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Implementing a Basic Package of Health Services in post-conflict Liberia: Perceptions of key stakeholders

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ABSTRACT

Recovery of the health sector in post-conflict countries is increasingly initiated through a Basic Package of Health Services (BPHS) approach. The country government and partners, including international donors, typically contract international and local NGOs to deliver the BPHS. Evidence from routine data suggests that a BPHS approach results in rapid increases in service coverage, coordination, equity, and efficiency. However, studies also show progress may then slow down, the cause of which is not immediately obvious from routine data. Qualitative research can provide insight into possible barriers in the implementation process, particularly the role of health workers delivering the BPHS services. The aim of this study was to explore perceptions of health service providers and policy makers on the implementation of the BPHS in post-conflict Liberia, using SRH services as a tracer and Lipsky's work on "street-level bureaucrats" as a theoretical framework. In July–October 2010, 63 interviews were conducted with midwives, officers-in-charge, and supervisors in two counties of Liberia, and with policy makers in Monrovia. The findings suggest health workers had a limited understanding of the BPHS and associated it with low salaries, difficult working conditions, and limited support from policy makers. Health workers responded by sub-optimal delivery of certain services (such as facility-based deliveries), parallel private services, and leaving their posts. These responses risk distorting and undermining the BPHS implementation. There were also clear differences in the perspectives of health workers and policy makers on the BPHS implementation. The findings suggest the need for greater dialogue between policy makers and health workers to improve understanding of the BPHS and recognition of the working conditions in order to help achieve the potential benefits of the BPHS in Liberia.

Introduction

The provision of health services is extremely challenging in countries emerging from prolonged and wide spread civil conflict. Providing health services in post-conflict countries is commonly impeded by damaged health infrastructure and limited government stewardship, domestic financial resources, and health workforce. This has often resulted in fragmented, uncoordinated and inefficient health service delivery by a range of stakeholders with limited national coverage (Kruk, Freedman, Anglin, & Waldman, 2009; Waters, Garrett, & Burnham, 2007).

To address these challenges, the concept of a Basic Package of Health Services (BPHS) approach has become an important feature of post-conflict health policy making (Ameli & Newbrander, 2008). This has been seen in post-conflict settings such as Afghanistan, Liberia, South Sudan, Somalia, the Democratic Republic of Congo, and Cambodia. In these countries, the BPHS consists of a limited list of cost-effective priority health services delivered at primary and secondary health care levels addressing the country's major health problems, but typically including key services for communicable disease control, immunisation, sexual and reproductive health (SRH) including maternal health, and newborn and child health. The BPHS is financed from a combination of domestic revenues and aid from international donor agencies, with non-governmental organisations (NGOs) commonly contracted to deliver the agreed package of services based upon a competitive bidding process, with stewardship and monitoring provided by the government and international partners. Potential advantages of the national roll out of a BPHS in a post-conflict setting may be rapid increases in health care coverage, coordination, equity, and efficiency; and standardisation of services, facilities, staffing, drugs and equipment (Ameli & Newbrander, 2008; Loevinsohn & Sayed, 2008; WHO, 2008).

The monitoring and evaluation of the implementation of BPHS in post-conflict settings relies predominantly on quantifiable

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indicators, such as the number of services provided in each of the facilities (MOHSW, 2009; Peters et al., 2007; WHO, 2008). While this information is crucial, it provides only one perspective on the implementation of the BPHS. Initially good results may be expected in response to the influx of substantial resources, but continued progress may be hampered by wider system issues or other barriers in implementation, as observed with the BPHS in Afghanistan (Palmer, Strong, Wali, & Sondorp, 2006; Strong, Wali, & Sondorp, 2005). Qualitative research can help explore these barriers and give insight on the perspectives of different actors involved in the translation of a policy into practice, particularly the front-line health workers implementing the policy through the delivery of services (Buse, 2007; Buse, Mays, & Walt, 2005; Pope & Mays, 1995; Pulzl & Treib, 2007).

In this study we explore the implementation of the BPHS using a case study of Liberia, following a "bottom–up" approach to explore how "front-line" staff influence policy implementation (Hill & Hupe, 2002; Matland, 1995; Pulzl & Treib, 2007; Sabatier, 1986). This is in contrast to "top–down" models which view implementation as a more rational linear process from policy formulation to execution and may fail to adequately recognise the role of front-line staff and limited resources and policy understanding.

