REVISED
NATIONAL COMMUNITY HEALTH SERVICES POLICY

MINISTRY OF HEALTH
Monrovia, Liberia

2016 - 2021

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ACRONYMS

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CBIS	Community-Based Information System
CBO	Community-Based Organization
CDD	Community Directed Distributor
CEBS	Community Event-Based Surveillance
CHA	Community Health Assistant
CHC	Community Health Committee
CHDC	Community Health Development Committee
CHDD	Community Health Department Director
CHO	Community Health Officer
CHFP	Community Health Focal Person
CHP	Community Health Promoter
CHS	Community Health Services
CHSD	Community Health Services Division
CHSS	Community Health Services Supervisor
CHT	County Health Team
CHV	Community Health Volunteer
CLTS	Community-Led Total Sanitation
CM	Certified Midwife
CSA	Civil Service Agency
DHO	District Health Officer
DHT	District Health Team
DOTS	Directly Observed Therapy Short course
DPC	Disease Prevention and Control
eMTCT	Elimination of Mother-to-Child Transmission
EPHS	Essential Package of Health Services
EVD	Ebola Virus Disease
FBO	Faith-Based Organization
gCHV	General Community Health Volunteer
HFDC	Health Facility Development Committee
HPD	Health Promotion Division
HMER	Health Monitoring, Evaluation, and Research
iCCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
iHRIS	Integrated Human Resources Information System
IPC	Infection Prevention and Control
ITN	Insecticide-Treated Net
km	kilometers
KMC	Kangaroo Mother Care
LMIS	Logistics Management Information System
MDD	Mass Drug Distributors
MGCSP	Ministry of Gender, Children and Social Protection
MIA	Ministry of Internal Affairs

MOE	Ministry of Education
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
MYS	Ministry of Youth and Sports
NGO	Non Governmental Organization
OIC	Officer-in-Charge
ORS	Oral Rehydration Salts
PA	Physician Assistant
RDT	Rapid Diagnostic Test
RM	Registered Midwife
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RN	Registered Nurse
SCMU	Supply Chain Management Unit
SOP	Standard Operating Procedures
SQS	Safe, Quality Health Services
TB	Tuberculosis
TTM	Trained Traditional Midwife
USD	United States Dollars
WHO	World Health Organization

Background

Consistent with *the National Health and Social Welfare Policy and Plan 2011–2021* (National Health Plan), the *Essential Package of Health Services* (EPHS) is designed to render services along three levels of care: primary, secondary and tertiary. The EPHS aims to provide more comprehensive services to the Liberian people while focusing on strengthening certain key areas that continue to perform weakly in the current system.

In 2015, the national policy on Community Health Services was revised to fully reflect the community health components of the National Health Plan. The *Revised National Community Health Services Policy* also encompasses the community health elements outlined in *the Investment Plan for Building a Resilient Health System in Liberia 2015 – 2021* (Investment Plan). The Investment Plan aims to restore gains in strengthening Liberia's health system and health services that were lost due to the Ebola Virus Disease (EVD) crisis, to provide health security by reducing risks due to epidemics and other health threats, to accelerate progress towards universal health coverage by improving access to safe and quality health services, and to narrow the equity gap for Liberia's most vulnerable populations.

Approximately 29% of Liberians, and 60% of rural Liberians, live more than one-hour walk (5 kilometers (km)) from the nearest health facility[1]. Community-based services are vital to the health and wellbeing of these communities. Additionally, the recent Ebola epidemic in Liberia and across West Africa highlighted the critical role that communities play in addressing their own health needs and changing their own health behaviors.

The Community Health Services Division (CHSD) of the Ministry of Health (MOH) is responsible for ensuring access to basic health services at the community level. In order to provide these services, the division is coordinating and collaborating with County and District Health Teams (CHTs and DHTs) as well as other MOH programs, partners, and communities to scale up community health activities in all of Liberia's 15 counties.

A key feature of this revised policy is the institution of a new cadre of Community Health Assistants (CHAs), who will be selected from and serve communities located more than a one-hour walk (more than 5km) from the nearest health facility. For communities located within 5km of a health facility, a tailored package of services will be delivered by other community cadres. Through established criteria, prospective CHAs will be selected by their respective communities to undergo an integrated and standardized CHA training. Upon successful completion of the training, these individuals will be certified as CHAs. Throughout training and continuing after certification, CHAs will be supervised to deliver an integrated and standardized service delivery package—which includes curative, preventive, promotive, rehabilitative and palliative services as well as epidemic surveillance services—to households in their communities.

