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Review

A Policy Analysis of the Primary Health Care Approach in Liberia

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Abstract: Primary health care (PHC), a holistic approach to health, was proposed at Alma-Ata in 1978 and has been the guiding principle for the health system rebuilding of Liberia, a post-conflict, low-income country. However, since its adoption, health care delivery and outcomes remain less than optimal. A comprehensive literature review of all current health policy documents in Liberia, with a focus on the PHC approach, was identified and analyzed using the Walt and Gilson policy framework. Three major 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 an explicit PHC strategic approach in the implementation plans of multiple policy documents. The poor health outcomes in Liberia, therefore, are indicative of problems with PHC that go beyond implementation to the policy level.

Keywords: primary health care; health policy; policy analysis; Liberia

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1. 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 [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.

Remarkable achievements have been made on the global scene since the Alma-Ata declaration. Notwithstanding, globally, the PHC approach has undergone several evolutions that have necessitated policy reforms in some instances [2]. 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 [3]. 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 [2]. 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 [4].

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 [5]. The bedrock of the policy was a PHC approach, with a complimentary Basic Package of Health Services (BPHS) [6], 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 [5].

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 [7]. 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, etc., to improve PHC coverage [7–9].

However, Liberia's primary health care delivery continues to face several challenges, despite several years of PHC implementation, especially in rural settings. This paper, therefore, analyzes the effectiveness of the policy to date in meeting the PHC objectives to identify possible gaps that can be addressed to improve PHC provision in Liberia.

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 [10]. 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 [10].

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 [11].

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 [12]. Emergency response capacity is being strengthened through an investment plan to make the system more resilient [13]. 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 [13].

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 [14]. 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 [15–19]. This paper aimed to critically analyze the

policy that governs the primary health care approach in Liberia to explore its alignment with addressing the current general state of health of the population.

2. Materials and Methods

This paper is a policy review of national policy documents and articles relating to the PHC approach in Liberia. A comprehensive web-based search was performed using the following search engines: Google and Google Scholar. Other online databases sourced were PubMed and Mendeley Library, employing different combinations of the keywords, "Primary Health Care", "Primary Health Care Policy", "Liberia", "Primary Health Care Approach", "Health Policy Analysis", "sub-Saharan Africa" and "Low-And-Middle-Income Countries". All potentially relevant information was downloaded for analysis. Current national, international, peer-reviewed, and grey literature were sourced, then snowballing was employed to include key publications found older than the selected timeframe (1 January 2001 to August 2019). The search was designed for the latest versions of all national health policy documents as well as relevant supporting articles to be accessed electronically. Only English language documents were considered for analysis and communication of this research findings.

The policy documents included in this analysis ranged from 2000 to 2020 (Table 1). 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) PHC essential elements. It must be acknowledged that the search conducted was limited only to electronically available documents. Documents not publicly available and those not adopted formally were not included for analysis. Consequently, the possibility exists that some current, up-to-date, relevant documents may not have been included in this paper.

Table 1. Summary of policy documents reviewed and year.

Policy Document	Year
National Drug Policy,	2001
National Health Policy and Plan	2007–2011
Basic Package of Health and Social Services,	2008
National Sexual and Reproductive Health Policy,	2010
Liberia National Community Health Services Policy	2011
Essential Package of Health Services	2011
National Health and Social Welfare Policy and Plan	2011–2021
National Human Resources Policy and Plan for Health and Social Welfare	2011–2021
National Health and Social Welfare Financing Policy and Plan,	2011–2021
Investment Plan for Building a Resilient Health System in Liberia,	2015–2021
National Policy and Strategic Plan on Health Promotion	2016–2021

The Walt and Gilson health policy analysis framework (Figure 1) was used for the extraction and analysis of all identified policy documents. The framework focuses on several key factors (Actors, Context, Process, and Content) and the complex interactions/interrelations between these factors within a given context [20,21]. The 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. 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, for 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 [20,21].

