Deliveries with skilled birth attendants rose from 29% to 51% in RBHS-supported PBF health facilities.

Background

The Liberian health system suffered serious setbacks during the 14-year civil war (1989-2003), when trained health workers fled the country, training institutions closed, and health facilities were demolished. Since the end of the conflict, domestic and international efforts and investments have helped produce steady gains. Nonetheless, Liberia’s maternal mortality ratio remains one of the highest worldwide, at 770 deaths per 100,000 live births. The infant mortality rate is 54 deaths per 1,000 live births, and the under-five mortality rate stands at 94 deaths per 1,000 live births (Liberia DHS 2013).

In January 2011, the average accreditation score of government health facilities (clinics, health centers, and hospitals) for delivering the Basic Package of Health Services (BPHS) was 84 percent, up from 38 percent in 2008; these scores rate a facility’s readiness to deliver care. However, the quality of care, which measures implementation of clinical standards, was only 38 percent in 2013.

**LIBERIA PBF INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS – KEY FUNCTIONS**

1) Regulator – MOHSW: Develop policies and guidelines.

2) Fund holder and purchaser – Office of Financial Management: Contract counties and NGOs, and pay bonuses upon verification of achieved results.

3) Implementing partners – County health teams and NGOs: Entities contracted to provide health services at county level.

4) Service providers – Health facilities: Sign performance agreement with implementing partners to provide health services.

5) Verification of achieved results – Conducted at three levels:
   a) Verification by implementing partners at health-facility level
   b) Counter-verification by central MOHSW at county level
   c) Community satisfaction by CBOs at community level

**Approach to Building Skills of MOHSW for PBF Implementation**

Performance-based financing (PBF) was widely viewed as a promising approach to accelerate quality implementation of the Essential Package of Health Services (EPHS). Between 2009 and 2012, the Rebuilding Basic Health Services Project successfully pilots PBF contracts with non-governmental organizations (NGOs). In Liberia, PBF uses incentives to achieve desired health outcomes by rewarding facilities and providers contingent upon achieving targets. In similar post-conflict settings such as Rwanda and Burundi, use of PBF demonstrated increased availability and quality of health services, improved use of the limited resources, improved management of health facilities, and enhanced motivation of health workers.

The RBHS project contributed significantly to strengthening the capacity of the newly created PBF unit and the MOHSW for successful implementation of nationwide PBF. Individual skills-building was the initial focus, and was accomplished by embedding a PBF advisor in the unit who, starting in January 2012,

**THE MOHSW PERFORMANCE-BASED FINANCING UNIT NOW LEADS PBF ACTIVITIES AT THE CENTRAL LEVEL AND PROVIDES OVERSIGHT, COACHING, AND MENTORING AT THE COUNTY LEVEL.**
Poor living conditions for health care workers are often cited as a cause of high attrition among workers in remote facilities. Upon receiving the PBF bonus, the Naama health facility in Bong County invested the funds to build this house for its health care workers.

provided training, coaching, and mentoring on key PBF concepts and principles. The objective was for the MOHSW to establish and build the capacity of a PBF unit that would assume ownership of PBF implementation by project’s end.

Later, project emphasis shifted to reinforce the PBF unit’s organizational skills. This was accomplished by training the PBF unit to undertake activities in key stages of PBF implementation and allowing time for on-the-job learning and acquisition of technical skills. As a result, the PBF unit contributed to the consultative process for developing PBF institutional and implementation arrangements, identifying roles and responsibilities of key players, developing an operational manual, and developing management tools for standardized nationwide implementation.

A committee comprised of the Minister of Health, deputy ministers, and donors governs PBF implementation at the MOHSW. The PBF unit provides technical oversight for implementation and coordination with other MOHSW programs. The various technical programs of the MOHSW play an advisory role.

At the county level, the PBF county steering committee, a subcommittee of the County Health and Social Welfare Board (CHSWB), provides oversight of PBF implementation. One of the functions of the committee is to monitor client satisfaction with services received at the facilities. This community assessment is conducted through contracted community-based organizations.

