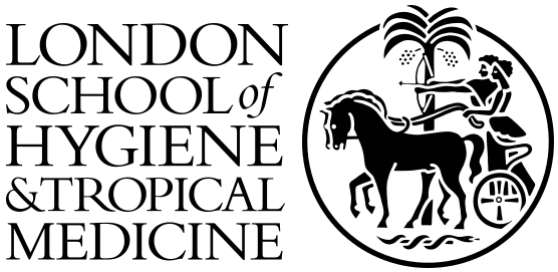

Perceptions on the implementation of sexual and reproductive health services through a Basic Package of Health Services:

A qualitative case study in post-conflict Liberia

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I, Dörte Wein, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis. The thesis is less than the 50.000 word limit, excluding references and annexes.

[redacted] 11/1/2012

Signature, date

Abstract

Background:

Countries recovering from war increasingly use the approach of a Basic Package of Health Services (BPHS) as a means of rapidly scaling-up health care services in a coordinated way. Liberia started the implementation of a BPHS in 2007 after emerging from 14 years of civil war. The sexual and reproductive health (SRH) situation in Liberia was particularly critical (maternal mortality ratio: 990/100000 live births). No study has explored how the BPHS has influenced the provision of SRH services in Liberia or indeed globally.

The aim of this study was to explore the implementation of a BPHS and its influence on the provision of SRH services in post-conflict recovery. The objectives were to (i) assess the availability of sexual and reproductive health services at facility level; (ii) explore health service providers' and policy makers' perception on how the implementation of the basic package has influenced the provision of SRH services using a health systems framework; (iii) develop recommendations for policy making regarding SRH and BPHS in post-conflict recovery.

The conceptual framework was based upon Lipsky's bottom-up theory on policy implementation which was then applied to a health systems framework.

Methods:

This study used qualitative methods consisting of 39 semi-structured interviews with services providers and supervisors in two counties of Liberia and 24 semi-structured interviews with policy makers in Monrovia. This was complemented by document review. The thematic analysis was based upon the conceptual framework.

Results and discussion:

SRH services included in the BPHS are not fully implemented. Delivery care and particularly Basic Emergency Obstetric Care were not completely available as planned. Family planning was limited, lacking a wider range. There were

gaps in the utilisation of services for sexual and gender-based violence and no clear definition of adolescents' reproductive health.

The study showed that SRH is high on the political agenda, being well represented within the BPHS. While the BPHS is considered a useful guiding tool for health recovery, a key challenge is its implementation due to competing priorities within a short time frame leading to limitations in service availability and ongoing issues regarding quality, service uptake, and community outreach. There is an important gap between the policy making and the implementation level in terms of perception of service provision and priorities. Workforce plays a key role in the effective implementation of SRH services with important implications of staff motivation for quality of care and service uptake. Existing mechanisms, namely the accreditation process, are not able to capture these limitations, indicating the need for more rigorous monitoring. The study highlights the importance of taking a health systems approach for the analysis of service delivery, to better understand the interdependence of its components.

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List of Acronyms

ART	Antiretroviral therapy
ARV	Antiretrovirals
BEmOC	Basic Emergency Obstetric Care
BPHS	Basic Package of Health Services
CEmOC	Comprehensive Emergency Obstetric Care
CHT	County Health Team
DFID	UK Department for International Development
EC	Emergency Contraception
EmOC	Emergency obstetric care
FP	Family Planning
HCT	HIV counselling and testing
HAC	Health Action in Crises
HIV	Human immunodeficiency virus
IEC	Information, Education and Communication
IPT	intermittent preventive treatment for malaria in pregnancy
IUD	Intrauterine device
JSI	John Snow Inc.
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package for Reproductive Health in Crisis Situations
MOHSW	Ministry of Health and Social Welfare
MSF	Médecins Sans Frontières (Doctors without border)
MVA	Manual Vacuum Aspiration
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PMTCT	Prevention of Mother to Child Transmission
RAISE	Reproductive Health Access, Information and Services in Emergencies
RBHS	Rebuilding Basic Health Services
SGBV	Sexual and other forms of gender based violence
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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Chapter 1. Background

1.1 Introduction

The aim of this study was to explore the implementation of a basic package of health services (BPHS) and its influence on the provision of sexual and reproductive health (SRH) services in post-conflict recovery in Liberia. The objectives were to:

1. Assess the availability of sexual and reproductive health services at facility level.
2. Explore health service providers' and policy makers' perception on how the implementation of the basic package has influenced the provision of SRH services using a health systems framework.
3. Develop recommendations for policy making regarding SRH and BPHS in post-conflict recovery.

Liberia was selected for the study as it is recovering from a 14-year civil war which ended in 2003. It started implementing a BPHS in 2007, with a particular focus on the reduction of maternal mortality.

This chapter provides a general background on health recovery in post-conflict settings and the concept of a BPHS, which is an increasingly popular strategy used in post-conflict settings. It then details the challenges of SRH in post-conflict settings, and concludes with the overall study aim and objectives. Chapter two of the thesis provides an overview of the health situation in Liberia and the use of the BPHS there. Chapters three and four outline the conceptual framework and the methodology used in the study. Chapters five and six present the results of the study and chapter seven discusses the study findings and provides policy and research recommendations.

The study was undertaken by a research student from LSHTM. It was part of the work plan of the World Health Organization (WHO)/Health Action in Crises (HAC), where the student has been employed for the past three years. The study was further funded by the RAISE Initiative.

1.2 Post-conflict health recovery

This thesis focuses on the recovery phase following a protracted armed conflict. Recovery refers to the process of restoration of the capacity of the government and communities to rebuild after crisis and to prevent relapses [1]. While death caused directly by conflict-related violence has decreased over the past years, the majority of morbidity and mortality are related to disruption of livelihoods, inadequate water and food supplies, the destruction of health systems and insecurity which often persist long after the end of the conflict, as experienced in Angola, Liberia and Sierra Leone [2].

It is important not to assume a linear and progressive movement from humanitarian relief to recovery, nor is recovery a mere link between relief and development. While humanitarian relief operations mainly aim at saving lives and alleviating suffering, development activities are geared towards sustainability. These two different objectives pose a challenge to the transition from one to the other [3]. As soon as the immediate needs are addressed, other activities aiming not only at the improvement of immediate health outcomes but at strengthening of the entire health system become necessary. While this process should start as soon as possible during the relief phase, formal, large scale reconstruction and development programmes are implemented in a later phase, usually after the signing of a peace agreement. There will be parallel needs to assure the humanitarian imperative, aimed at protecting lives and reducing disease and to set the foundations for development. This should include strengthening the institutional capacity to pursue longer term health development goals and development of the health care delivery system within an environment of good governance, to assure human security and extend social protection in health [4, 5].

Protracted crises and transition situations are critical periods in which often fewer resources than during the acute relief phase are available; yet the needs can be extremely high. The rapid turnover of operational health agencies in the affected areas and the winding up of many essential healthcare services can create a vacuum that may undermine achievements made during the

emergency relief phase and pose a threat to sustaining health services until longer-term development begins.

Despite such challenges, health recovery may offer an opportunity to reconsider the whole of the health sector and plan it on a more comprehensive and rational basis. Building an equitable and sustainable health system may become a realistic, although difficult target [6].

Conflict has a major impact on the entire health system, not only in terms of destroyed infrastructure, but on the system as a whole, encompassing governance, human resources and service delivery [3]. Effects on the health system include reduced financial resources, often due to increased military spending, severely constrained human resources, as trained staff have been killed during the conflict, have fled the country, and have not been trained during the crisis and overall limited service delivery due to destroyed infrastructure. In addition, the weakened government's capacity for policy making and its overall authority faces the challenge of fragmented and uncoordinated health service delivery by numerous non-governmental organizations (NGOs). Furthermore, there is usually tension between the need to quickly achieve results and capacity building and planning for sustainability in the country [2, 7, 8]. In view of this, Water et al. consider post-conflict health recovery to be threefold: an initial response to immediate health needs, the restoration of a package of essential health services and rehabilitation of the health system [7]. In a number of health recovery situations after prolonged conflict the concept of a BPHS has been applied. It is a limited list of well proven, cost-effective health interventions at primary and secondary level, targeted at priority health conditions [9-11]. This approach, which is supported by most international aid actors, will be explored in more detail below.

1.3 Basic Health Packages

An increasingly popular approach in health recovery is the use of basic packages of health care which is most commonly provided by NGOs. These packages are limited lists of public health services at primary and secondary levels of health care. They consist of a guaranteed minimum set of services to be provided.

Central principles of basic packages are access (coverage and utilization), equity, aiming at health service provision to as many people as possible, quality and efficiency [12, 13]. The concept of cost-effectiveness seems to be widely accepted. However, it might be too limited, not capturing all considerations that have an impact on the implementation of such a package. Such aspects include societal values, which apply particularly to SRH related services, such as abortion or contraception for unmarried persons. Other aspects to be considered are feasibility in terms of politics, finances and practicality, and also whether it is intended to be implemented immediately or over a longer period of time, as this inevitably has implications on the components to be included in the package [12, 14].

While the concept of priority setting through the packaging of health services has been around for quite some time, it has received increased attention through the World Development Report 1993, which posed the question how governments in low-income countries should spend their limited health budgets [15]. The report focuses particularly on the idea of cost-effectiveness, indicating that the number of health interventions should depend on the health expenditure per capita available in a given country. Basic health packages relate to the idea that comprehensive primary care is too expensive for most countries, forcing them to select essential services [16]. The advantage of the formulation of a minimum package is the shifting attention from input to output, measuring not merely the number of facilities per population but the number of facilities providing certain services [12]. Other justifications of a basic package are the shared use of inputs for several services as well as increased synergy of prevention and treatment. In addition, it might help in the planning for

investment in infrastructure and human resources [17]. However, in Uganda the implementation of a health package was undermined by rationing of infrastructure development and quality of care [18]. The formulation and costing of basic packages is therefore also a useful method for donors to provide financial support and to measure the implementation.

After the publication of the World Bank Report in 1993, there was increased interest by countries to design and implement such a package [19]. Basic health packages are put in place in both developed and developing countries, it is not a measure being taken particularly in health recovery situations. Yet, especially in post-conflict countries, where the health infrastructure has been destroyed and the capacity of the government to provide comprehensive health services is limited, the BPHS approach of rationalizing limited resources through prioritizing cost-effective interventions might be particularly appropriate; a basic package can be considered as a starting point for priority setting [17].

Cambodia was one of the first post-conflict settings to implement a Minimum Package of Activities in 1993 [20]. Later, Afghanistan, the Democratic Republic of the Congo (DRC), South Sudan, Somalia and Iraq adopted the BPHS approach as well [9, 21-24]. Building particularly on the example of Afghanistan, Liberia adopted a BPHS approach in 2007, defining a BPHS as a major cornerstone of the national health policy. The package is supposed to be available as a whole at all levels of the health system though implementation is taking place in an incremental approach [25, 26]. The national health policy developed an initial basic package, indicating that its content will change over time, as the health system improves and a wider scope of services can be implemented [11].

The development of a list of services to be provided as a package helps define the required financial inputs for health service provision. In addition, packaging services takes joint costs of different interventions into account, therefore reducing the overall costs [17]. The definition of a basic health package is the process of priority setting by choosing between alternative health services and programs and ranking these alternatives [27]. The main selection criterion for

services to be included in a basic package is cost-effectiveness. The process is not necessarily objective and some argue that it can be rather value laden, negotiation playing a major role, potentially leading to the inclusion of health services of debatable effectiveness [28]. In the priority setting process there is a tension between the need to use resources in a way that benefits the majority of a society on the one hand and the risk of neglecting the health needs and human rights of minorities on the other hand [29]. It may therefore be difficult to formulate a package for the whole population, with different groups of different needs [16, 30]. Besides cost-effectiveness, other criteria should include the epidemiological profile of a country, health expenditure per capita and available infrastructure [19]. Yet, the main difficulty in the decision making process is the usually limited information base. Particularly post-conflict settings may not have sufficient epidemiological data available. However, countries may choose to design a provisional package which will be modified, as information becomes available [17, 19].

The content of basic packages varies between countries. Table 1 shows the content of different BPHS packages for SRH (as SRH is the focus of the study).

Table 1: Sexual and reproductive health (STIs & HIV, maternal health, sexual violence) in different health service packages

Country	RH content of Basic Package
Afghanistan [24]	Adolescents: education STI/HIV
	Antenatal care Delivery care (EmOC/ referral) Postpartum care Family planning Care of the newborn
Southern Sudan [31]	control of HIV/AIDS
	promotion of reproductive health (safe motherhood, including safe pregnancy and family planning); EmOC, free MNRH services including Caesarean sections, HIV: train health professionals in HIV prevention and in the control, promoting condom use / social marketing Sexuality and MNRH teaching for young people in out-of-school activities
	Increase awareness of GBV (clinical staff and mass media), clinical care, rape kits, PEP
Haiti [10]	Recommended behaviour to prevent HIV transmission
	Referral for delivery/ deliveries, referral in case of complications, family planning, referral / management of complications after abortion
	Management of SGBV
Uganda [32]	Prevention and Control of HIV (standard precautions not specified), safe blood transfusions, promoting condom use
	Management of obstetric emergencies, operationalize EmOC services at HC III, IV and hospital level, refer high risk pregnancies, family planning, School Health: sex education, counselling and life skills
	Prevention and Control of SGBV, integrated strategy to address GBV in the health sector
Liberia [33]	STIs for adolescents, control of STIs/HIV, PEP, promotion and distribution of condoms
	Antenatal care, labour and delivery care, manage complications of pregnancy, including incomplete abortions, complicated abortions, emergency obstetric care, postpartum care, newborn care, family planning, family planning for adolescents, Referral system
	Mental health: rape or other sexual assault, rape exam

There is some limited evidence on the basic health packages in conflict-affected countries [12]. On the one hand, this approach might be positive for the policy dialogue, introducing cost and effectiveness considerations in priority setting, leading to a coordinated and rational way of health service provision instead of fragmented service provision as is often happening during an acute crisis; on the other hand, a key challenge is how it is implemented rather than its actual design [16, 17, 19]. The process of implementation was therefore the focus of this study.

Implementation of basic packages

The implementation of a basic health package requires the corresponding support system in terms of human resources, supplies and infrastructure. In addition, further mechanisms and regulations for implementation, such as protocols, accreditation as well as supervision have to be defined [12, 27]. Also, training curricula have to be adapted to the norms set by the package [17]. At the same time a basic package can also serve as a planning tool for investment in infrastructure, training and supplies [17]. Uganda for example adopted the approach in 1990, defining a Minimum Health Care Package, though considering that full implementation would take a long time, setting the target to 2018 [15].

Tarimo [34] claims that while basic health packages outline which task should be performed by health workers, they rarely define how this should be organized in terms of referral structure, supervision, quality of care or organizational management. In order to promote utilization of services, adequate geographic coverage as well as quality of services are important [16, 18]. It is further useful to inform the communities about the package and the services that should be guaranteed at which type of facility [17]. The implementation of such a package has to be monitored throughout, to allow for necessary adjustments. Afghanistan adopted a score-card system looking at six aspects of implementation: patients and community, staff, capacity for service provision, service provision, financial system and overall vision [35, 36].

For post-conflict settings, the most recent evidence comes from Afghanistan. It suggests that the BPHS helps to shape health sector priorities and influences allocation of resources towards primary healthcare [37, 38]. However, difficulties such as inaccessibility, cost, shortage of medicine, absence of doctors from facilities, negative staff attitudes, as well as shortcomings or inadequacy of equipment persisted [39].

Contracting for the implementation of basic packages of health

In terms of financing of the implementation of a basic health package, particularly in post-conflict settings, donors often take the responsibility for funding in the form of contracting NGOs for the implementation of the package, as seen in Afghanistan, Cambodia and DRC [13, 20, 23, 40]. In low-income countries the non-governmental sector may play a vital role in expanding access to quality services through its resources, expertise and infrastructure. Particularly during recovery, governments and donors often contract non-governmental providers to deliver health services in exchange of a payment, which usually covers salaries, recurrent costs, drugs and other consumable medical supplies, in order to expand coverage and improve quality of care [41-43]. Basic health packages often define the content of these contracts, specifying the types, quantity and quality of services that the provider should deliver for a specific period.

Contracting is considered a means to rapidly scale-up services and to overcome common difficulties in health service provision, such as the shortage of health care personnel and poor motivation in primary health care facilities [44]. There are different types of contracting, depending on the basis of reimbursement: cost-based, which implies that the contractor is reimbursed for the costs of the services; out-put based, by which reimbursement depends on the quantity of services provided; outcome-based, by which reimbursement is based on (health) outcomes; and performance-based, indicating that the contractor is reimbursed based on his performance, which is measured using objectives and targets defined by the contract [45]. The latter form of contracting is relevant to this study as it is being applied in Liberia; though it will not be the focus of this study. Support for the improvement of health services has traditionally focused on inputs, such as infrastructure, equipment, supplies etc. The rationale for paying for results rather than inputs is hoped to motivate providers to be more efficient and effective and therefore achieve better health outcomes [46]. Performance-based contracting has a clear set of objectives and indicators and a systematic way of collecting data on the progress of these pre-defined indicators. Contracts usually define consequences in terms of rewards or sanctions for the contractors, based on

their performance; this means that additional funding or bonuses are paid when predetermined service delivery targets have been achieved [47, 48].

Important challenges for the successful implementation of performance-based contracts seem to be political commitment and ownership, both at national but also at sub-national level, as all relevant actors must understand the scheme and the requirements to fulfil the contracts [48]. The rationale behind contracting for health services is the assumption that health services delivered by the limited public sector may not reach the entire population. Performance-based contracts that set clear expectations and predefined objectives for providers are supposed to improve efficiency, quality and cost-effectiveness of health service delivery and therefore increase equity [45]. The performance-based contracting mechanism can generate pressure on both public and private providers to improve their performance. However, particularly in post-conflict settings, competition among potential contractors may be limited, as long-term relationships can prevail in disrupted contexts where donors have already financed NGOs through grants. Such settings can also be characterised by weak governments who may not have the capacity to take on the required stewardship role [38, 42, 49-53].

Performance-based contracting seems to show positive results in terms of access to health services both in conflict-affected countries and those that have not experienced conflict [38, 52, 54-57]. Yet, it needs to be noted that evaluation projects with performance-based contracts have been rather weak, focusing on process indicators rather than overall health systems performance and better health outcomes [46, 51, 58, 59]. The effects on the entire health system are therefore not clear.

1.4 Sexual and reproductive health

Sexual and reproductive health (SRH) encompasses five core components: antenatal, perinatal, postpartum and newborn care, family planning, including fertility services as well as the elimination of unsafe abortion; combating sexually transmitted infections (STIs) including HIV, reproductive tract

infections, cervical cancer and other gynaecological morbidities; as well as the promotion of healthy sexuality [60]. At the International Conference on Population and Development in 1994 in Cairo, participants agreed on the provision of universal access to reproductive health by 2015 [61]. After initially having been left out of the Millennium Development Goals (MDGs), in 2007, this agreement has been taken up again by adding universal access to reproductive health by 2015 as New Target 5b, with the following indicators:

1. Adolescent birth rate,
2. Antenatal care coverage,
3. Unmet need for family planning,
4. Contraceptive prevalence rate.

However, many low income countries will not achieve the MDG health targets by 2015 [62]. The highest risk is unsafe sex, which WHO considers to be among the ten most important risk factors leading to disease, disability or death [63]. Other issues are pregnancy related complications, unmet need for contraception and unsafe abortion [64]. Countries in protracted crises and post-conflict recovery are particularly vulnerable as reflected in the higher maternal mortality rates compared to countries without conflict [65-70].

Over the past fifteen years, coverage and scope of SRH services in conflict situations have increased substantially [71]. However, there are still barriers to their full and effective implementation. Even the *Minimum Initial Service Package for Reproductive Health in Crisis Situations* (MISP), a set of priority activities to prevent and manage the consequences of sexual violence, reduce HIV transmission and prevent excess maternal and newborn morbidity and mortality in acute humanitarian settings does often not get implemented completely, and the scaling-up of more comprehensive services in recovery phases commonly does not take place systematically. Planning for comprehensive SRH services as one component of the MISP is not as straight forward as implied (figure 1) [72-78].

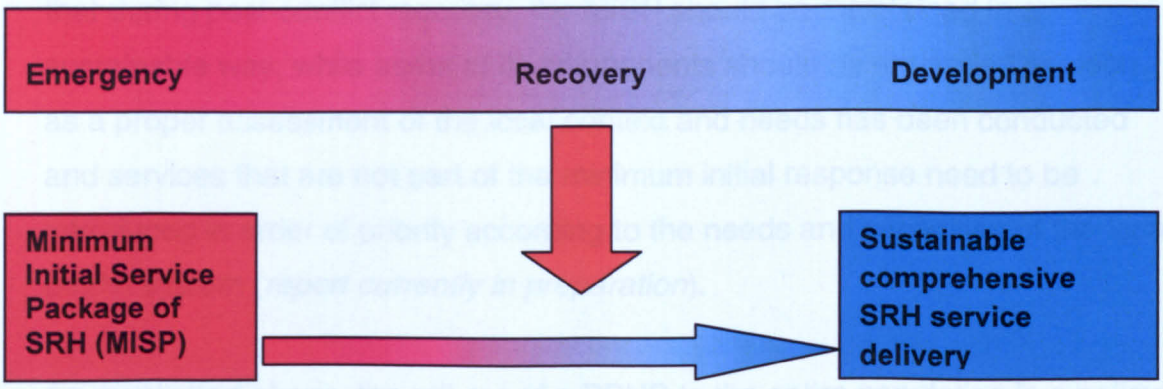

Figure 1: SRH services in post-conflict transition

While it is necessary to prioritize the MISP activities before providing comprehensive SRH services, planning and implementation of comprehensive SRH services should begin when the humanitarian planning process moves from short term to longer term; implementation should begin incrementally as soon as the MISP standards are reached [78].

There is general agreement on certain services to be included in comprehensive SRH service provision. These include ante and post natal care, normal deliveries and emergency obstetric care (EmOC), family planning and management of STIs, including HIV. However, there is some discrepancy regarding abortion (whether to provide safe abortion services or only post-abortion care after unsafe (illegal) abortion) and sexual and gender-based violence (SGBV) (whether to provide only medical response or prevention and management services). Furthermore, services for HIV/AIDS lack specificity (whether to only assure standard precautions, whether to provide prevention of mother to child transmission (PMTCT), whether to provide antiretrovirals). Infertility treatment is mentioned by the International Conference on Population and Development but not discussed in post-crises settings [72-76].

Recognizing the difficulty to scale up SRH services from the MISP to more comprehensive SRH services, WHO and the United Nations Population Fund (UNFPA) organized a global consultation on SRH during protracted crises and recovery in September 2009, aiming at consensus building on the modalities of SRH service provision during protracted crises and recovery. It was agreed

that during post-conflict recovery, the MISP should be maintained in a sustainable way, while some of its components should be expanded as soon as a proper assessment of the local context and needs has been conducted and services that are not part of the minimum initial response need to be introduced in order of priority according to the needs and capacities of the local health system (*report currently in preparation*).

As mentioned above, the roll-out of a BPHS to the entire population is a policy that is increasingly adopted by governments of post-conflict countries. Basic health packages are a means to rapidly scale-up health services in a coordinated way, and to streamline fragmented service provision. However, they might pose a risk for the availability and quality of SRH services and the scaling-up from MISP to comprehensive SRH services, particularly services in case of SGBV and SRH services for adolescents, as they are often not included in basic packages [79]. So far there is limited information on the implications of these packages for health service provision, particularly for SRH services.

1.5 Literature review: SRH service provision in post-conflict recovery

The following section provides a comprehensive literature review on the challenges of SRH service provision in post-conflict recovery. The literature search was conducted in Pubmed, RH Library, Global Health and Embase. Search terms included 'sexual and reproductive health', 'maternal health', 'maternal mortality', 'maternal welfare', 'obstetric care'; 'war', 'conflict', 'crisis', '(health system) recovery', '(health system) rehabilitation', 'Basic/Essential Package'. In addition to scientific articles, the literature review encompasses grey literature from key websites, such as UN agencies and NGOs working in the area of SRH, and governments of countries in post-conflict recovery. Only literature in English, published within the past fifteen years was included in the review. The purpose of this review is to outline the broad challenges for the provision of SRH services in post-conflict settings. It was not possible to conduct a systematic literature review looking at specific questions, such as

the provision of SRH services within a BPHS and the scaling-up of SRH services in recovery, as insufficient literature is available on this subject. The review first provides an overview of challenges of SRH service provision structured by key components of SRH. It then discusses the challenges of scaling-up services and the implications of basic health packages in this process.

Overall, the most established health services in stable humanitarian settings seem to be limited family planning methods, primarily oral contraceptives, antenatal care and condom distribution [80]. A wider range of contraceptives, emergency obstetric care, response to gender-based violence, STI/HIV/AIDS services other than condom distribution and youth friendly services do not seem to be routinely available in most sites [80]. The different areas will be described further in the following:

Safe motherhood

There seems to be a correlation between war and higher maternal mortality and also poor pregnancy outcomes such as premature deliveries, stillbirths and spontaneous abortions, mainly related to availability and access to healthcare [81-83]. The main challenge for safe motherhood is the consistent and accessible provision of good quality pregnancy and delivery care. Only a small proportion of deliveries are attended by skilled health providers [84].

One important limitation to women's access to life-saving services in cases of obstetric complications is the lack of basic EmOC services. The level of basic EmOC services as recommended by the UN is four facilities per 500.000 population, and one facility per 500.000 for comprehensive EmOC [85]. While coverage is usually met or even goes beyond the set target for comprehensive EmOC services, basic EmOC is often lacking [86]. This reflects a concentration of services in urban areas and a lack of adequate services in rural areas. Most of the time missing components are assisted vaginal delivery and removal of retained products. Underlying reasons seem to be shortage of trained staff, inadequate infrastructure, inadequate supplies in terms of drugs and equipment, but also poor working conditions and therefore compromised staff morale, all of these factors also having an impact on the quality of care.

Further challenges are gaps in communication and emergency transport systems and insufficient data collection [86, 87].

It seems that implementation of EmOC services in (post-) conflict settings can be successful if the projects focus only on EmOC services, strengthening all the health system aspects that are necessary for adequate EmOC service provision, such as infrastructure, training of staff and supply. In addition it seems that all signal functions for basic EmOC can be successfully implemented at primary health care clinics [87-89]. However, a key barrier is lack of ongoing training and adequate supervision [90].

Distance seems to be another barrier to receiving services, particularly in the case of obstetric complications [70]. Institutional delivery in rural communities in Afghanistan increased through intensive community mobilization. Provision of free services and transport to facilities at night, incentives to health service providers, maintaining privacy in the delivery room and the quality of services were also key factors in raising the number of institutional deliveries [91].

Family planning

Demand for family planning varies from one conflict-affected setting to another and depends largely on socio-demographic and cultural factors. However, research has indicated unmet need for family planning in a number of conflict-affected populations [83, 92, 93]. Other studies have highlighted the need to engage community members and leaders to improve understanding, acceptance and access of family planning as well as the need for training and close supervision of community health workers [94]. Family planning is usually available to a limited extent. However, it does not encompass a wide range of contraceptives; therefore needs for family planning are not met. This is due to intermittent supply, untrained staff and high costs, potentially leading to unsafe abortions, which frequently result in complications or death [76, 80, 95-99].

STI/HIV/AIDS

The relationship between conflict and STIs including HIV/AIDS seems to be rather complex. Increased prevalence of SGBV, forced migration and commercial sex as well as the destruction of the health system can reduce access to information about HIV prevention, to condoms, prevention of mother

to child transmission of HIV (PMTCT) services and anti-retroviral therapy (ART) and treatment for opportunistic infections. This can increase vulnerability to infection and onset of HIV/AIDS [100, 101]. In addition, the destruction of social and economic networks might lead to higher risk behaviour and therefore higher vulnerability to HIV infection in individuals during conflict than in non-conflict settings [99, 101, 102]. However, a systematic review of HIV prevalence in conflict affected and displaced people in sub-Saharan African countries did not indicate that conflict increases the spread of HIV, despite wide-spread sexual violence in these settings [103]. Possibly, the decreased mobility and accessibility of populations might decrease exposure and therefore transmission [83, 104-106].

Some post-conflict settings show an increase in HIV prevalence immediately following the conflict, indicating a higher risk of HIV transmission during the recovery phase than during the conflict [107, 108]. Concerns have been raised that the return of soldiers and refugees may increase the spread of HIV in post-conflict situations [107].

Studies have shown that it is possible to integrate HIV services into the overall health services as well as to improve morbidity and mortality outcomes by providing ART to conflict affected populations. However, this is faced with the challenges found in (post-) conflict settings, particularly the need of skilled human resources and the need to rely on outside support, such as international NGOs [109-111]. It seems that the ability to treat patients improves staff morale and contributes to health system strengthening [112].

Sexual and gender-based violence

Sexual and gender-based violence has always played an important role in conflict situations, which might be linked to cultural, economic, legal and political factors, such as the disruption of cultural norms, women's dependence on men and the lack of legal follow-up. Increase in sexual violence during conflict situations has been rather well documented [113-119]. This increase seems to be due to crowded conditions, trauma and alcohol abuse as well as the use of rape as means of intimidation or ethnic cleansing [76, 77, 114-116, 120-124].

The main perpetrators seem to be armed combatants. Evidence regarding intimate-partner violence is inconclusive, with some studies indicating higher prevalence of intimate violence as a result of conflict, while others do not show a significant difference between the periods during and after the crisis [115, 122, 123] . The obvious example of where conflict has resulted in a large-scale increase in sexual violence by civilians is DRC [113, 125-129].

SGBV can have major negative impacts on the victims, including STIs, unwanted pregnancies leading to unsafe abortions, other gynaecological problems as well as mental problems [113, 125-127]. It is also important to note that sexual violence does not necessarily end as soon as the conflict subsides; though data also show a decline in SGBV after crises compared to during the crises.

While the extent of sexual violence in (post-) conflict settings is documented, only few assessments regarding interventions are available [114, 121]. At the same time due to underreporting, monitoring of SGBV is difficult. This is also related to the complexity of the required care of rape survivors, including both, timely STI treatment and psychosocial support [130, 131]. There seems to be some indication that victims of sexual violence do benefit from post-rape psychological report but that the long-term effect of these interventions has not yet been adequately studied [126]. However, the quality of services available for rape survivors seem to be limited by lack of qualified staff, especially female staff and medical supplies, not allowing for adequate and confidential detection and management, with the required extra time allocated to counselling of clients [130, 131]. In addition, only a small percentage of women receive services within 72 hours after experiencing sexual violence. Women are reluctant to report SGBV due to lack of personal security and adequate services as well as shame and stigma. Other reasons are lack of awareness of the need to receive treatment within this period of time particularly for post-exposure prophylaxis services [76, 97, 116].

Adolescents' reproductive health

Adolescents have been neglected for a long time in conflict situations, underestimating the risks to which they are exposed. However, they appear to have an increased risk of being sexually abused compared to younger children and might be more likely to engage in unsafe sexual behaviour due to the lack of social structures as well as lack of information [132]. Conflict settings can deprive adolescents of their traditional social structures, making them more vulnerable to sexual abuse and exploitation [133, 134]. In addition to the higher potential risk in terms of reproductive health, adolescents also seem to have restricted access to information and services, such as contraceptives and condoms, leading to a large number of unwanted pregnancies. Socio-cultural barriers appear to be an important factor preventing adolescents from adequate information and condom use [135]. At the same time they seem to want more reproductive health education and services [132, 136].

Scaling-up SRH services in health recovery

Evidence suggests that the scaling-up of the scope and coverage of SRH services is challenged by inadequacies in the health system, characterised by fragmented infrastructure, broken information systems, and lack of human resources [71, 87, 137, 138]. The difficulty lies in the transition from an acute emergency situation to sustainable service provision [139]. As documented above, family planning, ante-natal care and condom distribution seem to be the most established and first adopted services; areas of concern include EmOC, responses to SGBV, service provision for adolescents and STI services, broader family planning supplies, and referral systems [72-76, 121].

