



# HOW CAN THE HEALTH SYSTEMS OF GUINEA, SIERRA LEONE AND LIBERIA BE IMPROVED?

*Results of three Open Space Conferences with participants from government and civil society, healthcare providers and users, community health volunteers and traditional practitioners, donors and aid organization*

meGem



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## EXECUTIVE SUMMARY

Between February and March 2016, three Open Space Conferences (OSC) were conducted – one per country in Guinea, Liberia and Sierra Leone. All conferences focused on the question how the respective national health system can be improved and which contribution communities can make to support government efforts. The Open Space Conference methodology is a participatory approach activating existing knowledge and capacities while leaving out external input and teaching. The conferences brought to the fore the lessons learned which could be drawn from the recent Ebola epidemic and used for rebuilding a more resilient and better health system. Participants included a cross-section of decision makers, healthcare providers including traditional healers and birth attendants, funders, supporters and users of health systems in the three countries. The same process has been conducted in the three neighboring countries, Guinea, Liberia and Sierra Leone in order to permit a comparison

of issues and shared learning amongst similarly affected countries.

In all three conferences, participants were highly motivated and involved in meaningful exchange of ideas with others. As a common trace, when reflecting on the challenges of each national health system, participants in all countries identified the responsibilities of their government and underlined the current short-comings and resulting needs. At the same time, they stressed that communities should be provided with opportunities to participate more in health system governance. Discussions focussed on access to and quality of health services, the health workforce situation including the conditions of service, loss of confidence in the health system, challenges related to infection prevention and control, the management of emergency situations, the needs of vulnerable groups and the optimal form of health education. There were similarities with respect to solutions in Guinea, Liberia and Sierra Leone.

*Stakeholder Premeeting in Liberia – Working on the list of participants to be invited to the OSC*





Assessment of different titles for the conference in Liberia

Some differences appeared regarding the possible dimensions of community contributions. While water, sanitation and hygiene (WASH) appeared to be highly important for general community life in Sierra Leone, it was discussed only in the context of health facilities in Guinea and Liberia. The services of community health volunteers and traditional medicine practitioners were not so central in Guinea, while important in the other two countries. Female genital cutting mutilation (FGC/M) and management of caesarean sections were only discussed in Guinea.

With respect to all issues related to missing infrastructure, only Liberian and Sierra Leonean participants were of the opinion that communities would be able and willing to contribute in-kind e.g. manpower, land, building materials or security services to their health infrastructure.

The three conferences brought about operational research and support needs with respect to community participation, health system governance, re-establishment of a trusted workforce, maintain-

ing infection prevention and control perpetually and managing trans-border health. It became clear that none of these issues can be tackled successfully without involving communities. The process of rebuilding and strengthening the post-Ebola health systems of Guinea, Liberia and Sierra Leone should factor in the force of community contributions in health. The Open Space Conferences have shown that energy and interest is endless if people have the feeling that their opinion and their ideas count.

## 1. – INTRODUCTION

“Identify the main challenges of your post-Ebola health situation and then find solutions” - this challenging task was given to 463 participants at three Open Space Conferences in the countries Guinea, Liberia and Sierra Leone. The task was further specified: “Discuss how communities can contribute to the identified solutions and how they can become active in collaboration with government”.

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The stakeholder groups were made up of a cross-section of decision makers, healthcare providers, funders, supporters and users of health systems in the Manu River region. Among them were directors of ministries dealing with health, district health teams, representatives of district, chiefdom and village administrations, medical staff from public, private and faith-based health facilities, traditional practitioners (healers and birth attendants), community health volunteers, professional associations, international non-governmental organizations (NGOs) and multilateral partners, representatives of Muslim and Christian congregations, members of civil society and community based organizations including Ebola survivors, police and military, radio and television. People were there to represent their organizations and professions, but they also represented their life situation and their experiences with the health system. Participants were as diverse as teenage mothers, market women, adolescents, fishermen, persons living with disabilities, parents etc.

Each of the three Open Space conferences had specific titles which had been determined in a pre-meeting of a fraction of the participating groups in the forefront, specific dates and organizing NGOs:

- In Guinea the “National Inclusive Forum for the improvement of the health system” was organized from 22nd to 24th March 2016 by the NGO TINKISSO Antenna.
- In Liberia the conference was titled “New Approach to improve the quality of health service in Liberia”, organized from 16th to 18th February 2016 by the New Africa Research Development Agency (NARDA).
- In Sierra Leone the “Inclusive national conference to improve healthcare in post-Ebola Sierra Leone” was organized from 2nd – 4th February 2016 by the Sierra Leone Adult Education Association (SLADEA).

The conferences were supported by the German Institute for Medical Mission (DIFAEM), facilitated by the Berlin-based MediationsGemeinschaft (meGem) and funded by the German Ministry of Economic Cooperation and Development (BMZ) via German International Cooperation (GIZ).

By focusing all conferences on solutions to identified challenges which strengthen public-private col-

laboration by tapping into existing capacities and needs at community level, the conferences contributed to the existing national dialogues between civil society and government health structures on needs of improvement in health. The following comparison and synthesis of the discussion results of the three country conferences explores potentials and opportunities for joint public-civil society action to restore effective and efficient health service delivery. It provides a valuable overview on how the situation is perceived by health care professionals as well as a wide range of population segments as well as ideas on which problems can be tackled in which way.

## **2. – METHODOLOGY OF THE OPEN SPACE CONFERENCE**

The Open Space Conference methodology is a participatory approach activating existing knowledge and capacities while leaving out external input and teaching. At pre-meetings in each country, a cross-section of all participating groups defined the title of the individual conference and ensured that all relevant stakeholder groups were invited. During the conferences, the participants set the agenda and brought in their own knowledge and the priorities for which they have a burning passion. In the first hours of the conferences, participants suggested the topics that were to be discussed in several small breakout discussion groups thereafter. The framework was given by the respective national theme of the conference. After the first round of defining discussion topics, a process of prioritization was conducted to reduce the number of suggested topics to a manageable number.

During the first two days, the issues suggested by the participants were discussed in depth in groups of 3-25 people. On day three of the conferences, the results of these group discussions were read to the complete audience and thereafter participants offered their priority issue for further discussion on community action. Thus, the Open Space methodology motivated and facilitated the expression of interests, the sharing of experiences of participants and the imparting of local knowledge on health and health system strengthening. All debates were documented by the participants themselves and compiled in a Book of Proceedings at the end of each Open Space Conference.





*Presenting the idea of Open Space in Guinea*

### **3. – SIMILARITIES IN DISCUSSION OF TOPICS AND SOLUTIONS**

The participatory conference format ensured in all countries that participants were highly energetic and continuously involved in the exchange with others. Participants in all countries expressed a high level of surprise and appreciation for a conference that was so interested in their own ideas and steering.

As a common trace, when reflecting on the challenges of each national health system, participants in all countries identified the responsibilities of government for the health system and underlined the current short-comings and resulting needs. The following expectations were expressed in Guinea, Liberia and Sierra Leone: Government should set up an appropriate health infrastructure to cover all geographic areas equally according to the common standards of accessibility. In all countries this would mean further health posts and hospitals. These facilities should be provided regularly with sufficient essential drugs and medical supplies. In Liberia, drug supply received special attention and emphasis and led to the recommendation of re-establishing a revolving drug fund health facilities. Mobile services for remote areas were seen as a necessary investment in all countries. Government should direct and guide the management and supervision of facilities properly so that corruption and mismanagement were minimized.

In all countries, participants also stressed that communities should be provided with opportunities to participate more in health system governance. The foundation for such participation would be regular meetings between district and community stakeholders for which community members would need some capacity building. In Sierra Leone it was suggested that communities and government health officials as well as local facility staff should develop a health service delivery charter for the catchment area of each health facility. Health service performance could then be monitored using a score card system which was suggested in Liberia. In Guinea, participation of communities would especially mean to control corruption with respect to user fees and undue selling of pharmaceuticals by health staff. Community-based health insurances were perceived by all participants, irrespective of country of origin, as a suitable instrument to improve ownership and financial resources for the local health system.

Another call on all three governments concerned human resource management in health. Governments should intensify efforts to train and deploy sufficient staff, to pay proper salaries based on education and professional experience, provide incentives for work in remote areas, equip workplaces properly and assure occupational health and safety. Participants in all countries also called for more and decentralized training institutions for health professions. These efforts would help reducing health worker frustration, increase interest in the profession and stop shortage and turnover of staff. In this con-



*Training of Open Space Team Assistants in Sierra Leone*

text community contributions were also discussed. Guinean, Liberian and Sierra Leonean participants were all of the opinion that communities can provide or facilitate accommodation and access to food for staff of their health facility as incentives to remain at their postings. Yet, community members among participants stressed their expectation that the relations between communities and the health workers would have to be intensified in order to really bring a change for the better in service provision.

