# A Policy Analysis Of The National Health Policy On The Primary Health Care Approach In Liberia

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Liberia

55th Master of Public Health/International Course in Health Development (MPH/ICHD)

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**A Policy Analysis Of The National Health Policy On The Primary Health Care Approach In Liberia**

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

by

**Jeffrey Eugene Dadzie**

Liberia

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# Abbreviations

**BPHS**: Basic Package of Health Services

**CHE:** Current Health Expenditure

**CHW:** Community Health Worker

**DHS:** Demographic and Health Survey

**EPHS:** Essential Package of Health Services

**EU:** European Union

**GDP:** Gross Domestic Product

**LMICs:** Low-and-Middle-Income Countries

**MDGs:** Millennium Development Goals

**MMR:** Maternal Mortality Ratio

**MoHSW:** Ministry of Health and Social Welfare

**NFP:** Not-For-Profit

**NGO:** Non-Governmental Organization

**NHSWPP:** National Health and Social Welfare Plan and Policy

**OECD:** Organization for Economic Co-operation and Development

**OOP:** Out-Of-Pocket

**PFP:** Private-For-Profit

**PHC:** Primary Health Care

**SARA:** Service Availability Readiness Assessment survey

**SDGs:** Sustainable Development Goals

**UHC:** Universal Health Coverage

**UNICEF:** United Nations Children's Fund

**USAID:** United Stated Agency for International Development

**WHO:** World Health Organization

# Abstract

**Background:** Primary Health Care (PHC), a holistic approach to health, was proposed at Alma-Ata in 1978 and has been adopted since 2007 by Liberia, a post-conflict, low-income-country, as the guiding principle for its health policy. The National Health and Social Welfare Policy and Plan (NHSWPP) of 2011-2021, provides the framework for the development of other health policy documents, that should all be in alignment with promoting PHC in service delivery. However, the PHC approach within health policies in Liberia has neither been reviewed or evaluated.

**Methodology:** A comprehensive policy review of all current health policy documents in Liberia focused on a PHC approach, were identified and analyzed using the Walt and Gilson policy triangle framework (1994).

**Results:** Majority of Liberia's Health policy documents were based on a PHC approach. However, three (3) major direct policy-related gaps were identified. **1.** The lack of explicit inclusion of the community as an actor in the formulation of several of the policy documents. **2.** The lack of timely revision of some policy documents. **3.** The lack of explicit PHC strategic approach in the implementation plans of multiple policy documents.

**Conclusions:** Despite employing the PHC approach to guide its strategic plan in improving the health of the population, major policy gaps hamper the implementation and achievement of the intended outcomes. The poor health outcomes in Liberia are indicative of problems with PHC which go beyond implementation only, but also up to the policy level.



**Keywords:** Primary Health Care, Health Policy, Policy Analysis, Liberia


**Word Count: 10,615**

# Introduction

The World Health Organization (WHO) defines health policy as decisions, plans, and actions that are undertaken to achieve specific health care goals within a society; considering visions for future health activities that shape short and medium term objectives to be met(1). Policies on Primary Health Care (PHC) are governed by principles established at the Alma-Ata Declaration of 1978 which called for health for all, promoting PHC as the basic unit of a functional health care system. The declaration laid out the framework for achieving this through improved first line health services closest to the communities needing such services; citizenry empowerment through community participation in planning, implementation and regulation of PHC; a focus on achieving equity in health status for all(2) and intersectoral governmental collaboration, as means of achieving health and an adjunct for development planning(3). Forty-one (41) years on after this pivotal moment in global health, considering the successes and challenges of the initiative, the WHO and partners have made renewed commitment at the Declaration of Astana in 2018 to continue to promote PHC, expanding on its fundamental principles to provide Universal Health Coverage (UHC) for all, as a step towards achieving the Sustainable Development Goals (SDGs) targets for health (SDG 3) by 2030(4).

Remarkable achievements have been made on the global health scene since the Alma-Ata declaration. Life expectancy is now 10 years more than in 1978, and the risk of dying before the age of 5 years has fallen by around two thirds(5). Notwithstanding, globally the PHC approach has undergone several evolutions that have necessitated policy reforms in some instances(6). Global economic, political, environmental and social situations have shifted the focus of the PHC implementation across different contexts and at different points in time. In many low and middle income countries (LMICs), varying degrees of gaps exist due to epidemiological transitions, emergence of outbreaks, wars, and occasionally the lack of governance(7). To mitigate the impact of these limitations, some LMICs such as Tanzania for instance, has adopted a reform to its PHC policy that allows contracting non-state providers (NSPs) for the delivery of PHC services(6), a strategy first used by many Organization for Economic Co-operation and Development (OECD) countries in the 1980s(7)with varied degrees of impact. Others such as Sri Lanka, a middle income country that has achieved outstanding health indicators and is deemed to be a success story in primary health care implementation, adopted a *selective* Primary Health care approach that is restricted to addressing the most serious health problems in a community, as opposed to the *comprehensive* Primary Health Care model recommended at Alma-Ata(8).

In Liberia, a low income, West African country, following 14 years of civil crisis that ended in 2003 and the resultant destabilization of the healthcare system, the Ministry of Health and Social Welfare ( MOHSW) formulated and promulgated the post-conflict National Health and Social Welfare Policy and Plan (NHSWPP) of 2007-2011(9). The bedrock of the Policy was a Primary Health Care Approach, with the complimentary Basic Package of Health Services (BPHS)(10), meant to provide essential preventive, promotive, curative and rehabilitative care at every level of the health system. Cardinal to this policy was making PHC services at every level, free of user fees and provided equitably to all, in order to increase access to high quality healthcare(9) in a post-conflict setting.

Following the implementation period, the policy was deemed relatively successful in many areas and enabled the country to achieve some of the Millennium Development Goals (MGDs) targets. On this back drop the present National Health and Social Welfare Policy and Plan of 2011-2021 (NHSWPP)was developed and adopted(11). Like the preceding plan, the current NHSWPP places emphasis on a PHC approach, to be made possible by two additional packages of services, the Essential Package of Health Services (EPHS) and the Essential Package of Social Services (EPSS). The EPHS and EPSS were to expand on the number of services covered by the BPHS, providing a more comprehensive set of services to improve PHC coverage(11)(12); addressing in addition to the direct factors affecting health, the social determinants of health as well including diet, lifestyle, relationships, income, housing, workplace, culture and environmental quality(13).

Although the 2014 Ebola epidemic across West Africa affected Liberia gravely, regressing some of the gains that had been made(14), the Government remains resolute to health system strengthening, through strengthened and effective primary care provision through a robust PHC approach; taking into account the recognition made at Alma-Ata that a sustained economic and social development can be gained through the promotion and protection of the health of the people(15). The NHSWPP 2011-2021 spells out primary care provision through services at the community and facility-based levels, encompassing a full range of PHC services.

As a clinical Medical doctor working in Liberia though, I have come to experience first-hand the deplorable state of health of the country despite several years of PHC implementation; most especially in the rural settings where I worked. This has brought me to the conclusion that an intrinsic problem existed with the provision of Primary Health Care services and that this problem could be more deeply rooted than implementation issues. I became intrigued into studying what the policies dictated in terms of PHC. This research paper is therefore an attempt at analyzing the effectiveness of the policy to date in meeting the PHC approach objectives as laid out at the Alma-Ata declaration, to identify possible gaps that can be addressed for improving PHC provision in Liberia.

# 1.0 Background


**Figure 1: Map of Liberia showing names of capital cities, towns, states, provinces and boundaries with neighboring countries, Source: AuctionTheGlobe.com, 2016**

Liberia is a developing country on the west coast of Africa, bordered by Sierra Leone on the West, Guinea at the North, Ivory Coast on the East and the North Atlantic Ocean on the Southern boundary (See Figure 1). It is a relatively small country that covers an area of about 111,369 km$^2$(16). The country has an estimated population of 4.7 million of which 49.70% are females and about 42.3% of the population is below the age of 15. Crude birth rate is about 33.80%(17)(18) and life expectancy is 62.9% for both sexes(19). Gross Domestic Product (GDP) per capita ($PPP) is $826, down from its peak of $ 1,217 in 1980(20)(21). Approximately half of the population in Liberia is poor, with 50.9% living in absolute poverty; highest among those with no formal education and those living in rural settings. While unemployment rate is relatively low 3.9%, compared to the sub-Saharan Africa average rate of 6.1%, 79.9% of employment is informal and an estimated 79.5% of employed individuals are said to be involved in "vulnerable employment"; that is employment characterized by marginal earnings, low productivity and difficult working conditions that undermine workers' rights(22). Only 64.7% of the population is literate, with more men literate, 77% compared to women, 54%(22)(23).

The country, which is divided into 15 political subdivisions called Counties and 5 regions, contains 40% of the rainforest in West Africa. Monrovia, the capital is the largest city and

serves as Liberia's administrative, commercial and financial hub and is home to about 29% of the country's population, making it the most populous city in the country(16). Liberia has a tropical climate, with approximately six months of rainy season that runs from mid-March to mid-October during which time the average temperature ranges from 24.5-26.5$^{o}$c. The remaining six months are dry with higher temperature ranges. Rainfall averages about 2000mm per year in the inlands and as high as 5000mm per year along the coastal areas which include the Capital, Monrovia(24).

Like many developing countries, Liberia is undergoing steady urbanization at an annual rate of change of 3.24%(25) and the country is considered one of the most urbanized in the region with roughly half of the population living in urban areas(26);in stark contrast to the rate of infrastructural development. This demography is indicative of the lack of economic opportunities in the rural areas as a result of a lack of public investment in subsistence farming, the major economic activity in the rural settings, coupled with elder control over land, making agriculture unattractive to the youths. The situation is further compounded by increased disparities in access to basic social services between populations in rural and urban settings. The country's road network is largely underdeveloped with only a mere 7% of the country's 66,000 miles of roads paved(27). The industrial sector is also relatively small and urban economic opportunities few.

English is the official spoken language and there are also over 20 indigenous dialects, spoken by numerous different ethnic groups which jointly constitute over 95% of the population that is considered Indigenous. The remaining 5% are a mix of descendants of liberated slaves returned from the United States of America, the 'Americo-Liberians', who formally declared Liberia a nation on July 26, 1847(28) and other foreign nationals. The minority Americo-Liberian elites held the rein on political and economic power for many years causing tensions that led to a military coup in 1980 and ultimately a fourteen (14) year period of civil war that ended in 2003.

The civil war resulted in a destabilization in the political, economic, social and healthcare fabrics of an already low-income country. At the end of the war, only 354 of the country's 550 health facilities were functional, mostly operated by Non-Governmental Organizations (NGOs) and nine out of ten doctors had fled the country. Health indicators were deplorable. The first post-war Demographic and Health Survey (DHS) of 2007 recorded an infant mortality rate of 71/1000 livebirths, one out of nine children died before their fifth birthday, sixty-one (61%) percent of children below two years did not receive recommended vaccinations and less than two fifth of births occurred at a health facility. Skilled birth attendance was only 46% and maternal mortality rate (MMR) was 994/100,000 livebirths. Malaria was the leading cause of death, accounting for 40% of mortalities in the hospital settings (29).

