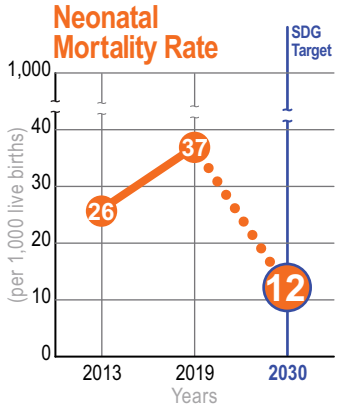
Community Health Roadmap

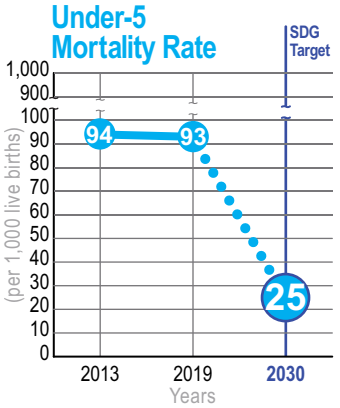
Bridging the SDG gap through accelerated primary health care at community level

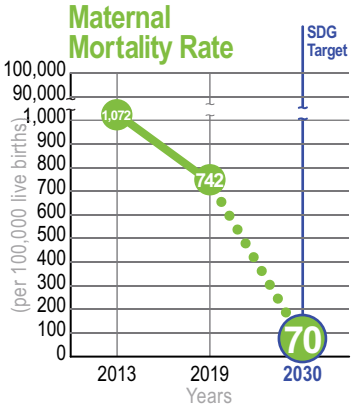
Community Health Roadmap

Liberia

2021 Update







At a Glance: Country indicators

Population (2019):
4,937,374

Total number of community health workers (CHWs):
CHAs: 3,513
CHSS: 395
CHVs: 5,000*
TTMs: 3,500

Gender disaggregation of CHWs:
CHA: Women 18%, Men 82%
CHSS: Women 49%, Men 51%

*In accordance with the new community health strategy, Community Health Volunteers will be rebranded as Community Health Promoters (CHPs)

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Community Health Overview

Liberia is in the fifth year of its **National Community Health Services Policy**, 2016-2021, and the country has recently finalized a new community health policy and strategy, whose overall goal is to meaningfully contribute to the reduction of maternal, neonatal, infant, child, and adolescent mortality and morbidity in all communities and the creation of child-friendly communities through disease detection, prevention and response.

Liberia will be hosting the third, international Community Health Worker Symposium in 2022. Two webinars are planned in February and May of 2022 and the in-person event is anticipated in September 2022.

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Community Health Overview

VISION: The Ministry of Health's vision for the new National Community Health Program is a coordinated national community health care system contributing to Universal Health Coverage (UHC) in which households have access to life-saving services and are empowered to mitigate potential public health risks in the community.

MISSION: The mission of the **Revised National Community Health Program Policy, 2022-2032**, is to extend the reach of the country's primary health care system through an integrated and standardized national community health model that can provide a package of essential, sustainable life-saving primary health care services and epidemic surveillance within all communities and to households on an equitable basis.

STATUS OF NATIONAL PLAN: The new National Community Health Services Policy and Strategy are informed by a review of the prior policy and the National Community Health Assistant Programme (NCHAP). The policy and strategy were developed with input from all stakeholders; and the new NCHP documents will be launched and disseminated in 2022 to include:

I. National Community Health Services Policy (2022-2032)
II. National Community Health Services Strategy (2022-2027)
III. Essential Package of Community Health Services (2022-2027)

Urgent Investment Actions (linked to new policy objectives):

1. Leadership, governance and community engagement: Strengthen community leadership and governance through implementing and supporting community mobilization, engagement and education for all community health services.

2. Monitoring, Evaluation, Research and Technology: Develop robust community-based surveillance, information and M&E systems for collection and use of high quality data. Foster data use for decision making to improve and reinforce the fidelity of community health programme implementation. Identify operational research opportunities and explore innovation to enhance quality and performance of the national community health programme.