An essential challenge in all countries appeared to be the loss of confidence of the population in health workers and the overall health services. Strengthening of ethical behaviour of staff was mentioned as a key need. In Liberia it was suggested to develop a Code of Conduct or Ethics for the health professions. This code would require guidance from government and could be provided from the central level. Communities, district health management officials and health facility staff should endorse it. It could then be followed up and monitored by community members – or, as Guinean participants pointed out, become part of community by-laws.

After having gone through similar experiences during the Ebola epidemic, participant groups of the three countries raised concerns about Infection Prevention and Control (IPC). They agreed that maintaining the high level of IPC established during the Ebola crisis will require additional and continuous efforts including enhanced management practices and better and faster information by government on potential future outbreaks. Triage spaces were not yet built in all facilities, and staff would need refresher training to make IPC capacities part of work practice. On the side of communities, committees for emergency management should be set up and become part and parcel of local management as well as district disaster response teams at the superior level. Psycho-social counselling and safe management of dead bodies should be services available in all communities. In border regions, a better cross-border exchange on health issues and a reactivation of emergency management within the existing Mano River Union framework was suggested by Guinean participants. IPC is closely connected with disease surveillance and reporting of infectious and non-infectious diseases. In all countries the need



was seen to improve local capacities in this respect. In Liberia and Sierra Leone, community health volunteers and traditional midwives and healers were seen as an integral part of community-level IPC.

Independent from country of origin, participants were furthermore concerned with government responsibility for improving the road infrastructure and ambulance availability. In addition, communication amenities between facilities for emergency management and referral seem to be missing in all countries. This would be of special relevance for women during pregnancy and childbirth. Better emergency arrangements would save the lives of mothers and their babies. In Guinea, the policy on free caesarean section was scrutinized in two discussion groups. As this policy was not being put into action it should be reformed and then enforced by government. Women's health received special attention in all countries. Participants concluded that women need more health and literacy education to improve health outcomes for themselves and their infants and children. Sexual exploitation of women should be persecuted by strong disciplinary action. Women should become part of health management committees at community level.

Discussion groups at all conferences dealt with the challenges that persons with disabilities face in the health care system. Communities and governments can jointly contribute to greater accessibility of health services, i.e. by building ramps, providing transport or organizing sign language support. The reduction of stigma and discrimination of disabled patients would have to be integrated into a Code of Conduct on ethical behaviour. The survivors of the Ebola epidemic and individuals affected by it received specific attention in all conferences. Psychosocial counselling and more overall support were seen as needs of Ebola survivors. This should include moral and financial support from communities. In Sierra Leone it was suggested to provide Ebola survivors with positions of authority in communities in order to increase preparedness of communities towards epidemic outbreaks. The conferences in Guinea and Sierra Leone gave room for the discussion of food security under the aspect of maternal and child health and the well-being of vulnerable households. In Liberia, a similar issue was discussed under the headline of poor community members. In both instances, community support was seen as the first option for action.

Health education for community members should generally be provided in the form of trainings or educational materials in local languages. Also media should play a bigger role in promoting health and healthy behaviour. This expectation was put forward in all conferences. The Liberian participants suggested in addition that health education should address traditional beliefs. The Sierra Leonean counterparts recommended using adult education for imparting knowledge on health; in Guinea, participants requested government to publish regular bulletins with health information especially for health workers and community members dealing with health issues.

## 4. – DIFFERENCES IN THE DISCUSSIONS

Though organized in a similar way and with the same amount of funding, there were still some differences between the actual meetings. Whereas the conferences in Guinea and in Sierra Leone took place in the respective capital cities, the conference in Liberia was conducted in the district town of Gbarnga. This led to differences in participation. High-level government officials from Monrovia were less represented in the Liberian conference, while a higher ratio of rural population could join of whom a share was not conversant enough in reading and writing. There was, however, a reading and writing office at each conference assisting participants who needed help. The full Book of Proceedings was read out to everyone on the third day. There was therefore no impediment to active contribution. On the other hand, heated discussions took place in Sierra Leone with ministry officials. Guinean participants discussed openly system-immanent practices of nepotism and corruption within the ministry and civil servants as well as other health care providers.

After the first conference which was conducted in Sierra Leone, an adaptation in methodology was made because the number of proposed topics was very high. In Sierra Leone participants could choose from 70 topics but had only about 1.5 hours for each in-depth discussions. In Liberia and Guinea a prioritization was done by participants after the first round of suggesting topics for the discussions. Thus, in Liberia and Guinea only 30 topics were offered for in-depth discussions and the participants

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had about 2.5 hours for exchange on each subject making it easier to explore the issues fully.

Some remarkable differences could be recorded with respect to the topics discussed. Water and sanitation (WASH) was a strong focus in Sierra Leone: the installation of clean water sources, their maintenance, hygienic behaviour, proper garbage disposal, community-led total sanitation (CLTS) were the issues at the forefront. Government was seen as responsible for the infrastructure, communities were perceived as capable of contributing to installation, maintenance and behaviour change. In Liberia and Guinea, WASH was dealt with as only a side-topic in the discourse on the improvement of health facilities. On the other hand, there was hardly any discussion on volunteer services and traditional practitioners like midwives and healers in Guinea. In the other two countries the roles and contributions of community health volunteers and traditional medicine in the process of strengthening the national health systems had a prominent place in the overall discourse. The discussions related to proper training of volunteers and traditional practitioners, close networking and communication with health facilities, supervision by health staff and even the issue of salaries for volunteers in Liberia. Participants underlined the need for better integration, recognition and appreciation of traditional medicine and called for a better guidance by government. Volunteers and traditional practitioners were seen as appropriate agents for health promotion.

Restricted to Guinea was the topic of female genital cutting/mutilation (FGC/M). Here, participants expected government and health workers to enforce existing laws. The discussion group agreed that health workers should be forced to report all instances of FGC/M to higher authorities. On the other hand, the Guinean participants did not discuss the problem of teenage pregnancies which was very prominent in both Sierra Leone and Liberia. There were some very specific topics like climate change and the problems arising from uncontrolled house pets which were only discussed in Sierra Leone.

In all countries, reflecting on the possible contributions of communities was a key task for the group exchange. In Liberia and Sierra Leone participants were of the opinion that communities could contribute manpower, land and building materials for infrastructural measures as well as provide security services for health facilities. Nothing of that kind was

suggested as a community contribution in Guinea. The Sierra Leonean participants underlined more the power of community by-laws as an instrument for behaviour and structural change.

## **5. – OPERATIONAL RESEARCH AND SUPPORT NEEDS**

The three Open Space Conferences in Guinea, Liberia and Sierra Leone provided a platform for different stakeholders of the health systems to discuss needs, approaches and open questions relating to the process of bringing the national health systems back to strength. A number of research and support needs can be derived from this fruitful discourse.

The first research and support need that can be identified is concerned with community participation in health system governance. It is of national and international interest to learn more about the role of communities in building a resilient health system. Community contributions to health system strengthening are highly influenced by the local context. Therefore more participatory exchange and planning processes are needed to generate joint approaches between community stakeholders and public health structures. In addition, it is important to identify the success and failure factors for health and facility management committees at community level. Operational research can help to find out what kind of support these committees would need to become active and effective forums for joint governance of the local health system. Last but not least, by-laws of the communities relating to health, water, sanitation and the environment are important tools to influence behaviour and the local situation. Research on by-laws will aid to better understand their range of influence as well as their effectiveness and challenges relating to enforcement.

The second research and support need relates to human resources in health. The loss of confidence of patients in their health services and of health workers in their workplaces is a very unique negative consequence of the Ebola crisis. How can this breach be bridged? Which measures are helpful to regain trust and confidence in the health system? The shortage of health workers in all three countries cannot easily be overcome. Therefore, the role, responsibilities, capacities and supportive poten-

tial of community health volunteers and traditional practitioners requires further exploration as well. All available means have to be used to strengthen the weakened health workforces in the region.

As a third research and support need IPC comes to mind. How can successful procedures, capacities and experiences be turned into perpetual changes? Which knowledge is still missing, which channels of imparting a deeper understanding have to be strengthened, which mix of training, refreshing, mentoring and on-the-job support is the right one? Capacity building and funding for IPC should also bring benefit to other fields of health service provision as well such as management of non-communicable diseases or maternal and child health.

Since the Ebola epidemic was a regional one with patients crossing borders and spreading the disease, trans-border health management has to move into the focus as a fourth research and support need. And it does not confine to communicable diseases only. Migrant workers cross borders in all three countries in high numbers every day. Prevention of disease transmission, management of health service usage, health education in the setting of migration are only some aspects in trans-border health management. Which role can regional institutions like the Mano River Union play in this respect?

## 6. – CONCLUSION

The Open Space Conferences brought together stakeholders from national, regional and district level, from government, civil society and the private sector. The conferences were characterized by a high level of motivation of all participants – they were passionate to get involved in rebuilding a health care system that will meet the needs of their communities and that will also be ready for any emergency that may occur. The discussion output and the needs identified by the participants provide guidance to decision makers and program managers on the issues to focus on and the priorities to respond to.

