power is imbalanced, recipients will believe they are being responsive and accommodating and donors will believe further accommodations should be made. That the measurement approach confirms these ‘truths’, does not diminish the value of the tool, it instead adds to the richness of the conversations that result.

One final thought. The assumption of this study and much of the literature is that country ownership has a connection to or influences development outcomes, in this case health outcomes. This study demonstrates that the description of country ownership considers many of the process elements that influence health outcomes. But are outcomes a step removed in the results chain and we should instead focus on process outputs? Is it reasonable to expect the donor and recipients’ interactions and what those interactions produce to directly affect the knowledge and behaviors of targeted populations? Or is the effect more distal? Does it matter if the influence is distal or proximal in an exercise that is qualitative and aimed at generating action oriented conversations? What value would it add if it were one or the other? It seems that the work of thinking on the influences of country ownership has just begun and while further thought is needed, this study makes a contribution to both the frame and content of that discussion.



## CHAPTER 6: AIM 4 - PLAN FOR CHANGE

### Introduction

The purpose of the plan for change is to develop strategies to address gaps and limitations that the study uncovered. The plan for change outlines next steps that the researcher will undertake after the dissertation is presented and accepted by the Dissertation Committee. The plan is a demonstrated application of leadership principles and public health policy that the researcher learned during the course of the Executive Leadership DrPH Program.

The plan for change, as outlined in the study proposal, included the following three parts; 1) recommendations for improving the measurement of country ownership; 2) specific policy recommendations for Liberian donors and recipients, in order to improve the ownership of the PBF process; and 3) recommended intervening variables for further study of the relationship between country ownership of PBC and health outcomes.

However, given the discussion in Aim 3, there is no need to plan for intervening variables. Therefore, the plan for change will include the first two parts. This one plan, addressing the two parts will include issues of resources (e.g. people, funds and other resources), players (e.g. decision-makers, researchers and other stakeholders) and parameters (e.g. law and policy, ethics and authority), where appropriate, and will be framed around selected steps of Kotter's Transformational Change (Kotter, 2007).

The findings of the study are intended to *create a sense of urgency*; the first of Kotter's (2007) steps in Transformational Change. The MOHSW has stated that the PBF scheme is the

main means of ensuring the delivery of health services in Liberia. This study provides a very early discussion of the implementation of the scheme in Lofa County and attention should be paid to these gaps in the scheme by the MOHSW, USAID and other stakeholders.

A stakeholder workshop will be convened with the objective of reviewing the results of the all respondents, confirming the findings and discussing the recommendations that come from the study.

Resources	Players	Parameter
<ul style="list-style-type: none"> <li>• <i>People</i>: The researcher</li> <li>• <i>Funds</i>: Travel to Liberia and Cost of workshop</li> <li>• <i>Other resources</i>: n/a</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Decision-makers</i>:               <ul style="list-style-type: none"> <li>– Heads of MOHSW departments</li> <li>– Leads of USAID Health Office</li> <li>– Other Government of Liberia officials (e.g. Ministry of Finance)</li> </ul> </li> <li>• <i>Other stakeholders</i> <ul style="list-style-type: none"> <li>– PBF Unit Personnel</li> <li>– Lofa County Staff</li> <li>– IRC Country Staff</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Law and Policy:               <ul style="list-style-type: none"> <li>– National Health Policy</li> <li>– USAID Health Strategy</li> <li>– National Health Policy on Contracting</li> </ul> </li> </ul>

Figure 17 – Resources, Players and Parameter of the Plan for Change

During the course of the application of the country ownership tool, the respondents highlighted a number of recommendations to improve the ownership of the PBF Process. These are listed according to dimensions below.

*Power, Legitimacy and Respect*

- Rethink the reimbursement scheme; rationalize the FARA and Pool Fund approaches to PBF; have all funds in a common basket
- Provide ‘seed’ funds for PBF scheme and replenish the funds after liquidation

### *Commitment and Responsibility*

- Clearly outline roles and authorities within the scheme and share this with all stakeholders.  
E.g. County Health Boards and its role as external verifiers of PBF data.
- Develop a Performance Evaluation Review (PER) system for the MOHSW to have managers account for the programs they implement and linking performance to results
- Establish greater autonomy for the PBF Unit to adjust implementation plans
- Strengthen and institutionalize collaboration between the NGOs delivering health services and the relevant CHSWT
- Create a stronger link between the NGO and CHSWT's operational plans

