



**THE MINISTRY OF HEALTH AND SOCIAL WELFARE
REVISED NATIONAL COMMUNITY HEALTH SERVICES
STRATEGY AND PLAN 2011-2015**



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Acronyms

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BPHS	Basic Package of Health Services
CBO	Community Based Organization
CCM	Community Case Management
CH	Community Health
CHAI	Clinton Health Access Initiative
CHC	Community Health Committee
CM	Certified Midwives
CHDC	Community Health Development Committee
CHS	Community Health Services
CHSD	Community health Services Department
CHSS	Community Health Services Supervisor
CHT	County Health Team
CHV	Community Health Volunteer
CHW	Community Health Worker
EHT	Environmental Health Technician
EPHS	Essential Package of Health Services
EPI	Expanded Program of Immunization
FCHV	Female Community Health Volunteer
gCHV	General Community Health Volunteer
HC	Health Center
HF	Health Facility
HHP	Household Health Promoters
HW	Health Worker
INGO	International Non-Governmental Organization

IRC	International Rescue Committee
IPT-SP	Intermittent Presumptive Therapy – Sulfadoxine-Pyrimethamine
ITN	Insecticide-Treated Net
LDHS	Liberia Demographic and Health Survey
LPN	Licensed Practical Nurse
MCHV	Maternal Child Health volunteer
MCVW	Maternal Child Health Worker
MNH	Maternal & Neonatal Health
MOHSW	Ministry of Health and Social Welfare
NCHCC	National Community Health Coordinating Committee
NIDS	National Immunization Days
OIC	Officer-in-Charge
RBHS	Rebuilding Basic Health Package
TB/DOTS	Tuberculosis – Directly Observed Treatment, Short-Course
TM	Traditional Midwife
TTM	Trained Traditional Midwife
VDC	Village Development Committee
VPD	Vaccine Preventable Disease
VHW	Village Health Worker

Executive summary

The overarching goal of Liberia's health and social welfare sector is to expand access to basic health and social welfare services of acceptable quality and establish the building blocks of equitable, effective, responsive and sustainable health and social welfare services service delivery system. This goal is measured by the attainment of two critical targets: reduction in the number of maternal related deaths by 10% and reduction in number of deaths in children under age five years by 15%.

The Basic Package of Health Services established by the Ministry of Health and Social Welfare has been successfully rolled out throughout the country and evidence indicates that the health status of the population is improving. However, maternal and child mortality remain high and major killers like malaria and diarrheal disease continue to be among the most common illnesses, while new diseases reflecting changes in lifestyle and diet threaten the population.

Despite the success of the Basic Package of Health Services, the public facility network continues to leave out a large proportion of the population living more than one hour walk from a health faculty. The health system workforce lacks the right mix of skills, and it should deploy according to service delivery needs. Skilled providers should be retained where they are needed most. Resources allocated for service delivery in both urban and rural areas do not closely reflect the size of the catchment population and facility workload. Referral linkages between the various levels of the system do not function well.

The health sector must become more effective by improving the responsiveness of services and strengthening referrals between all levels of all system. This will improve the interrelationship strengthening the existing workforce, producing additional workers and deploying and retaining workers according to service delivery needs. To achieve this, the Ministry of Health and Social Welfare, developed the National Health and Social Welfare Policy and Plans 2011-2021 which reflect the updated Essential Package of Health Services that will increase access and make health care and social protection available to all people in Liberia.

In view of the above, the National Strategy on Community Health Services is revised to reflect the community health components of the National Health Plan 2011-2021. This revised strategic plan is therefore intended to address all issues raised in the Ten-Year National Plan and enable the division to achieve the goals outlined in the Essential Package of Health Services.

The overall goal is to improve the health and social welfare status of the population of Liberia on an equitable basis at community levels.

Key objectives are:

- 1) To ensure that health promotion and health seeking behavior activities are encouraged in all communities

- 2) To increase access to and utilization of quality health and social welfare services
- 3) To make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision making to lower administrative levels ensuring a fair degree of equity.
- 4) To make health and social welfare protection available to all Liberians regardless of socio-economic status at a cost that is affordable.

As Liberia transitions from humanitarian response to development, there is a need for a rationalized approach to community health services.

Provision of quality community health services depends largely on the willingness and commitment of the service provider and communities served. The active involvement and participation of the community, manifested by their support and utilization, is essential for sustaining community interventions.

1. Introduction and Background

The Basic Package of Health Services (BPHS) established the framework to begin improving basic health services provision in post-conflict Liberia. Building upon successful implementation and strong health sector development, the Essential Package of Health Services (EPHS), launched in 2011, now includes scaled-up and additional services for all levels of the health care delivery system to provide more comprehensive services to the Liberian people. The EPHS also focuses on strengthening all levels through improved coordination between Health Promotion Division of the MOHSW and the County Health and Social Welfare Teams that continue to perform weakly in the current system.

Consistent with the National Health Policy, the EPHS will maintain three levels of care: primary (which includes community), secondary and tertiary. At the community level, a standard set of outreach, health promotion and referral services shall be provided by Community Health Volunteers (CHVs) for communities more than one hour walk (5km and above) from the nearest health facility..

The Community Health Services Division (CHSD) of the Ministry of Health and Social Welfare (MOHSW) has been reorganized to increase access to basic health services at the community level. In order to provide these services, the division coordinates and collaborates with County Health Teams as well as other programs, partners and communities to scale up community health activities in the counties. The division has developed a number of key documents, including the National Community Health Services Policy, the National Community Health Services Strategic and Plan. Additionally, gCHV training modules for Diarrhea, Malaria, ARI, and Essential Nutrition Actions have also been developed. In addition to setting down a policy orientation for community health services in Liberia, the division has conducted training of trainer's workshops in Diarrhea Case management in all 15 counties and piloted integrated community case management of ARI and malaria in four counties.

As Liberia transitions from the Basic Package of Health Services to the Essential Package of Health Services, there is a need for an evidence-based and standardized approach to community health services. This revised Community Health Services Strategic Plan is therefore intended to reflect the community health components of the Ten-Year National Plan and enable the CHSD to achieve the goals outlined in the Essential Package of Health Services.

This strategy is not intended to restrict or prohibit partners from doing more intensive local-level work with community health supporters or other community-level cadres. However, all partners are required to adhere to the Community Health Services Strategic Plan in conducting such work.

2. Vision and Goal

2.1 Vision

A healthy population with social protection for all.

2.2 Overall Goal

The overall goal is to improve the health and social welfare status of the population of Liberia on an equitable basis at community levels.

2.3 Strategic Objectives

- To ensure that health promotion and health seeking behavior activities are encouraged at all levels (individual, in all communities, service providers and socio-political)
- To increase access to and utilization of quality health and social welfare services
- To make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision making to lower administrative levels ensuring a fair degree of equity
- To make health and social welfare protection available to all Liberians regardless of socio- economic status at a cost that is affordable

2.4 Specific Objectives

- To enhance quality service provided by CHVs to the community
- To build capacity of CHVs and communities to contribute to the reduction of maternal, child and newborn morbidity and mortality
- To ensure that CHVs have adequate and uninterrupted supply of commodities
- To create an enabling environment for implementation for the CHS policy
- To ensure quality of health care at the community level

3 Justification for the Community Health Services

CHVs have been recruited and trained by various entities. NGOs involved in community health services over the past several years have developed a number of new cadres in areas where they work– mostly limited to health promotion roles. Various vertical programs within the MOHSW have also implemented community-level activities using community-level volunteers or workers (i.e. CHVs to support onchocerciasis and malaria programs). Although this community level work has been contributing to improve health conditions in the country, these efforts are not yet optimally coordinated. As Liberia transitions from humanitarian response to development, there is a need for a rationalized approach to community health services.

4 Learning from the past experiences of community health services

There are thousands of examples of small scale CHV programs implemented by NGOs across the world and many cases of larger scale programs with community-level cadres linked to Country health services. There are many instances of disappointing experiences with CHV programs but there are also examples of successful programs, operating at scale, continuing to play an important role in improving health status – particularly child health – over the long-term.