Community involvement and contribution can be seen as key to sustainable change and improvement even if means and wealth of communities are limited. Community participation fosters ownership and ownership triggers community investment even if it has to remain in-kind. The process of rebuilding and strengthening the post-Ebola health systems of Guinea, Liberia and Sierra Leone should factor in community force in health. The Open Space Conferences have shown that energy and interest is endless if people have the feeling that their opinion and their ideas count.

*Open Space team assistants and facilitators in Guinea*







## ANNEX A: GUINEA – DETAILED RESULTS

*Results of the First Open Space Conference*

### **“Forum National Inclusif pour l’Amélioration du Systeme de Santé en Guinee”**

[National inclusive forum for the improvement  
of the health system in Guinea]

22-24. March 2016

Conakry, Guinea



*The plenary setup in Guinea*

## **A 1. – THE CONFERENCE IN GUINEA**

From 22 to 24 March 2016, the Guinean non-governmental organization Tinkisso Antenna conducted an Open Space Conference in Conakry. Of the 160 persons participating in the OSC, about half came from Conakry and the other half from the regions Kindia, Boké, N’Zérékoré, Mamou, and Labé.

With 6 of 9 regions being represented, the conference was national in character. To strengthen intra-regional exchange, four participants came from Sierra Leone, and one from Liberia - who had all already participated at their respective national Open Space Conferences (OSC). Those Guinean participants who had participated in the OSCs in Sierra Leone and Liberia were also present at the OSC in Conakry. 35 individuals came from the public sector representing 22% of the overall participants. The following groups were represented:

- Ministry of Health (Headquarters)
- Ministry of Social Welfare (Headquarters)
- Regional and prefectural health officials (deconcentrated MoH offices)
- Medical and administrative staff from public, private and faith-based health facilities
- Professional associations at nurses, midwives, medical doctors
- Community Health Volunteers
- Multilateral and bilateral organizations: World Health Organization (WHO), International Organization of Migration (IOM), GIZ, United Nations Volunteers (UNV)
- Community members: elderly, market women, young women, people living with disabilities, youth
- Ebola survivors and families of deceased
- Representatives of Christian and Muslim congregations and faith-based organizations
- Representatives of various civil society and community-based organizations, incl. environmental NGOs
- Radio and TV journalists

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## A 2. – TOPICS RAISED AND DISCUSSED

### A. IMPROVEMENT OF HEALTH CARE FACILITIES AND MANAGEMENT

The quality of and access to health services in rural and remote areas were central topics in all debates. Improvement of equipment, infrastructure and hygiene of primary health structures and health centres were seen as key necessities. Government was perceived as responsible for building, maintaining and supplying health facilities with energy and water, sufficient equipment, drugs and a governance structure, in which the community should participate. Also further mobile services for remote areas were requested. All this should be based on an assessment of existing services and actual needs in the area. According to the participants, communities are willing to collaborate with prefectural directorates for health (DPS) in the management and monitoring of facilities. This could include a better inventory control of pharmaceuticals and health facility assets. It would require capacity building for community members to enable them to cooperate with the DPS in the management of facilities.

As part of water, sanitation and hygiene (WASH) appropriate waste disposal systems in health facilities



*Dr. Barry from the Ministry of Health brings in the government perspective*

was discussed by the participants. Youth engagement in environmental protection and communal hygiene was strongly encouraged. They were projected as change agents in communities to encourage careful handling of dangerous substances, proper waste disposal and respect for public hygiene.

The establishment of community-based health insurance schemes was debated as an instrument to improve accessibility of services in local health structures and to increase community ownership and investment. Communities could also take part in assuring accountability and sustainability if capacitated. However, social mobilization on health issues would require health education and promotion in local languages and the development of trust in the new system.

Furthermore, the participants requested the MoH and the medical board to publish regular bulletins on health issues to improve the perpetual education, training on the job and mentoring of health workers.

### B. HEALTH WORKERS AND HUMAN RESOURCE MANAGEMENT

Participants assessed the human resources situation in the health sector as having declined over the last two decades. Lack of capacities, frequent staff turnover, high frustration of staff with dissatisfying working and living conditions and limited career options were mentioned as major weaknesses in human resource management in health. Another major concern stated was payment which often does not arrive on time and in full quantity. Especially health workers posted to rural areas have to spend considerable amount of time negotiating disbursement of their salaries. Participants requested government to develop a comprehensive and transparent educational and professional experience based salary scheme and to ensure timely disbursement and effective delivery of salaries on all hierarchical levels.

Weak work ethics, lack of medical professionalism, shortage and maldistribution of health workers and little involvement of communities in human resource management were identified as shortcomings by the participants. They highlighted the disrespectful attitude many health staff take towards patients with low formal education leading to insufficient communication and information as well as neglect-



ful care of patients. According to participants, the Ebola crisis aggravated this situation and additionally caused a loss of confidence of patients in health care provision. To make it even worse, health staff on their side also lost confidence in their workplaces due to the high toll of lives that Ebola caused among health staff.



*Dr. Gisela Schneider from DIFAEM welcomes participants*

Participants concluded that more and decentralised training institutions are needed to develop professional capacities in the health sector. Curricula would have to be harmonised regarding the different health-related professions, and advanced trainings and mentoring systems as well as “mentoring on the job” should be introduced. This should be accompanied by regular performance reviews and quality controls conducted by qualified supervisors and supported by communities. Participants insisted that expatriate specialists should have the obligation to transfer knowledge and equipment to local colleagues, rather than leaving no trace behind at the end of their mission.

Participants called for a timely recruitment and a demand-based deployment of staff. This would in-

volve a review of the recruitment and deployment policy. They also supported periodic performance appraisals, the development and respect of career pathways, and capacity development interlinked with a respective increase of income to make health care a more attractive profession. Incentives for deployment in remote areas, scholarships for post-graduate studies, staff exchange between e.g. the countries of the Mano River Union were mentioned as measures to keep health personnel interested in their work. The discussions also identified how communities could support human resources in health: they could help by providing accommodation and access to food for health staff.

### MULTI-SECTORAL HEALTH CARE: SOCIAL WORKERS

Participants addressed the integration of social workers into the future public health system. Observing that people in vulnerable situations often have both health and social support needs, participants called on the respective ministries to collaborate closely on education, recruitment and deployment of social workers. This professional group could liaise with individuals and primary health care providers and community health workers, accompanying the patients through the health system and ensuring that their rights and needs are met.

Social and community health workers would need specialised education in order to complement rather than supplant each other. This multi-sectoral approach would have to be implemented on prefecture and community (Commune Urbaine, Commune Rurale) level to ensure that policies and practices of the integrated support system work and effectively reach those people who are the most vulnerable in the community and who do not get sufficient support – a concern the Ebola outbreak brought to the fore.

### C. REFERRAL SYSTEMS

The road and communication infrastructure as well as the lack of ambulances were a main concern of participants when considering service delivery in rural settings. Participants called on government to improve these basic infrastructures that would enable health professionals at different health care levels to integrate their services better. Knowledge transfer and referrals to hospitals should thereby

happen more smoothly and quickly. Participants suggested government to provide radio systems with solar panels to enable medical mentoring by experienced doctors of health workers in remote settings who face complicated disease and accident cases. Collaboration between local transport unions and the corresponding health unit was suggested to enable emergency transportation at a reduced price in case of emergency referrals, until sufficient ambulances are available. A community-based health insurance could assist in the recovery of these emergency transport fees.

The community health management team (envisioned by the participants to cooperate with the local health facility and the DPS) should assist in public health education as well as management of infectious disease outbreaks and other public health disasters. Participants underlined the situation of people who are not sufficiently conversant in reading and writing which leads to excluding them from certain parts of public life, especially from informing themselves and their families on emergency health issues. Public communication should be more adapted to realities and needs of



*Participants note down their issues for discussion*

#### **D. INFECTION PREVENTION & CONTROL AND EARLY WARNING SYSTEMS**

Participants saw a need for training and better organization of infection prevention and control (IPC). The training should continue and include Ebola, Lassa Fever, Measles, Yellow Fever, but also seasonal diseases like Cholera. Refresher trainings would lead to a better implementation of IPC practices and ensure health staff reporting to the disease surveillance section of the MoH.

communities. Their communication structures and power hierarchies should be better understood so that they can be used as established communication channels which do not exclude any community members from epidemiological information. This would help preventing rumours from spreading. Diversification of health information should include using simple French (*française facile*), by translating materials into other commonly used languages like Arabic and by making use of culture-specific pictograms. On a more general note, participants remarked that illiteracy should be de-stigmatised;





*Active participation in discussion groups*

community by-laws could support adult literacy projects in each community.

Given the experiences with the Ebola outbreak, participants called for early and complete information on public health emergencies, better government coordination of national and international interventions and an uncoupling of all these efforts from political party, domestic and regional power struggles.

In a related matter, the cross-border Ebola response was identified as a weak point that aggravated the (re-)import of Ebola from neighboring countries. Participants expressed their surprise on weak health intelligence and diplomatic infrastructure and called on the government to re-activate the existing framework of the Mano River Union. Cross-border IPC systems should be developed and maintained.