### *Capacity*

- Develop a system wide approach to the issue of human capacity in the MOHSW and the counties
- Explore plans for government only financing of the PBF scheme and systematic implementation
- Establish posts for dedicated persons at the county level tasked with PBF functions who understand the scheme and can lead activities
- Improve the situation of health workers by having all appropriate health workers employed by the Government of Liberia
- Develop a long term succession plan, including mentoring of young professionals, to foster the eventual movement of mid-level managers to senior management positions
- Include PBF in graduate level curriculum in universities in Liberia
- Strengthen the capacity of CHSWTs to implement PBF and the management capabilities at the health facility level

- Give greater focus to and address staff attrition at the county and health facility levels
- An assessment of the PBF scheme should be done to outline what inputs are needed to enhance the PBF scheme in Liberia

#### *Accountability*

- Improve timely quality feedback of program results and information flows including the wide distribution of the PBF reports
- Improve transparency of programmatic matters, especially below the senior level at the MOHSW
- Develop guidelines for improving the quality of data

Second, Kotter (2007) mentions *forming a powerful guiding coalition* and suggests that many entities underestimate change leadership and the importance of strong and powerful process leaders. The leadership of the MOHSW and USAID have set the tone for the PBF not only through rhetoric, but also in the structures that they have put in place at the MOHSW. However, gaps in the leadership remain. There are still leaders of the MOHSW that are key players in the PBF scheme, who need to be more engaged and a very particular focus needs to be given to the county level actors. If the MOHSW intends, as they have done in other counties, to eventually have a ‘contracting in’ model, that is where the MOHSW contracts to the CHSWT and the CHSWT sub-contracts services it needs, then a focused capacity plan needs to be developed and implemented. As mentioned, this will take leadership at the MOHSW and strong process management over the longer term.

The researcher will use relationships and connections built through this study to encourage other decision makers and stakeholders to participate in the workshop. The researcher has worked with several of the Assistant Ministers on other activities in Liberia over a number of

years and therefore would use that relationship to present this plan and have them use their influence to get others to the workshop. This approach is similar to what Yukl (2006) refers to as a personal appeal influencing tactic.

Once the players are at the workshop, the findings of the measurement of the country ownership of the PBF scheme would be presented, and a facilitated discussion of the findings and recommendations undertaken. Other recommendations would be solicited and an action plan for addressing the recommendations developed.

The approach to be used in the workshop is what Yukl (2006) refers to as consultation influence tactic where the facilitator will encourage the participants to suggest improvements in a proposal or help plan an activity or change for which the participants' support and assistance are desired.

Depending on who participates in the workshop, it is likely that the recommendations will be implemented. This likelihood is especially the case since the PBF continues to be a focus of the MOHSW and its funders, the World Bank started a PBF for hospitals and there are plans for expansion of the PBF to other counties in Liberia. The facilitator will have to pay keen attention to getting the right participants to the workshop and include implementation or follow up responsibility in the discussion.

<b>Suggested Core Participants</b>	<b>Rationale</b>
<b>USAID Health Team Leader</b>	Primary USAID PBF decision-maker and manager
<b>MOHSW Chief Medical Officer</b>	Responsible for the curative and preventative health services units; including community health services
<b>MOHSW Deputy Minister for Planning</b>	Provides oversight to the functioning of the CHSWT
<b>MOHSW Deputy Minister for Administration</b>	Responsible for MOHSW financial matters
<b>PBF Unit Manager</b>	Manages the day to day functioning of the MOHSW's PBF Unit
<b>IRC Country Director</b>	Leads IRC's efforts in Lofa County
<b>Lofa County Health Officer</b>	Leads the Lofa CHSWT

**Figure 18 - Suggested Core Participants at Plan for Change Workshop**

Third, Kotter (2007) argues for *communicating the vision* and argues that without a “sensible vision, transformation effort can easily dissolve into a list of confusing and incompatible projects” (Kotter, 2007). It is clear from the second round of interviews that the vision for the PBF scheme managed by the MOHSW was not shared widely. More importantly, it was not shared with the front line facility workers, those who are implementing the activities and do not understand how the scheme functions and what it means to them personally and for their work. The recommendation pertaining to strengthening the management capabilities at the facility level assumes that the vision for what will be managed will be shared and known. Nonetheless, the reiteration of the vision of the PBF scheme in Lofa will be a critical leadership activity of the action plan.

