Primary Health Care Approach in Liberia

Subjects: Health Care Sciences & Services

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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. Primary health care (PHC), a holistic approach to health, was proposed at Alma-Ata and has been the guiding principle for the health system rebuilding of Liberia, a post-conflict, low-income country.

primary health care | health policy | policy analysis | Liberia

1. Introduction

Remarkable achievements have been made on the global scene since the Alma-Ata declaration. Notwithstanding, globally, the PHC (Primary health care) approach has undergone several evolutions that have necessitated policy reforms in some instances [1]. Global economic, political, environmental, and social situations have shifted the focus of 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, the emergence of outbreaks, wars, and occasionally the lack of governance [2]. To mitigate the impact of these limitations, some LMICs, such as Tanzania, for instance, have adopted a reform to its PHC policy that allows contracting non-state providers (NSPs) for the delivery of PHC services [1]. Others such as Sri Lanka, a middle-income country that has achieved outstanding health indicators and is deemed to be a success story in PHC implementation, adopted a selective PHC approach that is restricted to addressing the most serious health problems in a community, as opposed to the comprehensive PHC model recommended at Alma-Ata [3].

In Liberia, a low income, West African country, following 14 years of civil crisis that ended in 2003 and the subsequent destabilization of the healthcare system, the Ministry of Health and Social Welfare (MOHSW) formulated the post-conflict National Health and Social Welfare Policy and Plan (NHSWPP) of 2007–2011 [4]. The bedrock of the policy was a PHC approach, with a complimentary Basic Package of Health Services (BPHS) [5], meant to provide essential care at every level of the health system. Cardinal to this policy was making PHC services at every level free of user fees to increase access to high-quality healthcare [4].

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 (MDGs) targets. Against this backdrop, the present NHSWPP of 2011–2021 was developed and adopted [6]. 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 additional packages were to

expand on the services covered by the BPHS, to include the recognition of the broader social determinants of health such as diet, lifestyle, employment and so on, to improve PHC coverage [6][7][8].

2. Overview of Liberia's Health System

The civil conflict of 1989–2003 resulted in a destabilization of 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 [9]. The first post-war Demographic and Health Survey (DHS) of 2007 recorded an infant mortality rate of 71/1000 live births, one out of nine children died before their fifth birthday, 61% 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 live births. Malaria was the leading cause of death, accounting for 40% of mortalities in hospital settings [9].

The healthcare system has since transitioned from crisis response to system rebuilding, but in 2014, Liberia 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 PHC 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 [10].

Post-Ebola, the country's healthcare system, which is organized on a decentralized, three-tier service provision model, is being revitalized. Autonomy for the 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 [11]. Emergency response capacity is being strengthened through an investment plan to make the system more resilient [12]. However, the health sector in the country is largely dominated by the private sector. The private for-profit (PFP) and not-for-profit (NFP) subsectors are estimated to provide 47% and approximately 30% respectively of health services [12].

The current NHSWPP is focused on a PHC approach strategy through service decentralization, provision of universal coverage through sets of predetermined limited entitlements encompassing the PHC essential elements within the direct purview of the Ministry of Health, and through intersectoral collaboration with other stakeholders for provision of other indirect services. Despite some gains from the policy implementation, certain aspects of the policy remain ambiguous and lack a clear strategic approach on implementation that results in a disconnect between what the policy aims to address and what is being realized in PHC in Liberia [13]. Capacity limitations and the failure to incorporate salient roles that align the policy with global trends inadvertently weaken implementation and adversely impact the effectiveness of the approach. As such, Liberia lacks in every aspect of the essential elements of PHC [14][15][16][17][18].

3. A Policy Analysis of the Primary Health Care Approach in Liberia

Findings generated from the utilization of the conceptual framework are largely in consonance with PHC approach implementation across sub-Sahara Africa (SSA). In Liberia, similar to many SSA countries, PHC is recognized as the modality for achieving health for all, and it is implicitly highlighted in most national health policies [9][13].

The main contextual factor within which the overarching NHSWPP was developed was the 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 OOP for health and the poor access to safe water and sanitation that existed in the country [6].

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 that are donor-dependent. Nonetheless, donor funding was not identified as such. However, for a public institution such as the Liberian government, emerging from a civil war with a poor economy and competing priorities for highly constrained public budgets, and which relies heavily on donor funding [19], donor funding might have been a highly ranked factor had such ranking been documented. Findings from Pakistan and Cambodia showed the huge influence and nature of donors on national health policy processes in LMICs [20].

Additionally, based on the four-system categorization of contextual factors [21], only three categories were identified: structural, cultural, and global/international. Situational factors, the fourth factor, which are transient factors such as civil conflicts and natural disasters, was not identified.

A striking observation in the situational analysis of the present National Health Policy of Ghana was the issue of unequal gender relations, a pertinent cultural factor [19]. This was not identified in Liberia's health policy as an issue factored in by policymakers. While gender equity issues were considered a component of the guiding principles of the NHSWPP, it was not articulated as a social problem directing policy prioritization. Yet gender inequity is an issue that exists in Liberia and has a documented impact on health-seeking behavior and the overall MMR [22]. 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 [23]. This 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.