## **E. REASONS AND AFTERMATH OF THE EBOLA CRISIS**

The discussion groups reflected on the reasons why Ebola became such a crisis in the country. The following reasons were mentioned: insufficient understanding of Ebola by communities and suspicion that the disease was a political “creation”; mistrust of public health interventions; lack of adequate local and national health capacities, equipment and trained health staff; resulting fear of Ebola by front-

line health workers and their discrimination by the wider community.

The health situation, stigmatization and discrimination of EVD-survivors were also topic of discussion. According to participants, they do not receive sufficient medical attention, and suffer from health complications, loss of job opportunities, livelihoods and problems with reintegration into the communities. Ebola survivors would require psycho-social counselling, moral support of communities and financial support such as scholarships, skills training and job offers. It was also suggested to provide Ebola survivors with positions of authority in the community to speed up reintegration and to support in the event of a future outbreak. Similar needs were reported for families of EVD-victims.

## **F. NUTRITION AND FOOD SECURITY**

As another cross-cutting topic, food security was raised especially for vulnerable groups. Harvesting, seed banks and crop sharing should be supported by communities to ensure a minimum-level distribution to vulnerable households. Knowledge on food growing and preparation choices should be imparted by local health workers and supported by public health education of the whole community, so as to maximise the nutritional value of available food items.





*Team assistants support the proceedings of the conference*

### **A 3. – ASPECTS RELATING TO VULNERABLE GROUPS**

The Open Space Conference also intended to reflect the needs of groups in vulnerable contexts. For this reason, persons representing these groups like women, elderly, young people or persons living with disabilities made up a significant part of the participants.

Participants addressed specifically the need for community-level protection of and special services for vulnerable groups, as many social circumstances have direct impact on individual and community health. Community by-laws and public institutions should direct state officials, elected councillors as well as elders to assist and protect persons in vulnerable situations. Participants elaborated that this would include women and children suffering from violent family members, exploitation by public officials, teachers, other community members, or in situations where they needed particular support, e.g. during and after pregnancy, loss of parents or husband, inheritance etc. State officials and community leaders should be held responsible for their

support; short comings should be followed up by disciplinary action.

#### **A. WOMEN**

Participants pointed out that women suffer most from weak health systems because they depend on reproductive health services as well as primary health services in their role as care takers of sick family members. At the same time, they are more vulnerable as their formal education, literacy, available budget and social standing in the community is often weaker than that of their male counterparts. Therefore, health workers should foster respectful relationships with female patients and caretakers of the sick. Women would need to be better informed about their rights towards health workers. Health services should be tailored more to their needs. Sexual favours and other kinds of exploitation by health workers should be discouraged and perpetrators strongly disciplined. Families and communities could play a role in improving women's health by involving women experienced in health care, including local birth attendants, in local health management committees. Furthermore, women can



*Facilitators Mariama Berete, Juliane Westphal and Mamadi Cissé explain the process*

benefit from adult education and income generating activities including microfinancing.

Participants called for government and health workers to enact laws forbidding FGC/M in Guinea, instead of taking a position of ambivalence to it. Health workers should be forbidden to enact or implicitly support the practice by none-reporting cases of FGC/M. Participants also called on government to clarify caesarean section (CS) policies, which currently seem to limit accessibility for pregnant women in need of CS. Services should be offered according to those policies.

## **B. INFANTS AND CHILDREN UNDER 5 YEARS**

Infants and children under 5 years of age were identified as particularly vulnerable. Participants suggested encouraging communities to become more actively involved in the wellbeing of young children, supporting their families together with the local health workers, to ensure appropriate nutrition, vaccination and WASH education.

## **C. PERSONS LIVING WITH DISABILITIES OR CHRONIC ILLNESSES**

Participants observed a lack of governmental support from people living with disabilities. Only specialised programmes of development partners would target this group, however, being accessible only in particular geographical areas or over a brief period of time. In order to improve their mobility hence access to services, health facilities should be equipped with ramps, rails etc. Mobile services should be offered to people with limited mobility and those with specific chronic conditions like diabetes, a complex condition with increasing levels of affliction in Guinea. Preventative measures such as public health education should address causes and preventative steps for all types of diabetes and other chronic conditions.

## **A 4. – COMMUNITY INVOLVEMENT**

Participants observed that the needs of communities are not sufficiently considered in national health policies and prefecture-level health plans because poor rural or urban communities lack capacities to

formulate their health needs. Therefore, community representatives should be capacitated to participate in health management committees. Involving communities would mean to regularly survey their needs and priorities and to evaluate the health services available to them. This could lead to the joint development of a health delivery charter in which all parties define their respective rights and responsibilities. Health care users and providers should jointly monitor the implementation of the health delivery charter.

In light of the key role international partners have in delivering or supporting health services, participants encouraged government to take a stronger coordination role so as to reach a better distribution of services across the country. Populations in all regions of the country should benefit from health programmes, instead of concentrations of development organizations in certain areas. At the same time, participants pointed out that development partners have their own policies, which are sometimes not harmonized with government policies on national, regional and prefectural levels. In particular, the roles of community engagement, health promotion and surveillance committees were defined very differently by the various intervening organizations. According to participants, the particularities of health interventions became particularly evident during the Ebola outbreak, but highlighted a long-term experience of communities engaging with various donors, NGOs and government programmes.

Health workers are central actors for the promotion of public health and health education. Participants called for more outreach of health workers to the general public and specifically to persons in vulnerable situations e.g. pregnant women or young children. This should be supported by closer interpersonal relationships between community members and health workers. Community life could more strongly reflect health issues. Participants suggested involving communities more closely in the hosting of health workers, provision of housing and food, integrating them into community life and thereby enabling them to share information and education more easily.

#### EDUCATION, COMMUNICATION AND HEALTH PROMOTION

Education is an important vehicle to improve health related knowledge to everyone. Participants re-

quested better integration of health education into (pre-) schools and adult education programmes. Respective ministries on central government level should coordinate budget needs, curricula and integrated role out of these efforts. Participants identified media as an underused partner for health education. Existing media networks should be used to disseminate quality health information in local languages, to discourage the spreading of rumours and encourage better relations between health workers and the population. The development of a specialised radio station on health was strongly encouraged, which should however not replace regular health education programmes in established radio and media outlets.

### A 5. – TOP 7 COMMUNITY ACTION PRIORITIES

In a final prioritization process the participants defined seven top priorities for further action among the many topics discussed during the first two days. These priority areas were:

- Priority 1. Establishment of mobile medical units
- Priority 2. Organizing a conference to found a network of faith-based health structures (Christian and Muslim)
- Priority 3. Founding community surveillance committees in health structures
- Priority 4. Putting in place a protection system for children and women
- Priority 5. Developing good sanitary practices
- Priority 6. Strengthening active community participation in the implementation of periodic diagnostic reviews [of the health system and community health needs]
- Priority 7. Founding a community-based health insurance





The participants in Guinea



The organizers in Guinea: Dr. Gisela Schneider of Difäm (3rd left) Aboubacas Camara of Tinkisso (4th left) and facilitators Tejan Lamboi (1st left), Anita Schroven (2nd left), Mamadi Cissé (5th left) and Juliane Westphal (6th left)



## **ANNEX B: LIBERIA – DETAILED RESULTS**

*Results of the First Open Space Conference*

***“New Approach to Improve the Quality  
of Health Service in Liberia”***

**16 -18<sup>th</sup> February 2016**

**Gbarnga, Bong County, Liberia**





*The OSC begins*

## **B 1. – THE CONFERENCE IN LIBERIA**

From 2<sup>nd</sup> to 4<sup>th</sup> February 2016, the Liberian non-governmental organization (NGO) New Africa Research Development Agency (NARDA) conducted an Open Space Conference in Gbarnga, Bong County. 171 persons participated in the Open Space Conference in Liberia from the Counties Maryland, Grand Cape Mount, Sinoe, Lofa, Margibi and Bong. The six districts selected from the overall 15 districts represented a wide geographical area. For strengthening interregional exchange, two participants came from Guinea, and one from Sierra Leone. Around 12 percent (21 participants) represented the public sector. The following participant groups took part:

- Ministry of Health and Social Welfare
- Ministry of Education
- Ministry of Transport
- County and district health teams
- Representatives of district administrations and chiefs
- Medical staff from public, private and faith-based health facilities
- Practitioners of traditional medicine
- Professional associations of nurses, physicians
- Community Health Volunteers
- Youth groups and social clubs
- Community members: elderly, market women, teenage mothers, bike riders, fishermen,
- Ebola survivors and families of deceased
- People living with disabilities
- Representatives of Christian and Muslim congregations and faith-based organizations
- Representatives of various civil society and community-based organizations
- Radio and TV reporters



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## **B 2. – TOPICS RAISED AND DISCUSSED**

### **A. BETTER HEALTH THROUGH WATER, SANITATION AND ENVIRONMENT**

Some consideration was given by participants to the equipment of health facilities with water, electricity and sanitation. In addition, the discussion groups on health education underlined the need to ensure that WASH activities are continuously promoted in households and schools.

