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The Primary Health Care Approach: Rhetoric or Policy? - A Review of National Health Policies in 8 Countries in Southern Africa

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Abstract

Introduction: The Primary Health Care approach (PHC) can contribute towards universal health coverage (UHC). However, implementing the PHC approach in Africa remains suboptimal. One way to ascertain political commitment to the PHC approach is its reflection in the national health policies (NHP). Several PHC initiatives have helped define and guide the PHC definition, implementation, and evaluation. These include the Alma Ata PHC conference, the Ouagadougou Declaration on PHC in Africa, and the Astana conference. The aim of this paper is to explore to what extent the guidance and characteristics of the PHC approach have been reflected and integrated into the National Health Policies (NHPs) in countries in the Southern African Development Community (SADC).

Methods: The READ approach was undertaken to analyze eight publicly available NHPs. A 12-point checklist was developed to extract relevant data from the policy documents. The WHO Health Systems building blocks are used as the analytical framework to understand the key features of the PHC approach mentioned in the policies.

Results: All the NHPs were developed after the Alma Ata conference in 1978. Six of the eight NHPs reviewed were updated after the Ouagadougou declaration on PHC in Africa in 2008. None of the NHPs were updated after the 2018 Astana PHC conference. Based on the checklist, Lesotho had the most integrated PHC elements (n = 12), while Eswatini had the least (n = 4). Based on the policy review, there seems to be commitment and priority placed on leadership, governance, and access to essential medicines. However, more still needs to be done to improve service delivery in terms of integrated patient centered care (only included in 3 out of the 8), health financing for primary care, integrated health information systems and the community health workers as part of the health workforce.

Conclusion: In conclusion, NHPs should guide implementation, and the NHP is a reference document for many organizations wishing to partner with the government in improving health care services. As such, it should be updated in line with the new evidence and learning and reflect the country's priorities to help align development actors.

Keywords: Primary health care, National Health policy, Sothern Africa

1. Introduction

Governments carry responsibility for developing and implementing health policy and plans. Evaluating a national health policy document from a process and content perspective can determine its value, worth, feasibility, and likelihood of success (Funk, Drew, Faydi, Freeman, & Ndyanabangi, 2011). Whether it is possible to conduct an objective assessment of a policy is a moot point; however, subjecting the document to a systematic evaluation process can lead to improvements or even major changes and considerable resource savings. Policy evaluation can ensure that a "poor" policy is not implemented, for instance, as it is unreal.

By the late 1960s, several events internationally influenced the development of the Primary Health Care (PHC) approach globally. Doubts about the vertical programs began to surface with the failure of the malaria eradication programs by US agencies and the World Health Organization (WHO) in the late 1950s (Cueto, 2004). New studies on community health showed that despite medical advances, there were still persistent health problems, and there was a relationship between the overall health of the population and the standards of living and nutrition (Cueto,

2004). The political landscape was also changing with the Cold War, and many African countries were beginning to gain their independence. In 1974, the UN passed a resolution on the need for a "new international economic order" to improve social conditions in underdeveloped countries. The WHO and UNICEF were instrumental in convening the first international conference on PHC in 1978, the Alma Ata conference, where the PHC approach was adopted as a key strategy for attaining Health for All (Cueto, 2004). PHC was also endorsed at the 1981 World Health Conference. Many African countries developed or updated their National Health Policies (NHPs) and national development plans in line with the PHC approach (WHO, 2008a).

Thirty years later, in 2008, the International Conference on Primary Health Care and Health Systems in Africa was held in Ouagadougou, Burkina Faso. The meeting reaffirmed the principles of the Declaration of Alma-Ata and expressed the need for accelerated action by African governments to improve health and revitalize primary health care as the key approach for achieving improved health outcomes. Many countries updated their NHPs and developed PHC revitalization plans (WHO, 2010).

A second international PHC conference, the Astana conference, was held in 2018 to review and check progress (WHO, 2018a). PHC was redefined as a "*whole-of-society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people's needs and preferences (both as individuals and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment."(WHO, 2018a)*. The conference identified three core elements of PHC, which are (1) meeting people's health needs, (2) systematically addressing the broader determinants of health, and (3) empowering individuals, families, and communities to optimize their health. Furthermore, PHC would be accessible, equitable, safe, high quality, comprehensive, efficient, acceptable, available, and affordable, and deliver continuous, integrated, people-centred, and gender-sensitive health care (WHO & UNICEF, 2018).

The PHC approach is both a philosophy and an approach to health service delivery (CNA, 2000; Langlois, McKenzie, Schneider, & Mecaskey, 2020). PHC is often seen as the most inclusive, effective, and efficient approach to addressing people's health and strengthening health systems, particularly in developing countries (WHO, 2018a). The PHC approach also provides the foundation for achieving Universal Health Coverage (UHC), helping advance country-focused, integrated, people-centred health services (WHO & UNICEF, 2018). Governments are committed to implementing the PHC vision as an integral part of the national health strategy.

However, decades later, many African countries need help to implement PHC models due to economic, human, and institutional capacity challenges (Chatora & Tumusime, 2004; WHO, 2008b). Some countries, such as Malawi, have begun to focus more on the Essential Health Package (EHP) following the realization that PHC as a strategy for achieving health for all was unclear, unfocused, and too general to be attained (Makaula et al., 2012). Most of those initial NHPs have since been updated; for example, the Botswana 1995 NHP was revised in 2011, the Eswatini 1983 Policy was updated in 2007, Lesotho 2004 NHP was revised in 2011, Tanzania 1990 NHP revised in 2003 and 2007, and the Zambia 1991 NHP revised in 2012 (NHP Botswana, 2011; NHP Eswatini, 2007; Lesotho NHP, 2011; NHP Tanzania, 2003; NHP Zambia, 2011). It is unclear whether these revised policies have continued to uphold PHC as the main strategy for health for all. Besides, the revised policies predate the Astana Conference in 2018 and may need to incorporate the new understanding of PHC. The main question answered in this paper is how the PHC approach has been integrated into revised NHPs of eight countries in the SADC.