3. Community Health Service Delivery: Increase equitable access to and utilization of a high quality, standardized and sustainable package of essential community-based interventions and services including health promotion for social and behavior change.

Urgent Investment Actions (linked to new policy objectives):

4. Community Health Workforce: Build human resource capacity of the community health workforce by digitizing and operationalizing pre-service and in-service training modules using blended learning techniques.

Enhance gender mainstreaming and emphasize the participation of females at all levels of the community health programme.

Strengthen human resource capacity through training institutes that institutionalize the national, competency-based training curriculum which is linked to career advancement opportunities, refresher training and ongoing mentorship and coaching for skills transfer.

Monitor the community health workforce to reinforce accuracy, utilization of drugs and medical supplies, referrals, surveillance and adherence to guidelines and protocols for quality improvement of community-based information systems.

5. Community Health Supply Chain System: Strengthen availability of community health commodities and accountability at all levels using standardized approaches, ensure timely reporting of consumption data, and link consumption data and CHWs monthly restock with eLMIS at facility, district, county and national levels.

6. Community Health Financing: Develop a costed roadmap for the national community health services programme. Advocate to partners and stakeholders to ensure there is alignment and coordination around needed resources in line with the national strategy and priorities for continuity and sustainability of community health services.

Description of Community Health Structure

Cadres:

Currently, 3,513 CHAs and 395 CHSS serve remote communities (located more than 5 kilometres (km) from a health facility). CHAs coordinate with other cadres, including: community health promoters (CHPs), trained traditional midwives (TTMs) and traditional birth attendants (TBAs) and, with community health leadership, Community Health Committees (CHC) and Health Facility Development Committees (HFDC).

Scale-up plan: The National Community Health Services Policy highlights the need to scale up the NCHAP in all counties and ensure quality performance. Scale-up is initially prioritized in Bassa, Bomi, Bong, Margibi, Monteserrado, and Lofa. Targets for full national scale: 5,000 CHAs and 500 CHSS. Scale-up also entails rebranding the current CHP cadre and recruiting them as community health promoters (CHPs) to support the work of CHAs.

Services offered:

Services in support of national policy prioritize the reduction of maternal, neonatal, infant, child and adolescent morbidity and mortality as well as the prevention and control of both communicable and non-communicable diseases.

CHPs work within 5 km of a health facility whereas CHAs focus on communities beyond 5km from the nearest health facility. CHAs offer curative services including iCCM and they also offer family planning services while CHPs focus more on promotive and preventive community health services and do not offer iCCM or family planning. CHSS conduct vaccine outreach and collect sputum.

Cases of gender-based violence cases are reported to the PHC facility for intervention by the Ministry of Gender and Children Protection.

Four service modules are under review for expansion of services:

1. Community engagement, health promotion and education, events-based surveillance
2. Reproductive, maternal and neonatal health
3. Child health
4. Special services (HIV, TB, leprosy, mental health)

Description of Community Health Structure

User fees:

None

Supervision:

CHAs and CHPs are supervised by the CHSS, who is assigned at the PHC facility. CHSS are required to spend 80% of their time in the community and 20% at the PHC facility. This includes at least two supervision visits per month. Each CHSS supervises 10 CHAs/CHPs on average.

Training:

Training for all CHSSs, CHAs and CHPs on the new national curriculum is planned for 2022-2023. Under the new policy, the training content and modules will be expanded to include: leadership, governance and community engagement; surveillance and community IDSR; maternal and reproductive health; child and adolescent health; HIV and TB prevention; eye health and NTDs; mental health and NCDs; and community health supply chain.

Remuneration:

Monthly salaries (taxable by law):

CHAs: US$70

CHSS: US$269 to US$313

(CHSS posted in remote locations are paid at the higher end of the scale)

Data collection:

Community-based information system (CBIS) is a sub-unit within the national data system (HMIS/DHIS2). Data generated by CHAs are collected and collated by CHSS on a monthly basis. CHSS enter reports into the CBIS; district and county data managers enter reports to DHIS2. DHIS2 data can be shared with PHC providers.