### **B. IMPROVEMENT OF HEALTH CARE FACILITIES AND MANAGEMENT**

The various discussion groups on this topic started by identifying current challenges in health care provision: health facilities not being up to standard, lack of medical equipment, supplies and drugs, irregular monitoring and supervision, and several difficulties related to the health workforce. The Government of Liberia was seen as being responsible for the framework conditions – the number of health facilities and deployment of sufficient and well-trained staff, the provision of equipment, supplies and drugs and the management including monitoring and supervision. The participants suggested performance appraisals of health facilities would require proper monitoring tools and regular supervisory visits. One discussion group regretted particularly the absence of x-rays and laboratory machines, a gap of well-trained nurses and technicians as well as the lack of disposable diagnostic equipment. The participants requested government to provide the necessary infrastructure, equipment and human resources. Extremely remote communities should be serviced by mobile health teams.

Participants saw opportunities for community contributions: communities can provide land and manpower for expanding existing or building new health facilities; they may recommend committed members for training as General Community Health Volunteers (GCHV); they can organize the protection of health facility premises; and they can either provide or facilitate housing for health staff. Communities should be completely involved in making decisions about health at district and community level in order to foster strong ownership of their local services. A community-based health insurance is regarded as an instrument for improving the finan-

cial situation of health facilities as much as increasing community interest and support.

### **IMPROVEMENT OF DRUG SUPPLY**

The supply of drugs was seen as a major weakness of health facilities in the country. National and county management of supplies including procurement of drugs on the international market, disbursement of funds to the counties and logistics to facilities were considered as at times inappropriate and delayed. Furthermore, there is a shortage of well-trained pharmacists which negatively influences the capacities of health facilities to order supplies anticipatorily and according to consumption rates. Management-induced shortages and stock-out of drugs combined with theft leaves patients with the burden to buy drugs in local private pharmacies. A re-establishment of a revolving drug fund at least of homogeneous groups of facilities such as faith-based institutions is seen as a means to make the supply of medication more reliable. This would leave more responsibility to the local government and the facilities. In addition, regular, quarterly reviews of the supply chain were suggested. This should also involve communities.

### **C. REFERRAL SYSTEMS FOR BETTER HEALTH CARE**

The poor road network, an inappropriate communication infrastructure, missing ambulances and limited collaboration between Trained Traditional Midwives (TTMs) and GCHVs impede the fast referral of at-risk patients to district or county hospitals. Participants called on government and development partners to equip health facilities with ambulances and to improve the roads. Additionally, maternal waiting homes should be set up at secondary level hospitals so that pregnant women can come well before delivery time. Private communications companies should be guided to make mobile phone and radio networks available in all communities. According to the participants, all infrastructure measures can be supported by communities with respect to land, local building materials and manpower. Furthermore, health facility staff, TTMs and GCHVs should closely collaborate and agree on emergency procedures.



*Participants select the discussion groups for their topics of interest*

#### **D. INFECTION PREVENTION & CONTROL AND EARLY WARNING SYSTEMS**

Several challenges were identified with respect to infection, prevention and control (IPC): health workers not following IPC protocols; limited management capacities to handle and control an emergency or outbreak; lack of triage spaces at facilities; lack of transportation; community members becoming careless regarding hygienic and other preventive measures; and insufficient procedures for managing dead bodies. Participants requested government and development partners to make sure that all health centers are supplied with sufficient IPC materials and triage space at all times. Ambulances should be provided at least to very remote areas. Locally, a monitoring and supervision system needs to be established to monitor that health staff is using these materials properly. According to participants, communities have to continue practicing preventive measures such as calling health teams for taking swabs of patients suspected of having died from a contagious disease. In addition, communities could set up transportation groups for emergency responses in hard-to-reach areas. Community members should report all suspicious disease occurrences to the local leaders or the GCHV for prompt action. Communities require education and constant mentoring in order to make preventive procedures and behavior an integral part of community life.

#### **E. HEALTH WORKERS AND HUMAN RESOURCE MANAGEMENT**

According to participants, human resource management in Liberia should improve with respect to deployment of sufficient numbers of health workers, better training especially in areas of specialization, consistent provision of medical supplies and medication as well as proper supervision, performance monitoring, enforcement of the code of conduct and career support. Health workers as public employees face several challenges: delays in payment; low salaries; unpaid overtime; lack of housing and transportation to the workplace in remote areas; insufficient knowledge about available insurance schemes; and lack of a loan scheme. Most of these issues need to be tackled by Government, while communities can facilitate and contribute solutions to some. Training, deployment and payment of government health staff are centrally managed issues. Participants noted that training institutions for health care professions do not exist at a decentralized level. Continuous medical education and on-the-job training are therefore hard to obtain. Training also does not sufficiently impart the needed competences such as specialized knowledge on the use of medical equipment or on the needs of disabled patients suffering from multi-morbidity. Government was requested to establish decentralized training institutions at county level. Communities



*NARDA Executive Director Lancedell Matthews underlines the importance of community capacities*

would be willing to help identifying and recruiting persons for the training in a medical profession.

One central issue discussed by participants was weak ethical behaviour of health staff towards patients finding expression in health workers not coming to work on time or for the full day, taking illegal fees from patients or leaving nursing tasks to family members. This concern was aggravated by the Ebola crisis and the loss of confidence and trust occurred on both sides of patients and providers. In order to improve the patient – health worker relationship, participants emphasized the application of a code of conduct in all health facilities. It was criticized that appropriate and ethical behaviour towards patients is currently not sufficiently emphasized in health school curricula. In addition, an official code of conduct has not been distributed to all health staff. Government should provide stronger guidance in this respect; it will then be up to the health management teams and the communities to supervise the application and implementation of the code of conduct.

Government at county and district level is further responsible for providing a work environment that fulfils the requirements with respect to infrastruc-

ture, supplies and well-being of personnel especially in remote areas. The county and district health management teams can collaborate with facilities regarding management and performance. Communities and especially community leaders can foster a culture of support towards the staff of a local health facility. In addition, they can provide or facilitate accommodation for health staff in the community.

#### GENERAL COMMUNITY HEALTH VOLUNTEERS (GCHV)

A defined number of preventive and curative tasks in health is conducted by General Community Health Volunteers. They boost the insufficient number of trained health workers in the country. However, participants noted that GCHVs are often inadequately trained for their tasks. Since they do not receive any incentive, many of them are not sufficiently motivated. They are not equipped with mobile phones making supportive calls to the health facility in difficult patient cases impossible. Participants therefore suggested institutionalizing health volunteer work by providing volunteers with a regular salary and proper equipment including medication for minor illnesses and a mobile phone. They should also be better trained and supervised by the





*An Open Space Team Assistant reads the Book of Proceedings to participants*

health facility. Communities can contribute to the health volunteer system by exempting volunteers from communion works as an incentive. In addition, community leaders can support health promotion conducted by GCHVs by gathering residents for educational sessions.

## **F. TRADITIONAL MEDICINE**

Trained Traditional Midwives (TTMs) and traditional healers (THs) form an accessible and frequented group of health practitioners in rural communities focussing on safe delivery and general disease management. During the Ebola crisis, TTMs for example took care of a lot of cases without sufficient knowledge on how to protect themselves. Participants expressed the need for Government recognition and appreciation of these efforts. However, TTMs often lack materials for safe deliveries and do not network sufficiently with nurses and midwives at the health centers. Officially, TTMs are not allowed to do home deliveries which actually means a loss of income for them. However, in order to increase the number of facility births they should receive a reimbursement for each home delivery avoided. Traditional healers are neither sufficiently integrated

in the health system though a lot of people seek their advice.

Participants requested government to guide traditional medicine through policy, to facilitate a closer collaboration with the health system and to provide training and preventive materials especially to TTMs. Since many TTMs and THs already conduct health education in their own communities, they could be deployed in health promotion with proper training and incentives. On the other hand, participants recommended to TTMs to make themselves visible in their communities and their local health facilities. They themselves should network and draft a policy on the principles of their work and present it to government.

## **G. REASONS AND AFTERMATH OF THE EBOLA CRISIS**

During and after the Ebola crisis persons who overcame an Ebola infection were stigmatized and discriminated. They experienced disgrace, fear, economic problems and were not free to move around. Most feel traumatized up to today. According to participants, the relationship between



All discussion results are noted on flipcharts and paper sheets

Ebola survivors and community members remains challenging. More awareness and sensitization on the suffering of Ebola survivors are needed. People affected by Ebola need psychosocial counselling and encouragement.

### **B 3. – ASPECTS RELATING TO VULNERABLE GROUPS**

The Open Space Conference also intended to reflect the needs of vulnerable groups in the population. For this reason, persons representing these groups like women, elderly, teenage mothers, young people or persons living with disabilities formed part of the participants.

#### **A. WOMEN AND INFANTS**

Women have a special high health risk due to pregnancy and birth. Bad roads, only few ambulances and poor communication between health centers and hospitals endanger women’s lives in emergency situations due to birth complications. There are only few maternal waiting homes to which women can go a while before their delivery time. Home

deliveries which are still very common are being made more difficult due to lack of electricity and the poor equipment and training of TTMs. In addition, women who are often the caretakers of health in a family require better knowledge on prevention and management of disease. This especially affects the health of infants and children under five years. However, low immunization coverage rates also endanger infant health.