A broad range of local and international stakeholders was identified. It is crucial to create an environment that allows a complex mix of actors representing a full spectrum of interests and agendas in public policy processes. Actors' involvements 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 an asymmetry in the influence that is wielded among actors, and it was found that this asymmetry is even more pronounced between donors and domestic health policy actors in LMICs. It was 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, while technical expertise was associated with the policy formulation stage [20]. While these results might hold in Liberia, they were not identified.

Of the twelve documents reviewed, documented evidence of the community 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, particularly in PHC [24].

Professional bodies provide technical guidance as well as advocacy for service providers' and patients' interests in the policy development process, and 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 broad 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 [24].

Only three of the complementary documents overtly addressed PHC as the overarching NHSWPP. Strategies for PHC service provisions were identified in the strategic plans of these documents; however, the explicit outline of plans for several key policy options was lacking, with 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 the PHC approach in Liberia [5]. This policy option has been implemented in many LMICs with varied incentives for the institution. In Liberia, the policy option was adopted to improve the health and social welfare status and promote equity in access to health in a post-conflict setting; by averting high OOP expenditure for the health of a population already improvised by civil conflict [5].

Like in most settings where this policy option has been adopted, 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 [6]. This ambiguity causes implementation difficulties at the service delivery end, which leads to heterogeneity in the implementation of the policy and inequity in utilization; (ii) Lack of explicit categorization of vulnerable groups—the policy aims to target certain "vulnerable groups" to encourage uptake of services [6]. For example, 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 the exempted categories [25], the interpretation and application of the fee exemption to the labeled vulnerable groups in Liberia is being left largely to service providers; (iii) Inadequate monitoring system for policy implementation. As such, there are high occurrences of indirect OOP charges for services that should otherwise be free [5]. 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 several factors at the peripheral levels including frequent stock out of essential medications [6].

While the trend in OOP expenditure as a percentage of current health expenditure has significantly decreased since 2007, with 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 SSA value of 36.7% [26].

A wide range of policy processes was identified, including such approaches as top-down, bottom-up, participatory, and consultative engagements with stakeholders. Health policy processes are theoretically broken up into four stages;(i) problem identification and issue recognition; (ii) policy formulation; (iii) policy implementation; and (iv) policy evaluation [21].

Many studies on health policies in LMICs have concluded that the first two stages are relatively well implemented, while the latter two are more problematic. A Ghanaian study found that contextual factors such as political ideologies, economic crises, an election year, change in the government, and international agenda were among issues that directed policymakers in the decision for maternal fees exemption [27]. This is considered the ‘top-down’ approach, in response to national priorities. Similarly, findings showed that policy actors of the 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, the bottom-up approach, in response to the needs of stakeholders, was also identified.

Optimal community participation as a relevant stakeholder, the bedrock of the PHC approach, was inadequately identified. This has detrimental consequences for the subsequent implementation and evaluation stages. Full community participation allows for a better understanding of policy options, better appreciation by the community of the government’s constraints and hence legitimizes whatever policy is eventually crafted. Bottom-up approaches, generated through the community, are generally considered more effective than top-down approaches, where modes of engagement are mandated by external funding initiatives mostly [24].

At the policy evaluation stage, the MoHSW was identified as responsible for monitoring and evaluation (M&E). 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. Factors impeding effective M&E in other SSA countries such as untrained staffs in the research and statistical units and shortage of data management facilities at the facility, district, and national levels could similarly be problematic in Liberia considering the MoHSW’s weak technical capacity and the poor health management information system (HMIS) [28].

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. 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 M&E of PHC activities that incorporate the end-users of services for the generation of feedback on the actual implementation process and

impact. A possible explanation for this omission is that, at the community level, there is a lack of technical capacity to fully understand the indicators which are to be monitored. Nonetheless, if communities are actively engaged in problem identification, they gain better insights and are therefore better equipped 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 M&E stage as well. Yet limited evidence of intersectoral involvement in the M&E processes was identified. While limited evidence could be found elsewhere of this collaboration, beyond the implementation of PHC programs, evidence of the establishment of intersectoral committees and teams to function at different levels of the health system in some SSA countries was identified [28]. Such committees could function in the monitoring of multisectoral PHC projects if such roles were spelled out in policy documents.

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 [29], and it extends beyond the availability of Community Health Workers and community health teams, 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.

The lack of timely revision of some policy documents was another gap identified. The National Drug Policy, for example, was promulgated in 2001 and remains the governing document for drug management across the country. The current drug policy, for instance, lacks a clear strategic approach to updating the country's essential drug lists. As a result, the present essential drug lists of Liberia contain no medication for the management of chronic Hepatitis B; even though WHO's essential list of drugs currently lists Tenofovir disoproxil fumarate, a drug available in Liberia, as a recommendation [30]. While there is no guideline on the frequency of policy revisions and it is mostly institution-specific, 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 [31][32].

Lastly, the lack of explicit PHC implementation plans in the strategic plans of many of the policy documents was identified as a direct policy-related gap. Since the overarching national health policy focuses on a PHC approach, definitive PHC implementation plans were expected in other complementary documents. A lack of explicit implementation strategies creates the probability of having a disparity between what policymakers intended to achieve by a set policy and what is being realized at the implementation level.

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