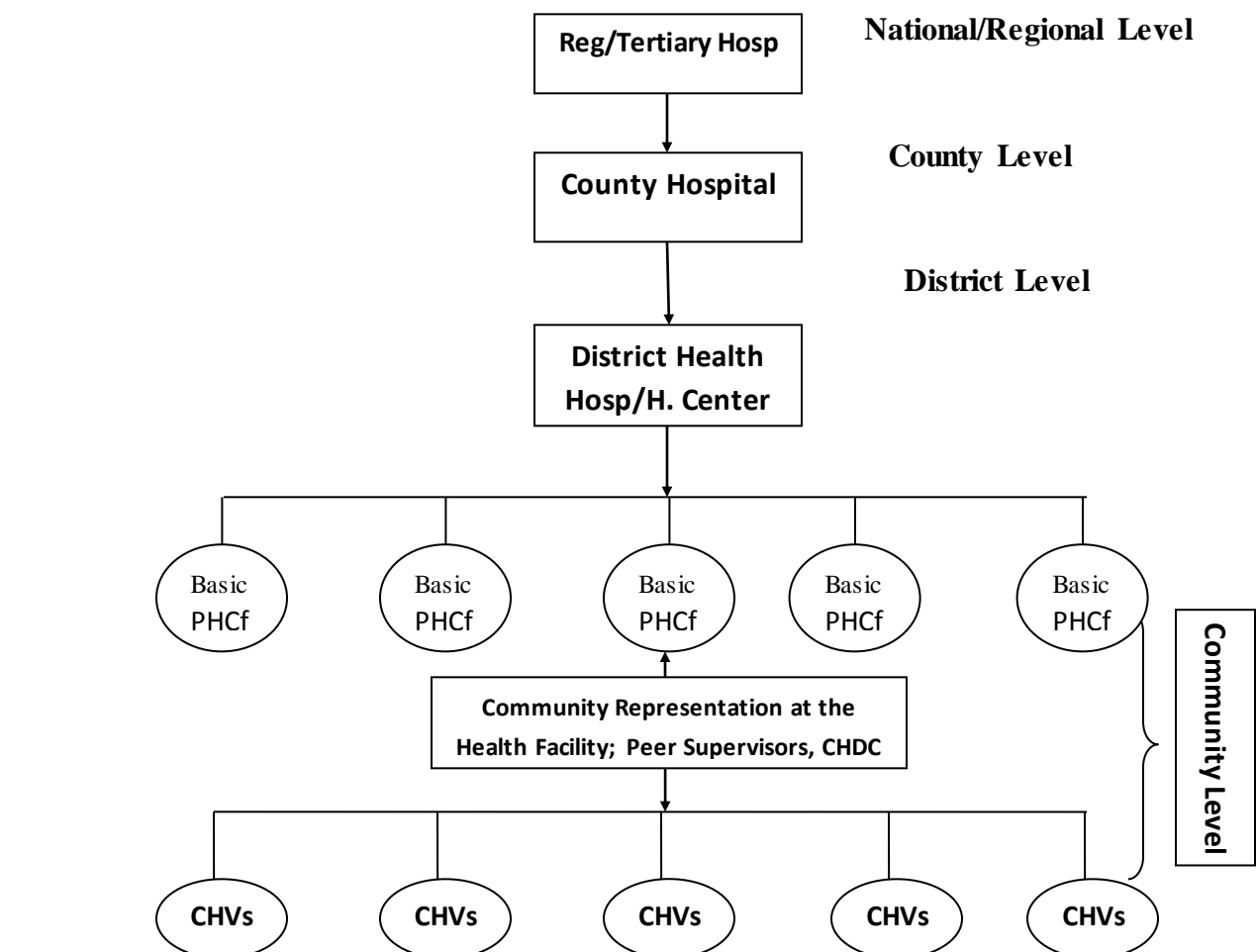
Lehmann and Sanders recent review is an excellent summary of the global experience with such programs. Several key findings of their review are:

- CHVs can improve access, coverage, and outcomes but are not a panacea. They are not a replacement for professional health workers.
- Effective CHV programs at scale are not cheap or easy; they require a considerable and sustained effort.

Key issues for successful implementation include selection, training, support and motivation (from health sector and community)

- Community ownership/ linkages – although some individuals will certainly be able to do so, CHVs as a group cannot be expected to take the lead in mobilizing communities; but mobilized communities are necessary for effective CHVs. It is important to effectively *institutionalize* community participation (Nepal’s Health Facility Management Committees and Mothers Groups)
- Motivation of CHVs is critically important. If not effectively addressed, attrition will fundamentally weaken a CHV program. To develop an effective national cadre, approaches to incentives need to be *scalable* and *sustainable*.
- As a rule, volunteer programs with no material incentives do not continue to perform on a sustained basis and relying on community financing generally doesn’t work.
- Role – in many cases the community has expectations with regard to a treatment role and is less supportive of CHW programs that only do health promotion work.

5 Organizational Structure and Coordination framework



5.1 Central level (Community Health Services Division):

The Community Health Services Division (CHSD) at the central level is responsible to coordinate the development and dissemination of policy, strategies, guidelines and protocols, and should ensure the implementation of all community health services activities including:

- Mobilization of resources for the implementation of community health services activities
- Development of a standardized core package of training and reporting materials are used and regularly supplied to CHVs. This package shall consist of training curricula, job aids, health management information system (HMIS) registrar/forms, and ledgers.
- Collaboration with partners in the monitoring and supervision of all community health activities in the country

5.2 County Community Health Department

CHVs shall be provided with robust support by their County Health Teams, including in-service training, supportive supervision and consistent resupply of any needed materials (e.g. job aids, reporting forms, medicines or other consumables)

- Ensure the coordination of all community health services activities in the county
- Ensure collaboration with health partners in the monitoring and supervision of all community health activities in the county

The Community Health Department Director shall coordinate all community level activities within the county.

5.3 District Community Health Department

At the district level, the District Health Officer (DHO) shall ensure the coordination and collaboration of monitoring and supervision of community health services activities.

5.4 Health Facility Level

- At each facility, a Community Health Services Supervisor (EHT, RN, PA, LPN and CM) will be assigned, with the function of providing technical support and supervision to the CHVs in the catchment population. CHVs will be supplied drugs and commodities from facility stocks. Each facility will include community services consumption in its projection of needs. External support will be necessary for some years to scale up and maintain community health services.
- The Community Health Service Supervisor shall provide robust support to the CHVs, which shall include in-service training, supportive supervision and consistent resupply of any needed materials (e.g. job aids, reporting forms, medicines or other consumables)
- Ensure regular supervision of CHVs from the nearest health facility. Supervision of CHVs shall be conducted on a monthly basis by the Community Health Services Supervisors.
- The health facility shall ensure continuous outreach services in the catchment communities of the facility

- With support from the facility, the Community Health Services Supervisor, along with the CM, shall plan and implement outreach services within the catchment communities
- Certified midwives, in collaboration with the Community Health Services Supervisor, shall provide technical oversight of TTMs working within their catchment areas.

5.5 Community Level

At the community a standard sets of outreach, health promotion and referral services will be provided for communities more than one hour walk (5 kilometres) from the nearest health facility by Community Health Volunteers in collaboration with partners, community leaders and programs. The structures at the community level includes CHC, CHDC and a cadre of CHVs

- The Community Health Committee (CHCH) is elected by the community and composed of 5-9 members depending on the size of the community. They meet on a monthly basis with CHVs to discuss health related issues in that community including providing some form of supervision to CHVs and mobilizing community to support CHVs
- The Community Health Development Committee (CHDC) is selected among members of the CHC. Each catchment community elects a person to serve on CHDC. The health facility OIC should serve as CHDC secretary. **The CHDC is umbrella group for the entire health facility catchment communities.** They also meet on a monthly basis at the health facility and discuss that can strengthen the health facility and its catchment communities
- CHVs shall be provided with robust support (in-kind and services) by their local communities
- CHV peer supervisors shall engage in supportive supervision and facilitate reporting of community-level data back to the health facility through the Community Health Services Supervisor.

5.6 CHV Cadres

MOHSW officially recognizes the following cadres of Community Health Volunteers (CHVs) that shall be able to cover the community health activities stated in the Essential Package of Health Services:

- General Community Health Volunteers (gCHVs)
- Trained Traditional Midwives (TTMs)
- Community Health Support Groups
 - a. Household Health Promoters (HHPs)
 - b. Community Directed Distributors (CDD)
 - c. School health volunteers
 - d. Mass Drug Distributors (MDD).
 - e. Community Directed Care Providers
 - f. Community Based Distributors
- CHV Peer Supervisor

6 The Selection Process of Community Health Structures and Volunteers

Series of community meetings with full community participation need to be held with different stakeholders at the community levels to form or restructure Community Health Committee (CHC). There should be meetings with each of these groups. The OIC/CHSS or

the DHO may need to have more than one meeting for each category of meetings mentioned below. Begin the meeting with a discussion starter. Example: River code exercise ('teach a man to fish') also use the guidelines included in CHEST kit and work with people who are ready.

7. Meetings

7.1. Category A: Planning Meeting with County Health Team

This meeting will discuss the plan and intended goals and objectives of the desired community health activity to solicit CHT approval. Discuss the benefits for the community.

7.2 Category B: Planning Meeting with District Health Team

This meeting should be attended by all partners and line ministries working in the district, including the DHT and District commissioners) to present the plan and outcome of your first meeting with CHT.