The National Health Policy and the National Health Policy on Contracting both support a strong, functional PBF scheme. The National Health Policy outlines key milestones for health services that are underpinned and supported by the National Health Policy on Contracting. The Policy on Contracting states that the Government of Liberia is the “provider of last resort for health services” (Ministry of Health and Social Welfare, 2008) and therefore contracting will provide “efficiencies in the health care system” (Ministry of Health and Social Welfare, 2008).

Therefore, that this scheme is country owned is in line with the goals of these policies. USAID's Health Strategy also supports the country ownership of the PBF. While providing technical and financial support to the implementation of the MOHSW's 10 year Health Plan, USAID's focus is on country ownership and integrated health systems (USAID, 2013). Therefore, the policy environment is supportive of the workshop proposed and its outputs.

Fourth, Kotter (2007) argues for *empowering others to act on the vision*. Respondents referred to the limited authority that the PBF Unit at the MOHSW had to implement all that was needed for the PBF scheme in Lofa County. They also referred to either a lack of clarity about roles or limited execution of those roles. Both these issues are included in the issue of empowering others. Kotter (2007) argues that there are a number of issues that could inhibit others' empowerment; organizational structure, compensation that makes them choose between self-interest and their work, or inconsistencies in how the program is being implemented makes them unsure of where they stand. These are very real obstacles that must be addressed if the PBF scheme is to achieve the vision it set for its self, that is "improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field" (Ministry of Health and Social Welfare, 2008).

Fifth, Kotter (2007) mentions *planning for and creating short term wins* and *consolidating improvements and producing still more change*. The MOHSW and USAID are engaged in periodically assessing the implementation of the scheme in Lofa. The action plan seeks to encourage this practice by prioritizing the tasks in the action plan and using each improvement sought to make more change. An example of this assessment is, by strengthening the capacity of CHSWTs to implement PBF; it is likely that a stronger link will be created between the CHSWT and NGO operational plans.

Finally, Kotter (2007) argues for *institutionalizing new approaches*. He argues that not anchoring changes in the organization's culture is one of the reasons why change is not sustained. In some senses, in the case of the MOHSW, creating a new organizational culture and anchoring it in that culture is the critical leadership task. Many of the respondents talked about the hope that the PBF scheme would change the attitude of health workers and make the delivery of health services more results focused. Since there are larger effects being sought by the PBF scheme, not just in Lofa County but in Liberia, there are more far reaching issues that need to be discussed and addressed. For example, it was noted that the MOHSW hired IRC because the Lofa CHSWT lacked the necessary capacity to manage and implement the scheme. To address this issue, the broader issues of in country capacity, stable employment with the MOHSW, succession planning and responsibility for results needs to be resolved.

It should be noted that this plan depends on securing funds to travel to Liberia and to host the workshop. This study was possible because the researcher travelled to Liberia for another research activity and was able to include interviews during her time in country. But the other research activity is ending and has limited, shorter travel times planned.

Whether the proposed workshop can be implemented or not, the researcher plans to make copies of the final findings available to USAID and the MOHSW and publish the results in a peer reviewed journal. Attempts will also be made to have follow-up discussions with key MOHSW and USAID personnel relating to this study. In that way, the findings will be shared broadly and actionable discussions will be had.