An additional complication appears to be that initiatives addressing SRH have a strong vertical and service-specific focus with separate planning, staffing and financing systems that do not work through existing health system structures [62]. In recovery situations where health systems are weak, this is even more likely to happen. However, concentrating on vertical services may compromise already weak systems and limit the long-term viability of the health services. It also risks duplication of services and uncoordinated training, recruitment and allocation of staff [62].

The literature review indicates that most of the existing evidence focuses upon SRH risk and far less on actual interventions or broader health systems issues [140]. Major constraints to improving SRH service delivery are human resources, both in terms of training and supervision, drugs and supply and information systems [141, 142]. This was particularly the case in attempts to scale-up services during health recovery [71, 87, 130, 131, 137-139]. Interventions seem to work as long as they are focusing on specific areas in terms of training, supply and infrastructure, as seen for EmOC and HIV management and as long as they have large support by international NGOs. While there is only little literature available about the implementation of SRH service in health recovery, there is even less evidence about implementation of SRH services as part of a BPHS and no empirical studies could be identified specifically on this issue.

1.6 Study aim and objectives

So far the thesis has outlined the challenges of health recovery in post-conflict situations and the use of the BPHS as an increasingly popular mechanism for addressing these challenges. It then described some of the key challenges associated with SRH in recovery situations. It further identified a lack of evidence on how services can be scaled up to meet SRH needs – particularly with regards to the implementation of the BPHS. The aim of this study was to explore the implementation of a BPHS and its influence on the provision of SRH services in post-conflict recovery. The objectives were to:

1. Assess the availability of sexual and reproductive health services at facility level.
2. Explore health service providers' and policy makers' perception on how the implementation of the basic package has influenced the provision of sexual and reproductive health services using a health systems framework.
3. Develop recommendations for policy making regarding SRH and BPHS in post-conflict recovery.

Chapter 2. Liberia

2.1 Country background

Liberia was chosen as a case-study site for several reasons. While different forms of BPHS are being implemented in several post-conflict settings, the government of Liberia seems to be particularly committed to this endeavour, stating in its health policy in 2007 to aim not only at improved health and equity in health but also at becoming a model of post-conflict health recovery [143]. This shows leadership and commitment, which are important factors for the recovery process [144]. Furthermore, maternal mortality is very high in Liberia, for which reason the reduction of maternal deaths is one indicator for the Liberian government to measure progress in health recovery.

Liberia had been exposed to civil unrest and violent conflict for fourteen years until 2003, leading to the death of an estimated 270,000 people and the displacement of 500 000 - out of a population of around 3 million [26]. While the entire country, consisting of 15 counties, had been affected by the conflict, the remote rural north-west (Lofa county) and south-eastern regions were most affected (see figure 2 below) [145]. In 2005, a civilian government was democratically elected, providing an opportunity of recovery and development. However, this is challenged by the low literacy rate of just 55%, a high unemployment rate, wide spread poverty and the lack of basic infrastructure, with low access to electricity, housing and water supply [26]. Since the end of the conflict, Liberia's position on the Human Development Index improved slightly over the past few years, going up to the 162nd position out of 169 in 2010 [146].

Figure 2: Map of Liberia with counties

2.2 Health service provision and status

The health system in Liberia is marked by the devastation caused by the armed conflict. A large number of health facilities in the country had been looted or were forced to be closed due to lack of staff and supplies. However, in 2006, there were 354 functioning health facilities and the number increased to 583 in 2009 [147].

After the conflict, the majority of facilities were running only with the assistance of NGOs and faith-based organizations; which still play a major role in service provision, managing about 80% of the facilities [148]. The majority of health expenditure in 2007/2008 came from donor sources (47%) and out of pocket spending (35%) [149]. Major constraints to health service provision were lack of qualified staff, most staff holding substandard qualifications: during the conflict often nurse-aides took up senior positions. After the conflict the number of medical doctors was reduced from 237 to less than 20 for the entire country [150]. A high degree of verticalization and fragmented service provision further hampered service delivery in Liberia. Most facilities required substantial infrastructural interventions and most of them presented with empty pharmacies [25]. By the end of 2009 a number of important international agencies left Liberia.

At the end of the conflict, Liberia presented as one of the countries with the worst health status in the world. Key health threats were malaria, acute respiratory infections, diarrhoea, tuberculosis, STI, worms and malnutrition [149].

In terms of SRH, the maternal mortality rate is high, and has increased between 1999 and 2008, from 578/100 000 to 990/100 000 [151]. The majority of births take place in the absence of skilled staff. Despite a decline over the past years, fertility rate is high (estimated 5.2 - 6.2), and contraceptive use is low, though there seems to be a high interest in contraceptives [149, 152, 153]. The coverage of antenatal care is rather high (80%), while post-natal care is low which is also linked to the fact that most deliveries take place at home [149, 152]. Further problems are teenage pregnancies - approximately half of all women in Liberia give birth by the age of 19. This is also fostered by early marriage. Of major concern is the fact that early childbearing increased between 2000 and 2007 [150, 152]. Teenage pregnancies often lead to unsafe abortions and therefore post-abortion complications, which further contributes to the high maternal mortality [154]. In addition, there is a high prevalence of SGBV; however, with the return of peace and security, its prevalence is

expected to decrease [11, 150]. Table 2 provides an overview of SRH indicators in Liberia:

Table 2: SRH related indicators in Liberia

Indicators	Liberia
Infant mortality total per 1,000 live births [155]	131
Under 5 mortality per 1,000 live births [156]	235
HIV prevalence [152, 156]	1.5 - 5.2
Fertility rate [152, 157]	5.2 - 6.2
Maternal Mortality ratio /100,000 live births [151]	990
Skilled birth attendance [158]	15%
Contraceptive Prevalence rate Any method [155]	6
Contraceptive Prevalence rate Modern methods [155]	6

Seven percent of health expenditure is spent on SRH - compared to 44% on malaria and 14% on child health. It is important to note that in terms of policy making the promotion of SRH appears to be high on the agenda of the Liberian government, as reflected in the national SRH policy and the Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality [154, 159].

2.3 Health system, national health policy and BPHS

In 2007, the Ministry of Health and Social Welfare (MOHSW), which was re-established in 2006, developed a National Health Plan, aiming not only at improved health and equity in health but also at becoming a model of post-conflict health recovery [25]. Overall, the plan is designed around four strategic orientations of Primary Health Care, Decentralization, Community Empowerment and Partnerships for Health. It aims at a shift from emergency humanitarian relief to development and from vertical programs to an integrated health system based on four pillars: the BPHS, human resources, support systems, and infrastructure. However, it seems that the main stress is put on service delivery through the BPHS, which is considered the corner stone of the National Health Policy, while less investment goes into health system strengthening, such as infrastructure and human resources [160, 161]. The health system has three levels of care besides the community level (table 3): hospitals, health centres and clinics.

As shown above, the implementation of the health policy faces several challenges. Public services are weak and depend on support from NGOs in more than 80% of facilities [148]. Gaps were already felt when Médecins sans frontièrs (MSF) left the country, even though a hand-over had taken place [160]. Decentralization is one important guiding principle in Liberia's new health policy. The aim is to build performing systems at county level, supported at central level. Each of the 15 counties will be responsible for service delivery, while policies are made at central level. However, lack of qualified human resources also hampers managerial capacities of the county health teams.

As a major cornerstone of the national health policy the BPHS was developed, recognizing that the MOHSW cannot do everything at once. The package is supposed to be available as a whole at all levels of the health system, though implementation is taking place in an incremental approach in terms of the percentage of health facilities offering the full BPHS free of charge. The aim was to provide the package in 70% of the health facilities by December 2010 [25, 26]. The national health policy also indicates that its content will change over time as the health system improves and a wider scope of services can be implemented [11]. The objectives and priorities of the BPHS in Liberia are as follows [161]:

- Improved child health
- Improved maternal health
- Increased equitable access to quality health care services
- Improved prevention, control and management of major diseases
- Improved nutrition status

The choice of the services to be included in the BPHS was mainly made based on their link with the principal policy objectives of the government of Liberia. Cost effectiveness was not the only inclusion criteria. Other issues were taken into account, such as the potential contribution to the reduction of morbidity and mortality in Liberia, safety and effectiveness, feasibility in the current Liberian context as well as the potential to remain sustainable [11]. The current package covers the following areas:

1. Services to be delivered
2. health staff present at each level of the health system and training needs
3. essential drugs available at each level
4. costing
5. operational plan for geographical and chronological roll-out of the basic package

In the Liberian BPHS SRH services are addressed in three categories:

1. Maternal and newborn health:
   - antenatal care
   - labour and delivery services
   - emergency obstetric care
   - postpartum care
   - newborn care
   - family planning
2. Reproductive and adolescent health:
   - family planning
   - STIs
3. Communicable diseases:
   STI/HIV/AIDS

SGBV is addressed under "mental health" and "emergency medicine". However, the response does not specify what kind of medical care, such as Emergency Contraception and post-exposure prophylaxis, is supposed to be provided.

Table 3 provides an overview of the three levels of health care in terms of staffing and services.

Table 3: Primary, secondary and tertiary health care in Liberia

Level of care	Health facility	Staffing	Beds and Equipment	SRH services
Primary	Health clinic	one nurse and one midwife	up to five beds	*from 8am to 4pm:* "Basic EmOC": postpartum haemorrhage, retained placenta, initial treatment and referral of cases of eclampsia and puerperal sepsis, complicated abortion and prolonged labour; Some deliveries, but rather supervision of traditional midwives to promote clean deliveries, recognition of danger signs and referral; Ante-natal care Family planning: pill, male and female condoms, injectables, IUD STI/HIV: promotion of condoms, ABC approach, awareness raising for VCT; VCT, ARV and PMTCT are not provided at this level but are expected to expand over next two years; Sexual education for adolescents.
Secondary	Health centre	two physician assistants, one registered nurse, four certified midwives, and a lab technician	up to 40 beds small laboratory, facilities for basic emergency care, such as adequate power source, communication, as well as an ambulance	Basic EmOC 24/7, assisted vaginal deliveries, manage more cases of eclampsia and puerperal sepsis; ANC/ PNC; Family planning: pill, male and female condoms, injectables, IUD STI/HIV: diagnosis and treatment of STIs VCT, ARV and PMTCT are not provided at this level but are expected to expand over next two years; Sexual education for adolescents.
Secondary	County referral hospital		more than 50 beds; common surgical capacities to provide basic intensive care	Comprehensive EmOC
Tertiary	John Fitzgerald Kennedy Medical Centre		will be rehabilitated as tertiary referral facility for the whole country	

Implementation of the Basic Package of Health Services

While the MOHSW of Liberia seemed to be mostly in control of the development of the BPHS, international partners did play an important role both in the design of the package and its implementation. The MOHSW acknowledged that the number and distribution of functioning health facilities run by the government was too limited to guarantee the availability of the BPHS to the entire population. In June 2008 only 5% of assessed health facilities had implemented at least 85% of the content of the BPHS. NGOs were therefore considered an important partner using performance-based contracting with the goal that by the end of 2009 40% of health facilities should be implementing the BPHS and by the end of 2010 70% [162]. The plan was to phase out NGOs gradually by shifting increasing responsibility to county health teams [148].

Currently, there are four mechanisms to implement the BPHS. The first one, 'Rebuilding Basic Health Services' (RBHS), has been funded by USAID since July 2009, which channels its funding through John Snow Inc., who administers performance-based contracting with NGOs in seven counties. The second mechanism is the pool-fund, with funding from DFID, European Commission, UNICEF and UNHCR, administered by the MOHSW. Performance-based contracting financed by the pool-fund started in November 2009 in five counties and was expanded to another four counties in April 2010 [163]. The third mechanism is funding provided by the European Commission and the Irish government directly to NGOs, not using a performance-based contracting approach. The fourth mechanism is with health facilities managed by the government of Liberia, without external support. While each county is supposed to be covered by one mechanism, encouraging partnership between agencies, with initial funding of one year, at present, most of the counties have a mixture of at least two mechanisms.

The rationale for performance-based contracting in Liberia was that this would extend the service coverage especially for underserved populations with provision of services to targeted groups; further, contracting is supposed to

help providing services that the government cannot provide due to limited human and technical capacities in a more cost-effective way [164, 165]. The main objective is the development of the capacity of county health teams who should be responsible for planning and resource coordination to rely less on external support over time.

Contracts are closely oriented along the BPHS and the National Health Strategy consisting of three components:

1. Delivery of the BPHS
2. Expansion of selected BPHS services
3. Strengthening of the County Health Team capacities

The implementation of the BPHS is regularly assessed through an accreditation process by the MOHSW, which gathers information on

- Human resources and facility management
- Pharmacy dispensary and storeroom
- Drugs and supplies
- Laboratory and diagnostic services
- Equipment
- Infection prevention and environmental sanitation
- Medical records, confidentiality and referrals
- Health services
- Operational space and utilities

The accreditation does not look at quality of services per se, but rather at the extent to which the standards as prescribed by the BPHS are in place. It assesses the existence of services and pre-requisites to provide quality services [166]. This assessment initially took place twice a year starting in 2008, but was then reduced to an annual assessment. The purpose is to prioritize activities and appropriately allocate resources to support those facilities and counties most in need. Each assessment provides a snapshot of the facilities in terms of the BPHS standards. At the facilities, assessment

teams gather information about staffing, records and vital statistics. They then ask specific questions to the officer in charge and designated staff in the different operational areas listed above. The following SRH services are assessed during the accreditation process:

- Maternal and newborn health:
    - Ante-natal care
    - Labour and delivery and post-partum care
    - Newborn care
    - Adolescent and reproductive health
- Child Health
- Communicable Diseases: HIV/AIDS
- Emergency Care
- SGBV

Most questions in each area refer to the availability of required equipment and supplies, but not at their actual use. Scores are being calculated based on a weighted average of performance in each component, giving most weight to health services with 40%. All other areas are each weighted 7.5% [167, 168]. Facilities that have met a score of 85% are provisionally accredited, and those that reach 100% of the assessment score are fully accredited [169]. The accreditation score is also part of the performance-based indicators for NGOs.

Besides the BPHS, several other policies have been developed to support service provision. Not all of them were finalized when the implementation of the BPHS started. Table 4 below gives an overview of those policies that are most relevant for this study. It further needs to be noted that in 2011 an expanded version of the BPHS, the Essential Package of Health Services was developed [170].

Table 4: List of relevant Policies and Strategies

Policies	Strategic Plans
National Health Policy and Plan (2007)	
A Basic Package of Health and Social Welfare Services for Liberia (2008) National Strategy and Policy for Community Health Services (2008) National Mental Health Policy (2009) Sexual and Reproductive Health Policy (2010) National Health Policy on Contracting 2008-2011	Roadmap for the Implementation of the BPHS (Jun '07) MMR Road Map: MOHSW GoL (2007 & 2010) National HIV/AIDS Strategic Framework II 2010-2014 (2010) Integrated Guidelines for HIV-AIDS Testing, Care, Treatment National Family Planning program strategy and operational plan (2010) Emergency Human Resources Report and Plan (2007-2011) National In-Service Education Strategy (2008) Policy Options to Retain Nurses In Rural Liberia: Evidence From A Discrete Choice Experiment (2010) The National Census of Health Workers in Liberia (draft 2010) Supervision Manual Final (2009)

Chapter 3. Conceptual Framework

This study explored issues related to the implementation of a policy, the BPHS, in post-conflict recovery with a focus on SRH services. This was done from the perspective of policy makers as well as implementers at facility level as important agents in the health system. This chapter outlines the theoretical basis and conceptual framework for this study. It will first discuss policy implementation theories in general and then focus on Lipsky's bottom-up theory. A health system framework was used as a means of breaking down the implementation process into manageable components (i.e. the parts of the health system). This will be explained further below.

3.1 Policy implementation theories

A policy process can be divided into agenda setting, formulation, implementation and evaluation [171]. Even though these four steps should not be seen in a linear process, and cannot be seen as entirely distinct entities, this study focused mainly on the implementation. The rationale for this focus is the increasing use of BPHS in post-conflict recovery but with little information about its implementation at the service delivery level. The following will provide an overview of implementation theory underlying the conceptual framework of this study.

The importance to assess and analyse the actual implementation was increasingly recognized, as it was realized that policies did not work out as planned in practice and there was a gap between what was planned and what happened as a result of a policy [172, 173]. Research on policy implementation assesses what happens between the policy expectations and the actual results on the ground. Theories on policy implementation distinguish between top-down models, whereby decision makers produce policy objectives and control the implementation stage and bottom-up models that consider low-level workers or 'street-level bureaucrats' as the main actors in policy delivery [174]. The top-down approach is a rather rational model, seeing policy implementation as a linear process between the formulation and its execution. Representatives of this approach, Van Meter, Van Horn,

Mazmanian and Sabatier were mainly interested to which extent implementation actions coincide with goals defined at central level [175]. Accordingly, Pressman and Wildavsky, important representatives of the top-down approach, suggested that effective implementation required clearly defined goals, available resources with a functional communication and control system in place [172].

The top-down approach was soon criticized as unrealistic, as it assumes a number of factors all to be in place at the same time, such as adequate time and resources, agreement as well as understanding of tasks and objectives by all actors, perfect communication and coordination, committed and skilled staff but also the ability of those in authority to demand and obtain full compliance by front-line staff [176]. The top-down approach starts with a policy and merely assesses to which extent it has been achieved over time [176]. It emphasizes the role of actors who design the policy and factors that can be manipulated from a central level [175, 177].

A key criticism towards the top-down approach raised by several representatives of the bottom-up approach, such as Hjern and Hull, Hanf, Barret and Fudge is the ignoring of political aspects influencing implementation and the neglect of other actors and their strategies besides policy makers and the fact that policy makers are considered the main actors [175]. These representatives of the bottom-up approach argue that this may lead to the underestimation of implementers, who potentially change policies. In their view, policy implementation can be better understood by looking at the policy from the viewpoint of target groups and implementers. The bottom-up theory recognizes that implementers play an important function as active participants instead of managers of policies that have been handed down to them and often deflect programs developed at central level toward their own end [176]. The theory further acknowledges that the relationship between central, regional and local actors, such as the ability of the centre to control lower levels in terms of operating rules like performance assessment, audits, incentives etc., influence the implementation of a policy to a great extent [178].

This should be explored from the implementers' perspectives in order to understand the implementation process.

One could argue that the bottom-up approach to policy research puts too much emphasis on the autonomy of local implementers, also considering that they can be influenced to a certain extent. Sabatier, who favours a synthesis of the top-down and bottom-up approach, argues that mechanisms can be put in place to overcome the central role of staff's constraining behaviour, such as choosing the staff and provide appropriate incentives and sanctions [176]. Yet, as seen in the background section of this thesis, these options are limited in post-conflict settings, therefore limiting the possibility of controlling staff behaviour. Moreover, the literature review on SRH services in post-conflict settings highlighted the central role of human resources for the availability of SRH services. The focus of this study was not to which extent a policy is being implemented, nor the effectiveness of a government program, but rather to understand underlying processes of the implementation process. It therefore took into consideration that policy implementation is influenced by several stakeholders. The purpose of this study was to develop a deeper understanding of how actors deal with a certain policy. For this reason, the bottom-up approach, exploring the perception of street-level bureaucrats was used. The next section will provide more detail about the bottom-up approach chosen for this study.

Lipsky: Street-level bureaucracy

There are several representatives of the bottom-up approach of policy research with different foci of attention. Hjern and Porter conducted most of their research in organizations, highlighting the importance of networks [176]. Their emphasis lies on the interaction of unions or agencies and therefore networking techniques. Berman distinguishes two levels of policy implementation; the central level, where the policy is designed and the micro implementation level, on which the central level only has minimal influence [175]. Lipsky, with his analysis of front-line staff in policy delivery agencies, who he called street-level bureaucrats, is one of the main representatives of the bottom-up theory [179]. Compared to Hjern he focuses more on the individual and his or her way of implementing a certain policy. Overall, while

researchers of the bottom-up approach focused on different aspects of policy implementation, they had in common that in their view implementers play an active role in the implementation process, potentially modifying a policy, adapting it to their working conditions [175].

Lipsky's approach was considered most appropriate for the purpose of this study, taking into consideration the Liberian context. Hjern's approach was not easily applicable to my study, as health workers in the post-conflict setting in Liberia are rather isolated, without the networking structures of unions. Lipsky focuses on the fact that people in public employment who are delivering government policies, typically cannot perform their jobs according to the standards of the decision making level due to a number of factors related to their working conditions [180]. Even though his research was mainly conducted in the American context, it seemed most applicable and relevant to my study. His theory, which therefore underlies the conceptual framework of this study, will be described in more detail in the following section.

According to Lipsky, workers of the public service have a critical position, as they deliver policies to citizens and stand in direct contact with the beneficiaries. While public health is the government's responsibility, health workers at facility level play a crucial role in the implementation of the policies. They exercise a certain discretion in terms of decisions about their clients, as they determine to an extent the amount and quality of services provided to patients [180].

Workers may not share the objectives and preferences of their supervisors and may not necessarily work towards the same goal. Their priority may lie in minimizing discomforts of the jobs and maximizing income and personal gratification. Furthermore, their compliance will depend on the extent they consider their managers legitimate to expect them to work in line with policies. In addition, workers at facility level usually have personal standards regarding who should receive a service [180].

The fact that lower-level workers may not share the same objectives as policy makers indicates that the analysis of policy implementation requires an understanding of the working conditions and the priorities of those who are actually delivering a policy. Working conditions include resources to provide services, goal expectations, but also the measuring of performance. If goals are stated in an ambiguous way, workers are more on their own in their service provision. This in turn makes the measurement of performance difficult, often focusing on quantifiable measures and less on quality [180].

Another important aspect of street-level bureaucracy is the fact that clients are often not voluntary, not having a choice as to where to obtain services. While street-level bureaucrats do not necessarily lose anything if they are not satisfying their clients, and have little incentive to perform, their clients have little information to compare or assess their treatment, nor can they easily discipline service providers. Both have an important impact on the relations between the workers and their clients and can even lead to neglect and abuse of patients. In addition, some workers may be biased towards particular groups of clients [180].

Patterns of practice as described above have the potential that low-level workers may indirectly change policies, adapting their tasks to the working conditions and setting their own priorities. This does not necessarily mean that they do not want to do their best implementing prescribed policies, but they have to work under the constraints that they usually encounter in their everyday work. The different aspects that influence the work of service providers leads to the argument that one cannot take for granted that workers' behaviour will conform to expectations of policies makers. Instead, there are several factors that might lead to a certain discrepancy between policy declaration and the actual policy implementation. These working conditions therefore need to be looked at closely. Translated to the health sector, this means that the nature of implementing large-scale health policies on a national basis might prevent health workers from implementing the ideal conception of the policy, which also has implications for the availability and quality of services [180]. It is therefore important to compare the policy to the reality on

the ground and to gain perspectives regarding the health system of both policy makers and front-line staff responsible for the actual delivery of a policy. Implementation is a complex process that involves a number of different actors at both 'top' and 'bottom' levels [179].The analysis of policy implementation in the health sector therefore requires to take the working conditions, in this case the entire health system into consideration. This means to go beyond monitoring inputs but instead to study what is happening at the level of actors who are at the delivery level in order to understand the translation of a policy into practice [173, 174, 181]. The monitoring and evaluation process of the BPHS focuses on technical inputs, activities, outputs and outcomes, but there is less understanding of underlying implementation processes and the perspectives of the actors involved regarding their working conditions.

3.2 Health System Approach

The implementation of the full BPHS depends on a number of factors related to the health system [182]. While front line health workers play a key role in the implementation of the basic package, the literature review showed that their work is influenced by work conditions, such as infrastructure, supplies but also supervision. To embrace both these aspects, the bottom-up approach to policy implementation research based on Lipsky's street-level bureaucracy theory was applied to a health system framework defined by WHO allowing for comparison between policy makers' and implementers' perception on the different health system components (see figure 3 below). This allows Lipsky's theoretical approach to be broken down into manageable components and to apply it to a practical example of policy implementation. Furthermore, it identifies how the different health system components are interlinked. There is increasing recognition of the need to take a health systems approach to analyse health service provision [183]. The analysis of potential facilitators and barriers of SRH service provision was therefore structured along the WHO health system framework. Taking into consideration WHO's normative role in public health and health system analysis, it was deemed appropriate to apply their framework to this study. The framework used is a further development of the health system building blocks and therefore the latest approach to health

system analysis as developed by WHO [183, 184]. It consists of the following components as illustrated in figure 3:

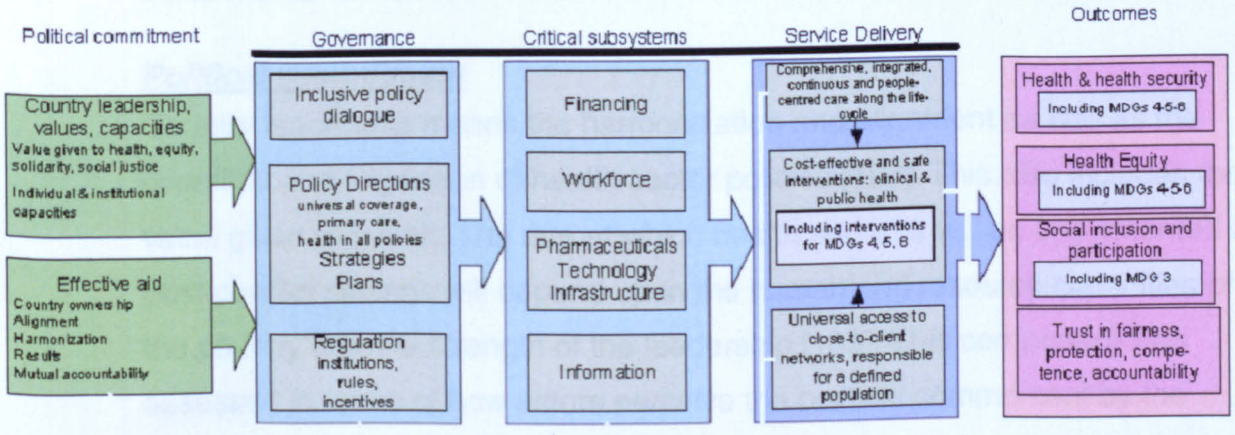

Figure 3: Health System Framework (WHO [184])

- Governance
  - Policy directions, strategies, plans
- Critical subsystems
  - Financing
  - Workforce
  - Pharmaceuticals, technology, infrastructure
  - Information
- Service delivery

In addition, political commitment, such as country leadership are considered important inputs for effective implementation of health services [184]. This study was interested in processes of the policy implementation and not in outcomes. The last component of the health system model in figure 3 will

therefore not be considered. Furthermore, this would not be possible at this stage of the implementation of the BPHS.
The following gives an overview of the definitions of the health system components with a focus on SRH services, adapted to my study:

Political commitment

Country leadership means the harmonization and alignment as well as the oversight and regulation of health sector policies [183]. This also includes the value given to health. The rate at which health services will be implemented in post-conflict settings will depend upon the human and resource capacities of the country and the strength of the leadership [185]. This component was assessed in terms of how actors perceive the political commitment by the MOHSW to the implementation of the BPHS.

The WHO framework also lists effective aid under political commitment. While important, this goes beyond the focus of this research and was therefore not studied.

Governance

According to the WHO model, governance includes an inclusive policy dialogue, policy directions and strategies and plans. Governance is supposed to ensure strategic policy frameworks and their implementation [183]. It has important implications for policy implementation at facility level both in terms of communicating and understanding of policy directions by lower level workers, which can be reached by an inclusive policy dialogue. Policy directions have to take decentralized entities, such as district health teams into consideration to assure understanding and therefore the implementation of services in peripheral areas. This study therefore explored how governance is perceived by actors, and how policies and strategies are understood at each level. Strategies for the policy implementation include performance-based financing mechanisms. This approach requires research by itself, focusing also on financing mechanisms. For the purpose of this study I only explored the perception of actors on how performance-based contracting influenced the provision of SRH services.

Critical Subsystems

Financing

Financing relates to both financing policies and tools and data on health expenditures of a country [183]. It was considered beyond the scope of this research to include national financing systems. Financing was therefore only addressed in terms of perceptions of the role of out-of-pocket spending by beneficiaries, as this was considered an important aspect of the implementation of the BPHS, which is supposed to be provided free of charge to patients.

Workforce

Workforce covers national workforce policies and investment plans, including norms and standards, but also advocacy [183]. Prolonged conflict has major negative effects on a country's health workforce, such as an imbalanced composition of health workers and deteriorating skills and training capacities. In addition the educational system is disrupted and qualified teachers are lacking [186, 187] . The lack of qualified staff, particularly female staff, and its uneven distribution is one major obstacle to the provision of SRH services [188]. The re-establishment of a human resource system can be challenged by lack of training capacities along with different types of health staff who have been trained in different settings [186, 187]. While ad hoc trainings in a vertical way might be the only possibility during acute emergencies, it will be important to have a more integrated and long-term approach during recovery [186].

Successful implementation of a policy will depend on the capacity as well as the motivation of health staff. This study explored the perception of policy makers and health workers on aspects related to workforce, such as training, supervision and motivation.

Pharmaceuticals, technology and infrastructure

The main focus of this component is reliable procurement, equitable access and quality ensured by norms, standards and policies [183]. The provision of reproductive health commodities faces several challenges such as increasing demand, insufficient and poorly coordinated donor funding and inadequate

logistic capacity in the countries, not only in post-crisis settings. While this study did not address details regarding the national drug procurement system, issues around supply at facility level were raised during the interviews.

Infrastructure plays an important role for the availability of services, particularly those that require running water and electricity, as well as a functioning referral system. Lower-level workers depend on the supplies and the infrastructure provided to them to perform their work. They will adapt to the conditions and provide services according to the availability of supplies and material. The perception of health workers of these aspects was therefore addressed during this study.

Information

Information includes both, facility and population based information and surveillance, as well as assessment tools and standards [183]. A functioning health information system should ensure reliable and timely provision of information about health determinants, health systems performance and health status at all levels of the health system [183]. This system however deteriorates during a crisis. As a result, there is often no information system as such, but rather a number of information storages by each agency. In my interviews I addressed the perception of actors on the information gathering process.

Service delivery

SRH service delivery has been discussed in detail above. The availability of some SRH services included in a BPHS may be affected by their complexity and the extent and quality of services will depend on the conditions under which health workers work and how they adapt to their working conditions. Service delivery can also be impacted by issues such as attitudes and priorities of workers at facility level. This is also influenced by the available infrastructure, such as electricity and water, the possibility to guarantee privacy during consultations, but also emergency transportation. The perception of actors on these factors was therefore part of my study.

The WHO health system model further includes cost-effective interventions and universal access under service delivery. These aspects were not part of

my research, as they would go beyond the scope of this study, requiring different methodologies than used for this research.

3.3 Summary

This study explored the implementation of SRH services through a BPHS. Taking Lipsky's theory on street-level bureaucrats as the theoretical basis of the study, the study explored the perceptions of health workers at facility level as well as of policy makers on the implementation process. This allowed for a better understanding of the process from the perspective of implementers in relation to the perception of policy makers. In order to facilitate the application of this theoretical framework of policy implementation to the practical example of the BPHS in Liberia, the perception of the implementation process and the conditions under which SRH services were provided was explored through a health systems framework.

Chapter 4 Methodology

The study drew on qualitative methods, using document review and semi-structured interviews. Interviews were conducted at three levels, front-line health staff at facility level, their supervisors at county level, and with policy-makers at the policy making level. In total, 63 interviews were conducted. This chapter describes the rationale for the use of qualitative data as well as the sampling, data collection and data analysis processes.