The country has since experienced several years of peace and stability since 2005 with the election of President Ellen Johnson-Sirleaf and a peaceful democratic transition of power to the present government led by President George Weah in 2018. The healthcare system is undergoing improvements and has transitioned from crisis response to system rebuilding. In 2014 though, the country was among other West African countries hit by the worst recorded Ebola outbreak to date. The outbreak which exposed the precarious foundation of the country's primary health care, led to the death of many health workers causing an 8%

reduction in the healthcare workforce and hundreds of deaths attributed to HIV, Malaria and Tuberculosis due to an estimated 50% reduction in healthcare service provision across the region during the outbreak(30).

Post-Ebola, the country's healthcare system which is organized on a decentralized three-tier service provision model (See Figure 2) is being revitalized. Autonomy for management of hospitals and peripheral health facilities is being delegated to counties, while the central/national level is tasked with policy and guidelines formulation and regulations, as well as provision of technical and financial support. A complementary National Policy on Community Health Services with the aim to identify, train and utilize Community Health Workers (CHW) to provide first line basic curative and health promotional services, especially in the underserved rural areas, is being implemented(31). Emergency response capacity is being strengthened through an investment plan to make the system more resilient(32). Despite this however, the health sector in the country remains largely dominated by the private sector, due to perceived better-quality service provision by the general public. The private for profit (PFP) and not-for profit (NFP) subsectors are estimated to provide 47% and approximately 30% respectively of health services(33). In Montserrado County, which host the capital Monrovia for instance, 53.1% of PHC provision is done by private providers, compared to just 31.9% by public providers(22).

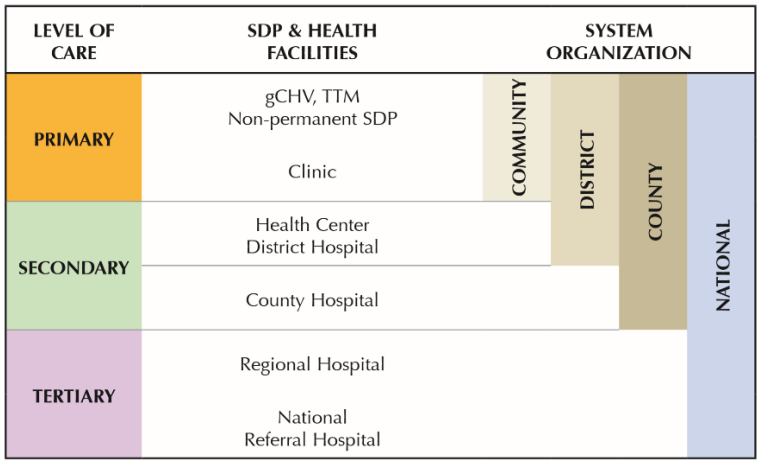


Figure 2: **Relation between facilities, levels of care and system organization, Source: Liberia National Health Policy 2011-2021**

Current health expenditure (CHE) per capita is USD$69, while current health expenditure as percentage of GDP is 15.2%; compared to the African regional values of USD$115 and 6.2% respectively(34). Despite this, the country's annual budgetary allocation to health is 11.7%, which falls short of the 15% allocation agreed on by world leaders at the Abuja Declaration in 2011(14)(35). Consequently 7.9 and 1.6% of the population spends >10 and >25% respectively of household expenditure or income on health(34). The sector also faces shortage of health workforce as well as inequitable distribution of the available ones between counties. The Health Workers Census of 2016 recorded 16,064 health workforces, of which 10,672 were public. Core clinical workers (Physicians, Physician Assistants, Nurses, midwives) numbered 4,756, of which 64.7% were registered Nurses and only 4.9% were Physicians(14). Montserrado County and three other counties account for 68.2% of this group of cadres with the rest distributed across the remaining eleven counties.

Liberia is yet to achieve the WHO's global target of 23/10,000 population for health workers' density. The current density is 11.8/10,000, with variation in distribution across the counties, with consequential impact on PHC provision(See Figure 3)(14).

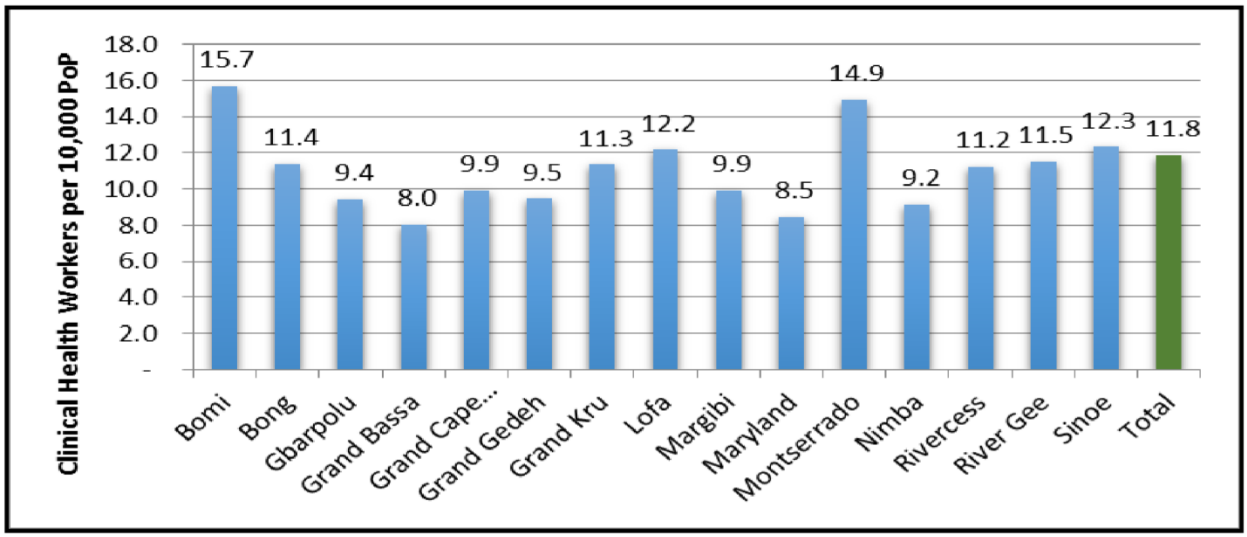


**Figure 3: Health Workers Density per County in 2016, Source: Joint Annual Health Sector Review Report 2016, MoHSW, Liberia**

## 1.1 Problem Statement

The Minimum package envisaged at Alma-Ata for Primary Health Care consist of eight (8) essential elements;(i) education concerning prevailing health problems and the methods of preventing and controlling them; (ii) promotion of food supply and proper nutrition; (iii)an adequate supply of safe water and basic sanitation; (iv) maternal and child health, including family planning; (v) immunization against the major infectious diseases; (vi)prevention and control of locally endemic diseases; (vii) appropriate treatment of common diseases and injuries and (viii) provision of essential drugs(36). All of these were envisaged to be addressed in a PHC approach through community empowerment, decentralization and partnership, utilizing technology appropriate for the setting involved. Thoroughly considered policies are therefore required within a given context, to provide the strategic framework for directing such service deliveries and to present appropriate and implementable systems and pathways to care, funding and on-going monitoring mechanisms(37).

The post-conflict NHSWPP and the current NHSWPP; along with the adjunct BPHS and EPHS, are focused on a PHC approach strategy through service decentralization, provision of universal coverage through sets of predetermined limited entitlements encompassing the PHC elements within the direct purview of the Ministry of Health and through intersectoral collaboration with other stakeholders for provision of other indirect services. These are made available at every tier across all geographic locations free of user fees(11)(12). Policies on community health services, health promotion, reproductive and sexual health, drugs, mental health, human resource for health are among policy options that are governed by the NHSWPP and that have been adopted to meet the objectives of a PHC approach in Liberia.

Consequently, the country has seen an improvement in some cardinal health indicators as a result of policy implementation. Under 5 mortality rate has fallen from 247 per 1000 live births in 1990 to 74.7 per 1000 livebirths in 2017(10)(19); neonatal mortality rate from 38 per 1000 live births in 2013 to 25.1 per 1000 live births in 2017(24)(19); maternal mortality ratio (MMR) from 1072 in 2013 to 725 per 100,000 live births in 2015(24)(19). Additionally life expectancy has increased from 58 years in 2009 to 62.9 years in 2016(10)(19) and immunization coverage for Diphtheria Tetanus Toxoid and Pertussis (DTP3) climbed from 65% in 2016 to 86% in 2017(14)(19).

Despite these gains, certain aspects of the policies remain ambiguous and lack clear strategic approach on implementation that results in a disconnect between what the policies aim to address and what is being realized in PHC in Liberia. Generally, the health policy development process involves a complex interplay of factors that require effective coordination and considerations to derive a document that fully reflects the multiplicities of priorities and interests(38). Capacity limitations, failure of incorporations of salient roles that align the policy with global trends in the Liberian context inadvertently weakens this process, and for PHC adversely impacts the effectiveness of the approach.

This, in combination with other complex socio-economic factors has the current MMR in Liberia still one of the highest in the world and 49% of births are still unattended by a skilled personnel(14). Access to basic care is inequitably distributed between rural and urban settings(39), 29% of the population, mostly rural, still has to walk over 5km/1 hour distance to access care(14) and referral between care levels are less than optimal with huge differences

between rural and urban facilities(40). Five point six (5.6%) percent of under-fives are wasted and 32.1% stunted(41), 30% of the population still lacks access to at least basic drinking water(42) and open defecation is practiced by 42% of the population(41). Additionally, endemic disease control remains underwhelming. Liberia's tuberculosis (TB) prevalence is 308/ 100,000 population, making Liberia one of the top 30 high burden TB countries in the world(43), HIV/AIDS prevalence while relatively low, 2.1%, compared to the regional rate, 56% of people living with HIV are not receiving lifesaving Antiretroviral therapy (ART)(44) and while 97% of health facilities in Liberia offer malaria treatment services, 40% were found lacking tracer items needed for service delivery during the 2016 WHO Service Availability Readiness Assessment survey (SARA)(14).

These data therefore suggest a need to examine the policy closely, to assess the synergy of the policy components on PHC with the outcomes that are to be achieved.

## 1.2 Justification

A policy concern is to what extent do the current health policy and complementary documents address the PHC approach in order to direct implementation activities towards mitigation of the prevailing health issues. There has been inadequate research conducted on the policy; to gauge its effectiveness, identify weaknesses and ascertain whether aspects need to be revised and adapted to reflect present realities. An evidence-informed basis for such decisions is needed hence, necessitating the undertaking of this research.

## 1.3 Thesis Objectives

To critically analyze the policy that governs the Primary Health Care approach in Liberia to explore its alignment with addressing the expected health indicators and the Sustainable Development Goals (SDGs) for health.