Participants requested quite a number of improvements from the Government including infrastructural measures like maternal waiting homes in all facilities and better roads. Districts should have ambulance teams which regularly maintain the vehicles. However, more qualified personnel as well as electricity through solar panels, water and radio communication systems are needed at each facility. Participants suggested establishing a mandatory rural service for practitioners sponsored by the government. In addition, more community outreach and education on ante-natal and post-natal care are needed to improve knowledge on safe delivery practices.

## B. CHILDREN AND ADOLESCENTS

The participants discussed in depths the reasons leading to teenage pregnancy. Religious and cultural beliefs impede comprehensive education about sexuality and contraceptives at home as much as in schools. Poverty, poor parental care as well as violence and crisis at home are aggravating factors. Homes for vulnerable children rarely exist. The participants recommended several solutions. They suggested to the Ministry of Education to include comprehensive sexuality education as part of the school curricula. This should also include the provision of educational and information materials. Awareness of family planning methods and livelihood training for both parents and children should be provided. There should also be a dialogue between the Government, and religious and traditional leaders. It was also suggested that the Ministry of Health should collaborate with the Gender Ministry in order to equip safe homes for children and adolescents in all counties.

Communities can also contribute to an improvement of adolescent health. Community leaders and community members can encourage families to speak openly about sexuality and to send their children

to school. It is also up to communities to create a caring and supportive atmosphere towards children and adolescents who got into trouble. Communities should also report and ostracise cases of child abuse and violence towards children.

## C. PEOPLE LIVING WITH A DISABILITY

People living with a disability face several challenges in the health system. Poor road conditions, lack of transport and missing ramps make access to health facilities difficult or impossible. Interpreters for sign language are usually not available. Persons with a disability, and especially women, report abusing and dehumanizing comments being made by staff of health facilities. Since disability is often interlinked with multi-morbidity and poverty, fees for medication also complicate access to medical care. Rehabilitation centers are located only in the capital Monrovia.

Participants called on government and communities to improve barrier-free access to health facilities including sidewalks on roads and ramps. Health staff should also be better trained with respect to

*Facilitation and documentation is in the hands of participants*







OS-Team puts up group work results

the needs of disabled people. The national code of conduct for health personnel should include respectful and appreciative communication and behaviour towards people living with a disability. Someone capable in sign language should be available in each community for the deaf. Participants also called on the Ministry of Gender, Social and Child Protection to consult more closely with the National Union of Organizations of the Disabled (NUOD) on issues pertaining to disability. Last but not least, the participants suggested free medication and prioritized treatment at health facilities as measures that would facilitate a life with a disability.

#### **D. THE POOR**

Participants also discussed the challenges of poor people in communities. They noted that they do not sufficiently participate in public life and community decision making because of their low living standard. At health facility level, they are not attended to properly despite the fact that poor families often suffer more health problems than richer segments of society.

Communities are seen as especially responsible for accepting and supporting the poor, for providing them with charities or job opportunities and for including them in their prayers for recovery. With respect to health staff, participants requested a behaviour change towards equal treatment of all patients independent of the level of poverty and income.

## **B 4. – COMMUNITY INVOLVEMENT**

Not all communities are yet as actively involved in their health system as would be possible. Participants noted that in some communities the leaders and main stakeholder are not active enough. Community members do not show sufficient ownership of their facility. The provision of staff quarters for health facility personnel is not common in all communities. In some communities even theft of equipment and machines occurs. According to participants, a first step towards greater involvement are regular stakeholder meetings on health issues involving community leaders, GCHVs, TTMs, health facility staff and health management teams at the district level. These meetings could also be used to find solutions to challenges such as housing for health staff or provision of security for facility equipment. In order to fulfil their steering role, community stakeholders in health need education on their roles and responsibilities.

In addition, it was suggested that community financing institutions should be approached to get involved in community health. They could financially support health improvement initiatives.

### **EDUCATION, COMMUNICATION AND HEALTH PROMOTION**

Health education at community level is not always as effective as it could be due to language barriers, high illiteracy rates and a lack of educational materials. Often the existing materials are treatment focussed and do not elaborate sufficiently on prevention and the situation of highly vulnerable persons like people with disabilities. Health education also rarely addresses traditional beliefs, values and norms which sometimes are barriers to preventive and healthy behaviour.

Participants underlined that health education and information materials have to be in local languages and messages best be conveyed by local facilitators such as GCHVs or TTMs. It is also very helpful to increase community engagement by making use of community groups or community-based organizations (CBOs) as well as influential persons such as religious leaders. In addition, traditional practitioners should become involved to promote behaviour change since they are the ones communicating exclusively on health-related issues with community residents. Media representatives should be trained in conveying correct health messages to their audi-

ence. Community health knowledge should also be incorporated into the adult literacy curriculum at community level. Special consideration has to be given to vulnerable and marginalized groups. Furthermore, awareness needs to be raised on local products that promote health such as healthy foods or the Moringa tree.

## B 5. – TOP 8 COMMUNITY ACTION PRIORITIES

In a final prioritization process the participants defined eight top priorities for further action among the many topics discussed during the first two days. These priority areas were:

- Priority 1. Involving communities in health facility management
- Priority 2. Expanding health facilities
- Priority 3. Building traditional healing centers
- Priority 4. Developing a code of ethics and a complaint system relating to health worker behaviour
- Priority 5. Enhancing health education and promotion through TTMs and GCHVs
- Priority 6. Improving infrastructure like youth centers, water provision etc. which also impacts on health
- Priority 7. Providing security services for clinics equipped with diagnostic machines
- Priority 8. Reducing maternal and infant mortality through expanded service provision based on community contributions to building, security and enforcement

Theme and discussion topics





## **ANNEX C: SIERRA LEONE – DETAILED RESULTS**

*Results of the First Open Space Conference*

### ***“Inclusive National Conference to Improve Health Care in Post-Ebola Sierra Leone”***

**2<sup>nd</sup> – 4<sup>th</sup> February 2016**

**Freetown, Sierra Leone**





*Facilitator Tejan Lamboi explains the process*

## **C 1. – THE CONFERENCE IN SIERRA LEONE**

From 2<sup>nd</sup> to 4<sup>th</sup> February 2016, the non-governmental organization Sierra Leone Adult Education Association (SLADEA) conducted an Open Space Conference in Freetown, Sierra Leone. The theme of the conference was: “Improve health care in post Ebola Sierra Leone”.

130 persons participated in the Open Space Conference in Sierra Leone, about half of them from Freetown, Western Area Urban District and the other half coming from the districts Bo, Bonthe, Bombali, Kailahun, Kenema, Moyamba, Port Loco, Pujehun, Tonkolili and Western Area Rural. With 11 of 14 districts being represented, the conference was national in character. For strengthening inter-regional exchange, five participants came from Guinea, and one from Liberia. Around 20 percent (25 participants) represented the public sector. The following participant groups took part:

- Ministry of Health and Sanitation
- Ministry of Social Welfare
- Ministry of Information
- Office of National Security
- District health teams
- Representatives of district administrations and council of chiefs
- Medical staff from public, private and faith-based health facilities
- Practitioners of traditional medicine
- Professional associations for nurses, physicians
- Community Health Volunteers
- International NGOs: Plan International, Conscience Intl., Save the Children, Médecins Sans Frontières MSF,
- Youth groups and social clubs
- Community members: elderly, market women, teenage mothers, bike riders, fishermen,
- Ebola survivors and families of deceased
- People living with disabilities
- Representatives of Christian and Muslim congregations and faith-based organizations
- Representatives of various civil society and community-based organizations
- Police, military and correctional services
- Radio and TV reporters



*No presentations were given. Only short guidance in the plenary*

## **C 2. – CLUSTERS OF TOPICS RAISED AND DISCUSSED**

### **A. BETTER HEALTH THROUGH WATER, SANITATION AND ENVIRONMENT**

Main issues discussed under this heading were access to clean water sources, their maintenance, hygienic behaviour and proper garbage disposal. While government, development agencies and NGOs are seen as responsible for installing the infrastructure, communities are regarded as agents for follow-up. The participants called for a vigorous implementation of government policies. Communities can take over monitoring of facilities, handling of chlorine and maintenance. Water management committees, hand pump mechanics and cleaning equipment are structures, competences and means needed for this at community level. Safe water points and toilets to end open defecation should first be established in schools, health facilities and at central community points. Community-led Total Sanitation (CLTS) is an approach perceived as feasible for Sierra Leonean communities. Participants reported that community members find it challenging to enforce community by-laws regulating behaviour relating to water and sanitation. More sanitary officers are required to support the communities e.g. in dealing with misbehaviour, identifying appropri-

ate places for burning or burying of garbage, etc. Medical waste disposal requires special capacity building for health staff and community members. Private companies i.e. the mining sector should be encouraged to install safe water sources and means of garbage disposal as well as to promote capacity building on water and sanitation in communities where they are active. In order to increase ownership, further sensitization, education and behaviour change communication via media and training outreach would be needed. This should not only target adults but also children and adolescent e.g. in school health clubs.