Monitoring and evaluation through the accreditation process of the BPHS in Liberia relies predominantly on quantifiable indicators, such as the number of facilities offering the services covered by the BPHS [162]. While this information is crucial in order to monitor the implementation process of the BPHS, it does not provide information about underlying processes, barriers or facilitators to SRH service provision. Qualitative data helped provide additional and more in-depth information with the potential to inform future designs of BPHS with particular insights into the implementation process and different perceptions of actors at different levels. This is important as it has been acknowledged that the BPHS was developed through the consensus among a centrally located group of leaders and experts [11]. This implies a top-down approach taking inputs from front line health workers less into account. Qualitative methods provide a useful strategy to investigate conditions around policy making and implementation of the BPHS. They allow for insight into perspectives and attitudes of health service providers, who otherwise have little opportunity to share their views. Interviews at the different levels in terms of management and policy making as well as implementation at health facility level have the potential to provide evidence for further development of basic packages. This is particularly important for this case study as evidence suggests that human resources play a crucial role for successful implementation of SRH services [189].

Semi-structured interviews allow to gather information on the same issues from all respondents who are at different levels in the health system [190]. They have the potential to also shed light on possible reasons why certain services

are provided and others not, and what is needed in order to provide lacking services. It was deliberately decided to only use semi-structured interviews and not focus group discussions. Focus group discussions have the advantage to provide information on the interaction between respondents. This aspect, while interesting, was considered less crucial for the study. Instead, semi-structured interviews allowed individual perspectives on the policy implementation from representatives of different levels and types of agencies were considered more critical. Another reason was the logistic challenge of bringing donors, policy makers and NGO representatives together to discuss this issue as a group. This would have been impossible for service providers who are based at rural facilities that are far from each other without any means of transportation. However, potential limitations of individual interviews, such as a possible bias when being interviewed by a foreigner who works for WHO, and therefore reservations to being fully open have been recognized and taken into account during the data analysis.

4.1 Sampling and sample sizes

Counties

Purposive sampling was applied for the selection of the counties included in the study. The counties were selected using the following criteria:

1. Presence of at least one health centre in the county to allow for assessment of all levels of the health system.
2. Minimum of one year duration of BPHS implementation to make sure that experience with the BPHS has been gathered.
3. Absence of additional massive aid since the peace agreement as seen in those counties most affected by the crisis.
4. Accessibility during the rainy season.

Table 5 provides an overview of the selection process:

Table 5: County selection criteria

Selection Criteria	Counties	Remarks/ Rationale
Number of health centres in the county, where the BPHS is being implemented: more than one	Grand Cape Mount, Lofa, Margibi, Maryland, Montserrado, Nimba, River Gee	Health centres are not present in all counties; in order to get the full picture of the implementation of the BPHS and the referral system, it is important to look at all three levels of the health system.
Duration of the implementation of the BPHS: minimum one year	Grand Cape Mount, Lofa, Montserrado, Nimba, River Gee	The full implementation of the BPHS is a gradual process that requires time. In order to fully assess experience with its implementation, a period of at least one year is required.
County has not received massive aid since the peace agreement	Grand Cape Mount, Nimba, River Gee	Some counties have received substantial support during and following the peace process, partially going beyond the BPHS. This might falsify the picture, as services are provided outside of the National Health Policy and are not likely to be sustainable. This is particularly the case in Lofa county, where additional projects provide services and an ambulance system.
Practical and logistic issues (accessibility):	Grand Cape Mount Nimba	Accessibility of counties in the south-eastern part of the country is very low, particularly during the rainy season.
Final choice	**Grand Cape Mount & Nimba**	

Based on the four selection criteria listed in table 5, data were collected in two counties: Grand Cape Mount and Nimba. It was decided to collect data in both counties as this had the potential of providing insight in potentially different challenges and facilitators for the provision of SRH services.

Health facilities

In order to get the full picture of the implementation of the BPHS, it was necessary to assess all three levels of care, clinic, health centre and hospital. At the same time, it was not feasible or necessary to visit each clinic in the counties. Based on discussions with experts in Liberia, it was estimated that one out of four clinics would provide an informative insight. In order to guarantee an even distribution across the county, at least one clinic in each district was selected. Further selection criteria for clinics were:

1. At least one facility per district, ideally two;
2. Inclusion in the accreditation process since January 2009;
3. Preference to clinics that are not located at main roads as far as they are accessible in order to also gain insight in challenging settings;
4. Inclusion of both clinics supported by the MOHSW/county health team only and those supported by an NGO.

In Grand Cape Mount County all the facilities that had been selected prior to the data collection were accessible. The hospital and both health centres were located near major roads and therefore easily accessible.

In Nimba County many clinics were not accessible due to the bad road conditions, which were even more deteriorated during the rainy season. Furthermore, a number of clinics were either temporarily closed or were run by a medical student due to absence of staff. This meant that in Nimba only four clinics were visited, but it was made sure that at least one facility per district, either a clinic or a health centre, was visited. All four health centres as well as the hospital were accessible and visited.

Data collection was hence conducted in total at 19 facilities: 2 hospitals, 6 health centres and 11 clinics (Grand Cape Mount: 1 hospital, 2 health centres, and 7 clinics; Nimba: 1 hospital, 4 health centres, and 4 clinics). Figures 4 and 5 show the clinics that were visited, and in the case of Nimba County, identify the clinics that had initially been selected but could not be visited either due to the unfavourable road conditions or lack of staff.

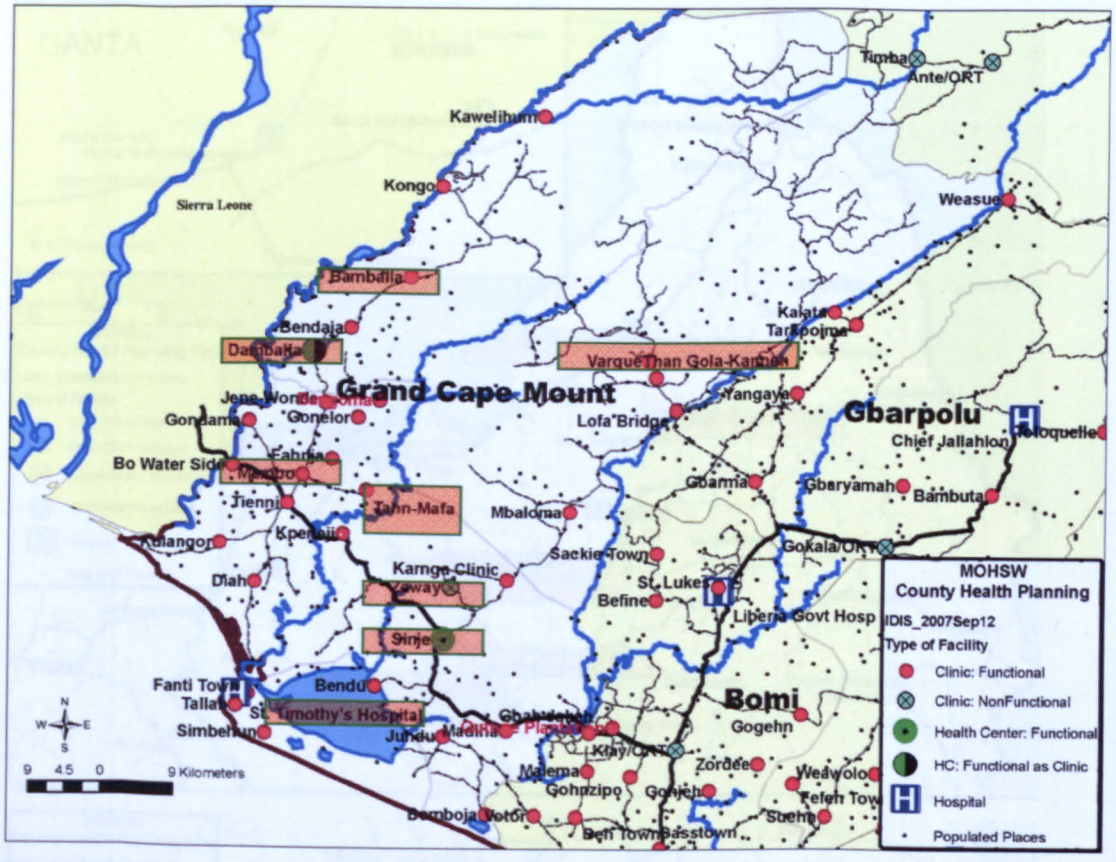

Figure 4: Map of Grand Cape Mount County, with visited facilities highlighted in orange boxes

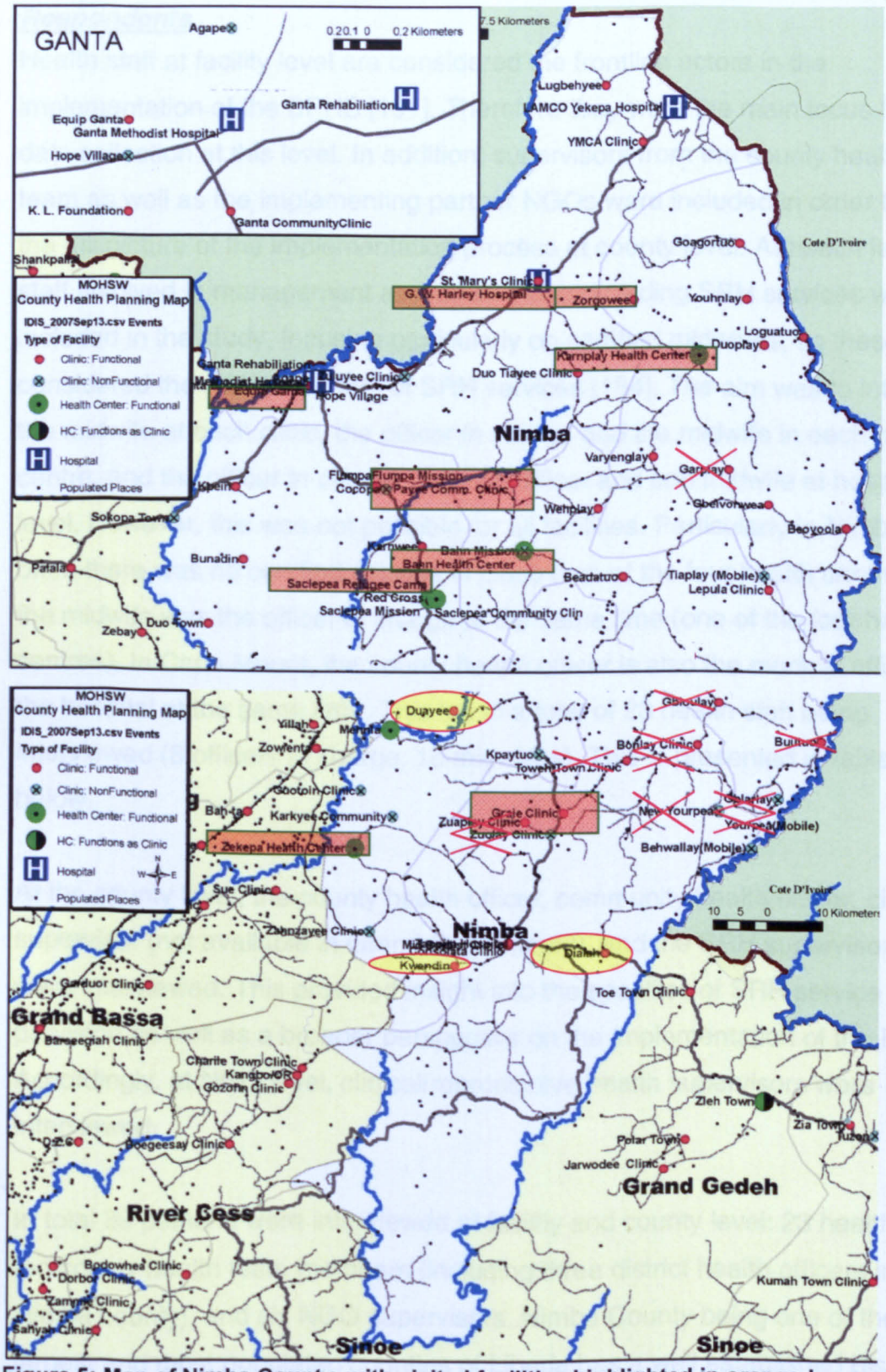

Figure 5: Map of Nimba County, with visited facilities highlighted in orange boxes

(Yellow circles indicate clinics that were visited but closed; red crosses indicate facilities that were planned to be visited but were inaccessible)

Respondents

Health staff at facility level are considered the frontline actors in the implementation of the BPHS [191]. Therefore they were the main focus for data collection at this level. In addition, supervisors from the county health team as well as the implementing partner NGOs were included in order to get the full picture of the implementation process at county level. At health facilities staff involved in management as well as those providing SRH services were included in the study, focusing particularly on certified midwives, as these are considered the main providers of SRH services [154]. The aim was to interview the midwife at each clinic, the officer in charge and the midwife in each health centre, and the officer in charge, medical officer and one midwife at hospital level. However, this was not possible for all facilities. Particularly in Nimba, often there was no certified midwife in place (two of the four health centres), or the midwife was the officer in charge at the same time (one of the four health centres). In Cape Mount, the county health officer is also the medical officer of the hospital at the same time. This led to a total of 23 health staff being interviewed (8 officers in charge, 15 midwives). This is presented in table 6 below.

At the county level, the county health officer, community health officer, clinical supervisor (not available in Grand Cape Mount), and the SRH supervisors were interviewed. This provided insight into the specifics of SRH service provision as well as a broader perspective on the implementation of the BPHS. Accordingly, at NGO level, clinical/reproductive health supervisors were interviewed.

In total 39 persons were interviewed at facility and county level: 23 health staff, ten county health team members (including three district health officers in Nimba county), and six NGO supervisors. Nimba County being one of the largest and most populated counties of Liberia has a well established district health system that supports the county health team. This is not as well established in Grand Cape Mount, where district health officers were not available for interviews.

A separate range of policy-level interviews took place in Monrovia with staff from the MOHSW, who are involved in the implementation of the BPHS, NGOs who are implementing the BPHS and other partners such as UN agencies and local NGOs providing SRH services. At policy making level, purposive sampling, also using snowball sampling was applied for the selection of interviewees. Interviewees were explicitly selected depending on their involvement in the implementation of the BPHS in Liberia. They were identified according to their implication in the selected counties, but also their involvement in the BPHS in Liberia in general. In addition, interviewees indicated other persons to me who were able to provide insight into this topic. The sample size was determined during the study process using a saturation approach. While the snowball approach may have the disadvantage of only interviewing respondents with similar view points, this was avoided by also taking a proactive approach of identifying interviewees. A total of 24 interviews were conducted at policy making level:

Government: 8

UN agencies: 3

International NGOs: 7

Local NGOs: 3

Donors: 3

The interviews sought to obtain descriptions of the interviewees' experience with the BPHS to gain information about how donors and NGOs under contract expect SRH service availability to be affected by the BPHS [189].

Table 6: Overview of interviewees by level

	Grand Cape Mount	**Nimba**	**Total**
Facility level	4 officers in charge, 8 certified midwives	4 officers in charge, 7 certified midwives	23: 8 officers in charge, 15 certified midwives
County/supervisor level	3 county health team, 2 NGO supervisors	4 county health team, 4 NGO supervisors	16: 10 county health team, 6 NGO supervisors
National/policy making level			24
			63

4.2 Topic Guides

Interview topic guides for the facility and county level were pilot tested and revised twice. The first pilot stage, which consisted of a convenience sample of two facilities within Montserrado County, led to significant changes in wording and sequencing of questions in the topic guide. It further provided an estimate of time requirements to complete the interview. The second pilot was conducted in one clinic in Monrovia. After this second pilot, only minor changes were made to the topic guide and no further piloting was required.
Interviews at facility and county level covered the following areas:

- Awareness of and experience with BPHS, particularly regarding SRH
- Challenges and needs in SRH services provision and how they are addressed through the BPHS
- Health system issues of SRH service provision, including infrastructure, supply, reporting, referral
- Work with the community, the county health team and the partner NGO

Interviews at policy making level were refined according to a preliminary analysis of the interviews conducted at facility and county level. Two interviews at policy making level were conducted immediately after the first phase of the field work for practical reasons, as both respondents left the country soon after and would not have been available for a later interview. Based on these two interviews, the interview guide was revised once more. Interviews covered the following areas:

- Challenges and needs in SRH services provision and how they are addressed through the BPHS
- Implementation of the BPHS
- SRH service delivery and uptake by the community
- Monitoring and evaluation / performance based contracting

All interview guides are provided in annexes 1 to 4.

4.3 Document review

A review of a number of documents mainly from the MOHSW of Liberia, regarding the national health plans and health policies around the implementation of the BPHS was also conducted. In addition, the availability of SRH services and required supplies and equipment (objective 1) was assessed through the review of the accreditation reports of the BPHS. The accreditation process assesses the availability of human resources, equipment, drugs and services that are included in the BPHS, focusing on quantitative data, but not on quality of services. The last assessment had been conducted six months prior to the data collection of this study and was therefore considered valid for the purpose of this study. The accreditation reports provide detailed information on the availability of supplies and equipment that are necessary for SRH service provision. The use of the accreditation reports had two benefits. First, it provided detailed insight in the assessment process of the MOHSW and the type of information collected to monitor the implementation of the BPHS. Second, the accreditation reports provide detailed information on the availability of drugs, supplies and equipment at facility level. Moreover, during the pilot testing of the interview topic guide for semi-structured interviews at facility level it was felt that assessing the health facility in terms of equipment and drugs, as had been planned initially, did not provide additional information that was not available from the accreditation report. It further seemed to give the impression to health staff that this study was another evaluation, putting them less at ease during the interviews. This would have been in contradiction to the way this study was presented to them and how I introduced myself to them, stressing that I was not evaluating them but was interested in their points of view. For this reason, it was decided to use available information from the accreditation report and to obtain further details during the interviews.

4.4 Data collection process

Data collection was done in two phases: Objective 1 (the assessment of SRH service availability) and part one of objective 2 (the exploration of health workers' perspective on SRH service provision) were addressed during the first phase in July and August 2010 in the two selected counties. Results were analysed preliminarily, in order to refine the interview guide for the second phase of semi-structured interviews addressing the second part of objective 2 (policy makers' perspective on the implementation of SRH service through the BPHS). This second phase of data collection was conducted in Monrovia in September and October 2010.

The first set of semi-structured interviews were held at county and health facility level in Grand Cape Mount and Nimba counties with health service providers, county health teams and supervisors from partner NGOs. The interviews were conducted by me, with a research assistant of Liberian nationality who was always present in order to translate as necessary. Due to limited mobile phone coverage in both counties, we showed up unannounced at the facilities. This however did not seem to pose a problem, as all interview partners were welcoming and agreed to be interviewed.

The research assistant was selected prior to piloting of the interview guides, as it was considered necessary for her to be part of the entire process. Based on discussions with the WHO country office and the MOHSW, selection criteria for the research assistant were:

1. Preferably female (as the majority of respondents were female)
2. Have a background in sexual and reproductive health (preferably midwife) plus additional studies
3. Work experience
4. Have an interest in operational research
5. Computer skills: word (ability to transcribe interviews on a computer)

The candidate was then thoroughly informed about the study and the data collection by me. A second person who had a background in research and interview transcription was additionally hired to assist in the transcription particularly of interviews held in Liberian English. All other interviews were transcribed by me.

Prior to each interview, I introduced myself and the research assistant, provided information about the study both orally and written, and gave the interviewees the opportunity to ask questions. Interviewees then signed an informed consent form, indicating that they had received all necessary information, that they participated voluntarily in the interview and that they agreed that information obtained during the interview could be used in the final report anonymously and confidentially. At facility and county level, all participants except for two agreed to be recorded during the interview.

The research assistant who accompanied me during data collection in Grand Cape Mount had been involved in a study on quality of health services conducted by USAID and the MOHSW. She had not revealed this during the selection process. For this reason, a new research assistant was chosen for interviews in Nimba. However, identifying a second research assistant with the required background was not possible. For this reason, the focus was put on the fact that she had a background in SRH. This may have had some implications on the data collection. It would further have been preferable to have the same research assistant throughout the entire time.

The second set of semi-structured interviews at policy making level, addressing part two of objective 2, was conducted with government staff (MOHSW and ministry of gender), implementing partner NGOs, local NGOs and UN agencies. No research assistant was present during this second phase, as all interviews were conducted in Standard English. Eight participants refused to be recorded. In these cases, detailed notes were taken.

Electronic versions of all interviews were recorded without attaching facility names to them. The recordings were kept on my computer and temporarily on the computer of the person hired to assist in interview transcription. They were deleted from this computer once all transcriptions had been completed. Table 7 below, which follows guidelines by Mason [192] on planning of qualitative research provides a summary of the data collection process.

Table 7: Summary table of data collection process

Objective	Data collection	Purpose	Justification	Respondents and approximate number	Time frame
Objective 1: Assess the availability of sexual and reproductive health services at facility level.	Review of accreditation Reports for Grand Cape Mount and Nimba Semi-structured interviews	Determine which SRH services included in the BPHS are available at health facilities; determine which pre-requisites are in place for service provision	The accreditation report provides rather detailed information about the availability of equipment, drugs and services; additional information could be obtained during semi-structured interviews.	Accreditation report and clinical records 2 hospitals 6 health centres 11 clinics *Total: 19 health facilities*	July/ August 2010
Objective 2 Part 1: Explore health service providers' perception on how the implementation of the basic package has influenced the provision of sexual and reproductive health services using a health system framework.	semi-structured interviews	Gather information about how health personnel at facility and county level perceive facilitators and barriers for the provision of SRH services and how the BPHS potentially affects their work	Semi-structured interviews have the potential to provide both factual information about the implementation of the BPHS and health providers' attitudes and opinion about this approach	Facility staff: 15 Certified Midwives 8 Officers in charge County Health teams: 2 County Health Officers 2 SRH supervisors 1 clinical supervisor 2 community health supervisors 3 District health officers NGOs: 5 SRH supervisors 1 clinical supervisor *Total: 39 semi-structure interviews*	July/ August 2010
Objective 2 Part 2: Explore policy makers' perception on how the implementation of the basic package has influenced the provision of sexual and reproductive health services using a health system framework.	Semi-structured interviews	Gain insight into the perspective of policy makers regarding the findings at facility level and their perspective on the implementation of the BPHS and SRH services	Semi-structured interviews have the potential to provide both factual information about the development of the BPHS and policy makers' interpretation of potential difficulties, and possible solutions through the BPHS	Government: 8 INGOs involved in implementation of the BPHS: 7 Local NGOs providing SRH services: 3 UN: 3 Donors: 3 *Total: 24 semi-structure interviews*	September/ October 2010
Objective 3: To provide recommendations to help Inform policy making for SRH services in health recovery.					

4.5 Data Analysis

Preliminary analysis of the interviews conducted in the first phase was undertaken to identify key issues to be included in the interviews in the second phase. A more in-depth analysis was then conducted in a systematic manner, applying guidelines to ensure rigour, such as by maintaining meticulous records of the data collection, by developing a systematic coding framework and by enhancing validity through comparing oral with written reports [193].

Coding Framework

The in-depth analysis used a thematic approach to group data into key themes emerging from the data and looking at possible relations between the themes, using the software NVivo to facilitate the organization of data [194]. A sub-set of interviews at each level (facility, supervisor, policy making level) was initially analysed to develop the coding framework. Based on this framework, all interviews were analysed in depth.

Themes were grouped by health system aspects using the conceptual framework as a guiding instrument. While during the entire coding process I remained open to all themes related to the health system components as well as others not linked to the health system, it became quickly obvious that all emerging themes were in fact linked to the health system components. The coding framework was therefore structured around the following main themes:

1. Health Service Delivery
2. Political Commitment
3. Policy Directions
4. Critical sub-systems: workforce, supply and infrastructure, information

Comparison between themes and identification of patterns was done to refine and relate identified categories and themes; for this I used the memo function in NVivo to establish inter-linkages between themes [195]. Applying Lipsky's theoretical framework, perceptions of policy makers and health workers were contrasted to identify possible differences between the two levels.

Any kind of observations that contradicted the overall analysis were taken into account during the analysis to make sure outliers were documented. This followed an iterative process with the coding scheme and grouping of data as the analysis progressed. Annex 6 provides the final coding framework.

4.6 Validity and Reliability

Triangulation has been discussed as one way of strengthening a study's validity [196]. This study used different types of data collection: document analysis and interviews. Interviews were also conducted with persons at different levels of the policy implementation process with different perspectives on the BPHS and SRH service delivery. Reliability can also be improved by accurate note-taking and transcriptions as well as discussing coding with colleagues [197]. This good practice of fieldwork was applied throughout the study. Data analysis was conducted in a systematic manner as described above to strengthen the reliability of the results [198].

4.7 Ethical considerations

Ethics approval was granted by the Ethics Committee of LSHTM and the MOHSW in Liberia. The researcher informed all respondents about the study and her role and asked for permission to record interviews. Interviewees signed an informed consent form. Anonymity and confidentiality was respected throughout the process.

Chapter 5. Results: Sexual and reproductive health service delivery

The conceptual framework of this study consists of the health system components of political commitment, governance, critical subsystems and service delivery. Study results will be presented accordingly, focusing first on service delivery and then on supporting elements of the health system. This first chapter on service delivery will cover the availability of SRH service, as well as issues around service provision as discussed by respondents, such as their perception on quality of care and service uptake. Here the focus will be on the perception of both implementers and policy makers, with attention to the potential influences of street-level bureaucrats on service delivery. The chapter provides an overview of SRH services at the 19 facilities that I visited in Nimba and Grand Cape Mount County. Service availability was assessed through a checklist based on the BPHS asking staff which services they provide. This was complemented by the review of the latest accreditation report from January 2010, six months prior to my visit to the facilities, which provides information about the availability of services as well as equipment and drugs required for each service. Contradictions between the two are highlighted where they occurred. The data analysis revealed no major differences between the two counties visited.

5.1 Safe motherhood

The service for safe motherhood that was mainly available was antenatal care, while facility based deliveries and particularly basic emergency obstetric care (BEmOC) and postpartum care were more limited. Table 8 provides an overview of the availability at the time of data collection:

Table 8: Availability of SRH services for safe motherhood according to different research sources at 2 hospitals, 6 health centres and 11 clinics

	Hospital Accreditation	Hospital Interviews	HC Accreditation	HC Interviews	Clinic Accreditation	Clinic Interviews
Services for the prevention of mother to child transmission of HIV (PMTCT)	2/2	2/2	n/a	4/6	n/a	1/11
Antenatal care (ANC)	2/2 (one no ferrous fumarate syrup) 86% - 100%**	2/2	None of the facilities had all services in place as listed in the accreditation form 86% - 100%	6/6	None of the facilities had all services in place as listed in the accreditation form 81% - 87%	11/11
Skilled care during delivery for normal delivery	2/2 79% - 100%	2/2	6/6 82% - 84%	6/6	7/11 (four clinics do not conduct breech delivery) 65% - 78%	8/11 (three clinics do not conduct breech delivery)
Essential newborn care	2/2 92% - 100%	2/2	5/6 95% - 100%	4/6	5/11 89% - 91%	0/11
Basic Emergency Obstetric Care (BEmOC)	Comprehensive Emergency Obstetric Care CEmOC 2/2	Comprehensive Emergency Obstetric Care CEmOC 2/2 but medical doctor not consistently present	2/6	1/6	0/11 (n/a)	0/11
Post partum care	2/2	2/2	4/6	5/6 space as an issue	6/11	3/11 space as an issue
Abortion care	2/2	2/2	4/6	1/6	7/11*	n/a

* Six out of seven clinics that provide abortion care according to the accreditation report did not have MVA in place, according to the same accreditation report

**average accreditation result for this component in Nimba and Grand Cape Mount counties

Antenatal care services were provided at all the facilities visited. However, according to the accreditation report, screening for high risk pregnancies was not fully taking place. This includes screening services for abnormalities of the reproductive tract, uterine fibroids, infection of the vagina, cervix or kidneys, acute surgical emergencies such as appendicitis, post-term pregnancy as well as pre-existing illnesses. These issues were not mentioned by respondents during the interviews. Furthermore, the rapid test for syphilis was only available at two clinics and two health centres and screening and treatment for anaemia was taking place at four out of the eleven clinics and at one health centre out of six that were visited. In terms of drugs and equipment, the accreditation report shows that ferrous fumarate syrup was lacking at all levels. During the interviews at all three health service levels, ante natal care was reported to be

well established and no concerns were raised about it by the health workers. The only exception to this was staff at all facilities noting that the rapid syphilis test was not available.

Skilled care during delivery was available at all facilities, but with the following limitations: Based on the accreditation report, four clinics did not conduct breech delivery and three clinics did not treat convulsions (all of these clinics were in Grand Cape Mount). The accreditation also showed that two of the six health centres performed vacuum extraction; though according to the interviews, vacuum extraction was not performed at any of the health centres. One clinic did not have a dedicated delivery room.

One of the six health centres and two of the eleven clinics only had a male officer in charge providing services for deliveries, but no certified midwife. Overall, six out of eleven clinics and five health centres had a certified midwife in place. At some facilities, staff complained to only have one delivery set; however, this might be sufficient considering the number of deliveries currently taking place at facility level.

One objective of the BPHS is to increase facility based deliveries. Data on deliveries at health facilities were obtained from each facility directly when possible and were complemented from data directly obtained at the MOHSW. However, official information about the catchment population of women of reproductive age for each facility was not available. Similarly, the numbers of deliveries taking place at the community were also not available. Therefore, it was not possible to estimate with any reliability the proportion of births taking place in the health facilities. However, the data can provide an indication of trends of deliveries in absolute terms taking place in health facilities. The summarized results for monthly deliveries between September 2007 and August 2010 in the health facilities for the two counties are presented in Figure 6[1]. The figure indicates that there has been some increase in facility based deliveries in Nimba County, though no substantial or sustained increase in

[1] Summarized results for deliveries at health facilities were preferred because the separate results for each health facility are small and so less reliable as they are more susceptible to the role of chance (stochastic fluctuation). In the case of missing data the average of the prior and next month was used.

facility based deliveries in Grand Cape Mount County during this period. The higher number of deliveries observed in Nimba county compared to Grand Cape Mount can be explained by the fact that half of the facilities visited here were health centres, while in Grand Cape Mount the majority of facilities visited were clinics (seven out of ten facilities visited). In Nimba County most of the increase can be observed during the period when the MOHSW started handing out the Mama & Baby Kit in February 2010, a kit for pregnant women that contains basic items for their baby.

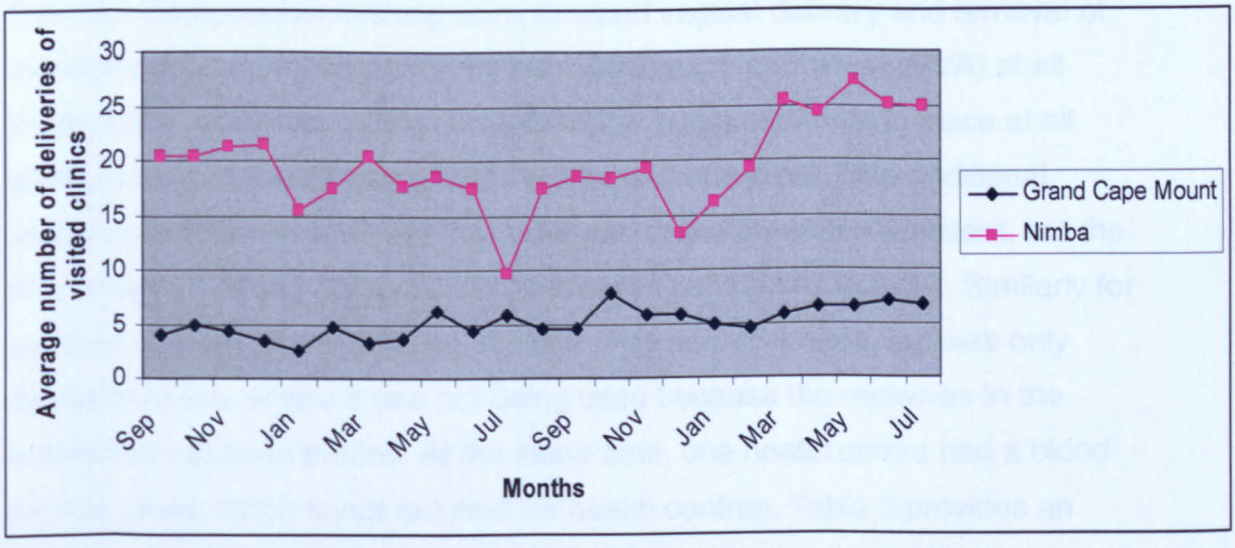

Figure 6: Summarized results for monthly deliveries between September 2008 and July 2010 of visited health facilities in Grand Cape Mount (n=10) and Nimba counties (n=9)

Here it needs to be noted that data collected by USAID for monitoring of performance-based financing showed a much larger increase between July 2009 (20%) and March 2011 (60%) [199].