7.3 Category C: Meeting with Health Facility OIC

This meeting should present the plan and brief the OIC on outcomes of meetings with the CHT and DHT. This meeting is attended by the OIC and the Community Health Services Supervisor and the CHDC (if already formed and functioning).

7.4 Category D: Meeting with Community Leadership

This meeting should be held with the community leadership: Chief, Women leaders, Youth leaders, teachers, Religious leaders, Elders, TTM heads/leaders, gCHVs (if already selected), and CHC/CHDC (if already selected). This meeting should create awareness/ provide information to the community about the planned program, enhance their understanding about the program and solicit their support for the successful implementation. At the end of the meeting, solicit community leadership support in organizing a general meeting with the community to provide information to all on the program.

7.5 Category E: General Community Meeting

This meeting is held to create awareness/ provide information to the community about the planned program, enhance their understanding about the program and solicit their support for the successful implementation.

During the meeting, facilitate a discussion on the importance of selecting a group of people to serve on the Community Health Committee, including:

- How to decide nominees: encourage community to select nominees by quarter, and women, youth or adult shall be selected to participate in the election.
- The nomination of candidates for the election: discuss with the community the roles and responsibilities of those selected.

In this meeting, the community shall be clearly informed on the importance of selecting CHVs who will be trained to provide service delivery at the community level. Additionally, discuss the selection criteria of CHVs and the roles and responsibilities of the selected community.

7.6: Category F: The Selection of Community Health Committees

The Community Health Committee (CHC) is representation of each catchment community of the health facility. It is composed of five to nine members depending on the size of the community. At a general community meeting, community members shall elect members of the Community Health Committee. Election of CHC is by democratic means. Community member nominate representative per quarter and shall include female, male and youth. The CHC shall elect its own leadership (who shall fill in the following positions: Chairman, Vice Chairperson Treasurer and Chaplain and other members). The CHC meets on monthly basis with CHVs and minutes of each meeting kept.

7.7 Category G: The selection of Community Health Development Committee (CHDC)

The Community Health Development Committee (CHDC) represents the catchments communities of the health facility. The CHDC is a member of the Community Health Committee who is selected by the CHC to represent the community at the health facility level. The CHDC and OIC who serve as secretary of this committee meet on a monthly basis to discuss issues surrounding the entire catchment communities of that health facility. In the absence of the OIC, his/her designee shall serve as secretary to the CHDC.

7.8 Category H: The Selection of CHV

Sensitization meeting, expectations of gCHVs and community (refer to community entry meetings- category A-E)

CHC presides over the election, but voting for gCHVs is done by the entire community. (See voting procedures for CHCs).

7.9 Category I: The Selection of CHV Peer Supervisor

7.9.1 Criteria for Selecting Peer Supervisor

Peer supervisors shall be selected by Community Health Services Supervisors (facility staff, partner supervisor, in consultation with CHT/DHT) based on the following:

- gCHV who has been trained and has been active for at least 3-6 months in the catchment community where he/she was originally recruited.
- Must be able to read and write
- He/she must have exhibited exceptional performance during the trainings to indicate that he/she is well skilled, organized and can lead. This includes administering treatments at his level as prescribed by national policy, making/facilitating community referrals, submitting activity reports, calling community meetings and conducting health education sessions, amongst others.

7.9.2 Terms of Reference of CHV Peer Supervisor

The term of reference of CHV Peer Supervisor shall include but not limited to:

- Willingness of gCHV to take on additional responsibility
- Previous performance
- Geographical location

- Supervise and monitor an average of 5 -10 CHVs living and working within 5 Km and above walking distance in the health facility catchment area
- Must have the ability to coordinate work of other CHVs
- Must collect, compile and submit community activity report

7.10 Category J: Selection and Function of Household Health Promoter (HHP)

Conduct series of meeting with the community to prepare them for the selection of household health promoters. Selection criteria are similar to CHV criteria except that all HHP should be middle-age women who have had long time experience in caring of children and more respected in communities.

Follow the care group model to have each household promoter works with ten households. Ten households choose their own HHPs who functions shall include:

- HHP shall link to gCHV
- Serve as role model; model behaviours' for others (community cleaning)
- helps with community mobilization, breeds competition

7.11 Category K: Selection of TTM/TBAs

TTMs/TBAs are pre-existing, traditional role within the communities and their selection is based on identifying the existing TTMs/TBAs hierarchies and leaders. The leaders and the TTMs shall identify those who shall participate in gCHV trainings (since many of these exist in each community)

7.12 Category L: Community Health Services Supervisor (CHSS)

A CHSS will be appointed, with the function of providing technical support and supervision to the CHVs in the catchment population.

8. Recruitment and Training of Service Providers

A core training package corresponding to the defined functions of the CHV shall be developed to reflect changes in the role of the different cadre. The package shall be competency-focused, relating to the CHV functions. Training approaches, materials, and job-aids will based on evidence and local best practices; and there will be provision for regular review and updating, keeping the content current.

- A common curriculum will be used by partners to support the implementation of planned community-based activities. The content will be limited to the identified priority areas and will focus on the CHVs expected tasks.
- Training will include all key functions – health education/ counseling, dispensing integrated community case-management, documentation and etc. CHV Supervisors shall be drawn on as trainers.
 - The CHSS or CM, OIC and other professional at the health facility shall be trained as trainers of gCHVs.
- The Training Unit at central should be involved in the development of all training materials.

- To ensure quality, for *every* training session, there should be at least one facilitator from central level. To the extent appropriate, *similar training approaches* should be used each time a new area of competency is being introduced to CHVs.
- The training will be hands-on and practical, with any necessary theory integrated into practical sections, rather than being presented separately.
- Methods should include use of models and visual aids (harmonized with job-aids and IEC materials to be used by CHVs in their program work); role-plays/ simulations; songs; hands-on observed practice.
- Training will be competency-based, ensuring that each participant has achieved mastery of the needed skills and associated knowledge before they are certified to provide the related service.
- Training will be delivered in short blocks (generally no more than 4 days at a time except for malaria that is 5 days), with each module including new skills that can be immediately applied.
- At the time of subsequent training blocks, there will be review of previous material and CHVs' experience applying it.
- At suitable points in training, when CHVs have been equipped to play a significant new role, they will be presented to the community, doing real-life demonstration of their new skills/ roles (e.g. assessing and treating children with fever)
- Orientation of other stakeholders' nurses' aides/ extension workers as well as other CHS focal points and supervisors and CHC members.
- The orientation process is an important opportunity to communicate to these various players the rationale and content of community health services. At community level, it will be appropriate that the orientation process engage *local opinion leaders*, securing their full understanding and commitment.

8.1 Training Intervention:

For consistency in training, the below listed modules or training materials will be developed or revised:

8.1.1 Working with *the Community on*:

- **Community Entry:** Train CHVs on appropriate Community Entry method eg. going through appropriate community structures for their designated community activities.
- **Community Mobilization:** Train CHVs in appropriate approaches to mobilize communities by:
 - identifying and solving problems
 - Carrying out community activities.

8.2 Advocacy and Community Empowerment: Train CHVs how to empower communities to identify and solve problems through community-led sustainable solutions

8.3 Health promotion: Train CHVs with effective communication and counselling skills community mobilization, advocacy and health education to bring about improved health seeking behaviors to prevent disease and promote healthier communities (through effective use IEC materials and effective Behavior Change Communication (BCC)) for the development and implementation of a BCC Action Plan

8.4 Integrated Community Case management: Train gCHVs in Case Management of selected diseases (malaria, ARI and Diarrhea) for the under 5 populations in their community through:

- Appropriate diagnostic skills
- Rational use of drugs
- Identification of Danger Signs and need for referral
- Counselling on Home management and Prevention eg. ITN use
- Data collection and Reporting
- Mass drug distribution (eg. Mectizan, ivermectin)

8.5 Recording & Reporting: Train CHVs to accurately record and report:

- their health activities including integrated disease surveillance: maternal & newborn, birth, death, Vaccine Preventable Diseases (VPD), diseases of epidemic potential
- to the appropriate structures according to established schedule (eg. CHC and Health Facility)

8.6 Supervision:

Train identified CHV peer supervisors on how to supervise 5 to 10 CHVs in their area through:

- The appropriate use of supervisory tools.
- The verification of CHV reports
- the rational use of drugs
- follow up visits in direct beneficiary's homes

8.7 Train CHC on how to monitor CHV activities

During orientation meetings, the CHCs are given some form training to enable they supervise CHVs in communities.

8.8 Training modules to be developed or updated to include:

- Essential Nutrition Actions
- Integrated training modules
- Water Sanitation and Hygiene (WASH)
- Directly Observed Treatment
- Journey of Hope
- Home Based Life Saving Skills
- CHEST KIT
- Integrated Community Case Management (Diarrhea, ARI, Malaria)
- School Health Curriculum
- Maternal and Child Health
- Mental Health
- Family Planning Training Module
- Supervisory Check list Training Module

9. Service Provision

The National Health Policy and Plan aims to improve the health and social welfare status of the population of Liberia on an equitable basis. The plan expects to achieve that goal through selective, highly cost-effective service package interventions for each age cohort that is likely to result in health improvement in the overall population.