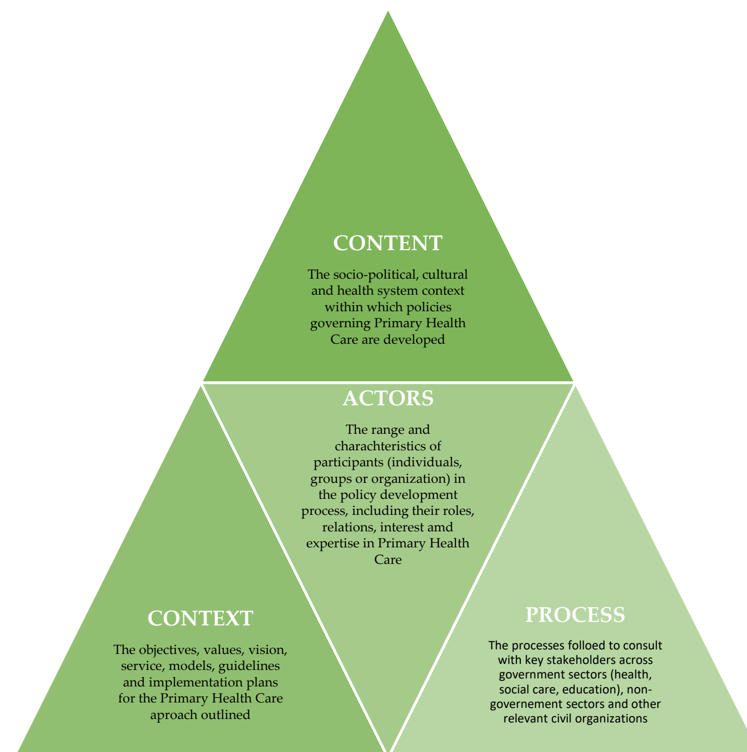

Figure 1. The Walt and Gilson Policy Triangle model (1994), adapted for the primary health care approach.

Context is the political, economic, social, and cultural factors, at the national and international level, 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 include 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 [20,21]. They could also be categorized as situational factors—mostly transient factors that are subject to change easily, such as 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. [20,21].

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

There were no limitations identified with the 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.

3. Results

Of the thirteen identified policy documents related to PHC, one was outdated, and therefore it is not being implemented currently and consequently was not considered for further analysis (Table 2). Of the remaining documents, two were found to have been drafted, and last revised over a decade but remain current operational policy papers.

In addition to an overarching National Health Policy, national drug, mental health, community health, and nutrition policies were common policy documents guiding PHC policy formulation and implementation that were identified in Liberia and therefore listed in (Table 1) [22–25].

Table 2. Policy documents identified, their status, level of adoption, and a short overview of each.

Policy Document	Status	Level of Adoption	Explanation of the Document
National Drug Policy, 2001 [26]	Current	National/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 Health Policy and Plan, 2007–2011 [27]	Outdated	National/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. Guided by the principles of PHC, Decentralization, Community Empowerment and Partnerships for Health.
National Nutrition policy, 2008 [28]	Current	National/subnational	Complements the NHSWPP and the Food Security and Nutrition strategy in supporting public actions to improve nutrition.
Liberia National Community Health Services Policy, 2011 [29]	Current	National/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 and Reproductive Health Policy, 2010 [30]	Current	National/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 Health and Social Welfare Policy and Plan, 2011–2021 [7]	Current	National/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. Guided by the principles of PHC, Decentralization, Community Empowerment and Partnerships for Health.
National Human Resources Policy and Plan for Health and Social Welfare 2011–2021 [31]	Current	National/subnational	Defines the vision for addressing the human resources 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 Health and Social Welfare Financing Policy and Plan, 2011–2021 [32]	Current	National/subnational	Ensures that services provided are affordable 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.
National Policy and Strategic Plan on Health Promotion 2016–2021 [33]	Current	National/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 [34]	Current	National/subnational	Defines the vision for mental health care that emphasizes community-based services, training of PHC providers in the recognition, prevention, and treatment of mental illnesses.
Complementary documents			
Basic Package of Health and Social Services, 2008 [35]	Current	National/subnational	Describes sets of standardized packages of services to be implemented at every level in the healthcare system.
Essential Package of Health Services, 2011 [8]	Current	National/subnational	Expands on the services provided in the BPHS and describes a standardized package of services to be implemented at every level in the health system.
Investment Plan for Building a Resilient Health System in Liberia, 2015 to 2021 [13]	Current	National/subnational	Complements the NHSWPP and outlines emergency response services and strategies, investment in system strengthening and capacity building.

The Basic Package of Health Services (BPHS), the Essential Package of Health Services (EPHS), 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 policy on PHC implementation. However, both the BPHS and EPHS were similarly identified in studies from other LMICs in terms of PHC papers, hence warranting their inclusion on the list.