Interview results at the three levels differed regarding the provision of facility based deliveries. Interviewees at all levels stated that facility based deliveries were a challenge; however, this was stressed the most by staff at facility level.

While they saw an increase in uptake of antenatal care, facility based deliveries seemed to be less accepted by the community. This will be discussed further below in the section on service uptake.

The perception at policy level varied. While some policy makers stated a clear increase in facility based deliveries, others did not confirm this and further

stated that a substantial increase was not a realistic objective at the moment, taking into account the limited number of certified midwives. Only one respondent at policy making level mentioned that facility based deliveries were an important problem.

Basic Emergency Obstetric Care (BEmOC) was fully implemented at only one of the six health centres. There were some inconsistencies between accreditation results and my interviews regarding which components of BEmOC were provided at health centre level as presented in table 9 below. The main components missing were assisted vaginal delivery and removal of retained products of conception by manual vacuum aspiration (MVA) at all levels. MVA, which according to the BPHS is supposed to be in place at all levels, was available at four health centres and one clinic. One additional health centre had an MVA set that belonged to the physician assistant, but the only midwife working at this health centre was not trained to use it. Similarly for assisted delivery, this should be in place in all health centres, but was only available at two, where it was not being used because the midwives in the facility had not been trained. At the same time, one health centre had a blood bank in place, which is not required for health centres. Table 9 provides an overview of the availability of the BEmOC signal functions at health centres, based on the accreditation report and the interviews:

Table 9: BEmOC availability at health centres

	Accreditation	Interviews
IV/IM Antibiotics	6/6	Antibiotics not always available
IV/IM Oxytocin	5/6	6/6
Anticonvulsant; magnesium sulphate	3/6	Magnesium sulphate not always available
Manual removal of placenta	6/6	6/6
Assisted vaginal delivery	2/6	1/6
Removal of retained products (MVA)	4/6	2/6

This lack of BEmOC is an important observation, as it seems that the monitoring of BEmOC was not taking place in a rigorous way. According to the accreditation report 2010, 126 clinics fully provided BEmOC [168]. However, looking more closely at all the signal functions of BEmOC, this was in reality not the case, both, according to the accreditation and the interviews. It is also important to note that one criterion for BEmOC is service provision around the

clock. This does not apply to clinics, which are only open from 8am to 4pm. The accreditation report does not assess BEmOC as a whole in one section, but one has to search the relevant components throughout the report. This might be a reason, why monitoring of this SRH component was inconsistent.

During the interviews most facility staff seemed to be particularly focused on family planning talking much less about issues around safe motherhood. Besides their difficulties to motivate pregnant women to come for delivery to the facility they did not specify the actual services they provided during delivery. Only one certified midwife at a health centre mentioned that complications during delivery were difficult for them. When probed further, most service providers only stated that they did not provide certain services such as assisted vaginal delivery and some of them reported not to do breech delivery.

Another difficulty that was mentioned by five of 23 facility staff was MVA, with concerns expressed about having to deal with the effects of a high number of illegal and often incomplete abortions. The same respondents mentioned the lack of MVA training and supplies as an important barrier. Some stated that the MVA kit was available at the facility, but they had not been trained and therefore were not able to use it. Others knew how to use it, as they had received training during the war from NGOs, but they did not have the equipment in place. Two supervisors explicitly mentioned BEmOC to be fully in place. Three mentioned that MVA was not in place, while they thought it should be.

BEmOC was mentioned by six respondents at policy making level as a service that was lacking. According to them this was mainly related to a staffing issue due to the shortage of certified midwives, as staff were not always at the facility and did not have all the skills to provide all components. Almost all policy interviewees stated that while some components of BEmOC were in place, there was no health centre where all signal functions were addressed. A large number further acknowledged that BEmOC has not been high up on their agenda due to the competing priorities within SRH and the BPHS and that there had been more focus on Comprehensive Emergency Obstetric Care

(CEmOC) which they did not consider realistic given the shortage of human resources.

> *"My concern right now, one area of SRH that we have failed on, and we are not the only ones, is EmOC. This is really something that we really need to get moving on. In the sense of facility based delivery of BEmOC, there have been severe delays in infrastructure, procurement and so on. And this was really because of all the competing priorities." [policy_donor2]*

> *"CEmOC requires lot of money. I don't think we have the resources to operate CEmOC now. So there should probably be more focus on Basic EmOC, which we missed so far. There is more focus on comprehensive than on basic EmOC. But reaching the services to the people, the opposite should happen." [policy_NGO6]*

Only one respondent was optimistic about the provision of EmOC services, saying that everything was provided even at clinic level and in case there was a complication referral could be done.

At policy making level MVA was also mentioned as one important component, though statements regarding MVA varied and were rather inconclusive. Two respondents questioned whether the use of MVA at clinic level, as indicated by the BPHS, was appropriate. While some respondents clearly stated that this was necessary, even though it was not yet in place, one respondent said that it was not appropriate, as conducting MVA presented a large responsibility for the midwife, who did not have the necessary back-up in case of complications, nor the space to keep the patient after the intervention.

Few policy makers claimed that training had taken place but health staff did still not use MVA even though the material was in place; others claimed that training had not taken place sufficiently and a few raised the issue of trained staff leaving the facility and this way the equipment behind without a trained person able to use it.

According to the accreditation report, the two hospitals visited provide CEmOC. Data from 2009 and 2010 regarding caesarean sections were incomplete, as shown in figures 7 and 8 below. For this reason, results need to

be interpreted carefully. However, there seemed to be irregular provision of caesarean section each month and absence of the medical doctor from the hospital for some periods had been recognized during the interviews.

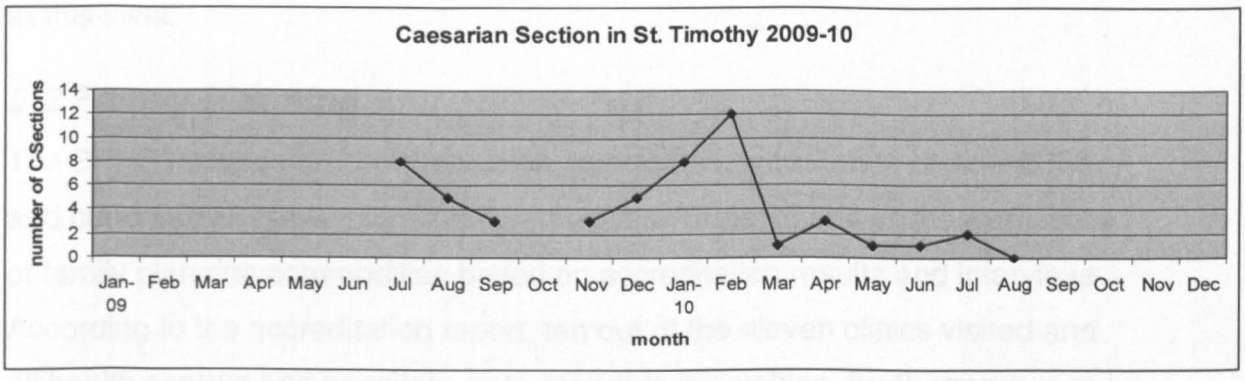

Figure 7: Number of C-Sections per months 2009-2010 in St Timothy hospital, Grand Cape Mount

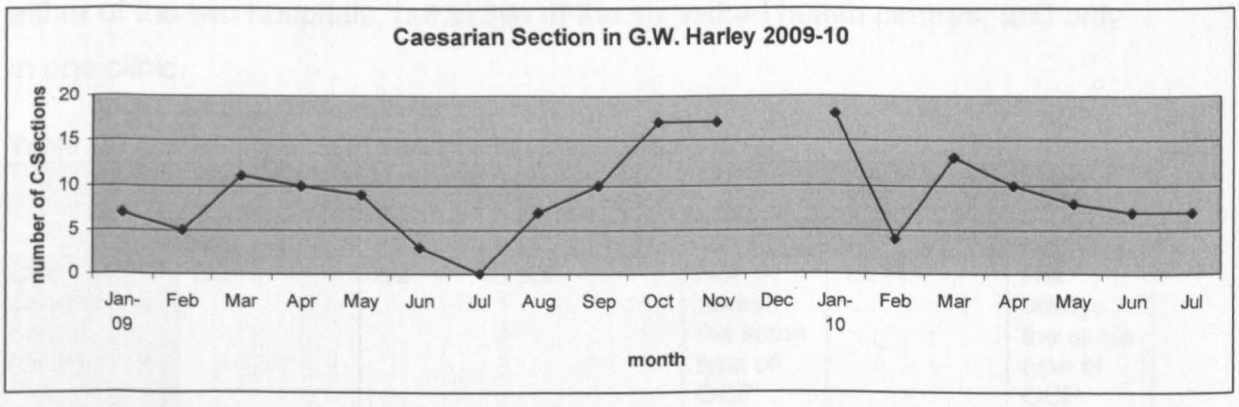

Figure 8: Number of C-Sections per months 2009-2010 in G.W. Harley hospital, Nimba

Essential newborn care was consistently available, with the exception for neonatal resuscitation at clinic level. Based on the accreditation, six of the eleven clinics provided neonatal resuscitation, though during the facility assessment it was found that only two did so. One health centre did not have the ambu bag in place and staff did not clear airways of newborn babies if necessary.

According to the interviews, training of staff for basic life saving skills was taking place; some of the staff that I interviewed had been to this training. Midwives at two facilities stated that they had been to the training recently and also had the material in place and had performed neonatal resuscitation at their facilities. One midwife stated that she had been waiting for the material

since the training. The remaining staff at clinic level did not provide neonatal resuscitation as they had not been trained. Essential newborn care did not seem to be an issue of concern at policy making level, as it was not discussed at this level.

5.2 Family Planning

The BPHS includes oral contraception, injectables, intrauterine device (IUD) and condoms as family planning commodities. Table 10 shows the availability of family planning commodities based on accreditation results and interviews. According to the accreditation report, ten out of the eleven clinics visited and all health centres and hospitals were providing injectables. Furthermore, one health centre and one hospital had the intrauterine device available. All facilities had oral contraception as well as condoms in place. In terms of counselling on informed choice for family planning, this was not provided in either of the two hospitals, but in five of the six visited health centres, and only in one clinic.

Table 10: Availability of SRH services for family planning

	Hospital Accreditation	Hospital Interviews	HC Accreditation	HC Interviews	Clinic Accreditation	Clinic Interviews
Oral contraception pill (OCP)	2/2	2/2	6/6	Not always the same type of OCP available	11/11	Not always the same type of OCP available
Injectables	2/2	1/2	6/6	5/6 Not regularly available	10/11	8/11 Not regularly available
Intrauterine device (IUD)	1/2	0/2	1/6	0/6	0/11	0/11
Male Condoms	2/2	2/2	6/6	6/6	11/11	11/11
Counselling on informed choice	0/2	2/2	5/6	6/6	1/11	11/11

During the interviews, most staff mentioned that they saw the main improvements for SRH services particularly in terms family planning. Eleven respondents listed family planning as their main focus. The majority of midwives highlighted the fact that over the past two years the supply of family planning commodities had increased substantially, and that they not only raised awareness on the need of family planning but also counselled patients on the advantages and disadvantages of each method. More than half of the staff mentioned their proactive approach to counselling on family planning, such as integrating it in the treatment, when patients come for other complaints. They further highlighted their ability to educate on the different methods of family planning, which they had learned in workshops. The only shortcoming in terms of family planning that was mentioned, though only by three staff, was the lack of injectables. The three staff that mentioned this lack of supply considered this a serious problem for service uptake as injectables was the preferred method by most women and adolescents, as they did not have to remember taking anything for three months, and they could easily hide it from their husbands. However, the fact that it was not constantly available posed a risk of unwanted pregnancy as most clients would not easily switch to the pill. Some service providers mentioned that the intrauterine device was lacking though seemed to be less concerned about this. Staff at both facilities at which the intrauterine device was available according to the accreditation report, stated that in fact it was not available. Overall, facility based staff saw the main barrier for the provision of family planning in the slow service uptake by the community. It was difficult to obtain conclusive data on service provision for family planning as there were a lot of missing data and widely varying numbers from one month to another. For this reason it was considered more careful not to rely on these data.

In contrast to health workers, nine respondents at policy making level stated that the main SRH service that was lacking was family planning. The challenge was seen in the knowledge and skills of staff to provide counselling and promote family planning uptake.

"SRH services, we also feel that - people are implementing some services, but we feel that it is weak at the moment. Especially family planning." [policy_gov2]

"Service providers have little skills to provide family planning. They focus on what they are comfortable with. If people do not receive the information, there will not be a demand." [policy_UN2]

Some respondents also mentioned that while procurement of commodities was not the problem, their actual distribution to the facility level was still difficult in some remote areas, representing a barrier to their availability to the end user.

5.3 STI/HIV/AIDS

Services for HIV/AIDS are part of the BPHS, though they are mainly concentrated at hospital level. Table 11 below shows the availability of SRH services at the facilities, comparing accreditation results with information obtained during the interviews. According to the BPHS HIV services such as voluntary counselling and testing as well as PMTCT are supposed to be expanded in a phased manner to eventually include all clinics. The accreditation does therefore not assess these services at clinic level. For the health centres, the accreditation showed that four of the health centres provided HIV testing. Three health centres provided prevention and treatment of opportunistic infections. ART as well as PMTCT seemed to be available at hospital level, as foreseen by the BPHS. However, it needs to be noted that machines for CD4 cell count were broken in both counties at the time of the visit.

Table 11: Availability of HIV/AIDS and STI services

	Hospital Accreditation	Hospital Interview	HC Accreditation	HC Interviews	Clinic Accreditation	Clinic Interviews
Availability of free condoms	2/2	2/2	6/6	6/6	11/11	11/11
Standard precautions for HIV	2/2	2/2	6/6	5/6 (1 no sterilizer)	5/11	3/11 (8 no sterilizer, one clinic no placenta pit, one no incinerator)
Management of sexually transmitted infections (STI)	2/2	2/2	6/6	6/6 (though one out of antibiotics)	11/11	11/11 (though two out of antibiotics)
Syphilis test	2/2	2/2	2/6	0/6	2/11	0/11
Prophylaxis and treatment of opportunistic infections	2/2	2/2	3/6	3/6	n/a	-
HIV counselling and testing	2/2	2/2	4/6	4/6	n/a	3/11 (one out of test)
Services for the prevention of mother to child transmission of HIV (PMTCT)	2/2	2/2	n/a	4/6	n/a	1/11
Antiretroviral therapy (ART)	2/2	2/2	n/a	3/6	n/a	n/a
Post exposure prophylaxis for HIV (PEP)	2/2	2/2	n/a	4/6	n/a	n/a

Standard precautions were in place in all facilities. Although a sterilizer was not supposed to be available at health centre and clinic level based on the BPHS all health centres and five of the eleven clinics had a sterilizer in place according to the accreditation report. However, I only found four health centres and three clinics with a sterilizer.

There were some inconsistencies in terms of PMTCT, which according to the BPHS is only supposed to be provided at hospital level, but which seemed to be in place in four out of the six health centres and at one of the clinics. Similarly, post-exposure prophylaxis is only supposed to be available at hospital level, but was also found to be in place in four of the six health centres.

Treatment of STIs was generally provided, though the rapid test for syphilis, which is supposed to be in place in all antenatal clinics, was only available at two of the health centres and two clinics, but at both hospitals. According to three facility staff, shortage of antibiotics seemed to be a barrier to consistent provision of STI treatment. Furthermore, some of the staff mentioned that they did not have the right equipment, such as a microscope, to do an adequate diagnosis. It needs to be noted that only these three staff mentioned STIs as a problematic area.

Interviewees rarely referred to HIV/AIDS services as part of SRH. At facility level this may be explained by the fact that only few HIV/AIDS services were planned for this level and were only starting at health centre level. Staff mentioned their outreach services to increase HIV/AIDS awareness and some talked about condom distribution and few mentioned PMTCT.

Similarly to the facility level, services regarding STI/HIV/AIDS were almost not discussed at policy making level. Some respondents explicitly acknowledged that they did not talk about HIV/AIDS services, as these were mainly implemented through a vertical approach by the national AIDS programme, as well as because it was not the main focus of donors. One NGO representative said that donors mainly emphasized family planning, while HIV was not sufficiently taken into consideration, and ARV was not available as needed.

5.4 Sexual and gender-based violence

According to the BPHS, services in case of SGBV are limited to initial counselling, rape exam and referral to a social worker. This means that psychosocial support, provision of post exposure prophylaxis and emergency contraception are not supposed to be provided at clinics and health centres under the BPHS, components that are required by the Minimum Initial Service Package of SRH services. Table 12 below shows the availability of those services to manage SGBV that are included in the BPHS.

Table 12: Availability of services in case of SGBV

	Hospital Accreditation	Hospital Interview	HC Accreditation	HC Interviews	Clinic Accreditation	Clinic Interviews
Initial counselling	2/2	2/2	6/6	Not seen any case during the past two years	11/11	Not seen any case during the past two years
Rape exam	2/2	2/2	5/6	No case	9/11	No case
Referral to a social worker	2/2	2/2	6/6	No case	11/11	No case
HIV testing for suspected rape cases	2/2	2/2	4/6	No case	n/a	No case
Overall accreditation result for SGBV	100%		86-93%		83-91%	

The accreditation assesses service availability in case of SGBV based on whether staff provided initial counselling, conducts a rape exam and refers the patient to a social worker. As reported by the accreditation, this took place in almost all facilities. Rape exam for all suspected cases was available in five of the six health centres and nine of the eleven clinics, HIV testing for suspected rape cases was in place in four of the six health centres (not required at clinic level), and initial counselling was available in nine clinics. Overall, the accreditation results for services for SGBV ranged between 83-100%.

Most staff mentioned that they had received training on SGBV, and that they knew how to do an initial clinical assessment in case of rape. Importantly though, all of the staff based at clinic and health centre level mentioned that they had not seen any case during the past two years. All clinic and health centre staff reported not having post exposure prophylaxis at their level, and that cases requiring post exposure prophylaxis would be transferred to the hospital level. Awareness by staff of SGBV seemed to be higher in Nimba than in Grand Cape Mount County, as it was mentioned more often as an area on which they had received training.

Two supervisors from NGOs explicitly stated that SGBV services were insufficiently available at facility level. They felt particularly that post exposure prophylaxis was missing at clinic and health centre level, and that it should be available at this level in order to be as close to the community as possible.

However, similarly to facility staff, most supervisors mentioned that rape victims usually did not come to the facilities for services.

Policy makers presented with mixed perspectives on services in case of SGBV. A few said that it was in place, one person even stated that this part of SRH services was going very well. Four respondents mentioned SGBV as a service that was lacking, particularly the provision of post exposure prophylaxis. Again this was not just seen as a procurement problem, but mainly as a human resource issue of health workers not providing the services. According to one respondent post exposure prophylaxis drugs expired at the facilities as service providers did not use them or did not even know they had the drugs.

> *"The issues of SGBV survivors are addressed, we have the treatment for survivors, especially rape, they get some treatment through the PEP kit. So, at all the health centres, where the BPHS is implemented, this kit is part of it, so at all the clinics where the survivors go, they get the treatment that they need." [policy_gov1]*

> *"We brought in all the rape kits to be used. And we had enough rape kits in Liberia to supply all the rape cases in Liberia this year. But they did not meet the demand. There are a lot of areas where the services providers do not provide the kit, and a lot of areas where the kit was not available." [policy_UN1]*

One respondent from a local NGO which is specialized on services in case of SGBV strongly felt that staff at most facilities were not well enough trained to provide adequate services, and that this service should only be provided at a few facilities in each county, were well trained staff was in place.

5.5 Adolescents' reproductive health

The definition of adolescents' reproductive health in the BPHS is rather vague and limited to education on reproductive health and on family life skills. Similarly, the way adolescents' SHR is monitored through the accreditation process is limited, merely asking whether health talks on information on birth spacing for adolescents are presented. According to the accreditation report, seven of the eleven clinics and five of the six health centres provide this kind of health talk, the overall accreditation results for adolescents' reproductive health range between 74% and 100%. This means that if only looking at the accreditation results, 'adolescents SRH' seemed to be well implemented.

Interviews revealed different perceptions between the three levels of what constituted adolescent reproductive health and whether it was provided. The problem of the high number of teenage pregnancies in Liberia was recognized by all respondents, and it was further acknowledged that teenage pregnancy was a major reason for the high maternal mortality in the country. However, the perception whether youth friendly services were currently in place differed between the three levels. A clear majority of health staff stated that their services were well suited to the needs of youth and were accessible for adolescents. Most of the staff explicitly said that youth who came to their facility were able to receive counselling and advice:

> *"So when they come, mainly I can deal with them. They can come straight to me because most of them know me; I can really talk to them on it...lecture them about it the side effect and everything and they choose, make sure the one they want they can take it." [Cape Mount_CM2]*

Moreover, staff felt that adolescents were comfortable talking to them, as underlined by one midwife:

> *"They trust me. When I'm walking on the street, all of them, sister, hello, oh!" [Nimba_CM5]*

Some staff also mentioned that they went to schools to inform adolescents about family planning, and a few also tried to work with the trained traditional midwives to provide information about family planning to the teenagers in their community. One respondent stated that they should have youth groups but

she had not yet been able to organize them. Three respondents said that outreach services for youth such as going to their schools or to the community were not possible as they had to be at the clinic all day. One respondent clearly said that nothing was done for youth, but she also stated that most of the school girls still were coming for family planning.

While the clear majority of staff interviewed felt that the services provided at the facility suited the demands and needs of adolescents in terms of SRH they claimed that it was difficult to motivate teenagers to come to the facility. This will be discussed further below.

Some supervisors felt that the services for teenagers were in place and the problem was mainly the youth's attitude, while others felt that there was a need for more youth friendly services in terms of opening hours and provision of a separate room for adolescents.

> *"So, adolescents' services should be reinforced, so that they are not going to have this kind of services by intimidation but a kind of service they would be happy to go along, to give their problem to the service provider, in a manner that they would like. I think if BHPS could do that, then, I think our SRH services would be a little improved. Many of our problems come from that area."[Cape Mount NGO_sup2]*

> *"You find a lot of young couple come, you start on, they don't continue, by the time you look they are pregnant. Some, you talk to them, ok, I'm coming back, they won't come back. And next time you see them, they are pregnant. The BPHS does address the needs for adolescents. Everything is in place. It is the attitude of the adolescents towards the Basic Package when it comes to reproductive health." [Cape Mount_CHT_sup1]*

Most supervisors and staff from county health teams felt that staff at facilities were doing their best to provide youth friendly services. However, two pointed out that the lack of midwives risked undermining this. Midwives were considered the main providers of SRH services and were therefore also responsible for adolescents SRH service provision. Two supervisors further felt that the lack of outreach services for adolescents was another important barrier in the provision of adolescent SRH services.

At policy making level, the opinions about youth friendly services differed widely among respondents. Few respondents at the policy-making level explicitly said that they felt that services were youth friendly at the facility level as one of the donors noted:

> *" When they [adolescents] come to the facility, I am pretty sure they can get the services, you know, they are very well trained in giving family planning health talks and all these things." [policy_donor_1]*

However, a large number of respondents at this level thought the contrary, stating that services at the facilities were not youth friendly for the following reasons: lack of skills by staff, old staff to which youth do not want to talk, negative attitude by staff towards adolescents, as well as lack of confidentiality and the fact that youth would meet their aunt or mother at the facility, and would therefore not feel comfortable asking for contraceptives. Several interviewees at policy making level felt that youth needed stand-alone centres with young service providers in order to provide youth with the opportunity to discuss SRH with their peers instead of health staff who are older than themselves, and also where they further do not risk to meet family members. Examples of such centres are run by YMCA in Monrovia and in the north of Nimba country. These centres are not related to the BPHS. According to interviews with representatives from YMCA, they are successful in attracting youth and motivating them to use contraceptives and VCT for HIV.

A few respondents mentioned that the opening hours of the facility were not youth friendly, as most of them close by noon or 2 pm, preventing adolescents to come to the facility after school. Only one person talked about the attitude of the adolescents, stating that youth would only go to a clinic if they felt sick but not in order to get information.

The findings indicate the need for further specification on how SRH services for adolescents should be provided both at facility and at community level, and the need for further awareness and training for staff to provide the services accordingly.

5.6 Perceptions of quality of services

Most staff seemed to be satisfied with the quality of services that they provided. Several staff pointed out that the quality of services was improving through the trainings they receive and the drug supply. Yet overall, quality of service delivery was not discussed to a great extent during the interviews, indicating that it was not of major concern for health workers; though two staff commented on the fact that they might be doing a better job if they were more motivated.

> *"The BPHS helps us provide good quality of services because we are trained." [Cape Mount_clinic2_CM]*

> *"The basic package really help us to provide good quality of services. By having our drugs available and by training us by giving us knowledge in what is to be done...by making us equipped in our service providing." [Nimba_HC2_OIC]*

The majority of supervisors similarly felt that the BPHS helped provide good quality of services through the setting of standards and the provision of equipment and drugs.

> *"I think the Basic Package is doing well. Yes, we are now knowledgeable, we know now that these things should be there in order to give a service, if you must give a good service. Yes, to put good quality services in place. So, every county health team, every clinic staff is working hard towards meeting the standards of the BPHS." [Cape Mount_CHT_sup4]*

When asked what they meant by quality services, supervisors' definition of quality of services mainly implied that staff did not ask for money for the services and that there was no drug stock at the facility. One respondent mentioned that quality has not been taken into account through the accreditation process, and another one said that there was a need to conduct exit interviews with patients to assess their perception of the quality of services. Another one mentioned that the quality of services was reduced by the limited space and therefore the lack of confidentiality. The few supervisors that raised concern over service quality saw the main underlying reason for this in the limited workforce.

In contrast to the facility and supervisor level, quality of service provision was mentioned by almost all respondents at policy making level as a major problem and an important issue to focus on next.

> *"For a while our focus was doors and windows and hand washing stations. Now we move on, how do you use them, do you greet the patient, what is the outcome from the patient perspective? This is a huge jump." [policy_NGO5]*

Here again, the lack of workforce was seen as the main reason for the low quality of SRH services, which affected the time spent with the patient but also the motivation to provide good services:

> *"The officer in charge will go to trainings and other things. If you don't have a second screener, the certified midwife has to do the screening, while she doing ANC, family planning, if you are integrating adolescents SRH, she will add that, PMTCT. And even the certified midwife will go to training. There will be a gap. How will you provide quality services?" [policy_NGO3]*

> *"The issue of staffing is a big challenge in Liberia currently. When we talk about quality of care, sometimes you even become mute; you don't want to pronounce it. If these two staff are there, every day, given that they are there, they are not even getting sick, the services are also expanding. Now, we have brought in PMTCT and we are expecting this person to really provide a counselling, at the same time the women waiting outside for PMTCT, others are waiting for family planning, so the issue of quality is questionable." [policy_NGO4]*

In addition to the lack of staff at the facilities the fact that health staff were frequently pulled out of facilities to go to trainings, affected quality further. At the same time, lack of skills was also mentioned as a reason for low quality.

> *"The service providers are not youth friendly. Family planning training does not mean that you know how to counsel the clients. Once the service providers have the skills, it will be ok." [policy_NGO7]*

The close link of lack of motivation by service providers and the negative attitude towards patients and therefore low quality of services was mentioned by six respondents. This was further linked to the lack of recognition coming from the government side but also the insufficient monitoring of facilities.

> *"Even if I am not friendly, nothing is going to happen; the government does not value me." [policy_NGO4]*

The need for closer monitoring of service provision, going beyond the accreditation was highlighted by most respondents at policy making level as will be discussed in the section on supervision. Several respondents referred to a study on quality of services, which had identified a discrepancy between the accreditation results and the actual quality of services, indicating that equipment was not used adequately.

5.7 Perceptions on service uptake

Service uptake was of more concern at facility level than at policy making level. This section will discuss the perception of health staff and supervisors for each area of SRH and will then talk about the perception at policy making level.

The majority of health workers noted that while they felt there was overall an increase in patients coming to the facility because services and drugs were free of and more qualified staff available, service uptake by the community was still a problem.

Ten respondents stated that the women came in large numbers for antenatal care, but then remained in their community to deliver. Only three staff said that the number of deliveries in their facility had increased over the past months, and linked this to the distribution of the Mama & Baby kit. However, they also noted that the numbers went down as soon as the kit was no longer available.

> *"We have something encouraging for them to come, we have the Mama & Baby Kit, that encourages them to come and which the MOHSW provided. And we have mosquito net, that also can encourage them to come. And once those things finish at the facility, you not see them again." [Cape Mount HC2_CM]*

The main reasons for the low number of deliveries taking place at facilities according to health staff were the trained traditional midwives providing delivery services at the communities and lack of transportation from the communities to the facility.

> *"Oh, yes, they will come! They will come throughout. You will only seem them with baby, 'oh, I delivered last night.' They will come throughout, they will always come for antenatal care, but when they are ready to give birth, they stay home." [Cape Mount_HC1_CM]*

Several possible reasons were listed for this low uptake of facility based deliveries. The main challenge noted by facility staff was the role of trained traditional midwives who were more accessible than clinics which were located further away from the communities. The pregnant women seemed to trust the trained traditional midwives more than the clinic staff as they have known them for a longer time. At the same time, clinic staff also suspected the trained traditional midwives to prevent the pregnant women from going to the facility as the traditional midwives wanted to earn money by conducting the delivery at home. Since services at the facility were free of charge, trained traditional midwives would lose their incentives that they usually received from families in the community.

> *"Delivery is a problem for us. Because we talk to the people to come and do delivery here. Some actually respond, some don't respond at all and they are not willing to come here at all. The reasons for some of those are people who are trained. The TTM, they are all over in the community. So most often the people are used to them. Even though we try to talk to them so that they can be delivered at the facility. But I think it has to be done in the way that, show them some benefit. So they can be encouraged to bring their patient from the community. So we really have to look at how to encourage delivery at the facility." [Cape Mount HC2_OIC]*

> *" Since we started giving them something, they are coming. But we had problem from the beginning. So I started consoling them, talking to them, the very government that say you people should do delivery in the home, they built place for you people there. They are the very same people who say you should come to the clinic. So, I beg you, please come to*

the clinic. We got package for you people here. So, from there, they started coming, and things are getting better at last." [Nimba_clinic1_CM]

Most staff stated that it would not be possible to increase facility based deliveries as long as trained traditional midwives were not officially integrated as part of the system and given an incentive for bringing pregnant women to the facility for delivery.

Other reasons according to service providers were lack of understanding of the danger in case of complications during the delivery, but also a lack of trust in the facility itself. This included that women might be scared of the delivery bed as well as of the unfamiliar staff at the facility, particularly if the only staff at the facility was male. Another reason listed by health staff was that most deliveries take place at night when clinics were officially closed and when it was more difficult to come to the facility. One officer in charge mentioned the attitude of clinic staff and the fear of pregnant women to get insulted when they come to the facility for delivery.