**Timeline for Implementation (February 2014 –December 2014)**

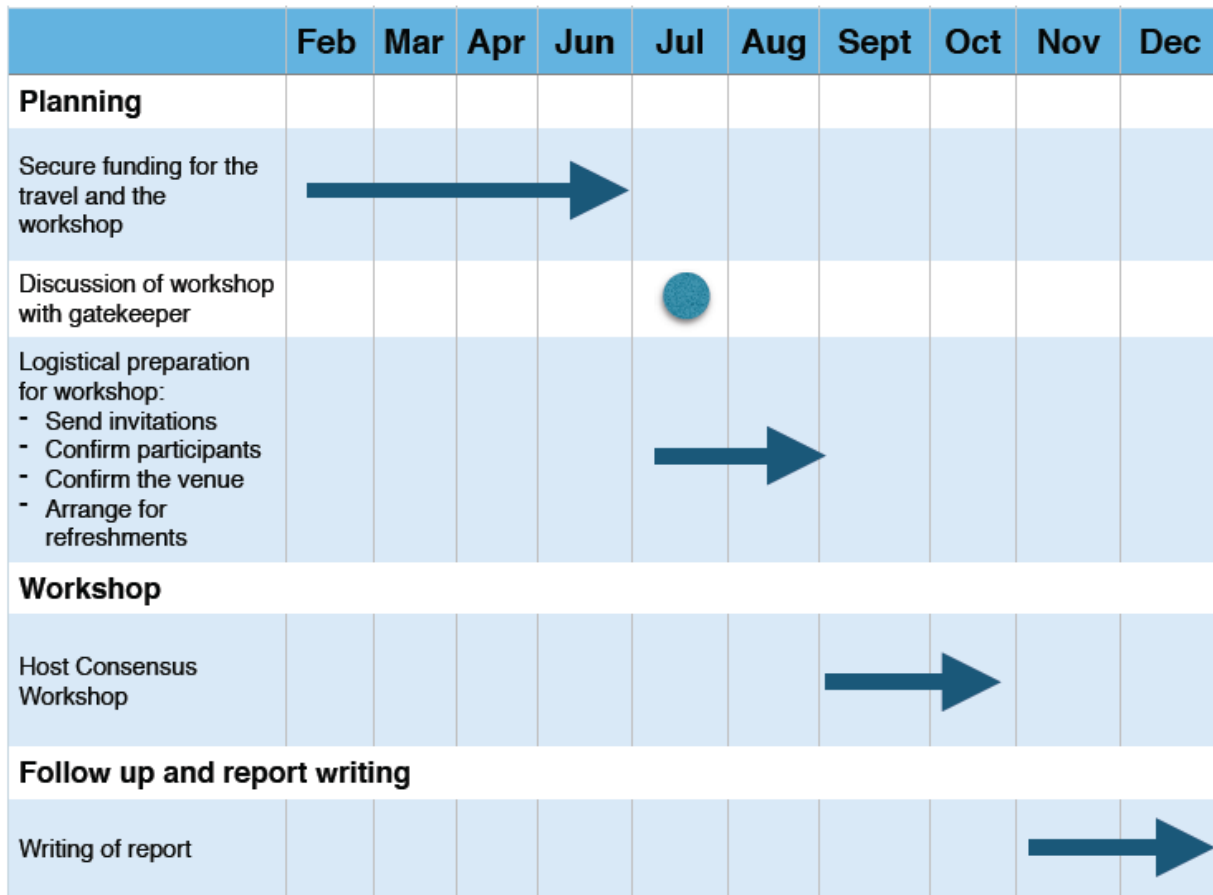


Figure 19 – Plan for Change timeline

**Budget**

Category	Amount	Assumptions
Personnel	\$0	The researcher will not charge for her time
Travel	\$7,050	1 person travels to Liberia for 2 weeks
Cost of workshop	\$800	30 participants and the use of a conference room at the MOHSW
Other costs	\$0	None
<b>Total</b>	<b>\$7,850</b>	

Figure 20 - Budget

### **Limitations of the Study**

One of the key limitations of this study is that the number of key informants interviewed is inadequate for qualitative theory development. While the persons interviewed are the experts associated with the implementation of the PBC system in Lofa County in Liberia and best placed to assist with determining intervening variables in that context, they do not constitute the breadth of available knowledge.

Further, since this measurement is being done in a very limited setting, the results are not generalizable. The insights gained can be referred to in similar settings but drawing conclusions on country ownership of the PBF scheme and using the derived variables in those settings based on this study without further study and adaptation is not advised.

This study will provide another instance of application of the Country Ownership tool and therefore provide useful feedback on the validity of its measurement of the concept. But again, given the specificities of this application, the use of this tool without further adaption is not advised.

## Country Ownership Measurement Tool

Thank you for agreeing to meet with me. The purpose of this interview is to measure the level of country ownership of the health sector performance based contracting process in Liberia.

The concept of country ownership, in the context of international development aid, is not a new one. It underpins the provision of international development aid; which assumes the following when providing funding:

- 1) the products and processes that a donor supports are a priority for developing countries;
- 2) that the recipient will participate in the implementation of the initiative;
- 3) that the recipient will maintain and sustain the products and processes after the donor countries have discontinued their support;
- 4) that recipient ownership of an aid funded initiative will lead to more successful outcomes; and
- 5) recipients will make decisions and take necessary steps, beyond what is detailed in program documents, to ensure successful outcomes.