This *Revised National Community Health Services Policy* addresses all issues relating to community health services and systems raised in the National Health Plan and the Investment Plan to facilitate the attainment of the goals outlined in the EPHS. It draws upon the relevant sections of the *National Health Promotion Policy and Strategic Plan*, the *Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia* as well other Government of Liberia (GOL) policies related to community health.

[1] Liberia Demographic and Health Survey, 2013

Therefore, all partners and other programs implementing community health activities in Liberia shall adhere to this revised policy.

Vision

The MOH's vision for Liberia's National Community Health Services is a coordinated national community health care system in which households have access to life-saving services and are empowered to mitigate potential health risks.

Overall Goal

The overall goal of the *Revised National Community Health Services Policy* is to extend the reach of the country's primary health care system via an integrated and standardized national community health model that can provide a package of essential life-saving primary health care services and epidemic surveillance within communities and to households on an equitable basis.

Guiding Principles

The priorities and recommendations laid out in this policy document are guided by the following principles:

- Health and gender equity – to ensure access and utilization of quality health services for vulnerable, hard-to-reach, key, and disadvantaged populations;
- Promotion of safe, quality health services (SQS) with emphasis on infection prevention and control (IPC);
- Decentralization – as a means of increasing the efficiency of public service provision and the responsiveness of services to local needs by stepping down management responsibilities from central level;
- Community Engagement and ownership of health – a people-focused approach that acknowledges the fact that people's knowledge, attitudes, and practices are important driving forces for social change will be utilized for planning and implementing community health services; and
- Networking and integration of services at all levels of the health care system.

Priorities of the Policy

The policy prioritizes the reduction of maternal, neonatal, infant, and child morbidity and mortality as well as the prevention and control of both communicable diseases and diseases related to malnutrition and poor living conditions. The following approaches will be used:

- Conducting health promotion;
- Deploying and supporting a motivated, fit-for-purpose cadre of CHAs;
- Empowering individuals and households to engage in safe family and environmental health practices.

Policy Objectives

The core objectives of the National Community Health Services Policy are to:

1. Strengthen community engagement and build the capacity of households to contribute to the reduction of maternal, neonatal, infant, and child morbidity and mortality and to address issues of public health concern;

2. Increase access to and utilization of a high-quality, standardized package of essential interventions and services, including IPC.

3. Strengthen support and governance systems for implementation of community health services;

4. Build human resource capacity for community health services via pre-service and in-service training, including IPC; and

5. Develop robust community-based surveillance and information systems linked with National Health Monitoring, Evaluation, and Research (HMER) systems.

Policy Objective 1: Strengthen community engagement and build the capacity of households to contribute to the reduction of maternal, neonatal, infant, and child morbidity and mortality and to address issues of public health concern;

A. Community Engagement and Community Support

The cornerstone for community engagement shall be communication with emphasis on dialogue between communities and stakeholders in the provision of health services.

Consistent with the National Health Plan, the EPHS has considerable focus on communication for demand generation and improvement in the provision of high-quality services to unreached communities. The emphasis is on community engagement practices that are evidence-based, client-centered, professionally developed, multi-channel, service-linked, and efficiently monitored.

The relationship between community health cadres and the community is critical. Accordingly, a key selection criterion for these cadres is that individuals must come from and reside in the communities where they serve. Therefore, community engagement is a necessary first step for the recruitment and deployment of the community health workforce and is vital to ensuring that community health achievements are sustainable. Communities shall be engaged, mobilized, and educated during the planning and implementation of the community health programs to:

- Identify socio-cultural barriers and prioritize evidence-based Reproductive, Maternal, Neonatal and Child Health (RMNCH) and adolescent health interventions for effective change in attitudes and behaviors;
- Identify, refer and report suspected diseases of epidemic potential utilizing MOH surveillance and reporting protocols;

- Participate in and take ownership of community health interventions, including IPC and community-led total sanitation (CLTS);
- Support treatment adherence and stigma reduction for priority diseases;
- Mobilize local resources to support health interventions; and
- Participate in planning, implementing, monitoring and feedback.

Community support requires an inter-sectoral, collaborative effort at all levels, especially between the MOH and Ministry of Internal Affairs (MIA).