Description of Community Health Structure

Health system linkages:

The CHA, CHPs and CHSS cadres are designed to improve overall linkages between community health and the PHC system. Significant planning and attention are devoted to improving CHA linkages with the health facility and across departments (EPI, family health, nutrition). Other opportunities include integrating community health supply chains with the national health system's forecasting, procurement and distribution platform; and integrating community-based information systems with DHIS2.

Community engagement

Community engagement and mobilization activities are undertaken by the CHA and CHP and other community health cadres in collaboration with CHCs, as envisaged in the National Health Promotion Policy for demand generation.

Primary Health Care Structure at Community Level: Supports service delivery, engagement and accountability

Ministry department responsible for community health: Community Health Services Division

PUBLIC HEALTH SYSTEM

The health facility development committee supports CHA interventions and monitors package implementation in the community

One County Hospital at the county level per 50,000-100,000 people

OVERSEES

Officer in Charge

Registered Midwife

The **Health Centre**, each at the district level, employs on PA or RN (serves as the Officer in Charge – OIC), a registered midwife (RM) and one Community Health Services Supervisor (CHSS). Each health centre provides care for 5,000-15,000 people.

Community Health Services Supervisor (CHSS)

The **CHSS** supervises up to 10 Community Health Assistants (CHAs) and supports traditional and community structures

SUPERVISES

CHAs

CHPs

CHAs engage community 5km or greater from the nearest health facility. **CHPs** engage communities within 5km of the nearest health facility.

ENGAGES

Each CHA engages a **community** of up to 350 people to provide preventative and curative material and child health services

ALTERNATIVE DELIVERY CHANNELS

PRIVATE (for profit)

Traditional medical healers, including country medicine doctors, tend to have no functional relationship with public or private health providers

Individual private health professionals (e.g., doctors, nurses, midwives, and **facilities** (e.g., pharmacies, clinics, drug shops) tend to offer curative and preventative services

PRIVATE (nonprofit)

Non-Governmental Private Facilities mainly provide preventative and curative health services

TRADITIONAL & COMMUNITY STRUCTURES

Community leaders (e.g., local council leaders, religious, leaders, teachers, youth groups) liaisons and organizations (e.g. mother peer groups, youth groups), conduct health promotion activities, primary for family care

Primary Health Care Priorities and Progress at Community Level

Service Delivery

Expansion of services and introduction of innovations

Priorities (2021-2022)

- Pilot Community Eye Health in Margibi county; integrate in new strategy
- Develop community TB sputum collection and directly observed therapy (DOT) strategy for inclusion in community health package
- Redirect the course of mental health toward the distribution of mental health drugs to persons living with epilepsy
- Integrate COVID-19 into routine CHW services
- Develop COVID-19 continuing clinical education for use by CHWs
- Scale up Sayana Press for family planning; integrate in CHW routine activities

Progress (Sept. 2021)

- Community Eye Health launched
- Inclusion of community TB into new policy
- COVID-19 successfully integrated into routine services
- Sayana Press scaled up in Bomi, Cape Mount and Gbarpolu counties

Health Workforce

Recruitment and accreditation

Priorities (2021-2022)

- Recruit additional CHAs in Bomi, Bong, Lofa, Margibi and Montserrado counties in line with scale-up priorities.

Progress (Sept. 2021)

- CHAs scaled up in all 15 counties; gap counties and districts targeted

Training

Priorities (2021-2022)

- Train CHWs in COVID-19 detection, prevention and response
- Conduct service module training for newly recruited CHAs
- Conduct training for all CHSSs, CHAs and CHPs in the new training curriculum

Progress (Sept. 2021)

- All CHSSs, CHAs and CHPs were trained in COVID-19 detection, prevention and response
- Newly recruited CHAs and CHSSs in Grand Bassa county trained

Supervision

Priorities (2021-2022)

