Republic of Liberia

MINISTRY OF HEALTH

NATIONAL COMMUNITY HEALTH PROGRAM STRATEGY

2023-2027

March 2023

Forward

The Government of the Republic of Liberia has been championing the cause of the Sustainable Development Goals (SDGs) to ensure it achieves Universal Health Coverage (UHC) for all in Liberia through its different layers of the health care systems in collaboration with global actors. The community health program of Liberia currently serves as the foundation of the health care delivery system. This revised strategy (2023–2027) will provide coverage to communities that are accessible within 5 km to facilities that still lack basic health-seeking behavior and to communities beyond 5 km from the nearest health facilities with basic life-saving skills and health-seeking behavior change opportunities. The Community Health workforce is a crucial driver for health systems strengthening and disease outbreak preparedness and response.

The Liberia Ministry of Health has recognized the role of the community health workforce ranging from disease outbreaks to behavioral changes and increased facility referrals due to the presence of the Community Health Assistant (CHA) since 2016. This Strategy is sensitive to guide community health activities implemented by the government and its partners.

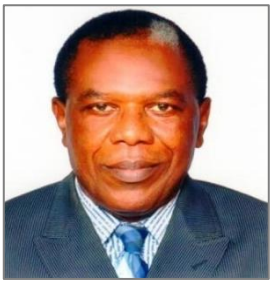
This Strategy aims to achieve its specific objectives by harmonizing and coordinating the implementation of the seven thematic areas of community health services to include well-coordinated leadership, governance, and community engagement structures; a fit-for-purpose community health workforce; a well-defined

community health service delivery by the community health workforce to improve health outcomes and strengthen active surveillance; a standardized training mechanism, and supervision processes; sustain and sufficient resources to fully fund community health service delivery; an efficient supply of commodities; and a national community-based information system, monitoring, evaluation and research to provide evidence and strengthening referral mechanisms.

The Strategy is developed through a consultative process involving all stakeholders from government ministries, MOH national programs and departments, divisions, county health teams, community health workforce and development partners (multilateral and bilateral) and implementing partners.

This policy shall be styled and known as the **National Community Health Program Strategy (2023–2027)**. This guide to the one Community Health Program has two approaches: **the CHA Strategy and the CHP Strategy**, for a robust implementation that will harness the achievement of Universal Health Coverage in Liberia. Therefore, we urge all donors, implementing partners, collaborating MOH programs and divisions, line ministries, and agencies to duly align to this policy for the smooth implementation of community health in the Republic of Liberia.

Hon. Wilhemina S. Jallah **MD. MPH, CHES, FLCP**
MINISTER



Acknowledgment

The Ministry of Health, on behalf of the Government of Liberia, extends its thanks and appreciation to the institutions and individuals who contributed to revising the National Community Health Program (NCHP) Strategy 2023–2027.

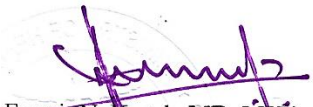
Our special recognition, thanks, and appreciation go to the following donors and implementing partners who provided technical and financial support to the revision of this NCHP Strategy: USAID, World Bank, UNICEF, International Rescue Committee (IRC), Last Mile Health (LMH), Partners in Health (PIH), EYElliance, and Community Health Initiative (CHI). Also, to those who made consistent technical input—WHO and Peace Corps, to mention a few., to our collaborating line ministries and agencies—the Ministry of Internal Affairs, Ministry of Youth and Sports, Ministry of Agriculture, Ministry of Gender and Children Protection, and the WASH Commission, we are indeed grateful for your collaborations and technical input as well.

We express our gratitude to the National Community Health Program, the Department of Planning and Policy, and other Divisions, Programs, and Units of the Ministry of Health. We also express profound thanks to the National Public Health Institute of Liberia for their full collaboration and the role played in developing this Strategy.

Finally, we would like to express our profound gratitude to a few individuals who made exceptional contributions towards the revision of this Strategy: Mr. S. Olasford Wiah, Director of the National Community Health Program, for his outstanding

leadership in driving the entire process; Hon. George P. Jacobs, Assistant Minister for Policy & Planning; Hon. Chea Sanford Wesseh, Assistant Minister for Vital Statistics; Mrs. Jannie M. Horace Shaikalee, Community Health Specialist of USAID; Mr. William E. Walker Jr., Deputy Director of National Community Health Systems: and Last Mile Health for its professional guidance.

Special thanks and gratitude to the senior management of the Ministry of Health under the stewardship of the Hon. Minister Dr. Wilhemina S. Jallah for creating the enabling environment for implementing community health services in Liberia.



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List of Acronyms

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CAHW	Community Animal Health Workers
CBIS	Community-Based Information System
CBO	Community-Based Organization
CEBS	Community Event-Based Surveillance
CHA	Community Health Assistant
CHC	Community Health Committee
CHO	County 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
CHW	Community Health Worker
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
HIV	Human Immunodeficiency Virus
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
MGCSP	Ministry of Gender, Children and Social Protection
MOA	Ministry of Agriculture
MIA	Ministry of Internal Affairs
MOE	Ministry of Education
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
MYS	Ministry of Youth and Sports
NCHP	National Community Health Program
NEHP	National Eye Health Program
NGO	Non-Governmental Organization
OIC	Officer-in-Charge
ORS	Oral Rehydration Solutions
PA	Physician Assistant
PLHIV	People Living with Human Immune Virus
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 Midwives
UHC	Universal Health Coverage
WHO	World Health Organization

Executive Summary

An essential element of the Revised NCHP Policy is **the institution of three recognized Community Health Workforce cadres in Liberia's health system – Community Health Assistants (CHAs), Community Health Promoters (CHPs), and Trained Traditional Midwives (TTMs)**. These cadres are selected by their respective communities and provided with appropriate training, are supervised to deliver an integrated and standardized service delivery package, which includes promotive, preventive, and curative services as well as epidemic surveillance, to all households located in all communities; ***both in communities beyond one hour walk (more than 5 kilometers (km) from the nearest health facility for promotive, preventive, curative and epidemic surveillance*** *and* ***communities within one hour walk of the closet health facilities for promotive, preventive and epidemic surveillance.***

The MOH's vision for the National Community Health Program is to expand access and delivery of high-quality services to all communities through a community health workforce managed by the government. This will be achieved through a coordinated national community health workforce in which households have access to life-saving services and are empowered to mitigate potential health risks.

The overall goal of the revised *National Community Health Program Policy* is to contribute to the reduction of morbidity and mortality through the provision of high-quality, cost-effective, standardized packages for community health services and to mitigate potential public health risks in all communities. Extend the reach of the country's primary health care system via an integrated and standardized national community health model

that can provide a safe package of essential life-saving basic health care services and epidemic surveillance to all communities and households on an equitable basis.

Chapter 1: Introduction

1.1 Background and Context

Based on the priorities outlined in the *Investment Plan for Building a Resilient Health System in Liberia* ***(Investment Plan)*** and the *National Health Policy and Plan 2022*, the MOH, with support from partners, revised the National Community Health Services (NCHS) Policy 2016-2021. Another element of this revised NCHP Strategy is **the institution of three recognized Community Health Workforce cadres in Liberia's health system – Community Health Assistants (CHAs), Community Health Promoters (CHPs), and Trained Traditional Midwives (TTMs).**

These cadres are selected by their respective communities, provided with appropriate training, and supervised to deliver an integrated and standardized service delivery package, which includes promotive, preventive, and curative services as well as epidemic surveillance, to households located more than one hour walk (more than 5 kilometers (km) from the nearest health facility and communities near facilities within one hour walk for promotive, preventive, and epidemic surveillance only. Trained professional health workers known as the **Community Health Services Supervisor (CHSS),** whose work will not only focus on providing supportive supervision but also ensure active mentorship, regular coaching, and the provision of selective services and interventions.

This NCHP Strategy 2023-2027 provides the strategic framework needed to ensure the full implementation of the NCHP Policy and execution of identified activities under the Strategic Investment Areas in the Investment Plan, most notably sustained community engagement and the fit-for-purpose, productive, and motivated health workforce.

The MOH expects all partners implementing community health activities in Liberia to align their programming to the NCHP Policy and Strategic Plan to ensure coordination, collaboration, transparency, and accountability and to avoid the duplication of most-needed resources.

Chapter 2: Situation Analysis

2.1 Overview of Community Health Systems

The community health landscape in Liberia reflects numerous efforts to move towards universal health coverage by enhancing access to essential life-saving services within the country's most remote communities. For over a decade, the community health program has been shaped by iterative policy reforms and the intervening Ebola outbreak. The 2008 National Policy and Strategy on Community Health Services was a post-conflict step towards coordinating community health worker (CHW) initiatives in Liberia, although gaps persisted. In late 2011, a pilot project was undertaken to evaluate a community-based HIV treatment model that relied on salaried, supervised, and trained CHWs to treat HIV. The pilot provided Liberia with model and advocacy tools for community health programming and commitments to upgrading community health programs. The reinvigorated Ministry of Health (MOH) officials were afforded—in part through the international community—the opportunities, network, guidance, and tools needed to restructure and scale the CHW Program that ultimately informed the 2016 Revised National Community Health Services Policy and led to the preparation of a Community Health Roadmap to outline a path to scale for CHW Programs in Liberia.

Notwithstanding, Liberia's experience with the Ebola outbreak highlighted the crucial roles played by communities in addressing their health needs. In 2015, with significant political prioritization and an immense sense of urgency to invest in a strengthened health workforce, the MOH began to mobilize a larger coalition of stakeholders in community health with an expanded Community Health Technical Working Group (CHTWG). Despite challenges around the alignment of differing agendas and priorities of the diverse stakeholders, the coalition ultimately developed the

Revised National Community Health Services Policy and planned for validation and endorsement in 2016.

Reform under the 2016 policy was the launch of the National Community Health Assistant (CHA) Program in July 2016, with remuneration for CHAs, a standardized approved MOH training package and supervision by a health professional called Community Health Services Supervisors (CHSSs). However, according to the Comprehensive Desk Review Report of December 2020, there were several challenges during the implementation phase of the National Community Health Assistant Program, including:

1. *The lack of commodity needs assessment at the onset impacted the supply chain.*
2. *The lack of MOH advocacy to increase government funding to the MOH to include support for the community health workforce.*
3. *The extended salary delays in MOH directly run counties of the programs— leading to attrition.*
4. *The lack of recruitment of more female CHAs to correct the male gender bias; the partial inclusion of district health teams and health facility staff in the NCHAP implementation.*
5. *The lack of a clearly articulated government transitional plan to take over the funding of the NCHAP.*
6. *The lack of a replacement plan (strategy) for staff leaving; the poor quality of improvement activities by generating more data to assess quality through the development of supervision processes and tools for the District Health Team and health facility; and the protracted stock-outs of CHA commodities.*

2.2 Reproductive Maternal Neonatal Child and Adolescent Health

Despite the odds, Liberia has made significant progress in improving the health quality status of its population, particularly in the indicators of infant and under-five mortality. The number of births in health facilities increased steadily from 37% in 2007 to 80% in 2019–20. Conversely, home births dropped from 61% to 19%, and the number of births delivered by traditional midwives decreased from 48% to 15%. While the total fertility rate of 4.2 children per woman remains higher than the global average, the unmet needs for family planning decreased from 35.7% in 2007 to 31.1% in 2013 but increased to 33.4% in 2019–20. In addition, infant mortality rates reduced from 71 deaths per 1,000 live births in 2007 to 63 deaths per 1,000 live births in 2019–20; under-five mortality has also slightly changed from 94 deaths per 1,000 live births in 2013 to 93 deaths per 1,000 live births in 2019–20; Maternal mortality also dropped from 913 per 100,000 live births over the period seven (7) years to 742 per 100, 000 live births in 2019–20.

Immunization coverage also increased dramatically from 39% of children ages 12–23 months in 2007 to 65% in 2019–20, with only 5.8% of children aged 12–23 months not receiving any vaccinations. According to the LDHS (2019) report, vaccination coverage among children aged 12-23 months and 24-35 months shows that 65% of children aged 12-23 months have received all vaccinations, while only 40% have received all age-appropriate vaccinations. Six percent of children aged 12-23 months have not received vaccinations of any kind. Among children aged 24-35 months, 31% have received all age-appropriate vaccinations. For children aged 12-23 months, basic vaccination coverage is higher among boys than among girls (67% versus 63%). Additionally, basic coverage is higher in urban than rural areas (66% versus 63%) and lowest in the Southeastern A region (54%) but highest in

the Northwestern region (72%). By county, basic coverage is high in Lofa (78%) and low in Sinoe (46%). In the case of multi-dose vaccines, coverage rates are highest for the first dose and decline for subsequent doses.

Despite these significant gains, major public health challenges remain, primarily in preventable communicable diseases, maternal and under-five morbidity, and malnutrition. In Liberia, the leading causes of under-five mortality are malaria, acute respiratory infections, diarrheal diseases, and malnutrition.[1] The magnitude and relevance of non-communicable diseases have also been on the rise, while the proportion of pregnant women receiving a postnatal care visit in the first two days after birth increased from 70% in 2013 to 80% in 2019-20. In 2013, an estimated 29% of women did not receive any postnatal care 2013. The country had one of the highest maternal mortality rates globally (742 per 100,000), with the major causes of maternal deaths attributable to preventable and treatable complications, such as hemorrhage, hypertension, unsafe abortion, and sepsis. About 30% of under the age of five live stunted; 10% are severely stunted; 3% are wasted; 1% are severely wasted; 11% of children are underweight, and 3% are severely underweight. [2]

Since its launch in July 2016, CHAs have treated nearly 1.76 million malaria, diarrhea, and pneumonia cases, conducted over 800,000 malnutrition screenings, and had over 7.8 million home visits - including 380,146 pregnancy visits. As of January 2022, 4,753 CHAs and 435 CHSSs have been trained, equipped, deployed, and incentivized in communities across the 15 counties. However, there remains a diverse number of CHVs across MOH programs for which this policy shall integrate into a new cadre

[1] Liberia Demographic and Health Survey, 2019-20

[2] Ibid

called the Community Health Promoters (CHPs) and fully address the TTMs' roles in collaborating with the CHAs and CHPs.

2.3 Gender Mainstreaming

According to the Liberia 2008 Population and Housing Census, women comprised 50% of the overall population and 49.1% of the rural population. The census also identified high illiteracy among the rural population, particularly among women, for numerous reasons ranging from cultural background, access to school and education, early marriage, and teenage pregnancy, among others, leading to inadequate female participation in developmental activities, especially those that are health and health related.

During the program's 2016-2021 implementation phase, only 18% of females were recruited to serve as CHA - which needed gender sensitivities. To tackle gender equity in NCHAP, we need to create awareness about gender-specific services and clearly define the role of women in the community health workforce during the recruitment process.

Confidentiality and privacy are also vital to women in certain health-related services and are often missing due to the unbalanced gender health workforce. This gap needs to be addressed in the service provision of the National Community Health Program of Liberia to meet the needs of clients' desires for a particular gender-specific service.

This policy shall address various approaches to render gender-sensitive services and increase awareness of gender barriers in communities. The services accessed by women and girls must check for any obstacles, deterrence, and disenchantment. Biases from facilities utilization against females are addressed on an ongoing basis.

Data gathering during recruitment of the community health workforce and establishing community health structures shall disaggregate by sex. There shall be gender-based indicators review on an ongoing basis. Data shall be collected and reported by gender disaggregation for future decision-making to close the gap in health equity between genders at all levels. Females will be prioritized for recruitment of all Community Health Workforce in Liberia unless otherwise indicated by the prevailing situation and the selection criteria at the time of recruitment.

Chapter 3: Strategic Framework

3.1 Mission

The mission of the Ministry of Health is to transform the health sector into an effective, efficient, and equitable system for quality health services delivery toward the attainment of universal health coverage and health security.

3.2 Vision

The National Community Health Program's vision is to expand access and delivery of high-quality services to all communities through a community health workforce managed by the government.

3.3 Goal

The goal is to contribute to the reduction of morbidity and mortality through the provision of high-quality, cost-effective, standardized packages for community health services and to mitigate potential public health risks in all communities.

3.4 Strategic Objectives

3.4.1: Priority Area 1: Leadership, Governance, Community Engagement & Empowerment

Strategic objective: *To strengthen community leadership and governance systems to support the implementation of all community health services and interventions through community mobilization, engagement, and training.*

Strategic Approach:

1. By the Local Governance Act, the MOH should work with other ministries and government agencies, such as the Ministry of Internal Affairs, to ensure that the program's leadership, governance, and community engagement are implemented and strengthened.
2. Beyond the national level, the institutional capacities of all structures (county, district, facility, and community) are also crucial for the effective design, ownership, accountability, and governance of the National Community Health Program.
3. To maintain momentum and support, policymakers (including national stakeholders and key decision-makers at the community, district, and county levels) must be provided with evidence-based information for decision-making and advocacy regarding core program areas.

Key Interventions and Activities

1. **Ensure community engagement and ownership through strengthening community structures, networks, and linkages.**

Key activities:

- Conduct mapping of community stakeholders and activation and or reactivation of community structures across the country as per the policy.
- Develop a digital database for existing community health structures.
- Maintain active CHC and HFDC by conducting monthly meetings with documented minutes that identify community health issues that can elevate to the district level for redress.
- CHC and HFDC to lead implementation and monitoring of action plans designed to improve community health, in

close collaboration with CHWs and other community health structures.