B. Health Promotion

Community health cadres will carry out selected health promotion activities at the community level, including:

1. Community Engagement and Social Mobilization: Empower individuals, families, and communities in order to enable them to take control over their health through positive behavior change;
2. Interpersonal Communication: Conduct door-to-door awareness activities to sensitize community members about various interventions to prevent and promote good health, including IPC measures;
3. Health Education: Roll out health messages, actions, and other interventions at the community level to create demand and promote health through community participation/ownership and provide health promotion messages and materials to educate household members on the prevention of diseases and promotion of healthy lifestyles;
4. Advocacy: Strengthen collaboration with partners and community leaders for community engagement (addressing any community concerns, misconceptions, etc); and
5. Social Marketing: Promote various health commodities to increase uptake.

The CHSD and Community Health Cadres will work and collaborate closely with all relevant divisions for training on the use of various tools, job aids, and health promotion materials and messages.

Policy Objective 2: Increase access to and utilization of a high-quality, standardized package of essential interventions and services, including IPC.

The MOH will address barriers in access to care for remote populations in Liberia through coordinated engagement of a broad range of community health cadres and structures, described in Policy Objectives 2 and 3.

A. Community Health Cadres

In previous Community Health Services policies, the MOH recognized two community health cadres – general Community Health Volunteers (gCHVs), tasked with providing limited promotive, preventive, and curative services, and a broader group of Community Health Volunteers (CHVs) primarily engaged in health promotion activities.

In the post-Ebola Investment Plan, the MOH prioritized the establishment of a more robust cadre of community health worker in remote communities more than 5km from

nearest health facility. The World Health Organization (WHO) defines a community health worker as follows:

> *"Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, [and] should be supported by the health system."*[1]

In Liberia, the MOH has named this cadre Community Health Assistants (CHAs). The MOH will also continue to recognize CHVs, who will play an active role in community engagement and health promotion. gCHVs who meet CHA criteria can be selected by communities to fill the role of CHA. Otherwise, they can remain as CHVs.

Community Health Volunteers (CHVs) include:

1. Trained Traditional Midwives (TTMs)
2. Community Health Promoters (CHPs)
3. Community Directed Distributors (CDD)
4. Mass Drug Distributors (MDD)
5. Community-Directed Care Providers
6. Community-Based Distributors
7. Community Accompaniers
8. Natural Leaders for CLTS
9. Youth Peer Educators

Community Health Assistants (CHAs)

CHAs shall be community-based links to the health system—providing services in the community, assisting individuals and groups to access health services, and educating community members on health issues. Therefore, communities must be highly engaged in the work of CHAs from the start. Community Health Committees (CHCs), elected by the community with guidance from the catchment Health Facility and the CHT, form the basis of community interaction and participation in the health system. Accordingly, CHCs must be activated *before* CHA selection can begin and should oversee selection of CHAs. The TOR for CHCs is included in Community Health Services Strategic Plan.

The general selection criteria for CHAs include the following:

- Must be a permanent resident in the community in which s/he serves;
- Must be between 18 and 50 years of age;
- Should be trust worthy and respected;
- Should be interested in health and development matters;
- Should be a good mobilizer and communicator;
- Should be available to perform CHA tasks;
- Should be physically, medically, mentally and socially fit to provide the required services, including walking long distances up to one hour or more to provide health services to people in their designated catchment area;
- Should have been involved in community project/s in the past;
- Should be able to demonstrate the ability to read and write, add, subtract and multiply in English and to successfully complete a test of literacy as part of their recruitment process;

[1] World Health Organization (2007), Geneva. Community Health Workers: What do we know about them.

- Fluency in the dialect that is spoken in the village or town where s/he is serving;
- Must be a Liberian; and
- Females should be given preference.

B. Roles and Responsibilities of CHAs

CHAs shall be supervised to deliver an integrated and standardized service delivery package, which includes preventive, curative, promotive, rehabilitative and palliative services and epidemic surveillance to households located more than a one-hour walk (>5km) from the nearest health facility.

The roles and responsibilities of CHAs shall include:

1. Household visits on a regular basis, ensuring each household in the catchment area is visited at least once a month;
2. Referral of cases requiring further management to health facilities and follow up;
3. Integrated disease surveillance and response (IDSR) – including Community Event-Based Surveillance (CEBS) – and disease prevention and control (DPC) activities;
4. Home-based services in:
    a. Reproductive health, including family planning, antenatal health, neonatal health, post natal health;
    b. Child health; and
    c. Nutrition;
5. Integrated Community Case Management (iCCM) for malaria, acute respiratory infection (ARI) and diarrhea with bi-directional referral system;
6. First aid;
7. Prevention, health education and promotion, and referral for communicable and non-communicable diseases;
8. Mental health; and
9. Health and hygiene promotion, and environmental sanitation.

Annex 1 outlines a full description of the Community Health Program Service package.