3.1. Primary Health Care Policy

A stand-alone policy document on PHC in Liberia was not found. At the National level, however, the overarching NHSWPP (both the outdated and current versions) [5,7] was documented implicitly based on a comprehensive PHC approach that was identified. Several other supporting and complementary documents to the NHSWPP were also identified.

All the supporting documents included implementation plans to complement that of the NHSWPP. However, of the twelve documents, only five had explicitly outlined PHC strategic plans. The remaining seven policy/complementary papers lacked clear implementation plans on the PHC approach.

3.2. Policy Analysis using the Walt and Gilson Policy Triangle

3.2.1. The Context

Ten pertinent contextual factors were identified (Table 3). Determinants of the factors were varied but 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, poor access to safe water and sanitation and stigmatization against individuals with mental health illnesses.

In terms of the context categories, three broad categories were identified, structural factors, global factors, and cultural factors [36]. An important cultural factor: gender norms/inequity, was not identified in the NHSWPP. Additionally, situational factors such as leadership change and social unrest were not identified as factors shaping the policy.

Table 3. Key factors influencing the National Health Policy on the primary health care approach.

Categories	Context Factors	Description/Determinants of the Factors
Structural	The Socio-Economic	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
		A growing number of refugees from neighboring countries
	Morbidity and Mortality	High maternal mortality ratio
		The 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
		A growing number of target groups (e.g., Children, adolescents, prisoners, substance abusers, elderly, victims of disasters)
		Fragmentation in service delivery

Table 3. *Cont.*

Categories	Context Factors	Description/Determinants of the Factors
Structural	Resources	Insufficient human resources 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 (WHO, United Nations Children Funds (UNICEF), United States Agency for International Development (USAID) and the European Union (EU)) and national stakeholders, including other non-health governmental ministries and agencies, functioning in capacities ranging from financial to technical supports were identified (see Table 4).

Table 4. Key stakeholders/actors involved in formulation of policies on the primary health care approach.

Policy	Year	Stakeholders	Role	Local Health Care Providers *	Community Representation
National Drug Policy	2001	**International** - WHO, UN Agencies, Consortium of international NGOs, EU	Financial support		NA
		Local - Ministries of Health, Finance and Justice, National Port Authority, National Drug Service, John F. Kennedy Memorial Medical Center	Technical support	A.M. Dogliotti College of Medicine, School of Pharmacy, Pharmacy Board, Liberia Bar Association	
National Health Policy and Plan	2007–2011	**International** - UNICEF, UNFPA, USAID, World Bank, WHO, EU **Local** - MoHSW, MOE, MOPEA	Steering committee	NA	NA
		- WHO, UNICEF, UNFPA, EU, USAID	Financial Support		
		International - WHO, USAID, UNFPA, Johnson and Johnson **Local** - Several MOH and inter-sectorial staffs, County Health Teams, County Superintendents, County Development superintendents, Unspecified NGO partners	Technical Assistance		

Table 4. *Cont.*

Policy	Year	Stakeholders	Role	Local Health Care Providers *	Community Representation
National Nutrition Policy	2008	**International** - UNICEF, WFP **Local** - Technical Working Group; MoHSW	Financial and/or technical support	NA	NA
Basic Package of Health and Social Services	2008	**International** - UNICEF, UNDP, Clinton Foundation **Local** - MoHSW, Liberia Malaria Control Program, Several unidentified experts in different health fields	Technical support and/or otherwise unspecified	Mother Pattern College of Health Sciences and Laboratory Technicians Association	NA
National Sexual and Reproductive Health Policy	2010	**International** - Unspecified Non-Governmental Organizations (NGOs) and development partners **Local** - Reproductive Health Technical Committee (RHTC), MoHSW, Unspecified line ministries	Technical Assistance	Unspecified health institutions and professional bodies	NA
Liberia National Community Health Services Policy	2011	**International** - USAID, UNFPA, WHO, UNICEF, CHAI, IRC, Maternal Health Integrated Program, Child Fund, Africare Liberia, BRAC–Liberia, EQUIP Liberia **Local** - MoHSW	Technical Assistance	NA	NA
Essential Package of Health Services	2011	**International** - WHO, UNICEF, UNFPA, Carter Center, Merlin **Local** - MoHSW, National Tuberculosis and Leprosy Control Program, County Health Officers, Directors of national health programs	Technical support	NA	NA
National Health and Social Welfare Policy and Plan	2011–2021	**International** - Unspecified individuals and organizations **Local** - Unspecified individuals and organizations	Unspecified	NA	Unspecified community, civil society, and religious groups
National Health and Social Welfare Financing Policy and Plan	2011–2021	**International** - Unspecified individuals and organizations **Local** - MoHSW, Unspecified individuals and organizations	Unspecified	NA	Unspecified community and civil society representatives involved