This Community Health Service Strategy takes the national plan objectives to the community level by mobilizing communities towards their active and dynamic involvement in implementing the interventions that contribute to their own health, and socioeconomic development, to release themselves from the vicious cycle of poverty and ill-health.

Provision of quality community health services depends largely on the willingness and commitment of the service provider and communities served. The active involvement and participation of the community, manifested by their support and utilization, is essential for sustaining community interventions.

At the community level the activities focus on effective communication aimed at behaviour change and access to safe water and basic social services. Community health services organised by the committee may include:

9.1 Disease prevention and control to reduce morbidity, disability and mortality

- Communicable disease control: HIV/AIDS, STI, TB, malaria, pneumonia, and diseases of epidemic potentials (Diarrheal diseases)
- Diseases surveillance; Acute Flaccid Paralysis, Yellow Fever, Lassa Fever,
- First aid and emergency preparedness/treatment of injuries/trauma
- IEC/BCC community mobilization, advocacy and health education for community health promotion and disease prevention

9.2 Family health services to expand FP, maternal, child and Adolescence health services

- MCH/FP, maternal care (focus Antenatal care; ITN, IPT, Iron), immunization, nutrition, C-IMCI
- Adolescent reproductive health (family planning commodities)
- Non-communicable disease control: NCDs, NTDs (Mass Drug Distribution)
- Nutritional deficiencies and school health de-worming services ,

- Community-based referral system, particularly, maternal danger signs, severe malnutrition

9.3 Health Promotion, Hygiene and environmental sanitation

- IEC community mobilization, advocacy and health education for water, hygiene and sanitation
- Waste management, Excreta/solid waste disposal
- Water supply and safety, including protection of wells
- Food safety
- Vector Control and occupational health and safety
- Personal hygiene and environmental sanitation
- Organizing community health days/health fairs

10. Supportive Supervision

Supervision is essential for the successful implementation and quality health care provision. Effective supervision is needed at all levels: national, county, district, health facility and community.

10.1 National-level

At the national level, the Community Health Services Division is responsible to:

- Develop, revise, and disseminate supervisory tools
- Orientate CHTs and partners on effective use of the tools
- Coordinate and supervise the formation of the community health structure
- Collect, and give feed back to CHTs on community activity report
- Conduct a monthly technical coordination meeting
- Conduct a quarterly Community Health Services Division coordination meeting with other programs and partners
- Conduct quarterly joint supervision for community health services activities

10.2 County-level

At the county level, the Community Health Services Department is responsible to:

- Conduct monthly community supervision at district and health facility levels with partners.
- Participate and monitor all training at the health facility and community levels
- Conduct quarterly joint supportive supervision at the facility and community levels.
- Conduct a monthly health coordination meeting with partners and other programs

- Coordinate the planning and implementation among partners to ensure adherence to MOHSW policies and to avoid duplication of activities

10.3 District-level

At the district level, the District Health Team is responsible to:

- Conduct monthly supervision of health facility and communities.
- Conduct a monthly health coordination meeting with health facility staff to discuss community program activities.
- Collect monthly community activities report from health facility and give feedback.

10.4 Facility-level

At the health facility level, supervision of community health activities will be done by a designated Community Health Services Supervisor (RN, PA, CM, EHT, and LPN). The designated Community Health Services Supervisor will function as follows:

- Spend nearly 100% of time in the field, equipped with motorcycle, gas, etc. to support activities in field.
- Prepare monthly activity schedules to ensure coverage of supervision activities.
- Conduct supervision for all CHVs on a monthly basis.
- Work with CHC/CHDC to provide support for all CHVs.
- Supervise CHV peer supervisors to make sure they are active in their supervision and have the capacity to perform required tasks.
- Assist in problem solving and critical decision-making.
- Use the standardized supervisory checklist for all supervision
- Collect, compile and validate CHV activity reports and submit to OIC on a monthly basis.
- Monitoring supply chain to ensure that adequate supply of drugs and materials are available in the community for CHVs work.
- Participate in planning and training CHVs
- Conduct joint quarterly supervision alongside the DHT (sampling of certain communities/CHVs and focus on problem solving)
- Give feedback from DHT to CHVs/CHV peer supervisors
- Participate in monthly meetings of CHCs in their communities.

- Assist in organizing and participate in CHDCs monthly coordination meetings at health facility.
- Provide technical support in planning and implementation of community programs.

10.5 Community-Levels

At the community level, the CHVs should be supervised on a monthly basis by the CHSS assisted by CHV peer supervisor who is responsible to:

- Collect and verify reports from CHVs and submit to CHV supervisor
- Conduct supervision on a 1-on-1 basis, using supervision checklist
- Re-stock CHVs supply during supervision in coordination with Community Health Services Supervisor

11. Motivation and Incentives

CHV motivation is an important component of community health care delivery. A standardized motivation package is required to support the work of CHVs within communities since CHVs as volunteers are not entitled to a monthly salary.

This package has to be incorporated into county specific health plans to enable counties and districts to properly utilize available scarce resources. Similarly, the filtered health service delivery packages targeted at community level should be incorporated into the community-based health plans. Below is a table of performance based indicators for CHVs.

Basic Visibility Supplies for CHVs	
Incentive/Motivation Components	Funding Source and Party Responsible
Standardized kit for implementers: <ul style="list-style-type: none"> • Vest • T-Shirt • Rain Gear • ID cards • Backpack • Signboards at CHV houses 	Pooled funding from vertical programs CHT/IP to submit gCHV listings to MOHSW
Essential Supplies for Implementation of Nationally Recognized Case Management Programs at the Community Level	
Essential Supplies for Programs (program areas and essential supplies to be determined by divisions managing each program): <ul style="list-style-type: none"> • CB-DOTS • CCM • ARV follow-up • Nutrition • Etc. Example supplies: <ul style="list-style-type: none"> • Ledgers/Job Aids • Wooden boxes for drug storage 	To be funded and supplied by each participating vertical program CHT/IP to submit gCHV listings to MOHSW

Essential Supplies for Other/Pilot Programs	
Essential Supplies for other/pilot Programs (program areas and essential supplies to NGOs for each program); Existing CHVs to be prioritized for participation and identification of any additional participants that are needed. Partners to work with CHDCs, CHCs to identify.	To be funded and supplied by NGOs running programs
Essential Supplies for Running Community Health Structures (CHDCs/CHCs)	
<ul style="list-style-type: none"> • Stationary Supplies • Transportation reimbursements? • Feeding? 	Implementing Partners (IPs) for USAID/pool fund money To be decided on county by county basis, but generally no incentive to be provided
Performance-Based Incentives to CHVs/CHDCs	
Distributed based on Performance-based funding of health facility: 65% to facility staff 35% to facility/community projects <ul style="list-style-type: none"> • CHDC project funds • CHV cash bonuses 	Quarterly review meeting of CHVs at the facility level (or grouping by district as necessary). CHTs administer performance-based bonuses to distribute at quarterly review meetings; CHDC to decide how to distribute along with CHSS to various CHVs based on performance.
Quarterly review meetings at district level	
<ul style="list-style-type: none"> • Transportation reimbursements • Feeding • No accommodation 	CHT and Primary recipients (IPs) for USAID/pool fund money. Review progress
CHC/gCHV/TTM monthly meetings at community level	
No incentive	Primary recipients (IPs) for USAID/pool fund money Monthly schedule for all catchments in the facility: Monthly meeting attended by CHSS, drugs distribution, supportive supervision, outreach (vaccination, IPT) on motorcycle, report collection, etc.
Motivate CHVs by providing advancement opportunities	
<ul style="list-style-type: none"> • Prioritization of high performing CHVs to fill facility support staff • Scholarship opportunities in the County for people to become health professional staff • Internal promotion within CHV structure (e.g. Peer supervisors) 	CHT HR to manage
Motivate, recognize, and appreciate gCHVs' efforts through recognition program/conference	
Motivate/reward outstanding gCHVs on an	CHT/IP