In addition to the direct service package described above, community health services should be fully integrated into outreach services at the following levels:

- Health Facility: Under the supervision of the Officer in Charge (OIC) of the health facility, the Certified Midwife (CM)/Registered Midwife (RM) and any other relevant health facility staff will coordinate with the Community Health Services Supervisor(s) (CHSS) at that facility for implementation EPHS-mandated outreach services within catchment communities located in remote and hard-to-reach areas.
- Community: CHAs shall be engaged to mobilize the community for outreach services and campaigns provided at the community level.

C. Geographic Coverage for Community Health Workforce

Beyond 5km from health facilities, CHAs shall provide an integrated package of preventive, promotive, and curative services. Efforts shall be made to upgrade eligible, qualified CHVs living in these communities. CHVs who do not meet the criteria or are not selected as CHAs shall continue to provide limited services beyond 5km and will be coordinated by the CHA that is working in their catchment area. Within 5km from health

facilities, CHVs will continue to provide limited services under the supervision of the health facility staff. The CHSS will be primarily dedicated to supervision of CHAs.

Community health cadres play several different functions within the broader health system and operate in varied settings:

> *Remote Areas:* One important function is to improve access to a limited set of evidence-based and high-impact interventions for the nearly 1.2 million persons living in households[1] located more than 5 km away or one hour walk from the closest health facility. These efforts are intended to encompass and complement a range of existing community-based initiatives, such as iCCM, CLTS, and CEBS, which aim to extend access to basic health services and promote ownership and mobilization around health-related matters.
>
> *Urban and Peri-Urban Settings:* CHVs can extend the continuum of care from the facility level to the household level via bi-directional referral mechanisms, surveillance, health promotion, outreach, and accompaniment of specified patient populations located within 5km of a health facility.

D. Household Coverage for Community Health Cadres

The established ratios for the community health cadres are:

1. One CHA to 40 – 60 households (up to 350 Population)
2. One CHV to 40 – 60 households (up to 350 Population)
3. Two TTMs to 40 – 60 households (up to 350 Population)
4. One Accompanier to 6-10 patients (not population-based)

Community Health Cadres will provide support at the level of the household. A household is defined as one or more people who live in the same dwelling place and also share meals or living accommodation. One CHA will provide the approved MOH integrated and standardized service delivery package to 40 – 60 households. However, in sparsely populated areas with walking distances greater than one hour between villages and/or villages with population less than 350, the minimum number of households will be reduced to ensure each community has at least one CHA available.

In urban and peri-urban areas, it is at the discretion of CHTs and DHTs to adjust the ratio of households to community cadres as needed.

Policy Objective 3: Strengthen support and governance systems for implementation of community health services.

Once community health cadres are recruited and trained, it is vital that they are:

- Supplied with the necessary equipment, medicines and other tools to perform their duties;
- Supplied with visibility materials (ex. identification cards) as prescribed by the MOH;
- Supervised and mentored for continuous quality improvement and assurance;

[1.] 2013 Annual Health and Social Welfare Report, Ministry of Health and Social Welfare, 2013

- Provided with appropriate remuneration and motivation or incentives; and
- Encouraged to continue their participation in the health workforce via career pathways and retention schemes.

A. Incentive

In contrast with other community health cadres, CHAs are expected to provide ongoing, continuous access to a standardized, integrated package of community health services at the level of the household. To commit CHAs to remain in their communities and dedicate a portion of every day to performing their role (an expected average of four hours per day), CHAs shall receive a base monthly incentive of seventy United States Dollars (70 USD)[1]. While CHAs are entitled to a monthly incentive, they are not civil servants.

The MOH shall ensure all partners and other programs implementing community health activities in Liberia adhere to this revised incentive package.

B. Motivation

Community Health Cadres may also receive other forms of motivation, both monetary and non-monetary, such as transportation, gifts in-kind, employment and advancement opportunities, involvement in national campaigns, and recognition events. Furthermore, communities themselves shall seek ways to recognize and actively encourage the efforts of community cadres.

CHVs are not entitled to any fixed, monthly compensation. However, when CHVs are engaged in project-specific initiatives, such as immunization campaigns, mass Insecticide Treated Nets (ITNs) distribution, or directly observed therapy short course (DOTS), monetary and non-monetary mechanisms of motivation may be considered:

- For programs wishing to incentivize community health cadres for campaigns, daily disbursement shall amount to 5 USD per day, not exceeding 10 days per month.
- For programs wishing to incentivize community cadres for ongoing, specialized, routine activities, community cadres shall receive a flat rate of up to 50 USD per month (commensurate to workload) or compensation at rates established prior to 2015, not exceeding those of CHAs.