### 1.3.1 Specific objectives

1. To explore key factors influencing the Primary Health Care approach in Liberia
2. To identify the key stakeholders involved in the formulation of the National Health policy and their respective roles.
3. To describe and analyze the Primary Health Care Approach as stated in the National Health Policy
4. To identify and analyze areas of gaps and limitations in the policy in relation to primary health care
5. To make recommendations to relevant stakeholders for future policy considerations and strategic planning based on the research findings

## 2.0 Methodology

This paper is a policy review of national policy documents and articles relating to the primary health care approach in Liberia. A comprehensive web-based search was performed using the Vrije Universiteit Amsterdam online database as well as the following search engines: Google and Google Scholar. Other online sources searched were PubMed and Mendeley Library, employing different combinations of the keywords, "Primary Health Care", "Primary Health Care Policy" , "Liberia", "Primary Health Care Approach", "Health Policies", " Analysis", "Health Policy Analysis", "Primary Healthcare Implementation" , "sub-Saharan Africa" and "Low-And-Middle-Income Countries". The search was made for latest versions of all national health policy documents as well as relevant supporting articles. All potentially relevant information was downloaded for analysis. Current national (mainly primary documents from Liberia's Ministry of Health and Social Welfare), international, peer reviewed, and gray literatures were sourced first, and then snowballing was employed to include key publications found older than the set timeframe which ran from January 1, 2001 to August 2019. Only English language documents were considered for analysis and communication of this research findings as English is the official language of the targeted audience.

The policy documents selected and analyzed were based on the criteria of being currently implemented policies and their alignment with one or more of the eight (8) Primary Health Care essential elements. It must be acknowledged that the search conducted was limited in that only publicly available policy documents that could be electronically accessed, were included and analyzed in this paper. Documents not publicly available and those not adopted formally were not included for analysis. Consequently, the possibility exist that some current, up-to-date relevant documents may not have been included in this paper.

### 2.1 Conceptual Framework

The Walt and Gilson health policy analysis framework commonly known as the Policy Analysis Triangle ( See Figure 4) was used for extraction and analysis of all identified policy documents (45)(46). This framework was selected because it affords a multidimensional approach to health policy analysis and it provides an excellent means for analysis of the Liberian Health Care Policy, which has undergone several changes over the past decades. Whereas most other attempts at analysis of a policy focuses almost entirely on the contents of the policy, thereby diverting a keen scrutiny of the processes which explains why a desired outcome of a policy fails to be achieved, the incorporation and consideration of other components of a policy this framework provides affords a deeper, analytical understanding. The conceptual framework, which was developed in 1994 by Gill Walt and Lucy Gilson focuses on several key factors (Actors, Context, Process and Content) and the complex interrelation and interaction between these factors within a given context; to influence health policy formulation and implementation and the consequential impact on the general health of the population.

Actors refer to all vested stakeholders, example national, international, Non-Governmental Organizations (NGOs), pressure and social society groups, funding organizations, private sector companies etc., whose actions impact the health policy. Anyone who has power and exercise it through the policy process(47).

Context is the political, economic, social and cultural factors, at the national and international levels, that have a bearing on health policy. These factors could be classified in several

different ways according to the nature of the factor and the role they play in the policy development process for policymakers. They could be *Macro-level context factors* which includes political, social and economic factors; *Meso-level context factors*- these are health systems' factors and *Micro-level context factors*- factors more associated with the implementation process(48). They could also be categorized as *Situational factors*- mostly transient factors that are subject to change easily like civil conflict, leadership change, natural disasters etc.; *Structural factors*-more rigid, relatively unchanging elements such as political, economic, demographic and technological factors; *Cultural factors*- gender norms/inequity, ethnicity and linguistic factors, stigmatization, religious factors etc.; and *International/Global factors*- International agenda, international cooperation in health etc. (47).

Content is the materials covered within a given health policy in fine details, while Process refers to the way policies are started, developed or formulated, negotiated, communicated, implemented and evaluated.

There were no limitations identified with utilization of the framework. However, because of the interconnected nature of the various components of the framework, several factors were identified to interact and overlap quite frequently, and this is reflected in the results and discussion sections of the paper.

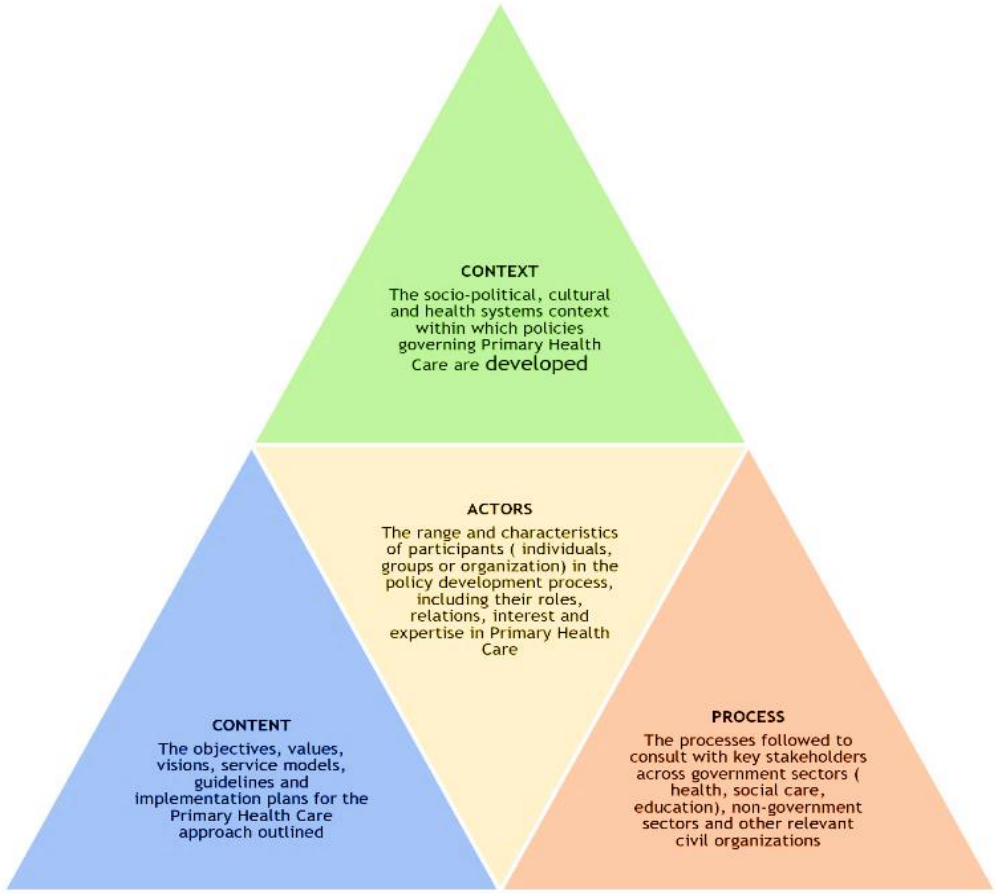


**Figure 4: The Walt & Gilson Policy Triangle Model (1994), adapted for the Primary Health Care Approach**

# 3.0 Results

## 3.1 Policy documents identified

Table 1 lists all the national primary health care related policy documents identified along with a brief overview of each document. The table also details the status of the documents; outdated or current, along with the level at which said policy is being adopted; national and/or subnational. Of the thirteen identified documents, one was outdated and therefore it is not being implemented currently and consequently not considered for further analysis. Of the remaining documents, two were found to have been drafted and last revised over a decade period. The Basic Package of health Services was identified as outdated nonetheless; the services proposed in the document are still being currently implemented. The National Drug Policy, one of the two outdated policies, was promulgated in 2001 but remains a currently identified operational policy paper.

In addition to an overarching National Health Policy, a National Drug, Mental Health, Community Health and Nutrition policy were common policy documents guiding PHC policy formulation and implementation that were identified in several studies on PHC in several sub-Sahara African and middle-income countries. These were also similarly identified in Liberia and therefore listed in table 1(49)(50)(51)(52). Policies on Decentralization was also commonly observed in the African studies as a guiding PHC policy document. However, in the case of Liberia, a Health Sector Decentralization Policy was correspondingly mentioned in the general National Health Policy as a policy document influencing the PHC approach in the country, but this document could not be electronically located, and it was therefore not included on the list.

The Basic Package of Health Services, the Essential Package of Health Services and the Investment Plan for Building a Resilient Health System in Liberia were not identified as actual policy documents. They were found to be papers complementing the overarching National Health Policy on PHC implementation. However, both the BPHS and EPHS were similarly identified in the aforementioned studies from other LMICs in terms of PHC papers, hence these warranted their inclusion on the list.

**Table 1: Policy documents identified, their status, level of adoption and short overview of each**

| Policy document | Status | Level of adoption | Explanation of the document |
|---|---|---|---|
| **National Health Policy and Plan, 2007-2011**(53) | Outdated | National and subnational | Outlines the objectives, strategies and resources to reform the health sector to effectively deliver quality health and social welfare services to the people of Liberia; with vision to improved health and social welfare status and equity in health. Guided by the principals of Primary Health Care, Decentralization, Community Empowerment and Partnerships for Health. |
| **National Health and Social Welfare Policy and Plan, 2011–2021**(11) | Current | National and subnational | Outlines the objectives, strategies and resources to reform the health sector to effectively deliver quality health and social welfare services to the people of Liberia; with vision to improved health and social welfare status and equity in health. Guided by the principals of Primary Health Care, Decentralization, Community Empowerment and Partnerships for Health. |

| | | | |
|---|---|---|---|
| **Liberia National Community Health Services Policy, 2011**(54) | Current | National and subnational | Defines the vision and overall goals for national community health services, specifying the framework of implementation that integrates the community, clinics and health centers with the County and National health system, through trained community health volunteers. |
| **National Sexual & Reproductive Health Policy, 2010**(55) | Current | National and subnational | Guides the delivery of comprehensive Sexual and Reproductive Health (SRH) services across the country and defines the vision of SRH through principles of equity and universal coverage. |
| **National Drug Policy, 2001**(56) | Current | National and subnational | Guides the utilization of available resources in the development of pharmaceutical services to meet Liberia's requirements in the prevention, diagnosis and treatment of diseases by using efficacious, high quality, safe and cost-effective pharmaceutical products |
| **National Human Resources Policy and Plan for Health and Social Welfare 2011-2021**(57) | Current | National and subnational | Defines the vision for addressing the human resources (HR) problems in the health sector to ensure that everyone at every tier receives equitable and affordable access to motivated, productive, fairly paid, qualified health and social welfare workers. |
| **National Nutrition policy, 2008**(58) | Current | National and subnational | Complements the NHSWPP and the Food Security and Nutrition strategy in supporting public actions to improve nutrition. |
| **National Policy and Strategic Plan on Health Promotion 2016-2021**(59) | Current | National and subnational | Guides activities directed at the adoption and maintenance of healthy behaviors and practices among individuals, families and communities through information, education, advocacy, mobilization and empowerment. |
| **Mental Health Policy and Strategic Plan for Liberia, 2016-2021**(60) | Current | National and subnational | Defines the vision for mental health care that places emphasis on community-based services, training of PHC providers in the recognition, prevention and treatment of mental illnesses. |
| **National Health and Social Welfare Financing Policy and Plan, 2011-2021**(61) | Current | National and subnational | A document with the overarching goal to ensure that services provided are affordably to the population, while preventing catastrophic household health and social welfare expenditures. It is based on the PHC principles of equity, quality, efficiency, decentralization, sustainability and partnerships. |
| **Complementary documents** | | | |
| **Basic Package of Health and Social Services, 2008**(62) | Current | National and subnational | Describes sets of standardized packages of services to be implemented at every level in the health system; to ensure and promote universal access to essential health services across the country. |
| **Essential Package of Health Services, 2011**(12) | Current | National and subnational | Expands on the services provided in the BPHS and describes standardized package of services to be implemented at every level in the health system; to ensure and promote universal access to essential health services across the country |
| **Investment Plan for Building a Resilient Health System in Liberia, 2015 to 2021**(32) | Current | National and subnational | Complements the NHSWPP and outlines emergency response services and strategies, investment in system strengthening and capacity building. |

### 3.1.1Primary Health Care Policy

A stand-alone policy document on Primary Health Care in Liberia was not found. At the National level however, the overarching National Health and Social Welfare Policy and Plan (NHSWPP) (both the outdated version of 2007-2011 and the current 2011-2021 version) (9)(11) were documents implicitly based on a comprehensive PHC approach that were identified. Several other supporting and complementary documents to the NHSWPP were also identified. This finding was constant with findings from other LMICs, namely Sri Lanka, Nigeria, Uganda and Ghana, which also lacked independent Primary Health Care policies. In all the mentioned countries, PHC was guided by the general health policies and an amalgamation of policy documents related to PHC(49)(50)(52)(63), similar to what was identified for Liberia.