Table 4. *Cont.*

Policy	Year	Stakeholders	Role	Local Health Care Providers *	Community Representation
National Human Resources Policy and Plan for Health and Social Welfare	2011–2021	**International** - Unspecified individuals and organizations **Local** - MoHSW, Unspecified individuals and organizations	Unspecified	NA	NA
Investment Plan for Building a Resilient Health System in Liberia	2015–2021	**International** - WHO, UNFPA, UNICEF, USAID, CDC **Local** - MoHSW	Technical assistance and support	NA	NA
National Policy and Strategic Plan on Health Promotion	2016–2021	**International** - WHO, UNICEF, USAID, UNFPA, CDC, USAID **Local** - MOE, Ministry of Youth and Sports, Ministry of Planning, Finance and Development, Ministry of Information, Cultural Affairs and Tourism, Environmental Protection Agency, National AIDS Commission, County Health Teams, Ministry of Health and Social Welfare	Financial and/or Technical Support	NA	Liberia Crusaders for Peace (LCP) Inter-Faith-Religious Council
Mental Health Policy and Strategic Plan for Liberia	2016–2021	**International** - WHO, UNICEF, Other unspecified International Non-Governmental Organization, International experts from several international universities, IMC **Local** - MOH, Ministry of Gender, Children and Social Protection, MOE, County Health Officers, Social Workers	Financial and/or Technical support	Mental Health Clinicians, Accreditation bodies	NA

Abbreviations: NA = Not Available, CDC = Centers for Disease Control and Prevention, CHAI = Clinton Health Access Initiative, IRC = International Rescue Committee MHIP = Maternal Health Integrated Program, EU = European Union, IMC = International Medical Corps, MOE = Ministry of Education, MoHSW = Ministry of Health and Social Welfare, MOPEA = Ministry of Planning and Economic Affairs, NGO = Non-governmental Organization, UNDP = United Nations Development Program, UNICEF = United Nations Children's Fund, UNFPA = United Nations Population Fund, USAID = United States Agency for International Development, WHO = World Health Organization, * Local Primary Healthcare Providers, Local Academic Institution, Professional Councils and Associations.

Three documents, the National Policy and Strategic Plan on Health Promotion, the National Health and Social Welfare Financing Policy and Plan, and the overarching NHSWPP, had no documented evidence of service users (the community) representation or consultation in the process of the policies formulations. Additionally, there was an underrepresentation of professional bodies and local health care providers identified, as evidenced by only four out of the twelve policies mentioning such representation.

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 [37].

3.2.3. The Content

The NHSWPP mainly focused on the provision of PHC and made specific references to a PHC approach in the implementation strategy. This includes eleven essential areas of service deliveries and five priority support systems to provide PHC (Table 5). The services identified were consistent with the PHC elements and expanded beyond that in three other service provisions, school health, prison health, and eye health services.

The EPHS, BPHS, and the National Community Health Services were 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.

The remaining policy documents were found to complement the NHSWPP and were 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 5. Content analysis of policy documents concerning the primary health care approach.

Policy Document	PHC Content Focus	Service Provision Plans and Clear Guidelines
National Drug Policy, 2001	Focuses on: - legislative and regulatory frameworks for the procurement, storage, distribution and management of pharmaceutical products in Liberia	No specific reference to PHC
National Nutrition Policy, 2008	Focuses on: - nutritional status of the population, through 12 highlighted priority areas that encompass prevention, promotion, and curative actions in addressing nutrition.	No specific reference to PHC
Basic Package of Health and Social Services, 2008	Focuses on: - strengthening PHC and decentralization basic services universally without user fees	Addresses six national priority health areas focused on a PHC approach: 1. Maternal and Newborn Health 2. Child health 3. Reproductive and Adolescent Health 4. Communicable Disease Control 5. Mental Health 6. Emergency Care
National Sexual and Reproductive Health Policy, 2010	The focus on: - SRH services without implicit reference to PHC Community participation and the recognition of SRH as basic human rights issues.	No specific reference to PHC
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: - strengthening of care at the community level - affected by trained CHVs. It ensures access to health for populations beyond a 5km radius of a health facility by outreach services that bring healthcare closest to the users.	There is the availability of clear service provision plans and strategies, grounded on a PHC approach.
Essential Package of Health Services, 2011	Focuses on: strengthening PHC and decentralization, by the provision of basic services universally without user fees	See above at National Health policy service provision