More specifically, we use the work of Michael Lipsky as a theoretical framework for our study. Lipsky focuses on the ways in which individuals (street-level bureaucrats) delivering government policies adapt policies according to their working conditions. He notes how workers may not fully share the objectives and preferences of the policy makers and may not necessarily work towards the same goal (Lipsky, 2010). Health service providers therefore play a crucial role in the shaping of policies during their implementation as they exercise discretion in terms of types, quantity, and quality of services provided to beneficiaries. Lipsky's approach was selected as it focuses upon workers delivering government policies in sub-optimal working conditions which accorded closely with the observed situation in Liberia. Lipsky's focus on the role of individuals (rather than other bottom–up theorists such as Hjern and Porter who focused on networks (Hjern & Porter, 1981)) also reflected the isolated working conditions experienced by health workers in Liberia. We were also interested in how the perception of the policy implementation by the street-level bureaucrats compared with policy makers in Liberia and so included policy makers from the Liberian Ministry of Health and Social Welfare (MOHSW), international donors, NGOs and the UN in the study.

The aim of our study was therefore to explore perceptions of health service providers and policy makers on the implementation of the BPHS in post-conflict Liberia. We use SRH services (including maternal health) as a tracer for the implementation process as they represent a major part of the services included in the BPHS and the promotion of SRH appears particularly high on the agenda of the MOHSW, reflecting the high maternal mortality and reproductive health needs in Liberia (MOHSW, 2010d,e).

Liberia

Liberia experienced civil war between 1989 and 2003, leading to the deaths of an estimated 270,000 people and the displacement of 500,000 people out of a population of around 3.7 million. Following a comprehensive peace agreement in 2003 and a transition period, in 2005 a civilian government was democratically elected, providing an opportunity for recovery and development. However, many challenges persist such as wide spread poverty, lack of basic infrastructure, weak government institutions, low literacy, and high unemployment (IMF, 2008). Maternal mortality in Liberia increased from an already high 578 maternal deaths per 100,000 deliveries in 1999 to 990 per 100,000 deliveries in 2008. The vast majority of births take place without skilled staff. Approximately half of all women in Liberia have their first child before the age of 20, with early childbearing increasing between 2000 and 2007. The fertility rate remains high (estimated 5.2–6.2), and contraceptive use is low despite high demand for contraceptives (MOHSW, 2008b; Msuya & Sondorp, 2005; WHO, 2010). High levels of risky sexual behaviour are also reported among adolescents and young people (Kennedy et al., 2011).

During the conflict most government owned health facilities had stopped functioning unless they received international assistance through humanitarian NGOs or faith-based organizations (MOHSW, 2007b). In the period following the peace agreement of 2003 these same organisations managed approximately 80% of all the health facilities in Liberia (MOHSW, 2007b) and managed to expand health service delivery, in particular to areas that had been most affected by the war and were home to many refugees and internally displaced people. However, due to the limited government leadership and absence of a uniform policy in this period, these expanded services were fragmented and skewed in coverage. The majority of health expenditure in this period came from donor sources (47%) and out of pocket spending (35%) (GoL, 2009). A major constraint to health service provision was a lack of qualified staff, with many health care workers, particularly nurse-aids, holding sub-standard qualifications while also having to take up senior positions in health facilities (Msuya & Sondorp, 2005). Most facilities also required substantial improvement to infrastructure and drug supply chains (MOHSW, 2007a).

After the democratic elections of a new President and parliament, a new leadership was appointed at the MOHSW in 2006. Following an inclusive consultation process involving existing health cadres from throughout Liberia and the international partners including donors, UN agencies and NGOs, the MOHSW presented a new health policy and plan (MOHSW, 2007a). The policy and plan represented a shift from emergency humanitarian relief to development and from vertical programmes to an integrated health system based on four pillars: the BPHS, human resources, support systems, and infrastructure; with health service delivery through the BPHS considered the corner stone of the National Health Policy (MOHSW, 2007a, 2007b, 2008a, 2008c; Pavignani, 2009). The BPHS is financed from a combination of domestic revenues and aid from major bilateral and multilateral donor agencies such as USAID and the World Bank. The BPHS covers health services, health facility staffing and training, costing and planning, and drug supplies (with the drug supply system in the process of being centralised but stocks still being provided by international agencies at the time of the study). Staffing patterns and salary scales were set for the various types of health facilities.

The core services reflect those found in other BPHS of SRH, newborn and child health, immunisation services, nutrition, and communicable disease control. The SRH services included in the Liberia BPHS are summarised in Box 1.

Liberia's new national health policy comes with a strong notion of decentralisation and sets the vision that it will be the health authorities at the next administrative level, the County Health Teams (CHTs), who will be responsible for the implementation of the BPHS in their counties. However, to bring in sufficient capacity, NGOs are contracted to assist the CHTs to deliver the BPHS while also strengthening the capacity of the CHTs. The NGOs therefore play a major role in the counties to ensure rehabilitation of health facilities, provision of drugs and other supplies, supervision and staff training. Health staff are employed by the government, but the NGOs directly pay the staff their salaries.

To assess County and NGO performance, a monitoring and evaluation system has been set up to be able to measure progress on a range of indicators, such as number of women attending ANC