### 3.1.2 Implementation Plans

All the supporting documents included implementation plans to complement that of the boarder NHSWPP in some specific aspect, in improving the general health indicators. However, of the twelve current identified and detailed documents, only five had explicitly outlined Primary Health Care strategic plans. The remaining seven policy/complementary papers lacked clear implementation plans on the primary health care approach.

## 3.2 Policy Analysis using the Walt and Gilson Policy Triangle

### 3.2.1 The Context

The context within which the general health policy, which directs the other key documents presented in this paper, was developed is summarized in Table 2. Ten pertinent contextual factors were identified, and these included the socioeconomic situation, the demographic dynamics, morbidity and mortality, nutritional factors, access to safe water and sanitation, access to health and social welfare services, resources for health, decentralization operations and status, the international agenda and stigmatization.

The determinants of these factors identified were varied but were collectively based on a need to address the overwhelming high maternal and child mortality, high burden of communicable diseases, lack of access to quality health care, inequity in access to health care, the financial impoverishment brought on by high out-of-pocket (OOP) expenditure for health, the poor nutritional status of the general population and poor access to safe water and sanitation and stigmatization against individuals with mental health illnesses. The overall general socioeconomic decline brought on by the civil conflict and the resultant decline in health and social services predicated a need to improve the health status of the country, to meet the World Health Organization (WHO) health objectives outlined in the Millennium Development Goals (MDGs). PHC was not implicitly referenced as an influencing factor in the NHSWPP or any other regional health policy document examined.

In terms of the context categories, three broad types were identified, structural factors, which are not subject to a lot of changes and these included all the key context factors except international agenda which is identified here as a global factor, and stigmatization, a cultural factor. An important cultural factor, gender norms/inequity, which is seen as contextual considerations in other regional health policy formulation process such as in the case of

Ghana(64), was not identified in the NHSWPP. Additionally, situational factors such as leadership change and social unrest were not identified as factors shaping the policy. However, the lingering effects of the country's 14 years of civil conflict was mentioned.

**Table 2: Key Factors Influencing the National Health Policy on The Primary Health Care Approach**

| Policy | Context Categories | Context factors | Description/Determinants of the factors |
|---|---|---|---|
| National Health and Social Welfare Policy, 2011-2021 | Structural | The Socio-Economic Situation | Marginal economic growth |
| | | | Deepening poverty |
| | | | Post-conflict |
| | | | Inequity in economic development between rural and urban settings |
| | | | Democratic election/legitimate government |
| | | Demography | Relatively young population |
| | | | Population growth |
| | | | Growing number of refugees from neighboring countries |
| | | Morbidity and Mortality | High maternal mortality ratio |
| | | | High infant mortality rate |
| | | | High under 5 mortality rates |
| | | | High burden of communicable diseases (e.g. Malaria, TB, HIV) and high prevalence of mental health disorders |
| | | Nutrition | High prevalence of malnutrition |
| | | Water and sanitation | Low access to improved sources of water |
| | | | Significant disparities of access to sanitation between urban and rural settings |
| | | | Increasing sanitation problems in populated, urban areas |
| | | Access to health care And social welfare | Insufficient health facilities |
| | | | Growing number of target groups (e.g. Children, adolescents, prisoners, substance abusers, elderly, victims of disasters) |
| | | | Fragmentation in service delivery |
| | | Resources | Insufficient human resource for health |
| | | | High Out-of-pocket and donor funding, low government expenditure for health |
| | | | Frequent stock-outs of drugs at health facilities, unregulated drug management system |
| | | Decentralization | Dysfunctional or non-existent management system |
| | Global | International Agenda | Millennium Development Goals |
| | Cultural | Stigmatization | Attitude towards mental health |

### 3.2.2 The Actors

Major international and national stakeholders, including other non-health governmental ministries and agencies, functioning in capacities ranging from financial to technical supports were identified (see Table 3).

International funding organizations such as the World Health Organization, United Nations Children Funds (UNICEF), United States Agency for International Development (USAID) and the European Union (EU) were major actors identified that provided technical support in addition to funding. Considering Liberia's post-conflict status, the International Rescue Committee (IRC), which is an organization that carries out response activities in humanitarian situations cause by conflicts and natural disasters, was found to be an actor associated with the policy process of one of the policy papers identified.

Conversely, except for three of the documents, the National Policy and Strategic Plan on Health Promotion, the National Health and Social Welfare Financing Policy and Plan and the overarching National Health Policy, there were no documented evidence found of service users (the community) representation or consultation in the process of the policies formulation. Additionally, there was underrepresentation of professional bodies and local health care providers identified, as evidenced by only four out of the twelve papers documenting the participation of said category of actors. The identified professional councils were mostly clinical, Medical, Dental, Nursing and Physician Assistant councils and association. Health education institutions, Medical College and an Allied Health training institute, as well as the Liberian Bar association were a few of the other identified actors.

Similarly, there was no documented evidence of the Private Sector's engagement in the policy process, although the WHO recommends a participatory engagement with the private sector(5). However, review of the national health policies of Ghana, Sri Lanka, Uganda and Tanzania, other LMICs also did not identify the private sector as actors in the policy process.

**Table 3: Key Stakeholders/Actors Involved in Formulation of The National Health Policy and Related Policies On The Primary Health Care Approach**

| Policy | Year | Stakeholders | Role | Local Health care providers* | Community Representation |
|---|---|---|---|---|---|
| **National Health Policy and Plan** | 2007-2011 | **International**<br>• United Nations Children Funds (UNCEF)<br>• United Nations Population Funds (UNFPA)<br>• United States Agency for International Development (USAID)<br>• World Bank<br>• World Health Organization (WHO)<br>• European Union (EU)<br>**Local**<br>• Ministry of Health and Social Welfare (MoHSW) | Steering committee | No available data | No available data |

| | | | | | |
|---|---|---|---|---|---|
| | | • Ministry of Education (MOE)<br>• Ministry of Planning and Economic Affairs (MOPEA) | | | |
| | | • World Health Organization (WHO)<br>• United Nations Children Funds (UNCEF)<br>• United Nations Population Funds (UNFPA)<br>• European Union (EU)<br>• United States Agency for International Development (USAID) | Financial Support | | |
| | | **International**<br>• World Health Organization (WHO)<br>• United States Agency for International Development (USAID)<br>• United Nations Population Funds (UNFPA)<br>• Johnson and Johnson<br><br>**Local**<br>• Several MOH and inter-sectorial staffs<br>• County Health Teams<br>• County Superintendents<br>• County Development superintendents<br>• Unspecified NGO partners | Technical and/or Expert support | | |
| **National Health and Social Welfare Policy and Plan** | 2011–2021 | **International**<br>• Unspecified individuals and organizations<br>**Local**<br>• Unspecified individuals and organizations | Unspecified | No available data | Unspecified community, civil society and religious groups |
| **Liberia National Community Health Services Policy** | 2011 | **International**<br>• United States Agency for International Development (USAID)<br>• United Nations Population Fund (UNFPA)<br>• World health Organization (WHO)<br>• United Nations International Children Educational Fund (UNICEF)<br>• Clinton Health Access Initiative (CHAI)<br>• International Rescue Committee (IRC) | Technical and/or Financial support | No Available data | No available data |

| | | | | | |
|---|---|---|---|---|---|
| | | • Maternal Health Integrated Program (MCHIP)<br>• Child Fund<br>• Africare Liberia<br>• BRAC –Liberia<br>• EQUIP Liberia<br>**Local**<br>• Ministry of Health and Social Welfare (MoHSW) | | | |
| **National Sexual & Reproductive Health Policy** | 2010 | **International**<br>• Unspecified Non-Governmental Organizations (NGOs) and development partners<br>**Local**<br>• Reproductive Health Technical Committee (RHTC), MoHSW<br>• Unspecified line ministries | Technical support | Unspecified health institutions and professional bodies | No available data |
| **National Drug Policy** | 2001 | **International**<br>• World Health Organization (WHO)<br>• Other unspecified UN Agencies<br>• Consortium of international NGOS<br>• European Union (EU)<br>**Local**<br>• Ministries of Health, Finance and Justice<br>• National Port Authority (NPA)<br>• National Drug Service (NDS)<br>• John F. Kennedy Memorial Medical Center | Financial support and/or Technical support | A.M. Dogliotti College of Medicine<br><br>School of Pharmacy<br><br>Pharmacy Board<br><br>Liberia Bar Association | No available data |
| **National Human Resources Policy and Plan for Health and Social Welfare** | 2011-2021 | **International**<br>• Unspecified individuals and organizations<br>**Local**<br>• Ministry of Health and Social Welfare (MoHSW)<br>• Unspecified individuals and organizations | Unspecified | No available data | No available data |
| **National Nutrition Policy** | 2008 | **International**<br>• United Nations Children's Fund (UNICEF)<br>• World Food Program (WFP)<br>**Local**<br>• Technical Working Group; MoHSW | Financial and/or Technical support | No available data | No available data |
| **National Policy and Strategic Plan** | 2016-2021 | **International**<br>• World Health Organization (WHO)<br>• United Nations International Children | | | • Liberia Crusaders for Peace (LCP) |

| | | | | | |
|---|---|---|---|---|---|
| **on Health Promotion** | | Educational Fund (UNICEF)<br>• United States Agency for International Development (USAID)<br>• United Nations Population Fund (UNFPA)<br>• Centers for Disease Control and Prevention (CDC)<br>• United States Agency for International Development (USAID)<br>**Local**<br>• Ministry of Education (MOE)<br>• Ministry of Youth and Sports (MYS)<br>• Ministry of Planning, Finance and Development<br>• Ministry of Information, Cultural Affairs and Tourism (MICAT)<br>• Environmental Protection Agency (EPA)<br>• National AIDS Commission (NAC)<br>• County Health Teams (CHTs)<br>• Ministry of Health and Social Welfare (MoHSW) | Financial and/or Technical Support | No available data | • Inter-Faith-Religious Council |
| **Mental Health Policy and Strategic Plan for Liberia** | 2016-2021 | **International**<br>• World Health Organization (WHO)<br>• United Nations International Children Educational Fund (UNICEF)<br>• Other unspecified International Non-Governmental Organization (INGOs)<br>• International experts from several international universities<br>• International Medical Corps (IMC)<br>**Local**<br>• Ministry of Health (MOH)<br>• Ministry of Gender, Children and Social Protection<br>• Ministry of Education (MOE)<br>• County Health Officers<br>• Social Workers | Financial and/or Technical support | Mental Health Clinicians<br><br>Accreditation bodies (Liberia Board of Nursing & Midwifery and the Liberia National Association of Physician Assistants) | No available data |