- Community structures and CHWs work collaboratively on effective, evidence-driven social and behavior change approaches for relevant health-promoting behaviors in support of the essential health services delivery package.
- Community structures and CHWs to conduct community engagement, projects, and mobilization within their communities in support of essential health services.
- HFDC presents community health issues during the regular district health board review meetings for resolution (raising to county level or central level as applicable).

2. Build capacity of CHC and HFDC structures as per the Policy.

Key activities:

- Orient CHCs and HFDCs on their roles and responsibilities, the standard operating procedures, meeting management tools, and other guidance in line with the national community health policy and MOH's Decentralization Leadership and Governance Guidelines
- CHTs and DHTs conduct Joint Integrated Supportive Supervision and provide mentorship and coaching for CHCs and HFDCs based on gaps identified.

3. **Strengthen community accountability systems at all levels**.

Key activities:

- HFDC to conduct community client satisfaction checks on the quality of care delivered at the health facility.
- HFDC to implement Community Scorecard appraisal to identify areas of improvement
- Establish mechanisms for CHCs to solicit community member feedback and conduct satisfaction checks on community health issues
- Conduct District and Community Quality Improvement Projects identified through community structures meetings and JISS.

3.4.2: Priority Area 2: Community Health Workforce

Strategic objective: *Strengthen human resource capacity for the community health workforce to improve service delivery through pre-service training; institutionalization of NCHP training curriculum in health training institutions for career advancement; in-service training; refresher training (competency-based modular training package) and mentorship for technical capacity building skills transfer.*

Strategic Approach:

Recruitment of all CHSS, CHAs, and CHPs within the community health workforce will follow a rigorous process focusing on gender mainstreaming and significant community engagement and ownership per the policy. They will undergo comprehensive, standardized pre-service and in-service training. The remuneration specified in the NCHP SOP (2023 – 2027) will complement non-monetary schemes such as motivation packages

and career development opportunities. MOH and its partners may endeavor to pilot performance-based incentives and ensure the continuation of incentive provisions.

Key Interventions and activities

1. **Recruit and incentivize CHSS, CHAs, CHP, and TTMs (where applicable) as outlined in the NCHS Policy.**

Key activities:

- Conduct gap analysis on the community health workforce in the fifteen counties.
- Recruit additional CHAs and CHSSs based on the gap analysis.
- Recruitment of CHPs where applicable for gradual scale-up.
- Collaborate with Family Health Division to select TTM in the 15 counties per policy.
- Provide incentives for all CHAs and CHSSs to improve performance, retention, and time spent in the community.

2. **Address gender disparity in the community health workforce.**

Key activities:

- Ensure NCHP SOPs are gender sensitive to address recruitment and training challenges to enhance female participation in the implementation of the NCHAP at the community level
- Collaborate with appropriate line ministries to prioritize female community health workers in their national adult literacy programs

3. **Develop a career development plan for community health workers.**

Key activities:

- Develop the Community Health Workers' needs assessment tools
- Conduct training needs assessment amongst Community Health Workers.
- Develop a career plan, identify, and select beneficiaries through a comparative vetting process,
- Develop county-specific MOU on career development pathways.
- Conduct advocacy on resource mobilization to support the CHW career plan.

4. Incorporate community health workforce in National Human Resource Policy/SOP.

Key activities:

- Placement of all CHSS on GOL payroll,
- Revision, dissemination, and rollout of the updated CHW Human Resource Policy/SOP.
- Develop or update the job description of CHTs staff where applicable to include the community health workforce.

5. Certification of Community Health Workforce.

Key activities:

- Provide Community Health Workforce (CHSS, CHA, CHP, TTM) with an approved certification of completion of the MOH standardized approved pre-service training package.
- Respective CHT and governance systems will issue the certificates. NCHP will develop a standardized certification format.

3.4.3: Priority Area 3: Community Health Service Delivery

Strategic objective: *To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with an emphasis on RMNCAH+N.*

Strategic Approach:

Trained and supervised CHWs will deliver an integrated and standardized service package, which covers preventive, promotive, and curative services, and epidemic surveillance to the households they serve, coupled with the referral of patients to primary health facilities as NCHP SOPs to ensure consistency. CHWs shall fully use all channels for referral to provide communities with access to high-quality community-based care as needed. Counter-referral systems will be strengthened, with facility staff trained to record and provide appropriate feedback and discharge instructions for patients to share with their CHWs. The referral pathway shall include data collection that informs community contribution to the overall access to service utilization and the documentation of outcome.

As evidenced by past disease outbreaks and responses, the community health workforce plays an essential role in community-based surveillance, community engagement, and infection prevention and control (IPC) services, which are key components of the service delivery package. High-quality, consistently applied IPC measures and Water, Sanitation, and Hygiene (WASH) practices will also help to prevent and contain future outbreaks.

Key Interventions and activities

1. **Increase delivery and coverage of standardized integrated community-based health services.**

Key activities:

1. Expand the scope of the community health services to include services as needed.
2. Increase demand and utilization of the standardized integrated package of Community Health Services.
3. Strengthen referral pathways and linkages between the communities and health facilities.

4. Operationalize workload based on population, services and interventions
5. Revised existing curriculum and SOPs and developed SOPs for new services.
6. Strengthen the capacity for of CHWs for services delivery through training, mentoring, coaching, refresher training.

A. Community Engagement and Empowerment (Module 1)

1. Conduct annual community profiling (household mapping and registration)
2. Conduct routine household visits
3. Conduct health promotion, health education, and social behavior change intervention.
4. Conduct health outreaches and campaigns as required.
5. Conduct awareness on WASH Services within the community using the CSTS approach

B. Integrated Disease Surveillance, Emergency Preparedness, and Response (Module 2)

1. Detect, respond and report suspected cases and events using the community cased based definition
2. Conduct contact tracing for suspected and confirmed cases at the community level
3. Conduct home-based monitoring, follow-ups, and psychosocial support
4. Collaborate with community structures to compose an emergency plan
5. Strengthen linkages for reporting events between the community and health facility

C. Reproductive, Maternal, Newborn and Adolescent Health+ Nutrition (Module 3)

1. Conduct counseling for (Family Planning, ANC, Birth Plan, Facility Delivery, PNC, Nutrition, Exclusive Brest Feeding,

Psychosocial Support, and Immunization)

2. Provide Family Planning Services at the community level including provision of OCP, injectable (Sayana Press) and condoms.
3. Identify, and refer for ANC visits, facility-based delivery, danger signs, and follow-ups.
4. Provide Sulfadoxine - Pyrimethamine (IPTp) for pregnant women for the prevention of Malaria.
5. Provide HBMNC within 48 hours upon returning to the community after facility delivery
6. Establish and support Mother-Support Groups at the community level using the integrated Big Belly Business concept.
7. Provide Adolescent Sexual and Reproductive Health Information and services
8. Provide Folic Acid supplementation for prevention of anemia for adolescent girls
9. Provide information, counseling, and referral pathway for SGBV/SH/SEA

D. Child Health + Nutrition (Module 4)

1. Provide Integrated Community Case Management (iCCM) Services (identify and treat cases of Malaria, Pneumonia, and Diarrhea for children under 5 years).
2. Provide testing and treatment for children ages 6-13 years for Malaria.
3. Identify children and mobilize communities for CHSS to conduct vaccine outreach services.
4. Conduct defaulter tacking to inform CHSS for community base routine immunization.
5. Provide counseling and routine MUAC screening for all children under 5 years.
6. Provide micronutrient powder, deworming, and Vitamin A

supplementation to children under 5 years

F. Communicable Disease (Module 5)

F1 Human Immunocompromised Virus

1. Conduct awareness and sensitization of HIV to reduce stigmatization and discrimination.
2. Mobilize and conduct community-based counseling and testing (using first-line test; determinant) and ensure patient privacy and confidentiality; if positive, refer for confirmation.
3. Provide treatment buddy for PLHIV,
4. Conduct contact investigation and default tracking
5. Identify and refer suspected cases of HIV.
6. Conduct follow-up visits and refer using the community referral pathway for HIV.
7. Identify and refer clients presenting with medication side effects.

F2 Tuberculosis (TB)

1. Conduct awareness and sensitization of TB to reduce stigmatization and discrimination.
2. Mobilize and conduct community-based counseling and sputum collection for TB and ensure patient privacy and confidentiality.
3. Provide direct observation therapy (DOT) and treatment buddy services for TB.
4. Conduct contact investigation and default tracking
5. Identify and refer suspected cases of TB.
6. Conduct follow-up visits and refer using the community referral pathway for TB.
7. Identify and refer clients presenting with medication side effects.

G. Non-Communicable Diseases (Module 6)

G1 Mental Health

1. Educate, counsel, and mobilize for behavior change
2. Create demand to enhance the promotion of treatment and referral for mental, neurological, and substance use disorders.
3. Screen, refer, and accompany (treatment buddy) suspected clients for mental health services
4. Make follow-ups for treatment adherence, refill, and referrals
5. Identify and refer clients presenting with medication side effects

G2 Neglected Tropical Diseases (NTDs)

1. Educate, counsel, and mobilize for behavior change
2. Create demand to enhance the promotion of treatment and referral for NTD Cases.
3. Screen, refer, and accompany (treatment buddy) suspect clients for NTD Services
4. Make follow-ups for treatment adherence, refill, and referrals
5. Identify and refer clients presenting with medication side effects

G3 Eye Health

1. Conduct awareness and sensitization for eye health services
2. Conduct near vision screening and provide appropriate reading glasses
3. Identify eye health conditions as per the job aid and refer
4. Mobilize the community for eye health outreach services

G4 NCDs

1. Create awareness of diabetes and hypertension and make a referral for interventions
2. Follow-up with diabetic and hypertensive clients to ensure compliance with the treatment regimen
3. Provide health education on a healthy lifestyle

G5 Self-Care and First Aid

1. Provide first aid case management for bleeding, broken bones, burns, wound care, animal bite, poisoning, and choking using local materials and referrals.
2. Provide education and guidance on self- Care Interventions
3. Monitor and follow up to ensure compliance and refer for immediate care of health conditions that pose risks for the patients.

3.4.4: Priority Area 4: Community Health Training and Supervision

Strategic objective A: *To build human resource capacity for community health services via pre-service and in-service training; ensuring that all training modules are digitized, and the blended learning process incorporated*

Strategic Approach:

The integrated and standardized NCHP curriculum will be used to train the community health workforce. This package will be delivered through pre-service training to develop the workforce. Out of this curriculum, we will develop a tailored in-service training package for continual professional development. The MOH will work with health training institutions to integrate the NCHP Curriculum into formal education.

To ensure quality assurance and improvement, we will conduct routine supervision at all levels (Central, County, District, Facility, and Community) to attain and maintain high-quality delivery.

A standardized supervision tool will be utilized for supportive supervision at all levels. During supervision, CHWs will undergo mentoring and coaching to address knowledge and skills gaps.

Feedback mechanisms, proper documentation of lessons learned, best practices, success stories, and challenges will be strengthened at all levels.

Key Interventions and activities

1. **Train and deploy the community health workforce to deliver the essential package of Community Health Services**

   Key activities include:

   - Revise and develop a competency based integrated NCHP Curriculum and SOPs
   - Digitize the NCHP Curriculum (pre-service and in-service)
   - Provide training for all community workforce, using the revised competency based integrated NCHP Curriculum and SOPs
   - Certificate and deploy CHWs in areas of assignment
   - Provide in-service training for continual competency building

Strategic objective B: *Strengthen supportive supervision, mentoring, and coaching to ensure quality assurance and improvement at all levels.*

Key Interventions and activities

1. **Ensure Joint Integrated Supportive Supervision, mentoring, and coaching for quality assurance and quality improvement by national, county, and district supervisors.**

   Key activities include:
   - Revised the JISS tools and SOPs to reflect the NCHP services
   - Integrate overall community supervision tools into national eJISS
   - Conduct national level bi-annual eJISS (25% health facilities and 4 communities: 2 within and 2 beyond 5km per facility)
   - Conduct county-level quarterly eJISS (75% health facilities and 4 communities: 2 within and 2 beyond 5km per facility)
   - Conduct district-level monthly eJISS (100% health facilities and 6 communities: 3 within and 3 beyond 5km per facility)
   - Conduct QI activities at all levels

2. **Ensure Routine Supportive Supervision, mentoring, and coaching for quality assurance and quality improvement by CHSSs.**

   - Conduct monthly community-level routine supervision using the NCHP standardized supervision checklist for all catchment communities.
   - Conduct QI activities at the community level

3.4.5: Priority Area 5: Monitoring, Evaluation, Research, and Technology

Strategic objective: *To develop robust digital health tools and systems that will use community-based surveillance, information, and M&E systems to report high-quality data for use to improve program implementation fidelity at the community level and to engage in operational research and innovations to enhance the continued quality improvement of the program.*

Strategic Approach:

Quality information is crucial for programmatic decision-making and resource mobilization and allocation. Monitoring will include the systematic collection and analysis of program data to measure progress and make recommendations for corrective action using integrated and standardized data collection and reporting tools. Community-level service statistics and reporting shall feed into the Community Based Information System (CBIS), a sub-system of the National Health Information System (HIS).

Human resources levels and needs will be tracked through a community health workforce database (iHRIS), managed at the national, county, and district levels. Cost-effective and sustainable mHealth innovations will be harnessed to improve access to and quality of programmatic feedback where deemed expedient. Program implementation fidelity will be monitored through existent verification of mechanisms by CHSD the National M&E Unit; data quality will be assured through accelerated feedback and periodic integrated data quality reviews and audits using standardized tools and approaches.

Program effectiveness will be regularly assessed, and impact will be evaluated through commissioned formative, midterm, and end-line evaluations; reviews of community health research

priorities will be integrated into the National Health Research agenda and findings thereof will inform program adaptation and policy decisions. Regular feedback will be enhanced through an integrated performance review forum with key community health stakeholders at the community, district, county, and national levels.

Key Interventions and activities

1. **Update and maintain an integrated, functioning, and user-friendly CBIS.**

   Key activities:

   - Updating CBIS reporting tools and processes to reflect NCHP policy and strategy; modifications, strengthening mechanisms for data collection, analysis, utilization, and feedback at all levels,
   - Conduct routine facilitate coaching and mentorship, document and publish best practices and lessons learned during implementation,
   - Establish a functional CBIS/M&E Technical working group to provide technical guidance for the design and implementation of CBIS,
   - Build technical skills for software development and programming for dedicated technical staff.

2. **Increase access to high-quality care by strengthening bi-directional referral feedback systems tracking community and primary health facilities.**

   Key activities:

   - Improve and Standardize referral forms to assure ease of disaggregation by diseases and interventions,

- Develop sustainable, cost-effective innovative mHealth solutions for the real-time provision of bi-directional referral feedback across levels of care

3. **Improve project accountability and learning through robust monitoring, evaluation, and feedback mechanism**.

Key activities:

- Strengthen capacities for data management, analysis, information product generation, and use, and produce quarterly performance feedback or bulletin.
- Integrated and focused the training of M&E personnel in data management, analysis, presentation, technical briefing, report writing, program performance review, implementation fidelity monitoring, etc.

4. **Establish and maintain a community health workforce database at the national, county, and district levels.**

Key activities:

- Built a web-based tracking portal (i.e.: developing a Community Health Workforce Instance of the iHRIS database) to manage and report progress on training, deployment, attrition, and other indicators of interest.

5. **Establish and implement community health services operational research agenda:**

Key activities:

- Collaborate with the HMER to ensure that the National Community Health research priorities are incorporated into the National Health Research agenda and, where applicable, protocols and clearance are obtained, build a partnership for community health research design and implementation, and publish research findings of international standards.

6. **Conduct a mid-term evaluation and programmatic review (5 years) and an end-line or comprehensive evaluation (10 years)**

Key activities:

- Conduct midterm evaluation of the Policy
- Conduct midterm evaluation of the strategy
- Conduct end-line evaluation of the Policy
- Conduct end-line evaluation of the strategy

7. **Strengthen and scale up Digital CBIS activities.**

Key activities include:

- Develop and implement digital CBIS tools that incorporate mHealth reporting by CHWs that promote bidirectional feedback systems,
- Advocate for partnership with network providers to expand coverage in areas with CHWs,

- Employ context-based solution for mobile health reporting (internet transfer, SMS, Bluetooth transfer),
- Develop and implement cost recovering strategy for asset management and security of mHealth gadgets for CHWs.
- Introduction of real-time digital reporting by Community Health Workforce.

3.4.6 Priority Area 6: Community Health Supply Chain Systems

Strategic objective: *To strengthen community health commodity availability and accountability at all levels— using standardized approaches in the supply of community health commodities; ensuring timely reporting of logistics data (consumption, stock on hand, losses and adjustment, days stock out), and linking CHWs' restock and logistics data with the eLMIS at the health facility, district, county, and national levels.*

Strategic Approach:

Providing adequate, quality-assured community health commodities and logistical support for the continuous implementation of the community health services program. The community health commodities will be integrated into the national supply chain system and aligned with existing policies and plans.