C. Performance-Based Incentives

For all cadres, performance-based incentives, linked to monitoring and evaluation systems, shall be designed and implemented by the MOH and its partners. The goal of these schemes will be to identify mechanisms to improve and direct CHA and CHV performance and provide consideration for specialized functions. Performance-Based Incentive schemes shall be piloted, adapted, and scaled up based on results and lessons learned. MOH shall ensure continuity of any such incentive provisions.

D. Career Development and Retention

[1]Or its Liberian Dollar Equivalent

The CHSD, in collaboration with the Health Promotion Division (HPD) and the Environmental and Occupational Health Division, will work closely with the Human Resources Unit within MOH, as well as other relevant stakeholders such as the Civil Service Agency (CSA) and the Ministry of Education (MOE), Ministry of Youth and Sports (MYS), Ministry of Internal Affairs (MIA) and Ministry of Gender, Child and Social Protection (MGCSP) to develop an integrated career development plan for CHAs that creates a pathway for continued learning and advancement for motivated CHAs while also encouraging retention of these individuals within the health sector.

The involvement of communities and their leaders plays a critical role in empowering and retaining CHAs. Communities should ensure continuous engagement with and participation in CHA activities.

E. Supply Chain and Logistics

The provision of adequate quality-assured medicines, supplies, and logistical support is critical for ensuring Community Health Services (CHS) activities proceed smoothly without interruption as well as facilitating the attainment of desired health outcomes at the community level.

The CHSD of the MOH shall therefore:

- Ensure that national supply chain and commodity documents are reflective of the latest international guidelines and protocols for community health programs and, similarly, that curriculum and SOPs for CHAs are aligned with national protocols;
- Ensure the full integration of the community supply chain into the existing national supply chain;
- Ensure that all key pharmaceutical policy documents incorporate CHA supply chain requirements;
- Ensure that all materials intended to facilitate CHA activities are delivered to CHAs through a clearly defined framework within the health facility;
- Work closely with the Supply Chain Management Unit (SCMU) to ensure medicines, medical supplies, and other logistic needs for CHAs are adequately quantified at the national level, based on county needs, and are supplied to health facilities in a timely manner to prevent stock-outs at community level; and
- Ensure that oversight responsibilities for rational utilization are clearly delineated to the responsible pharmaceutical arm of the MOH and in coordination with county level administration.

F. Supervision

Supervision is critical for ensuring an acceptable level of performance and motivation for CHAs, as well as for ensuring strong linkages between community and facility-based services. Community Health Services Supervisor(s) (CHSS) shall be assigned to the health facility and supervised by the OIC. CHSSs are required to be a professionally trained health worker (Registered Nurse (RN), Physician Assistant (PA), CM/RM, Environmental Health Technician (EHT)). The CHSS shall provide field-based supervision to CHAs working in remote catchment communities of the health facility. One CHSS shall supervise up to 10 CHAs. For health facility catchment areas with more than 10 CHAs operating, additional CHSSs shall be recruited. As stated above, CHVs

providing services within 5km of the health facility shall fall under the supervision of health facility staff.

Supervision shall focus on those activities and tasks that are most important for the CHAs as well as the health of the communities they serve. Supervision is intended to facilitate improved quality of services delivery by the CHAs to their respective communities. Supervision shall also enable continuous monitoring and data collection and serve as a mechanism for other critical support functions such as re-supply of commodities for service provision.

Integrated and standardized Supervisory Checklists and Tools shall be developed and used for the supportive supervision of all community health activities. The CHSD shall ensure strict adherence to the utilization of these Checklists and Tools.

G. Institutional Framework for Policy Implementation

1. **Central Level:** The MOH maintains a stewardship role for the implementation of the National Community Health Services Policy. At the central level, the CHSD is responsible for coordinating the implementation and monitoring of the Policy. The CHSD will be tasked with:
   a. Developing and disseminating CHS policy, strategies, guidelines, standardized training package, protocols and reporting tools.
   b. Ensuring that the implementation of all community health services and activities complies with the standards laid out by the MOH.
   c. Coordinating all community-based interventions implemented by partners and stakeholders, including other programs/divisions and units within the MOH.
   d. Identifying priorities and gaps in the implementation of the policy and mobilizing resources to address these needs.