| | | | | | |
|---|---|---|---|---|---|
| **National Health and Social Welfare Financing Policy and Plan** | 2011-2021 | **International**<br>• Unspecified individuals and organizations<br>**Local**<br>• Ministry of Health and Social Welfare (MoHSW)<br>• Unspecified individuals and organizations | Unspecified | No available data | Unspecified community and civil society representatives involved |
| **Basic Package of Health and Social Services** | 2008 | **International**<br>• United Nations Children's Funds (UNICEF)<br>• United Nations Development Program (UNDP)<br>• Clinton Foundation<br>**Local**<br>• Ministry of Health and social Welfare (MoHSW)<br>• Liberia Malaria Control Program<br>• Several unidentified experts in different health fields | Technical support and/or otherwise unspecified | Mother Patern College of Health Sciences<br><br>Laboratory Technicians Association | No available data |
| **Essential Package of Health Services** | 2011 | **International**<br>• World Health Organization (WHO)<br>• United Nations Children's Fund (UNICEF)<br>• United Nations Population Fund (UNFPA)<br>• Carter Center<br>• Merlin<br>**Local**<br>• Ministry of Health and Social Welfare (MoHSW)<br>• National Tuberculosis and Leprosy Control Program<br>• County Health Officers<br>• Directors of national health programs | Technical support | No available date | No available data |
| **Investment Plan for Building a Resilient Health System in Liberia** | 2015-2021 | **International**<br>• World Health Organization (WHO)<br>• United Nations population Fund (UNFPA)<br>• United Nations Children's Fund (UNICEF)<br>• United States Agency for International Development (USAID)<br>• Centers for Disease Control and Prevention (CDC)<br>**Local** | Technical assistance and support | No available data | No available data |

| | | | | | |
|---|---|---|---|---|---|
| | | • Ministry of Health and Social Welfare (MoHSW) | | | |

*Local Primary Healthcare Providers, Local Academic Institution, Professional Councils and Associations

### 3.2.3 The Content

Table 4 summaries the content of the various policy-related documents and also indicates the presence or absence of explicit PHC implementation plans for each of the policy papers. The NHSWPP mainly focused on provision of PHC and made specific reference to a PHC approach in the implementation strategy. Eleven essential areas of service deliveries was identified in the implementation plan; Maternal and Newborn Health Services, Child Health Services, Reproductive Health Services, School Health Services, Prevention and Control of Communicable Diseases, Prevention and Control of Neglected Tropical Diseases, Prevention and Control of Non-communicable Diseases, Eye Health Services, Emergency Health services, Mental Health Services and Prison Health Services. In addition, five priority support systems in order to provide PHC were also identified in the plans; Leadership and Management, Pharmaceutical Services, Diagnostic Service, Facility Infection prevention and Control and Health Management and Information Systems. The services identified were constant with the PHC elements and expands beyond that in three other service provisions, School health, Prison health and Eye health services. The identified strategic approach is also constant with identified recommendations by WHO that aligns the PHC approach with the integrated vision of the SDGs and the eventual achievement of UHC(5).

Both the Essential and Basic Packages of Health services and the National Community Health Services were also found to have a focus on PHC through provisions of universal access to basic and essential health services free of user fees as well as strengthening of community health delivery services; all by explicitly outlined services.

The remaining policy documents were found to complement the NHSWPP and are focused on various aspects of general health and social service provision. Nonetheless, there were no specific references to PHC identified in their strategic plans.

**Table 4: Content Analysis of The National Health Policy and Related Policy Documents in Relation to The Primary Health Care Approach***

| Policy Document | PHC Content Focus | Service provision plans and clear guidelines |
|---|---|---|
| **National Health and Social Welfare Policy and Plan, 2011–2021** | Emphasizes PHC as the foundation and model for service delivery by focusing on health promotion, provision of essential care at all levels universally, closest to the users; placing citizens and patients in equal partnership with care providers in decision making. This is to be achieved through decentralization and intersectoral collaboration on elements of the PHC approach not in the direct purview of the MoHSW. | The PHC approach is implicitly mentioned in the accompanied Health Plan, to be affected by the Essential Package of Health services (EPHS)* through eleven service delivery areas:<br>1. Maternal and Newborn Health Service<br>2. Child Health Services<br>3. Reproductive Health Service<br>4. School Health Services<br>5. Prevention and Control of Communicable Diseases |

| | | |
|---|---|---|
| | | 6. Prevention and Control of Neglected Tropical Diseases (NTDs)<br>7. Prevention and Treatment of Non-Communicable Diseases (NCDs)<br>8. Eye Health Service<br>9. Emergency Health Services<br>10. Mental Health Services<br>11. Prison Health Services<br>And five priority support system:<br>1. Leadership and management<br>2. Pharmaceutical services<br>3. Diagnostic service<br>4. Facility infection prevention and control<br>5. Health Management Information Systems (HMIS) |
| **Liberia National Community Health Services Policy, 2011** | The document reflects the community health component of the NHP of 2011-2021 which focuses on a PHC approach; through strengthening of care at the community level, to be affected by trained Community health Volunteers (CHVs). It ensures access to health for populations beyond a 5km radius of a health facility by outreach services, brings provision of basic curative, preventive and promotional health services closest to the users. | There is availability of clear service provision plans and strategies, grounded on a primary health care approach. |
| **National Sexual & Reproductive Health Policy, 2010** | The focus is on the provision of Sexual and Reproductive health services without implicit reference to PHC, nonetheless, reference is made to equity and universal accessibility at all levels, community participation and the recognition of SRH as basic human right issues. | No specific reference to PHC |
| **National Drug Policy, 2001** | Focuses on the legislative and regulatory frameworks for the procurement, storage, distribution and prescription of pharmaceutical products in Liberia. Drug management falls under the broader NHP that focuses on judicious utilization of drugs, and the assurance of availability at all times at all levels to promote PHC. | No specific reference to PHC |
| **National Human Resources Policy and Plan for Health and Social Welfare 2011-2021** | Focuses on the recruitment, training and equitable distribution of motivated, appropriately skill mixed health workforce at all levels of the health sector.<br>It supports the overarching goals of the NHP which focuses on a PHC approach. | No specific reference to PHC |
| **National Nutrition policy, 2008** | Focuses on improving the nutritional status of the population, especially the most vulnerable including infants and children, through 12 highlighted priority areas that encompasses prevention, promotion | No specific reference to PHC |

| | | |
|---|---|---|
| | and curative actions in addressing nutrition.<br>The policy complements the NHP that is based on a PHC approach. | |
| **National Policy and Strategic Plan on Health Promotion 2016-2021** | Guides actions that provide the necessary conditions and support to enable the promotion and protection of health in Liberia through seven thematic areas that include Strengthening Community actions for health.<br><br>The strategic health priorities addressed in the Policy and Strategic Plan include reproductive, maternal, new born and child health; mental health; disabilities; communicable diseases, with focus on the priority diseases; non-communicable diseases and neglected tropical diseases. | No specific reference to PHC |
| **Mental Health Policy and Strategic Plan for Liberia, 2016-2021** | Focuses on provision of mental health care services at levels of care, through active community engagement and training of Primary care providers, CHVs and other cadres of health professionals and task shifting by training teachers, village leaders, traditional healers etc. in the identification, basic mental health and psychosocial skills and referral capabilities. | No specific reference to PHC but there are specific strategies geared at offering preventive, promotive, curative, rehabilitative and supportive Mental health services |
| **National Health and Social Welfare Financing Policy and Plan, 2011-2021** | Focuses on the supervision and standardization of finances to implement the NHP 2011-2021, with a goal of affordable health care to the population, while avoiding catastrophic household expenditures for health | No specific reference to PHC |
| **Basic Package of Health and Social Services, 2008** | Focuses on strengthening PHC and decentralization, by provision of basic services universally without user fees, at every care level | Addresses six national priority health areas focused on a primary health care approach:<br>1. Maternal and Newborn Health<br>2. Child health<br>3. Reproductive and Adolescent Health<br>4. Communicable Disease Control<br>5. Mental Health<br>6. Emergency Care |
| **Essential Package of Health Services, 2011** | Focuses on strengthening PHC and decentralization, by provision of basic services universally without user fees, at every care level | See above at National Health policy service provision* |
| **Investment Plan for Building a Resilient Health System in Liberia, 2015-2021** | Focuses on health system strengthening. It complements the NHP 2011-2021 and overs 3 key objectives areas:<br>1. Universal access to safe health services within the EPHS<br>2. Building the public health capacity for prevention, preparedness, alert and | No specific reference to PHC |

| | | |
|---|---|---|
| | responsiveness through a robust Health Emergency Risk Management System<br>3. Promotion of an enabling environment that restores trust in the health authorities' ability to provide services through community engagement | |

**Only current documents are detailed in this table***

### 3.2.4 The Process

Apart from three of the documents that lacked relevant data, the Liberia National Community Health Services Policy, National Nutrition Policy and The Essential Package of Health Services, a total of four approaches were identified in the policy formulation process. Two out of the four, Consultation, Participation or a Mix of both were methods of engagements with the policy actors that were identified in the process of the policies formulation (See Table 5). These approaches described the type of engagement. The last two approaches, identified as 'bottom up' approach in response to the need of stakeholders or 'top down', responding to national priorities, were approaches that described the method of engagement.

The consultative method of approach was found to be the singular most utilized method of approach compared to the rest, accounting for about 44% of the identified method of engagements. The remaining methods identified were either participatory or unspecified. This is in contrast to results seen of the policy formulation process in many sub-Saharan African countries, where the participatory method was the most frequent method identified(15). However, the overarching NHSWPP was identified to have employed a mix of the consultative and participatory methods. It was unspecified about what type of approach was utilized with specific stakeholders.

Comprehensive review of previous policies, situational analysis and experiences gained from implementation of previous policies were also identified as considerations made in the formulation process and are listed in the table. The Ministry of Health and Social Welfare was identified as the main agency for monitoring and evaluation of the policies at the national and subnational levels. Other unspecified health partners were also identified as monitoring partners at different levels. However, there were lack of documented evidence of community participation in monitoring and evaluation of any aspect of policy implementation in any of the policy documents examined. Similarly, examination of the National Health Policies of Ghana, Rwanda and Sri Lanka other LMICs with better PHC systems than Liberia, found no explicit representation of the community in the monitoring and evaluation process of their respective health policies also(64)(65)(66).