The important elements of understanding country ownership include:

- 1) the relationship between donor and recipient;
- 2) the transfer of funds from donor to recipient;
- 3) the interplay of power, capacity, accountability and responsibility between donor and recipient; and
- 4) the intention of creating goods or services to improve the socio-economic situation in a recipient country.

I have developed a definition of country ownership using the dimensions: power, legitimacy and respect; commitment and responsibility; capacity; and accountability.



I would like to ask you a series of questions to help me assess country ownership of the health sector performance based contracting. Allow me to walk you through how the responses will be recorded and summarized.

*(Go to next tab and summary tab to show how the tool works)*

I will be asking a minimum of nine other key informants to complete this tool. The responses will collated, and I will summarize them so that individual responses will not be evident. I will also be the only person with access to the workbooks with the individual responses. Through these measures, your response will be kept confidential.

I would like to record our conversation. Please say if I have your permission to record. Do you have any questions about what we have discussed so far?  
May I proceed?

Country governments have the power and legitimacy to set priorities and make decisions that are respected by the donors					
	USAID	MOHSW	Lofa County	IRC	Comments
USAID and MOHSW participated in the design of the performance based contracting (PBC) system					
PBC framework is aligned to the National Health Strategy and USAID's Strategic Assistance document					
USAID made changes in its programming strategies in order to effectively support the PBC process					
USAID participated in the last PBC programme review hosted by the MOHSW					
USAID and MOHSW participated in decision-making about allocation of resources for the PBC process					
There is a PBC coordinating Unit					
The PBC coordinating Unit is empowered to take action for making adjustments in PBC program implementation					
The PBC Coordinating Unit is empowered to convene meetings of committees, partners or CHWST					
Key Actions/Recommendations					

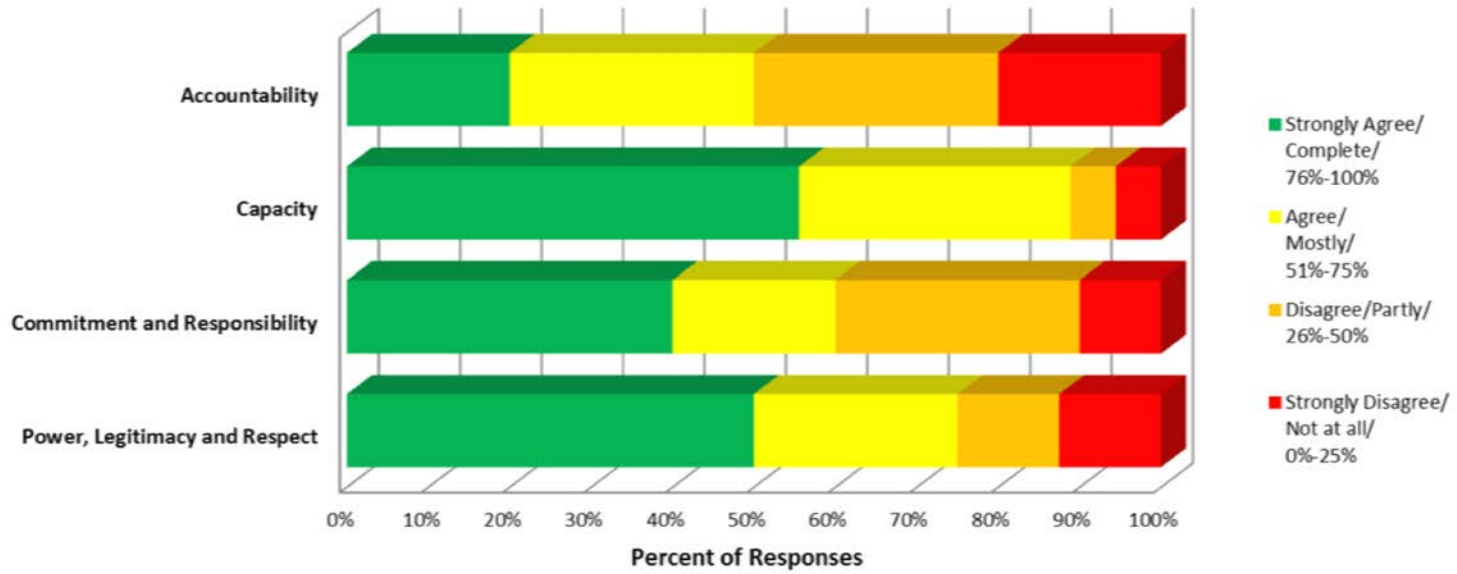
**Commitment by political stakeholders to take responsibility for aid funded programs that address an identified need**