2. **County Level:** The Community Health Department of each CHT shall be responsible for integrating all community health activities into their county operational plan. The Community Health Department Director (CHDD) shall be responsible for coordinating and overseeing the implementation of all community health activities captured under this policy, in consultation with the County Health Officer (CHO). The Community Health Focal Person (CHFP), assigned by the CHT, shall work under the supervision of the CHDD to coordinate all community health activities in the county. The Terms of Reference (TOR) for the CHFP is included in the Community Health Services Strategic Plan.

3. **District Level:** At the district level, District Health Officers (DHOs), along with the DHTs, shall ensure the coordination, collaboration, and supervision of community health services and activities at facility and community level.

4. **Health Facility Level:** The OIC is responsible for coordinating all health-related activities in all catchment communities for each health facility. Health Facility Development Committees (HFDCs), formerly known as Community Health Development Committees (CHDCs), shall meet monthly at the health facility to discuss community health activities and facilitate strong links between the health facility and catchment communities. HFDCs shall report to the applicable district-

level community development structure as specified by the MIA. The TOR for the HFDC is included in the Community Health Services Strategic Plan.

5. **Community Level:** CHCs, which exist in each catchment community, are responsible for coordinating all health-related activities for each catchment community and reporting to the HFDC. The TOR for the CHC is included in the Community Health Services Strategic Plan. CHCs and community members shall also directly engage with and encourage health activities.

6. **Other Line Ministries, Development Partners and Civil Society Organizations;**
   a. MIA: In accordance with Liberia's move towards decentralization and inter-sectoral collaboration for development, Community Health Structures (CHCs, HFDCs) will be accountable to the applicable district-level community development structure, under the direct supervision of the local authority of the MIA.
   b. MOE: The MOE shall take the lead in providing quality education to the Liberian people, so that potential community health cadres are able to read and write, function in their roles, and access further training in the health sector. Particular emphasis shall be placed on girls' education to narrow gender gaps in terms of literacy, access, and retention. Furthermore, MOE shall work with relevant training institutions to support the integration of community health content in existing, pre-service health training programs as well as potential, subsequent accreditation of CHAs.
   c. MYS: As the lead ministry involved in youth empowerment, MYS will collaborate with MOH in integrating CHAs with the National Youth Empowerment Program.
   d. MGCSP: MGCSP shall work to ensure women are represented and engaged in leadership positions and decision-making processes related to community health. MGCSP shall also work in collaboration with MOE and MOH to encourage the recruitment and retention of females within the community health cadres.
   e. Legislature: The Legislature shall declare health equity as a national development priority and ensure the sustainability of community health activities through the allocation of county and national budget support – including the possibility of a pooled funding mechanism. They shall also support the enactment of legislation that promotes improvements in the health of communities.
   f. Civil Society: Civil society, including community based organizations (CBOs) faith-based organizations (FBOs), local non-governmental organizations (NGOs), shall advocate for the establishment of a pool fund for sustaining the CHA program. Civil Society shall also function as an accountability mechanism to ensure the Ministries and other stakeholders fulfill their respective obligations. Finally, Civil Society shall work closely with community health cadres to facilitate implementation of community health activities, to strengthen community health structures, and to promote linkages between the community and health facility.
   g. Donors and Development Partners: To promote and ensure sustainability of community health program, donors and development partners and advocate with and support the GOL to establish innovative financing mechanisms.

Donors and partners shall also provide technical and financial assistance for policy and program implementation.

H. Integration

All vertical programs of the ministry shall collaborate with the CHSD to implement activities including meetings, trainings, monitoring, supervision, community engagement, etc. The CHSD shall coordinate closely with focal persons of these vertical programs to ensure that policies, strategies, and plans are shared and harmonized to avoid duplication and facilitate the efficient utilization of available resources. Program alignment shall also be carried out at county level.

Policy Objective 4: Build human resource capacity for community health services via comprehensive pre-service and in-service training, including IPC.

A. Pre-Service Training

CHA Training Package: An integrated and standardized training package shall be developed and used for training of CHAs. The package shall include promotive, preventive, and curative services as well as modules on logistics, monitoring, and surveillance.

CHA Training Requirements: CHA candidates must be nominated by their communities, through the work of CHCs, using established selection criteria. In order to become a CHA, candidates must undergo and successfully complete the MOH integrated and standardized training modules, regardless of their previous functions or trainings as CHVs. Before deployment, CHAs must demonstrate a minimum level of core competency, as measured by established skills check tools that are included in the training package and administered by the CHSS. Similarly, CHAs may not progress to the next training module without demonstrating mastery, via supervision tools, of the content and skills upon which they have been previously trained.