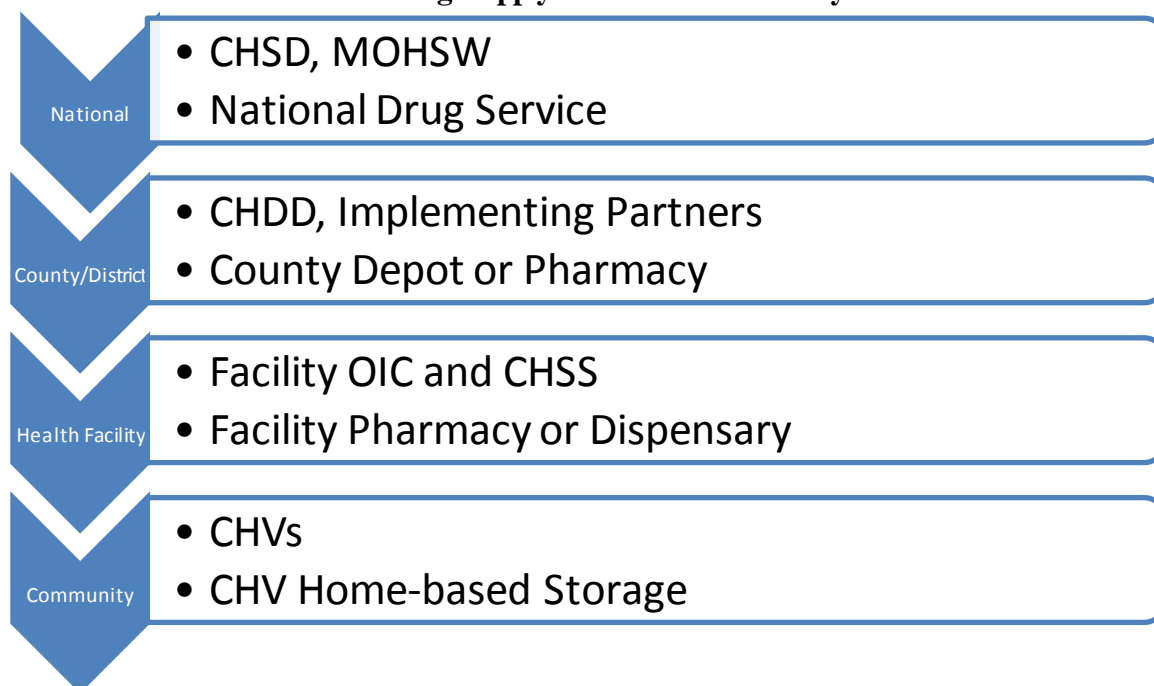
annual basis	
Involvement in National Health Campaigns, CHVs should be prioritized for running campaigns	CHT/IP to organize participation Cash incentive provided by National Campaign
Supervision	
Regular supportive supervision of CHVs <ul style="list-style-type: none"> • Motorcycles for CHSS • Fuel support for CHSS • Maintenance of motorbikes 	CHT/IP
Community Support	
Community Mobilization Strengthening of Community Health Structures Training/Activities	Community Members, supported by CHSS IP to provide funding, or can incorporate into meetings Community Health Division has curriculum

12. Supply Chain and Logistics

There can be no effective community case management without a constant supply of medicines to treat each of the childhood illnesses. Without an uninterrupted supply of medicines to treat childhood illnesses at sites outside health facilities, Community case management cannot succeed. At all levels, there should be an uninterrupted flow of supply of medicine.

Availability of materials, commodities and drugs supplies at all levels is key to the success of all programs. To achieve this, necessary arrangement for supplies, transportation, storage and adequate information must be in place.

Below is the flow chart showing supply chain for community health services activities.



12.1 National level

At the national level, the CHSD in collaboration with other programs and partners work with Supply Chain to ensure that adequate supplies, drugs and commodities for CHVs use are available at NDS. CHSD is responsible for the availability of all CHVs materials.

12.2 County level

At the county level, the CHDD and partners in collaboration with the county pharmacist order adequate supplies from NDS base on county consumption and store in the county drugs deport.

12.3 District level

At the District level, the DHT and partners ensures that reports and requisitions for drugs and other commodities to be use by CHVs are prepare on time and submitted to the county community health department on a monthly basis. DHT ensure that drugs and supplies are available at HF at all time.

12.4 Health Facility Level

At the health facility level, the OIC or CHSS ensures that reports and requisitions for drugs and other commodities to be use by CHVs are prepare on time and submitted to the community health department on a monthly basis. Drugs should be stored separately from other health facility supplies. They are responsible to supply CHVs on a monthly basis base on consumption and even during supervision if necessary. Help CHVs in compiling their monthly requisitions.

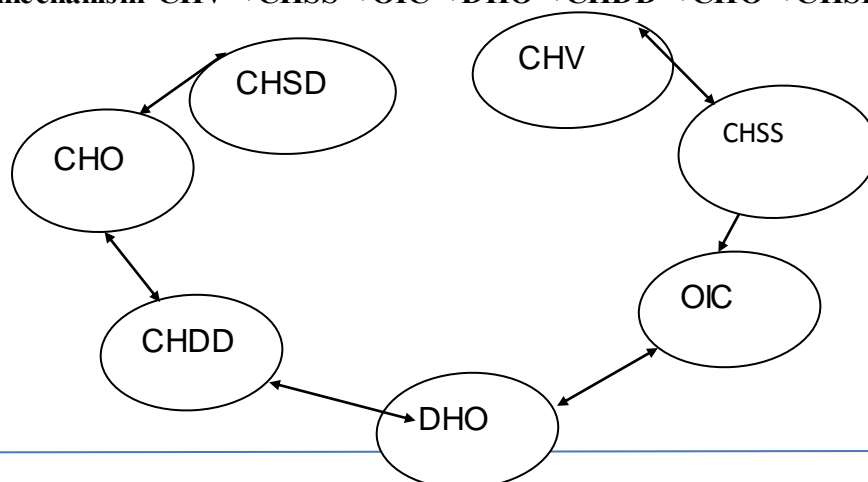
12.5 Community Level

At the community level, CHVs order for all necessary supplies on a monthly basis base on their consumption from their health facility in collaboration with their supervisor. CHVs must use these supplies for intended purposes

13. Community Health Management Information System Strategy-

The community health volunteers will maintain registers recording daily activities and reporting monthly to Community Health Services Supervisor facilities. The CHSS report to health facility, the facility report to DHT, to the CHT and CHT report to CHSD. CHVs are encouraged to use ledgers developed by HMIS for recording. The CHSS review the ledgers on a monthly basis, compile and, analyze report for submission. Feedback is given during supervision and monthly Community meetings.

15.5 Figure showing Information system flow from community to Central and Feedback mechanism CHV→CHSS→OIC→DHO→CHDD→CHO→CHSD



14. Monitoring and Evaluation

The flow of community health data shall follow the HMIS protocol. CHVs shall be responsible for filling out and submitting monthly community-level HMIS data based on information recorded in their ledgers. This data shall be collected by CHV supervisors, who shall submit information to their health facility to be compiled. Data at the health-facility level shall be reported to the CHT on a monthly basis for onward submission to National HMIS. Systems shall be put into place such that information from the national and county levels is reported back to facilities, CHV peer supervisors, and CHVs.

14.1 Monthly Meetings

Monthly meetings are held in each community by the CHCs, CHVs and sometimes the CHSS and or the OICs. The secretary to the CHC keeps minutes of each meeting. The CHDC who is a member of the CHC use information from the meeting to set up agendas for the monthly health facility catchment community meetings. These meeting are also held monthly and the OIC serve as secretary.

14.2 Quarterly Review Meeting

Quarterly review meetings are held on a quarterly basis with CHVs, OICs, DHOs and the CHSS. The significance of this meeting is to review the activities of CHVs in each catchment community. Progress and challenges reported and plans for the next quarter developed.

14.3 Program Mid-term Reviews

Programs or partners implementing project will conduct a review meeting mid way of the project to look at progress and challenges and decide on a way forward that will produce the desired goal set.

14.4 Annual Review

Annual review meetings are held each year either at the beginning of a physical year or at the end. The review meetings will look at progress made towards planned activities and determined how much was achieved. Challenges/constraints and how to turn them into success for the future is closely reviewed. Lessons learnt from the year can be used to plan activities for the coming following year.

15. Operational Research and Development

The MOHSW will promote a culture of inquiry into the best methods for delivering of community health services. To achieve this and ensure coordination of community research activities, the CHSD will coordinate closely with the existing Research Unit of the MOHSW to carry out operational, program action-oriented research.

The CHSD will also work with other autonomous institution created to organize and conduct community based research. The MOHSW shall be consulted in all matters regarding community health related research by third parties.

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

16. Quality Assurance at Community Level

Quality Assurance is the systematic approach to assuring that the details of health care are done right, in order to improve program and health workers performance. Quality Assurance includes all activities and processes that contribute to defining, designing, assessing, monitoring, and increasing the quality of health care. Quality Assurance should be at all levels: Central, County, District, Health facility and Community

Quality Assurance in community case management can make case management more effective and safer; this includes giving the right amount of medicine for the right duration, which increases the efficacy and prevents children from being harmed by inappropriate doses of medicine.

Quality Assurance also improves community health volunteers' motivation. Quality Assurance can provide evidence needed for program scale-up and increase community ownership of case management thereby bringing about sustainability.