The supervisors also saw the main challenge in services provision in the reduced uptake of facility based deliveries. Possible underlying reasons for this as listed by the supervisors, were similar to those listed by health staff, such as, the fact that women did not like certain practices at the facility, women had more trust in trained traditional midwives, as they are their first point of contact in the community, but also because the trained traditional midwives did not want to lose their source of income. Also, one supervisor mentioned the negative attitude of health staff as a barrier.

Low service uptake also seemed to be an issue for family planning. Four health workers listed the uptake of family planning as one of the challenges for service provision. They explained this mainly by cultural and religious reasons, particularly with husbands not wanting their wives to take contraceptives. Several midwives explained that for this reason, most women preferred injectable contraceptives over pills, as this way their husbands would not find out that they were on contraceptives. They also felt women were hesitant to visit the health facility for family planning because they did not want other

people knowing they were taking contraceptives. Other reasons according to health staff were ignorance about family planning and rumours about side effects. However, several staff highlighted that this has already improved, through their individual counselling as well as the health talks on family planning.

> *"Our people here, they really don't want to take this pill. But we can't just sit and look at them. Each time they come, for hospital or clinic, we tell them our health talk. We explain it to them our health talk, we tell them, this pill is very good, because it also helps you to plan your family. So, we need to counsel them, talk to them, tell them the importance of it and the bad side of it. So, this year it has very been improved." [Cape Mount_clinic3_CM]*

As noted above, another reason for not taking family planning was the intermittent supply as beneficiaries were not willing to switch contraception types.

> *"The only thing we are out presently is Depo (injectables). And the people get vex with me, they 'but you are talking to us for this thing for us to prevent or space our children then you are out of Depo? Then how you want us to do it?' Then we can tell them but you switch to the tablets, they will say 'no, but I don't like tablet I prefer the three months injection.' For the past months we out of Depo." [Nimba_hospital_CM]*

Intermittent supply also meant that patients would only receive a prescription for drugs and contraceptives, which they would then have to buy on their own costs at a pharmacy, instead of receiving them for free at the health facility.

Staff also mentioned that the community were not willing to wait long at the facility to receive services.

> *"The reason why some of them are not coming is... some of them said they would stay a long time in the facility. They stay long because of the shortage of many staff to cater to them. Like for example today, you see one CM that's assessing about fifty to seventy-five pregnant women; I mean they are going to stay long! For that some of them get tired. They will complain that whenever people go to that place, they can stay long, but when you got two or three midwives in the*

assessment room, as soon as they are there, to see them, it will be easy." [Nimba_DHO3]

Supervisors had a similar perception as service providers on the uptake of family planning services. Most respondents highlighted family planning as a service that has been put in place successfully, but the behaviour change to accept the services was still taking time. They also listed religious and cultural reasons for not accepting family planning.

Most health workers had attended training on the management of victims of SGBV. However, all of them stated that they had never seen any case in their facility. Some mentioned that they had seen cases of physical abuse, though no sexual violence. According to the health staff this was due to the fact that families preferred to keep this to themselves, and not get the facility or even the police involved.

In terms of service uptake by adolescents, most staff stated that their family planning services were youth friendly, but it was rather the attitude of the adolescents that prevented them from taking contraceptives. Some staff stated that adolescents refused to use condoms, even when they were given to them.

"I tried to talk to them (...) we can give them something (condom), but most of them when they go, they can throw it away. They can't use it, most of them carry, they lit fire, some of them use it with balloon all those things; and we still talking to them." [Cape Mount_clinic7_CM]

However, several staff felt that service uptake by adolescents was increasing and many teenagers came to the facility to obtain family planning information and supplies. Others noted a need to go to the community to raise awareness and to talk to the parents who seemed to encourage their children to become pregnant.

"Sometimes you talk to them on it but it's difficult, I'm trying my best but it is not easy, because they got the parents involved in it. But the parents not taking it, because they are not really educated so it's hard to get them, they say 'hey, leave the girl, the girl's reached the age now, the girl supposed to born, she's reached to womanhood now, she's supposed to born so you cannot stop the girl'. So, it's hard but

I'm trying my best. That's the challenge I have right now."
[Cape Mount_clinic7_CM]

Health workers felt that at the clinic they were doing well, and saw the problem rather on the side of the adolescents, and not related to the services provided at the facilities. The reasons for this as listed by the health staff ranged from lack of time and the distance to the facility, over ignorance and lack of awareness, as well as stubbornness. Furthermore, the cultural background was listed as a reason, particularly in Grand Cape Mount, where religious reasons seemed to play an important role, and where, according to the health staff, parents even supported their children to have children and would not want them to be on contraceptives. This means that health staff felt that once adolescents came to the facility for SRH services, they received the services that they required in a youth friendly way. Also, intermittent supply of injectables was a barrier to the use of family planning by adolescents. This seemed to be the preferred method by teenagers, with most adolescents apparently unwilling to switch to a different method if supplies of injectables run out.

While health staff at the facilities felt very strongly about the attitude of adolescents preventing them from service uptake, this was discussed less at county and supervisor level. Only four supervisors mentioned lack of awareness and attitude as reasons for low family planning uptake among adolescents.

Service uptake was discussed to a lesser extent at policy making level than at implementation level and was seen more positively. While nine policy makers stated that service uptake was adequate and had been increasing and was therefore not a major issue, five felt that service uptake was problematic, and linked it mainly to the low quality of services. The main reason according to policy makers for increased uptake of services was the provision of free services. Another factor that was mentioned was the Mama & Baby Kit. However, at the same time several respondents pointed out that this method was not sustainable and did not motivate women to keep coming for facility based deliveries once the Mama & Baby Kit was no longer available.

"Facility based deliveries are also increasing. Now we have the Mama & Baby Kit, and the facility based deliveries are increasing. People are coming, even if services were not free, people would be coming." [policy_NGO2]

"The Mama and Baby Kit does increase the number of facility based deliveries, but we actually did a survey, asking the women if they would come back if the kit was not there, and they clearly said that they would only come back as long as they get the kit, not for the service. So it is not sustainable." [policy_NGO5]

While one respondent argued that the kit mainly served as a magnet, others felt that if beneficiaries were not convinced by the quality of services they received, they would not come back, even if they had initially come for services because of the Mama & Baby Kit.

The main reason for low service uptake for SRH services according to policy makers seemed to be the negative attitude of health workers, which was mentioned by fifteen respondents particularly when talking about facility based deliveries and family planning. Regarding family planning, cultural reasons for low uptake were listed by six respondents and low skills of staff by another four respondents. In terms of facility based deliveries, the perception that trained traditional midwives were trusted more than facility staff was mentioned by three respondents. Other reasons listed for low SRH service uptake in general were the distance and the road conditions, the irregular supply of family planning commodities, the absence of staff from the facility, particularly at night, when most deliveries took place and the lack of confidentiality, particularly for adolescents. One reason for low uptake of SRH service by adolescents as mentioned by policy makers was the fact that they do not want to mix with older clients. Finally, several respondents considered service uptake a question of time, as the increase in service uptake required behaviour change.

"Access to facilities is really problematic - the road conditions, the rainy season, all that makes it really difficult. And when you do get there, the staffing may or may not be there. Everybody knows you are going, so getting family planning or

treatment for an STI is difficult, everybody will know. I think there are a lot of barriers." [policy_NGO5]

"There is also a challenge of changing behaviour, of traditional midwives, of women. Maybe it is safer to go and deliver at the facility, but I am totally understanding that this lady don't want to deliver at the facility, because the midwife is rude, she don't have light, she is not paid for this extra time and in the night there is no ambulance to pick her up. She is alone. So, I understand that this woman decides to deliver at home with her neighbour, which is also a trained traditional midwife, she will take care of the kids, at home, comfortable..." [policy_gov3]

"Manpower! You have one CM who is tired; you have one doctor who is not even there. You don't have anybody to trust, and then you come and nobody is there. So, human resources are a challenge, even for service uptake." [policy_NGO2]

Several respondents expressed the concern that the health system was not yet ready for a substantial increase in service uptake, as the facilities were not equipped particularly for deliveries taking place at night, and staff were not sufficient in terms of numbers to respond to an increased number of deliveries.

Perceptions on community outreach

Community outreach is not explicitly part of the health system model used for this study. However, data analysis was not restricted to predefined topics but was open to further aspects that were discussed by respondents during the interviews. Community outreach plays an important role for service uptake and therefore access to services.

Health workers saw a need to conduct outreach services to talk to the trained traditional midwives to refer pregnant women, to encourage the uptake of family planning and to create youth groups to provide the opportunity for youth friendly SRH services. However, most staff also acknowledged that this was not taking place at the moment, mainly due to lack of staff and the fact that they were obliged to be at the clinic during opening hours. Some also mentioned that they had no transportation to go to the communities. Some staff mentioned that they sometimes went to the community during the

weekend to raise awareness for family planning, though the main topics during these outreach services seemed to be HIV/AIDS and malaria prevention. Few also mentioned that they tried to raise awareness for services in case of SGBV.

> *"No, is difficult, because we have to be at the clinic. I have problem for myself that will not permit me go to get to the community. The clinic open from 8 to 4. And no transport to go to the villages." [Cape Mount_Clinic4_CM]*

> *"They will actually need some. The community would love to have some visitation from the professional people but because they are very less, they are not reaching the people. Yes, if we were many, some could be charged with the responsibility of doing outreach in the community but because they are not many, they are just confined in the health facility." [Nimba_DHO3]*

Supervisors also saw a great limitation in outreach services. According to one supervisor, staff did not want to go to the community, as they were not trained to conduct meetings with community people. Supervisors mentioned the great number of community health volunteers trained to take care of the community component, which so far has been lacking. However, the same respondents expressed concerns that these volunteers would also need motivation and would not be effective, as long as they cannot expect an incentive for their work. In addition, several respondents highlighted the need for supervision of these volunteers by clinic staff, but were not sure whether this was realistic.

> *"The community health volunteers coming on board, they too, are looking at motivation. What can be done for them if they have to take part in health services? Because it's like, they used to be community health workers, now we are saying they are community health volunteers, but we want them to do something to help us. So it is almost like making them workers again. So, they are telling us, if we do this, what do you have to give us? So, they are not really functional because of this issue of motivation." [Cape Mount_CHT_sup1]*

The importance of community outreach was highlighted by twelve of the 24 respondents at policy making level. Reasons for this need were the perception that there were not sufficient facilities and distances were too far for beneficiaries to take up SRH services such as family planning; another reason was the need to create awareness for SRH services and to promote behaviour change.

> *"Before the war, we had school programs in all the schools. We had a nurse in the school, a counsellor at the school, if they wanted FP product, they can get it right there. But that is no longer there. That is an area, they need to create awareness and then have the FP services available." [Policy_gov1]*

However, respondents felt that the community component had been neglected when the implementation of the BPHS started. Staff at the facilities did not have the required support in terms of staff numbers or logistics, such as transport to provide outreach services, and training for community health volunteers had only started recently, at the end of the five year implementation period of the BPHS.

> *"The community component came after 5 years. BPHS is almost ending, but community part is just coming in." [policy_NGO1]*

Several respondents expressed concerns that the community volunteers would be overburdened with too many responsibilities and not be effective, as they would expect incentives for their work, while the MOHSW considered them to be volunteers.

A similar challenge has been observed regarding the trained traditional midwives, who seemed to be afraid of losing their salaries as well as their status, if the policy of conducting deliveries only by skilled attendants at facilities was further reinforced and services were provided for free at facility level. The role of trained traditional midwives seemed to be important to consider for the implementation of SRH services. Respondents highlighted that communities had developed a lot of confidence in trained traditional midwives that they represented a challenge to motivate women to come to facilities.

While this issue was not discussed with the same emphasis as at health facility level there seemed to be agreement at the policy making level on the need to redefine the role of trained traditional midwives, in terms of linking the community to the facility. At the same time, there was a recognized need to develop income generating activities for them, to provide an alternative source of income, and this way motivate them to bring women to deliver at facility level. However, most respondent acknowledged that currently, it was difficult to take deliveries out of the hands of trained traditional midwives for the following reasons: they were still the preferred choice by the community, as they were closer to them and they were trusted, women have more confidence in them than in the facilities as stated by five respondents, and staff at facilities were not always available, particularly at night. While several respondents stated that trained traditional midwives did not have the required skills to conduct deliveries particularly in the case of complications, their central role in the community and the need for a strategy to still give them a role in linking the community with the facility was recognized.

5.8 Summary

This study assessed the availability of SRH services in two counties in Liberia. SRH services are available to a certain extent, though not fully according to the BPHS: The findings suggest some inconsistencies with the provision of services provided under the BPHS. The fact that there was consistency in the range of services that were (and were not) available across facilities in the two counties indicates system-wide issues rather than issues related to individual health facilities.

Overall, the SRH services that are part of the BPHS were only partially in place. Commodities for family planning were available at all facilities to a certain extent, but most facilities reported a shortage or lack of a wider range of commodities – particularly injectables and intrauterine device. Similarly, antenatal care was generally available at all facilities, with the exception of screening and treatment of anaemia and syphilis at clinic and health centre level and with limitations in terms of screening for high risk pregnancies. Health

workers were not concerned about antenatal care and these specific aspects of it, indicating that indirectly they influence to which extent this component of the BPHS got implemented.

Other BPHS services that were not adequately in place included MVA at clinic level and assisted vaginal delivery at health centre level. This means that complications during child birth were not well addressed in facilities other than hospitals. In terms of SGBV as well as adolescents SRH, the main problem seemed to be the lack of agreement regarding what should be provided. Psychosocial support and post exposure prophylaxis seemed to be highlighted as important services in case of SGBV, but also the most difficult to provide, which was the reason why they were not planned by the BPHS at this stage. Yet, post exposure prophylaxis was available at some facilities. This implies inconsistencies between the BPHS on paper and its implementation. The need for adolescent SRH has been recognized, though without sufficient detail on what this actually meant at facility level. This issue is directly related to the BPHS, not providing adequate guidance on certain aspects of SRH.

While this study was not conducted to validate or verify the accreditation process, but rather used the accreditation result as additional source of information regarding SRH service availability, some discrepancy between the accreditation report and my interviews were noted. Overall the accreditation report seemed to provide a more positive picture of SRH service provision than was in reality the case. For example, if an MVA kit was available at a facility, this did not mean that it was being used. However, the way it was documented in the report one gets the impression that MVA was in fact provided. Similarly, according to the accreditation reports services in case of SGBV were provided at most facilities. However, only through the interviews it turned out that service uptake was a major problem in this area and in reality services had not been provided for the past two years. In terms of family planning, intermittent supply of contraceptives was reported to be a major challenge for service uptake, as patients did not easily switch from one commodity to another. This did not come to light by assessing drug supply once a year. Finally, in terms of BEmOC, the accreditation report did not present an easy overview of the signal signs to be provided, making a clear understanding whether BEmOC

was fully in place or not difficult. This is an important aspect of the BPHS, highlighting the need to monitor its implementation rigorously, making the important distinction between the availability of prerequisites for service provision and the actual delivery and uptake of services.

My research only looked at the availability of services but did not obtain information about the actual quality and uptake of services, only on the perceptions of respondents. As seen in the discrepancy between some accreditation results and those obtained during the interviews, this is an important aspect to consider and they were discussed during the interviews. Overall, staff were positive about the quality of SRH services provided at their facilities and saw the main limitation in SRH service provision in the actual uptake by beneficiaries and the lack of outreach services to encourage service uptake. Trained traditional midwives seemed to play an important role both in preventing pregnant women from coming to the facility but also acting as a bridge between the community and the facility. While the lack of community outreach was also recognized at policy making level, policy makers were more concerned about service delivery at facilities and low quality of care, which they considered the main barrier to service uptake, including the attitude of beneficiaries. This implies a discrepancy of perceptions between policy makers and implementers, possibly having implications on the policy implementations through the street-level bureaucrats. This aspect will be explored further in the next chapter.

Chapter 6. Results: Exploring perceptions on supporting health system components

The second objective of this study was to analyse underlying processes for the provision of SRH services by exploring the perception of health service providers at facility level, their supervisors at county level as well as the perception of policy makers through semi-structured interviews. While the previous chapter focused on the service delivery component of the health system, this chapter will discuss the relevant components of the health system that emerged from the interviews. The chapter is organized along the health system components as outlined in the conceptual framework. As with the previous chapter there was no substantial difference between the two counties regarding the challenges and opportunities identified by interview respondents. For this reason, results will be presented for both counties together.

6.1 Perceptions of political commitment

Political commitment is defined as country leadership and capacities. In this case this was also translated to the county health teams, and how they work together with NGOs. It also includes the value given to health and the individual and institutional capacity [184]. Based on the responses by health workers, this latter aspect was interpreted in terms of how staff felt supported in their work by the government, i.e. the county health teams.

Whether staff felt supported in their work depended on their definition of support. Staff that defined support by the provision of drugs and equipment, which was the majority, felt rather well supported, while those that thought mainly of economic incentives, felt discouraged. While some staff stated that the county health team supported them in terms of supplies, it seemed that the majority of staff felt more supported by the NGOs than by the county health teams and the MOHSW. This perception was fostered by the fact that some health workers receive their incentives from NGOs, which gave the impression that the government was less involved than the NGOs.

"County health team are not supporting us... we only get the incentive from the NGO that are taking care of the hospital, IRC. For everything we responsible for ourselves. Renting, feeding...county health team is doing nothing...They see this an IRC hospital, so they don't do nothing here." [Nimba_hospital_CM]

"Maybe they don't want to improve the staff, the staff should remain in poverty.... It difficult to even get good food." [Nimba_Clinic_3_CM]

However, some respondents acknowledged that the county health team and the ministry were *"trying"* and some staff explicitly stated that they were supported by the county health team.

The perception of the greater involvement of NGOs than county health teams was shared by most supervisors. Several respondents from county health teams highlighted the advantageous position of NGOs, who seemed to have more financial means to provide support to facilities than the county health teams, for example by hiring an additional staff or by providing non-monetary incentives, but also taking staff from facilities and hiring them as their supervisors with a higher salary.

"So if an NGO sees that, they say, ok, look, we add one more person, and besides that we think that we add a little amount across the board to all our clinic staff. That's impressive. If that is approved, it's a score for them." [Cape Mount_CHT_sup1]

Several supervisors from NGOs felt that the collaboration with the county health team was difficult in terms of sharing plans and scheduling joint supervisions.

Only a few said that they worked well together.

"They (county health team) want us to do for them what they should be doing. I don't see that as capacity building. They see meetings and joint supervision with us as additional work and want to be compensated. The county health team is not helping." [Cape Mount_NGO_sup2]

The main factor that facilitated the collaboration between the county health team and the NGOs seemed to be the provision of vehicles, fuel, food and per diem by the NGOs to the county health team. While several respondents from NGOs found the work with the county health teams difficult, principally because the county health team requested compensation for any work that they had to do together with the NGOs, most members of county health teams perceived their relation with the NGOs as cordial because of the support they receive from NGOs:

> *"I think it is cordial one, because when we call them at anything, they will come to our aid even we have monthly meeting and they help to provide lunch or give them transportation reimbursement." [Cape Mount_CHT_sup3]*

This is an important observation considering that the role of NGOs is to work together with county health teams with the objective of capacity building and eventually handing over to the county health teams. The BPHS is implemented through performance-based contracting of NGOs. The relationship between county health teams and NGOs seemed to be influenced by this mechanism. This will be discussed further below.

The relationship between the government and the international partners as well as a perceived lack of national leadership were the main issues discussed at policy making level. Seven of the 24 respondents both partners and government felt that overall there was a lack of leadership in terms of SRH, particularly at the level of the Family Health Division at the ministry, but also seen in lack of ownership of facilities by the county health teams. They saw the fact that there was no focal person for family planning within the Family Health Division both as an indicator for lack of commitment as well as an explanation for lack of leadership. However, this lack of leadership was not only seen in terms of family planning but also for emergency obstetric care, which according to several respondents had not sufficiently been on the agenda during the past years. While several respondents pointed out that there was no leadership from the ministry of health, two respondents stressed that at the top level of the ministry there was strong leadership, while further below in the hierarchy people seemed to be less committed.

"I don't think family planning is honestly addressed. It is not. They (MOHSW) don't have a focal person for FP. They don't have allocated funding for family planning commodities. It is USAID that is helping with them, and UNFPA is also providing some. So, if those partners are not there, then what happens? At least if they have the family planning drugs available, at every health centre, regularly, not every two months." [policy_gov1]

"There has been some effort to get women into the clinics for ANC, but the effort of getting them in for deliveries has been mainly NGO led. I don't think there has been a push from the ministry." [policy_donor2]

International partners, both UN representatives and donors felt that the government should not only develop policies but plans how to implement them. Four respondents highlighted that the BPHS comprehensively addressed SRH but there had been a failure to effectively implement these services.

"I think there has been a comprehensive understanding of what constitutes SRH, at least from the policy and document side. How that has been implemented is another issue, but I think there has been a largely comprehensive perspective. The partners pushed for it, but I don't think the implementation has been quite as comprehensive as the policy side." [policy_donor2]

Lack of commitment to SRH services by the government seemed to be further reflected in the lack of encouragement of human resources. While this is a larger health system issue not restricted to SRH services, it is important to consider for the implementation of SRH services. Six respondents pointed out that while the BPHS required qualified staff to provide services, staff did not receive the necessary economic motivation to do so. This was seen by some respondents, both government and partners, as a sign for lack of commitment from the government side. At the same time, respondents acknowledged the challenges faced by the government due to their limited financial resources available to improve salaries. However, lack of commitment to motivate staff was also seen in the fact that only few staff from the MOHSW went to facilities to follow up on the implementation of health services, as highlighted by three respondents.

6.2 Governance: Policy directions BPHS

This study focused on the policy direction of the BPHS and its implementation. Governance includes setting policies and ensuring that the policies are understood and then implemented by health workers [184]. This can be reached by an inclusive policy dialogue, as implied by the health system model used for this study.

Interviews with health workers revealed that the understanding of the BPHS varied among the health staff at the facilities. Although some staff acknowledged that the BPHS had been introduced to them and most of the staff said that they had heard about it, the majority of staff interviewed did not know what the BPHS was.

> *"When we came, people used to be coming from the ministry to tell us about the basic health package, but they can't really go into detail about it." [Nimba HC4_CM]*

> *"I've been hearing about it. But I don't know." [Nimba_clinic1_CM]*

A number of respondents associated the BPHS with a reduction in salary incentives, rather than anything more substantial.

> *"First of all, the BPHS from the introduction, it creates little problem for us health workers. Because by this the NGOs, IRC, MSF were here paying the health workers with high incentives; but during the introduction of the basic health package, the incentives were paid by the NGOs to health workers according to the policy of the basic package, it was cut down. So, that's it, reduction in the incentives and reduction in the manpower." [Nimba_DHO3]*

> *"Though, it is not easy, but for the BPHS is very, very discouraging." [Nimba HC3_CM]*

A few of the staff asked me after the interviews to explain to them what the BPHS implied.

A number of staff had some vague ideas of the BPHS, usually focusing on one or two characteristics of it. These ranged from training, improvement of buildings and supply to working hours, staffing and supervision. The fact that

services and drugs were free was mentioned by six out of the 23 staff. Some associated the BPHS with one specific service, such as referral of pregnant women, family planning or management of SGBV cases. Two staff mentioned that the BPHS had some priority areas, and listed services for women as such. Even though most staff were not aware of the priority areas of the BPHS, almost all staff pointed out that the reduction of maternal mortality was one of the main objectives of the MOHSW.

Most supervisors understood the concept of the BPHS and appreciated its function in terms of standard setting and guiding their supervision.

> *"We are ok with it because now we know what we expect of our facilities, and we know what the ministry expects of us in the line of basic package." [Cape Mount CHT_sup1]*

Only one supervisor respondent did not know what the BPHS involved. A few supervisors highlighted just one characteristic, such as free services or reduced human resources and one stated that she had to find out about the BPHS by herself:

> *"Nobody has taught me. Every time I hear BPHS, and sometime, when those people come from the ministry to go for BPHS accreditation, I am always behind them, so, I try to see what they are really looking for." [Cape Mount_CHT_sup1]*

Most supervisors thought that the BPHS was a good orientation also for the health staff, indicating that supervisors assumed a better understanding by health staff than was in reality the case.

At the policy making level the BPHS was seen very positive by all respondents, whereby the main strength seemed to be the enforcing of standards to be followed by the facilities. The BPHS was seen as a guideline and helped prioritizing and standardizing training curricula and health services. Ten of the 24 respondents clearly stated that this helped provide good results. The majority of respondents only came to work in Liberia or at the MOHSW once the BPHS was already developed and about to be implemented. One respondent who had been around during the transition from relief to recovery highlighted that in the beginning there were a lot of difficulties regarding the

partners' adherence to the BPHS and some reluctance by relief NGOs to implement the BPHS, as they did not agree with the standard approach to service delivery and salary structure.

There was general agreement at policy making level that staff at facilities should have an understanding of the BPHS in terms of its standards and purpose, and that it was necessary to have a policy that made sense to those who were implementing it. Understanding the benefits of the BPHS was considered to help staff in promoting their own work and to understand what they are supposed to be doing and why it is they are doing it.

> *"I think policies like that should be sold to the people. You talk about maternal mortality reduction. You make a good policy, but it is with the ministry of health, how to reduce maternal mortality. But the midwife doesn't know. The person who is delivering mothers has not heard about it. Who is going to implement it? Isn't it the midwife? There is a barrier between the policy maker and the implementer." [policy_NGO6]*

> *"I think they should know the BPHS, because it is a national government policy, they are the implementers, they are expected to articulate and provide to the people who they serve. But we need to have a better language and to be more consistent in disseminating that language." [policy_gov8]*

While some respondents at policy making level felt that staff understood the BPHS, not everybody did and two respondents were aware that staff often associated the cut in incentives with the basic package but not the key services, which they saw as a challenge for implementation.

> *"I think what it does is making sure that all the way down to every staff level at the facility, people know the BPHS and know what those standards are." [policy_donor1]*

> *"When the BPHS came, with good intention... But then it came with a salary cut. To take away the salaries from the health workers. If you go to the country anywhere, you say that you are implementing BPHS, they say, you are the people who took away our money? Because this is the way they see at the BPHS. So it is not about the services. It is about cutting their salaries. So people don't understand what are the services in the BPHS. If you send a nurse out, and all*

she knows is that the BPHS is about cutting incentives, then she will wonder what she is doing out there." [policy_NGO6]

One respondent clearly highlighted the benefits of explaining the benefits of the BPHS to health staff.

"We are going to try to explain to them how it benefits the country not to have women die. People have a vested interest not to have women die all the time. You have to logically explain things to people, how it is going to benefit them." [policy_NGO9]

The actual process of policy implementation of the BPHS was discussed only at policy making level. The same respondents who considered the BPHS a good policy saw the main problem in its implementation. The main constraints were the lack of human resources, the need for close monitoring as well as the high reliance on international partners. Several respondents at policy making level said that while the policy in itself was good, guidelines for its implementation took too much time to be developed, and more guidance for the planning of implementation was required.

It was also mentioned that while the BPHS addressed SRH services, it did not go into detail how these services should be implemented. For example, health talk on family planning or SRH services for adolescents are mentioned without explaining what was actually meant by this. This gap between the BPHS on paper and the actual implementation was mentioned by ten respondents at policy making level.

"The BPHS did a good job in saying what the standards are, but there is still a lot of work to be done to implement those standards, and then the final challenge is making sure that education is given to the community." [policy_donor1]

Another issue in the implementation of the BPHS as mentioned by ten policy makers was the focus on the facility level with too little attention to the community level.

Perceptions on the expansion of the BPHS

Part of the policy direction of the BPHS is that it is supposed to be revised and expanded after a first implementation period of five years. When asked about the need to expand the BPHS, staff at facility level felt that they provided the SRH services that were needed by the population, but saw the main challenge in the low service uptake and therefore saw no need to expand the BPHS.

> *"Even the ones they told us to provide, for the people to accept it, it was not easy. Even though all was not acceptable, we are still trying to convince the people so that they can accept it. So I don't really looking at anything different no more." [Cape Mount_HC2_OIC]*

> *"The services really match the needs of the community; nothing missing. As I said it already difficult for them to come. They first have to understand the benefits. It takes time." [Nimba_HC2_OIC]*

The perception of the BPHS by supervisors was similar to that of the service providers. Most supervisors saw the main challenge for service provision in the low acceptance of the basic package, particularly SRH services by the communities.

> *"They have been increasing the number of services. It is the utilization of the services. That's where the problem is, getting the people to really use the services, the services that are offered." [Cape Mount_CHT_sup1]*

> *"But from the overall, but when it comes to uptake of family planning activities in this county, it is very low. People don't believe in it. Other services, sometimes they come for antenatal care, but during the third visit, they are lost and then they deliver in the community with the TTM. And also again, when it comes to SGBV, people...At the hospital before we would maybe see one or two cases per month...So, actually, people are not taking advantage of reproductive health activities." [Nimba_CHT_sup1]*

Interviews at policy making level revealed some discrepancies in the perception of the implementation of the BPHS and the provision of SRH services and therefore the need to expand services. Several respondents referred to the percentage of the implementation of the BPHS implying a good

service delivery. At the same time, they acknowledged that the actual SRH service provision was still lagging behind.

> *"Our goal was to increase access; we should be able to implement the BPHS in 70% of the facilities by the end of this year. But at the moment we are at 80%, so it is going well. What is lagging behind is the quality. We said the first thing we wanted was to make the services available. So, the first thing we wanted was to improve access first. And then, later on we improve quality. So, we started with the access and that has worked well. We have managed to deploy people at the facility and to provide the supply. Even if there is still a need to improve a lot of things. We also realize that in the implementation of the services, some services are lagging behind." [policy_gov2]*

> *"The BPHS is so focused on maternal and child health. So, if it is going to do anything to meet the needs of the population, it is going to be around women and children and SRH. But has it adequately done that? No. I think it is just the complexity of delivering services, not just SRH issues. I think it is such as huge system to put in place, where there was no system before." [policy_donor1]*

> *"Adequate care is not provided, but at least there is something, I wouldn't expect more, especially if the workforce is so low." [policy_donor3]*

Views regarding the expansion of the BPHS differed among respondents at policy making level, and some respondents had contradictory opinions regarding the need to expand the scope of services of the BPHS on the one hand and the great difficulties to implement services on the other hand. The same respondents who had stated that the package was not yet fully implemented said that the BPHS was only basic, as implied by its name, and its implementation time frame was now coming to an end, and therefore the package needed to be expanded. Looking at SRH specifically, nine of the 24 respondents stated that the package needed to be expanded, while six felt that the BPHS was already too ambitious and lagging behind in implementation. It needs to be noted that respondents who advocated for an expansion and also those who preferred to focus on the implementation of the current package all listed SRH services that they felt were currently not well established, such as

family planning, adolescents' SRH, SGBV management and emergency obstetric care. SRH services not yet included in the package but that were required according to nine respondents included treatment for cervical cancer, menopause and abortion, as currently only post-abortion care was included in the BPHS.

Interviews revealed tension between the attempt to accommodate a number of competing priorities and to implement what has been planned on one side and the notion of the BPHS only being basic, implying a need to scale-up and add services on the other side.

> *"This is basic and it is good to start with, but now things are changing, there are higher expectations, expecting more services." [policy_NGO3]*
>
> *"You could add more services, but if you don't have the workforce to address it, it will be chaos. There will be a demand and then in the end it will have less impact." [policy_donor3]*
>
> *"If you refer to the needs of the population, they should expand it pretty fast. So, realistic and practically - certainly, they don't have the full package down at this point. But I think they can still expand on it." [policy_donor1]*

A few respondents proposed that the tension between the need to scale up services and the limitations of the health system to do so could be addressed by a more flexible approach to the implementation of the BPHS. While currently, all facilities should have the same services available, some respondents suggested that not all facilities needed to scale-up, but certain services should only be added to facilities that were doing rather well in the provision of SRH services, while other facilities should refer to these facilities.