The rationale for the policy review was the need to understand the level of continued political commitment to PHC particularly on elements such as integration and how the Astana declaration of 2018 is reflected in current NHPs. An abundance of guidance manuals and scholarly output on how to develop policy and evaluate the implementation of policy are available. (Collins, 2005; Gilso, Orgill, Shroff, & World Health Organization, 2018; Langlois, Daniel, Akl, & World Health Organization., 2018; Terwindt & Rajan, 2016; Weiner, 2005) However, once a policy has been developed, there is minimal guidance available on how to assess the processes and content issues that are likely to lead to the policy's success (Funk et al., 2011). This paper provides a checklist to help evaluate the content of the health policy document in line with the PHC approach.

2. Methods

2.1 Study Design

A document analysis was performed using the READ approach (**R**ead your materials, **E**xtract data, **A**nalyse data and **D**istil your findings (Dalglish, Khalid, & McMahon, 2021)). Data were extracted guided by a checklist adapted from the WHO checklist for evaluating a mental health policy (Funk et al., 2011). The mental health policy checklist allows for analyzing content and processes needed in developing a mental health policy. Some countries

have already started to use the checklist to assess the content of their policy documents and plans for mental health. Even though the WHO formulated the checklist to assess the content and processes of mental health policies, the approach can be widely applied to other health policies and plans generally (Funk et al., 2011).

The WHO checklist is divided into two sections on Process and Content Issues with twenty-eight questions rated on a four-point scale (1 = yes/to a great degree, 2 = to some degree, 3 = no/not at all, 4 = unknown). Seven questions, with 12 items, were included in the extraction tool as these were deemed directly relevant to PHC and could be rephrased to fit the PHC elements described in the definition above from the Astana declaration. None of the process questions were included, as this review focused only on the content of the policy documents. The rating scale used in the analysis had three points on the WHO scale and excluded the fourth item, 4 = unknown. Anything unknown from the policy or not included was rated a 3, meaning it was not mentioned.

2.2 Inclusion and Exclusion Criteria

Countries with a publicly available national health policy document and located within the Southern Africa Development Community (SADC), a regional economic community with a common plan for its future (SADC, 2021), were included. Only policies written in the English language were included for pragmatic reasons.

The WHO definition of a health policy is used in this paper, which defines a health policy as an overarching formal statement of intent on health covering vision, goals and broad policy directions and priorities (WHO, 2010). On the other hand, the strategic health plan or other frameworks usually focus on measures and instruments for implementing or operationalizing the policy. Only the National Health Policy (NHP) was included in the review. The health strategies and disease-specific policies, such as HIV policy and strategy, were excluded to ensure a comparison of similar documents.

2.3 Document Search and Selection

The published NHPs for included SADC countries were identified through an internet-based search, initially using Google to locate the official websites of the relevant country's Ministry of Health. If the NHP was unavailable on the official government site, the WHO global file repository website was used to retrieve the NHPs (WHO Country Planning Cycle database, 2022). Only policy documents that matched the WHO definition of a policy and were labelled as an NHP were included. As such, the National health strategies from South Africa and Zimbabwe were excluded. The search was done in October 2022.

Another search for relevant publications on policy analysis and the PHC approach in Africa was conducted on the WHO Africa region website (WHO Regional Office for Africa, 2022) and Google scholar. Articles were screened using the titles for papers that referred to overall national policies of countries in the SADC region and not, for example, disease or age-specific policies. These articles were stored and managed using the Endnote referencing software.

2.4 Data Analysis

As part of the READ approach to document analysis, the relevant data was extracted from the checklist in an excel document as described in the study design and summarised. Based on the WHO checklist, the rating scale was used in the following way:

1 = yes/to a great degree, given if a concept or issue was mentioned and described, for example, if the essential health package is mentioned and its components described.

2 = to some degree, given if a concept or issue was mentioned but not described. For example, the policy can say an integrated health plan with no clear description.

3 = no/not at all refer to a concept that is not mentioned at all or is unclear.

A comparison was made across each of the questions for the countries and summarised with some comments to explain the rating. A word count to check the frequency of using certain words and phrases was also done. The terms and phrases analyzed all relate to part of the elements of PHC as provided in the Astana declaration quoted in the introduction, such as "integrated", "community", "multisectoral", "intersectoral", "people-centred care", "gender" and "community health workers".

These key elements of the PHC are presented using the six WHO Health Systems building blocks as the analytical framework (WHO, 2010). i.e., 1) Service Delivery related to people centred care, integrated care and Universal Health Care (UHC) 2) Health workforce related to multisectoral collaboration and community health workers 3) Leadership and Governance related to community involvement or participation, decentralisation and PHC coordination 4). Health financing related to affordability as part of UHC 5) Access to essential medicines related

to comprehensive care and essential health packages 6) Health information systems. There are many overlaps and linkages within these relationships but the WHO building blocks serve as a useful guide for countries when strengthening their health systems to achieve UHC and improve overall health outcomes. The PHC approach is a strategy to achieving similar outcomes i.e., UHC and improved overall health outcomes.