Table 5. *Cont.*

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: 1. Maternal and Newborn Health Service 2. Child Health Services 3. Reproductive Health Service 4. School Health Services 5. Prevention and Control of Communicable Diseases 6. Prevention and Control of NTDs 7. Prevention and Treatment of NCDs 8. Eye Health Service 9. Emergency Health Services 10. Mental Health Services 11. Prison Health Services And five priority support systems: 1. Leadership and management 2. Pharmaceutical services 3. Diagnostic service 4. Facility infection prevention and control 5. HMIS
National Human Resources Policy and Plan for Health and Social Welfare 2011–2021	Focuses on: - recruitment, training, equitable distribution of motivated and appropriately skill mixed health workforce	No specific reference to PHC
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 - affordable health care to the population	No specific reference to PHC
Investment Plan for Building a Resilient Health System in Liberia, 2015–2021	Focuses on health system strengthening and 3 key objectives areas: 1. Universal access to safe health services within the EPHS 2. Building the public health capacity for prevention, preparedness, alert and responsiveness through a robust Health Emergency Risk Management System 3. Promotion of an enabling environment that restores trust in the health authorities' ability to provide services through community engagement	No specific reference to PHC
National Policy and Strategic Plan on Health Promotion 2016–2021	Focuses on: - promotion and protection of health - Strengthening Community actions for health, covering areas from reproductive health to 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 - active community engagement - training of primary care workers, CHVs and other health cadres - task shifting by training teachers, village leaders, traditional healers etc.	No specific reference to PHC

Abbreviations: CHV = Community Health Volunteer, EPHS = Essential Package of Health Services, HMIS = Health Management Information System, MoHSW = Ministry of Health and Social Welfare, NCD = Non-communicable Disease, NTD = Neglected Tropical Disease, PHC = Primary Health Care, SRH = Sexual and Reproductive HealthThe Policy Formation Process.

Aside from three of the documents that lacked relevant data (Liberia National Community Health Services Policy, National Nutrition Policy, and the EPHS), a total of four approaches were identified in the policy formulation process (Table 6). 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. These approaches described the type of engagement. The last two approaches, identified as the 'bottom-up approach in response to the need of stakeholders or 'top down', responding to national priorities, which are methods of engagement, were also identified.

Table 6. Process analysis: Process, Stakeholders, Monitoring and Evaluation.

Policy Document	Process	Stakeholders Involved	Monitoring and Evaluation
National Drug Policy, 2001	Consultative Participatory	Internal and external stakeholders including non-health sector actors	Yes
National Nutrition Policy, 2008	No Relevant Data	Internal and external stakeholders	Yes
Basic Package of Health and Social Services, 2008	Prioritization Process	Internal and external stakeholders	Yes
National Sexual and Reproductive Health Policy, 2010	Participatory	Internal and external stakeholders	Yes
Liberia National Community Health Services Policy, 2011	No Relevant Data	Several internal and external stakeholders	Yes
Essential Package of Health Services, 2011	No Relevant Data	Internal and external stakeholders	No relevant data
National Health and Social Welfare Policy and Plan, 2011–2021	Participatory Consultative Situational Analysis	Representatives from communities, civil society groups, district, the county as well as other internal and external stakeholders	Yes
National Human Resources Policy and Plan for Health and Social Welfare 2011–2021	Consultative Participatory Situational Analysis	Internal and external stakeholders	Yes
National Health and Social Welfare Financing Policy and Plan, 2011–2021	Participatory Evidence-Based (Literature Review) Consultative	Internal and external stakeholders	Yes
Investment Plan for Building a Resilient Health System in Liberia, 2015 to 2021	Consultative	Internal and external stakeholders	Yes
National Policy and Strategic Plan on Health Promotion 2016–2021	Participatory	Internal and external stakeholders	Yes
Mental Health Policy and Strategic Plan for Liberia, 2016–2021	Consultative	Internal and external stakeholders	Yes

The MOHSW was identified as the main agency for monitoring and evaluation of the policies at the national and sub-national levels. However, all policy documents reviewed lacked evidence of community participation in monitoring and evaluation of any aspect of policy implementation.

3.2.4. The Gaps

Gaps were identified as either policy-related or implementation-related (Table 7). 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 gaps.