Key Interventions and activities

1. **Strengthen integration of the community health supply chain into the national supply chain system**

   Key activities:

- Update the community health supply chain SOP to align with the national supply chain master plan for use by all counties and supporting partners.
- Update, print, and disseminate SOP, Guideline for forecasting and quantification of the Community Health Commodities
- Revise and digitize Community Health Supply Chain data collection, reporting, quantification, and forecasting tools

2. **Ensure availability of essential community health commodities at service delivery points.**

   Key activities:

   - Conduct annual quantification for community health commodities
   - Procure and distribute community health commodities

3. **Build capacity on community health commodities management and safety at all levels.**

   Key activities:

   - Develop and update training materials for community health commodities management and safety
   - Conduct training on community health commodities management and safety
   - Provide appropriate storage facilities for community health commodities at all levels

3.4.7: Thematic Area 7: Community Health Financing

Strategic objective: *To develop a costed plan or roadmap for advocacy and sustainability of the community health services program, ensuring that partners align needed resources with national strategy and priorities for the continuity of the services.*

Strategic Approach:

Successful implementation of the NCHP Policy requires sustained coordination between partners and several divisions and units at all levels within the MOH, and long-term success depends primarily on the MOH's capacity and available resources to lead the National Community Health Program. The MOH must work with other ministries and government institutions, such as the Ministry of Finance and Development Planning and the Ministry of Internal Affairs, to ensure that all aspects of the program are implemented and managed well. Beyond the national level, the institutional capacities of the county and community health structures are also crucial for the effective design, ownership, accountability, and governance of the National Community Health Program. Moreover, to maintain momentum and support for this program, policymakers must be provided with effective, evidence-based advocacy and education materials around core program areas.

Key Interventions and activities

1. **Conduct high-level advocacy activities to implement and sustain the community health policy.**
   Key activities include
   - The Ministry of Health through the annual GOL budgeting process, allocates sustainability of the NCHP; legislative budget hearings, or other engagements with the legislature.

- Special sessions on the sustainability of the National Community Health Program will be conducted during the Annual Health Conference and donor's conferences.
- Engage County Health Team through its SMT showcase NCHP costed plan with the county legislative caucus for local resource allocation.
- Conduct county and district levels advocacy meetings with local leaders and stakeholders on sustaining the program.
- Ensure continued engagement with GOL line ministries and agencies, CBOs, CSOs, and FBOs; a comprehensive sustainability CHW roadmap implementation at all levels. These work along with the CHCs and HFDCs to achieve a sustainable roadmap.

2. **Build MOH institutional capacity to ensure long-term implementation and sustainability of the Community Health Program.**

   Key activities:
   - Institution of Fees-For-Service to Sustain the National Community Health Program
   - Introduction of community-based health insurance
   - Introduce a drug-revolving fund for Community Health and ensure an adequate and timely supply of commodities

3. **Establish coordination mechanisms and regular engagement activities with donors, partners, and line ministries.**

Key activities:

- Strengthen NCHP coordination structures (CHSD/Partner Coordination Meeting, CH TWG, NCHP Bi-annual Review Meetings, County Quarterly Review Meeting), updating the Terms of Reference for regular engagement with key stakeholders.
- Ensure regular stakeholder alignment, smooth implementation, and adherence to the 'One County, One Partner' strategy through continuous engagement in the coordination structures.
- Coordination structures shall be a forum to continuously monitor the status of program funding, track resources directed towards the program, identify funding gaps, and mobilize domestic and external resources to ensure full program funding.

4. Develop a National Community Health Transition Plan to increase domestic financial contribution to the program.

Key activities:

- Design and implement a government-led National Community Health Transition Plan to progressively increase financial contribution to the program.
- Develop a roadmap outlining the process for transition.
- Monitor transition strategy implementation through the development of action plans and additional tools for tracking progress.

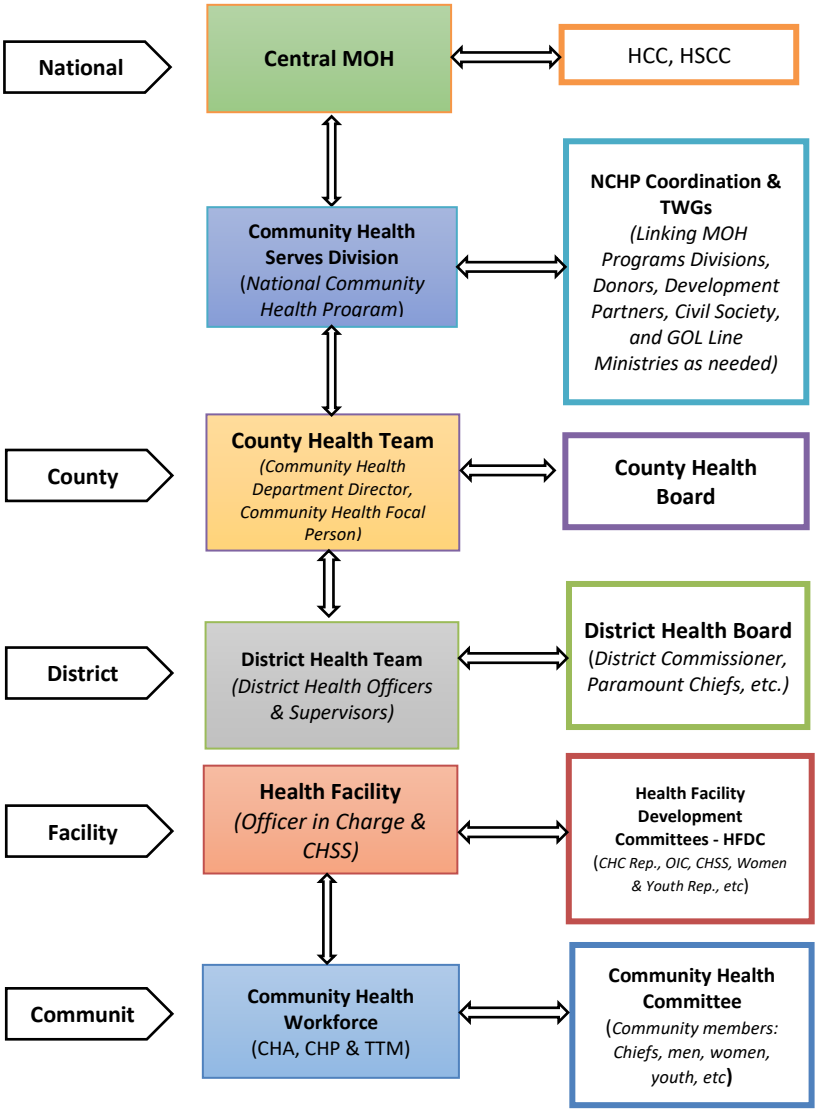
5. **Increase and Build MOH institutional capacity at all levels to ensure long-term implementation and sustainability of the Community Health Program.**

   Key activities:
   - Increase involvement of county-level staff in financial planning and implementation of the program.
   - Strengthen the capacity of county-level staff for program budgeting, Public Financial Management, and others identified in county capacity assessments and transition plans.
   - Adopt and implement monitoring frameworks for standardized payment mechanisms, expenditure tracking, and transition plan implementation.

6. **Developed a detailed costed plan for all community health workforce implementation.**

   Key activities:
   - Develop a detailed costing of National Community Health Program activities through active participation of technical stakeholders.

Chapter 4: Institutional Framework for Strategic Plan Implementation



4.1 National Level

Under the supervision and direction of the Director of the Community Health Services Division, the NCHP will be coordinated while ensuring that the implementation of all community-based interventions and services complies with existing national policies and standards. All collaborating divisions, units, and vertical national programs shall fully support this arrangement for the smooth implementation of all community health activities in Liberia.

The CHSD shall conduct a monthly Community Health Coordination Meeting (CHCM) and as may be needed, Technical Working Group (CHTWG) meetings to coordinate partners and programs implemented at the community level, complemented by advisory sub-group meetings as necessary. The CHTWG and advisory sub-group shall provide strategic guidance, technical expertise, and support on matters relating to the implementation of community health services and interventions in the country**.**

Additional in-depth Community Health Review meetings will be convened on a quarterly and bi-annual basis to assess and improve implementation progress and overall performance of the NCHP. Additionally, a National Bi-annual Community Health Services Inter-Ministerial Coordination Committee shall be conducted to identify areas for coordination and collaboration between the MOH and other line ministries and to address larger challenges related to the long-term sustainability of the NCHP. Full detail of standing committee meetings is included in the annex of this strategy. Notwithstanding, the specific functions of the CHSD shall include but are not limited to

- Liaise with other MOH divisions and line ministries to develop an integrated and standardized service delivery package and training curriculum

- Collaborate with the Health Financing Unit to map all partners and resources dedicated to community health
- Coordinating the development of the community health implementation plan on an annual basis
- Advocate for allocation and facilitate mobilization of resources for the provision of community health services and implementation of community health activities
- Coordinate partners and community health activities of other MOH divisions, programs, and departments
- Convening quarterly review meetings and periodic retreats to review progress and generate buy-in
- Coordinate all capacity building, monitoring, and supervision activities to be implemented to strengthen the Community Health Program
- Collaborate with Health Quality Management Unit to conduct joint quarterly monitoring and supportive supervision visits to provide support to CHTs, especially County Community Health Focal Persons and DHT staff
- Generate and disseminate information, reports, interest stories, and best practices to improve program implementation.
- Collaborate with the HMER, Supply Chain Management, and Personnel Units/Divisions to develop and maintain CBIS, Community Supply Chain, and Community Health Workforce databases/systems
- Conduct midterm and end-line evaluation of the NCHP Policy and Strategy implementation.

4.2 County Level

Under the supervision of the County Health Officer (CHO), the Community Health Department Director (CHDD) shall coordinate partners supporting community health activities and oversee the implementation of all community health services activities. The

CHDD shall work closely with the national CHSD Director to ensure that all community health personnel and structures operate as defined in their terms of reference. All vertical programs at the county level shall collaborate to plan and implement community-level programs in line with the broader MOH Community Health Program. The CHDD through the **Community Health Focal Person (CHFP)** of the CHT shall:

- Coordinate all community health activities and interventions
- Access the progress and challenges of the NCHP implementation through review meetings and stakeholders' engagements at the county, district, and community levels
- Ensure that community health activities are integrated and aligned to the county's annual operational plan
- Conduct supervision (routine, and joint supportive supervisory visits), and monitoring at the community level.
- Ensure that recruitment, training, and deployment of CHWs (CHSS, CHA, and CHP) is done in line with the NCHP Policy
- Provide monthly updates or reports of all community health activities implemented in the county
- Maintain a detailed updated database for all CHWs (CHSS, CHA, CHP, and TTM) in the county
- Organize mentorship programs/activities for newly recruited CHSS, CHA, and CHP in the absence of funding for conducting regular training to fill in the existing gap in the community.

4.3 District Level

Under the supervision of the CHDD, the District Health Officer (DHO) shall ensure coordination and supervision of all community health activities are included in its regular monthly district work plan. The DHO shall ensure the implementation of all community health activities as outlined in the policy and strategy.

- Coordinate community health activities in the district and ensure that community health services and interventions are integrated and aligned to the district operational plan
- Conduct monthly supportive supervisory visits to CHWs in the district
- Ensure that community health issues are discussed during district quarterly review meetings
- Review issues elevated by the HFDC to the District Health Board and identified actionable solutions

4.4 Health Facility Level

Under the supervision of each OIC, the CHSS will provide supportive supervision, mentoring, and coaching to the CHAs and other community health cadres as defined by the NCHP policy within the health facility catchment areas as described in his or her Terms of Reference. The CHSS will work with each community through continuous engagement to empower the community, coordinating all community health activities within the facility's catchment communities.

The Health Facility Development Committee (HFDC), which functions as the board of the health facility, is responsible for advocacy of all health-related activities in the catchment communities of the health facility and reports to the District Health Team and District Health Board. Moreover, at the health facility level, a regular monthly meeting of the HFDC will be held

to discuss issues relating to the health of the communities; identify risks, develop action plans to address those risks, and ensure the full implementation of the action plan. These meetings MUST be chaired by the HFDC Chairperson while the CHSS and OIC attend these meetings and provide only technical guidance.

4.5 Community Level

Community Health Committees (CHCs), working closely with the CHWs (CHAs, CHPs, and TTMs), are responsible for coordinating all health-related activities in their respective communities and reporting to the HFDCs. The CHCs will facilitate the work of these CHWs through in-kind gifts and services from their local communities. The Town Chief of each community by default is a member of the CHC. The CHC will work with its community to recruit CHAs and CHPs of good moral standing with the community. All CHAs, CHPs, and TTMs are answerable to their CHC. Additionally, the CHC shall encourage linkages to local civil society, non-governmental organizations (NGOs), other partners, and staff of line ministries at the community level, focusing on community engagement, participation, and the promotion of healthy living.

4.6 Other Line Ministries, Development Partners, and Civil Society Organizations

- **Ministry of Internal Affairs (MIA):** The Community Health Structures (CHCs and HFDCs) will be accountable to the District Coordination Team or other designated district-level coordinating body of the MIA.

- **Ministry of Education (MOE):** Shall collaborate with training institutions to provide quality education, with a

particular focus on girls' education, so that potential CHAs and CHPs can meet the minimum literacy and numeracy standards to function in their roles. This should include the exploration of accelerated alternative education opportunities to create career pathways for community health cadres. Furthermore, MOE shall support the integration of community health content into existing, pre-service health training programs as well as potential, subsequent accreditation of CHAs and CHPs.

- **Ministry of Youth and Sports (MYS):** Shall collaborate with MOH to integrate CHAs and CHPs into the National Youth Empowerment Program and other relevant programs.

- **Ministry of Gender, Children, and Social Protection (MGCSP):** Shall collaborate with relevant ministries and institutions to ensure women are represented in leadership positions and involved in decision-making processes related to community health. The MGCSP shall also collaborate with MOH to encourage the recruitment and retention of females within the community health cadres.

- **Ministry of Finance and Development Planning (MFDP):** Shall support the MOH by providing adequate budgetary allocation to ensure the government ownership and sustainability of the NCHP and to promote equitable access to quality healthcare for all Liberians, irrespective of their location.

- **Legislature:** Shall declare health equity as a national development priority and accordingly allocate resources to sustain community health activities.

- **Civil Society:** Community-based organizations (CBOs), faith-based organizations (FBOs), and local NGOs shall advocate for the establishment of a pool fund for the sustainability of the Community Health Program. Civil Society shall ensure that Ministries and other stakeholders are accountable for fulfilling their respective obligations.

- **Donor and Development Partners:** Shall advocate and support the Government of Liberia (GOL) to establish innovative financing mechanisms to promote the sustainability of the Community Health Program and shall also provide technical and financial assistance for policy and program implementation.

Chapter 5: Monitoring and Evaluation

Monitoring and evaluation of the National Community Health Program will be essential to inform decision-making vis-à-vis the scale-up of the program. The MOH will ensure unified and coordinated monitoring and evaluation system consistent with its National M&E Policy and Strategy Provisions. An integrated monitoring framework consisting of a standardized matrix of indicators, including core indicators for monitoring the NCHP Policy and Strategy implementation will exist to guide M&E efforts and avoid risks of duplication of efforts.

A comprehensive indicator reference will be developed and updated from time to time to promote standardization in the measure and presentation of indicators; such a Monitoring Framework shall be informed by the revised NCHP Policy and Strategy (see Annex 2). The National Community Health Program will contribute to achieving set national indicators. The framework includes indicators to assess service delivery (quality, access, efficiency) and indicators of health status (impact). Indicators relate to the six strategic objectives and have primarily been derived from those already reflected in the National Health Plan Monitoring and Evaluation Framework.

Program adaptation and management decisions will be data-driven, and the data used to inform program management decisions will be sourced from routine HIS (RHIS), surveys, and assessments. The routine systems (CBIS, HMIS), program assessments, and service coverage surveys will be the major sources of data collection and will inform the output and outcome indicators. On the other hand, the impact indicators will rely largely on surveys such as the Liberia Demographic Health Survey (LDHS).

The MOH and partners will adhere to the use of one M&E system; fully coordinated for effective health system management. The MOH will also plan and lead quarterly biannual, and annual reviews with key stakeholders at different levels. Data quality improvement interventions such as data quality audits or verifications, M&E-related technical capacity development, tool development, and routine program monitoring will be undertaken regularly on the central level to the counties; by the CHTs to the districts; by districts to the facilities; and facilities to communities. During the implementation of the strategic plan, periodic progress reports (quarterly, bi-monthly, annual) will be produced at different levels. The reports will inform annual health sector reviews that will involve all key stakeholders. The performance indicators and the respective targets for monitoring the contributions of the National Community Health Program are highlighted in Annex 2.

The NCHP and its partners will develop an Operational Plan and Implementation Guidelines which will serve as the basis for a final evaluation that will be conducted at the end of 5 years of implementation of this Strategic Plan. The MOH and stakeholders will jointly agree on the timing and terms of reference. This evaluation will inform the planning and programming for the next phase.