Table 1. 12-point checklist for evaluating an NHP for alignment with the PHC approach. Results from the table are mapped in Figure 3

#	Question
1	Is the primary health care approach mentioned as a general approach to health care in the country?
2	Do the values, principles and objectives in the policy promote key PHC elements such as:
	-Integrated care
3	-Community participation
4	-Multisectoral collaboration
5	-People-centred care
6	-Comprehensive care
7	Is Universal Health Coverage mentioned addressing?
	-Access
8	-Affordability, including PHC financing
9	Is an Essential Health Package (EHP) clearly described?
10	Does the policy establish a coordinating body to oversee major decisions in PHC?
11	Does the policy address an integrated national health information system from the primary level?
12	Does the policy address advocacy for community health workers and other health workforce at the primary level?

3. Results

There are sixteen countries in the SADC region, which are: Angola, Botswana, Comoros, Democratic Republic of Congo (DRC), Eswatini (formerly known as Swaziland), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia, and Zimbabwe (SADC, 2021). Five of these countries, Angola, Comoros, DRC, Madagascar, and Mozambique, were excluded because their policies were not in English. No NHPs could be located for Zimbabwe, South Africa, and Mauritius at the time of the review, and only their national health sector strategies were available and therefore excluded from the review. There were eight NHPs found as PDFs finally selected from Botswana, Eswatini, Lesotho, Malawi, Namibia, Seychelles, Tanzania, and Zambia (Table 2). Eswatini was formerly known as Swaziland, the name used in the NHP, and it changed its name to Eswatini in 2018; as such, Eswatini has been used in this paper.

Table 2. List of countries and National Health Policies reviewed.

Country	First NHP published	NHP reviewed	Link to the source (accessed 28 April 2022)
Botswana	1995	National Health Policy 2011 (revised)	https://www.moh.gov.bw/Publications/policies/revised_National_Health_Policy.pdf
Eswatini	1983	National Health Policy 2007	https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/swaziland/ministry_of_health_-_national_policy.pdf
Lesotho	2004	National Health Policy 2011	https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/lesotho/health_sector_policy_2011-22_2_3.pdf
Malawi	2017	National Health Policy 2017	https://www.health.gov.mw/index.php/policies-strategies
Namibia	1998	National Health Policy Framework 2010-2020	https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/namibia/namibia_policy_framework_2010-2020.pdf
Seychelles	Undetermined	National Health Policy 2016	http://www.health.gov.sc/wp-content/uploads/National-Health-Policy_final-26062015.pdf
Tanzania	1990	National Health Policy 2003 (also 2007 in Swahili)	https://www.healthresearchweb.org/files/Tanzania%20National%20Health%20Policy%202003.pdf
Zambia	1991	National Health Policy 2011	https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/zambia/nhp_prepared_23_january_2012.pdf

The World Health Assemblies in 1977 and 1981 and the Alma Ata declaration in 1978 stimulated health policy formulation in Africa (WHO, 2008a). Six of the NHPs reviewed in the paper were the second revised versions following these events (Botswana NHP, Eswatini NHP, Lesotho NHP, Namibia NHP, Tanzania NHP and Zambia NHP). Except for Namibia, Seychelles and Eswatini, five countries selected had separate standalone policies and strategies specific to PHC. Tanzania had another more recent NHP revised in 2007, but it was only available in Swahili, so the English 2003 NHP was used in this paper. It was not clear from the literature search whether this was Seychelles' first NHP or whether they had been another before this.

The results are presented first, showing the situation assessment, which describes the economic and socio-political overview of the countries as explained in the NHPs. Secondly, the key elements of the PHC approach, as defined in the Astana declaration, quoted in the introduction, are presented using the WHO Health Systems building blocks as the analytical framework.

3.1 Overview of the Countries

Optimal PHC implementation assumes a conducive economic and socio-political environment, which is lacking in much of Africa and affecting its implementation (Chatora & Tumusime, 2004). Three countries under review are low-income, four middle-income, and one high-income (Figure 1). They have relatively small populations, with Seychelles, Botswana, Lesotho, Eswatini and Namibia with under three million people (World Bank, 2020). Tanzania is the biggest, with an estimated 59 million people, while Malawi and Zambia have 19 and 18 million people. All eight countries have a relatively young population, with 50% (4/8) of them having more than 40% of the population below 15 years. Malawi has the highest dependency rate, with 64% of the population under 15 years, and Seychelles has the lowest, with 22% under 15 years (World Bank data, 2021).

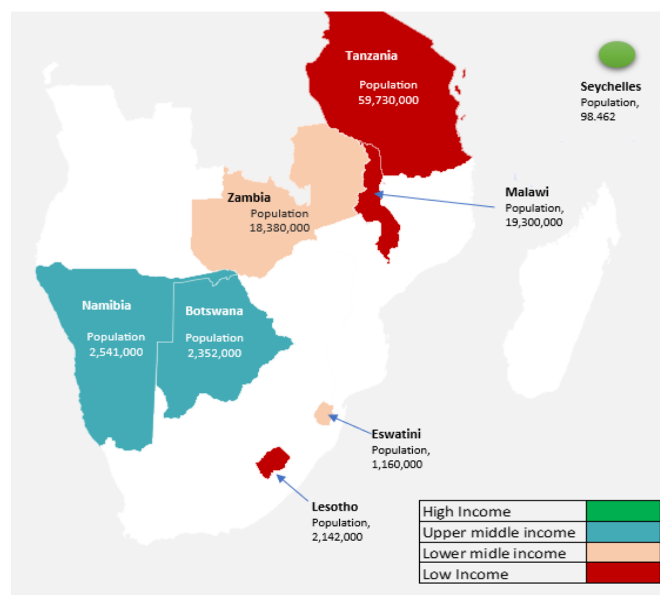

Figure 1. Overview of the countries with NHPs reviewed in the paper. Map generated in Excel and Population figures are for 2020 based on www.worldometers.info/world-population extracted 28 April 2022