Table 7. 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 and Health Communication	• NHSWPP • National Health promotion Policy • National Human Resource for Health Policy	• Inadequate human resource • Inadequate technical support • Inadequate community representation	Policy and Implementation
Promotion of food supply and proper nutrition	• NHSWPP • Nutrition Policy • National health promotion policy • Community Health Policy	• Inadequate intersectoral collaboration	Implementation
An adequate supply of safe water and basic sanitation	• NHSWPP • National Health Promotion Policy • Community Health Policy	• Inadequate intersectoral collaboration	Implementation
Maternal and child health, including family planning	• NHSWPP • Maternal and Newborn Health policy • Child Health policy	• Lacks a clear strategic approach for the inclusion of men in family planning • Lack of a clear and strategic approach on post-abortion care services	Policy and Implementation
Immunization against the major infectious diseases	• NHSWPP • Maternal and Newborn Health policy • Child Health Policy	• Distribution impediments	Implementation
Prevention and control of locally endemic diseases	• NHSWPP • BHPS • EPHS • National Investment plan • National Financing Policy • National Human Resource Policy	• Inadequate human resources • Inequitable distribution of health facilities and trained personnel	Implementation
Appropriate treatment of common diseases and injuries	• NHSWPP • BPHS • EPHS • National Investment Policy • National Health Financing Policy	• Lack of adequate monitoring and supervision of the BPHS and EPHS	Implementation
Provision of essential drugs	• NHSWPP • National Drug Policy • National Health Financing Policy • National Investment plan	• Lack of a clear strategic approach to guide the updating of the Essential Drugs List • Inadequate revision of policy document	Policy and Implementation

* Policy documents directly related to meeting the correlated PHC element. Abbreviations: BPHS = Basic Package of Health Services, EPHS = Essential Package of Health Services, NHSWPP = National Health and Social Welfare Policy and Plan.

4. Discussion

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 [10,14].

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 [7].

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 [38], 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 [39].

Additionally, based on the four-system categorization of contextual factors [36], 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 [38]. 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 [40]. 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 [41]. 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 one study found that this asymmetry is even more pronounced between donors and domestic health policy actors in LMICs. The study 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 [39]. 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 [37].

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 [37].

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 [6]. 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 [6].

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 [7]. 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 [7]. 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 [23], 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 [6]. 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 [7].

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% [42].

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 [36].

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 [43]. 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 [37].

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) [44].

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 [44]. 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 [45], 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 [46]. 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 [47,48].

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.

This study has several limitations due to the type of data collected. First, it was only possible to review those health-related policies that were available electronically via web search. It is possible that some policies may exist that were not included in the review due to this reason. Secondly, the analysis was limited to include only those health policies that clearly listed primary health care as an approach; the review did not include those policies from other sectors that were not related to health. Finally, the paper is reflective of the impacts of changing governments, as it analyzes policy documents formulated and

adopted by two previous regimes, and they remain the governing health policy documents of the current government (2018–present).

5. Conclusions

As a post-conflict country, the findings highlight the prominent focus that is placed on PHC in Liberia. This is evidenced by the central role the PHC approach is given in the overarching NHSWPP. 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 care (UHC) and achieve the sustainable development goals (SDGs) for health.

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. 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 the execution of PHC policies in several of the policy documents has left room for misinterpretations at the implementation level.

The NHSWPP, while a bold document with ambitious plans, is not enough. Multisectoral policies, collaborations and actions, empowered communities, and efficient utilization of limited resources are also required.

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 equal room to learn, not only from the experiences gained to date but also in emulating experiences from other LMICs where the approach has been more successful. 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. Future researchers need to conduct further exploratory qualitative research, especially at the community level, to conduct in-depth examinations of the limitations involved with community engagement in the policy process.