This need for more flexibility was noted by three respondents, not only in terms of services but also in terms of human resources and opening hours. Instead of the type of facility, the catchment population should be used as a determining factor for the number of staff at a facility. Similarly, clinics that only have patients in the morning should have the flexibility of having less staff at the facility in the afternoon.

"The BPHS is an imperfect document, especially in terms of staffing level. Its development was a continuous process of compromising, and its great disadvantage is its inflexibility. Some rural clinics do not need six staff. So, instead of this blueprint for staffing we need more flexibility." [policy_gov8]

Performance-based financing

Performance-based financing is used as a strategy to effectively implement the BPHS. This mechanism seemed to put pressure on NGOs but not on county health teams to meet performance indicators, having major implications on the role of NGOs and their relation with the county health teams. While staff at facility level and their supervisors were not aware of performance-based financing - also when probed, respondents at policy level had mixed views of this approach. Five respondents saw the role of NGOs as the main implementers of the BPHS as a barrier to strengthening the national system. They felt that some partners were not willing to evolve and to hand over to the government.

"The issue with the BPHS is, the vision of the government is to restore a health system with government health facilities, human resources, payroll. In a country that has been fragmented in conflict this is some sort of reconciliation. But right now NGOs are largely implementing the BPHS. This is inconsistent with the national vision. NGOs need to be willing to evolve, to hand over to the government. USAID is currently running SRH." [policy_gov8]

"The problem is reproductive health services are supposed to be government supported services. But the big challenge is, because if performance-based remains on the NGO side, they want to increase the number of family planning, the number of deliveries. So you are pushed, but then you have the supply issues and the staffing. So, what do you improve first? So, performance based contracting maybe helps the NGOs to push the required services, but the system cannot perform faster than what is already there." [policy_NGO6]

One NGO representative acknowledged that they took away the ownership from the county health teams if they did not step back from direct service implementation. But at the same time, they felt under pressure to perform, and blamed the government for lack of responsibility. Six respondents from NGOs stated that there was no ownership from county health teams, holding the partners back in service implementation. Some of them felt they had to bypass the county health teams in order to successfully implement SRH services and to fulfil the performance-based contracts.

> *"CHT did not buy in (PBF). It is really a matter of convincing the CHTs. Their slowness is affecting us. We failed to do what we were supposed to do, because we needed their blessing. It's like they are doing us a favour. It is very frustrating." [policy_NGO6]*

> *"So there is a lot of frustration, because we are accountable to different types of groups. The county health team is accountable to the MOH, while we are obligated to work with them, and alongside the MOH, but a lot of things we are pushed to make happen from the donor side. So, you need to decide, I can take longer to do it, to help somebody else to learn how to do it or just do it myself and be done with it...There is a lot of more consequences for an NGO than for the county health team. If they don't do it, nothing much happens. If we don't do it, we lose our funding." [policy_NGO5]*

Two respondents from NGOs appreciated the approach of performance-based contracts, as according to them it motivated the implementing partners and therefore improved the services. However, one of them acknowledged that so far this has remained at the NGO level, and has not yet translated to the level of health facility staff. Six respondents criticized that too much effort was being put in place to reach indicators, often in a way that did not contribute to health system strengthening. One example included incentives paid to officers in charge to participate in trainings in order to meet training indicators. It was further mentioned by two respondents that the monitoring of the performance-based financing lay outside the national monitoring and evaluation system. In

addition, the focus on indicators, which were frequently modified, was perceived as time consuming for all actors and confusing for health staff.

> *"One of our focus is the monitoring and evaluation, getting data out, and regarding how we are doing on all these things, almost has a backwards effect, because, it continually confuses and kind of blurs what it is we are after...we are so focused on reporting and tallying, and they spend so much time on it...there are so many indicators to look at, and they change, there is continuously new indicators being pushed in. One month one particular data element would seem out of whack, and there will be this push to correct that, and then all of a sudden it will be forgotten, and then another one will come in..." [policy_NGO5]*

This perception was also shared by one supervisor in the field, who stated that facility staff complained about the confusing and constantly changing indicators, of whose purpose they were not even aware.

One international partner acknowledged that the county health teams were not sufficiently part of the performance-base financing process, such as the data reviews and sharing of strategies to improve indicators. This meant that performance-based financing was considered useful in terms of getting the partners involved and developing a data driven culture but may not be sustainable and may even undermine health system strengthening as well as a true partnership between international partners and national counterparts.

6.3 Critical Subsystems

Critical subsystems of the health system are financing, workforce, pharmaceuticals/ technology/ infrastructure and information. All of these, except financing (which was not explored in-depth) emerged as themes during the interviews and will be discussed in this section.

Workforce

Workforce seemed to be the main constraint to provision of SRH services under the BPHS, underlining the importance of taking their perception into account to understand processes of policy implementation. Staff motivation and high staff turnover were frequently highlighted as key problems. This section will first address human resources in terms of policies as mainly discussed at policy making level and then consider different aspects related to workforce as mentioned by all respondents.

Human resource policy

The human resource situation was listed as the main limitation to effective SRH service implementation by all respondents. While health workers mainly talked about their working conditions and low motivation, respondents at policy making level discussed it in terms of the overall policy:

> *"I like to think that human resources will come salaries will be better, so the motivation will be better, and the neglected areas, like family planning, SGBV, emergency obstetric care, youth...will come" [policy_NGO1]*

Most respondents felt that human resources at facility level were inadequate, particularly for the provision of SRH services, which mainly relied on midwives. Seventeen of the 24 respondents stated that there were not enough staff available, particularly certified midwives were missing. Several respondents noted that the MOHSW was lagging behind in the development of the human resource policy, for which reason a number of issues in terms of health staff management and motivation were not adequately addressed.

Several respondents felt that because of the lack of midwives, certain SRH services were overlooked as the midwives felt overstretched and therefore

unmotivated. They stated that the facilities could currently not afford to offer all SRH services of the BPHS due to these limitations of staff. Specifically, it was currently not realistic to advocate for facility-based deliveries as midwives would reach burn-out if numbers increased. In addition, high staff turnover seemed to lead to lost trainings and this way jeopardizing the provision of complicated services, such as BEmOC.

A number of respondents at policy making level highlighted the need to not only look at the number of staff but their skills to make sure that they were qualified to provide SRH services. This was closely linked with the concern about the quality of service provision. Furthermore, most respondents recognized the need for increased outreach services to improve service uptake but that this was impeded by lack of staff.

Ten respondents additionally mentioned the low skills of health staff to provide quality SRH services. This was further fostered by the fact that the wrong kind of human resources has been trained over the past years, as highlighted by one respondent: In 2006, there were 454 nurses available. The target for 2011 was 655. However, in 2010 1393 nurses were available. At the same time, in 2006, 297 certified midwives were available, and the target for 2011 was set at 725. However, only 412 certified midwives were registered in 2010 [200, 201]. In addition, respondents noted that the available health staff were poorly distributed, with the majority of midwives working at hospital level. This meant that there was a mismatch between the staff and the services that are supposed to be provided at the facilities. This mismatch was exacerbated by the fact that there is no career path for midwives and so many certified midwives want to become nurses or change careers entirely. This explains the low increase of the number of midwives since 2006. A few donor and NGO respondents noted that there was a need for the MOHSW to look at the role and the status of midwives in order to make people aspire to become a midwife.

> *"...somebody was saying, 'we just get those people trained and get them out there'. Like, if they were some sort of commodity. If I am sent to River Gee for a couple of years, I want something in return. You would think that there is a*

career path, that there is supportive supervision - we care about you. We haven't gotten there..." [policy_don2]

Supervisors from the county health team and NGOs had a similar perception of the workforce and its implications on the implementation of the BPHS. The challenge to get and keep skilled staff, particularly certified midwives at the facilities was highlighted by eight of the sixteen supervisors.

They felt that the implementation of the BPHS was challenged by the lack of workforce, limiting the SRH services that are implemented as well as the way they are implemented.

"Let's just limit it to that manpower because if people are there ready to do those things that are expected of them, obviously those things will be provided. It is just useless to send pile of reproductive health materials somewhere when somebody is not there to properly manage it." [Nimba_CHT_sup1].

"But the reproductive health, where we have problem, there is lack of certified midwives, and because of that, the reproductive health area is not effective... just, say 50%." [Nimba_NGO2_sup1]

Working conditions

Eight of the 23 health workers highlighted that they were alone in the facility, which did not allow them to exchange ideas or to consult with a colleague in case they were not sure what to do. In addition, they felt that the workload particularly on the certified midwives was heavy because it included a range of SRH services and because they could be called upon at night despite the official working hours of clinics from 8am to 4pm. For this reason, several respondents indicated the need of an assistant.

"I alone now. It can be very busy. And sometimes you want to exchange with somebody. Like if you have question. Make sure you are doing the right thing." [Nimba_clinic4_OIC]

"One person will not the whole night...like the other night I did two deliveries here one night I came to work 8 o'clock in the morning stay there until the next morning then I went home I

still went back to work and stay there until in the evening. One person cannot work like that." [Nimba_clinic3_CM]

The fact that health staff had to work outside of the official working hours was highlighted by eight respondents. In addition, some midwives stated that they did not feel comfortable conducting deliveries alone at night.

"Because at night patient comes, we use lantern or torch light...that something you don't really feel good." [Cape Mount_clinic1CM]

It is important to note that while most staff highlighted the workload as a factor that rendered their work difficult, it was not necessarily the number of patients they had to see on a daily basis - a number of staff even stated that they had to wait for the patients during the day - but the fact that they had to work outside the official working hours.

"We have no specific time, they say emergency, we coming, they say we much work from 8 to 4 but in the interior here, you, over more than 36 villages and town here...the work is hard, we work 24 hours." [Cape Mount_clinic4_CM]

Several respondents highlighted that the constraints in terms of human resources were particularly felt in the area of SRH, as this area was handled mainly by midwives, who were most difficult to get at the facilities.

Most supervisors acknowledged the difficult working conditions and the need to try to motivate and encourage the staff. In addition, they advocated for better recognition of certified midwives, who for them were the main stakeholders for SRH services but at the same time received the lowest incentive compared to nurses and medical doctors.

"The clinicians cry and we ourselves feel for them. Actually, it is not fair on their part. You couldn't go spend a lot of time in school and you come you cannot get money and even sustain your family." [Nimba_NGO2_sup2]

The perception of the working conditions of midwives differed among the respondents at policy making level. There was general agreement that the incentives were too low. Working conditions were discussed by eight respondents, stating that staff were overworked which had an impact on the quality of work. Two respondents felt that the workload was appropriate. Three respondents felt that midwives should be compensated for additional work outside of the official working hours and the majority of respondents saw a need to take into consideration the challenges that the midwives faced and to encourage them to go to remote areas.

> *"You send a certified midwife to Bambala, she has no additional incentive, no hardship payment, why should she stay?!" [policy_NGO3]*

However, government respondents were less sympathetic to the needs of health workers. Four respondents from the government stated that it was part of a midwife's job to provide emergency services as required, even at night and during weekends.

> *"The health workers understand, this is what it entails to be a health worker, you have to work after hours." [policy_gov5]*

Motivation

Five health workers stated that they felt discouraged by the low incentive, which was often paid irregularly. Three staff simply stated that there was nothing to motivate them. The low incentive is important to note as in the perception of a number of staff the incentive was closely linked to the BPHS, and therefore the entire BPHS was considered to be discouraging for staff. Some staff perceived the low incentive as a lack of recognition by the ministry of health. This is also linked to the perceived deteriorated working conditions compared to the relief phase, during which incentives were higher and more staff were working at the facilities.

> *"No, to be frank with you, I was motivated at the time that MSF, the NGOs here at that time they were paying more. MSF was here at that time so most of our friends decided to come in the rural area were receiving more pay, we say oh,*

we at the city since our pay less let us go down at least to help the people that we will be able to do something. But unfortunately for us when we got here MSF left. IRC came, so they cut down everything. They said they going by government policy." [Nimba_hospital_CM]

Low motivation due to the low incentive often led to staff turnover, undermining service provision:

"So, if they can improve on that (incentive). Or if they can provide other way of motivating the worker, it will be fine. But if it remains like this, it will be a problem. Because people will leave. And then with them the training is lost." [Cape Mount_HC2_OIC]

"We don't have manpower. We had so many, I think four to five employees that were assigned here. We had registered nurses and certified midwives that were all here. But they all abandoned this place... The certified midwives we had, they all left." [Nimba_HC1_OIC]

Low motivation and high staff turnover also seemed to be a concern of supervisors. Several supervisors from both county health team and NGOs mentioned the difficulties of keeping staff at the facilities, and the constant need to encourage them to stay. According to the supervisors, the difficulty of staff retention had implications on service provision, not only because of the lack of staff, and the fact that staff provided services less effectively than they should, but also because of the loss of training efforts.

"For my area is kind of difficult, because change is a gradual process so in order to reach the standard for BPHS is gradual so we are on a day to day basis trying to teach or supervise to coach our people to standard but it becomes difficult because staff are always withdrawing. So after you have gone like maybe 50-60% they will stop and you have to move to new person." [Nimba_NGO1_sup1]

As noted above, the BPHS was being implemented using the performance-based financing approach. This approach is supposed to contribute to the motivation of staff and this way improve service provision [202]. However, since staff were not aware of this mechanism, the motivating factor has not translated to the facility level.

At policy making level, the issue of staff motivation was also highlighted as an issue influencing service availability and quality of services. Furthermore, there was agreement among respondents that there was a need to improve incentives to motivate staff to go to rural areas, and to stay there for a period of time, instead of only a few months. Staff turnover was highlighted as a problem by half of the respondents as trainings got lost and facilities remained without staff for periods of time.

> *"So after we did that training, we also brought in the MVAs to be available for those facilities. But due to the high staff turnover, in some facilities where the staff came from for the training, when you do follow-up, you find out that they are no longer there. So, you have the MVA there, in a facility that no longer has somebody trained to use it. And you have a trained midwife in a different facility where the MVA is not in place." [policy_UN1]*

One respondent from the government explicitly did not consider staff turnover as a problem as staff would just go to another facility and provide services there.

International partners from NGO and donor side highlighted the need for increased recognition of health workers, particularly midwives. This was highlighted by several respondents, who said that staff did not feel valued, as representatives from the MOHSW did not go to facilities and staff were not on the government payroll and therefore did not feel part of the health system. For this reason, some partners tried to put in place their own mechanisms of staff recognition.

> *"Nothing motivates them. We have a newsletter that shows how well everybody is doing. And people like that here. Who had more deliveries, the women like that stuff, this kind of competition, to tell them if they do their job well." [policy_NGO9]*

Most respondents saw low motivation as one reason for low quality of work. This again highlights how service providers influence the implementation of the BPHS. It seemed that midwives, who work in private settings on the side, where they earned more money, provided better services there.

"If you are not satisfied, you do not put an effort, you do not provide good quality services. We can see this in the staff that works in two jobs. A government, B private. The same person can be so different! In the private, they greet the patient and all those things." [policy_gov6]

Supervision

Supervision and training were important components related to the workforce, and support to the implementation of the BPHS. Sixteen of the 23 health workers interviewed seemed to be very appreciative of the supervision that they received and acknowledged that they needed it. According to them, supervision consisted of observation during service provision and feedback on their work. Another positive aspect also seemed to be not to feel left alone:

"...at least they could come." [Nimba_clinic3_CM]

Supervisors also felt that their supervision played an important role, contributing to improved quality of health services and acting as a motivational factor for staff. They provided regular supervision by observing health staff in their provision of services, and correcting them afterwards and by checking the records as well as the material needed at the facilities.

"The supervision helps them to improve. Because every time when we go, we carry the same checklist. They know exactly what they are supposed to do. So the supervision is a guideline for them, because even if they want to go, they will say, the people will come behind us." [Cape Mount_CHT_sup3]

"Our supervision provides information on certain issues, we bring some information, key information, for example postpartum haemorrhage, and discuss this with the staff. The midwives, they get so excited: 'This is the kind of supervision we need!'" [Cape Mount_NGO_sup2]

In contrast, at policy making level, the seventeen respondents who commented on supervision either said that supervision was not taking place or was inadequate. They felt supervision was essential to ensure sufficient levels of service quality and to also motivate staff and to show that they were being cared about. Several respondents stated that the kind of supervision that was currently taking place was too irregular and that supervisors did not know what to look for. They further criticized the checklist approach, focusing too little on observation of client interaction and too much on supplies and reporting. Several respondents further highlighted that trainings were not effective if they were not followed-up by close supervision and they would prefer to have less trainings and more supervision than is currently the case.

> *"People in the facility do not know what they need in terms of supervision. There is no correlation between supervision and quality of services. At least a percentage of the supervision should be direct observation." [policy_donor2]*

Training

Similarly to the supervision, responses from health staff at facilities about SRH training were positive. Nine of the 23 respondents said that training was helpful for them, it helped them update their knowledge and experience and eleven respondents stated that they could use what they learned in the workshop in their every day work. They gave examples of how they applied newly acquired skills in practice such as neonatal resuscitation and adolescent family planning. Moreover, most staff acknowledged that they had not known how to provide certain SRH services before and that they had only learned it through the workshops, such as treatment of STIs, neonatal resuscitation, counselling for family planning and adolescent SRH. Here again, the fact that they were alone at the facilities and therefore needed training as an opportunity to gain experience and get new ideas was highlighted by several staff.

> *"They help a lot. It is the workshop that helps me to go forward. When you go to workshop it gives you some experience than sitting here using one man's idea. It motivate me to do my work, because sometimes I even find myself like I'm doing nothing." [Cape Mount_clinic5_OIC]*

"First, when they (adolescents) used to come really, that time I never went for workshop; when they used to come, we really used to tell them that 'you haven't reached the age for family planning'. But since I went for the workshop, when we went for adolescent workshop, they've made us to understand that so long they start receiving, any age, can take it. So, when they come, mainly I can deal with them." [Cape Mount_HC2_CM]

Only two respondents criticized that the trainings interfered with their work as they would be away from their clinic. Three staff felt that there was a mismatch between the trainings and the supply of materials as material often arrived long after the training had taken place or equipment would arrive but adequate training had not yet been provided.

According to the supervisors, considerable SRH training was provided as part of the BPHS roll-out, which in their perception contributed to the improvement of staff competence in this area, as stated by four supervisors. They also felt that staff were eager to apply newly acquired knowledge in practice. Supervisors saw the need for trainings as refresher for their staff.

The perception of training on SRH services was mixed among respondents at policy making level. While it was seen as a necessity, considering the low skills of health service providers, the way it was currently being implemented was criticized by most respondents. The main issue was the amount of training and the fact that staff spent more time in trainings than actually providing services at the facilities. One NGO representative clearly stated that she would deny any training, as it interrupted service provision by taking out health workers from the facilities for periods of time, leaving facilities unstaffed. This interruption of health service provision was seen as a major problem as many staff, either officers in charge or midwives were already alone at the facilities. In terms of SRH services, this particularly affected the provision of BEmOC, which should be available 24/7 and facility based delivery in general. Several respondents also commented that training was ineffective and not translating into improved services, with examples given on counselling on family planning and the use of MVA. For this reason, several respondents advocated for less

training but closer follow-up and supervision. Only one respondent at policy making level felt that once health staff have received training, they are able to provide services effectively.

> *"We realize that even though people are trained, they do not use their skills, they continue to be weak, we want to change the strategy and send a mentor after the training." [policy_gov2]*

> *"It is not effective training. You see information is thrown at the participants, they get certificate, but the work environment is not there." [policy_NGO6]*

Another major issue highlighted by several respondents at policy making level was the mismatch between trainings and supply. The BPHS provides a list of equipment to be available at each facility. However, at several occasions it was mentioned that training had taken place, but supplies to apply the new skills were not available, as for example IUD and Norplant for family planning.

> *"IUD - I went to one clinic which had had an extensive training on IUD, but they don't do IUD because they don't have the kits. So this training is lost. Why would you do training on IUD if you don't have the kits? Because you have a training budget..." [policy_NGO9]*

A number of respondents noted the absence of a systematic training plan to implement the BPHS which contributed to this disconnection between trainings, material and service provision.

> *"Who knows who decides what kind of training is being conducted. The MOH has its own agenda, then the donors decide what they want to fund, USAID decides what their high impact areas are, the CHT have their own ideas. [policy_NGO3]*

> *There is no systematic implementation of training in order to implement BPHS. But this is needed." [policy_NGO1]*

Finally, some respondents felt that training was not conducted in an effective way giving staff only theoretical knowledge, but too little practice. Most training seemed to be classroom trainings with too little practice, which would be

needed for certain services, such as the insertion of IUD or the application of MVA.

Pharmaceuticals, Technology, Infrastructure

The health system component concerning pharmaceuticals, technology and infrastructure was mainly discussed in terms of supplies of drugs and equipment, as well as infrastructure such as clinic space and electricity.

Supplies

Supply of equipment and drugs was listed by half of the staff as the main improvement since the implementation of the BPHS, which provides a detailed list of drugs and equipment to be available at facilities.

> *"We have so many things we use and work, the clinic material, we have them." [Cape Mount_clinic1_CM]*

> *"We used to be short of drugs. But this time, we are no more short of drugs. We always have our drugs." [Nimba_clinic3_CM]*

While most staff stated that they almost had no drug stock out, they later mentioned that they had some difficulties with maintaining family planning commodities which forced family planning users to have to change the type of family planning which often resulted in them refusing and thereby halting contraceptive protection.

Supervisors were also positive regarding supply of drugs and equipment. Most of them stated that there was no drug stock out, and three respondents particularly mentioned family planning commodities to be always available. One supervisor stated that the supply of commodities was not the problem, but rather to get the end user to actually use it.

Supply was seen as a challenge to SRH service provision from the perspective of policy makers. Half of the respondents stated that drug supply was poorly managed, particularly from the central level to the health facilities, and constituted a bottle neck for services provision – particularly for family planning and post exposure prophylaxis. According to three respondents, this was less an issue of logistics than of priority setting.

"I am not quite pleased with the rate of contraceptive use. And I can say that it comes from the supply end and the demand of services. In terms of the supply end, we, along with USAID bring in all the contraceptive commodities. And I know that we bring in enough for Liberia. But if you get out there to the level of the facility, you will find that there are stock outs or most of the methods are not made available to the clients." [policy_UN1]

Three respondents linked the irregular supply of drugs to low service uptake, as patients preferred to buy their drugs directly at the market, without having to queue at the facility, where they would only receive a prescription. One respondent mentioned the difficulty of keeping patients motivated to use family planning commodities, as they might have to switch from one commodity to another, when the first drug was out of stock. Another respondent felt that the lack of regular supply of equipment of drugs was in addition a demotivating factor for service providers at the facilities.

Infrastructure

Lack of space and limited ambulance services were the main challenges listed by health staff when talking about infrastructure. More than half of the service providers felt that their clinic was too small, requiring them to conduct assessments in the same room as deliveries and having no space for postpartum stay. This was a major issue in terms of confidentiality.

Referral was seen as a challenge by three respondents, as often the ambulance was taken by another patient in a different area of the county, forcing them to either wait or to find other ways of private transportation by the relatives of the patient. In addition, several staff felt that the fact that there was no transportation from the community to the clinic was a major limitation for pregnant women coming to deliver at the facility.

"Really, we don't have transportation. If you telling people say at night bring patients to the clinic to deliver there must be transportation available." [Nimba_clinic3_CM]

Another challenge in terms of infrastructure was the lack of electricity and therefore light at the clinics. As highlighted above, midwives had to conduct deliveries at night using torch light, about which they did not feel comfortable.

Observations by supervisors regarding infrastructure were similar to those of the facility staff. Five of the sixteen supervisors listed the lack of space and the limited referral services as main constraints to the provision of SRH services. The lack of space was considered an issue particularly because of the lack of confidentiality (despite confidentiality being a required part of the BPHS accreditation checklist). Four supervisors also mentioned the lack of a vehicle to conduct supervision as a limitation.

Infrastructure was only discussed by few respondents at policy making level. Two respondents mentioned the difficulty of referral, due to the challenges in getting an ambulance. Moreover, two respondents stated that space was an issue in service provision, as it was a barrier to confidentiality. The lack of provision of water and electricity was further mentioned by two respondents, as it put a challenge on deliveries taking place at night.

> *"If you talk about access, most of the facilities are not electrified, so at night, doing a delivery with a headlight, it is terrible. If people are coming for delivery to the facility because maybe they have complication, you need to have a real source of light. So, this is one of the challenges." [policy_NGO1]*

Information

Health information did not seem to be a major issue in SRH service provision from the perspective of health workers. At supervisor level it was particularly discussed in relation to performance based financing, as the number of indicators confused health staff and made it difficult for them to understand priorities.

At policy making level a few respondents saw a problem in the information for EmOC as the signal functions were not systematically assessed, making it difficult to have a clear picture which facility was providing which component.

Several respondents highlighted that a separate assessment for EmOC was taking place to identify the gaps in EmOC care which suggests that that the accreditation process did not provide adequate information about EmOC provision.

A few more respondents praised the maternal death reporting that had very recently been introduced, with the respondents feeling that it would improve understanding of underlying reasons for maternal death and thereby improve services accordingly.

Accreditation

The implementation of the BPHS is monitored through an accreditation process. Staff appeared to be pleased with the accreditation process for three main reasons. In their perception, it contributed to an increased supply of equipment and guided them in their knowledge on health services. Moreover, some of the health staff saw the accreditation process as a motivational factor to improve the accreditation results from one review to the next. According to most respondents it forced them to update their knowledge before the accreditation team came to their facility.

> *"It is good. It helps us. Because, after the accreditation team comes and they throw questions to us, what we answer what we don't able to answer that one they cross us wrong, and after everything they grade us and then next time you want to improve!" [Cape Mount-clinic1_CM]*

> *"Like for family planning, they come, they ask you about family planning, how you give them out, what you tell the patient. And we tell them. They are making us to know that the patient should make their own choice. So I learn from that." [Cape Mount_hospital_CM]*

Respondents also enjoyed the involvement of the MOHSW in the accreditation process and felt it made the MOHSW more engaged in their work:

> *"It's helpful (...) They brought in new things. It's fine, it's very fine. Because if it doesn't be so, they will just forget about ourselves and we will just be there." [Nimba_clinic1_CM]*

Only three respondents felt that the accreditation did not contribute to the improvement of their facilities, as they did not see any changes resulting from the process, such as provision of additional equipment. Another staff questioned the need of asking for certain material that could not be used at the facility because staff had not been trained. Another respondent questioned the process in the way that the facilities get penalized if commodities are not available, while this was the fault of the supporting agency or MOHSW.

Similarly to the facility staff, most supervisors appreciated the accreditation process as it helped them, as well as the NGOs and the donors to see where they stood in the implementation of the BPHS and guided the supervisors in terms of what to look for and to understand where the gaps were.

> *"The accreditation process is very good. It is challenging. It makes people to study. It is very educative. It makes a donor to be moved or the partner to be moved, to make sure that things are put into the right place. Equipment is supplied to the rightful area that they are supposed to be. Services are rendered to that area." [Cape Mount_CHT_sup4].*

However, three of the sixteen clinic supervisors pointed out that the accreditation check-list assessed items that were not supposed to be in a clinic, such as the IUD set, or items on which staff had not been trained such as MVA. There were also complaints that they were not being supplied with the equipment against which they were assessed:

> *"So, for example, you ask for x-ray machine. Who is supposed to give us an x-ray machine? You are supposed to give me the x-ray machine. So, if I don't have it, is you. So if I don't have it, you give me a 0!" [Cape Mount_CHTsup1]*

Policy makers saw the accreditation process as a useful starting point to monitor the implementation of the BPHS, though they also highlighted several issues. While only one respondent stated that the accreditation process contributed to the improvement of services, eight respondents criticized its focus on supply and saw a need to also look at quality of services and whether

and how staff used certain equipment. Specific examples regarding SRH services were counselling for family planning, SRH services for adolescents, and the use of MVA. Furthermore, BEmOC did not seem to be properly assessed through the accreditation, as it did not rigorously look at all components. For this reason, respondents stated that the accreditation provided a more positive picture of BEmOC implementation than was in reality the case. One respondent found it more important to assess the quality of services than conducting the accreditation. However, most respondents acknowledged that this approach, to first focus on the equipment and only later on the correct use of this equipment was appropriate in this post-conflict setting.

Another aspect that was criticized in was the fact that it did not represent the true picture of the facilities as it took place only once a year. According to several respondents, clinics moved items between the facilities only for the accreditation. For this reason, five respondents said that the process should be ongoing. Three respondents highlighted that it contributed to a healthy competition between the county health teams and the partners and motivates staff to get involved.

6.4 Summary

This chapter explored the perceptions of health workers and policy makers regarding components of the health system and their influence on SRH service delivery as part of a BPHS. Health workers and supervisors seemed to have similar perceptions on the implementation of the BPHS. They felt that they provided the SRH services that were needed by the community and that the BPHS was a key facilitator in the provision of equipment and drugs. They further appreciated the BPHS accreditation process and supervision and training, as these components contributed to increased supply as well as improvement of knowledge and skills of health workers. Training and supervision were encouraging, as some staff felt "left alone in the bush" requiring feedback and acknowledgment. A limiting factor seemed to be the perceived lack of recognition of health workers by the government and the

limited involvement of the ministry of health, as reflected in the low incentives and lack of visits of the facilities. This indicates a lack of understanding of the importance of the role of street-level bureaucrats fur the successful implementation of the BPHS. Many health workers also had a negative image of the BPHS, as it was associated with a decrease in economic incentives and reduction of human resources compared to the relief phase. This appeared to lead to decreased motivation and high staff turnover as well as less effective service provision, highlighting the influence of street-level bureaucrats on service provision. Yet, neither supervisors nor health workers were particularly concerned about the quality of services.

The main facilitators discussed at policy making level were the attention given to SRH services within the BPHS and the standard setting through the BPHS, helping all actors to focus on the same issues. Yet, even though SRH seemed to be taken into account on paper in the BPHS, insufficient leadership and dependence on international partners for the implementation of SRH services appeared to be problematic. Here, tension between the role of the NGOs who were under pressure to produce results but were expected to support the county health teams through capacity building seemed to be an issue.

A number of challenges in terms of implementing this policy were listed by respondents at policy making level, of which the majority were linked to the workforce, i.e. the street-level bureaucrats. These included the low number of health staff and the high staff turnover, inadequate skills of service providers as well as their negative attitude and low motivation. Based on the interviews with health workers this seems to be directly linked to the BPHS, which they mainly associate with cuts in incentives and human resources. Linked to these issues, another area of concern in the policy makers' perception was the quality of services. Strategies to address the issues linked to the workforce, such as training and supervision were seen as absolutely necessary to improve service provision, but were also considered to be inadequate. Another challenge for SRH service provision that was linked to the health system was the irregular supply of drugs and equipment despite being listed in detail in the BPHS. For these various reasons, policy respondents raised concerns about virtually all SRH services that were included in the BPHS: family planning,

SRH services for adolescents, management of SGBV and BEmOC. Here, competing priorities seemed to further undermine effective implementation. Service uptake was seen as a challenge by some respondents but not all, though there seemed to be in agreement to strengthen the community aspect of the BPHS and to identify new roles of trained traditional midwives to serve as a link between facilities and communities.

Overall there was some discrepancy in the judgement of the implementation of the BPHS and the provision of SRH services between the policy making and the implementation level, particularly in terms of the perception of quality of care and service uptake, implying important limitations in the policy implementation process.

Chapter 7. Discussion

The objectives of this study were to assess the availability of SRH services at facility level and to explore health service providers' and policy makers' perception on how the implementation of the basic package has influenced the provision of SRH services. This was done by applying a health systems framework to Lipsky's bottom-up theory on policy implementation. Based on this, recommendations for policy making regarding SRH and BPHS in post-conflict recovery were developed.