The PBF unit’s capacity was strengthened by RBHS as part of a package of health systems strengthening activities addressing: quality of care; accurate and timely reporting of data; functional supply chain management; and rewarding delivery of quality health services by motivated professional health workers.
Results

Performance-based financing spurred a results-driven culture within the MOHSW. Collaboration increased between the various programs in the counties, which was facilitated through monthly touch-base meetings and quarterly reviews where successes and constraints are discussed and consensus is reached on the way forward. Over 250 health facilities in 12 of Liberia’s 15 counties implemented performance-based financing and registered notable achievements between July 2011 and December 2013.

The proportion of pregnant women who were tested for HIV at their first antenatal visit and counselled after receiving their results increased from 26 percent to 81 percent; the proportion of pregnant women who received the second
preventive malaria treatment (IPT2) increased from 33 percent to more than 50 percent; the proportion of deliveries conducted by skilled birth attendants in facilities increased from 29 percent to more than 50 percent, and the couple years of protection (CYP) per quarter in PBF facilities increased from approximately 2,500 to more than 12,500. These increases in counties and facilities implementing PBF are greater than the average increases in non-PBF facilities.

In counties supported by RBHS (Bong, Lofa, Nimba, Bomi, and River Gee), deliveries by a skilled birth attendant improved and has been above 60 percent between October 2012 and December 2013, whereas the same indicator hovers around 30-40 percent in Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Maryland, and River Cess counties. This trend is observed across almost all monitored PBF indicators (e.g., IPT2, CYP, stock-out of tracer...
A performance-based bonus system allowed health facilities to reinvest in facility improvements, conduct outreach to catchment areas, and sensitize communities to take advantage of preventive services.

The proportion of pregnant women who received the second preventive malaria treatment (IPT2) increased from 33% to more than 50% in RBHS-supported PBF health facilities.

Photo: Robin Hammond
drugs). Underperformance in the counties mentioned above occurred due to a series of changes that affected the performance of monitored indicators. The management of health facilities changed from international NGOs to county health teams. Due to lack of efficient administrative systems in place, channeling of funds to the counties was slow, disrupting scheduled activities and delaying decentralized PBF implementation.

Some indicators have not improved since PBF implementation began. For example, the proportion of facilities with no stock-outs of tracer drugs decreased, and the proportion of pregnant women who tested positive for HIV and were initiated on antiretroviral (ARV) therapies failed to improve. Frequent shortages of essential medicines were to blame.

The quality of the national health management information system (HMIS) improved through implementation of the PBF scheme, as PBF requires careful data verification. Data reported by county health teams and NGOs were counter-verified by teams from the central MOHSW during routine monitoring and evaluation visits. After quarterly counter-verification visits, data accuracy scores are computed and implementers receive feedback. The average accuracy score from April 2013 to December 2013 was about 80 percent, compared to the accuracy score for the previous nine months (July 2012 to March 2013), which averaged about 70 percent. The accuracy score compares data from the HMIS against the data from the ledgers and registers managed by health facilities.

Health facilities generated extra income through the performance-based bonus system. These bonuses allowed health facilities to reinvest in facility improvements, conduct outreach to catchment areas, and sensitize communities to take advantage of preventive services. Health workers testified that the bonus helped them take care of basic expenses, including tuition for dependents.

**Way Forward**

RBHS fostered national ownership of PBF implementation through coaching and training the MOHSW PBF unit. The PBF unit now leads PBF activities at the central level and provides oversight, coaching, and mentoring at the county level. PBF’s focus on results has had a positive impact across MOHSW divisions and units. The last three years of implementation demonstrated encouraging results toward achievement of key indicator targets. The MOHSW and the PBF unit have matured in their ownership and leadership of performance-based financing, and have shown their potential to accelerate progress towards Liberia’s national health goals.
The following are suggestions for ensuring that performance-based financing led by the MOHSW will continue to make steady progress.

- Ensure continued skilled and dedicated staffing of the PBF unit.
- The PBF unit should shorten the length of time needed to provide quarterly feedback to implementers, so that health facilities and providers can make changes in a timely manner.
- While the central MOHSW is currently responsible for counter-verification, this function could be sourced out to a third party, which would strengthen the validity and reliability of results. Independent counter-verification team(s) established at the county level might be more cost efficient and further strengthen the capacity of the counties.
- The amount of the performance-based bonus will need to be continually re-evaluated to determine the amount required to effectively motivate behaviors.
- Advocacy to the central government for a dedicated performance-based financing annual budget to ensure the sustainability of this approach.

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