CHSS Training Package: CHSSs must be a professional health worker (RN, PA, RM/CM, EHT). A specialized training package, with emphasis on supply, operations, monitoring, and supervisory functions shall be developed to provide additional essential skills for successful program management, quality supervision, and coordination with planned outreach services. CHSS training will also include sessions on facilitation skills and relevant technical content for CHA-level service provision, as CHSSs will serve as trainers of CHAs. OICs and the CHFP shall also undergo the CHSS training to enable them to provide oversight to the CHSS and the CHA program respectively.

CHV Training: All CHVs shall receive training in principles of community engagement and mobilization; health promotion and education; and referral. Specialized programs working with CHVs shall utilize standardized training modules in their particular area of focus in coordination with the relevant MOH divisions.

B. In-Service/Refresher Training

In-Service/Refresher training interventions will be focused on findings from supportive supervisory field visits, as well as training needs assessments. These periodic training

interventions will be conducted to appropriately address identified gaps and reinforce evidence-based best practices. In-Service/Refresher training should occur at least twice per year.

Policy Objective 5: Develop robust community-based surveillance and information systems linked with National HMER systems

A. Monitoring and Evaluation

Monitoring will be a continuous process, and information will be collected on activities implemented and results achieved by CHAs. Data generated through the monitoring process shall be used for informed programmatic decision-making at all levels.

The CHSD, together with the HMER Unit, shall:

1. Update and maintain an integrated and functioning community-based information system (CBIS);
2. Strengthen and maintain functioning of monitoring and review mechanisms;
3. Ensure timely and ongoing integration with the Human Resources Information System (iHRIS) in order to capture community health workforce information;
4. Collaborate with the SCMU to create standardized community logistic and supply chain management forms that will feed into Liberia's Logistics Management Information System (LMIS);
5. Initiate appropriate corrective actions, including mentoring and coaching**,** where data indicate a gap in the delivery of services.
6. Strengthen the set-up of the CEBS system as part of IDSR activities;
7. Document best practices and lessons learned during implementation; and
8. Conduct ongoing evaluation of programmatic effectiveness.

Integrated and standardized Community Health Services Monitoring and Evaluation Tools will be developed and used for the monitoring and evaluation of all community health activities, including CEBS activities and compliance with IPC standards. Adherence to the utilization of the integrated and standardized Monitoring and Evaluation Tool for the monitoring and evaluation of all community health activities shall be ensured. Data flow, analysis, and validation will be carried out in accordance with the protocols jointly defined by CHSD and HMER, in collaboration with the DPC unit. Furthermore, CHSD and HMER will monitor and ensure adherence to overall implementation standards set in this policy, and appropriate action will be taken to address identified deviations from national standards.

B. Operational Research

The MOH shall promote a culture of inquiry, documentation, and dissemination. Community health research shall endeavor to explore strategies, interventions, tools, and knowledge that can enhance the quality, coverage, effectiveness, and performance of the health system at the community level. To achieve this and ensure coordination of community research activities, the CHSD will work closely with the HMER Unit to carry out operational, programmatic, and result-oriented research.

The CHSD shall also collaborate with other autonomous institutions created to organize and conduct community-based research. All parties wishing to conduct community-health-related research must consult and receive authorization from the MOH and approval from the National Ethics Review Board.

The National Ethics Review Board will apply approved ethics guidelines and internationally accepted standards to determine the appropriateness of all community-health-related research. MOH and partners will support national, county, and community health service providers to participate actively in sub-regional, regional, and global exchanges in order to further community health and social welfare interests of the country, learning from the best practices of others, as well as sharing and documenting its own experience.

Annexes

Annex 1: Approved MOH Integrated and Standardized Service Delivery Package for Community Health Assistants (CHAs).

Annex 2: List of key supporting documents

A N N E X 1

Community Health Assistant (CHA) Service Package

CHAs shall be supervised to deliver an integrated and standardized service delivery package, which includes preventive, curative, promotive, rehabilitative, and palliative services and epidemic surveillance to households located more than one hour walk (more than 5km) from the nearest health facility.

PART ONE: CORE SERVICES (CORE PACKAGE)

1. General Activities for Service Delivery

i. Routine household visits, ensuring each household in the catchment area is visited at least once a month
ii. Health promotion including Infection Prevention and Control (IPC); Information, Education and Communication (IEC) and Behavior Change and Communication (BCC)
iii. Community engagement, coordination, and mobilization for all areas listed in service package

2. Integrated Disease Surveillance and Response (IDSR) and disease prevention and control (DPC)

i. Build relationships, communicate and coordinate with other community key informants, resource persons, and existing formal and informal networks for information dissemination and reporting
ii. Community mapping and population registration including birth recording
iii. Community death recording with special emphasis on maternal and neonatal death
iv. Identify priority diseases and event triggers as they occur in the community (CEBS), including early case detection through active case finding
v. Adherence to IPC standard practices and community awareness of general IPC principles.