	USAID	MOHSW	Lofa County	IRC	Comments
The PBC Coordinating Unit's work plans have elements that can be mapped directly to elements of the National Health Strategic Plan					
The work plan defines technical and/or cost sharing responsibilities for USAID, MOHSW and other partners					
Other partners involved in the PBC process have specific plans that are linked to the PBC Operational Plan					
The PBC Coordinating Unit has institutionalized a set of standards for the PBC program that conforms to accepted practice					
The PBC Coordinating Unit has processes in place for quality assurance and management at national, county and facility levels.					
An organizational chart or similar document defines lines of authority and accountability for the PBC Coordinating Unit					
There are identified leadership structures at the national and subnational levels with the authority for planning, implementing and managing the PBC program					
Managers at all levels are held accountable for results					
Coordination between MOH and USAID is functioning to ensure the successful implementation of the PBC program					
Key Actions/Recommendations					

Countries have the capacity to sustain initiatives and programs							
		USAID	MOHSW	Lofa County	IRC	Facility	Comments
1	The knowledge, skills and competences for the PBF related posts are documented						
2	PBF Coordinating Unit has adequate capacity in core functions (e.g. Technical and monitoring)						
3	Percentage of full time and/or part time government-level PBF related posts filled (people currently working)						
4	There are an adequate number of PBF related posts at the county level						
5	PBF related posts are permanent government posts (i.e. establishment posts that are reflected in the entity's official organisational structure and budget) - whether filled or vacant posts						
6	There is a capacity development plan to fill gaps identified in knowledge, skills and competences needed to implement the PBF system						
7	Human capacity to manage the PBF scheme is being built through colleges, universities and/or technical schools						
8	Human capacity to manage the PBF scheme is being built through routine supervision and/or on-the-job training (OJT) and mentorship						
9	There is a national database or register of who is receiving necessary training to avoid duplication and assure complementarity						
10	External technical support is required on an ongoing basis to fulfill routine tasks related to implementing the PBF scheme which is usually the responsibility of government						
11	There is basic ICT infrastructure (telephones, internet access and email) in place at the national and sub-national levels						
12	Necessary equipment and supplies (e.g. computers and stationery) are available for a functioning system						
13	PBF Coordinating Unit uses structured processes for planning and managing change						
14	Policies programs and resources are in place to support capacity building in preparation for a transition to government-only financing and management						
15	There are specific budget line items within the national budget to provide adequately for functioning PBF units						
16	PBF Coordinating Unit has well-established systems for HR planning and management of HR resources and procedures to support current and anticipated levels of staff						
17	There is an acceptable rate of staff turnover at the national level						
18	There is an acceptable rate of staff turnover at the county level						
<b>Key Actions/Recommendations</b>							

Governments and political actors are accountable to both their citizens and donors for programs, systems and strategies						
	USAID	MOHSW	Lofa County	IRC	Facility	Comments
National guidelines exist that document the procedures for recording, collecting, collating and reporting PBC programme monitoring data						
National guidelines exist that provide instructions on how data quality should be maintained from the health information system(s)						
PBC indicators have been selected according to explicit criteria including usefulness, scientific soundness, reliability, representativeness, feasibility and accessibility						
Facilities and partners delivering the same services use standardized data collection and reporting forms						
Staff who submit reports consistently get feedback.						
There is an accurate and timely information flow between the PBC Coordinating Unit and partners						
During previous data auditing visits, all source documents (e.g. completed forms) have been available for auditing purposes						
Financial resources/investments for PBC are monitored and reported						
Database(s) for electronically capturing and storing data generated for/by the PBC system is functional						
USAID shares funding levels and staffing information in a timely manner						
Key Actions/Recommendations						