**Table 5: Process Analysis: Process, involved stakeholders, Monitoring and Evaluation**

| Policy Document | Process | Stakeholders involved | Monitoring & Evaluation (M&E) |
|---|---|---|---|
| **National Health and Social Welfare Policy and Plan, 2011–2021** | MoHSW carried out a participatory and consultative policy and planning process, that included analysis | Representatives from communities, civil society groups, district, | • Ministry of health and Social welfare monitors adherence to the policy |

| | | | |
|---|---|---|---|
| | of the experience gained from implementation of the previous health policy as well as the prevailing health and social welfare situation | county as well as other internal and external stakeholders | |
| **Liberia National Community Health Services Policy, 2011** | No relevant data | Several internal and external stakeholders | • The MOHSW along with unspecified health partners monitors and supervises all community health activities at the county level<br>• District level monitoring and supervision by the District Community health department |
| **National Sexual & Reproductive Health Policy, 2010** | MoHSW carried out a participatory policy formulation process | Internal and external stakeholders | • Ministry of Health and Social Welfare monitors the policy implementation |
| **National Drug Policy, 2001** | Extensive consultations with external experts and participation of a wide range of participants on a workshop for the policy development | Internal and external stakeholders including non-health sector actors | • The Government of Liberia (GOL) through an unspecified ministry/agency carries out M&E |
| **National Human Resources Policy and Plan for Health and Social Welfare 2011-2021** | MoHSW conducted a consultative and participatory process in the policy development, that included analysis of the health workforce and the implementation experience of the 2007 NHP | Internal and external stakeholders | • The MoHSW will effect monitoring and evaluation guided by the National Monitoring Policy and Strategy for health and social welfare |
| **National Nutrition policy, 2008** | No relevant data | Internal and external stakeholders | • MoHSW will carry out Monitoring and evaluation at the central level, community providers will carry out M&E at the community level |
| **National Policy and Strategic Plan on Health Promotion 2016-2021** | Policy developed through a participatory process, that considered failures in the health system's response during the 2014 Ebola Epidemic | Internal and external stakeholders | • The MoHSW will conduct periodic monitoring and evaluation at every level of implementation of the policy |
| **Mental Health Policy and Strategic Plan for Liberia, 2016-2021** | An extensive consultative process was conducted in the policy development | Internal and external stakeholders | • The MoHSW will undertake monitoring and evaluation of the policy implementation |
| **National Health and Social Welfare Financing Policy and Plan, 2011-2021** | The policy was developed through a participatory, evidence-based process that involved numerous studies, reports and stakeholders' consultations at the county and national levels | Internal and external stakeholders | • Monitoring and evaluation are carried out by a designated department at the central level, and unspecified stakeholders, in accordance with the National Monitoring and Evaluation Policy and Strategy, which is linked with the Integrated Financial Management Information System and incorporated into the Health Management Information System (HMIS). |

| | | | |
|---|---|---|---|
| **Basic Package of Health and Social Services, 2008** | Developed has a result of a prioritization process | Internal and external stakeholders | • Periodic monitoring by the MoHSW, via service indicators |
| **Essential Package of Health Services, 2011** | No relevant data | Internal and external stakeholders | • No relevant data |
| **Investment Plan for Building a Resilient Health System in Liberia, 2015 to 2021** | Developed through an extensive set of consultative, technical retreat and stakeholder validation meetings, both local and internationally, that ran for a period of six months | Internal and external stakeholders | • Monitoring and evaluation are done at the central and country levels, utilizing output and impact indicators. M& E is in line with that of the overarching National Health Policy |

## 3.3 The Gaps

Table 6 details the gaps identified in the policy documents and the level at which these gaps exist in relevance to the delivery of the eight elements which are essential to the PHC approach. The gaps were identified as either policy-related or implementation-related. Of the policy gaps, the lack of end users (community) representation in the policy development process was identified in eight of the twelve policy documents examined. A lack of timely policy revision was also identified as a policy-related gap in one of the policy papers and the lack of explicit PHC strategic plans in the implementation plans of eight out of the twelve documents analyzed was also identified as a direct policy related gap. The remaining gaps identified were all implementation related and included inadequate human resource, inadequate technical support, inadequate intersectoral collaboration, inequitable distribution of health facilities and trained personnel and inadequate monitoring of policies implementation.

One particular striking observation was the identification of implementation gaps for all the essential PHC elements that were not directly within the purview of the Ministry of Health; the elements that needed to be addressed through meaningful intersectoral collaboration. These were the promotion of food supply and proper nutrition which requires collaboration with the Ministry of Agriculture and; adequate supply of safe water and sanitation, requiring the involvement of the Ministry of Public Works.

**Table 6: Areas of Gaps in the Policy relative to the 8 Essential Primary Health Care Elements and the Policy Best Suited to Address each**

| Primary Health Care elements | Policy* | Gap | Level of gap existence |
|---|---|---|---|
| **Education concerning prevailing health problems and the methods of preventing and controlling them** | • NHSWPP<br>• National Health promotion Policy<br>• National Human Resource for Health Policy | • Inadequate human resource<br>• Inadequate technical support<br>• Inadequate community representation | • Policy and Implementation levels |
| **Promotion of food supply and proper nutrition** | • NHSWPP<br>• Nutrition Policy<br>• National health promotion policy | • Inadequate intersectoral collaboration | • Implementation |

| | | | |
|---|---|---|---|
| | • Community Health Policy | | |
| **Adequate supply of safe water and basic sanitation** | • NHSWPP<br>• National Health Promotion Policy<br>• Community Health Policy | • Inadequate intersectoral collaboration | • Implementation |
| **Maternal and child health, including family planning** | • NHSWPP<br>• Maternal and Newborn Health policy<br>• Child Health policy | • Lacks a clear strategic approach for inclusion of men in family planning<br>• Lack of a clear and comprehensive strategic approach on post-abortion care services | • Policy and implementation levels |
| **Immunization against the major infectious diseases** | • NHSWPP<br>• Maternal and Newborn Health policy<br>• Child Health Policy | • No gap identified | |
| **Prevention and control of locally endemic diseases** | • NHSWPP<br>• BHPS<br>• EPHS<br>• National Investment plan<br>• National Financing Policy<br>• National Human Resource Policy | • Inadequate human resource for health<br>• Inequitable distribution of health facilities and trained personnel | • Implementation |
| **Appropriate treatment of common diseases and injuries** | • NHSWPP<br>• BPHS<br>• EPHS<br>• National Investment Policy<br>• National Health Financing Policy | • Lack of adequate monitoring and supervision of the BPHS and EPHS | • Implementation |
| **Provision of essential drugs** | • NHSWPP<br>• National Drug Policy<br>• National Health Financing Policy<br>• National Investment plan | • Lack of a clear strategic approach to guide the updating of the Essential Drugs List (EDL)<br>• Inadequate revision of policy document | • Policy and Implementation |

***Policy documents directly related to meeting the correlated PHC element**

# 4.0 Discussion

The intent of this paper was to examine the current National Health and Social Welfare Policy and Plan (NHSWPP) and other PHC-related policy documents to identify along the full continuum of the policies, modalities and activities in place on PHC; and analyze how these fitted into the global objectives of a primary health care approach to health service provision. It was expected that all the complementary policy documents to the NHSWPP would conform to the general principles of PHC provision as the overarching NHSWPP and include definitive PHC objectives, with clear-cut strategic plans to accomplish this. What was found instead was that several of the documents had parallel objectives of improving the general health of the population, often without a convergence point on implementation as the overarching NHSWPP. Only the Basic and Essential Packages of Health Service documents and the National Community Health Services policy overtly mentioned PHC and its guiding principles and had accompanying PHC implementation plans.

Findings generated from utilization of the conceptual framework are largely in consonance with findings of the PHC approach implementation across sub-Saharan Africa. In Liberia, like many sub-Saharan African countries, PHC is recognized as the modality for achieving health for all and it is implicitly highlighted in most national health policies, including Liberia's NHSWPP (14)(10). There is a level of political commitment to PHC in Liberia as evidenced in the policy documents identified by successive governments' focus, nonetheless, a combination of factors has created some of the gaps that have marred the process. Limitations identified were mostly implementation related; lack of adequate human resource for health, inadequate resource allocation, inadequate intersectoral collaboration, inadequate technical and financial support and inequitable distribution of health workers. Liberia being a low resource country, most of the implementation gaps are almost to be expected since PHC itself as proposed at Alma-Ata is based on an assumption of good economic performance, which unfortunately is not the case in most sub-Sahara African counties, Liberia included (14). Using the Walt and Gilson policy analysis triangle conceptual framework, the context, actors, content and process involved in the NHSWPP and complementary policy documents development were examined.

## 4.1 Context

Regarding context, understanding and overcoming contextual barriers is crucial to effective implementation of any policy and a wide range of factors were identified to have been taken into consideration to achieve this. The main contextual factor within which the general health policy was developed, was a documented and identified need to achieve the MDGs health objectives by addressing the high maternal and child mortality, high burden of communicable diseases, the lack of equitable access to health, the poor nutritional status of the population, high out-of-pocket expenditure for health and the poor access to safe water and sanitation that existed in the country. PHC as a standalone factor was not implicitly referenced as an influencing factor but as this was not identified in other regional national health policy documents as a contextual factor of consideration, it therefore seemed to be a governing norm and was recognized as such. However other drivers could have also weighed in on the considerations made, such as the availability of donor funding and incorporation of donors' priorities, as is the situation in most developing health care systems which are donor dependent. Nonetheless, donor funding was not identified as such. One study gauging factors influencing health policy entrepreneurs in West Africa found that donor funding and

international pressure were the least ranked considerations for such individuals with personal capitals(67). The same however cannot be expected of a public institution like the Liberian government, emerging from a civil war with a poor economy and competing priorities for highly constrained public budgets. The government being incapacitated to adequately invest in its health sector relies heavily on donor funding(33). Therefore, donor funding might have been a highly ranked factor had such ranking been documented. Findings from Pakistan and Cambodia, two LMICs, showed the huge influence and nature of donors on national health policy processes in LMICs, including an influence on context, hence substantiating the earlier assertion made(68). Although the geo-political situations in these two countries differ from Liberia, they share a similar economic bearing which makes external validity of the study results applicable to Liberia.

Additionally, based on the four system categorization of contextual factors (47), only three categories were identified; Structural, Cultural and Global/international which respectively correspond to(i) factors least susceptible to change, at least in a short term; (ii)factors associated with cultures and traditions; and (iii) factors influenced by the global/international occurrences and dynamics. Situational factors, the fourth factor, which are transient factors such as civil conflicts and natural disasters was not identified. Mention was made though of the lingering effects of the civil conflict a few years earlier, especially on health indicators. A striking observation in the situational analysis of the present National Health Policy of Ghana, a sub-Saharan, low-middle-income African country, was the issue of Unequal Gender relations, a pertinent Cultural factor(64). This was not identified in the NHSWPP as an issue that was factored in by policymakers when prioritizing the policies that would govern PHC in Liberia. While gender equity issues were considered a component of the guiding principles of the national health policy, it was not articulated as a social problem directing policy prioritization. Yet gender inequity is an issue that exist in the country and has a documented impact on health seeking behavior and the overall MMR(24). In Liberia, only 54% of females are literate compared to 77% of males; 54.6% of female headed households face food insecurity compared to 49.9% of male headed households and among those formally employed, females earn far less than their males counterparts(22). This therefore clearly illustrates the issue of gender inequity that should have been a paramount consideration, especially for a country embracing the PHC approach, which is grounded on a right-based foundation.