All eight countries share a colonial history, which shaped the adoption of the PHC approach even before it was formalized in 1978 (Chatora & Tumusime, 2004; Kasonde, Martin, & World Health Organization, 1994; Makwero, 2018). Colonial health systems were typically fragmented, discriminatory, and urban-focused curative health services (Kasonde, 1994). Post-independence governments were committed to ensuring universal access, equity, and social justice, which are the fundamental principles of PHC (Maluka et al., 2018). For example, Botswana, which obtained its independence in 1966, incorporated community participation, intersectoral collaboration, and preventive healthcare as central to its healthcare system during the late 1960s and early 1970s (Molutsi, 1998). In Tanzania, the 1967 Arusha Declaration sought to make basic health services available closer to the population (NDP, 2016). Similarly, countries that became independent later, such as Namibia in 1990, a decade after the Alma Ata declaration, only adopted the PHC approach in 1990 (Chatora & Tumusime, 2004).

3.2 Primary Health Care Approach

There are two ways of looking at primary health care. The first, primary care as the first level of health service delivery, is clearly explained in all the eight NHPs. The second, a focus of this paper is primary health care as a philosophy and strategy for service delivery where communities are involved, participate, and are empowered in their health development. The interrelationships among health determinants are also addressed (WHO, 2008). Table 3 shows how each country defines and describes PHC within the NHP. PHC is mostly understood as essential health care provided as close to the community as possible and integrates prevention, treatment, rehabilitation, and care. However, PHC as a general approach or strategy to health service delivery is mentioned in five NHPs. The Tanzania NHP explicitly mentions PHC as the cornerstone of their health care system; Namibia has PHC as a policy goal. Lesotho, Malawi, and Zambia NHPs mention PHC as a key principle. Botswana, Eswatini and Seychelles did not mention the PHC approach. However, the Botswana and Eswatini NHPs, explained in the introduction that they had evolved from a PHC focus to the current strategy. In Eswatini, there was an evolution from the initial 1983 NHP, which was founded on the principles of PHC, to the updated 2007 NHP, based on the principles of health promotion. Similarly, Botswana transitioned from the first 1995 NHP, which had gone through various reforms to align with the PHC approach. There is no explanation why the current Botswana NHP does not mention the PHC approach as the key strategy.

Table 3. Definition of primary health Care based/used in the national health policies

Botswana	**A main health care delivery model at the 2nd and 3rd levels of the five-tier system comprising individual/family, primary health clinics/centres, primary hospitals, district/secondary hospitals, and referral hospitals. Primary care is provided through a network of clinics, health posts and mobile stops, and community-based preventive and promotive services.**
Eswatini	The first level of care, which provides health education, promotes food supply and proper nutrition, improves access to clean water and basic sanitation, promotes maternal and child health (including family planning, immunization, prevention, and control of endemic diseases), improves treatment of common illnesses and injuries, and provide essential drugs.
Lesotho	Basic health care services available nearest to the population at the community level.
Malawi	Essential basic health care based on practical, scientifically sound, and socially acceptable methods and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (adopted from WHO 1978).
Namibia	Care that embodies these key principles: people-centred care, health equity, solidarity and social inclusion, health authorities that can be relied on and communities where health is promoted and protected. Orientation of social services from curative and remedial social work to a developmental approach emphasizing the prevention of social ills and empowerment of individuals, groups, and communities.
Seychelles	Care delivered through a network of community-based facilities offering a well-defined, cost-effective health intervention package centred on disease prevention, health promotion, multisectoral collaboration and each individual, family and community taking responsibility for its health. Essential health care model to achieve universal health coverage.
Tanzania	Essential health care that emphasizes community involvement and ownership, multisectoral collaboration, equity and accessibility to health care, empowerment through decentralization of health services and providing promotive, preventive, curative, and rehabilitative interventions.
Zambia	Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals, families, and communities at a cost that the community and the country can afford to maintain (adopted from WHO 1978)

3.3 Elements of PHC Presented Using the WHO Framework for Health Systems

The Astana declaration (2018) provides key elements of the PHC approach to build a strong and sustainable health care system. The key features of the PHC approach reviewed below include people centred care, integrated care, community involvement/participation, multisectoral collaboration, comprehensive care, and universal health coverage. The WHO Six Building Blocks Framework (WHO, 2010) serves as a valuable guide for countries and healthcare systems aiming to strengthen their healthcare infrastructure. By prioritizing service delivery, health workforce, health information systems, access to essential medicines, health financing, and leadership and governance, healthcare systems can work toward providing equitable, affordable, and high-quality care for all, which is aligned with the vision of the primary healthcare approach. These building blocks are fundamental to achieving the goal of universal health coverage and improving the overall health and well-being of populations around the world. The building blocks are not fully aligned to the PHC approach but are used as a general framework to describe the whole health system. These criteria are not provided in any hierarchy of importance.

3.3.1 Service Delivery

Good health service delivery considers how the health care services are provided including the quality and access to the services. Based on the PHC approach, services should be delivered in a manner that is people centred and integrated.