Supervision is the heart of quality assurance in community programs. Supervision is the main process for collecting data and monitoring quality in community case management. Quality monitoring should be a routine activity, ideally initiated through competency- based training for CHVs. Supervision and feedback can improve quality and boost motivation.

Partnerships with the community can increase quality of services. When community members select CHVs, they are participating in quality assurance by defining the characteristics that they want in a CHV. Community mobilization activities and community management structures are means through which the community participates in defining, demanding, and working toward good quality of care in both community based and facility based services.

Annex 1: Community Health Services Strategic Work plan:

No	Expected Results	Strategies	Activities	Main targets	Indicators	Phase of implementation
A.	STRATEGIC OBJECTIVE 1: To build capacity and strengthen Communities to support the delivery of EPHS at community levels					
1	Partners / Stakeholders and communities are actively using MOHSW national policies and strategies in planning and implementing community-based activities	Make available all the necessary documents (e.g. Policies, guidelines, training manuals, treatment strategies, supervision and monitoring tools etc)	Finalize, print and distribute the Revised Community Health Services policy and strategies	CHSD, CHTs, Partners, stakeholders	# of partners Stakeholder, CHTs, working in line with the National community health services and polices	January –June, 2012
			Conduct regular monthly/quarterly coordination meetings and supervision	CHSD, CHTs, Partners, stakeholders CHVs, communities donors,	# of monthly/quarterly review coordination meeting minutes and supervisory reports	2011-2015
2	Community Health structures in 88 health districts in 15 counties Re- activated or established	Re-activated or structured all communities in 88 districts are to fully participate in community-basd activities	1. Conduct advocacy/sensitization meetings in communities	District commissioners, paramount, clan and Town chief, youth, women and civil society groups	# of advocacy/sensitization meeting held and minutes available	2012-2013
			Conduct training on the community health services policy and strategy	CHC, CHDC, CHV	# of CHC, CHDC, CHV trained	2012-2013
			Conduct monthly coordination meeting		# of meetings and minutes	2012-2015

3	Planning, implementation, supervision, monitoring and evaluation is Coordinated and improved	establish coordination mechanism for proper planning, implementation, supervision, monitoring and evaluation of community based intervention			Attendance listing	
			Conduct partners mapping in each county		# of partners in each county	
		strengthen the mechanism for supervision and monitoring of activities at community levels	Conduct Monitoring visits Conduct Joint monitoring and quarterly supervision	CHSD, CHTs, Partners, stakeholders CHVs, communities donors,		2012-2015
					# of reports from joint quarterly supervision and monitoring visits	
				CHT, CHVs, Partners	# of monitoring visits and available reports	
B.	STRATEGIC OBJECTIVE 2. To raise awareness of community members to implement preventive health interventions (for the selected public health programs) by providing them with the necessary and appropriate information, and making the commodities and/or services available (where applicable).					
1	Households and/or individuals are practicing/ implementing preventive health measures for the selected public health programs	Build capacity of households and/or individuals to practice/ implement preventive health measures for the selected public health programs	Training IEC/BCC material production and distribution Airing of health message on local Radio Stations House to house health talk, Group discussion on community health issues	CHVs, community members	# % of households and/or individuals practicing/ implementing preventive health measures for the selected public health programs	2011-2015
2	Incident of malaria related morbidity	Empower communities all community member including	Create awareness on the use of ITN	Community members Pregnant women	% of community members sleeping	2011-2015

	and mortality reduced	pregnant women and children under five sleep under ITN overnight	Make ITN available in all communities Implement IRS activities in communities	CHVs Health workers	under ITN every night	
3	Incident of malaria in pregnancy reduced	Ensure every pregnant woman take IPT 2 before delivery	Create awareness on the use of important of IPT Make IPT available in all health facilities and communities	Community members including pregnant women CHVs	% of pregnant women having IPT2 (not less than 80%) by	2011-2015
4	Number people doing voluntary testing increased	Create awareness on the use of important Reaching many persons with information on voluntary testing and counseling	Create awareness on the use of important voluntary testing Make testing centers accessible	Community members including pregnant women CHVs	% of increase in the coverage of voluntary testing	2011-2015
5	Immunization coverage increased	-Full Immunization for all children under one year -Reaching every children under one year of age using the RED Approach. -Routine Immunization	-Create awareness on the use of important of Immunization -Implement RED strategic approach	CHVs, Community members, Health facility staff	Immunization Coverage increase to 85% with pent-3	2011-2015
	Child and maternal mortality reduced	-Reaching every children under one year of age using the Reaching Every District(RED)	Create awareness	Community health volunteers, Community	% of reduction in child and maternal mortality achieved	2011-2015

6		Approach -Reaching every pregnant woman using the REP approach.		members, Health facility staff		
7	DOTs coverage increased	Referral of all suspected TB cases to health facilities, tested and positive cases put on treatment	Create awareness Train CHVs Make testing centers accessible	Community members, Health facility staff CHVs	% increase in DOTs coverage	2011-2012
C. STRATEGIC OBJECTIVE 3: To provide prompt and appropriate treatment to patients within 24 hours of onset of symptoms of infections (for selected diseases).						
1	Complications and mortality in under fives is reduced	-All cases detected or presented are given prompt and effective treatment within 24 hours	-Training of gCHVs in childhood diseases (malaria, ARI and Diarrhea) -Create awareness -Train gCHVs in using RDT	gCHVs Caregivers, CHVs Health facility staff	% of cases (detected or presented) is given prompt and effective treatment within 24 hours of onset of symptoms	2012-2015
2	Suspected or presented cases confirmed before	-All suspected cases that are detected or presented benefited from Parasitological diagnosis	-Create awareness on	gCHVs caregivers	% of suspected cases that are detected or presented benefited from Parasitological diagnosis	2012-2015

	treatment (eg malaria)	(e.g. using RDTs in the case of malaria)	confirmatory diagnosis before treatment. -Create awareness to discourage self treatment	mothers and fathers	(e.g. using RDTs in the case of malaria)	
		- Strengthen the mechanism for supervision and monitoring of Community activities.	-Diligent, timely supervision & mentoring of gCHVs to ensure quality of service.	CHT, partner sup. Team	# of gCHVs performing RDT correctly. (Supervisory report)	2012-2015
		3. Ensure the availability and Access to quality medicine and other commodities (in the community for CCMP.)	Make available adequate supply of RDTs medication for CCM of Malaria	NMCP, & Partners gCHVs & community target pop	Commodity Monthly report (report will reveal stock out)	
3	Increased malaria, ARI, TB, diarrhea case detection	5. Establish a well functioning community based surveillance system.	Conduct baseline and follow up survey	MOH & partners	# of baseline surveys conducted and analyzed	
4	severe disease cases referred within 24 hours of detection or presentation	Prompt referral of all severe disease cases for appropriate management within 24 hours of detection or presentation	-Training of gCHVs -Create awareness for caregiver and community members	gCHVs caregivers and community members	% of severe disease cases are referred for appropriate management within 24 hours of detection or presentation	2011-2015

D. STRATEGIC OBJECTIVE 4: to establish a functional community-based surveillance system						
1	A functioning community-based surveillance system is in place	Revised community health policy to include Surveillance strategies,	-Consultative review and finalize the Community Health Policy and strategy Document -Produce and distribute community HMIS register	CHSD, EPI, M&E Unit, Partners ,CHTs	# of meetings held and minutes % of communities covered by HMIS	2012-2015
						2012-2015
			-Roll out HMIS training at county, facility and Community levels		# of CHVs, CHCs trained in disease surveillance reporting	2012-2015
2	Cases of the different diseases under surveillance reported at community level	Institute Community disease data base at all levels	Community meeting to create awareness on community opinion leaders	CHSD, EPI, M&E Unit, Partners ,CHTs	# of community meeting held and documented	2012-2015
D. STRATEGIC OBJECTIVE 5: To secure (ensure) the commitment and participation in CBI among partners/stakeholders at all levels of the health delivery system including the community level.						