## 4.2 Actors

In terms of actors, a broad range of local and international stakeholders, both specified and often unspecified, were identified. It is crucial to create a nurturing environment that allows such a complex mix of actors representing a full spectrum of interests and agendas in such public policy processes. For any system, more so those in low-and-middle-income countries, such a diversity helps to ensure transparency, quality and effectiveness of the policy, as well as fostering the establishment of legitimacy of said policy. The identification of actors representing both national and international interests in the general health policy document and several of the supporting PHC policies is indicative of some level of adherence to good practices. Actors involvement were identified as either in a financial or technical capacity and for most international stakeholders, both capacities. As is often the case in most policy processes, there is usually an asymmetry in the influence/power that is wielded among actors

and one study found that this asymmetry is even more pronounced between donors and domestic health policy actors in LMICs. The study, which was conducted in two aid-dependent LMICs found that donors influences are exerted at different stages of the health policy process; control of financial resources was commonly associated with priority setting and policy implementation; technical expertise with the policy formulation stage(68). The implementation and evaluation stages were influenced by an ability to control indirect financial and political incentives or direct control of financial resources(68). While these results might hold true in Liberia as well from personal experience, they were not explicitly recorded and therefore not identified. However, an additional nuance also observed from personal experience is that these international actors/stakeholders, who are in most cases implementation partners of vertical programs, create their own policies and standards to govern their programs. These often then run parallel to the general public policies. This thereby inadvertently undermines the effectiveness of established public policies and the local system's ability to provide quality PHC services.

Of the twelve documents reviewed also, documented evidence of community (end users, civil society groups, religious organizations etc.) representation as key stakeholders in the process was identified in only three of the policy papers. Additionally, representation of professional councils/experts was identified in only four. The significance of the community and professional bodies in the health policy development process has been recognized and advocated for in the international health arena for many years, particularly in PHC(5). Professional bodies for instance are meant to carry-out several key functions including accreditation of service providers and facilities and regulation of standards of procedures to promote quality assurance. In the policy development process, while they do not directly make the policies, they provide key technical guidance as well as advocacy for service providers and patients' interests, all of which can have an influence on the policy process. The importance of this role cannot be overemphasized especially in a low resourced health system such as Liberia. The WHO advocates that meaningful engagement with a board range of actors, including professional bodies, through a participatory process, is required in the governance and support of policy frameworks integrating PHC into the broader health system context(5) . Anecdotally though, in Liberia where shortage of health workers exists, many individuals on the boards of professional councils are also working in some capacity at the Ministry of Health. This presents a conflict of interest and hinders the neutrality that professional associations/councils are meant to maintain from the government to effectively provide expertise opinion on policy priorities identification and advocacy. It even leads to fragmentations within councils and undermines the purpose of the bodies.

## 4.3 Content

For content analysis, only three of the complementary documents overtly addressed PHC, along with the overarching NHSWPP. Strategies for PHC service provisions were identified in the strategic plans of these policy documents however, explicit outline of plans for several key policy options were lacking; user fees suspension being one of the most important. With the introduction of the BPHS in 2007, user fees suspension for basic PHC services was introduced and remains in place to date. This exemption underpins and is intricately woven into the PHC approach in Liberia (10). This policy option is one that has been implemented in many LMICs with varied incentives for institution. In Uganda, abolition of user fees was passed

in 2001 by a presidential directive during the presidential election campaign period, probably in a bid to garner votes for reelection(63), highlighting the strong linkage between politics and public policies and the assertion that "politics cannot be divorced from health policy"(47). On the other end, suspension of user fees in Liberia was done to improve the health and social welfare status and promote equity in access to health in a post-conflict setting; by averting catastrophic expenditure for health of a population already improvised by civil conflict(10).

Like in most settings where this policy option has been adopted though, it falls short of full achievement of the intended objectives and several inconsistencies emerging from the NHSWPP were identified for this occurrence. (i) A lack of clear definition of services to be included- the NHSWPP refers to the services affected by user fees suspension as "priority services" without an explicit explanation of what they are(11). This ambiguity causes implementation difficulties at the service delivery end. Personal experience has shown that at the health facility and clinic levels, services exempted from fees are more readily clarified and easy to identify, since they are basic/essential services at the primary care level. However, the line of demarcation becomes progressively obliterated at higher levels, leaving service providers at the hospital level in most instance undecided about what services to be charged. This causes heterogeneity in the implementation of the policy and inequity in utilization; (ii) Lack of explicit categorization of vulnerable groups -an aim of the policy is to target certain "vulnerable groups" to encourage uptake of services(11). Like in Ghana where exemption of health service fees for some "categories" of users was unsuccessfully implemented because, among other factors, service providers had difficulties in the identification of some of the exempted categories(50); the interpretation and application of the fee exemption to the labeled vulnerable group in Liberia is being left largely to service providers; (iii) Inadequate monitoring system- the MoHSW possesses limited technical capacity to effectively monitor this policy implementation. As such, there is high occurrences of indirect out of pocket charges for services that should have otherwise been free(10). This creates an environment for corruption and an unintended negative effect of limiting access to PHC services because of perceived cost; and (iv) Poor gatekeeping system- Patients are known to frequently self-refer at levels inconsistent with their health needs due to a number of factors at the peripheral levels including frequent stock out of essential medications(11). Due to poor referral and gatekeeping systems, this exposes patients presenting at hospital levels to the probability of being charged for services that are otherwise free, since at higher levels demarcation of fee-exempted services is not easily delineated always.

One of the paramount objectives for user-fees exemption was to protect the population from the high out of pocket expenditure for health that existed following the civil conflict(10). While the trend in out-of-pocket expenditure as a percentage of current health expenditure is significantly decreased since 2007 and the initiation of the user fee exemption policy, 47.2% in 2016 compared to 66.2% in 2007, it remains noticeably higher than the average sub-Saharan Africa value of 36.7% (23). Although a definite causal relation between user fees exemption and the percentage of out of pocket expenditure cannot be assumed, as many other factors must be taken into consideration, this trend still leaves room to ponder the effects of the lack of clearly outlined policy implementation plans on the long-term sustainability of this policy option or any other policy option affected by policy ambiguity.

## 4.4 Process

A wide range of policy processes was observed in this policy review, including such approaches as a top-down, bottom-up, participatory and consultative engagements with stakeholders. Health policy processes are generally theoretically broken up into four stages;(i) problem identification and issue recognition- which explores how issues are included or excluded from the policy agenda; (ii) policy formulation- which explores the actors, their interaction, power dynamics and how policy decisions are arrived at; (iii) policy implementation-the actualization of the policy and (iv) policy evaluation-identifies what occurs after a policy is enacted, how it is monitored(47).

Many studies on health policies in low- and middle-income countries have concluded that the first two stages are mostly implemented well, while distinct shifts and disparities with high income countries policy development processes become more evident in the latter two stages. One study from Ghana found that contextual factors such as political ideologies, economic crises, election year, change in the government and international agenda were among issues that directed policymakers in the decision for maternal fees exemption(69). This is considered the 'top-down' approach, in response to national priorities. Similarly, findings from the policies reviewed showed that policy actors of the general NHSWPP and other policy documents in Liberia took into consideration the situational analysis of the country, incorporating those into the decision making and eventual policy development process. However, in addition to this, the 'bottom-up' approach, in response to the needs of stakeholders, was also identified. The agendas of international donors, as stakeholders were found to have been considered.

Nonetheless, optimal community participation as a relevant stakeholder whose views were to be taken into consideration, the bedrock of the Primary Health Care approach, was inadequately identified. This has detrimental consequences for the subsequent implementation and evaluation stages. Full community participation allows for better understanding of policy options, allows for better appreciation by the community, of the government's constraints and hence legitimizes whatever policy is eventually crafted. Bottom-up approaches, generated by and through the community are generally considered as more effective than top-down approaches where modes of engagement are mandated by external funding initiatives mostly(5).

At the policy evaluation stage, the Ministry of Health was identified as the main agency carrying out monitoring and evaluation of the PHC policy implementation. Several other unspecified partners were also mentioned. However, the degree to which monitoring is comprehensively carried out at all levels, from the top central level, to the bottom community level was unclear. Considering the Ministry of Health's weak technical capacity and the poor Health Management Information System (HMIS), personal experiences have shown that reliable data collection is quite scanty and where available, they are often not acted upon. Problems found associated with effective monitoring from a study on Botswana, a LMIC are almost similarly shared in Liberia as well. These included (i) untrained staffs in the research and statistical units, (ii) resignation or transfer of relatively well-trained personnel, (iii) and shortage of data management facilities at the facility, district and national levels(15).

In addition, only the National Community Health Services policy listed the community as partners in the evaluation process. The community was noticeably omitted in the NHSWPP

and the other policy documents in this regard. A high quality of care is essential for building trust in the community and for ensuring the sustainability of the health system. Information on the quality of care can best be generated through periodic monitoring and evaluation of PHC activities, that incorporates the end users of services for generation of feedback on the actual implementation process and impact. Regular feedbacks from the community equips the system with the necessary information to learn, adapt, identify and address unintended consequences of policies implementations. However, the community was not identified as a partner in the monitoring and evaluation of the implementation phase of the policies and this finding was also noted in the national health policy documents of some LMICs(64)(65)(66). A possible explanation for this is that the challenge posed to community participation in the monitoring and evaluation processes is, at the community level, there is largely a lack of technical capacity to fully understand the indicators that need to be monitored. Nonetheless, if people/communities are actively engaged in problem identification, they gain better insights of such problems and are therefore better equip to evaluate and monitor activities addressing these problems.

Similarly, considering the multisectoral component of most of the essential PHC elements that need to be fulfilled by policy implementation, a more concerted, aligned intersectoral engagement is required in the monitoring and evaluation stage as well. The Ministry of Health is not technically, financially or legally capable of carrying out monitoring of services not directly within the scope of the health sector. Yet limited evidence of intersectoral involvement in the monitoring and evaluation process was identified in the policy documents reviewed. Intersectoral collaboration is one of the pillars of PHC and a strong recommendation for a successful PHC approach. While limited evidence could be found elsewhere of the extension of this collaboration beyond the implementation of PHC programs, evidence of the establishment and existence of intersectoral committees and teams to function at different levels of the health system in some sub-Saharan African countries was identified(15). Such committees could function in the monitoring of multisectoral PHC projects, if such roles were clearly spelled out in policy documents. Among the many constraints hindering intersectoral collaboration in PHC identified in one study, a less supportive policy context was found to be one of the most important(70).

### 4.5 Direct Policy-related gaps

While implementation gaps are acknowledged, the focus of this paper was to identify gaps within the NHSWPP and PHC-related policy documents themselves. As such three major policy related gaps were identified.