3. Reproductive, Maternal, Newborn and Child Health

A. Reproductive Health

i. Family planning promotion, counseling, and service provision; referral for additional family planning counseling and services where needed

B. Maternal and Neonatal Health

i. Antenatal Care (ANC)
    a. ANC education and promotion and referral to health facilities for ANC visits
    b. Identification of danger signs in pregnancy and referral to health facilities
    c. Referral to facilities for deworming tabs, pre-natal vitamins and Insecticide-Treated Nets (ITNs)
    d. Birth planning and preparedness, including education on items needed for delivery and birth spacing

e. Awareness on elimination of Maternal-to-Child Health Transmission of HIV (eMTCT) and referral to facilities for identified HIV positive mothers (collaborate with HIV/eMTCT officers where available)
f. Treatment of malaria

ii. Home-based Maternal and Newborn Care
a. Post-partum home visits
b. Well-being check for mother and newborn
c. Identification and referral for maternal danger signs.
d. Identification and referral for neonatal danger signs.
e. Counsel about danger signs for mother and newborn, the need for prompt recognition and care-seeking, and advise on where to seek early care when needed
f. Promotion of essential care of the newborn and essential nutrition actions, including exclusive breastfeeding, supportive counseling, and troubleshooting of breastfeeding problems, referral when needed
g. Promote hygienic umbilical cord care, including chlorhexidine application, and skin care
h. Support for Kangaroo Mother Care (KMC) application
i. Identify and support newborns who need additional care (e.g. Low birth weight, sick, HIV-positive mother)
j. Provide birth spacing and family planning counseling
k. Promote birth registration and timely vaccination

C. Child Health

i. Integrated Community Case Management (iCCM) of:
a. Diarrhea including provision of Oral Rehydration Salts (ORS) and zinc
b. Pneumonia including provision of Amoxicillin and pediatric paracetamol
c. Malaria: referral of suspected cases if Rapid Diagnostic Tests (RDTs) are not available; confirmed case management with Artemisinin-Based Combination Therapy (ACT) for children under-five when RDTs are available and pre-referral treatment for severe cases; provision of pediatric paracetamol

ii. Community-based bi-directional referrals, particularly for newborns, for danger signs and other emergency cases

iii. Integrated outreach services including:
a. Vaccination drop-out tracing for all under-fives;
b. Under-five Vitamin A administration and de-worming during campaigns

D. Nutrition

i. Mid-upper arm circumference (MUAC) screening and referrals for malnourished children

ii. Nutrition education for caregivers and households, including: optimal nutrition for women, exclusive breastfeeding up to 6 months for infants, optimal complementary feeding starting at 6 months with continued breastfeeding to 2 years of age and beyond, nutritional care for the sick and malnourished

PART TWO: ADDITIONAL SERVICES (FULL PACKAGE)

1. **First aid**
    i. Principles of First Aid, including prevention and basic response

2. **Communicable Diseases**
    i. HIV/AIDS education and prevention messaging, and counseling for treatment adherence
    ii. Tuberculosis (TB) education and prevention messaging, and counseling for treatment adherence
    iii. Leprosy education, counseling, and referral
    iv. Awareness on stigma and discrimination

3. **Mental Health**
    i. Identification, referral, and monitoring of patients in the community with signs and symptoms of mental health disorders
    ii. Awareness on stigma and discrimination

A N N E X 2

Key Supporting Documents

This Revised Community Health Services Policy is part of a larger framework of the Liberia MOH, established to carry out system strengthening and build a resilient health care system. Furthermore, services delivered in the community must be integrated with other relevant MOH divisions, particularly health promotion. Therefore, users of this policy are advised to consult the following related documents:

National Health and Social Welfare Policy and Plan 2011 – 2021

Investment Plan for Building a Resilient Health System in Liberia 2015 – 2021

National Health Workforce Plan

Essential Package of Health Services

National Community Health Services Strategic Plan 2016 – 2021

National Community Health Services Operational Plan 2016 – 2017

National Community Health Services Implementation Guide

National Health Promotion Policy

Community Health Services Road Map

Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality

Guidelines for National Decentralization