Annexes

Annex 1: Essential Package of Community Health Services

This revised integrated and standardized package of essential community health services and interventions will be delivered by CHA, CHP, and TTM under the supervision of their CHSS. This EPCHS includes preventive, curative, and promotive services as well as epidemic surveillance drawn from lessons learned from the implementation of the 2016 - 2021 CHS Policy and the DPC 3 priorities for Community Health.

Liberia - Essential Package of Community Health Services (EPCHS)						
Service Category	**#**	**Core Services**	**CHA**	**CHP**	**TTM**	**Comment**
Module 1: Community Engagement *(Community Entry, Mobilization, Empowerment, and WASH)*	**M1 A: Community Entry, Mobilization and Empowerment**					
	1	Conduct household registration and community profiling	X	X		**Old**
	2	Conduct routine household visits; ensuring each household is visited and all pregnant women and children are captured and identify any disease condition and refer as needed	X	X		**Old**
	3	Map out all pregnant women, conduct regular follow-up visits and ensure timely referral for ANC visits and facility delivery	X	X	X	**Old**
	4	Conduct health education for Social Behavior Change, and Promotion for awareness on each health service of this package (Disease surveillance, SRMAH, Child Health and well-being, HIV, TB, Eye Health, Mental Health, NTDs, NCDs, and WASH)	X	X		**Modify**

	5	Conduct birth registration of newborns for certification	X	X		**New**
	6	Conduct community engagement, and mobilization for all services as indicated in the service delivery package	X	X		**Old**
	7	Work with CHC and HFDC to conduct Community conversation	X	X		**New**
	8	Work with CHC and HFDC to conduct Community Action Planning	X	X		**New**
	M1 B: Water Sanitation and Hygiene – WASH					
	9	Provide education and health promotion on Water Safety, Hand Washing, Hygiene, and safe waste disposal (WASH)	X	X		**Old**
	10	Promote Open Defecation Free (ODF) community	X	X		**Old**
Module 2: Disease Surveillance *(CEBS - Prevention, Control, and Response)*	11	Build good relationships, communicate, and coordinate with key community informants, and community resource persons (Community Animal Health Workers, retired health workers, religious leaders, traditional healers, etc.)	X	X		**Modify**
	12	Do formal and informal networks for information dissemination and community birth and death notification with special emphasis on maternal and neonatal death	X	X		**Old**
	13	Detection and early reporting of identified priority diseases and event triggers: (unexplained cluster of animal or human deaths), as they occur in the co immunity, including early case detection through active case finding.	X	X		**Modify**

Liberia - Essential Package of Community Health Services (EPCHS)						
Service Category	**#**	**Core Services**	**CHA**	**CHP**	**TTM**	**Comment**
Module 3: Sexual, Reproductive, Maternal, Newborn, and Adolescence Health	**M3 A: Sexual, Reproductive, Maternal, and Newborn Health (SRMNH) + Nutrition**					
	14	Conduct counseling for Family Planning, make referrals for Family Planning where applicable, and promote condom usage for Family planning purposes and STIs/STDs prevention.	X	X		**Old**
	15	Distribution of MOH-approved FP products including condoms, tablets, Sayana Press (self-injectable), and refer for additional family planning services where applicable.	X	X		**Modify**
	16	Monitor all pregnant women, promote early and timely Ante-Natal Care visits (ANC), and educate on reportable conditions (danger signs in pregnancy, referrals, counter referrals, and follow-up), birth planning, delivery preparedness, and child spacing.	X	X	X	**Old**
	17	Identify danger signs in pregnancy and make a timely referral to health facilities and follow up on counter referrals	X	X	X	**Old**
	18	Ensure health facility delivery, conduct post-partum and postnatal services visits, screen for PNC danger signs, and make timely referrals.	X	X		**Old**
	19	Encourage male involvement in pregnancy, facility delivery planning, and accompaniment for delivery	X	X	X	**New**

	20	Promote continuous and exclusive breastfeeding from birth up to 6 months and the introduction of complementary feeding (the use of locally available food items and preparation methods) for children older than 6 months.	X	X	X	**Old**
	21	Provide and educate on the use of Misoprostol to control Postpartum Hemorrhage			X	**New**
	23	Distribute IPTp to pregnant women to prevent malaria during pregnancy	X	X		**New**
	M3 B: Adolescent Health + Nutrition					
	24	Provide sexual and reproductive education to prevent teenage pregnancy, unwanted pregnancy, abortion, and the transmission of STIs to improve the health outcomes of adolescent	X	X	X	**Old**
	25	Provide folic acid and prenatal vitamins to adolescent girls	X	X		**New**
	26	Provide education on menstrual hygiene and distribute sanitary pads to all adolescent girls	X	X	X	**New**
Module 4: Child Health	**M4 A: Integrated Community Case Management**					
	27	Counsel on danger signs of a sick child and when to seek care (referrals and counter referrals)	X			**Old**
	28	Assess, diagnose (using mRDT), and treat Malaria, Pneumonia, and Diarrhea using approved MOH essential medication including Rectal Artesunate for Malaria. Educate caregivers on how to insert Rectal Artesunate.	X			**Old**

	29	Make timely referrals of danger signs of Malaria, Pneumonia, and Diarrhea of the sick child, particularly newborns and other childhood emergencies	X			**Old**
	30	Assess, diagnose (using mRDT), and treat Malaria for children 6 - 13 years and make a timely referral of danger signs	X			**New**
	M4 B: Immunization					
	31	Promote immunization services and benefits	X	X		**Old**
	32	Conduct social mobilization during immunization days, including the identification of children for routine vaccination with appropriate notification to CHSS for intervention	X	X	X	**Modify**
	33	Conduct defaulter tracking, and mobilize all children under two for immunization	X	X		**New**
	34	Identify zero dose children and missed communities for immunization services	X	X		**Old**
	M4 C: Nutrition					
	35	Conduct screening for all children 6 months to five years using MUAC and assessing for edema and refer for checkups, treatment, and HIV testing	X	X		**Modify**
	36	Mobilize communities and encourage them to address food diversity, frequency, and nutrition security at the household level using the SBC portfolio	X	X		**New**
	37	Provide micronutrient powder (MNP), Vitamin A Supplementation, and deworming tablet	X	X		**New**

	38	Encourage the introduction of complementary feeding at 6 months and above to improve child nutrition status	X	X	X	**Old**
	39	Follow up on all children on treatment for severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) and especially defaulters encouraging their mothers/caregivers to allow them to complete the program	X	X	X	**Old**

Module 5: Communicable Disease	**M5 A: Human Immune-compromise Virus and AIDS**					
	40	Provide awareness on the prevention, treatment, care, and management of HIV (healthy lifestyle, promoting physical activity, healthy diet, and maintaining of healthy weight), and work with community members to reduce stigma and discrimination	X	X		**New**
	41	Mobilize the community for voluntary counseling and testing **(Counseling and testing will be done by CHSS)**	X	X		**New**
	42	Track lost to follow-up (defaulters) clients in the communities and encourage re-entry and adherence	X	X		**New**
	43	Identify and refer all suspected HIV cases including exposed infants with HIV to testing	X	X		**Old**
	M5 B: Tuberculosis (TB)					
	44	Provide awareness on the prevention, treatment, care, and management of TB and work with community members to reduce stigma and discrimination	X	X		**New**
	45	Mobilized community for sputum	X	X		**Old**

		collection of all presumptive TB cases for testing (Sputum collection will be done by CHSS)				
	46	Mobilized community, Identify and refer all presumptive TB cases for testing and treatment	X	X		**Old**
	47	Track and refer loss to follow-up clients and encourage re-entry and adherence	X	X		**New**
	48	Create awareness of Isoniazid Preventive Treatment (IPT) uptake	X	X		**New**
	49	Conduct DOTS - Directly observed treatment short-course for clients needing home treatment	X	X		**New**
Module 6: Non-Communicable Diseases	**M6 A: Eye Health**					
	50	Create awareness of eye health problems including distance and near vision to prevent blindness and minimize the fear for eye health services	X	X		**New**
	51	Identify and dispense appropriate reading glasses for community	X	X		**New**
	52	Identify and make a timely referral of community members with eye diseases/conditions for facility base management.	X	X		**New**
	M6 B: Mental Health					
	53	Identify, refer, and follow up with persons with Mental, Neurological, and Substance Use issues, postpartum depression and postpartum psychosis (perinatal mental health conditions)	X	X	X	**Modify**
	54	Create awareness to reduce stigma, promotion of rights and anti-discrimination, and the prevention of	X	X		**New**

		physical, emotional abuses, and discriminations				
	55	Counsel caregivers of persons with mental health conditions on the importance of knowing the risks factors, signs, and symptoms of mental health conditions	X	X		**New**
	56	Follow up with clients, provide adherence counseling, and encourage clients for refill services at the health facility	X	X		**New**
	57	Identify and refer clients presenting with medication side effects to health facilities	X	X		**New**
	M6 C: Neglected Tropical Diseases (NTDs)					
	58	Create routine awareness of NTDs condition with an emphasis on the integration of NTDs services and ending stigmatization and discrimination against people affected by NTDs	X	X		**Old**
	59	Conduct active case findings to identify and refer all cases of Human rabies, LF, Hydrocele, BU, Leprosy, and Yaws to health facilities for management	X	X		**New**
	60	Conduct contact tracing for both new and old clients in communities for reportable priorities diseases of NTDs (community triggers)	X	X		**New**
	61	Conduct mass drug administration at the community level	X	X		**New**
	62	Educate lymphedema clients on the use of the Home-Based Self Care (HBSC) Kits	X	X		**New**
	M6 D: Hypertension and Diabetes					

	63	Provide community awareness on diabetes, and hypertension	X	X		**New**
	64	Identify suspected cases of hypertension and diabetes and notify CHSS for intervention	X	X		**New**
	65	Follow-up with diabetic and hypertensive patients to ensure compliance to the treatment regimen	X	X		**New**
	66	Provide health education on a healthy lifestyle (avoidance of harmful substance use and smoking cessation) and promote physical activity, healthy diet, and the maintenance of a healthy weight.	X	X		**New**
	67	Work with CHC and HFDC and facilitate community action for a healthy lifestyle and well-being.	X	X		**New**

Annex 2: DPC3 High Priority Interventions - Community

INTERVENTION NAME, CLUSTER AND PLATFORM			
Intervention Code	**Intervention Name**	**Cluster**	**Platform**
C1	Antenatal and postpartum education on family planning	RMNCAH	Community
C10	Education on hand washing and safe disposal of stools	RMNCAH	Community
C11	Pneumococcus vaccination	RMNCAH	Community
C12	Rotavirus vaccination	RMNCAH	Community
C14	Provision of vitamin A and zinc supplementation to children according to WHO guidelines	RMNCAH	Community
C16	Childhood vaccination series (Diphtheria, Pertussis, Tetanus, Polio, BCG, Measles, Hepatitis B, Hib, Rubella)	RMNCAH	Community
C2	Counseling of mothers on providing thermal care for preterm newborns (delayed bath and skin-to-skin contact)	RMNCAH	Community
C20	School based HPV vaccination for girls	RMNCAH	Community
C21	Mass drug administration for lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiases, yaws, trachoma, and foodborne trematode infections	Infectious Disease	Community
C25	Education campaigns for the prevention of gender-based violence	RMNCAH	Community
C30	Provision of condoms to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender populations, and prisoners	Infectious Disease	Community

C32	Routine contact tracing to identify individuals exposed to TB and link them to care	Infectious Disease	Community
C35	In all malaria-endemic countries, diagnosis with rapid test or microscopy (including speciation) followed by treatment with ACTs (or current first-line combination)	Infectious Disease	Community
C4	Promotion of exclusive breastfeeding and complementary feeding by community health workers	RMNCAH	Community
C42	Management of lymphedema	Infectious Disease	Community
C43	Early detection and treatment of Chagas disease, human African trypanosomiasis, leprosy, and leishmaniases	Infectious Disease	Community
C44	Total treatment for yaws	Infectious Disease	Community
C45	Identify and refer patients with high risk including pregnant women, young children, and those with underlying medical conditions	Infectious Disease	Community
C46	In the context of an emerging infectious outbreak, provide advice and guidance on how to recognize early symptoms and signs and when to seek medical attention	Infectious Disease	Community
C6	HIV education and counseling for pregnant women, sex workers, people who inject drugs, men who have sex with men, and transgender individuals, and PLHIV and their partners	Infectious Disease	Community
C8	Detection of malnourished children and referral to appropriate level of care	RMNCAH	Community
C9	Detection and treatment of childhood infections (iCCM), including referral of danger signs	RMNCAH	Community
EPHS11	IEC/BCC on immunization	Infectious Disease	Community
EPHS17	DOTS and defaulters tracing	Infectious Disease	Community

EPHS25	IEC/BCC on spread of filariasis, symptoms and case management	Infectious Disease	Community
EPHS29	Case reporting and management of bites and rabies	Infectious Disease	Community
EPHS34	Early detection and treatment of eye infection	Infectious Disease	Community
EPHS36	First aid management of eye injury	NCD	Community
EPHS38	Mass drug distribution, administration for NTDs	Infectious Disease	Community
EPHS8	Deworming of children	RMNCAH	Community
HC45	Opportunistic screening for hypertension for all adults and initiation of treatment among individuals with severe hypertension and/or multiple risk factors	NCD	Community
TOTAL			**31**

Annex 3: One County One Partner Strategy

Summary

The One County, One Partner Strategy states that there can only be one implementing partner and/or donor supporting the National Community Health Program per geographic county in Liberia. The goal of this strategy is to reinforce alignment and quality implementation across counties, guide financing of community health priorities, ensure transparency, and facilitate result-based coordination and mutual accountability for improved results. Additionally, while this arrangement seeks to ensure uniformity in the implementation of community health services and interventions, it creates opportunities for collaboration with

other partners and or donors to ensure the full implementation of the **Essential Package of Community Health Services** in all communities in the 15 counties.

Partner Commitments

If a partner wishes to implement the National Community Health Assistant Program in a county, they are ***agreeing*** to:

- Ensuring there is at least one Community Health Assistant (CHA) in each community all Communities further than 5Km from a health facility according to the MOH Community Health Policy.
- There are sufficient Community Health Services Supervisors (CHSS) to maintain a 1:10 ratio with CHAs
- Train all CHSS and CHAs according to the Human Resources for Health Standard Operating Procedure
- In cases where CHSS and CHAs are not on the government payroll, the implementer must pay incentives to CHSS and CHAs in accordance with Human Resources for Health Standard Operating Procedure and in coordination with the Community Health Services Program
- *Provide CHSS and CHAs with required logistical support and non-medical supplies (ie motorbike, fuel, commodity box, rain gear, life jackets where applicable) in accordance with the Community Health Services Implementation Standard Operating Procedure.*
- Provide technical assistance to the County Health Team aimed at building their capacity to *assume both all programmatic and financial management*

responsibilities of the National CHA Program in accordance with the Community Health Services Implementation Standard Operating Procedure. Technical Assistance provided will be based on the National Capacity Assessment done and tracked through the county capacity development tracker.

- Taking full responsibility for the successful implementation of the program based on the revised National Community Health Policy, strategies, and Implementation SOP.
- Link, and procure services and funding from other partners who can complement them while they served as lead partners
- Work with county and community leaders during the selection process to ensure gender balance community health workforce
- Ensure provision and functionality of a digital device used for data collection and digital training content.

If a partner wishes to implement the National Community Health Assistant Program in a county, they are ***not agreeing*** to implement or provide support not included in the Community Health Services Policy, Strategy, or accompanying Standard Operating Procedures.

Ministry of Health Commitments

The Ministry of Health is ***agreeing*** to the following to support implementing partners and donors to implement the National CHA Program:

- Track the individual CHSS and CHAs that are on the government payroll and ensure that they have the

necessary credentials to perform their given function.

- All new CHSS recruits are on the government payroll and CHSS to government payroll to increase government ownership and decrease the financial burden on partners and donors.
- Facilitate and coordinate meetings between donors and implementing partners to ensure efficient use and allocation of financial and human resources.
- Provide regular and timely commodities for CHSS and CHAs that are outlined in the Community Health Services Supply Chain Standard Operating Procedure.

Joint Commitments:

The Ministry of Health and implementing partners and/or donors are jointly agreeing to the following:

- Track technical assistance activities to the County Health Team through the nationally standardized County Capacity Building Tracker.
- Evaluate the performance of Technical Assistance through the County Capacity Assessment completed in accordance with the Community Health Services Implementation Standard Operating Procedure.
- Evaluate the performance of implementation through review of key indicators through standing coordination and review meetings.
- Recruit CHSSs in case of gaps or scale-up
- Strong collaboration with partners implementation at the HFs and community within the 5 KM
- Track and monitor financial resources allocated to the National CHA Program

Annex 4: Community Health Workforce Terms of Reference (TORs)

Regional Desk Officer (RDO)

The Regional Desk Officers (RDOs) shall be the primary staff to ensure the effective implementation of the NCHP in each county, focusing on the managerial and technical components of the program for quality improvement and assurance. RDOs shall serve as the direct link between CHSD and the County Health Teams and they shall coordinate and supervise program implementation in their respective regions to ensure the proper functionality of the program. RDO shall ensure the fidelity of the program, i.e., that CHSS supervise each CHA at least twice monthly using the approved checklist and other tools to ensure program quality and that CHFPs conduct regular retain IFI supervision, and is maintaining active engagement with all CHWs, CHT Supervisors, partners and other county level collaborators.