The lack of explicit inclusion of the community as an actor in the formulation process of several of the key policy papers, a direct policy-related gap identified, raises major concerns about the content and implementation of PHC in Liberia. Community participation, among other principles, is a major focus of the PHC strategy(2) and it extends beyond the availability of Community Health Workers and a community health teams, which were observed in some of the reviewed policy documents. This participation also more critically encompasses the active engagement of the community in identifying and making decisions about their health priorities; both at the subnational and national levels. Several explanations and plausible reasons for this exclusion may exist; (i) The overarching health policy lacks an explicit definition of what/whom the community is. This ambiguity sets the tone for who may have

been considered the community and therefore mentioned as stakeholders. This situation is not uniquely a Liberian situation but also has been identified as one of the barriers to full community participation across most health systems worldwide. In health, the *community* is often defined as people living within a specific geographic border, but one paper, citing an earlier study from 2001 highlighted that communities could also be people with shared goals or believes, people who share a common culture or value system, and people who are defined by planners as having common interests(2); (ii) Community participation is context-specific and therefore subject to heterogeneity in its interpretation and application. While several frameworks exist for community participation, identification and evaluation, complexities in finding and applying an appropriate framework for a given context can present a major challenge (2) and (iii) A large array of health indicators employ community participation as a strategy, as such the probability of attaching specific recognition for a given situation may be left to assumption (15).

Another policy-related gap identified was the lack of timely revision of some policy documents to enable the reflection of the current state of health and social welfare issues. The National Drug Policy for example was promulgated in 2001 and remines the governing document for drug management across the country. With epidemiological and demographic transitions occurring across sub-Saharan Africa, it's difficult to ensure efficiency and effectiveness with such policies that are outdated. For instance, the current Drug Policy lacks a clear strategic approach on updating of the country's essential drug list. As a result, the present essential drug list of Liberia contains no medication for the management of chronic Hepatitis B; even though WHO's essential list of drugs currently has Tenofovir disoproxil fumarate, a drug available in Liberia, listed as a recommendation(71). While there is not a generalized guideline on the frequency of policy revisions and it is mostly institution specific, it is generally accepted that policies in high-risk settings, such as healthcare, require frequent updates. The WHO regional office for Africa (AFRO) recommends the cycle of health policy revision to range from five to ten years, while strategic plans are recommended a five year revision cycle(72). PHC aside from being an actionable approach, is also a concept. Concepts are dynamic and subject to change based on ideologies, new realizations and evidence. Consequently, policies governing such concepts must remain relevant through frequent revisions.

Lastly, the lack of explicit PHC implementation plans in the strategic plans of many of the PHC related policy documents was identified as a direct policy related gap. Since the general health policy which is referenced by all other policy documents focuses on a PHC approach, definitive PHC implementation plans was expected. A study on Child and Adolescent Mental Health (CAMH) policy in South Africa similarly found that there was a lack of policy development and explicit implementation plans in most provincial/subnational health policy documents, even though the overarching national health policy which directed the scripting of these documents had such implementation plans. The study observed and concluded that such omissions could negatively impact service delivery for CAMH across the country(37). Likewise, while there is not a direct, linear cause and effect consequence documented by the preterition of explicit mention of PHC in the strategic plan of health policy documents, it can be deduced that such omissions could contribute to implementation gaps for PHC in Liberia. A lack of explicit implementation strategies creates the probability of having a disparity between what policy makers intended to achieve by a set policy, and what is being realized at the implementation level. An argument can further be made for this by the WHO's recommendation that calls for

stronger emphasis on PHC if the health related Sustainable Development Goals were to be successfully met in order to achieve Universal Health Coverage(5). This would require that policy documents are synchronized in their goals and strategic plans in achieving strong PHC outcomes.

### 4.6 Strengths and limitations

This paper presents the first opportunity, after the civil conflict in Liberia, to examine and analyze the Primary Health Care approach in relation to the policies presented in the National Health Policy and other PHC-related policy documents. This therefore positions this work in a critical place of capacitating future researches as a working document for information.

However, this study has potential limitations. External validity of the findings may not be practical in all settings as the post-conflict context of Liberia may contribute to a significant degree towards the implementation gaps and other findings identified. Similar findings may therefore not exist in another country without a similar contextual factor. In addition, even within the country (Liberia), because of differences in demography, resource allocation, health infrastructure distribution between counties, there is a possibility of the generation of different results between counties.

Also based on the nature of the study, a policy review which was dependent on publicly available policy documents only and on the study selection criteria of including only policy documents in alignment with the essential elements of PHC, a possibility exist of selection biases that could have impacted the results. However, efforts were made to include all current publicly available PHC-related policy documents and the findings were compared and contrasted, as best as possible, with national health policy documents and policy research papers from other countries with similar socio-economic context as Liberia; to ensure the validity of the results.

# 5.0 Conclusion

As a country that has emerged from a civil conflict, the aforementioned findings highlight the prominent focus that is placed on Primary Health Care in Liberia in a bid to improve the health and social welfare status of the population. This is evidenced by the central role the PHC approach is given in the overarching National Health and Social Welfare Policy and Plan. In consonance with international and regional health care agendas, the country through the NHSWPP and accompanying policy documents, is fostering an enabling environment to promote universal health coverage and achieve the Sustainable Development Goals for health. Nonetheless, twelve years on after the first post-conflict National Health Policy which laid out the framework for a PHC approach and eight years into the implementation of the current ten-year NHSWPP, much is still required to ensure the full and efficient implementation of PHC.

Despite a focus on PHC, with each essential element of PHC addressed by at least a portion of the policy, implementation has largely been less than optimal, sadly reflective of findings from many other sub-Saharan African countries. In addition to the many financial and technical constraints hindering the effective and efficient implementation of PHC in Liberia, the lack of explicit strategies on execution of PHC policies in several of the policy documents has left room for misinterpretations at the implementation level. If policies are implied and are not made explicit enough, they lose the essence of the guidance they are meant to provide and therefore would not work. User fees exemption policy, which strongly underpins the PHC approach in the country, for example has a large variation of implementations across the health system because of the lack of clear definition on some aspects of the application of the policy.

The NHSWPP in of itself is a bold document, with ambitious plans for the delivery of high quality and safe primary care which is critical to a PHC approach however it is not enough. Multisectoral policies, collaborations and actions, empowered people and communities, essential public health functions and efficient utilization of limited resources are also required. Together these components provide the mechanism to achieve the highest attainable standard of health and well-being for all. Community participation/engagement, a crucial component of the PHC strategy, at this point is merely perfunctory at most and lacking detailed outline on the modalities of engagement within the arching National Health Policy and some of the supporting policy documents. This precludes the purpose of the community's involvement and negates some of the important roles the community is meant to fulfill in a PHC approach. Several other key contextual factors, processes and content considerations have not been addressed adequately in the present policies, to ensure a PHC that is equitably, effectively, efficiently and accessibly provided. Capacity strengthening at the primary care level is still far from what is required. Huge discrepancies exist between policy contents and implementation. Effective implementation can be assured when a clearly spelled out and robust system that links goals and successive actions is created and utilized. Plans must be clearly defined and articulated with the necessary political, administrative, technical and financial resources made available to potentiate them.

In addition, the scope and reach of health policy documents go beyond being mere statute papers; they are also working papers that evolve with implementation and time and therefore require periodic revisions to reflect and mitigate emerging challenges and incorporate new evidences and experiences gained from implementation. With some of the policy papers reviewed being outdated, it comes as no surprise that they do not reverberate some critical current practices needed to address the health needs of the population and as such present limitations for primary health care implementation in the country.

Lastly though, it should be stated that the country, through its leaderships and political commitment to improving the health and social wellbeing of the people have made some noteworthy achievements in PHC over the years. For a post-conflict country, Liberia's Health Policy on PHC presents an excellent case study of a post-conflict state embracing the Alma-Ata principles to address the health needs of its people; building on an almost entirely reconstructed health structure. However, there is equally room to learn, not only from the experiences gained to date, but to also emulate experiences from other LMICs where the approach has been more successful. Sri Lanka for instances spends far less on health, compared to Liberia, has a larger population than Liberia and yet it has better health outcomes than Liberia. This point outs that financial resources alone are inadequate to guarantee success in PHC. Good policies and efficient utilization of resources are also equally required to produce positive results. That said, further research is needed to elucidate more on some of the questions and findings raised in this paper.

## 5.1 Recommendation

### 5.1.1 Recommendations directed at the Ministry of Health

1. That the Ministry of Health and Social Welfare, along with relevant stakeholders, conduct timely revision of outdated PHC policy documents, cognizant of the policy cycle as recommended by WHO. It is only through revisions and updates that direct policy related gaps negatively impacting implementation can be identified and addressed in a timely manner.

2. The Ministry of Health needs to do more in terms of fostering effective community participation. As such, a clear framework on the identification, involvement and evaluation of community engagement needs to be identified and adopted. Clearly defined mechanisms should be instituted to ensure that community participation, especially in the policy development process, goes beyond just a fulfillment of international requirements to that of a practical, actualized involvement. The Ministry of Health should direct and monitor the County Health Teams in the establishment of boards and committees between health facilities and community structures, which would go a long way in building and promoting this engagement. Involvement needs to be strengthened also especially in the monitoring and evaluation stages of policies implementation through capacity building.

3. That the Ministry of Health fosters a more comprehensive intersectoral collaboration with other government ministerial stakeholders outside of health. More needs to be done to ensure alignment of inter-ministerial policies that address the PHC approach with that of the National Health Policy. The collaboration between the health sector and other sectors needs to be properly defined with appropriate, well defined mechanisms for this collaboration clearly spelled out, especially at the peripheral/primary levels.

4. Financial allocation for PHC should be made explicit from the general health care expenditure as is the case in other countries. This would allow for better management and monitoring of funds. In addition, greater efforts need to be asserted for efficient utilization and management of meager funds.

### 5.1.2 Recommendations directed at Policy Makers

5. Policy makers need to ensure that all health policies related to the Primary Health Care approach are in alignment with the guiding general National Health Policy. This can be achieved by inclusion of very explicit PHC policies; accompanied by specific, measurable, achievable, relevant and time bound strategic plans and actions.

6. That the user fee exemption policy, one of the ill-defined policies, is revisited by an appropriate evaluation team set up by Ministry of Health and other stakeholders involved in the policy process. If a continuance of the policy is decided, that a robust

and effective monitoring system is set up to complement its implementation, thereby ensuring that equity and fairness in improving coverage for the poor and vulnerable is achieved.

7. Policy makers should ensure the expansion and support of the role of professional bodies in the policy development process as they play crucial regulatory and advocacy roles. There should be clear articulation of their involvement and mechanisms need to be adopted to ensure the neutrality of stakeholders on professional boards from that of the Ministry of Health.

8. Future policymakers need to consider a boarder contextual environment in terms of identification and prioritization of needs. Gender inequality issues in particular need to be clearly articulated within policy documents as it is an issue of far reaching effects. Strategic plans to address this require explicit outlined actions in all health policies.

### 5.1.3 Recommendations directed at the Community

9. The community, through Community Health Workers, civil society groups and religious groups need to advocate for greater involvement in the formulation, planning and implementation of health policies that are reflective of their needs and concerns. This advocacy can be at the national, subnational and local levels

### 5.1.4 Recommendations directed at Researchers

10. Future researchers need to conduct further exploratory qualitative research, especially at the community level to examine in-depth the limitations involved with community engagement in the policy process, to identify suitable means to address such gaps.

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