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References

1. World Health Organization (WHO). *WHO | Health Policy*; World Health Organization: Geneva, Switzerland, 2013.
2. Maluka, S.; Chitama, D.; Dungumaro, E.; Masawe, C.; Rao, K.; Shroff, Z. Contracting out primary health care services in Tanzania towards UHC: How policy processes and context influence policy design and implementation. *Int. J. Equity Health* **2018**, *17*, 118. [CrossRef] [PubMed]
3. Saif-Ur-Rahman, K.M.; Mamun, R.; Anwar, I.; Saif-Ur-Rahman, M. Identifying gaps in primary healthcare policy and governance in low-income and middle-income countries: Protocol for an evidence gap map. *BMJ Open* **2019**, *9*, e024316. [CrossRef] [PubMed]
4. Soma, H. Sri Lanka's approach to Primary Health Care: A success story in South Asia. *Gall. Med. J.* **2011**, *16*, 24. [CrossRef]
5. Ministry of Health and Social Welfare (MoHSW). *National Health Policy*; Ministry of Health and Social Welfare (MoHSW) of Liberia: Monrovia, Liberia, 2007.
6. Lee, P.T.; Kruse, G.R.; Chan, B.T.; Massaquoi, M.B.F.; Panjabi, R.R.; Dahn, B.T. An analysis of Liberia's 2007 national health policy: Lessons for health systems strengthening and chronic disease care in poor, post-conflict countries. *Glob. Health* **2011**, *7*, 37. [CrossRef] [PubMed]
7. Ministry of Health and Social Welfare (MoHSW). *National Health and Social Welfare Policy and Plan 2011–2021*; Ministry of Health and Social Welfare: Monrovia, Liberia, 2011.

8. Ministry of Health & Social Welfare. *The Republic of Liberia. Essential Package of Health Services, Primary Care: The Community Health System*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2011.
9. The Adolescent Girls' Advocacy & Leadership Initiative (AGALI). Policy In Brief Liberia. 2012. Available online: https://live.fhi360.org/what-the-world-needs-now-is-girl-centered-advocacy/ (accessed on 28 August 2021).
10. Downie, R. *The Road to Recovery, Rebuilding Liberia's Health System*; Center for Strategic & International Studies: Washington, DC, USA, 2012.
11. Marston, B.; Dokubo, E.K.; van Steelandt, A.; Martel, L.; Williams, D.; Hersey, S.; Jambai, A.; Keita, S.; Nyenswah, T.G.; Redd, J.T. Ebola Response Impact on Public Health Programs, West Africa, 2014–2017. *Emerg. Infect. Dis. J.* **2017**, *23*, S25–S32. [CrossRef] [PubMed]
12. Ministry of Health and Social Welfare (MoHSW). *National Policy and Strategy on Community Health Services 2008*; Ministry of Health and Social Welfare (MoHSW): Monrovia, Liberia, 2008.
13. Ministry of Health and Government of Liberia. *Investment Plan for Building a Resilient Health System in Liberia*; Ministry of Health and Government of Liberia: Monrovia, Liberia, 2015.
14. Gilson, L.; Orgill, M.; Shroff, Z.C. *A Health Policy Analysis Reader: The Politics of Policy Change in Low-And Middle-Income Countries*; World Health Organization: Geneva, Switzerland, 2018.
15. Ministry of Health and Social Welfare (MoHSW). *Joint Annual Health Sector Review Report 2016*; Ministry of Health and Social Welfare: Monrovia, Liberia, 2016.
16. Kim, J.; Babcock, C.; Barreix, M.; Bills, C. Comparison of patient referral processes between rural and urban health facilities in Liberia. *African J. Emerg. Med.* **2013**, *3*, S17–S18. [CrossRef]
17. Global Nutrition Report. *2018 Nutrition Country Profile*; Global Nutrition Report: Monrovia, Liberia, 2018.
18. World Health Organization (WHO). *WHO Global TB Report 2018*; World Health Organization: Geneva, Switzerland, 2018.
19. Joint United Nations Program on HIV/AIDS (UNAIDS). *The Western and Central Africa Catch-Up Plan Putting HIV Treatment on the Fast-Track by 2018*; United Nations: Geneva, Switzerland, 2018.
20. Gill, W.; Gilson, L. Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy Plan* **1994**, *9*, 353–370.
21. Steinbach, R.; Kwiatkowska, R. Principal Approaches to Policy Formation | Health Knowledge. *Public Health Action Support Team*. 2016. Available online: https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/problems-policy-implementation (accessed on 28 August 2021).
22. Uzochukwu, B. *A Case Study from Nigeria Primary Health Care Systems (PRIMASYS)*; World Health Organization: Geneva, Switzerland, 2017.
23. Agongo, E.E.A.; Agana-Nsiire, P.; Enyimayew, N.K.A.; Adibo, M.K.; Mensah, E.N. *Comprehensive Case Study from Ghana Primary Health Care Systems (PRIMASYS)*; World Health Organization: Geneva, Switzerland, 2017.
24. World Health Organization (WHO). *A Case study from South Africa Primary Health Care Systems (PRIMASYS)*; World Health Organization: Geneva, Switzerland, 2017.
25. Perera, H.S.R. *Case Study from Sri Lanka Primary Health Care Systems (PRIMASYS)*; World Health Organization: Geneva, Switzerland, 2017.
26. Ministry of Health & Social Welfare (MoHSW) Republic of Liberia. *National Health Policy and National Health Plan 2007–2011*; Ministry of Health & Social Welfare (MoHSW): Monrovia, Liberia, 2007.
27. *Ministry of Health and Social Welfare (MoHSW) Liberia National Community Health Services Policy*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2011.
28. Ministry of Health and Social Welfare (MoHSW) Liberia. *National Sexual & Reproductive Health Policy Ministry of Health & Social Welfare Republic of Liberia 2010*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2010.
29. Ministry of Health and Social Welfare (MoHSW) Liberia. *National Drug Policy*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2001.
30. Ministry of Health and Social, Welfare (MoHSW) of Liberia Republic. *National Human Resources Policy and Plan for Health and Social Welfare 2011–2021*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2011.
31. Ministry of Health and Social Welfare (MoHSW). *Government of Liberia National Nutrition Policy*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2008.
32. Ministry of Health and Social Welfare (MoHSW). *National Policy and Strategic Plan on Health Promotion 2016–2021*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2016.
33. Ministry of Health and Social Welfare (MoHSW). *Mental Health Policy and Strategic Plan for Liberia*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2016.
34. Ministry of Health and Social Welfare (MoHSW). *National Health and Social Welfare Financing Policy and Plan 2011–2021*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2011.
35. Liberian Ministry of Health and Social Welfare. *Basic Package of Health and Social Welfare Services*; Liberian Ministry of Health and Social Welfare: Monrovia, Liberia, 2008.
36. WHO&UNICEF. *A Vision for Primary Health Care in the 21St Century*; WHO: Geneva, Switzerland, 2018.
37. Eastman, C.; Dolo, F. *Liberia Health Sector Scan*. 2016, Volume 10, pp. 1–12. Available online: https://aeiglobal.com/PDFs/Health_Sector_Scan_Building_Markets_v4.pdf (accessed on 28 August 2021).