The RDOs will primarily work at the county level to ensure the following:

1. Serve as the direct link between CHSD and the County Health Teams. They coordinate and supervise program implementation in their respective regions to ensure the proper functionality of the program.
2. Ensure the work plans of CHFPs are strategic in addressing program needs.
3. Coordinate with CHFPs to share monthly and quarterly updates and generate quarterly narrative reports for CHSD highlighting progress against planned activities, challenges, lessons learned, and recommendations to

improve program performance.

4. Regularly communicate with the counties through the Community Department Director (CHDD) on the issue of concern to the NCHP.
5. Collaborate with County Health Teams (CHTs) on annual leaves and coverage plans for CHSS.
6. Collaborate with CHT HR Manager to ensure contracts of CHAs and CHSS are up-to-date.
7. Collaborate with CHTs to;
    - Organize a leave schedule for CHSS and a leave coverage plan.
    - Review contracts and support CHT to file and timely submit.
    - Support partners for timely payment of both CHSSs and CHAs incentive
8. Coordinate with MoH, CHTs, and Partners for the following;
    - Availability of all assets and materials needed for community health services in the region
    - Follow up on all county-specific action points from all meetings (including BRMs) and ensure that CHTs follow up for tangible results to improve performance in the region
    - Monitor county performances through the DHIS2/CBIS and Kobocollect and provide regular, timely feedback to the CHSD and CHTs.
    - Develop and maintain a database system of all CHSSs, CHAs, and other cadres and training received.
    - Ensure that NCHP commodities and supplies are

adequately and timely distributed for the program function.

- Ensure that CHSS is conducting supervision as per the NCHP policy and guidelines.
- Ensure quality community health services are provided in accordance with approved guidelines and protocols.

Community Health Focal Person (CHFP)

POSITION TITLE:	**Community Health Focal Person (CHFP)**
REPORTS DIRECTLY TO:	Community Health Department Director (CHDD)
SUPERVISORY ROLE:	● Support Officers in Charge (OICs) and District Health Officers (DHOs), who supervise Community Health Services Supervisors (CHSSs)
DEPARTMENTAL/FUNCTIONAL RELATIONS:	● National Community Health Program (NCHP)) ● Health Promotion Focal Person ● District Health Teams
EXTERNAL RELATIONS	● Health Partners ● Community Leadership
PURPOSE	
● Provide leadership, supervision, and coordination of community health activities in the county; Strengthen implementation of Community Health Program at the county, district, and community levels.	
KEY RESULT AREAS	
● Program Management and Quality Improvement ● Logistics and Commodity Management ● Health System Management	

DUTIES

General Management Functions:

- Support the dissemination of the Community Health Services Policy, carrying out program advocacy to promote support and involvement of county, district, and community leaders
- Facilitate the selection and recruitment of CHAs and CHSSs in consultation with the community leaders, the CHDD, and implementing partners
- Liaise with stakeholders to organize training of CHAs and CHSS, including with training institutes, county health teams, district health offices and non-governmental agencies working in community health service programs
- Facilitate the distribution of community health commodities and supplies, coordinating with County Pharmacist, DHOs, OICs, CHSSs and other stakeholders
- Assist CHSSs and CHAs to plan and implement community health service interventions
- Participate in planning, review, and appraisal of Community Health Program activities organized at community, county, and national levels
- Provide regular reports on the implementation of planned activities, key challenges, bottlenecks and follow-up actions to the CHDD with CHSD in copy.

Technical Duties:

- Participate in joint supportive supervision for CHAs and CHSS in coordination with DHOs, OICs, and implementing partner agencies
- Facilitate Community Health Program and selected monthly community health committee (CHC) meetings in coordination with CHSS and OICs

Supervisory Function:

- Supportive supervision for CHAs and CHSSs

Staff Management

- Monitor and to ensure that District Health Teams, OICs and CHSSs are providing supervision and oversight of community

EDUCATIONAL QUALIFICATION

- AA/BSC degree in Physician Assistant, Registered Nurse (BSc) or Certified /BSc Registered Midwife.
- EHTs with diplomas in environmental health may be recruited where there is a shortage of the professionals listed above.

WORK EXPERIENCE

- Two (2) years of experience as a supervisor or material management and one (1) year of practitioner experience in the public or private health sector. Clinical

experience is strongly preferred.
OTHER REQUIREMENTS
• Commitment to health and passion for serving rural areas • Passion for fieldwork in remote communities with a willingness to walk long distances and endure long motorbike rides several times a week • Experience in public/community-based health preferred • Experience supervising/mentoring health workers preferred, and ability to manage a team • Confidence working in a community setting with a variety of people and stakeholders. • Computer literate with experience in internet • Previous experience operating a motorbike on bush and difficult roads

Community Health Services Supervisor (CHSS)

POSITION TITLE	**Community Health Services Supervisor (CHSS)**
REPORTS DIRECTLY TO	Officer in Charge (OIC)
DIRECTLY SUPERVISES	Community Health Assistants
DEPARTMENTAL/FUNCTIONAL RELATIONS	• District Health Team • Community Health Focal Person • Health Promotion Focal Person • Community Health Department Director
EXTERNAL RELATIONS	• Community Health Department • Health Partners • District Health Team • Community Leadership
PURPOSE	
• Provide leadership, training, and high-quality clinical mentorship to a team of Community Health Assistants (CHAs).	

KEY RESULT AREAS

- Staff Performance Management and Quality Improvement
- Logistics and Commodity Management
- Health System Management

DUTIES

General Management Functions:

- Work with facility management to set supervision goals for the team each week.
- Assist communities in the selection of new or additional Community Health Assistants (CHAs), Community Health Promoters (CHP), and TTM as necessary
- Provide feedback on curriculum development and carry out training of the CHAs.
- Adhere to the protocols for operating motorbikes and maintaining communication.
- Conduct community entry activities in close collaboration with the County Community Health Focal Person
- Provide guidance as communities select membership for Community Health Committees (CHCs)
- Participate in monthly meetings of CHAs and CHCs in catchment communities to discuss problems, challenges, and progress
- Liaise with clinic staff to help coordinate outreach services to catchment communities
- Give feedback from District Health Team (DHT) to CHAs
- Help organize monthly Health Facility Development Committee (HFDC) meetings at a health facility.
- Under the direction of and in close coordination with the OIC, serve as secretary to the HFDC and participate as a non-voting member of the committee.

Technical Duties:

- Follow up to ensure that patients referred by CHAs, TTMs and CHPs are seen by facility staff, that referral and counter-referral of patients are documented, and that CHAs provide appropriate follow-up at the community level
- Support CHAs to engage the community in action planning and identification of key health needs and challenges on a quarterly basis.
- Within their expertise and limits, respond to urgent and emergent cases as they arise in the community during routine supervision and programmatic activities
- Develop and manage weekly supervision schedules to ensure all CHAs receive adequate field supervision and that catchment populations are offered high-

quality CHA services according to intervention protocols
- Provide technical support in planning and implementation of community programs
- Liaise with OIC, Registered/Certified Midwife and other health facility staff conducting monthly clinical outreach programs to ensure community mobilization and coordination with CHA, CHPs and TTMs in the catchment area.

Supervisory Function:
- Work with catchment communities to identify simple context-appropriate transportation means for referral of cases to health facilities
- Provide continuous mentoring in accurate collection and timely reporting of data generated from community
- Coach CHAs, CHPs and TTMs to support on-the job problem solving and critical decision-making skills
- Evaluate CHAs, CHPs and TTMs' knowledge and skills – with particularly emphasis on clinical care delivery - by utilizing skills check and supervision tools as well as observation and patient interview/audit
- Conduct monthly supportive supervision visits and monitor WASH conditions in communities
- Conduct formal performance evaluation and structured feedback sessions with CHAs, CHPs and TTMs
- Observe, assess, and supervise CHAs, CHPs and TTMs
- Conduct performance reviews for CHAs, CHPs and TTMs using available data
- Manage individualized plan of performance improvement for each CHACHPs and TTMs and coach them, to ensure they have the capacity to perform required tasks

Staff Management
- Monitor and ensure that CHAs, CHPs, and TTMs are at their assigned areas and implementing their duties and maintaining positive relationships with communities

Logistics and Commodity Management
The position holder will:
- Be accountable for all commodities and supplies delivered from the facility to the CHA, CHPs, and TTMs in the community
- Be responsible for oversight of CHAs, CHPs, and TTMs in their management of commodities and supplies
- Utilize standardized supply chain management forms and reporting tools to record consumption and request additional commodities
- Turn over all expired, damaged and/or obsolete commodities to the OIC for

proper disposal
EDUCATIONAL QUALIFICATION
• AA/BSC degree in Physician Assistant, Registered Nurse (BSc) or Certified /BSc Registered Midwife. • EHTs with a diploma in environmental health may be recruited where there is a shortage of the professionals listed above.
WORK EXPERIENCE
• Two (2) years of experience as a supervisor or material management and one (1) year of practitioner experience in the public or private health sector. Clinical experience is strongly preferred.
OTHER REQUIREMENTS
• Commitment to health and passion for serving rural areas • Passion for fieldwork in remote communities with a willingness to walk long distances and endure long motorbike rides several times a week • Experience in public/community-based health preferred • Experience supervising/mentoring health workers preferred, and ability to manage a team • Confidence working in a community setting with a variety of people and stakeholders. • Computer literate with experience in internet • Previous experience operating a motorbike on bush and difficult road

Community Health Assistant (CHA)

POSITION TITLE	**Community Health Assistant (CHA)**
REPORTS DIRECTLY TO	Community Health Services Supervisor (CHSS)
DIRECTLY SUPERVISES	Not applicable (none)
DEPARTMENTAL/ FUNCTIONAL RELATIONS	• Health Facility • Other community stakeholders including:

	○ Community Health Committee (CHC) ○ Trained traditional midwives (TTMs) ○ Community leaders ○ Community Animal Health Workers ● Health Facility Development Committee (HFDC)
EXTERNAL RELATIONS	● Health Partners / District Health Team / Community Health Focal Person Health Promotion Focal Person ● Community Health Department Director
HOURS OF WORK	● CHAs are expected to work an average of 4 hours per day, at least 20 days per month. Work schedules should be jointly determined with CHSS and Community Health Committee (CHC). ● CHAs are also expected to respond, within their limits, in the case of unexpected health emergencies.

PURPOSE

- Provide an integrated and standardized service delivery package of preventive, promotive, and curative services to households located more than one-hour walk (>5km) from the nearest health facility, within the designated catchment for each CHA.
- The service package shall focus on disease prevention, surveillance (Human and Zoonotic diseases), and reproductive, maternal, neonatal, and child health, including integrated Community Case Management of Childhood Illnesses, other special services including HIV testing, eye health, mental Malaria treatment for children above 6 years.
- Participate in periodic Ministry of Health (MOH)-led campaigns for the delivery of key interventions within the Essential Package of Health Services (EPHS).
- Conduct ongoing community mobilization, health education, and health promotion on health-related issues.
- Collaborate and coordinate with other community-based service providers in the community to ensure the provision of basic services.

KEY RESULT AREAS

- Routine Community Engagement and Health Promotion
- Household Mapping
- Availability for Service Provision
- Active Disease Surveillance

- Good Asset Management
- Timely Referrals
- Monthly Accurate Reporting

DUTIES
General Management Functions: ● Be present in community at least 20 days a month and weekly for supervision ● Meet with and mobilize community health structures to resolve issues related to emergency referrals and other matters that affect the health of community members ● Keep all documents and forms confidential ● Keep all supplies organized and in a safe place, particularly protected from damage, misuse, or theft ● Attend all trainings scheduled by the NCHP or representative (i.e. County Health Team, District Health Team or Health Facility) ● Attend all CHC meetings and serve as secretary ● Attend all monthly CHA meetings at the HF
Technical Duties: ● Implement all services outlined in the Minimum Service Delivery Package for CHAs in accordance with national policies, standards, and protocols, including Integrated Disease Surveillance and Reporting / Community Event-Based Surveillance ● Promote early care seeking for community members with illnesses ● Encourage and support patients in seeking care from the health facility when necessary
Reporting Function: ● Utilize standardized notification channels for appropriate disease surveillance and alert reporting ● Accurately report data on standard reporting forms and provide forms to CHSS at the end of each month ● Accurately report and ensure that performance is in accordance with minimum performance indicators ● Communicate health concerns or problems in providing services to supervision team ● Use weekly and monthly planners to schedule and conduct routine visits and active case finding in their catchment community

- Provide follow up according to goals and objectives outlined by the CHSS

Assets Management

- Under the supervision of the CHSS, accountable to store all commodities properly and securely–including medical and non-medical supplies–required to carry out delivery of the service package
- Make requests to the CHSS for resupply of medical and non-medical supplies and commodities required to carry out delivery of the integrated service package to the community
- Alert the CHSS to assist in proper disposal of damaged, obsolete, or expired medical and non-medical supplies and commodities within 20 days
- Alert the CHSS in less than one week in case any missing or damaged item
- Return all assets to the CHC before leaving the program

EDUCATIONAL QUALIFICATION

- Must have the ability to read and write

WORK EXPERIENCE

- Prior work experience with Community Health Program is an advantage
- He/she must have experience in other community development work

OTHER REQUIREMENTS

- A resident in the community with age 18 to 65 years
- Trustworthy and respected.
- Interested in health and development matters.
- A good mobilizer and communicator.
- Available to perform CHA tasks.
- Capable of walking long distances at least one hour to provide health services to people in their designated catchment area.
- Involved in community project/s in the past; could be an added advantage
- At least 6 grade student and above and must have the ability to read with understanding and write, add, subtract and multiply to successfully complete a test of literacy as part of their recruitment process.
- Fluency in the dialect that is spoken in the village or town
- A Liberian; and
- Females with these qualifications shall be given preference.

Community Health Promoter (CHP)

POSITION TITLE	Community Health Promoter (CHP)
REPORTS DIRECTLY TO	Community Health Services Supervisor (CHSS)
DIRECTLY SUPERVISES	Not applicable (none)

DEPARTMENTAL/ FUNCTIONAL RELATIONS	• Health Facility
	• Other community stakeholders including:
	  ○ Community Health Committee (CHC)
	  ○ Trained traditional midwives (TTMs)
	  ○ Community leaders
	  ○ Community Animal Health Workers
	• Health Facility Development Committee (HFDC)

EXTERNAL RELATIONS	• Health Partners / District Health Team / Community Health Focal Person, Health Promotion Focal Person • Community Health Department Director
HOURS OF WORK	• CHAs are expected to work an average of 4 hours per day, at least 20 days per month. Work schedule should be jointly determined with CHSS and Community Health Committee (CHC). • CHAs are also expected to respond, within their limits, in the case of unexpected health emergencies.
PURPOSE	
• Provide an integrated and standardized service delivery package of preventive, and promotive, services to households located less than one-hour walk (<5km) from the nearest health facility, within the designated catchment for each CHP. • The service package shall focus on disease prevention, surveillance (human and Zoonotic diseases), and HIV & TB • Participate in periodic Ministry of Health (MOH)-led campaigns for the delivery of key interventions within the Essential Package of Health Services (EPHS). • Conduct ongoing community mobilization, health education, and health	

promotion on health-related issues.
- Collaborate and coordinate with other community-based service providers in the community to ensure the provision of basic services.

KEY RESULTS AREAS

- Routine Community Engagement and Health Promotion
- household mapping
- Availability for Service Provision
- Active Disease Surveillance
- Good Asset Management
- Timely Referrals
- Monthly Accurate Reporting

DUTIES

General Management Functions:
- Be present in the community and work for 4 hours per day and at least 20 days a month and weekly for supervision
- Meet with and mobilize community health structures to resolve issues related to emergency referrals and other matters that affect the health of community members
- Keep all documents and forms confidential
- Keep all supplies organized and in a safe place, particularly protected from damage, misuse, or theft
- Attend all training scheduled by the NCHP or representative (i.e. County Health Team, District Health Team or Health Facility)
- Attend all CHC meeting and serve as secretary

Technical Duties:
- Implement all services outlined in the Minimum Service Delivery Package for CHPs in accordance with national policies, standards, and protocols, including Integrated Disease Surveillance and Reporting / Community Event-Based Surveillance
- Promote early care seeking for community members with illnesses
- Encourage and support patients in seeking care from the health facility when necessary

Reporting Function:
- Utilize standardized notification channels for appropriate disease

surveillance and alert reporting
- Accurately report data on standard reporting forms and provide forms to CHSS at the end of each month
- Accurately report and ensure that performance is in accordance with minimum performance indicators
- Communicate health concerns or problems in providing services to supervision team
- Use weekly and monthly planners to schedule and conduct routine visits and active case finding in their catchment community
- Provide follow up according to goals and objectives outlined by the CHSS
- Ensure timely referrals to HFs and make follow on feedback from HFs

Assets Management
- Under the supervision of the CHSS, accountable to properly and securely store all asset including mobile devices and other promotive supplies to carry out delivery of the service package
- Return all assets to CHC before leaving the program and alert the CHSS in a week in case of any missing or damaged item(s)

EDUCATIONAL QUALIFICATION

- Must have the ability to read and write

WORK EXPERIENCE

- Any prior work experience with Community Health Program is an advantage
- He/she should have knowledge on community development activities

OTHER REQUIREMENTS

- A resident in the community from age 18 to 65 years
- Trustworthy and respected.
- Interested in health and development matters.
- A good mobilizer and communicator.
- Available to perform CHA tasks.
- Capable of walking long distances of at least one hour to provide health services to people in their designated catchment area.
- Involved in community project/s in the past; could be an added advantage
- At least 6 grade student and above and must have the ability to read with understanding and write, add, subtract and multiply to complete a test of literacy as part of their recruitment process.