People-centred care: This refers to people having access to health services that are provided in a way that responds to their life course needs and preferences, are coordinated across the continuum of care and are safe, effective, timely, efficient, and of acceptable quality (WHO, 2015:8). People-centred care is a key component of the PHC approach that overlaps and cuts across all the other features and strategic areas. It focuses on health interventions that address people’s legitimate needs and expectations. Reaching the underserved, marginalized, and vulnerable is also part of meeting people’s health needs. Addressing equity concerns and gender sensitivity is one of the key principles of the PHC approach.

Botswana, Tanzania, and Zambia NHPs mentioned adopting a client or patient charter and were rated a 1, which means this criterion was met. The charter will display the patient's rights and responsibilities to safe, timely, quality care. It is intended to ensure accountability of the health facilities and health workers to the patients. Seychelles, Lesotho, and Malawi were also rated 1, as they had indicators and outcomes on client satisfaction in their monitoring framework. Patient-centred care is part of the values of the Seychelles NHP. These six countries also mention gender sensitivity as one of their key guiding principles. From the word frequency analysis, Malawi and Zambia have the most gender mentions, 19 and 14 times, respectively, both as a principle and mainstreamed across the different policy initiatives and strategies.

Namibia NHP does not mention people-centred care but has gender as one of the guiding principles and was rated 2, which means the criteria are met to some extent. Eswatini NHP did not mention people-centred care or gender and was rated a 3, which means it is not mentioned. Women's health situation is mentioned in the context section of the NHP. Still, as there is nothing else within the body of the policy on gender, that is, in the vision, mission, objectives, scope, principles and policy direction, they were rated as not having met this criterion.

Integrated care: PHC seeks to avoid fragmentation of services and ensure a functional linkage or referral system between primary and other levels of care (WHO, 2018). Referral systems are not always well-defined or available and can have limited influence on the level at which users access services (NHSSP, 2014; PESS, 2014). The first two health system levels, primary and secondary, are typically the first referral points and offer integrated services. Strengthening the referral system across all levels and services is a critical policy action. The health system's strength depends on patients being seen at appropriate levels of care without burdening the system.

The NHPs mentioned integrated care at differing levels and across different health conditions. Table 4 shows how each country defined and described integrated care within their NHPs.

Table 4. Definition of Integrated Care based on the national health policies.

Botswana	Attainment of universal coverage of a high-quality package of essential health services (EHSP) (as stated in the Integrated Health Services Plan (2010) referenced in the NHP
Eswatini	Undetermined from the NHP as it is not mentioned
Lesotho	The health service provision which approaches health issues holistically such that treatment of diseases will be coupled with aspects of nutrition, hygiene, and promotion of healthy lifestyles
Malawi	Essential health services package
Namibia	Not clearly defined. Examples are provided of Integrated Management of Newborn and Childhood Illness (IMNCI) PMTCT integrated into maternal and newborn PHC services.
Seychelles	A strong health system capable of responding adequately to present and future health challenges. Through an optimal national primary health care, quality three-tier national referral system, collaboration with the private sector and support of effective complementary health care services.
Tanzania	Essential health services package
Zambia	Service that is coordinated and streamlined to take advantage of similar functions, skills, resources and targeted populations. This is particularly related to the Integrated Disease Surveillance and Response Strategy (IDSR) that Zambia adopted from WHO-AFRO to monitor, prevent, and control priority notifiable infectious diseases in the country. Other examples given are the Integrated Reproductive Health (IRH)

Zambia, Lesotho, Namibia, and Tanzania were rated a 1, which means they met this criterion, as they mentioned integrated care and provided examples of services to be integrated. The Zambia NHP had the most examples of integrated care, focusing on integrating reproductive health services, mental health, and preventive chemotherapy for neglected tropical diseases and mass immunization. In Lesotho, integrated care is holistic treatment focusing on integrating the management of acute nutrition, hygiene, and healthy lifestyles at the primary level. In Namibia, integrated care focuses on preventing mother-to-child transmission of HIV, maternal and neonatal health, and integrated management of newborn and childhood illnesses (IMNCI). Tanzania mentions the essential health package (EHP) as integrated care.

Malawi, Seychelles, and Botswana were rated 2, which means the criteria were met to some extent, as they mentioned integrated care but with fewer details of what it meant in their context. Seychelles has integrated health

care as a policy objective though no detail is provided. Botswana NHP mentions an integrated national health services plan with no details and integrating health services such as substance abuse into the school curriculum. Health promotion is the cornerstone of the Botswana NHP, which integrates several diseases though this is not explained. Swaziland NHP does not mention integrated care.

Universal Health Coverage (UHC): Access and coverage of services is an essential part of service delivery. UHC addresses access and affordability of health services (Seidman, 2017). PHC is a strategy to address UHC (WHO, 2019). In restructuring their health systems, most countries have focused on ensuring health facilities are available within a certain geographical reach for everyone structured into a two-, three- or four-tier health system (Chatora & Tumusime, 2004). UHC has been divided into access and affordability for the analysis, even though some countries like Zambia may not have used the exact term UHC. Affordability is addressed under the health pillar on financing.

All the NHPs have access to health services as a key principle. Access to health services is also mainstreamed across all the policy focus areas. All were rated a 1, which means they met the criterion. In Seychelles, 86% of the people take less than thirty minutes, mostly via public transportation or walking, to get to a health facility, while in Lesotho, 79.5% of people are within less than two hours walking distance from a fixed health facility. In Malawi, one of the key outcomes is increasing the percentage of the population with access to a health facility offering 24-hour quality EHP within a 5 km radius. One of the policy measures in Zambia is to ensure a health post is established within a 5 km radius of sparsely populated areas. Botswana. Namibia, Eswatini, Botswana, and Tanzania do not mention distances to health facilities.