### Country Ownership of Performance Based Contracting Process: Summary Results





**APPENDIX 2: RESPONSE CATEGORIES FOR THE COUNTRY OWNERSHIP MEASUREMENT TOOL**

<b>Dimensions</b>	<b>Question Numbers</b>	<b>Response Categories</b>
Power, Legitimacy and Respect	1-8	Strongly Agree Agree Disagree Strongly Disagree No Answer
Commitment and Responsibility	1-9	Strongly Agree Agree Disagree Strongly Disagree No Answer
Capacity	1-2 & 4-16	Completely Mostly Partly Not at all No Answer
	3	76 -100% 51 - 75% 26 - 50% 0% - 25%
	17-18	Strongly Agree Agree Disagree Strongly Disagree No Answer
Accountability	1-7	Completely Mostly Partly Not at all No Answer

### APPENDIX 3 – AIM 3 INTERVIEW GUIDE

Thank you for agreeing to speak with me again. Let me remind you of what we spoke of the last time we met. I asked you a number of questions that together presented the level of country ownership of the health sector performance based financing (PBF) process in Liberia (*show the tool and the summary of the key informants responses*). I asked the same questions of more than nine other people and combined all the responses to get a summary of all responses (*show the master summary sheet*).

Now I would like your opinion on what factors may influence country ownership contributing to the current status of health outcomes.

First, let us take a minute to talk about the health outcomes. Health outcomes focus on changes in knowledge, practice, and service coverage for particular health program areas. For the purposes of this study I used the following health outcomes:

- Percent of deliveries that are facility based and attended by a skilled birth attendant
- Women who completed 4+ antenatal visits during their last pregnancy
- Women who received 2 doses of intermittent preventive therapy (IPT) during their last pregnancy; and
- Percentage of children under 1 year who received DPT3/ pentavalent 3 vaccination

These four indicators represent three health program areas that are delivered at the health facility level in Liberia. Assessing three health areas will indicate whether any improvements are a function of a particular area or point to system-wide improvements.

By analyzing data, I was able to determine that these health outcomes had (*improved, declined/showed no change*) from 2011 to 2013. **Discuss findings.**

I would like to get your opinion on how country ownership of the health sector performance based contracting system may have contributed to these health outcomes. Your response will be collated with the other respondents, analyzed and themes identified from the questions asked.

The information will not be attributed to any one person but will be seen as collective responses. I will be the only person with access to notes that identify who provided particular comments, so your comments will be confidential.

I would like to record this interview, please say if I have your permission to record. Do you have any questions about what we have discussed so far?

May I proceed with the questions?

As we did the last time, let's start with the first dimension of country ownership:

### **Power, Legitimacy and Respect**

1. The model of the PBF process was based on the Ministry of Health and Social Welfare sub-contracting with implementing partners, and Lofa County being part of the oversight of program delivery. How do you think this model contributed to (*improved, declined/showed no change*) health outcomes?

*Prompts:*

- a. What do you think are the factors relating to the model that helped or hindered?

Central management? Management of government services by IRC? Service provision guidance by Lofa county?

2. Do you think funding decisions affected the achievement of status of health outcomes? If yes, how? If no, why?

*Prompts:*

- a. Did it matter that the final decision about budgets came from the MOHSW or USAID?
- b. Would implementation have been different if the entity who made the final decision was different? How?

*Let's move on to the next dimension:*

### **Commitment and Responsibility**

1. In what ways do you think planning by the PBF Coordinating Unit helped or hindered the achievement of improved health outcomes?

*Prompts:*

- a. Was it their ability or inability to implement according to the plan?
  - b. Was it their ability or inability to make adjustments to plans?
  - c. Was it because there were (or were not) guidelines for implementing services e.g. the PBC Manual?
  - d. What do you think could have been done differently, and how might this have changed the status of health outcomes?
2. Would you have organized the PBF structure differently? If so, how? If no, how do you think the leadership structures contributed to the health outcomes?
  3. What is your vision of a fully functioning PBF Unit? Could this have contributed differently to improved health outcomes?
  4. What are the gaps between your vision and the current set up?

*Let's move on to the next dimension:*

## Capacity

1. How do you think the present staff contributed to the status of health outcomes?

*Prompts:*

- a. Did you have staff covering each area of implementation?
  - b. In your opinion, do you think people were adequately trained?
  - c. Could you have gotten more qualified people?
2. Do you think the existing infrastructure (computers, equipment, internet connection) contributed to the status of the health outcomes?
  3. If there was is a plan, what do you think will be the contribution of that plan to improve human resources to health outcomes?