- Fluency in the dialect that is spoken in the village or town
- A Liberian; and
- Females with these qualifications shall be given preference.

Trained Traditional Midwives (TTM)

POSITION TITLE	Trained Traditional Midwives (TTM)
REPORTS DIRECTLY TO	Certified Midwives/ Register Midwives
DIRECTLY SUPERVISES	Not applicable (none)

DEPARTMENTAL/ FUNCTIONAL RELATIONS	• Health Facility
	• Other community stakeholders including
	  ○ Community Health Committee (CHC)
	  ○ Community Health Assistants (CHAs)/ Community Health Promoters (CHPs)
	  ○ Community leaders
	• Health Facility Development Committee (HFDC)

EXTERNAL RELATIONS	• Health Partners / District Health Team / Community Health Focal Person/Health Promotion Focal Person/RH Supervisor • Community Health Department Director
HOURS OF WORK	• TTMs are expected to work an average of 6 hours per week, Work schedule Can be jointly determined with CHA, CHP and Community Health Committee (CHC). • TTMs are also expected to respond, within their limits, in the case of unexpected health emergencies.
PURPOSE	

- Provide an integrated and standardized service delivery package of preventive, promotive, services to households located more than one-hour walk (>5km) from the nearest health facility, within designated catchment for each TTM
- Identification and support of women who are struggling with ANC adherence, facility birth planning, breastfeeding through additional visits to home
- Coordinate and facilitate monthly Women's Health Support (WHS) meetings
- Refer and accompany pregnant women to facilities for deliveries
- Breastfeeding and nutrition support
- Identification of danger signs and referrals

KEY RESULT AREAS

- Availability for Service Provision
- Timely Referrals for delivery, ANC, and danger signs for pregnant women

DUTIES

General Management Functions:

- Be present in community at least 20 days a month and weekly for supervision
- Meet with and mobilize community health structures to resolve issues related to emergency referrals and other matters that affect the health of community members
- Keep all documents and forms confidential
- Keep all supplies organized and in a safe place, particularly protected from damage, misuse, or theft
- Attend all trainings scheduled by the NCHP or representative (i.e. County Health Team, District Health Team or Health Facility)
- Attend all CHC meetings

Technical Duties:

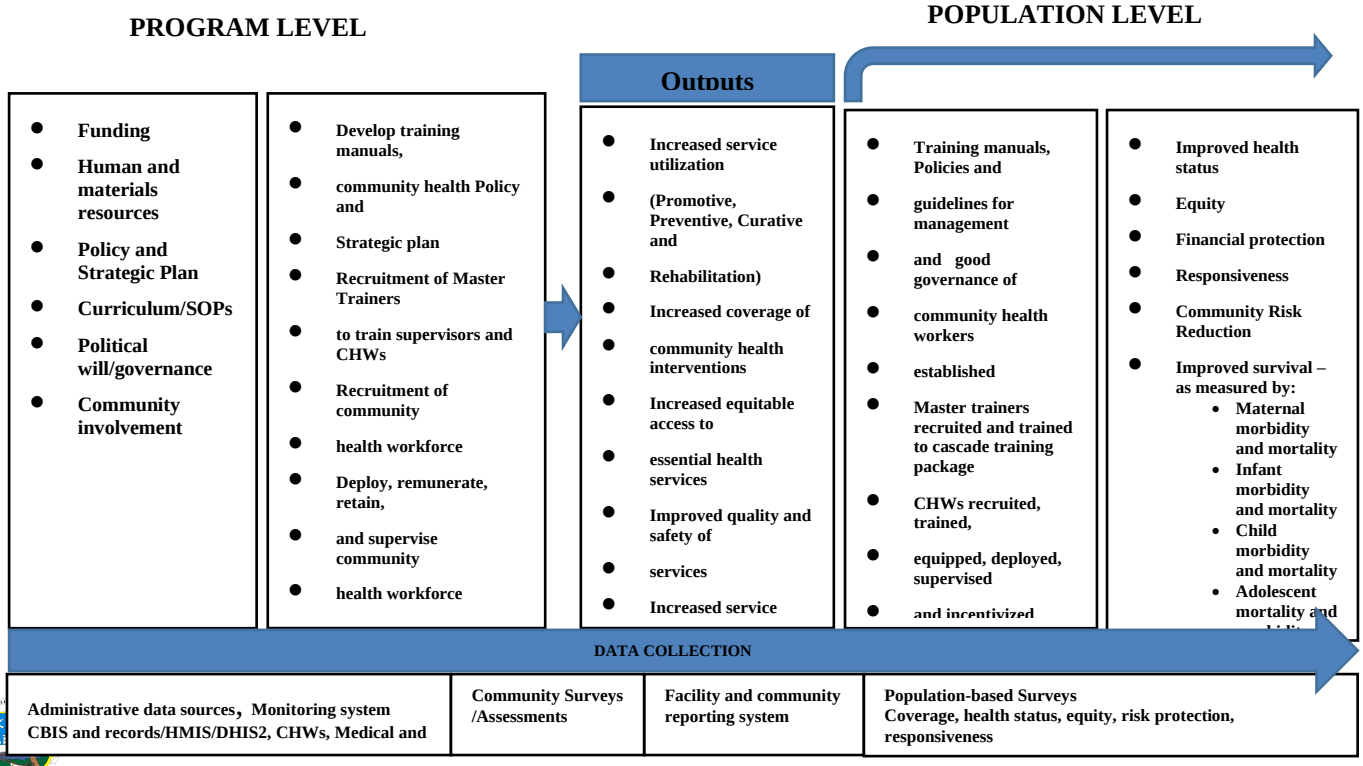
- Implement all services outlined in the Minimum Service Delivery Package for TTMs in accordance with national policies, standards, and protocols,
- Promote early care seeking for reproductive health activities.
- Encourage and support patients in seeking care from the health facility for ANC, delivery, and PNC.

Reporting Function:

- Partner with the CHA/CHP for appropriate community based and health

facility delivery and reproductive alert reporting
Assets Management ● Under the supervision of the CHSS, accountable to properly and securely store all asset including mobile devices and the promotive supplies to carry out delivery of the service package
EDUCATIONAL QUALIFICATION
● N/A
WORK EXPERIENCE
● Any prior experience as TBA is an advantage ● Subjected to initial trial period of three (3) months from the effective date of the service agreement to the end of the third month
OTHER REQUIREMENTS
● Must be a resident in the community in which she serves. ● Must be a woman 25 years old and above. ● Should be trustworthy and respected. ● Should be interested in health matters (RMNCAH) ● Should be a good mobilizer and communicator. ● Should be available to perform TTM tasks. ● Should be capable of walking long distances up to one hour or more to provide health services to people in their designated catchment area. ● Fluency in the dialect that is spoken in the village or town ● Must be a Liberian.

Annex 5: National Community Health Program Logic Model



Annex 6: Monitoring and Evaluation Framework – NCHP Indicators (2023 – 2027)

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Objective 1: To strengthen community leadership and governance systems to support the implementation of all community health services and interventions through community mobilization, engagement and training.											
PA1: Leadership, Governance & Community Engagement	Ensure community engagement and empowerment through strengthening community structures, networks, and linkages	1	% of routine home visit conducted by CHA/CHP	Y	Monthly	CHA/CHP Ledger	0	# of home visit conducted by CHA/CHP			Accepted
PA1: Leadership, Governance & Community Engagement	Ensure community engagement and empowerment through strengthening community structures, networks, and linkages	2	% of plan CHC meting conducted according to protocol	Y	Quarterly	CHC meeting minute	0	# of communityies with established and functional CHC	Total number of communities targeted for the establishment of CHCs	IFI report	Accepted
PA1: Leadership, Governance & Community Engagement	Build capacity of CHC and HFDC structures as per the Policy.	3	% of health facilities conducting at least three (3) HFDC meetings during the quarter (disaggregated at levels - i.e District, National)	Y	Quarterly	Meeting minutes	0	health facilities conducting at least three (3) HFDC meetings during the quarter	Total Number of health facilities implementing Community Health Assistance Program	IFI report	Accepted
PA1: Leadership, Governance & Community Engagement	Build capacity of CHC and HFDC structures as per the Policy.	4	% of targeted communities Health Committees conducting at least three (3) CHC meetings during the quarter	Y	Quarterly	Meeting minutes	0	# of CHC conducting at least 3 CHC meetings during the quarter	# of functional CHCs	IFI report	Accepted
PA1: Leadership, Governance & Community Engagement	Strengthen community accountability systems at all levels.	5	% of targeted health facilities achieving the minimum threshold on client satisfaction	Y	semi - annual	Composite checklist		# of facilities assessed to have met minimum threshold on client satisfication		IFI and Client perception	Accepted
PA1: Leadership, Governance & Community Engagement	Strengthen community accountability systems at all levels.	6	% of DHT submitting timely risk mitigation progress report based on Community Scorecards appraisal system feedback (disagregated by timely and complete)	Y	Quarterly	Composite checklist	0	# of DHT submitting timely risk mitigation progress report based on Community Scorecards appraisal system feedback	Total # of DHT in NCHP catchment	IFI report	Accepted
PA1: Leadership, Governance & Community Engagement	Strengthen community accountability systems at all levels.	7	% of planned Community Quality Improvement Projects implemented	Y	Quarterly	IFI	0	# of planned CQI projected implemented	Total planned CQI projects	IFI report	Accepted
PA1: Leadership, Governance & Community Engagement	Strengthen NCHP coordination mechanisms and regular engagement	8	% of planned NCHP coordination meetings conducted (disaggregated by Levels - i.e Donor level, Partners Level, Subnational partner level)	Y	N/A	Meeting minutes		# of planned NCHP coordination meetings conducted	Total number of planned coordination meeting	Activity report	Accepted
PA1: Leadership, Governance & Community Engagement	Strengthen NCHP coordination mechanisms and regular engagement	9	% of planned bi-annual NCHP review meetings for which final report published were published/circulated	Y	N/A	Meeting minutes	0	# of bi-annual meetings for which reports were produced and published	# of planned Bi-annual review meetings conducted	Activity report	Under Disscusion
PA1: Leadership, Governance & Community Engagement	Strengthen NCHP coordination mechanisms and regular engagement	10	% of NCHP TWGs organized with clear TOR	Y	N/A	TOR	0	# of TWG with Written TORs	Total TWG assessed	IFI	Under Disscusion

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 2: To Strengthen human resource capacity for the community health workforce to improve service delivery through pre-service training; institutionalization of NCHP training curriculum in health training institutions for career advancement; in-service training; refresher training (competency-based modular training package) and mentorship for technical capacity building skills transfer											
PA2: Community Health Workforce	Recruit and incentivize CHSS, and CHAs, and where applicable CHP and TTMs. as outlined in the NCHP Policy.	11	Community Health Workers (CHA, CHPs) to Supervissors ratio [to be disaggregated by cadre of workforce]	Y	Bi-Annual	Count total ative community health workforce by cadre and apply formula	0	# of community health workers in each cadre	# of CHSS	HR database	Accepted
PA2: Community Health Workforce	Recruit and incentivize CHSS, and CHAs, and where applicable CHP and TTMs. as outlined in the NCHS Policy.	12	Community Health Workforce to Population Ratio [to be disaggregated by cadre of workforce]	Y	Quarterly	Count total ative community health workforce by cadre and apply formula	0	# of community Health Workers in each cadre	Total population in Catchment	HR database	Accepted
PA2: Community Health Workforce	Recruit and incentivize CHSS, and CHAs, and where applicable CHP and TTMs. as outlined in the NCHS Policy.	13	Community Health workforce retention rate (disaggregated by sex and cadre)	N	Quarterly	# of community health workers retained at end of period versus totl community health workers brought forward at the beginning of quarter	0	Total CHW at the end of quarter	Total CHT at the beginning of pperiof	HR database / IFI	Accepted
PA2: Community Health Workforce	Recruit and incentivize CHSS, and CHAs, and where applicable CHP and TTMs. as outlined in the NCHS Policy.	14	% of community health workers (CHA, CHSS) receiving their full monthly incentive (disagregated by on time)	Y	Quarterly	Payslip, mobile money alert notification date	0	# of CHW receiving full remuneration for all the periods (applicable) prior to assessment	Total # of active CHW (disaggregated)	IFI	Accepted
PA2: Community Health Workforce	Addressing gender disparity in the community health workforce	15	Community Health Workforce Sex Ratio (disaggregated by cadre)	Y	Quarterly	HR database		Total Male CHW	Total Female CHW	HR data	Accepted
PA2: Community Health Workforce	Develop a career development plan for community health workers.	16	% of targeted training institutions with NCHP curriculum integrated into their career development program (11 institutions)	N	Annual	Training Institution curriculum	0	Total training institutions with NCHP curriculum integrated info Institution curriculum	Total training institutions assessed	IFI	Accepted
PA2: Community Health Workforce	Incorporate community health workforce in National Human Resource Policy/SOP.	17	% of CHSS on GoL payroll	Y	Monthly	Payroll database	0	Total CHSS on GoL Payroll	Total CHSS	IFI	Accepted
PA2: Community Health Workforce	Certification of Community Health Workforce	18	% of CHWs certified following satisfactory completion of the MoH standardized and approved training package	N	Annual	Academic report	0	CHW certified following satisfactory completion of the MoH standardized and approved training package	Total CHW admitted to program	Academic report	Accepted

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with emphasis on RMNCAH+N.											
PA3: Community Health Service Delivery	Integrated Disease Surveillance, Emergency Preparedness, and Response (CEBS)	19	# of notifiable condition or disease reported through active case search as per IDSR/CEBS guideline (disaggregated by triggers /conditions)	Y	Monthly	eIDSR	0	# of notifiable condition or disease reported through active case search as per IDSR/CEBS guideline	N/A	eCBIS/CEBS	Accepted
PA3: Community Health Service Delivery	Integrated Disease Surveillance, Emergency Preparedness, and Response (CEBS)	20	Proportion of identified contacts traced	Y	Monthly	eIDSR	0	# of contacts traced by CHWs	# of contacts Identified for follow-up	eCBIS/CEBS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	21	Referral success rate [Disaggretated by purpose of referral] % of community based referrals acknowledged by facility	Y	Monthly	Completed counter referral forms	0	# of community based referrals for which counter referral was acknowledged and coccumented by CHWs	Total Community based referrals to health facilities	eCBIS/IFI	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	22	% of mothers who received HBMNC/PNC within 2 days of retuning to the community after childbirth.		Monthly	MSR	0	# of mothers who received HBMNC/PNC within 2 days of childbirth	# post partum mothers / visits reported	HMIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	23	% of neonates who received HBMNC/PNC within 2 days of birth		Monthly	MSR	0	# of neonates who received HBMNC/PNC within 2 days of birth	Total live births in catchment	HMIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	24	# of community based referrals to health facility due to CHWs initiatives (disaggregated by reasons for referrals)	Y	Monthly	Referral ledger/lip	0	# of referrals by CHWs (disaggregated by reason for referral)	N/A	HMIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	25	% of Pregnant women counselled by CHWs on birth preparedness [for integration consideration: disaggregated by levels of care; e.g Health facility and community]	N	Monthly	MSR	0	# of Pregnant women counselled on birth preparedness	Total estimated pregnant women in catchment population	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	26	Number of pregnant women reached with nutrition-specific interventions	N	Annual	Survey	0	TBD (this would be a composite measure taken into consideration the interventions - e.g growth monitooring, IYCF, Counselling, etc)	0	Ideally survey	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	27	% of estimated adolescent girls receiving Iron Folic Acid Supplementation [disaggregated by Community & Facility]	Y	Monthly	MSR	0	# of adolescent girls who received iron folate acid supplementation	Estimated adolescents in catchment	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	28	# of adolescent girls who received nutrition education	N	Quarterly	Client survey	0	# of adolescent girls who received nutrition education	N/A	Survey	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	29	# of home based deliveries reported by CHWs	Y	Monthly	MSR	0	# of home based deliveries reported	N/A	DHIS2	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	30	Proportion of newborns and children referred for danger signs by CHWs	Y	Monthly	MSR	0	0	N/A	0	Accepted