38. Khan, M.S.; Meghani, A.; Liverani, M.; Roychowdhury, I.; Parkhurst, J. How do external donors influence national health policy processes? Experiences of domestic policy actors in Cambodia and Pakistan. *Health Policy Plan* **2018**, *33*, 215–223. [CrossRef] [PubMed]
39. Buse, K.; Mays, N.; Walt, G. *Making Health Policy*; Open University Press, McGraw-Hill Education: Berkshire, UK, 2005.
40. Ministry of Health of Ghana. *National Health Policy*; Ministry of Health of Ghana: Accra, Ghana, 2007.
41. Ministry of Health and Social Welfare (MoHSW), Republic of Liberia. *Liberia Demographic and Health Survey*; Ministry of Health and Social Welfare of Liberia: Monrovia, Liberia, 2013.
42. Liberia Institute of Statistics & Geo-Information Services (LISGIS). *Household Income and Expenditure Survey 2016*; LIGIS: Monrovia, Liberia, 2016.
43. The World Bank. Unemployment, total (% of the total labor force) (modeled ILO estimate) | Data. World Bank Gr 2019. Available online: https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS (accessed on 28 August 2021).
44. Koduah, A.; van Dijk, H.; Agyepong, I.A. The role of policy actors and contextual factors in policy agenda setting and formulation: Maternal fee exemption policies in Ghana over four and a half decades. *Health Res. Policy Syst.* **2015**, *13*, 27. [CrossRef] [PubMed]
45. World Health Organization (WHO). *Report on the Review Of Primary Health Care In The African Region*; WHO: Brazzaville, Republic of the Congo, 2008.
46. Topp, S.M.; Abimbola, S. The Alma Ata Declaration at 40: Reflections on Primary Healthcare in a New Era. *BMJ Glob. Health* **2018**, *3*, 791. [CrossRef]
47. World Health Organization (WHO). *World Health Organization Model List of Essential Medicines*; World Health Organization: Geneva, Switzerland, 2019.
48. World Health Organization (WHO). AFRO: Leadership and governance—The Health System—AHO. *World Health Organ. Reg. Off. Afr.* **2018**. Available online: https://www.afro.who.int/ (accessed on 28 August 2021).