*Prompts:*

- a. Will it improve the health outcomes?
  - b. Will there be no difference because the root cause of the status of health outcomes is something else?
4. In what ways has the leadership and management of human resources contributed to the successful implementation of the PBFs?

*Prompts:*

- a. Do you think the leadership and management was proactive? If yes, how? If no, why?
- b. Do you think the PBF implementation could have benefited from the leadership being more proactive? If yes, how? If no, why?
- c. Do you think the leaders were looking at ways to improve human resources in order to successfully implement the PBF system?

*Now to the final dimension:*

## **Accountability**

1. Do you think guidance documents and standards were helpful in setting the tone for achieving successful implementation of the PBFs?

Prompts:

- a. From the guidance documents, do you get the impression that PBF Coordinating Unit is serious about accountability? Quality of reporting? About the achievement of health outcomes?
2. Do you think adequate information (i.e. budgeting, planning and adjustments in program delivery shared in a timely manner) has been shared between all levels of implementation for successful achievement of health outcomes? If no, what has hindered the process? If yes, what have been some helping factors?
3. Do you think resources (i.e. staff, equipment and funding) have been adequate?

Prompts:

- a. If yes, how do you think this affected the (*improved, declined/showed no change*) health outcomes from 2011 to 2013?
- b. If no, what types of resources were inadequate and what more of existing and types of new resources would you need to achieve improved health outcomes?
- c. Ask about deployment of resources (e.g. were the resources deployed in the right areas?)

## **Final Comments/Questions**

Are there any additional comments you would like to make on country ownership of the PBF system and its relationship to health outcomes?

*Thank you for your time and reflections. I much appreciate it. I will be collating and analyzing the responses from the nine other key informants and as soon as the report is finalized, I will share it with you. Do you have any questions on this interview?*

**APPENDIX 4: DATA DICTIONARY**

**LQAS**

<b>Indicator</b>	<b>Questionnaire #</b>	<b>Question #</b>	<b>Indicator Calculation</b>
<b>Percent of mothers of children age 0-23 months who made/received at least 4 antenatal care visits during last pregnancy</b>	<b>6</b>	<i>16</i>	<i>Q 16: Answer = &gt;/4 (“number of times”)</i>
<b>Percent of mothers of children age 0-23 months who received second dose of IPT for malaria during pregnancy</b>	<b>6</b>	<i>17 &amp; 18</i>	<i>Q 17: Answer = 1 (“Yes”) &amp; Q 18: Answer = 2 (“no. of times SP taken”)</i>
<b>Percent of children age 0-23 months whose births were in a facility and attended by skilled birth attendant</b>	<b>6</b>	<i>25 &amp; 26</i>	<i>Q 25: Answer = 1, 4 (“Clinic/Health Center/Hospital,” “Maternal Waiting Home”) &amp; Q 27: Answer = 1, 2 (“Doctor”, “Nurse/ Midwife”)</i>
<b>Percent of children age 12-23 months who received DPT3/pentavalent-3 vaccination before 12 months (with card and without card verification)</b>	<b>5</b>	<i>14 &amp; 11 or 14</i>	<i>Q 14: Answer =1 (“Yes, verified on card”) + (“Date of last Penta vaccination recorded”) &amp; Q 11: Answer = &gt;/24 months (“Child’s date of birth”) or Q 14: Answer = 2 (“Yes, mother says so”)</i>



HMIS

<b>Indicator</b>	<b>Numerator</b>	<b>Denominator</b>
<b>Women who made/received at least 4 antenatal care visits during last pregnancy</b>	<i>Number of women who made 4 or more visits to ANC in last month</i>	<i>5% of the population of the county</i>
<b>Women who received second dose of IPT for malaria during pregnancy</b>	<i>Number of women who received 2<sup>nd</sup> dose of IPT in last month</i>	<i>Expected pregnancies (5% of the population of the county)</i>
<b>Women whose births were in a facility and attended by skilled birth attendant</b>	<i>Total deliveries in facility by skilled birth attendants</i>	<i>Expected deliveries</i>
<b>Percent of children under 1 year who received DPT3/pentavalent-3 vaccination before 12 months</b>	<i>Total children under 1 year who received DPT3/pentavalent-3 vaccination</i>	<i>Population of children under 1 (3% of population of county)</i>

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