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with emphasis on RMNCAH+N.											
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	31	Number of stillbirths (late fetal deaths) reported by CHWs	N	Monthly	MSR	0	0	N/A	0	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	32	Number of neonatal deaths (0–27 days) reported by CHWs	Y	Monthly	eIDSR	0	Number of neonatal deaths (0–27 days)	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	33	Number of marternal deaths reported by CHWs	Y	Monthly	eIDSR	0	Number of marternal deaths	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	34	# of persons counselled on modern Contraceptive methods	N	Monthly	MSR	0	# of persons counselled on modern Contraceptive methods	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	35	# of acceptors or users of modern contraceptive (disaggregated by new and continued users)	Y	Monthly	MSR	0	# of acceptors or users of modern contraceptive (disaggregated by new and continued users)	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	36	[# of cycles] of Contraceptive commodities dispensed or distributed (disaggregated by commodity type)	Y	Monthly	MSR	0	# of Contraceptive commodities dispensed or distributed (disaggregated by commodity type)	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Reproductive, Maternal, Newborn, and Adolescent + Nutrition	37	% of self-administered sub-cutaneous injectable (Sayana Press) clients referred to facility for the management of adverse event	Y	Monthly	MSR	0	# of self-administered sub-cutaneous injectable (Sayana Press) clients referred to facility for the management of adverse event	# of self-administered sub-cutaneous injectable (Sayana Press) clients reporting adverse event	eCBIS	Under Disscusion
PA3: Community Health Service Delivery	Child Health + Nutrition	38	% of estimated Children 12-59 months receiving at least two doses of de-worming medication during the year	N	Monthly	MSR	0	# of Children 12-59 months receiving at least two doses of de-worming medication during the year	Estimated children aged 12 - 59 months	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	39	% of Children aged (6-11 months) who received Vitamin A Blue supplementation (100,000, iu)	Y	Monthly	MSR	0	# of Children aged (6-11 months) who received Vitamin A Blue supplementation (100,000, iu)	0	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	40	% of Children (12-59 months) who received Vitamin A Red Supplementation (200,000 iu)	Y	Monthly	MSR	0	# of Children (12-59 months) who received Vitamin A Red Supplementation (200,000 iu)	Estimated children aged 12 - 59 months	eCBIS	Accepted

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with emphasis on RMNCAH+N.											
PA3: Community Health Service Delivery	Child Health + Nutrition	41	% of children 6-23 months who received Multiple Micro Nutrient Powder (MNP)	Y	Monthly	MSR	0	# of children 6-23 months who received Multiple Micro Nutrient Powder (MNP)	0	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	42	Proportion of children presenting with fast breathing and or chest indrawing who were [referred/treated?]	N	Monthly	MSR	0	children presenting with fast breathing and or chest indrawing who were [referred/treated?]	children presenting with fast breathing and or chest indrawing identified and reported	eCBIS	Under Disscusion
PA3: Community Health Service Delivery	Child Health + Nutrition	43	% of children <5 years suspected cases of Malaria confirmed using mRDT by CHA	Y	Monthly	MSR	0	Total Malaria cases (RDT positive by CHA)	total suspected malaria cases at the community level	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	44	mRDT positivity rate (Community level)	Y	Monthly	MSR	0	Total RDT positive reading recorded	Total malaria rapid diagnostic test conducted (+ve + -Ve)	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	45	% of children <5 years who tested positive for Malaria (mRDT) and were treated with ACT within 24 hours by CHA	Y	Monthly	MSR	0	# of children <5 years who tested positive for Malaria (RDT) and were treated with ACT within 24 hours (by CHA)	Total mRDT positive cases among under five population	eCBIS	Under Disscusion
PA3: Community Health Service Delivery	Child Health + Nutrition	46	Proportion of Malaria cases with danger signs given rectal artesunate suppositories as a pre-referral drug (by CHA)	Y	Monthly	MSR	0	Malaria cases with danger signs given rectal artesunate suppositories as a pre-referral drug (by CHA	Malaria cases with danger signs referred by CHA for presentation of danger signs	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	47	% of children 6 - 13 years who tested positive for Malaria (mRDT) and were treated with ACT within 24 hours (by CHA)	Y	Monthly	MSR	0	# of children 6 - 13 years who tested positive for Malaria (RDT) and were treated with ACT within 24 hours (by CHA)	# of children 6 - 13 years who tested positive for Malaria (RDT) at Community level	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	48	% of children <5 years treated for Diarrhea with ORS and zinc (by CHA)	Y	Monthly	MSR	0	# of children <5 years treated with ORS and Zinc for Diarrhea (by CHA)	# of children <5 years diagnosed with diarrhoea by CHA	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	49	% of children <5 years treated for Pneumonia with antibiotics for presenting with fast breathing and or chest indrawing (by CHA)	Y	Monthly	MSR	0	# of children <5 years treated for Pneumonia with antibiotics	# of children <5 years diagnosed with pneumonia	eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	50	% of children under 5 assessed and classified as being mal-naurished (disaggregated by MAM, SAM, etc)	Y	Monthly	MSR	0	children under 5 assessed and classified as being mal-naurished based on MUAC classification	# of children (<5 yrs) screened using MUAC	eCBIS	Accepted

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Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with emphasis on RMNCAH+N.											
PA3: Community Health Service Delivery	Child Health + Nutrition	51	Number of children under five (0-59 months) reached with nutrition-specific interventions	N	Annual	Survey	Nutrition-specific interventions refer to interventions that address the immediate determinants of foetal and child nutrition and development. These include Vitamin A and zinc supplementation, exclusive breastfeeding, dietary diversity promotion and food fortification	TBD (this would be a composite measure taken into consideration the interventions - e.g growth monitooring, IYCF, OTP, IPF, etc)	N/A	Ideally survey	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	52	Number of defulted children (0-59 months) mobalized by CHA/CHP for immunization services by CHSS	Y	Monthly	MSR	0			eCBIS	Accepted
PA3: Community Health Service Delivery	Child Health + Nutrition	53	Number of children (0-59 month) reffer by CHA/CHP to the facility for immunization	Y	Monthly	MSR	0			eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Human Immunocompromised Virus - HIV)	54	# of coinfected clients treated for HIV/AIDS and TB via direct observation Theraphy (HIV DOTs) by CHWs	N	Monthly	MSR	0	# of coinfected clients treated for HIV/AIDS and TB via direct observation Theraphy (HIV DOTs) by CHSS	Total number of HIV/AIDS -TB co-infected clients identified in community by CHW	eCBIS	Under Disscusion
PA3: Community Health Service Delivery	Communicable Disease (Human Immunocompromised Virus - HIV)	55	% of HIV+ve clients receiving HIV treatment via direct observation Theraphy (HIV DOTs) by CHWs	Y	Monthly	MSR	0	# of clients receiving HIV treatment via direct observation Theraphy (HIV DOTs) by CHSS	Total # of persons eligible (Tested +ve) for HIV DOTs in CHA catchment	eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Human Immunocompromised Virus - HIV)	56	% of persons screened and tested for HIV by CHWs through CHA/CHP mobilization initiatives	Y	Monthly	MSR	0	# of persons screened and tested for HIV by CHSS through CHA/CHP mobilization initiatives	# of persons screened for HIV by CHSS	eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Human Immunocompromised Virus - HIV)	57	Number of condoms distributed for prevention of spread of STI	N	Monthly	MSR	0	Number of condoms distributed	N/A	eCBIS	Under Disscusion
PA3: Community Health Service Delivery	Communicable Disease (Tuberculosis - TB)	58	# of persons screened for TB at community level by CHWs	Y	Monthly	MSR	0	# of persons screened for TB at community level	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Tuberculosis - TB)	59	% of presumptive TB cases for which sputum was collected by CHWs	Y	Monthly	MSR	0	Total presumptive / suspected cases of Tb for which sputum was collected by CHSS	Total number of presumptive TB in CHSS catchment	eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Tuberculosis - TB)	60	% of person screened and sputum collected by CHSS for testing at the health facility through CHA/CHP mobilization initiatives	Y	Monthly	MSR	0	# of person screened and sputum collected by CHSS for testing at the health facility through CHA/CHP mobilization	Total screened for TB by CHSS	eCBIS	Accepted

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with emphasis on RMNCAH+N.											
PA3: Community Health Service Delivery	Communicable Disease (Tuberculosis - TB)	61	% of known cases of TB in community, receiving TB treatment via direct observation Therapy (TB DOTs) by CHWs	Y	Monthly	MSR	0	# of clients receiving TB treatment via direct observation Therapy (TB DOTs)	Total TB cases identified	eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Tuberculosis - TB)	62	% of TB cases lost to follow-up identified and reintroduce to care	N	Monthly	MSR	0	# of TB cases lost to follow-up identified and reintroduce to care	Total TB cases lost to follow-up	eCBIS	Accepted
PA3: Community Health Service Delivery	Communicable Disease (Tuberculosis - TB)	63	# of patients presenting with medication side effects identified and referred	N	Monthly	MSR	0	# of patients presenting with medication side effects identified and referred	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Non-Communicable Disease (Mental Health)	64	Number of cases of Mental or Neurological health conditions identified and reported at community level (Depression, Anxiety, PTSD)	N	Monthly	MSR	0	Number of cases of Mental or Neurological health conditions identified and reported at community level	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Non-Communicable Disease (Mental Health)	65	Number of cases of mental or neurological health conditions linked to institutional based care through NCHP mobilization initiatives	Y	Monthly	MSR	0	Number of cases of mental or neurological health conditions linked to institutional based care through NCHP mobilization initiatives	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Non-Communicable Disease (Mental Health)	66	Number/proportion of people with mental, neurologic and substance use disorders (MNS) referred	N	Monthly	MSR	0	Number/proportion of people with mental, neurologic and substance use disorders (MNS) referred	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Non-Communicable (Neglected Tropical Diseases - NTDs)	67	# of persons reached through mass drugs distribution by CHA/CHP	Y	Monthly	MSR	0	# of persons reached through mass drugs distribution by CHA/CHP	N/A	eCBIS	Accepted
PA3: Community Health Service Delivery	Non-Communicable (Eye Health)	68	% of person screened and failing visual acuity test	Y	Monthly	MSR	0	# of person screened and failing near visionisual acuity test	# of person screened for visual impairement	eCBIS	Accepted
PA3: Community Health Service Delivery	Non-Communicable (Eye Health)	69	% of persons screened and receiving reading glasses	Y	Monthly	MSR	0	# of persons receiving reading glasses to correct visual impairement	Total number of persons diagnosed with vu=isual impairement at community level	eCBIS	Accepted
PA3: Community Health Service Delivery	WASH	70	% of sampled communities achieving minimum threshold on WASH standards (to be assessed using a composite checklist)	N	Annual	Survey	0	# of sampled household achieving minimum threshold on WASH standards	Total number of households survey	Survey	Under Disscusion

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based intervention and services with emphasis on RMNCAH+N.											
PA3: Community Health Service Delivery	WASH	71	Percentage of households with year-round access to improved water source	N	Annual	Survey	Access to an improved water source means that the home or compound is connected directly to a piped system or that a public fountain, well, or standpost is located within 200 meters of the home. Year-round means that water is available during the time(s) of the year when the water supply is least reliable. No particular level of water quality is implied, but access must be to water used for drinking, cooking, cleaning and bathing. Unimproved surface water sources, such as rivers, lakes, and streams, are not be counted.	Number of households in the sample with access to an improved water source	Total number of households in the sample	Survey	Under Disscusion
PA3: Community Health Service Delivery	WASH	72	Proportion of households that has hand-washing station with soap or ashes	Y	Annual	Survey	0	Number of household that has washing station with soap or ashes	Total number of households survey	survey	Under Disscusion
PA3: Community Health Service Delivery	WASH	73	% of sampled communities declared Open Defecation Free (ODF)	Y	Annual	Survey	0	Number of communities declared Open Defecation Free (ODF)	Total number of communities survey	Survey	Under Disscusion
PA3: Community Health Service Delivery	WASH	74	Number of community dwellers having correct knowledge of hand-washing practices	N	Annual	Survey	0	Number of community dwellers having correct knowledge of hand-washing practices	Total number of communities survey	Survey	Under Disscusion
Strategic Object 4A: To build human resource capacity for community health services via pre-service and in-service training; ensuring that all training modules are digitized and blended learning process incorporated											
PA4: Community Health Training and Supervision	Train and deploy community health workforce to deliver the essential package of Community Health services	75	# of CHWs (CHSS, CHA, and CHP) trained using NCHP standardized and digitize pre-service training modules	Y	Quarterly	Participant list	0	# of CHWs (CHSS, CHA, and CHP) trained using NCHP standardized and digitize pre-service training modules	N/A	HR database	Under Disscusion
PA4: Community Health Training and Supervision	Train and deploy community health workforce to deliver the essential package of Community Health services	76	# of refresher training conducted for CHSS, CHA, and CHP using in-service training modules for CHWs	Y	Quarterly	Participant list	0	# of refresher training conducted for CHSS, CHA, and CHP using in-service training modules for CHWs	N/A	HR database	Under Disscusion
PA4: Community Health Training and Supervision	Train and deploy community health workforce to deliver the essential package of Community Health services	77	# of CHSS who are on GOL payroll	Y	Quarterly	MOH Payroll	0			HR database	Under Disscusion

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Objectvie 4B: Strengthen supportive supervision, mentoring and coaching to ensure quality assurance and improvement at all levels.											
PA4: Community Health Training and Supervision	Ensure Joint Integrated Supportive Supervision, mentoring and coaching for quality assurance and quality improvement by national, county and district level supervisors.	78	# of Joint Integrated Supportive Supervision visit to Community Health Workers	Y	Quarterly		0	# of Joint Integrated Supportive Supervision visit to Community Health Workers	N/A	eJISS	Under Disscusion
PA4: Community Health Training and Supervision	Ensure Routine Supportive Supervision, mentoring and coaching for quality assurance and quality improvement by CHSSs.	79	# of routine coaching and mentorship conducted by CHSS	Y	Quarterly		0	# of routine coaching and mentorship conducted by CHSS	N/A	eJISS	Under Disscusion
PA4: Community Health Training and Supervision	Ensure Routine Supportive Supervision, mentoring and coaching for quality assurance and quality improvement by CHSSs.	80	% of Districts Health Teams with functional CH QI Team	N	Quarterly		Function here implies that there must be an established Community Health Quality Improvement Team at District; that there must be a Terms of reference to the effect of the established structure, There must be a focal person to lead the CH-QA-QI initiative; there must be a recent meeting minute to the effect of the coordination activity of the CH_QI team	# of Districts Health Teams with functional CH QI Team	Total # of DHTs assessed	IFI	Under Disscusion
PA4: Community Health Training and Supervision	Ensure Routine Supportive Supervision, mentoring and coaching for quality assurance and quality improvement by CHSSs.	81	% of DHTs convening at least one quarterly QI meeting	Y	Quarterly		0	% of DHTs convening at least one quarterly QI meeting	Total DHTs with functional CH QI Team	IFI	Under Disscusion

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Objective 5: To develop robust digital health tools and systems that will use community-based surveillance, information, and M&E systems to report high-quality data for use to improve program implementation fidelity at the community level and to engage in operational research and innovations to enhance the continued quality improvement of the program.											
PA5: Monitoring, Evaluation, Research and Technology	Update and maintain an integrated, functioning and user friendly CBIS.	82	eCBIS reporting rate (disaggregated by reporting entities and eCBIS platform)	Y	Quarterly		0	# of CHA's/CHSS or reporting entities submitting real time report through eCBIS mHealth application within specified time period	Total number of reporting entities	0	Under Disscusion
PA5: Monitoring, Evaluation, Research and Technology	Increase access to high-quality care by strengthening tracking of bi-directional referral feedback systems between community and primary health facilities.	83	# of referrals with real time counter referrals feedback through mHealth platform (mHealth innovations for counter referrals)	Y	Monthly	MSR	0	# of referrals with real time counter referrals feedback through mHealth platform (mHealth innovations for counter referrals)	0	eCBIS	Under Disscusion
PA5: Monitoring, Evaluation, Research and Technology	Improve project accountability and learning through robust monitoring, evaluation and feedback mechanism;	84	% of monthly service reports submitted by CHAs, CHPs, and CHSSs using digital solutions (disaggregated by timeliness and completeness)	Y	Monthly	MSR	0	# of monthly service reports submitted by CHAs, CHPs, and CHSSs using digital solutions (disaggregated by timeliness and completeness)	Total expected reports	eCBIS	Under Disscusion
PA5: Monitoring, Evaluation, Research and Technology	Improve project accountability and learning through robust monitoring, evaluation and feedback mechanism;	85	% of targeted interventions meeting minimum IFI index score	Y	Quarterly		% of targeted interventions meeting minimum IFI index score				Under Disscusion
PA5: Monitoring, Evaluation, Research and Technology	Establish and implement a community health services operational research agenda:	86	% of clients who are satisfied with CHWs service using the standard client satisfaction survey (Perception Study) and results published	Y	Quarterly		0				Under Disscusion
PA5: Monitoring, Evaluation, Research and Technology	Establish and implement a community health services operational research agenda:	87	% of planned or publiched Community Health research integrated into the National Health Research agenda	N	Annual		0				Under Disscusion
PA5: Monitoring, Evaluation, Research and Technology	Establish and implement a community health services operational research agenda:	88	% of published Community Health research meeting Local IRB standards and approval	Y	Annual		0				Under Disscusion