3.3.2 Health Workforce

A well performing workforce consists of adequate human resources with the necessary knowledge and skills to delivery services. More importantly, based on the primary health care approach, there is a need for multisectoral collaboration across departments and organizations for health care needs to be comprehensively met.

Multisectoral collaboration: The Ministry of Health is the sole custodian of the people's health within the countries, with the legal mandate and responsibility to formulate policies, regulations, norms, standards and guidelines for health services in the country but not the sole provider of responses and interventions (WHO, 2018b). Beyond the health sector, many other sectors, such as education, agriculture, housing, and water, significantly contribute to health. Since PHC encompasses preventive activities, these other sectors become more important. In Africa, healthcare delivery is highly pluralistic and dependent on many international and national civil society organizations. The church is a key health stakeholder in some countries such as Lesotho, Malawi, and Zambia.

The PHC approach recognizes the need for multisectoral collaboration to achieve positive health outcomes and implement a Health in All Policies approach espoused by the World Health Assemblies in 1978. Intersectoral collaboration is the only component of the PHC approach explicitly acknowledged and reflected in all the NHPs, especially related to prevention, promotion, and addressing the social determinants of health. All the NHPs were rated with 1, which means they fully met this criterion. Seychelles mentions the health in all approach, and in Malawi and Namibia, an intersectoral approach with a health sector working group is provided. Botswana formed a national health council with various ministries, and it is a key objective in Zambia and a key strategy for achieving the NHP objectives in Tanzania. In Lesotho and Eswatini, the participation of other sectors in health planning, funding, implementation, and M&E is one of the guiding principles.

Community Health Workers (CHWs): An integral part of the PHC approach is the involvement of the community (see next section), and as part of that, the presence of CHWs is a key part of the health workforce. CHWs health workers are part of the frontline health care workers at the community level, especially in rural and remote areas, conducting different health-related tasks (WHO, 2017). Only the Lesotho NHP mentions advocacy for community health workers and is rated 1, which means they met this criterion. The Tanzania NHP has a brief mention of community health workers with no details on advocacy, so it is rated 2, which means the criteria were met to some extent. The other six NHPs do not mention community health workers and are rated 3, which means they did not meet this criterion.

3.3.3 Leadership and Governance

Effective leadership and governance ensure the existence of policy frameworks, effective oversight, collaboration across sectors, provision of appropriate incentives, attention to system design and accountability; as such, it cuts across all the different elements. However, a key distinguishing factor of the PHC approach is the involvement and participation of the community as an integral part of its leadership and governance strategy.

Community involvement: This refers to health services that empower individuals, families, and communities to

participate and optimize their health outcomes (WHO, 2018). The structure of the health system has the community as the first level of health service delivery. All the NHPs mentioned community involvement and participation and were rated a 1, which means they met this criterion. Lesotho, Tanzania, Zambia, Malawi, Namibia, and Botswana mentioned it the most. They described community involvement as a key principle and value guiding the NHP and mainstreamed it across the different policy measures and initiatives. In Eswatini, strengthening community action and involving service beneficiaries is one of the guiding principles. In the Seychelles NHP, community participation is mentioned as part of the organization and structure of their service delivery. Tanzania had the most frequent word references to community involvement ((n = 7), including communities contributing to the overall PHC budget through in-kind labour or resource contributions (Maluka & Chitama, 2017).

Decentralization: In addition, the decentralization process, a key public reform policy in Africa, a core strategy to place decision-making authority at the lower levels, is part of community involvement (Langlois et al., 2020). Malawi, Zambia and Eswatini mentioned adopting a decentralization policy, while Lesotho developed a decentralization plan. In lesser detail, Namibia, Botswana, Tanzania, and Seychelles also mentioned decentralization. In Seychelles and Namibia, power has been devolved to the regional level. In Tanzania, Zambia, Botswana, Lesotho and Malawi, power has been devolved to the district level, which oversees the lower community level of care. The Lesotho NHP provides the most details on their decentralization action plan with district health management teams established to oversee PHC services. Power has been devolved to Swaziland's chiefdoms, urban government, and regional levels.

PHC Coordinating body: Lesotho and Malawi were the only countries that mentioned establishing a coordinating body to oversee major decisions in PHC, one of the questions on the checklist. In contrast, the remaining six countries do not mention any PHC coordinating body.

3.3.4 Health Financing

A good health financing system raises adequate funds for health, protects people from financial catastrophe, allocates resources and purchases goods and services in ways that improve quality, equity, and efficiency.

Affordability: One of the barriers to accessing health care is the cost of the services. Affordability is a critical element in the PHC approach and a key part of the UHC mission. PHC financing is not explicitly mentioned in the policies. However, affordability is mentioned in all NHPs as part of the mission, objectives or principles and values and rated a 1 for all, which means they met the criterion. Seychelles and Zambia offer free public health care with user fees removed in Zambia. The Essential health package will be free or highly subsidized in Botswana and Lesotho. Public health is free for specific vulnerable groups in Eswatini. The Tanzania MoH will set up a community health fund to help with user fees. Namibia will consider universal health insurance if out-of-pocket expenses increase. There is no mention of a national health insurance scheme or free services in Malawi.

3.3.5 Access to Essential Medicines

Procurement and supply programs need to ensure equitable access to quality-assured and cost-effective medical products. In addition, the availability of adequate medical products helps to ensure comprehensive care can be provided, a key part of the primary health care approach or at least a prioritized set of essential services.