1	Partners/stakeholders and communities are actively involved in securing required resources (human and financial) for Community Based Initiative planning and implementations.	Ensure Partners/stakeholders and communities are actively involved in securing required resources for Community Based Initiative planning and implementations	Mobilize resources by developing and submitting project proposals	International Partners, Donors and UN Agencies	# of Donors / partners contributing to CBI	2012-2015
2	Increase in financial resources from the partners committed to disease control	Mobilize financial resources and ensure it is committed to disease control	Meet with partners, donors regularly plan community-based activities together	International Partners, Donors and UN agencies	Amount of funds available for CBI	2011-2015
3	Coordination for planning, implementation, supervision, monitoring and evaluation	Conduct regular coordination meetings are held	Conduct regular monthly/quarterly coordination meetings	International Partners, Donors and UN agencies	# of meetings and minutes available	2011-2015
4	All partners reporting regularly (e.g. quarterly) to the division of Community Health Services	Collect regular reports from all partners	Make available reporting tools Collect report quarterly	International Partners, Donors and UN agencies	# of partners reporting regularly	2011-2015

Annex 2: COMMUNITY HEALTH COMMITTEE (CHC) OPERATIONAL GUIDELINES

1. Introduction and background

The Community Health Committee is elected by the community with guidance from the catchment Health facility and the County Health Team. Members of this committee form the basis of community interaction and participation in improving and setting up priorities agenda for managing its own health. A member from each CHC is to serve on the Community Health Development Committees (CHDCs) which provides a mechanism for coordination and participation at the health facility level. The CHC is to oversee and assist in the selection of CHVs and provide administrative support. CHCs will be formed in all communities to provide these functions. However, communities with health facilities are exempted from the task of selecting and training the general Community Health Volunteers (gCHVs), but will fulfil all other functions of a Community Health Committee.

2. 1 Membership of CHC

- Each member shall be elected by the community
- Membership should follow the guidelines on diversity of sex, ethnicity and religion
- Membership should comprise of 5-9 members (avoid even numbers)

2. 2 Roles and responsibilities of CHC

- Oversees the selection of the community health volunteers in a community meeting
- Supports and assists in the supervision of CHVs (gCHVs, TTMs, HHPs and other health volunteers)
- Provides and directly ensures that CHVs (gCHVs, TTMs, HHPs and other health volunteers) are supported and motivated by the community by providing labor and other identified forms of motivation/compensation
- Holds meetings ideally once a month, but may call an emergency meeting when necessary.
- Assists CHVs to promote the prevention of communicable diseases such as: malaria, TB, HIV/AIDs, diarrhea etc
- Oversees the management of public water and sanitation facilities in the community
- Ensures proper waste management -Proper refuse disposal
- Assists the CHVs to promote the use of ITNs among the population, especially the under five children and pregnant women
- Assists CHVs carry on public awareness about the importance of health services, such as nutrition, etc at community level.
- Manages the community health fund, mobilize voluntary contributions, keeping up-to-date expenditure records, where applicable
- Mobilizes local labor and ensures community motivation
- Facilitates community involvement in the security of the community health facility and other assets
- Assist in the investigation of any maternal or neonatal/infant/child death which occurs in the community and take the appropriate preventive actions.
- Mobilizes community to set up emergency transport system and strategy for raising funds
- Ensures that TTMs encourage health facility delivery and utilization of ANC and PPC services

- Ensures that committee structure is in line with Ministry of Health and Social Welfare guidelines for youth, religious, and gender representation
- Appoints or elects a member to serve a two year term on the CHDC
- Ensures that CHVs provide monthly reports to the CHSS
- Establishes a system to safeguard items (i.e. bicycle and medical/drug supplies) supplied to gCHVs and other volunteers for promoting community health in the community

2.3 Accountability

The Community Health Committee is first accountable to the Community Assembly and secondly to Community Health Development Committee of the catchment area. The Town Chief and CHSS will provide supportive supervision and coordinated intervention as needed.

2.4 Composition Of CHC

The committee shall comprise of a total number of 5- 9 elected members. Every attempt should be made that at least 30 % of the members are women. Even number should be avoided. Membership should include representatives from schools, religious organizations, CBOs, etc, where applicable.

2.5 Criteria For Election To Membership

- Should be respected member of the community
- Should be a permanent resident in the community
- Should be able to sustain himself or herself
- Willing to perform his or her functions of the committee as volunteer
- Should attend regular meetings of the community
- Should not be less than 18 years and not above 70 years
- Must be able to speak the local language

2.6 Election:

The OIC/CHSS of the catchment area in consultation with the CHT or DHT will mobilize the community and call a community meeting to elect members to the CHC.

After the initial elections, representative from the CHC will form the CHDC that will assist the CHT in a three years cycle of community mobilization. The terms of reference (TOR) for the committee and responsibilities of each shall be explained. Notice of the election shall be made at least one week prior to election. Officers shall be elected by the community members present at a called meeting. Election shall be conducted by secret ballot.

2.7 Powers Within The Committee:

The officers and functions of the committee shall be as follows:

- a. **The officers** shall be elected from among and by the elected members.
- b. **Chairperson**
 - Shall be responsible for convening meetings and coordinate functions of the committee.

- Provides leadership to the committee
 - Serves as liaison between the clinic and the community
- c. **The co-chairperson-** shall assume chairperson duties in the absence of the Chairperson.
- d. **The treasurer** shall perform the following:
- Keeps funds and financial records
 - Report money received on behalf of the committee at meeting
 - Shall make yearly financial report or when ever requested to do so.
- e. **The secretary shall have the following duties:**
- Seeks and prepare agenda for the meeting in collaboration with the chairperson or the co-chair
 - Takes and keep minutes
 - Maintains all correspondences and other documents/records of the committee.
 - Keeps records of activities of CHVs in the community.
- f. **CHC elected representative to the CHDC membership:** Two year term of office and this representative may be reselected for only one additional term of tenure, provided that they are still serving on the constituent CHC.

2.8 Tenure of office:

The committee shall occupy office for a period of three years. They may contest for another 3 years of tenure after which they have to retire. By-election shall be held during the next scheduled meeting to fill vacant positions in case of death, resignation/desertion or impeachment of an officer.

The post of a member or officer who misses two consecutive meetings **without valid excuse** shall be declared vacant and shall be filled as stated above during next scheduled meeting. Two members of the community shall be nominated by committee members and voted upon in a case of a non officer member. Officers may be nominated from among the committee members.

2.9 Installation of the community health committee

The committee shall be officially installed by the OIC/CHSS or an appropriate officer/official. This could be the town chief, clan chief, town ship or district commissioner an influential person etc. This is also an opportunity for advocating for its functions and motivating its members.

2.10 Procedures for community health committee meetings

The Secretary in collaboration with the Chairperson shall call meetings at least quarterly and monthly in county according to agreed date. Emergency meetings can be convened any time. Each meeting shall have clearly specified agenda developed through consultation between the Chairperson, Secretary, and other members of the committee and community residents. The CHVs input will also be solicited prior to the meeting. Additional items for inclusion on this agenda will be action points and topics covered at the CHDC meetings.

2.1.1 Common items which should be featured in the agenda

include:

- a. Overall health status of the community and ways of addressing health problems
- b. Performance of the health facility/services
- c. Performance of Community Health Volunteers
- d. Community participation and commitment
- e. Empowerment of the community CHVs support/motivation and incentive

The Secretary shall read preceding minutes; once the minutes are approved by members, the secretary will then proceed with the meeting agenda.

3. Responsibilities of the officer in charge at facility catchment area

The Officer in Charge (OIC) of the catchment health facility shall have oversight responsibilities technically. He or she shall ensure that reports from the CHVs and CHC are forwarded to CHT. He or she shall ensure that in-service training is provided on continual basis. The CHSS and OIC at the catchment health facility shall liaise with District Health Officer (DHO) to ensure that reports are sent to CHT. The CHSS shall also keep records on the composition and performance of each CHC and CHVs. Other programs staff members in the Ministry shall liaise with the CHSS and OIC in implementation of their programs at community level.

4. Linkages:

The Community Health Committee shall collaborate with other structures in the community, CHDC and relevant authorities. The CHC shall report to the CHDC and the catchment health facility. The CHC shall co-ordinate with the quarter and town chiefs, district/township commissioner, where possible and other civil authorities.

Annex 4: Community health development committee (CHDC) operational guidelines

1. Introduction and background

The Ministry of Health and Social Welfare considers the Community Health Program as an important component of the health care delivery system of Liberia. The National Health Policy and the Essential Package for Health Services (EPHS) identify specific activities that should be implemented at the community level with community participation.

The Community Health Services Policy considers a well functioning Community Health Committee (CHC) which is necessary for ensuring community responsibility, ownership and participation in safeguarding its health. Moreover, the involvement and representation of the community at the catchment area facility is essential in creating an integrated community primary health system. This will be accomplished by CHC representation at Community Health Development Committee (CHDC). Hence, the Ministry of Health and Social Welfare (MoHSW) requires that the Community Health Development Committee and Community Health Committee structures be activated or established. This process will be considered prior to the selection and training of the Community Health Volunteers (CHVs).