Priority Area	Key Intervention	#	Indicator	Core Indicator ? (Y/N)	Frequency	Means of Verification	Indicator Discription	Numerator	Denominator	Data sources	Comments
Strategic Object 6: To strengthen community health commodity availability and accountability at all levels— using standardized approaches in the supply of community health commodities; ensuring timely reporting of logistics data (consumption, stock on hand, losses and adjustment, days stock out) and linking CHWs' restock and logistics data with the eLMIS at the health facility, district, county and national levels.											
PA6: Community Health Supply Chain Systems	Strengthen integration of the community health supply chain into the national supply chain system	89	Rates of Stock out of essential community Health commodities and supplies (disaggregated by commodities)	Y	Monthly		0	# of essential or tracer community health supplies or commodities reported to have ran out of stock during the period			Under Disscusion
Strategic Object 7: To develop a costed plan or roadmap for advocacy and sustainability of the national community health program, ensuring that partners align needed resources with national strategy and priorities for the continuity of the services											
PA7: Community Health Financing	Conduct high-level advocacy engagement for the sustainability of the NCHP Policy and Strategy	90	Visibility rate of costed NCHP transitional and sustainability strategy	N	Annual		0	# of community health financing stakeholders having access to copy of the costed NCHP transitional and sustainability strategy	total number of community health financing stakeholders during a specific period		Under Disscusion
PA7: Community Health Financing	Conduct high-level advocacy engagement for the sustainability of the NCHP Policy and Strategy	91	# of National, County and District advocacy meetings held	Y	Quarterly		0				Under Disscusion
PA7: Community Health Financing	Build MOH institutional capacity to ensure long-term implementation and sustainability of the Community Health Program.	92	# and % of Facilities that implement the Fees-For-Service to sustain the National Community Health Program	Y	Quarterly		0				Under Disscusion
PA7: Community Health Financing	Build MOH institutional capacity to ensure long-term implementation and sustainability of the Community Health Program.	93	GOL allocation to NCHP as a share of total GOL allocation to health service delivery	Y	Annual		0				Under Disscusion

Annex 7: National Community Health Program Supply Chain Commodities Projection (2023 to 2027)

S/N	Program	Product Description	Basic Unit (BU)	Estimated Cost (BU)	Pack Size	Estimated Cost (Pack Size)	Estimated Annual Qty (2023)	Estimated Cost (2023)	Estimated Freight Cost
1	EDP	Amoxicillin 250 mg Dispersible	Tab	$0.02	100	$2.37	655,355	$15,531.92	$3,106.38
2	EDP	Oral Rehydration salt, 20.5g/L	Sachet	$0.06	1,000	$60.55	105,384	$6,380.98	$1,276.20
3	EDP	Paracetamol 100mg	Tab	$0.01	100	$0.83	1,732,063	$14,376.12	$2,875.22
4	EDP	Zinc Sulphate 20mg	Tab	$0.01	100	$1.24	491,790	$6,098.20	$1,219.64
5	EDP	Albendazole 200 mg	Tab	$0.03	1,000	$32.39	10,279	$332.92	$66.58
6	EDP	Ferrous Sulphate 200 + Folic Acid 0.25mg	Tab	$0.003	1,000	$2.97	565,545	$1,679.67	$335.93
7	EDP	Mebendazole 100 mg	Tab	$0.01	1,000	$14.62	8,927	$130.51	$26.10
8	EDP	Mebendazole 500 mg	Tab	$0.14	100	$13.66	5,477	$748.19	$149.64
9	Nutrition	Vitamin A 100000 IU	Cap	$0.02	1	$0.02	1,360	$29.91	$5.98
10	Nutrition	Micronutrient Powder (MNP)	Sachet	$0.02	1	$0.02	7,011,808	$154,259.78	$30,851.96
11	EDP	Dispensing Bags Medium	Pc	$0.01	100	$0.56	227,579	$1,274.44	$254.89
12	EDP	Examination Gloves Large	Pc	$0.12	100	$12.11	136,548	$16,535.92	$3,307.18
13	EDP	Examination Gloves Medium	Pc	$0.12	100	$12.11	318,611	$38,583.82	$7,716.76
14	EDP	Safety Box	Pc	$0.55	25	$13.84	20,849	$11,541.91	$2,308.38
						Sub-total		**$267,504.29**	**$53,500.86**
15	FP	Cycle Beads	Each	$1.44	1	$1.44	328	$471.80	$94.36
16	FP	Male Condom 53mm	Each	$0.03	1	$0.03	5,382,648	$161,479.45	$32,295.89
17	FP	Microgynon	Cycle	$0.26	1	$0.26	125,815	$32,711.79	$6,542.36
18	FP	Microlut	Cycle	$0.30	1	$0.30	39,317	$11,795.12	$2,359.02
19	FP	Female Condom 17 cm	Each	$0.50	1	$0.50	30,108	$15,053.81	$3,010.76
20	FP	Sayana DMPA 104mg/0.65mL	Amp	$0.85	1	$0.85	169,850	$144,372.21	$28,874.44
						Sub-total		**$365,884.18**	**$73,176.84**
21	Malaria	Artemether 20mg + Lumefatrine 120mg (1x6) tabs	Blister	$0.47	30	$14.10	57,970	$27,245.81	$5,449.16
22	Malaria	Artemether 20mg + Lumefatrine 120mg (2x6) tabs	Blister	$0.48	30	$14.40	115,940	$55,651.01	$11,130.20
23	Malaria	Artemether 20mg + Lumefatrine 120mg (3x6) tabs	Blister	$0.45	30	$13.50	96,616	$43,477.35	$8,695.47
24	Malaria	Rapid Diagnostic Test (mRDT)	Test	$0.20	25	$5.05	340,708	$68,823.06	$13,764.61
25	Malaria	Artesunate 100mg Suppository, 2 Suppositories	Blister	$0.63	1	$0.63	5,000	$3,150.00	$630.00
						Sub-total		**$198,347.23**	**$39,669.45**

S/N	Program	Product Description	Basic Unit (BU)	Estimated Cost (BU)	Pack Size	Estimated Cost (Pack Size)	Estimated Annual Qty (2024)	Estimated Cost (2024)	Estimated Freight Cost
1	EDP	Amoxicillin 250 mg Dispersible	Tab	$0.02	100	$2.37	669,118	$15,858.09	$3,171.62
2	EDP	Oral Rehydration salt, 20.5g/L	Sachet	$0.06	1,000	$60.55	107,597	$6,514.98	$1,303.00
3	EDP	Paracetamol 100mg	Tab	$0.01	100	$0.83	1,768,436	$14,678.02	$2,935.60
4	EDP	Zinc Sulphate 20mg	Tab	$0.01	100	$1.24	502,118	$6,226.26	$1,245.25
5	EDP	Albendazole 200 mg	Tab	$0.03	1,000	$32.39	12,243	$396.57	$79.31
6	EDP	Ferrous Sulphate 200 + Folic Acid 0.25mg	Tab	$0.003	1,000	$2.97	673,658	$2,000.76	$400.15
7	EDP	Mebendazole 100 mg	Tab	$0.01	1,000	$14.62	10,633	$155.46	$31.09
8	EDP	Mebendazole 500 mg	Tab	$0.14	100	$13.66	6,524	$891.22	$178.24
9	Nutrition	Vitamin A 100000 IU	Cap	$0.02	1	$0.02	1,620	$35.63	$7.13
10	Nutrition	Micronutrient Powder (MNP)	Sachet	$0.02	1	$0.02	8,352,232	$183,749.10	$36,749.82
11	EDP	Dispensing Bags Medium	Pc	$0.01	100	$0.56	232,358	$1,301.21	$260.24
12	EDP	Examination Gloves Large	Pc	$0.12	100	$12.11	139,415	$16,883.18	$3,376.64
13	EDP	Examination Gloves Medium	Pc	$0.12	100	$12.11	325,302	$39,394.08	$7,878.82
14	EDP	Safety Box	Pc	$0.55	25	$13.84	21,287	$11,784.29	$2,356.86
						Sub-total		**$299,868.84**	**$59,973.77**
15	FP	Cycle Beads	Each	$1.44	1	$1.44	390	$562.00	$112.40
16	FP	Male Condom 53mm	Each	$0.03	1	$0.03	6,411,631	$192,348.94	$38,469.79
17	FP	Microgynon	Cycle	$0.26	1	$0.26	149,866	$38,965.19	$7,793.04
18	FP	Microlut	Cycle	$0.30	1	$0.30	46,833	$14,049.95	$2,809.99
19	FP	Female Condom 17 cm	Each	$0.50	1	$0.50	35,863	$17,931.60	$3,586.32
20	FP	Sayana DMPA 104mg/0.65mL	Amp	$0.85	1	$0.85	219,179	$186,302.31	$37,260.46
						Sub-total		**$450,159.99**	**$90,032.00**
21	Malaria	Artemether 20mg + Lumefatrine 120mg (1x6) tabs	Blister	$0.47	30	$14.10	66,211	$31,119.25	$6,223.85
22	Malaria	Artemether 20mg + Lumefatrine 120mg (2x6) tabs	Blister	$0.48	30	$14.40	132,422	$63,562.73	$12,712.55
23	Malaria	Artemether 20mg + Lumefatrine 120mg (3x6) tabs	Blister	$0.45	30	$13.50	110,352	$49,658.38	$9,931.68
24	Malaria	Rapid Diagnostic Test (mRDT)	Test	$0.20	25	$5.05	389,146	$78,607.41	$15,721.48
25	Malaria	Artesunate 100mg Suppository, 2 Suppositories	Blister	$0.63	1	$0.63	5,250	$3,307.50	$661.50
						Sub-total		**$226,255.27**	**$45,251.05**

S/N	Program	Product Description	Basic Unit (BU)	Estimated Cost (BU)	Pack Size	Estimated Cost (Pack Size)	Estimated Annual Qty (2025)	Estimated Cost (2025)	Estimated Freight Cost
1	EDP	Amoxicillin 250 mg Dispersible	Tab	$0.02	100	$2.37	683,169	$16,191.11	$3,238.22
2	EDP	Oral Rehydration salt, 20.5g/L	Sachet	$0.06	1,000	$60.55	109,856	$6,651.79	$1,330.36
3	EDP	Paracetamol 100mg	Tab	$0.01	100	$0.83	1,805,573	$14,986.26	$2,997.25
4	EDP	Zinc Sulphate 20mg	Tab	$0.01	100	$1.24	512,662	$6,357.01	$1,271.40
5	EDP	Albendazole 200 mg	Tab	$0.03	1,000	$32.39	12,856	$416.39	$83.28
6	EDP	Ferrous Sulphate 200 + Folic Acid 0.25mg	Tab	$0.003	1,000	$2.97	707,341	$2,100.80	$420.16
7	EDP	Mebendazole 100 mg	Tab	$0.01	1,000	$14.62	11,165	$163.23	$32.65
8	EDP	Mebendazole 500 mg	Tab	$0.14	100	$13.66	6,851	$935.78	$187.16
9	Nutrition	Vitamin A 100000 IU	Cap	$0.02	1	$0.02	1,700	$37.41	$7.48
10	Nutrition	Micronutrient Powder (MNP)	Sachet	$0.02	1	$0.02	8,769,844	$192,936.56	$38,587.31
11	EDP	Dispensing Bags Medium	Pc	$0.01	100	$0.56	237,238	$1,328.53	$265.71
12	EDP	Examination Gloves Large	Pc	$0.12	100	$12.11	142,343	$17,237.73	$3,447.55
13	EDP	Examination Gloves Medium	Pc	$0.12	100	$12.11	332,133	$40,221.36	$8,044.27
14	EDP	Safety Box	Pc	$0.55	25	$13.84	21,734	$12,031.76	$2,406.35
						Sub-total		**$311,595.72**	**$62,319.14**
15	FP	Cycle Beads	Each	$1.44	1	$1.44	455	$655.77	$131.15
16	FP	Male Condom 53mm	Each	$0.03	1	$0.03	7,481,458	$224,443.74	$44,888.75
17	FP	Microgynon	Cycle	$0.26	1	$0.26	174,872	$45,466.81	$9,093.36
18	FP	Microlut	Cycle	$0.30	1	$0.30	54,648	$16,394.28	$3,278.86
19	FP	Female Condom 17 cm	Each	$0.50	1	$0.50	41,847	$20,923.61	$4,184.72
20	FP	Sayana DMPA 104mg/0.65mL	Amp	$0.85	1	$0.85	275,424	$234,110.35	$46,822.07
						Sub-total		**$541,994.57**	**$108,398.91**
21	Malaria	Artemether 20mg + Lumefatrine 120mg (1x6) tabs	Blister	$0.47	30	$14.10	69,522	$32,675.21	$6,535.04
22	Malaria	Artemether 20mg + Lumefatrine 120mg (2x6) tabs	Blister	$0.48	30	$14.40	139,043	$66,740.86	$13,348.17
23	Malaria	Artemether 20mg + Lumefatrine 120mg (3x6) tabs	Blister	$0.45	30	$13.50	115,870	$52,141.30	$10,428.26
24	Malaria	Rapid Diagnostic Test (mRDT)	Test	$0.20	25	$5.05	408,603	$82,537.78	$16,507.56
25	Malaria	Artesunate 100mg Suppository, 2 Suppositories	Blister	$0.63	1	$0.63	5,513	$3,472.88	$694.58
						Sub-total		**$237,568.03**	**$47,513.61**

S/N	Program	Product Description	Basic Unit (BU)	Estimated Cost (BU)	Pack Size	Estimated Cost (Pack Size)	Estimated Annual Qty (2026)	Estimated Cost (2026)	Estimated Freight Cost
1	EDP	Amoxicillin 250 mg Dispersible	Tab	$0.02	100	$2.37	697,516	$16,531.12	$3,306.22
2	EDP	Oral Rehydration salt, 20.5g/L	Sachet	$0.06	1,000	$60.55	112,163	$6,791.48	$1,358.30
3	EDP	Paracetamol 100mg	Tab	$0.01	100	$0.83	1,843,490	$15,300.97	$3,060.19
4	EDP	Zinc Sulphate 20mg	Tab	$0.01	100	$1.24	523,428	$6,490.51	$1,298.10
5	EDP	Albendazole 200 mg	Tab	$0.03	1,000	$32.39	13,498	$437.21	$87.44
6	EDP	Ferrous Sulphate 200 + Folic Acid 0.25mg	Tab	$0.003	1,000	$2.97	742,708	$2,205.84	$441.17
7	EDP	Mebendazole 100 mg	Tab	$0.01	1,000	$14.62	11,723	$171.39	$34.28
8	EDP	Mebendazole 500 mg	Tab	$0.14	100	$13.66	7,193	$982.57	$196.51
9	Nutrition	Vitamin A 100000 IU	Cap	$0.02	1	$0.02	1,786	$39.28	$7.86
10	Nutrition	Micronutrient Powder (MNP)	Sachet	$0.02	1	$0.02	9,208,336	$202,583.39	$40,516.68
11	EDP	Dispensing Bags Medium	Pc	$0.01	100	$0.56	242,220	$1,356.43	$271.29
12	EDP	Examination Gloves Large	Pc	$0.12	100	$12.11	145,332	$17,599.72	$3,519.94
13	EDP	Examination Gloves Medium	Pc	$0.12	100	$12.11	339,108	$41,066.01	$8,213.20
14	EDP	Safety Box	Pc	$0.55	25	$13.84	22,190	$12,284.42	$2,456.88
						Sub-total		$323,840.35	$64,768.07
15	FP	Cycle Beads	Each	$1.44	1	$1.44	478	$688.56	$137.71
16	FP	Male Condom 53mm	Each	$0.03	1	$0.03	7,855,531	$235,665.93	$47,133.19
17	FP	Microgynon	Cycle	$0.26	1	$0.26	183,616	$47,740.15	$9,548.03
18	FP	Microlut	Cycle	$0.30	1	$0.30	57,380	$17,214.00	$3,442.80
19	FP	Female Condom 17 cm	Each	$0.50	1	$0.50	43,940	$21,969.79	$4,393.96
20	FP	Sayana DMPA 104mg/0.65mL	Amp	$0.85	1	$0.85	289,195	$245,815.87	$49,163.17
						Sub-total		$569,094.30	$113,818.86
21	Malaria	Artemether 20mg + Lumefatrine 120mg (1x6) tabs	Blister	$0.47	30	$14.10	72,998	$34,308.98	$6,861.80
22	Malaria	Artemether 20mg + Lumefatrine 120mg (2x6) tabs	Blister	$0.48	30	$14.40	145,996	$70,077.91	$14,015.58
23	Malaria	Artemether 20mg + Lumefatrine 120mg (3x6) tabs	Blister	$0.45	30	$13.50	121,663	$54,748.36	$10,949.67
24	Malaria	Rapid Diagnostic Test (mRDT)	Test	$0.20	25	$5.05	429,033	$86,664.67	$17,332.93
25	Malaria	Artesunate 100mg Suppository, 2 Suppositories	Blister	$0.63	1	$0.63	5,788	$3,646.52	$729.30
						Sub-total		$249,446.43	$49,889.29