While basic packages of health care are becoming increasingly popular in post-conflict settings, there is limited evidence on their impact generally and none specifically on SRH services [16]. This study contributes to filling this evidence gap by exploring underlying processes not captured by existing reports in Liberia which rely on monitoring data such as those from the accreditation process.

There are six key findings drawn from this study: First, SRH is high on the political agenda, being well represented within the BPHS. This is an important finding, as the literature had suggested that certain areas of SRH, such as management of SGBV and adolescents' SRH might be left out of basic packages [79]. It also indicates that a BPHS does not necessarily undermine the potential to advocate for SRH services, which was seen as a potential risk [79]. Second, while the BPHS is considered a useful guiding tool for health recovery, a key challenge is its implementation due to competing priorities within a short time frame leading to limitations in service availability and ongoing issues regarding quality, service uptake, and community outreach. Insufficient political commitment to implementation seems to play a further role. Third, there is an important gap between the policy making level and the implementation level in terms of perception of SRH service provision and priorities, potentially undermining effective service delivery. Fourth, workforce plays a key role in the effective implementation of SRH services with important implications of staff motivation for quality of care and service uptake. The fifth key finding is the fact that existing monitoring mechanisms, namely the

accreditation process, are not able to capture these limitations, indicating the need for more rigorous monitoring [203]. The sixth key finding is the importance of taking a health systems approach for the analysis of service delivery, to better understand the interdependence of its components, such as the key role of human resources, and the implications of consistent supply for service uptake.

This chapter will discuss the study findings based upon the conceptual framework. It will then reflect on the study's limitations and strengths, and then provide policy and research recommendations.

7.1 Service delivery

SRH service availability

The first objective of this study was to assess the availability of sexual and reproductive health services at facility level. Based on the interviews with health workers and policy makers, this encompassed the availability of services as well their perception on the quality of services and the uptake by beneficiaries.

This study showed that certain aspects of SRH services seem to be well addressed in Liberia. These include family planning methods, particularly oral contraception, antenatal care and condom distribution. Yet, more complicated services are limited due to lack of skilled staff as well as lack of equipment and regular supply as seen in the lack of BEmOC. Other gaps include in the consistent provision of delivery care, particularly assisted vaginal deliveries and removal of retained products, as well as safe post-abortion services. Furthermore, the demand for contraception is not being met due to intermittent supply.

The study observed that the provision of post-abortion care remains inadequately addressed given the lack of MVA outside of hospitals; this issue has also been raised in other studies in Liberia [204]. This is an important aspect as unsafe abortion is still an area within SRH that is neglected, while at

the same time it has been shown that MVA can be safely administered by midwives [205, 206]. Maternal mortality in relation to unsafe abortion is particularly high in countries where abortion is illegal, as is the case in Liberia [207]. This policy issue goes beyond the BPHS, but needs to be considered in order to tackle maternal mortality effectively. The lack of adequate EmOC services and MVA are important to consider, as obstetric haemorrhage and unsafe abortion are leading medical causes of maternal mortality [207, 208]. It further highlights the importance of focusing more on the actual skills for delivery services, particularly EmOC than merely on skilled attendance in terms of numbers [209].

The study findings also indicated an intermittent supply of contraceptives which was posing a barrier to the uptake of family planning. In addition, the provision of oral contraceptives may not be meeting the needs of women who seem to prefer injectables.

Overall, the findings show that services identified as SRH challenges in post-conflict settings are also of concern in Liberia [64, 86, 210]. The inadequate provision of SRH services implies that despite being included in the BPHS provision of more comprehensive services remains an ongoing issue. Even prior to the development of the BPHS, the Joint Needs Assessment in Liberia in 2004 identified those services that remain lacking today as priority areas, highlighting the need for EmOC, the high rate of teenage pregnancies and the high risk of unsafe abortions [211]. Studies in other countries showed that the implementation of these services in isolation is possible, even for complex services such as EmOC [87-89]. However, as part of a whole package where it is not the only priority this seems to be more challenging and there is little evidence on how this can be overcome.

According to this study competing priorities within the BPHS undermine the full implementation of SRH services. The fact that even within the BPHS competing priorities render SRH service provision challenging needs to be reconsidered, as it implies that even though the BPHS was developed as a tool for priority setting, it seems too ambitious despite being called basic.

Based on my findings, it was not possible for policy makers to focus on all of its components at the same time, leaving SRH services such as BEmOC and SGBV off the agenda. There is little practical evidence documented regarding this aspect of competing priorities undermining the full implementation of BPHS. However, this finding supports the observation that packages are often not adapted to resource and capacity constraints and are the result of competing priorities of decision makers rather than the result of a real priority setting effort [28] and this way risk spreading scarce capacity and resources thin [212]. The fact that so far it has not been possible to adequately focus on all SRH services included in the BPHS implies that it may take considerable time to fully implement a BPHS, possibly more than the five years planned by the MOHSW [157]. One year after implementation of the BPHS had started, an assessment in Nimba county showed that no facility provided all services included in the package, indicating a rather slow implementation process of the basic package [213]. The need for realistic priority setting within a reasonable time frame is an important lesson learned for the implementation of SRH services through a BPHS, requiring further attention.

Conversely, certain services that are not planned by the BPHS for lower levels were in fact available in some facilities, such as post exposure prophylaxis, voluntary counselling and testing and blood transfusion at health centre level and PMTCT at one clinic. While it could be seen as a positive sign that some additional services are being put in place, this might be happening at the expense of other services planned by the BPHS. This inconsistency in the provision of certain services may be partially explained by discrepancies between the BPHS and other national health policies, such as the National Sexual and Reproductive health policy, which does include post exposure prophylaxis and PMTCT even at clinic level [154].

Perception of quality of care

Quality of services was only discussed as a problem at policy making level. This indicates an important discrepancy between staff at facilities who believe that thanks to training and supervision they have the skills to provide quality SRH services and policy makers who believe they do not. The finding that health workers think that they provide good quality of care has two

implications. First, it indicates that they are not inclined to see the necessity to improve their work. Second it shows that feedback during supervision is not adequate, and the message that policy makers strongly feel that quality of care is low does not reach the facility. However, it may also indicate that policy makers do not have the full picture of what is happening at facility level. Policy makers mainly criticized the lack of counselling skills for contraceptives and the negative attitude of midwives towards women who came to deliver at the facility. The issue of negative attitudes among health staff seems to be relevant to facility based deliveries, with certified midwives at facilities perceived to be not as sympathetic and supportive as trained traditional midwives who are known and trusted by the women. This seems to be one important reason for the low numbers of deliveries at facilities. However, while policy makers listed negative staff attitude as a reason for low uptake for most services, this may in reality be limited to facility based deliveries. The certified midwives that I interviewed seemed to be motivated to provide counselling for family planning, including to adolescents and underlined that youth trusted them. My findings support results from a study on health seeking behaviour by USAID, which reported negative staff attitude and poor communications with patients as a barrier to uptake of health services such as deliveries [214]. But it is also in line with a quality assessment by USAID, which identified indicators related to health worker–patient interaction as the indicators with the highest scores, putting into question the negative staff attitude as a barrier to family planning uptake as was often suggested by policy makers [215]. Moreover, a study on adolescents' health in Liberia did not suggest that negative staff attitude prevents youth from seeking health services, or that lack of access was a reason for not taking contraceptives [216]. This observation raises two issues: First, policy makers may not have the right picture of service provision at facility level and the possible barriers to service uptake. This has important implications for policy making in terms of defining youth friendly services. Second, it raises the question why staff attitude is negative towards women who come for delivery but not towards patients who come for family planning. One possible explanation might be, as was mentioned during the interviews, that midwives do not feel comfortable providing delivery care in clinics that are not suitable, particularly as women often come outside opening hours and only

once there are complications. Negative staff attitude towards women who come for delivery care to the clinic has also been found to be the case in other countries [204, 214, 217, 218]. The poor attitude of health staff may be partly explained by the low staff motivation reported in this study. Improvements in staff motivation, training, supervision and also health facilities themselves may help to increase uptake of services. In Afghanistan, this was further improved through the provision of incentives to health workers [91].

The divergence of views may also be due to the different interpretations of quality, as service providers seem to focus more on technical skills rather than personal interaction with patients [215]. There exists a great body of literature about perceptions of quality of care, which goes beyond the focus of this study and will therefore not be discussed here.

Quality of care depends to a great extent on training and supervision, which may currently not be adequate in Liberia. In-service training takes up an important part of the implementation process of the BPHS. Yet, according to policy makers this does not follow a structured plan and is not taking place in an effective way. In-service training for EmOC and Basic Life Saving Skills for health staff began in 2004 [170]. However, the study findings suggest that this training may not be as effective as required. This may be linked to high staff turnover of health care workers, leading to loss of trained staff but also to the fact that training is not followed-up by adequate supervision, according to policy makers. Moreover, during the interviews some policy makers also criticized the checklist approach to supervision, with the Policy and Procedure Manual for county-level supervision containing 30 pages of checklists for supervisors, focusing a lot on the presence of staff, equipment and drugs instead of direct observation [219]. My findings support the results of the quality assessment by USAID mentioned above, which did not find any correlation between the number of supervision visits and the level of quality, or between training and quality [215]. Similarly, the challenges of supervision were also observed in other countries which have implemented the BPHS such as Afghanistan where supervisors often did not have sufficient training and skills in observing health worker performance as seems to be the case in Liberia as well [220].

Overall, the findings suggest that supervision activities need to be strengthened in Liberia by closer supervision after trainings, improved supervisory skills, and by relying on observation of service provision rather than asking theoretical questions, as this seems to provide a more realistic picture of the skills and practices of health workers [215]. The importance of supervision has been recognized in Liberia's National Health Policy to be implemented as of 2011 [170].

Perception of service uptake

Service uptake was raised as a major issue from the perspective of service providers and to a lesser extent at policy making level. There are clearly underlying socio-economic structural issues that prevent patients from accessing services which lie outside the BPHS and the health system but these lie beyond the scope of this study. Instead it focused on the BPHS and SRH services, showing a close linkage between quality of care and service uptake.

Health workers listed mainly cultural reasons for low service uptake and argued that it was mainly a matter of time that the communities would understand the benefits of SRH services provided at health facilities. This observation is in line with studies on health seeking behaviour and maternal health in Liberia which also indicate a distrust in the health facilities and some 'modern' medical methods such as the use of a delivery bed [214, 217].

Policy makers saw one barrier to uptake in the low skills of health workers. This may apply particularly to deliveries and EmOC services. This finding, that possibly low skills and therefore low quality of delivery care prevent women from service uptake, supports findings from other countries, which suggest that uptake increases once services are of acceptable quality, focusing on skills of service providers [221-224]. Similarly, the finding that the Mama & Baby Kit alone does not improve uptake in a sustainable way, implies that it does not address the actual underlying issue, as it is not a motivator for health workers to provide services in a more patient-friendly way. According to the interviews, women do not come back if the kit is no longer available – while according to other studies it seems that women would come back if they had a positive

experience with a provider [214]. This raises the question whether it is useful to focus on increasing access when services are not adequate; instead the starting point should be to improve EmOC services, which will also improve the perception of services among beneficiaries, and then promote uptake of maternal health. Community mobilization has been shown to be possible and effective, as long as existing community structures, particularly trained traditional midwives, are taken into account and close supervision of community volunteers is guaranteed [221, 222]. In Afghanistan this led to significant increases of institutional delivery [91].

One approach to addressing the low uptake of family planning is the use of community outreach through community health volunteers [153, 170]. However, this may face several challenges. According to this study, the preferred methods of adolescents are injectables which would require close supervision of community health volunteers. Considering that already close supervision and motivation of health staff at facilities are currently an important challenge, these aspects will have to be closely monitored in order to implement community outreach successfully. Community health volunteers in Liberia are also not supposed to get any incentives for their work. Moreover training at the level of community health volunteers as well as the supervisory skills of health workers are expected to be rather limited in Liberia [225]. This reservation based on my findings is supported by experience from other countries. Community-based provision of injectable contraceptives has been shown to be possible in Madagascar, though here extensive training and close supervision were put in place, and community health workers were able to keep a small percentage of each injectable that they sold [226]. Family planning uptake through community outreach and involvement of community leaders in Afghanistan also included close supervision of community health workers [94].

In terms of interventions to increase the demand of SRH services by adolescents the evidence base seems to be weak, as only few SRH programs measure their impact on service use by adolescents [227]. The approach of youth centres, as praised by several respondents does not seem to be cost effective [227].

7.2 Perceptions on political commitment

The second objective of my study was to explore health service providers' and policy makers' perception on how the implementation of the basic package has influenced the provision of sexual and reproductive health services using a health systems framework. The following sections will discuss the perceptions of actors regarding the different health system components which came out as most relevant during the interviews.

SRH services are high on the political agenda and well represented in the BPHS, taking up more than half of the package [11]. During the interviews at policy making level, the BPHS was praised as a useful standard setting tool and a good policy; though it was also noted that its implementation was lagging behind. While the implementation of the BPHS started in 2007, the national SRH policy was not developed until 2010. Similarly, other supportive policies and plans, such as the National Family Planning Policy and the Human Resource Policy only became available towards the end of the initial implementation of the BPHS [153, 154, 191] . Yet, effective implementation of a BPHS requires a corresponding support system to be in place [12, 30].

Results of this study suggest that there is strong national leadership in terms of developing the BPHS and supporting policies. This is an important aspect as first, adequate ownership by local governments and the Ministry of Health is an important requisite for implementation, and second, particularly in recovery situations, the development of a basic package is often rather donor driven [12, 16, 19]. However, the findings suggest that commitment to implementation seems to be limited in Liberia. This finding supports the indications of an informal survey by USAID of participants of the National Review Conference which showed that out of 42 participants only six had read the policy documents [228]. This may be partly due to the high turnover of actors, making many of them being unaware of the existing policies [229]. However, it may also reflect a lack of commitment to implementation as effective implementation would require actors to know the details and activities of each policy.

Respondents in my study criticized the lack of a dedicated unit for family planning within the Family Health Department at the MOHSW. Furthermore, political commitment should extend to district and community levels [230, 231] [231], yet NGOs reported difficulties to work with county health teams and the MOHSW was criticized for not being active at facility level. International partners felt a lack of commitment from the county health teams. This seemed to be further undermined by the county health teams' limited ability of financial and other management due to the centralized financial, procurement and infrastructure processes [232]. Finally, the staff's perception of not being valued by the MOHSW is an important indicator that political commitment does not reach the implementation level.

7.3 Perceptions on governance: Policy direction and strategies

Based on the issues discussed in this study, governance was interpreted as the overall policy directions around the BPHS and the understanding of the policy at all levels. Performance-based financing is the strategy used to implement the BPHS.

One underlying reason for the inadequate implementation of some SRH services may be related to inconsistent policy direction as well as discrepancies between the policy making and the implementation level in terms of policy understanding. This section will discuss examples of unclear guidance for the implementation of the BPHS and of divergences between the policy making and the implementation level as seen in the understanding of the BPHS itself and the performance-based financing approach, as well as in the different perceptions regarding priorities, challenges and the need to expand services.

At the policy making level the BPHS is considered helpful as it guides partners to work in line with each other and the MOHSW. It further establishes a minimum set of services to be in place. Standard setting through the BPHS was seen as a facilitator to steer all partners in the rehabilitation of the health system. It guided implementing partners and the MOHSW particularly regarding staff development, such as training and supply of equipment and

drugs. In this way, the BPHS in Liberia helped to organize and streamline health care in this post-conflict setting. This is an important finding as these settings are often characterized by the absence of a policy framework within which a large number of NGOs operate in an uncoordinated way with diverging priorities and agendas making coordination and consensus finding difficult [212, 233-235]. Studies from other post-conflict countries such as Mozambique and Kosovo highlight the substantial value of a clear health policy guiding the recovery process and defining long-term priorities and the BPHS provides a mechanism by which to do this in Liberia [7].

However, the perception of the BPHS as a standard setting tool did not appear to be shared at implementation level. The majority of health workers did either not know what the BPHS was, misunderstood it, or focused on only one specific aspect of it. It could be argued that a full understanding of the BPHS is not necessary for the provision of SRH services, as long as the health staff fulfil their required work. However, the lack of understanding of the BPHS among health workers can have implications for its implementation. As discussed above, political commitment to policy implementation is needed at all levels of the implementation process. Implementers both at county level and health facility level influence how policies are experienced and therefore what impact they have [236]. Policy implementation comes down to the people who implement it: the 'street-level bureaucrats', as outlined in the conceptual framework. They tend to shape the policy in response to their understanding of it but also in terms of their working routines, values and interests. This way they directly affect policy implementation and outcomes [180, 237, 238]. The successful implementation of a policy therefore requires understanding of the policy by those who are involved in its implementation, that they have sufficient information not only technically, but about the entire program, its monitoring process as well as common goals of all actors [238]. This means that actors at the implementation level need to see the underlying problem and how the policy addresses this problem and to feel that they have the capacity to contribute [238].

The findings from this study suggest that health workers were not sure what the BPHS actually meant, but associated it with cuts in incentives and human

resources and therefore increased workload. This in turn negatively affected their motivation and their performance. A study on the perception of nurses in South Africa regarding the removal of user fees revealed similar findings, as the policy contributed to a decline in health workers' morale and attitudes towards patients [178]. Communication and consultation around the implementation of the BPHS may be important drivers in increasing their motivation to provide the services included in the BPHS given the critical role of policy implementers in influencing how policies are experienced and impacts achieved [236].

It needs to be noted that not all respondents at policy making level seemed to be aware of this lack of understanding and the negative perception of the BPHS at health facility level. Most of the policy respondents stated that they thought that it was necessary that staff had a basic understanding of the BPHS, and most felt that this was in fact the case. This further highlights the disconnection between the policy making level and implementation level at the health facilities.

The BPHS is not entirely clear on whether deliveries should take place at clinics. While the BPHS states that midwives in rural clinics should focus on supervision of trained traditional midwives, my findings showed that they seem to believe they have to conduct deliveries, and measures are in fact taken to increase facility based deliveries – while they have inadequate infrastructure and feel uncomfortable conducting deliveries, particularly at night. This observation has been raised in other documents as well [11, 203]. It highlights the need for specification of how to implement services that are part of such a package [34].

There is also an inconsistent approach with regards to obstetric care. There are plans in Liberia to provide CEmOC at certain health centres while BEmOC was not even fully implemented at this level. Based on this study, BEmOC has so far been neglected, whereas measures have already been taken to build CEmOC centres at certain health centres. This does not correspond with the UN guidelines for emergency obstetric care but more importantly may be unrealistic, considering the lack of medical doctors in rural areas [85]. This

finding supports other findings in the literature, which showed that often there are more CEmOC services put in place than recommended while the number of BEmOC services does not meet the requirements, resulting in a particular lack of such services in remote areas [86]. This risks being the case also in Liberia with the risk of overstretching health services and increasing inefficiency and inequity as access will be reduced in rural and remote areas [170, 239].

Another example of lack of detail on how to implement services is adolescent SRH. The national SRH policy merely states that SRH services targeting adolescents need to be scaled-up, without specifying how. Similarly, the quality assessment of 2010 assesses whether the health workers ensure that services are 'adolescent friendly', without specifying what this means [215]. My study findings suggest that health workers at facilities feel that the services that they provide are adolescent friendly, whereas policy makers highlighted the lack of youth friendly services as one important limitation of service provision. This finding shows that there is a need for a clear definition of youth friendly services which has to be communicated to all levels.

The strategy to implement the BPHS through performance-based financing does not seem to be understood at facility level either. The purpose of performance-based financing is to motivate agencies implementing the BPHS (including their service providers) to be more efficient and more effective [240, 241]. Its advantages are seen in the clear set of objectives and indicators. However, my study suggests that health workers were not aware of performance indicators and did therefore not seem to be motivated towards specific goals. Based on the interviews, often changing indicators due to changing donor priorities seemed to confuse health workers and the advantage of clear objectives and indicators did not seem to reach the facility level.

Performance-based financing may also have a negative effect in terms of health system strengthening, as it forced partner NGOs to improve their performance through methods which did not necessarily have a long-term effect. According to my findings NGOs bypassed county health teams to

achieve results, while county health teams saw the performance-based financing approach as an approach which had nothing to do with them. This is an important finding for two reasons: first, national and sub-national ownership of this approach was highlighted as an important prerequisite; and secondly, capacity building at county level is one of the objectives of performance-based financing [148, 242]. Moreover, strengthening health system performance is a key objective of contracting-out health services through a BPHS [44]. Yet, my study suggests that the need for short-term results in Liberia may be impacting upon the longer-term sustainability of the health system. Strategies that were put in place to improve SRH performance indicators do not appear sustainable, such as the Mama & Baby kit which may temporarily increase the number of facility based deliveries but does not address the underlying challenges. This issue requires further attention in future research.

Discrepancies between policy making and implementation level exist not only in terms of the understanding of the BPHS but also in terms of other aspects of service implementation. For example, during the interviews most health staff highlighted family planning as one of the main services that they provide, stressing their skills to counsel on informed choice. Respondents at policy making level mentioned family planning as one of the services which was particularly weak, stressing the lack of skills of health workers. Health workers see the main barrier in the service uptake, whereas policy makers see the main barrier in the actual service provision at facility level. While both might be right, as low quality of services at facility level will have an impact on service uptake, the diverging perception regarding health service provision is an indicator for a disconnection between the policy making and the implementation level. As noted above, this was also reflected in the way that health staff were positive about the supervision and training they received and that they felt contributed to good quality of SRH service provision, while the policy makers were concerned about the ineffective supervision and training and quality of services.

The different perceptions of the barriers for service provision also influenced the views on the need to expand SRH services. While several respondents at policy making level saw a need to expand the BPHS in terms of SRH services,

most health staff already felt overwhelmed by the different SRH services which they were supposed to provide. At the policy level, some contradictions were apparent. There seemed to be consensus that services provided at facility level were of low quality due to low human capacity at facilities in terms of numbers and skills, affecting particularly crucial services such as BEmOC, post-abortion care, family planning with skilled counselling on informed choice, and management of SGBV. Yet, many respondents also focused on the fact that the first implementation phase of the BPHS was coming to an end and therefore the BPHS should be expanded. Some respondents referred to the high accreditation results as an indicator of the extent to which the BPHS was implemented while simultaneously listing SRH services they thought were inadequately provided. While according to the National Health Policy expansion was supposed to happen according to the improvements of the health system, and human resources as well as a reliable procurement system remain a challenge, many policy makers focused on the expansion of the package. The situational study of the BPHS from 2010 concluded that there was a need to consolidate the current levels of services, human resources and infrastructure before considering an expansion of the BPHS [225].

The discrepancy between policy making and implementation is particularly pertinent here given that the national health policy for the coming ten years includes an Essential Package of Health Services, which consists of the BPHS and a phased expansion to include other services such as treatment of non-communicable diseases, essential child nutrition and eye health [170]. Additional services in the area of SRH include reproductive cancer and treatment of obstetric fistula. There is a risk of burdening health workers with additional services, while these may not yet have the capacity to adequately provide current services. Furthermore, some strategies and plans supporting the implementation of the BPHS still need to be developed such as for delivery of emergency obstetric care [203]. The tension between the fact that not all SRH services are fully implemented and the need to provide even more services to the population raises again the question of a realistic time frame within which SRH services as part of a BPHS can be fully implemented. There

is no clear answer to this question, and further studies are needed to explore the appropriate phasing-in of additional services.

All these findings indicate the need for clear definitions of how to implement services included in the BPHS with effective communication between the different levels of implementation, a focus on only the services that are part of the package and a rigorous monitoring of the implementation. This last issue will be discussed further below.

7.4 Critical subsystems

Of the four WHO critical subsystems used in this study, workforce was highlighted the most by respondents. The analysis further showed that information is another issue requiring attention. These two issues will therefore be discussed in the following.

Workforce

Workforce, particularly certified midwives, seem to be one of the main bottlenecks for the provision of SRH services as part of the BPHS, not only in numbers, but in terms of skills and motivation. The limited number of certified midwives in Liberia, particularly in rural areas, challenges the adequate provision of SRH services. As discussed above, this has important implications for service delivery, quality of care and therefore service uptake [69, 243]. My study findings suggest that the changes that came along with the BPHS, particularly the decreased salary, translated into a feeling of lack of recognition among midwives and therefore decreased motivation, compared to the relief phase. While according to my interviews, most facilities used to have several midwives before the BPHS was introduced, now many facilities struggle to find and keep certified midwives. Many of them seem to leave the field entirely or try to find work as supervisors with NGOs. While the issue of human resources is recognized by the MOHSW these underlying issues may not be adequately addressed.

The MOHSW recognizes the role of certified midwives as the first line health providers for SRH and the need for a trained, educated and skilful workforce as the foundation in order to increase access to quality health services but

there is little detail how career paths for midwives can be made more attractive [157, 244]. In 2007 the MOHSW developed an emergency human resource plan in order to increase and distribute health workers in a coordinated manner, identifying the numbers by which to increase each health cadre until 2011 [200]. In 2010 another National Policy on Human Resources for Health was developed [191]. In addition, in 2010 a Workforce Optimization Model was developed to calculate the workforce needed to provide the BPHS [245]. These documents indicate that the importance of human resources is fully recognised by the MOHSW. However, the documents remain rather general and provide little detail on how to provide sufficient quantity and quality of health care staff. Moreover there seems to be a major focus on numbers and redistribution of health workers, taking underlying reasons for turnover or shortage such as motivation and lack of recognition less into account. The Workforce Optimization Model proposes cost-savings through reallocation plans for midwives [245]. However, high staff turnover of certified midwives with many midwives leaving the field or going back to school to become nurses due to the lack of a career path and the comparatively lower salary, are likely to undermine this plan. The model does not provide details on how the reallocation should be done and how careers for certified midwives can be made more attractive. This lack of specificity appears to be a common problem in human resources policy development in post-conflict recovery–reflecting the complex post-conflict contexts and limited time-periods available to develop health policies [246].

The implementation of the BPHS started in 2007, whereas most supportive policies regarding human resources were not published until 2009 and 2010. Studies from other post-conflict countries have shown how the successful implementation of health policies is undermined by the absence of appropriate human resources and human resource policies [246].

My findings support the evidence that health service quality and efficiency can also be linked directly to health workers' motivation [247, 248]. In turn, the most important factor for utilization of services, is the constant presence of dedicated staff [223]. According to Lipsky, street-level bureaucrats, in this case health workers, work in non-conducive conditions under high demands, while

not having all the resources to do their job well. Their concern is to control their stress and the complexity of their every day work [180]. This requires a combination of financial incentives but also recognition of their work, decent working conditions, clear and supportive guidance and objectives, training, and supervision from higher-levels within the health sector – particularly the MOHSW which is currently perceived by some health workers as not to care about them [249].

Communication is also key, such as clearly explaining objectives and rationales of certain policy changes, as health workers may feel threatened by certain changes – as seen in the limited understanding and rather negative perception of the BPHS as well as in the diverging perceptions of service implementation between the policy making and the implementation level [178, 247, 249, 250]. This may be particularly important during the post-conflict recovery, which brings a number of changes for health workers compared to the relief phase, such as different roles of trained traditional midwives, the level of the incentive and the number of staff per facility, as seen in the interviews. Both the content of policies and how they are communicated will determine workers' perceptions of how these changes might affect them [247].

The suggestions that the certified midwives have a negative attitude towards pregnant women who come to the clinic to deliver, but are much nicer when pregnant women come to their private delivery home where they earn extra money, raises the question who should get motivated in order to increase facility based deliveries: the pregnant women through the Mama & Baby Kit or the certified midwives? The Mama & Baby Kit may not address the actual underlying problem regarding facility based deliveries.

The issue of motivation extends to community health volunteers and trained traditional midwives. There are no plans to provide incentives to these cadres. However, this study found that trained traditional midwives play a crucial role in the uptake of facility based deliveries, as they are the link between the community and the facility. The national health policy plans to implement a number of community-level SRH services such as education and the distribution of family planning commodities through community health

volunteers and trained traditional midwives, but states that no incentives are planned for them and incentives need to be decided locally [170]. This may have to be reassessed, as the actual integration of trained traditional midwives can play a vital role to improve outcomes of maternal health [251]. Without any incentive, their motivation may be seriously undermined.

Information

The main monitoring mechanism of the BPHS is the accreditation, which will therefore be the focus of this section. The Liberian accreditation system aims at determining to which extent health facilities meet the standards set by the BPHS [166]. It assesses the prerequisites for the implementation of the BPHS, such as equipment and drugs, human resources and knowledge of staff regarding certain services.

While the accreditation process seems to be a useful monitoring and guiding instrument for all actors, there are a number of limitations which seem to have implications for SRH services. First, the accreditation report provides the picture of a well-prepared facility once a year which based on the interviews does not reflect the reality. It does not give insight into daily challenges, such as intermittent supply, which has major implications for provision of family planning, BEmOC and treatment of STIs and therefore for service uptake. An ongoing process throughout the year might provide a more realistic picture.

Secondly, the accreditation records theoretical availability of services rather than actual provision and utilisation. For example, clinics are recorded highly for providing SGBV services even if they have never actually seen a patient. It focuses on equipment, without assessing whether and how well the equipment is used. This leads to overestimation of services in place, ignoring the lack of specific components. For these reasons accreditation results need to be interpreted with caution.

According to the National Health Policy 2011 currently there are no reliable data on health personnel, infrastructures, and equipment, indicating that a health facility census will need to be conducted to establish baseline information [170]. In addition, a detailed assessment of EmOC was in

preparation after my field work [225]. This confirms that insufficient information is provided by the accreditation process.

My finding, that the accreditation provides a more positive picture of the implementation of SRH services through the BPHS suggests the need for more rigorous monitoring. The need for meaningful evaluation of basic health packages in post-conflict settings is well recognised [16, 17, 19, 252]. One example of monitoring the implementation of a basic health package is the balanced scorecard used in Afghanistan. Even though this method also presents with limitations, it goes beyond the accreditation process used in Liberia, taking into account patient and staff perspectives and technical quality of service provision and provider-patient interaction [36].

It needs to be noted that the performance-based indicators go beyond the accreditation, with a current shift from quantity to quality. Indicators related to SRH include skills, such as staff competency for family planning counselling and uptake, such as couple years contraceptive protection provided and facility based deliveries [253]. However, this is only an emerging monitoring system with quarterly meetings of NGOs, which was not fully in place during my data collection. For this reason, I have not been exposed to it and have to focus on the accreditation process. Moreover, it seems that this system is mainly focused on NGOs and does not involve county health teams, and is not part of the national health information system. There also seem to be discrepancies between the performance-based indicators and the ledgers at the facilities [254].

7.5 Application of findings to the Conceptual Framework

The conceptual framework of this study acknowledges the need of taking a bottom-up perspective to analyse policy implementation in order to understand underlying processes of the actual execution of a policy. The health system framework helped breakdown Lipsky's bottom-up theory on policy implementation by applying it to specific elements of the health system.

The conceptual framework highlights the important role of health service providers as active participants having an influence on how a policy is being

carried out. One important factor in Liberia is the limited availability of health workers and the high staff turn-over. Street-level bureaucrats rather leave the field, which undermines full policy implementation. Other findings of this study confirm Lipsky's theoretical framework as well:

According to Lipsky, street-level bureaucrats change policies based on their working conditions, aiming at minimizing discomfort and trying to fulfil the job under non-conducive conditions. This seems to apply to midwives in Liberia in several aspects: Through their attitude midwives seem to prevent women from coming to the facility for deliveries. A possible explanation for this may be the fact that they feel uncomfortable providing delivery care in non-conducive conditions, particularly outside of opening hours. Similarly, while they are supposed to do outreach services and provide supervision to trained traditional midwives, they do not do this, due to lack of means of transportation, lack of training to hold community meetings and lack of incentive.

The interview findings suggest that health workers might be willing to provide better care if they felt more motivated and recognized. In this way they choose to implement the policy not fully in the way intended by policy makers. This is in line with Lipsky's theory, who argues that street-level bureaucrats have little incentive to perform and usually have nothing to lose if they do not perform according to the policy direction.