2. The community health development committee (CHDC)

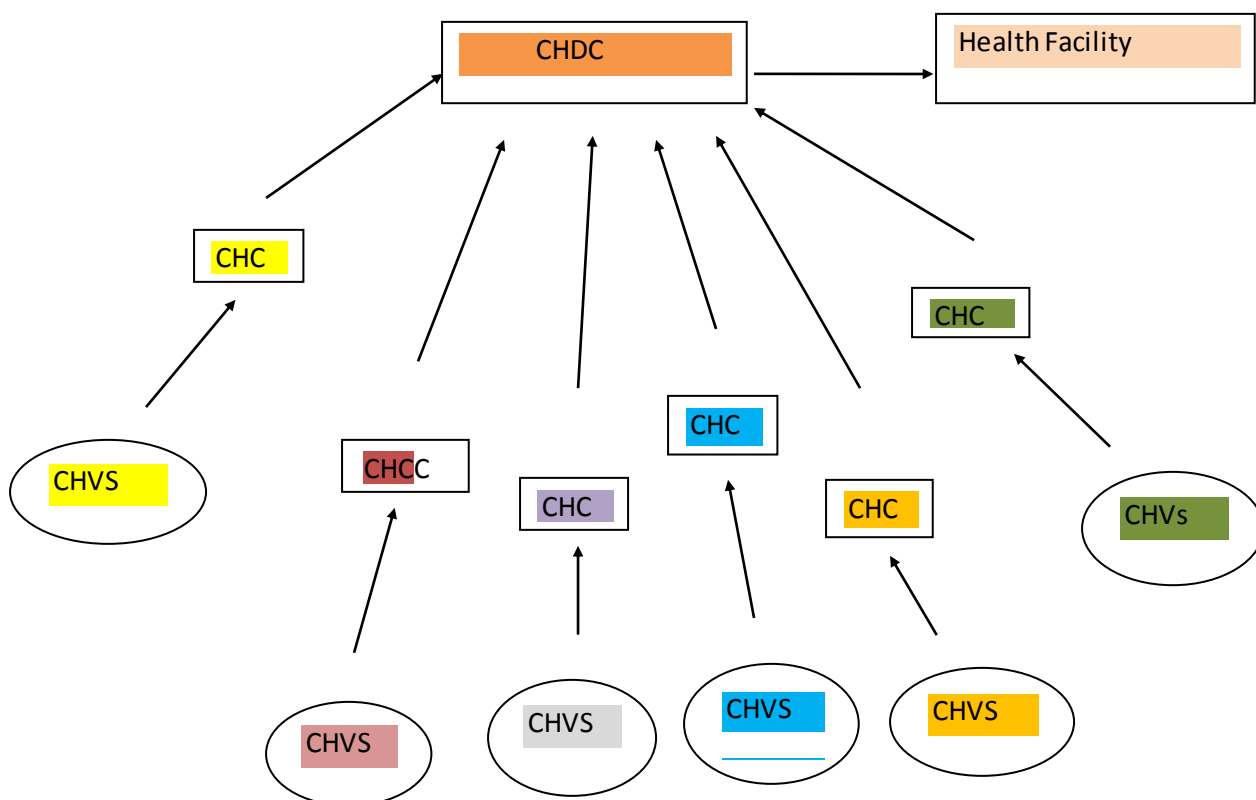
Communities in Liberia are represented by community health committee (CHCs), which are responsible for coordinating and supporting CHVs, as well as mobilizing communities for health actions. To coordinate those diverse CHCs and provide an interface between them and the Health facilities, community health development committee is required for each health facility. The CHDC's primary responsibility is to act as a governing body for all CHCs in the facility catchment area.

- The facility OIC shall serve as secretary to the CHDC.
- The CHDC which is to meet monthly provides a direct connection between community members and the District Health Team (DHT)/County Health Team (CHT).
- The CHDC meeting will serve as the forum for advising the health facility (DHO & CHT) of health ppriorities in its catchment area
- Assists the CHCs resolve health issues arising in their communities
- Monitors and ensures that equitable services are provided by CHVs across communities
- Provides over sight responsibility for facility operations, including regular monitoring of quality services, such as resource management and surveillance information
- Assists in the mobilization of communities through CHCs.

2.1 Membership of CHDC

- The CHDC shall comprise of one member from each community's CHC.
- The female members of this body should not be less than 30%.
- Membership should reflect ethnic and religious diversity in the catchment population.

The diagram below shows the relationship between the Health facility, CHDC and CHCs



2.2 Roles and responsibilities of CHDC

1. Assists the CHCs resolve health issues arising in their communities
2. Monitors and ensures that quality equitable services and support are provided for the CHVs across the community.
3. Provides oversight responsibility for facility operations, including regular monitoring of quality services, such as resource management
4. Provides a mechanism for surveillance information
5. Assists in the mobilization of communities through the CHCs to support facility development (e.g., building of placenta pit)
6. The elected CHDC chairperson will represent, attend, and participate in scheduled quarterly reviews with members of the CHT and partners
7. Reviews current status of health facility as it relates to the community level and communicates to the CHC or CHV bodies on such issues like “stock-outs; increased need for surveillance activities; and rapid community mobilization campaigns etc.
8. Assists in planning and forecasting district health needs and resources as requested
9. Participates in annual reviews of District Health Plans.
10. Mobilize communities to provide lodging for facility health workers.
11. Assist in the dissemination of health messages and related campaigns.
12. Acts as a forum for sharing best practices and comparing community health issues and cross cutting public health concerns between the communities.

Term of reference for community health services supervisor

Title of position: Community Health Services Supervisor

Responsible to: Officer In-Charge (OIC) of the assigned health facility.

Objective: Responsible for the day to day supervision of community level EPHS Services in assigned catchment communities of the health facility

Responsibilities:

1. Conducts supportive supervision of gCHVs in assigned catchment communities
2. Provides continuous mentoring in accurate collection and timely reporting of data generating from the community.
3. Participate and attend monthly meetings of CHVs and CHCs to discuss problems, challenges and progress.
4. Assist the CHVs to carry on active TB case searching and defaulter tracing in assigned catchment communities.
5. Assists health facilities outreach teams to plan program that will increase immunization coverage.
6. Assist OIC in the training and supervision of the gCHVs to recognize danger signs in children under -five years of age for prompt referral to the health facilities.
7. Plan with OIC and participate in all CHV trainings
8. Works with catchment communities to identify simple transportation means for referral of cases to health facilities
9. Assists the CHVs in the distribution of IEC/BCC material and messages for promoting healthy behaviors in communities.
10. Supervise CHVs to conduct regular community based growth monitoring, nutrition screening and counseling
11. Monitor proper utilization of established ORT corners in communities
12. Assists the CMs in the supervision of the TTMs in recognizing high risk pregnant women in the communities for referral to the nearest HF.
13. Supervises CHVs to promote family life education and substance abuse prevention.
14. Supervises CHVs during community based interventions such as ITNs and condoms distribution, as well as education on their proper utilization.
15. Assist the gCHVs to identify patients with mental health problems in the communities for appropriate referral to the nearest health facilities.
16. Prepare monthly report on community activities including collated reports from the CHV peer supervisor and submit to OIC for submission to District Community Health Officer.
17. Assists the gCHVs in establishing weekly schedules of community awareness talks and activities.

Annex 4: Glossary

1. **Artemisinin-Based Combination Therapy**---a combined therapy for the treatment of malaria
2. **Antenatal Care**---Care given to a pregnant woman during pregnancy or during childbirth
3. **Acute Respiratory Infection**--- inflammation of one or both lungs. A case in which people's air sacs in the lungs are filled with fluid, preventing oxygen from reaching blood cells and nourishing the other cells of the body.
4. **Basic Package of Health Services**---see EPHS
5. **Cadres**---category of volunteers
6. **Community Based Organization**----non-governmental organizations working directly at the community level
7. **Community Health Committee**---a committee set up in the community to seek the health welfare of the community people
8. **Coordination**-- the combining of diverse groups to make a unit
9. **Collaboration**---the act of working together with one or more people in order to achieve something
10. **Environmental Health Technician**----one trained in environmental health technology including hygiene promotion, community mobilization, disease surveillance, water quality analysis etc; person responsible for community level public health activities.
11. **Evaluation**---the act of considering or examining something in order to judge its value, quality, importance, extent, or condition.
12. **General Community Health Volunteer**----a volunteer who lives and works directly in a community; one who is involve in the management of community cases.
13. **Health Center**----consulting room, private clinic, treatment center, doctor's office.
14. **Health Facility**---a place where health services are administered/ or place where one goes to get treated when he/she is sick.
15. **Household Health Promoters**----volunteers who work directly with household populations.
16. **National Immunization Days**---- designated days for mass vaccination of the population of a sector of the population.
17. **Officer-in-Charge**---- a professional health worker assigned as head of a health facility rural communities
18. **Performance based financing**----giving CHV money or other rewards based on their performance in Community health activities.
19. **Postnatal**—occurring immediately or soon after birth; relating to an infant immediately after birth
20. **Supervision**----a process by one directs, regulates, controls, or give guidance
21. **Trained Traditional Midwife**-----Women who are given basic skills to carry out delivery voluntarily in the community.

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