Comprehensive Care: Five NHPs mention comprehensive health care in detail and describe the different health services. These were rated with a 1, which means they met this criterion. For Namibia, comprehensive care is mentioned concerning prevention and emergency obstetric care, Zambia, mental health, medical rehabilitation services and palliative care. Lesotho offers comprehensive services for victims/survivors of gender-based violence and occupational health and hazard management. In Botswana, one of the policy initiatives is for the MoH to define a comprehensive essential health package with a special emphasis on health promotion and preventive health care. The Seychelles NHP has comprehensive care as part of the objectives and principles. The Tanzania NHP was rated a 2, which means they met this criterion to some extent. There is a mention of dispensaries providing comprehensive PHC services though this is not explained. Eswatini and Malawi NHPs were rated a 3, which means they did not meet the criteria on the checklist. They do not mention comprehensive care but refer to a comprehensive NHP and human resources plan.

Essential Health Package: The EHP is a prioritized, limited package of basic and cost-effective health services determined based on experience and ability to significantly impact most people's health status (WHO, 2020). The Essential Health Package (EHP) is mentioned in detail in 3 countries. Tanzania, Botswana, and Malawi, where EHP is the service delivery model. Eswatini, Lesotho, and Zambia were rated a 2, which means they met the criteria to some extent, as there is a brief mention but no detail of what the EHP included. Namibia and Seychelles were rated a 3, which means they do not mention the EHP.

3.3.6 Health Information Systems

A well performing system ensures the production, analysis, dissemination, and use of timely and reliable information. As part of the PHC approach, having integrated health information systems will ensure all the necessary information is collected and utilized for decision making. Integrated health information systems or disease surveillance are mentioned in Seychelles, Tanzania, Lesotho, Namibia, and Botswana NHPs, rated a 1, which means they met this criterion. In Namibia, the focus is on integrating parallel resource programs into the mainstream health information system. The other four countries mention it in general across all levels. Zambia was rated a 2, which means they met the criteria to some degree, as there is mention of an integrated financial management information system, which may contain disease surveillance. Eswatini and Malawi were rated a 3, which means they do not mention integrated health information systems.

Rating Scale
1 Yes/ to a great degree
2 To some extent
3 No/not at all

	PHC approach in general	Integrated Care	Community Participation	Multisectoral Collaboration	People-centered care	Comprehensive Care	Universal Health Coverage	Essential health package	PHC Coordinating body	Integrated Health Information System from	CHWs advocacy
Botswana	3	2	1	1	1	1	1	1	3	1	3
Eswatini	3	2	1	1	3	3	1	2	3	3	3
Lesotho	1	1	1	1	1	1	1	1	1	1	1
Malawi	1	2	1	1	1	3	1	1	1	3	3
Namibia	1	1	1	1	2	1	1	3	3	1	3
Seychelles	3	2	1	1	1	1	1	3	3	1	3
Tanzania	1	1	1	1	1	2	1	1	3	1	2
Zambia	1	1	1	1	1	1	1	2	3	2	3

Figure 2. Checklist for evaluating an NHP for alignment with the PHC approach. The heat map provides information on how each country ranked according to the PHC elements identified using the 3-point rating scale

Six of the eight countries` NHPs reviewed have integrated more than 60% of the PHC elements on the 12-point checklist (Figure 2). Lesotho NHP included all 12 features of the PHC approach. Overall, the frequency of NHPs being rated one on the 12-point checklist were Lesotho (n = 12) and Tanzania (n = 9), Botswana (n = 8), Malawi (n = 8), Namibia (n = 8), Zambia (n = 8), Seychelles (n = 7) and Eswatini (n = 4). The Eswatini NHP has the least elements of PHC mentioned. The NHPs fully addressed community participation, multisectoral collaboration and universal health coverage.

4. Discussion

For any health systems to be strong, all the six building blocks need to be addressed in the context of primary health care. Based on the policy review, there seems to be commitment and priority placed on leadership, governance, and access to essential medicines. However, more still needs to be done to improve service delivery in terms of integrated patient centered care, health financing for primary care, integrated health information systems and the community health workers as part of the health workforce.

There are variations in how the PHC approach is defined and understood across the countries. There seems to be some agreement that PHC should offer essential or basic services, whether at the first level (clinics or community) or second level (hospitals), like in Botswana, where they have primary hospitals. Malawi and Zambia have adopted the WHO 1978 definition in their policy. Five countries explicitly include the PHC approach as a cornerstone or underlying principle of the health care system. Seychelles, Eswatini and Botswana do not mention it. This can somewhat correlate with country income. The PHC approach is the most logical way of organizing the health system in low-income countries where access and affordability are critical issues. It can also ensure that stronger health systems are built at the primary care level as it addresses the six WHO building blocks for health systems.

In both high and upper-middle-income countries, such as Seychelles and Botswana, the PHC approach is not mentioned. The countries that were explicit about the PHC approach as a guiding principle and philosophy in the NHP were also low-income and lower-middle-income countries, such as Tanzania, Malawi, Lesotho, and Zambia. The two exceptions were Namibia, an upper-middle-income country with the PHC approach as a policy goal, and Eswatini, a lower-middle-income country that does not mention the PHC approach. Various contextual issues could also explain these discrepancies related to the economy, politics, population size, and structure. For example, Eswatini is a small country of just over one million people, health access may present differently, and the PHC approach may be understood differently. This paper does not delve into these contextual issues but only focuses on self-reported NHPs. However, the NHPs show that despite differences in income status and population density, most countries have made primary health services geographically accessible to all.