### **ISSUES OF CLIMATE CHANGE, POLLUTION AND DEFORESTATION**

In additions the topic of climate change and pollution was raised. Deforestation due to charcoal production, land erosion due to sand harvesting, burning of household waste especially in urban settings as well as use of chemicals in mining were listed as threats which require action. Government is expected to install a measurement system for air pollution in cities as well as to ban the use of harmful chemicals in mining. On the other hand, it was suggested to let the citizens contribute to financing of proper waste management. Also, communities should be guided and supported to find alternative



*Participants select their discussions according to their interest*

areas for sand harvesting or to promote the usage of wonder stoves.

#### ISSUES OF HOUSE PETS

As a third thematic area, the challenges of controlling house pets were raised in two groups. Pets were seen as sources for spreading skin disease, rabies and even Ebola due to eating the vomit of Ebola patients. In addition, they cause accidents in road traffic and bad smells when dying in the streets. Government is called to install a stricter policy on pet ownership and to better control animals without owners. Furthermore, rabies vaccine should be made available and affordable to communities.

#### NUTRITION AND FOOD SECURITY

Measures suggested to improve the nutritional situation were enforcement of by-laws on harvesting of crops, support of mechanized farming, timely distribution of seeds, installation of storage facilities and preparation for natural disasters. Furthermore, controls of food safety and improvement of transport facilities to markets would be required. Communities can contribute by setting up quality monitoring and supervision schemes. Participants also saw a need for community sensitization on nutrition and the promotion of prolonged breast-feeding.

## B. IMPROVEMENT OF HEALTH CARE FACILITIES AND MANAGEMENT

Improvement of equipment and infrastructure of Primary Healthcare Units (PHU) and health centres was intensively discussed. Government was perceived as responsible for the supply of facilities with energy and water, sufficient equipment, drugs and good governance structures. Also further mobile services for remote areas were requested. All this should be based on an assessment of existing services. According to the participants, communities are willing to collaborate with district health management teams in the management and monitoring of facilities. This could include a better inventory control and recording of health facility assets. Chiefs were seen as key stakeholders who should play a leadership role. It would require capacity building for community members to enable them to cooperate with government in the management of facilities. The idea was raised to establish community-based health insurance schemes to increase ownership and investment. Communities could also take part in assuring accountability and sustainability if capacitated. However, social mobilization on health issues would require health education and promotion in local languages. Participants requested an understandable dialogue between health staff and patients with low education. Patients sometimes feel insufficiently informed.



### C. REFERRAL SYSTEMS FOR BETTER HEALTH CARE

In the context of emergency referrals, the road infrastructure was being discussed. Lack of water and land ambulances, bad road conditions and poor communication systems between PHUs and referral hospitals were reported to endanger severely sick patients especially in hard to reach areas with difficult terrain like Bonthe district. The poor road network was also seen as one factor hampering development and investment. The participants called on government to collaborate with local Councils on the improvement of the road network. In their perception community stakeholders could also take ownership of road maintenance and rehabilitation as well as monitoring of road construction contracts.

With a view to the national level, participants thought about a national emergency call line. A country-wide system of emergency services accessible by one phone number would be time-efficient, take responsibility from health workers, and prevent catastrophic emergency health outcomes.

Another issue raised was the national health information system that poses challenges in rural settings. Registries and reporting forms are insufficiently supplied, computers and internet are not available, and capacities and competences on reporting are weak. This situation could be improved by government and development partners through simplification and harmonization of reporting tools, more training, incentives for reporting and the time-



*Groupwork for bees and butterflies: participants acting as bees diligently nurture the discussion; participants acting as butterflies take ideas from one group to another*

However, communities would require financial support, tools and equipment for these tasks. In addition, the governmental provision of radio systems with solar panels as well as ambulances was suggested. Communication companies were asked to extend their network coverage to remote areas. On community side an investigation into immediately available vehicles for referral transportation was recommended.

ly provision of forms and information technology. Furthermore, the participants requested the District health Management Teams (DHMTs) as well as the Ministry of Health and Sanitation (MoHS) to publish quarterly bulletins on health issues.



*Women and men suggest their topics*

#### **D. INFECTION PREVENTION & CONTROL AND EARLY WARNING SYSTEMS**

Participants saw a prevailing need for training and better organization infection of prevention and control (IPC), integrated disease surveillance and response (IDSR) as well as emergency management. The training on IPC should continue and include priority diseases such as Ebola, Cholera, Measles, Yellow Fever etc. Regular refresher trainings would lead to a better implementation of IPC practices. Health workers and communities should be provided with simple case descriptions including pictures. Health staff should be trained to report properly and timely according to urgency to the disease surveillance officer in the DHMT. Traditional practitioners should be included in surveillance and contact tracing. It was suggested to provide phones with closed user group (CUG) network to staff of primary health units for immediate reporting. It was also proposed to build triage structures in all facilities and to improve the management of contagious medical waste.

Communities should establish a committee for public health emergencies and disaster management; the districts should have rapid response teams (RRT) and ideally also a district emergency center. All these structures would need logistical support including finances and transport facilities. In the

group discussions, the need for psycho-social counselling was also stressed. Government is expected to provide technical guidance and to establish counselling units especially in educational institutions and correctional centers. At community level social workers could be trained to provide psycho-social counselling.

A heated discussion was led on the political handling of emergencies like the Ebola crisis. In hindsight, participants observed a delayed and regionally biased response of the government during the Ebola outbreak. They called for early and complete information on public health emergencies, better political coordination and a standing fund for crisis management. Corruption should be prevented and health experts evenly distributed in the country. In another discourse, the formation of a health team for trans-border emergencies at the level of the Mano River Union was discussed. This team should consist of the ministries of health, national security, foreign affairs and defense, in addition to civil society, local authorities, media, transport operators and trade. Tasks of this team would be to strengthen integrated disease surveillance and response, to generate political commitment and funding support, to harmonize the health regulation systems of the countries and to collaborate with international donors and health partners.



*Media Coverage made the conference known*

## **E. HEALTH WORKERS AND HUMAN RESOURCE MANAGEMENT**

The human resources situation in health has been challenging at all times in Sierra Leone. Lack of capacities, frequent staff turnover, high frustration of staff with dissatisfying working and living conditions, insufficient occupational health and safety guidance and limited career options are major weaknesses seen on the side of healthcare suppliers. Weak ethical behaviour leading to unfair treatment of patients, shortage and maldistribution of health workers and little involvement of communities in human resource management are shortcomings identified on the users' side. According to the participants, the Ebola crisis has aggravated this situation and additionally caused a loss of confidence of patients in health care provision as well as of health staff in their workplaces.

Concerning capacity development participants concluded that more training institutions might be needed at national level or a higher intake of students in existing institutions. They called for a more decentralized provision of medical and nursing training. Curricula would have to be regularly reviewed and the quality of training should be constantly monitored. The range of trainings should include specializations, public health, primary health care, as well as ethical studies. Scholarships and overseas training should be linked to an obligation to serve in-country for a certain number of years. The deployment of expatriate health staff by development agencies should be connected with an obligation to train and impart knowledge to local staff.

The participants also developed recommendations for management of human resources. They called for a timely recruitment and a demand-based deployment of staff. This may involve a review of recruitment policy. They also supported periodic performance appraisals, the development of career pathways, and the assessment of capacity development needs to make health care more attractive and professional. Serious management of occupational health and safety including a national policy and its adaptation and implementation at institutional level would help to improve confidence of health staff in their workplaces and employers. The participants also reflected about incentives since retention of health staff is a challenge in the country. Awards, loans for housing and vehicles, allowances for deployment in remote areas, scholarships for post-graduate studies, staff exchange between e.g. the countries of the Mano River Union might be some measures to keep health personnel interested in their work.

The communities can play a role in the management of human resources in health. They can help in providing accommodation to health staff. In addition, participants stressed that community members would be interested in participating in health management teams and support health promotion. To this end, community members, health volunteers, and also traditional healthcare providers would need capacity building and empowerment.



## F. TRADITIONAL MEDICINE

Treatment by traditional practitioners like healers and traditional birth attendants is often more accessible and affordable than modern health care and therefore used despite legal attempts of containment. In addition, traditional medicine often better responds to underlying traditional health and disease concepts of the population and thereby supplements modern medicine. A strong representation of traditional practitioners among the participants led the discussions on traditional medicine. They stressed the importance of traditional medicine and called on government for legal recognition of traditional practitioners as part of the health system. This would also include a legal regulation of their operations and a harmonization and integration of traditional healing practices into the health services. In this context, government was requested to provide logistical support to traditional birth attendants. The participants also discussed the need for capacity development; training centres would be needed as well as processes of certification. There was also the need expressed to develop a data base of traditional practitioners according to specialization. International exchange visits as well as regular national meetings to exchange experiences would help to empower traditional healers and midwives.