Lipsky's theory notes how street-level bureaucrats may not share the objectives of their supervisors or policy makers. This is reflected in the finding that health workers seem to have a different definition of quality of services than policy makers, indicating that they implement SRH services according to what they feel appropriate under their working conditions, which does not necessarily correspond to the intention of policy makers.

The study further draws attention to the importance of the relationship between central, regional and local actors, such as the need of health workers to feel recognized by the MOHSW, as this further influences the implementation of a policy [178]. By putting health workers in the centre of health policy analysis, this study acknowledges their critical position as they deliver policies, in this case SRH services to beneficiaries and stand in direct contact with them [180].

It also helped highlight how health workers clearly have an influence on how the policy gets delivered on the ground. However, it seems that this change to the policy is not happening actively, but rather passively as a response to the working conditions. Moreover, external factors impacting the work of health workers play as an important role. It seems that the BPHS is also not fully implemented due to limitations imposed upon street-level bureaucrats, such as the inconsistent and therefore inadequate provision of drugs.

The analysis of this study took the entire health system into consideration, focusing on those components that were highlighted by actors. This helped to extend understanding beyond the monitoring and evaluation of just the BPHS itself and beyond the focus of service delivery [173, 174, 181]. The health system perspective allowed identifying interrelations between health system components, as for example the importance of the pharmaceutical supply system for the uptake of family planning services or the role of the workforce and their motivation for the quality of services.

7.6 Reflections on the field work

One important factor to be taken into consideration was my role as the principal investigator and my affiliation with WHO. Respondents may have possibly provided the answers that they thought I wanted to hear. While it is difficult to assess the extent to which this was actually the case, it needs to be highlighted that most respondents did not shy away from being rather critical of key authorities, for example the MOHSW. Moreover, I tried to overcome potential barriers by introducing myself as an independent researcher and by stressing on several occasions that I was interested in learning from the service providers, rather than conducting an evaluation. I was also accompanied by a Liberian research assistant who translated as necessary and conducted some of the interviews. At the policy level, my link with WHO seemed to be rather an advantage as several respondents became more open when they learned that I was affiliated with WHO. However, they may also have responded in a way to please WHO.

While data collection in Grand Cape Mount went rather smoothly, with all preselected facilities being accessible, data collection in Nimba County was

much more challenging. I was initially informed by the county health team that the selected facilities were accessible. However, this turned out not to be the case for all of them. The selection had to be readjusted several times due to clinics being closed, road closures, and the car breaking through a bridge which prevented further travel to one of the clinics (Duayee clinic).

Overall, the data collection process was an important learning experience. If I had the opportunity to go back to conduct a similar research, I would make sure to spend more time in the country before starting the actual data collection, as I felt that I could have benefitted from getting to know better the people, the language and the country with its history prior to conducting interviews.

While recording during the interviews was crucial for my data analysis, it clearly put many respondents at unease. Possibly, this was even enforced by the fact that I asked respondents to sign a consent form. It may have been more appropriate to gather oral consent from respondents, as this would not oblige them to write down their names before being interviewed.

7.7 Study Limitations

The study had a number of methodological limitations. First, the research at health facilities was conducted in two counties and so the findings cannot be generalised across Liberia. The study also excluded hard-to-reach counties and hard-to-reach facilities within Grand Cape Mount and Nimba due to logistical reasons. As a result, findings may be more positive in the selected countries and health facilities than those that were excluded. However, this is difficult to verify and accreditation results do not show significant differences between the visited facilities and the rest of the counties [168, 255]. Second, the study did not include the perspective of SRH care users or community members and so cannot benefit from their insights and experiences on SRH service provision. It also did not obtain the perspectives of trained traditional midwives who play an important role in the provision and uptake of SRH services. While the importance of these perspectives is fully recognized, their

inclusion was not possible given the scope and focus of this study. Third, it has been argued that at least two people should analyse the data in order to improve consistency and reliability [194]. However, for issues of feasibility and originality, only I analysed the data. The study also did not include a systematic review but this was due to the fact that sufficient literature does not exist on this particular subject to support a systematic review. Fourth, most respondents at the policy making level only arrived in Liberia at the time of the implementation of the BPHS and were only able to offer little information about the historical development of the BPHS and changes it had brought about in terms of SRH services provision. Certain potentially key informants were not interviewed such as representatives from USAID who played important roles at the development of the BPHS but were no longer in the country. However, the information obtained during each interview indicated that saturation was reached as no new themes were emerging from the data collected.

The study also excluded a number of issues. First, the study did not assess the implications of performance-based contracting for the implementation of SRH services. This is an important aspect as it is the implementation mechanism chosen for the BPHS in Liberia. However, to meaningfully evaluate this mechanism would have involved obtaining data on financial inputs and process outcomes which was considered beyond the scope and focus of the study. Second, policy implementation can also be studied from the perspective of budgetary processes, budget allocation and budget implementation. This may have provided additional information on the implementation of the BPHS. However, this was again considered beyond the scope of this study. Third, the implication of vertical programmes for the implementation of the BPHS, most specifically the national HIV/AIDS Programme, might need further attention. For example, some respondents explicitly did not talk about HIV/AIDS, as this was part of the national programme outside of the BPHS. Further research could shed light on the possible consequences for these services.

7.8 Study strengths

This study addresses the knowledge gap regarding the implications of a BPHS for the delivery of SRH during post-conflict recovery. This is an important contribution as only a few studies address the issue of policy implementation of a BPHS globally and there is very little evidence for its implications for SRH services. It also contributes to the limited literature of SRH services in conflict affected countries. While the findings from this study apply only to Liberia, they may nevertheless be insightful for other post-conflict settings. The study has also identified issues for further research (summarised in the recommendations section below).

The conceptual framework helped to analyse the situation by incorporating broader elements such as health systems components and also implementation processes. It also sought to add clarity to the multiplicity of factors influencing SRH services in post-conflict situations.

The use of qualitative research methods provided new and more in-depth insight into the implementation process, going beyond quantitative data such as the accreditation process used in Liberia.

Overall, the study addresses a policy issue of importance within the area of health recovery in post-conflict settings. The support provided by WHO and RAISE to conduct this study indicates the interest of policy makers in the findings, which have been shared with the MOHSW and the WHO country office in Monrovia, as well as the regional office and the headquarter of WHO.

7.9 Recommendations

The third objective of this study was to develop recommendations for policy making regarding SRH and BPHS in post-conflict recovery. The following recommendations are for both policy making and further research.

Policy making

1. The BPHS serves as a standard setting tool and guidance for all actors. In order to take full advantage of this, it should be used more rigorously to coordinate training and supervision for example by developing a systematic training plan followed by all actors.
2. Actors should focus on key services included in the BPHS, rather than going beyond the BPHS at the cost of services that are part of the BPHS.
3. The implementation of community outreach services needs to be adequately supported to increase service uptake; however a first step should be to ensure consistent provision of services.
4. Effective policy implementation will require improved communication between the different levels to overcome discrepancies between the policy making and the implementation level, including ideas from health workers on how to improve SRH service uptake.
5. Workforce is the key to successful service implementation. A more participatory approach might give health workers a better understanding of expectations, ownership of their work, better recognition by the MOHSW and therefore higher motivation for service provision.
6. Rigorous monitoring beyond the accreditation as well as supervision of actual provision of services are required to have a better understanding of potential underlying factors of maternal mortality.

Further research

1. Community outreach has been highlighted as an important factor for services uptake. Further research is required on the perspectives of trained traditional midwives to understand their motivations in order to improve community outreach.
2. This study focused on the perceptions of policy makers and implementers, but not of beneficiaries. Further research on patients' perceptions should help improve service uptake.
3. Human resources with low motivation and high staff turnover have been identified as one important bottle neck to SRH services provision. Further research should shed light on the question why some health workers stay at a rural facility for a long time, while high staff turnover undermines service provision at other facilities.
4. Vertical programmes continue to be implemented in parallel to the BPHS in Liberia. It would be valuable to further analyse the implications of these vertical programmes, such as the national HIV/AIDS programme for the BPHS and for SRH services more specifically.
5. Performance-based contracting was chosen as the implementation mechanism for the BPHS. Further research could identify its implications for the BPHS and SRH service provision, with a perspective of its contribution to health system strengthening.
6. The approach to explore the health policy implementation process in Liberia may be replicated in other post-conflict settings, as the application of a health system framework to Lipsky's street-level bureaucrat theory helps to add clarity on the implementation process.

7.10 Conclusion

The aim of this study was to explore the implementation of a BPHS and its influence on the provision of SRH services in post-conflict recovery in Liberia. It did so by assessing the availability of sexual and reproductive health services at facility level and by exploring health service providers' and policy makers' perception on how the implementation of the basic package has influenced the provision of sexual and reproductive health services, using a health system framework.

The study identified six key findings: SRH is high on the political agenda, as seen in the number of SRH services within the BPHS. However, being included in the BPHS clearly does not mean that all services get implemented. This might be undermined by too many competing priorities to be implemented in too short a time frame. Furthermore, the study identified discrepancies between the policy making and implementation level. Addressing these might contribute to more effective service delivery by increasing quality and uptake of services. Finally, the lack of certain services is not clearly reflected in the accreditation reports. For this reason there is a risk to overestimate the provision of crucial services such as BEmOC and management of SGBV.

The study highlighted the importance of taking a health system perspective, identifying human resources as the key component, and linking it to other aspects such as quality of care. Overall, the BPHS seems to be a valuable approach for post-conflict recovery, aligning all partners in the same direction. SRH services are reasonably well taken into account within the package, though effective service provision requires a realistic time frame and rigorous monitoring of the implementation process.

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Annexes

Annex 1 Interview guide: facility level

Before we start, I would like to make sure that you know that this is not at all an evaluation. I am rather interested in understanding under which conditions you are working, what is helping you and what might make it difficult. So I would really like to learn from you about your experiences in providing health services.

1. As a start, can you describe to me what a typical working day looks like for you?

   How long have you been working here?

2. Are you aware of the BPHS? Can you tell me about it?

   Probe: What is it about? Content?

   Are you aware of any priority areas within the BPHS/ health services at the facility?

3. How was the BPHS introduced to your facility?

   Probe: Was it explained to you? By whom? Did you receive a document that describes the Basic Package?

   What kind of training or information about the BPHS did you receive? Tell me about it.

   What did you learn during this training? Did this training help you provide health services?

4. Tell me about your experience *with the BPHS* regarding the provision of SRH services.

   Probe: Has the BPHS had an effect on your every day work in providing SRH services?

   Has the BPHS influenced the availability of SRH services in this facility? Which ones?

   Are there more SRH services available now than before? Which SRH services are you providing? Can you talk about it a bit?

5. In your opinion, what are the main challenges for SRH service provision?
6. Do you feel that these challenges are being addressed adequately at this facility *(through the BPHS)*?
7. In your own experience, what helps you in providing SRH services at this facility? Which services?
8. What are the main challenges for SRH in this community?
9. Do you feel that the SRH services that are provided at the facility match the needs of the community?

Are there SRH services missing in the BPHS that you think should be included?

SGBV: PEP, EC; HIV testing;

Probe: What are possible barriers to the availability of some services? Which ones?

How do you think these barriers can be overcome?

10. In your opinion, how do you address the SRH needs of adolescents?

Probe: In your opinion, what are the main issues for adolescents that need to be addressed? How do you address these issues?

11. Explain to me how you work with the community to provide services and raise awareness for SRH services.

Probe: Which activities for SRH services take place within the community? Are there any difficulties? If yes, which ones?

Describe to me the role of the TBAs/TTMs. How do you work with them?

12. Do you feel that you have appropriate infrastructure to provide SRH services of the BPHS?

Probe: space, electricity, water supply; waste management; specific equipment for services

13. Do you feel that you have appropriate supply/ equipment to provide SRH services of the BPHS?

Who supplies them? If not: what is missing? What do you do if you run out of supplies?

How does the supply system work? (where do you place your order?) (different suppliers for different drugs?) Have you experienced any drug stock out during the past months? Which drugs?

14. How does the referral work (to this facility, from this facility)? What are the difficulties, if any? How do you resolve them?

Probe: How far is the next higher level facility? How do you communicate? How long does it take to get an ambulance? Is the ambulance always available?

15. Tell me about the support that you receive to provide SRH services

Probe: by the Ministry of health, CHT, NGOs or other agencies? How? What is missing?

16. Do you feel that the BPHS helps you provide good quality of SRH services?

17. Do/did you receive in-service training for SRH services? Which one?

Tell me how you perceive the training. (impact on your work)

Do you feel that the training is necessary/appropriate for you?

18. Tell me how you are being supervised in your work.

Probe: How does the supervision take place? Is it supportive?

19. In terms of quality of services, do you know what your supervisors look for? Does the supervision help you improve the quality of care?

20. How do you perceive the accreditation process for the BPHS? How does it help you improve your provision of SRH services?

21. Tell me about what motivates you to provide SRH services in this facility.

22. How do you experience the collaboration with the CHT? With the NGO?

Probe: What is working well?

What are the difficulties, if any? How does it help you?

23. What challenges do you see in the provision of SRH services?

24. Is there anything you would like to add about any of the things we have discussed today on what are the key things influencing SRH services at this facility?

Annex 2 Interview guide county level

Before we start, I would like to make sure that you know that this is not at all an evaluation. I am rather interested in understanding under which conditions you are working, what is helping you and what might make it difficult. So I would really like to learn from you about your experiences in providing health services.

1. As a start, can you describe to me the role of the CHT?

How long have you been working with the CHT?

2. Can you please describe to me how the BPHS was introduced to your county?

Probe: Was it explained to you? By whom? Did you receive a document that describes the Basic Package?

3. Explain to me how you introduced the BPHS to the facilities.

4. Please tell me about your experience with the BPHS for the provision of SRH services in your county.

Probe: In your opinion, has the BPHS had an effect on the provision of SRH services in your county?

Probe: Do you see a difference in the availability of SRH services since last year and before? Which ones? How?

5. In your opinion, what are the main challenges for SRH service provision?

6. Do you feel that these challenges are being addressed adequately through the BPHS?

7. In your own experience, what helps you in providing SRH services at facilities?

8. What makes provision of SRH services difficult? Which services?

Probe: Do you feel that the facilities are able to provide all SRH services that are included in the BPHS? Basic EmOC, SGBV, SRH services for adolescents

9. What are the main challenges for SRH in this county?

10. Do you feel that the SRH services that are provided at the facility match the needs of the community?

    Probe: What are possible barriers to the availability of some services? Which ones?

11. How do you think these barriers can be overcome?

12. In your opinion, how are the SRH needs of adolescents addressed?

    Probe: In your opinion, what are the main issues for adolescents that need to be addressed? How do you address these issues?

13. Explain to me how you work with the community to provide SRH services and to raise awareness for SRH services.

    Probe: Which activities for SRH services take place within the community? Are there any difficulties? If yes, which ones?

14. Do you feel that the facilities have the appropriate infrastructure to provide SRH services of the BPHS? *Probe: space, electricity, water supply; waste management; specific equipment for services*

15. Do you feel that the facilities have appropriate supply/ equipment to provide SRH services of the BPHS?

    Please explain to me how the supply system works.

16. How does the referral work in this county? What are the difficulties, if any? How do you resolve them?

    Probe: What are the distances? How do you communicate? How long does it take to get an ambulance? Is the ambulance always available?

17. Tell me about the support that you, as the County Health Team receive (from the MoH, from NGOs, other)?

18. What kind of support to you provide to the facilities to provide SRH services?

19. Do you feel that the BPHS helps providing good quality of SRH services?

20. How is the CHT involved in in-service training for SRH services?

21. Tell me how you provide supervision for SRH services to the facilities.

    What do you look for to assure or improve the quality of SRH services?

22. How do you perceive the accreditation process for the BPHS? How does it help you improve the provision of SRH services?

23. Tell me about what motivates staff at the facilities to provide SRH services.

24. How do you experience the collaboration with Equip/IRC (NGO)?

    What are the difficulties in working with the NGO if any? How does it help you?

25. How do you perceive the reporting system for the BPHS?

Probe: Is there more work in addition to the monthly reports for the health information system? What do you know about performance-based contracting?

26. What challenges do you see in the provision of SRH services?

27. Is there anything you would like to add about any of the things we have discussed today on what are the key things influencing SRH services in this county?

Annex 3 Interview guide NGOs

Before we start, I would like to make sure that you know that this is not at all an evaluation. I am rather interested in understanding under which conditions you are working, what is helping you and what might make it difficult. So I would really like to learn from you about your experiences in providing health services.

1. As a start, can you describe to me what a typical working day looks like for you?

How long have you been working here?

2. Can you please describe to me how the BPHS was introduced to your county?

Probe: Was it explained to you? By whom? Did you receive a document that describes the Basic Package?

3. Explain to me how you introduced the BPHS to the facilities.

4. Please tell me about your experience with the BPHS for the provision of SRH services in your county.

Probe: In your opinion, has the BPHS had an effect on the provision of SRH services in your county?

5. Has the BPHS influenced the availability of SRH services in this county? Which ones? How?

Probe: Do you see a difference in the availability of SRH services since last year and before? Which ones? How?

6. In your opinion, what are the main challenges for SRH?

7. Do you feel that these challenges are being addressed adequately through the BPHS?

8. In your own experience, what helps you in providing SRH services at this facility? Which services?

9. What makes provision of SRH services difficult? Which services?

Probe: Do you feel that the facilities are able to provide all SRH services that are included in the BPHS? Basic EmOC, SGBV, SRH services for adolescents

10. Are there SRH services missing in the BPHS that you think should be included?

Probe: SGBV: PEP, EC; HIV testing;

11. In your opinion, are services provided in an integrated manner?

Probe: who is offered HIV testing? (only pregnant women?)

Who provides FP, HIV counselling etc.? (same person?)

12. Do you feel that the SRH services that are provided at the facility match the needs of the community?

Probe: What are possible barriers to the availability of some services? Which ones?

13. How do you think these barriers can be overcome?

14. Do facilities provide SRH services that are not included in the BPHS? If yes, which ones? Are there other programmes addressing SRH services that are not included in the BPHS (management of sexual violence, youth friendly services)

15. In your opinion, how do you address the SRH needs of adolescents?

Probe: In your opinion, what are the main issues for adolescents that need to be addressed? How do you address these issues?

16. Explain to me how you work with the community to provide SRH services and raise awareness for SRH services.

Probe: Which activities for SRH services take place within the community? Are there any difficulties? If yes, which ones?

19. Do you feel that the facilities have the appropriate infrastructure to provide SRH services of the BPHS? *Probe: space, electricity, water supply; waste management; specific equipment for services*

20. Do you feel that the facilities have appropriate supply/ equipment to provide SRH services of the BPHS?

Please explain to me how the supply system works.

21. How does the referral work in this county? What are the difficulties, if any? How do you resolve them?

Probe: What are the distances? How do you communicate? How long does it take to get an ambulance? Is the ambulance always available?

22. Do you feel that as the County Health Team you are sufficiently supported by the Ministry of Health to provide SRH services in your county?

23. What kind of support to you provide to the facilities to provide SRH services?

24. Do you feel that the BPHS helps you provide good quality of SRH services?

25. How is the CHT involved in in-service training for SRH services?

26. Tell me how you provide supervision for SRH services to the facilities.

27. What do you look for to assure or improve the quality of SRH services?

28. How do you perceive the accreditation process for the BPHS? How does it help you improve the provision of SRH services?

29. Tell me about what motivates staff at the facilities to provide SRH services.

Probe: Do you receive any kind of incentives for your work, in addition to your salary?
Do you feel that the incentives are adequate?
Is there a lot of staff turn over in this facility? If yes, why?
30. How do you experience the collaboration with the CHT?
What are the difficulties in working with the DHT/CHT, if any? How does it help you?
31. How do you perceive the reporting system for the BPHS?
Probe: Is there more work in addition to the monthly reports for the health information system?
Is there separate reporting for performance-based contracting?
32. Are there any costs such as for material, drugs that need to be covered by the patients?
33. In your opinion, is the budget for the BPHS sufficient to provide all services? (SRH services?)
34. What challenges do you see in the provision of SRH services?
35. Is there anything you would like to add about any of the things we have discussed today on what are the key things influencing SRH services in this county?

Annex 4 Interview guide policy level

1. Can you describe to me your experience how the BPHS was developed/designed, particularly the components related to sexual and reproductive health?
   Who was involved /in which way/ to what extent?
   Focus on your experience, SRH advocates, MoH attitudes

   What were the criteria for the services included in the BPHS, particularly SRH?
   Did the MISP play a role as a guiding instrument? (Do you think it should have played a role?)

   How was the number of staff (CM) defined for each facility? What do you think about the current staffing standards?

   How was the incentive structure defined? What do you think about it?

2. In your opinion, what are the main challenges for SRH in Liberia in terms of needs by the population?

3. What are the main challenges in terms of SRH service provision in Liberia?

4. To what extent do you feel that these challenges are adequately addressed through the BPHS policy?
   To what extent do you feel it addresses essential SRH services adequately?
   (SGBV: what is the rationale for not having PEP and EC at each facility level? adolescents' SRH: how should the BPHS address the needs of adolescents?)

5. The implementation of the BPHS is a gradual process in terms of putting in place requirements and resources for service provision. Do you feel that the way priorities were set in terms of what to address first are adequate for the needs for SRH services?

6. How do you think the transition from the humanitarian relief phase to the implementation of the BPHS has influenced the provision of SRH services?
   Distribution of home delivery kits - now promotion of facility delivery
   Downsizing of staff per facility
   Decrease of salary/incentive compared to relief NGOs
   Training of staff
   Focus on maternal mortality

During my field work I found a few topics about which I would like to talk to you in a bit more detail.

7. Do you feel that the way the BPHS is currently being implemented at facility level it addresses adequately the SRH needs? How does the policy work in reality?
   What are the strengths?
   What are the weaknesses/ challenges?
   One CM per clinic: working overtime, responsible for too many tasks at once (ANC, delivery, FP, outreach), regardless of catchment population (?)
   143 US$ incentive for CMs, regardless of location
   Role of TTMs and TBAs?
   Lack of space (therefore lack of confidentiality)
   Adolescents

It seems that MVA is not available at the majority of clinics. What are the reasons for that? How do you look at the plan for more CEmOC centers, instead of ensuring BEmOC first?
There seems to be some inconsistency in terms of deliveries at facility level. The BPHS states "Some deliveries may be done at the clinic by the midwife, but this activity is constrained by the availability of the midwife and the working hours of the clinic". However, all CMs state that they work at night and on weekends, and that they are told to encourage TTMs to bring pregnant women to the facility for delivery. What is your view on this?
How do you look at the fact that all CMs in clinics are obliged to work overtime (night, weekends), without compensation? (official working hours: 8-4)

8. The roadmap for the implementation of the BPHS prescribes a training for all health workers about the BPHS. (also: Branding of the BPHS (RBHS, accreditation) In your opinion, what understanding should the staff at facility level have of the BPHS?
   More specific
   Implications for SRH
   Based on my field work, it seems that most staff at the facility level, seem to know the components of the BPHS, but do not seem have a full understanding of the BPHS.

9. Increasing service uptake by the population is a key objective of the BPHS. To what extent do you think it is currently achieving this, particularly regarding SRH services?
   Where do you see the challenges in service uptake? What can or should be done about that?

10. In your experience, what is the impact of performance-based contracting for the BPHS for the availability of SRH services?
    selection of performance-based indicators
    awareness of staff of performance-based indicators

11. In your perception, how do you perceive the possibilities to monitor and evaluate SRH services?
    Accreditation
    Quality

Indicators

Underlying reasons for maternal mortality

12. Is there anything that you would like to add regarding the key issues influencing SRH services?

Annex 5 Consent form

Study title: "Exploration of how a Basic Package of Health Services is supporting sexual and reproductive health service availability in Liberia"

Expert Interview Participant Consent Form

I have read and understood the information sheet about this interview, and I have a copy of it for me to keep. I understand what is required of me for this interview and what will happen to me if I take part in it.

My questions concerning this study have been answered by

Dörte Wein

I understand that I can stop participating in this interview at any time without giving a reason and that if I do there will be no effect, positive or negative, on me.

I agree to take part in this study.

Signature: .....
Date:...../...../.....

Signature of investigator: .....

* * * * *

I do / do not agree that quotes arising from my participation in the study may be included, anonymously, in any reports about the study.

Signature: ..... Date:...../...../.....

Signature of investigator: .....

Annex 6 Coding Framework

A Political commitment	Yes	29	65	2011-03-18 16:18
Tree Node	Encouragement of TBAs TTMs	Yes	17	19
Tree Node	Priorities	Yes	5	11
Tree Node	relation NGOs and CHTs	Yes	23	41
B Governance	Yes	5	7	2011-03-14 16:17
Tree Node	BPHS	Yes	58	127
	Tree Node	Accreditation	Yes	53
	Tree Node	BPHS expansion	Yes	23
	Tree Node	SRH		15
	Tree Node	Standard		15
Critical Subsystems		0	0	2011-03-18 16:26
Tree Node	Financing		1	1
Tree Node	Human Resources	Yes	48	119
	Tree Node	Motivation	Yes	45
		Tree Node	staff turn over	
	Tree Node	Supervision	Yes	49
	Tree Node	Training	Yes	41
	Tree Node	Working conditions	Yes	4
		Tree Node	Incentive	
		Tree Node	work load	
		Tree Node	working hours	
Tree Node	Information		11	20
Tree Node	Infrastructure		13	33
	Tree Node	electricity		6
	Tree Node	Referral and transportation		19
	Tree Node	Space		14
Tree Node	Supply	Yes	47	117
Service delivery	Yes	52	156	2011-03-14 15:14
Tree Node	adolescents SRH	Yes	16	26
Tree Node	Policy implementation	Yes	28	74
	Tree Node	changes since BPHS	Yes	31
	Tree Node	Performance-based contracting		21
	Tree Node	transition from relief to recovery	Yes	9
Tree Node	Quality	Yes	33	60
	Tree Node	Confidentiality		12
Tree Node	Service uptake	Yes	53	184
	Tree Node	adolescents	Yes	40
	Tree Node	community outreach		40
	Tree Node	reasons for increased service uptake	Yes	2
	Tree Node	reasons for lack of uptake		45
		Tree Node	CHVs	
		Tree Node	TBAs	Yes

Integrating Statement

This research project is part of the larger Doctor of Public Health (DrPH) programme; this integrating statement constitutes part of the requirements for thesis submission for DrPH students.
During my first days at the school one of the librarians said to me: "oh, you are doing a DrPH...That's like a PhD, just smaller, right?" No, it is definitely not smaller.

The programme is intended for students who already have practical experience in the field of public health and who want to increase their scientific knowledge as well as analytical skills required for a leadership role in public health practice. The programme encompasses a taught component for six to nine months, a Professional Attachment (now called Organisational and Policy Analysis Project) for about six months and a research project. This combination seeks to equip students both with the skills crucial for leadership roles in public health policy and practice and with the expertise to conduct and evaluate research independently.
I chose this programme several years after completion of my master's degree in public health and after having worked in the field both with the United Nations and with a non-governmental organization. I was eager to return to an academic environment, having missed an evidence-based approach to public health programming and planning in the field. Rather than aiming for an academic career I was interested in increasing my analytical and research skills and to improve my critical thinking in combination with practical application to help to inform future policy and decision making. Moreover, I was looking for an opportunity to conduct research in public health not in isolation but with a direct application to political and organizational issues. I found this possibility with this DrPH programme.

Taught component

The taught component at the beginning of the programme consists of two compulsory modules: *Evidence-based Public Health Practice* and *Leadership, Development and Management*. The first module on Evidence-based Public

Health Practice covers research paradigms, teaching critically reviewing and evaluating studies as well as a better understanding of the process of evidence-based policy making. For the first assignment for this module I analyzed the potential of getting a policy to protect minors from sexual exploitation in Benin on the political agenda. This involved the analysis of the legitimacy, feasibility and support of this policy in the population. It further required an analysis of actors involved in the policy making process, such as the ministry of family and child and the ministry of justice as well as different organizations that are involved in legal protection of women and girls and those who are active in the fight against HIV/AIDS. The potential for public and media support was also examined. This was a valuable assignment, forcing me to think of all different influences of policy making in an environment which is not necessarily open to this kind of policy.

The second assignment of the first module consisted of a systematic literature review on the effectiveness of lay health workers in health promotion in children under five years based upon evidence from randomized controlled trials. This assignment allowed me to apply the skills and methods acquired during the course on critical appraisal of research articles. Overall this module clearly improved my critical approach to research studies as well as my understanding of the linkage between research and policy making and the overall policy processes.

The second module aimed at improving management skills for public health programmes. This was mainly pursued by reviewing case studies and applying organizational theories for their analysis. The assignment required me to apply management frameworks and theories to a situation previously encountered in a work setting. I analysed a non-governmental organisation (NGO), for which I had worked previously, whose employees were not committed to the organisation's overall values. The analysis applied theories of leadership and its importance for staff motivation to formulate recommendations in order to increase employees' commitment. This was an important exercise, looking back at a difficult work experience from a viewpoint of organizational theories.

In addition to these two modules that are geared explicitly towards DrPH students, I selected modules from MSc courses to fill gaps prior to my research project. These included qualitative methods, sexual health and social epidemiology.

Professional attachment

The purpose of the professional attachment is to understand how public health organizations function in influencing public health policies and delivering public health goals. In order to do this, students spend several months with a public health organization, observing to which extent the organization is able to deliver its public health policy objectives. I chose the World Health Organization, as I had worked there before and was interested in analysing the organizational features I had observed during my work experience.

My professional attachment aimed to gain insight into the role of WHO, particularly the Department of Recovery Transition Programs within the Cluster of Health Action in Crises in the health recovery process of Darfur. The objective was to identify possible reasons why the recovery process was not progressing as intended by the Department of Recovery Transition Programs. The process of developing and advocating for a recovery strategy in a protracted crisis as in Darfur demanded a strong leadership from WHO towards other health actors working in the region, but also within WHO, the cluster of health action in crises and the department of recovery transition programs. Leadership was therefore the focus of my study. Transformational leadership and organizational culture represent two sides of the same coin: management of culture is uniquely associated with leadership while cultural norms of an organization also define leadership. These two aspects of organizational theories served as theoretical frameworks of this study. I spent five months, from July until November 2008, with WHO, Geneva, conducting semi-structured interviews, participant observation and document review. This assignment helped me gain better insight into the processes within WHO as well as their influence on actors outside the organization.

Research project

My research project emerged from my work at WHO during my professional attachment. I had the fortunate opportunity to work as a Public Health officer at WHO headquarter in the area of health system strengthening in post-conflict and post-disaster settings while continuing my DrPH programme as a part-time student. I was able to choose a research project closely related to my responsibilities at WHO. One of my tasks as a public health officer was to organize a global consultation on sexual and reproductive health during protracted crises and recovery. This consultation identified important knowledge gaps regarding sexual and reproductive health and policy making in post-conflict settings. For this reason, I decided to conduct my research on the influence of a basic package of health services on the provision of sexual and reproductive health services in post-conflict Liberia. During this project I was able to benefit from the course work of the DrPH, particularly the critical appraisal of research as well as my improved understanding of policy processes. Furthermore, my experience during the professional attachment proved to be extremely relevant, as I was familiar with the environment of WHO and had gained experience conducting semi-structured interviews. The combination of working at WHO while conducting independent research clearly increased my understanding of policy making, and of the role of WHO as a normative agency and its collaboration with other UN agencies. At the same time, my field work for my data collection allowed me to gain close insight into processes in a health recovery situation. Thanks to this experience, I now feel to be in a better position to engage in higher level programme and policy dialogue around health system strengthening and policy making, than I did before entering into the DrPH programme.

Overall, the entire DrPH programme helped to provide me with the necessary skills and knowledge to better understand and analyse public health research and policies. I value the theoretical knowledge as well as the practical experience and skills acquired throughout the programme. I feel that I am now