Integrated care is also understood and described differently in the NHPs. The most common way presented by Botswana, Malawi, and Tanzania is equating integrated care with the essential health package (EHP) offered at primary and secondary care levels. The EHP does not necessarily mean that these services are provided in an integrated way. Priorities in the EHP differ across countries. For example, maternal health is mentioned in Botswana, acute malnutrition in Lesotho and IMCI guidelines in Tanzania. Although some of these services are integrated, they constitute separate service bundles sometimes within one health facility and can be disjointed from each other. These bundles of health services are typically selected around donor priorities in low-income countries (Sherr K et al., 2013). As such, bundles of vertically integrated programs can run parallel, focusing on different components of PHC with weak coordination. This parallel program integration can result in missed opportunities for quality comprehensive PHC. Though it advances the PHC approach, the EHP intervention risks perpetuating the vertical projects and fragmentation of PHC programs in Africa. Integrating or coordinating these different vertical programs into one primary care model is necessary to achieve UHC. Equitable financing for and access to a range of services should not just be for a handful of privileged programs (Chaitkin M et al., 2019). The upper-middle-income countries are now prepared to take on more financial responsibility for their health and focus on more comprehensive services (Burkot et al., 2019).

Seychelles views integrated care as part of building a strong health system and referral networks across all levels of care. Lesotho also considers integrated care a holistic approach encompassing all primary care services. Zambia uses integrated care to coordinate different services and use different skills and functions to address the target population. While the EHP mentioned above can be considered integrated care, mention of the term integrated care or other types is relatively few within the NHPs, only 4 out of 8 (50%). Yet, it is a key element of the PHC approach and strategy for achieving UHC. A systematic review of integrated models in LMICs shows that ‘adding on’ services (or linkages) may improve the utilization and outputs of healthcare delivery even though there is no evidence that a fuller form of integration improves healthcare delivery or health status (Dudley & Garner, 2011). A later systematic review on integrated care in the UK and internationally suggested that integrated care models may enhance patient satisfaction, increase the perceived quality of care, and enable access to services (Baxter et al., 2018). However, this review only considered studies carried out in developed countries or members of the Organisation for Economic Collaboration and Development (OECD). There is a need for an updated review of the utility of integrated care at PHC level in LMICs and Africa to inform policy direction.

Integrated health information systems are still generally not prioritised within the policies. Furthermore, data utilization for decision-making is still lacking, even though policymakers may develop many monitoring plans and health indicators to measure health outcomes (Burkot et al., 2019). Whilst other health workforce are mentioned and prioritised in the policies, there is still limited advocacy and support for community health workers, who are the frontline for community health services, especially in countries with a vast rural population. However, it could well be that this is not represented in the national policy but is covered in other specific policy documents.

4.1 Limitations of the Research

The review only focused on NHPs in English, which can bias the results as there are many contextual differences across the countries. A more comprehensive study including all countries may be necessary. The unit of analysis in this study is the national health policy. There is a risk of overinterpreting the results. Much richer information could have come from a combination of secondary and primary data sources. However, for this study, a pragmatic choice was made to use documentary evidence: the national policy documents exclusively. Thus, the convergence of information from multiple sources is limited, and construct validity is undermined. The countries and areas where primary care elements were missing may be addressed in other specific policy documents outside this research’s scope.

4.2 Implications for Policy

There are important implications for primary health care based on how it is understood and integrated within the NHPs. The NHPs guide national health priorities and can affect national health investment decisions. As such, the moderate alignment between the NHPs and some of the PHC elements envisioned in the WHO Astana declaration should be a pressing concern for policymakers and international health players. NHPs need to be updated to reflect this revised understanding of PHC.

The variations in definitions of primary health care and integrated care affect how it is implemented or success is measured, which can result in a disconnect between policy and practice. This review adds value to the body of literature as it compares policies across countries in southern Africa and can inform efforts to standardize and measure PHC efforts in the region. Clarity of concept and approach around integrated people-centred health care is necessary to avoid implementation gaps and a lack of understanding of what works. Integration may improve the service uptake and coverage of health services. Still, there is limited evidence that integration results in improved patient experiences or health outcomes compared to other service delivery models. This lack of rigorous evidence on integrated care is reflected in its sparse mention within the NHPs. More research is needed to understand integrated healthcare delivery models and how we can optimize them to inform policy direction.

The PHC approach is still considered the most effective vehicle for achieving health goals in LMICs. Achieving acceptable health outcomes and patient experiences in healthcare will require sustained optimal implementation of the PHC approach and continued commitment, prioritization, and incorporation in the NHPs even as they get revised and updated. There are still many policy questions around defining and operationalizing specific PHC elements, such as the best models for integrated, patient-centred, and comprehensive care. More funds for qualitative and quantitative research on primary care are necessary to expand the knowledge and evidence base for the policy and practice for primary care.

5. Conclusion

In conclusion, what gets prioritized in national policy in any given country needs to be interpreted within the contextual differences. Improving health outcomes in Africa will require political commitment and the implementation of evidence-informed health care approaches. The PHC approach is still considered the most effective vehicle for achieving health goals in LMICs. Achieving acceptable health outcomes and patient experiences in healthcare will require sustained optimal implementation of the PHC approach and continued commitment, prioritization, and incorporation in the NHPs even as they get revised and updated. There are still many policy questions around defining and operationalizing specific PHC elements, such as optimal health care delivery models for integrated, patient-centred, and comprehensive care. More funds for qualitative and quantitative research on integrated patient-centred care in primary care in Africa are necessary to expand the knowledge and evidence base for the policy and practice.

Data Availability

The authors confirm that the data supporting the findings of this study are available within the article and the corresponding tables and graphs. Additional information is available upon reasonable request from the corresponding author.

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