## G. REASONS AND AFTERMATH OF THE EBOLA CRISIS

The discussion groups reflected on the reasons why Ebola became such a crisis in the country. The following reasons were mentioned: insufficient understanding of Ebola by communities and suspicion that the disease was a political “creation”; resulting mistrust of public health interventions; lack of response capacities, equipment and trained health staff; resulting fear of Ebola by frontline workers; customary burial procedures; movement within and across borders. The health situation and the stigmatization and discrimination of people having survived the Ebola virus disease (EVD) were also topic of discussion. According to participants, they are challenged by insufficient medical attention, health complications, lack of job opportunities, loss of livelihoods and problems with reintegration into the communities. Ebola survivors require psychosocial counselling, moral support of communities and financial support such as scholarships, skills training and job offers. It was also suggested to provide Ebola survivors with positions of authority

in the community to speed up reintegration and to support in the event of a future outbreak.

Similar needs were reported by participants for families of deceased due to Ebola. Surveys to identify the families of deceased as well as a needs assessment would have to be conducted. Many require livelihood and psychosocial support, especially children.

As a last group the needs of health workers in the context of a disease like Ebola were discussed. It was recommended to provide them with free health insurance.

## C 3. – ASPECTS RELATING TO VULNERABLE GROUPS

The Open Space Conference also intended to reflect the needs of vulnerable groups in the population. For this reason, persons representing these groups like women, elderly, teenage mothers, young people or persons living with disabilities formed part of the participants.

### A. WOMEN

Women especially suffer from all general shortcomings of the health services because they are the ones who use them the most – either for themselves or for family members they are taking care of. In addition, women are more often affected by poverty and illiteracy. Accessibility and affordability of services were mentioned by participants as key challenges. Especially pregnant women are often in need of fast referral to a hospital for emergency obstetric care. Communities could play a role in improving women’s health by involving more women in health management committees, encouraging helpful cultural practices like breastfeeding or by influencing men to become involved in maternal health of their wives or girl-friends. Furthermore, women benefit from adult education and income generating activities including microfinancing. Women’s participation in literacy courses could be supported by by-laws in the communities as well as provision of teaching and learning materials. Free health care for pregnant women, lactating mothers and infants should also be kept up and enforced. This should also include ante-, peri-, and post-natal care as well as adequate nutrition. The participants



*The newswall displays all groupwork reports*

suggested that traditional birth attendants should be trained to take over part of these tasks. Community Health Volunteers should be encouraged to take pregnant women to the hospital in emergencies. Vaccines should be available in good quality to both, women and infants. Last but not least, health workers should foster cordial relationships with the female patients.

## **B. INFANTS**

The health situation of infants is closely related to women's health, education and life situation as well as the quality of health care. Teenage pregnancies are a special risk factor for infant health. Pregnancy and birth complications, nutritional imbalances and teenage pregnancies promote preterm birth, low birth weight and birth defects. Low levels of education and poverty endanger the thriving of the child. Malnutrition and diseases then become an even greater threat. Communities can participate in encouraging women to register for ante-natal care. They can assure that pregnant women get a good

nutrition. The health facility should provide trained birth attendants, proper facilities and supplies like vaccines and drugs.

## **C. CHILDREN AND ADOLESCENTS**

The participants agreed that children and adolescents need protection, education, shelter and health care. Children's rights should be protected which does include stopping child trafficking and sexual abuse. Courts should be motivated to address children's cases. This may require more education on children's rights. Families and communities not protecting children's rights and wellbeing should be penalized. The participants also called on traditional and religious leaders to stop early marriages and other harmful traditional practices. Instead, children and adolescents should be educated in civic responsibilities and family life. The participants suggested that child protection networks, psycho-social counselling and safe homes for children should be set up.

## C 4. – COMMUNITY INVOLVEMENT

Teenage pregnancies should be discouraged by all means. Participants saw root causes for teenage pregnancies in domestic violence, negative influences of the peer group, lack of education and the availability of pornographic films. They called on government to enforce the law on domestic violence and to introduce age restriction on pornographic movies. Communities could support these efforts by sensitizing on peer group influence and by providing basic amenities for young people. In addition, more sensitization on family planning methods, comprehensive sexuality education in homes, schools and communities as well as counselling services could have an effect on teenage pregnancies. Often girls who become pregnant as teenagers drop out of school. Rewards should be introduced to those who continue and complete their school career.

From the perspective of participants, school health clubs would increase the health-related knowledge of children and adolescents. This policy should be enforced by government; coordinators among the teachers need to be identified and trained. A school health club entails hygiene promotion and training on different health topics. It should have a sick bay, proper hygiene facilities with disinfectants and a refuse disposal site.

### D. PEOPLE LIVING WITH A DISABILITY

Persons living with disabilities struggle with inaccessible infrastructure, communication barriers, stigmatization and discrimination. Participants observed a lack of support from government, NGOs and health partners. In order to improve their health situation, health facilities should be equipped with ramps, rails, elevators etc. Participants also called for continuous interpreters of sign language in all government clinics. Also health information should be made accessible e.g. in braille or by sign language interpretation. Government is also called upon to pass a national policy on disability in the health sector. This should be communicated to all staff.

Participants felt that the needs of communities are not sufficiently considered in national health policies and district health plans due to lack of communication and involvement. Therefore, community stakeholders should be capacitated to co-manage health care through health management committees. Involving communities should include surveying their needs and perceptions on health care services using a health service score card. This could lead to the joint development of a health care delivery charter in which both parties define their responsibilities and expectations. Users and providers should then also jointly monitor the implementation of the community health charter. Crucial tools for community action on health are by-laws which could regulate hygiene issues as well as contributions of the community to the local health centre. This could e.g. be watchmen services or maintenance support. A national data base on community by-laws on health as well as exchange forums between chiefdoms would strengthen the political power and enforcement of by-laws.



SLADEA Executive Director Bamike Williams (left) with colleague Sheku Mansaray



Community health volunteers and the staff of health centres are central actors for the promotion of healthy behaviour. Participants called for more outreach of health workers to persons in need and at risk e.g. pregnant women or young children. This should be supported by closer interpersonal relationships between community members and health staff. It is also suggested to upgrade traditional birth attendants and maternal and child health aid to professional midwifery. Community life should more strongly reflect health. The creation of health clubs for various age, gender and traditional groups including school health clubs would support this.

#### EDUCATION, COMMUNICATION AND HEALTH PROMOTION

Adult education for reducing illiteracy is an important vehicle to improve health related knowledge. Participants requested better guidelines on health education, an updated curriculum including emergency health issues as well as sufficient reading materials in different local languages. Government should enhance efforts in this respect including budget allocation to the non-formal education division in the Ministry of Education, the development of a unified national curriculum and the provision of specialists in adult education. This could also be retired curriculum specialists who impart their knowledge to the younger generation. Adult educators in the communities can embark on sensitization and research relating to health. They can also encourage community health volunteers.

Furthermore, media should be more strongly involved in health education. From the participants' point of view, a partnership between national health authorities and the independent radio network should be set up to push a nation-wide dissemination of health information. The participating media representatives suggested to form a media organization focusing on health reporting. Funding would be required for training and research. At a local level, a better communication between community health workers and the local media would help in targeting communication on health issues at identified gaps and needs.

### C 5. – TOP 10 COMMUNITY ACTION PRIORITIES

In a final prioritization process the participants defined ten top priorities for further action among the many topics discussed during the first two days. These priority areas were:

- Priority 1. Better educate traditional birth attendants and community health volunteers
- Priority 2. Improve WASH facilities and increase behaviour change
- Priority 3. Provide affordable, accessible and available primary health facilities
- Priority 4. Improve maternal and child health
- Priority 5. Reduce teenage pregnancy
- Priority 6. Promote community engagement in health
- Priority 7. Establish and maintain functional community surveillance structures
- Priority 8. Improve traditional medicine
- Priority 9. Improve health education through media collaboration
- Priority 10. Prepare for a potential future Ebola outbreak

## LIST OF ABBREVIATIONS

BMZ	German Ministry of Economic Cooperation and Development
CBO	Community-based organization
CLTS	Community-led total sanitation
CUG	Closed user group (in mobile communication)
DIFAEM	German Institute for Medical Mission
DPS	Prefectural directorates for health (Guinea)
EVD	Ebola Virus Disease
FGC/M	Female genital cutting/mutilation
GCHV	General Community Health Volunteer (Liberia)
GIZ	German International Cooperation
IDSR	Integrated disease surveillance and response
IPC	Infection prevention and control
IOM	International Organization of Migration
meGem	MeditationsGemeinschaft
MoH	Ministry of Health
NARDA	New Africa Research Development Agency
NGO	Non-governmental organization
OSC	Open Space Conference
PHU	Primary Healthcare Unit (Sierra Leone)
RRT	Rapid response teams
SLADEA	Sierra Leone Adult Education Association
TH	Traditional healers (Liberia)
TTM	Trained Traditional Midwives (Liberia)
UNV	United Nations Volunteers
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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