- Conduct Implementation Fidelity Initiative (IFI) supervision during COVID-19 and integrate with electronic Joint Integrated Supportive Supervision (eJISS). IFI assesses the extent to which programmes are implemented as intended and results are measurable

Progress (Sept. 2021)

- CHSS supervise CHA twice a month
- IFI supervision conducted for 3 of 4 quarters (due to COVID-19)
- Community health supervision integrated into eJISS

Health Workforce *(continued)*

Remuneration/reward and advancement

Priorities (2021-2022)

- Transition CHWs to electronic payment methods

Progress (Sept. 2021)

- All CHSSs are now paid through their individual bank accounts; all CHAs are now paid through mobile money

Health Information Systems

Data reporting and information systems

Priorities (2021-2022)

- Convert CBIS to eCBIS for real-time monitoring
- Launch digital health policy

Progress (Sept. 2021)

- eCBIS SOP is being developed
- Digital health policy is completed; launch is pending

Supply Chain Management

Supply chain management (including commodities)

Priorities (2021-2022)

- Ensure CHA supplies are aggregated with health facility requisition; 20% of health facility drugs are earmarked for the NCHAP and stored at the health facility separately
- Introduction of the CHA kitting system

Progress (Sept. 2021)

- CHA supplies are restocked based on consumption by CHSS during regular supervision
- CHA kitting system: design completed; launch and implementation are pending

Health products

Priorities (2021-2022)

- Improve availability of commodities for maternal and child health; coordinate drug availability among partners
- Scale up the use of digital tools nationally, including the use of mobile phones for routine data collection and the use of eJISS; digitize CHA programme curriculum; enhance learning and knowledge through innovative videos and tools

Progress (Sept. 2021)

- iCCM drugs (amoxicillin, paracetamol, zinc and ORS) provided
- Digital pilot projects ongoing; lessons learned will be used to improve digital health in Liberia

Finance

Finance

Priorities (2021-2022)

- Mobilize sustainable financing to scale up to 5,000 CHAs and 500 CHSS
- Identify domestic financing for CHA and CHSS salaries (estimated at US$4.5 million/year)
- Prioritize the NCHAP in the government's annual budgeting cycle and include the programme in funding requests to donors and ministries

Progress (Sept. 2021)

- The Government of Liberia is not financially potent enough to take over the NCHAP currently, the government pays only 7% of CHSS salaries and has no budget to cover CHA salaries

Leadership and Governance

System design and policies

Priorities (2021-2022)

- Support strengthening of community-based information system (CBIS) and IFI implementation to increase quality improvement and service delivery
- Conduct innovative demonstration projects alongside the approved service delivery package to help inform improvements to CHA and CHSS tasks, including immunization, the Sayana Press (injectable contraceptive) and nutrition
- Finalize and integrate the CHP strategy in line with the NCHAP to create efficiencies and streamline coordination

Progress (Sept. 2021)

- Meetings held quarterly to review programme progress, address challenges and make data-informed decisions
- IFI implementation commenced
- CHP strategy in progress

Leadership and Governance *(continued)*

System management and leadership

Priorities (2021-2022)

- Build capacity for governance and management; conduct county-level capacity assessments and develop organizational capability plans across all 15 counties to identify operational readiness for NCHAP transition to government

Progress (Sept. 2021)

- Capacity-building assessment completed; capacity-building plan developed for each county
- 5 out of 10 capacity-building sessions held for staff at central level; staff enrolled in post-graduate professional programmes (M&E, project planning and management)

Political priorities

Priorities (2021-2022)

- Strengthen collaboration across government agencies, civil society, religious and community leaders, and other partners towards sustainability

Progress (Sept. 2021)

- Full coverage of community health activities expanded to all 15 counties

Leadership and Governance *(continued)*

Coordination

Priorities (2021-2022)

- Institute the 'One County, One Partner' approach and ensure a smooth transition among partners. The approach intends to streamline coordination and avoid duplication of resources by ensuring only one implementing partner supported by one donor per county

Progress (Sept. 2021)

'One County, One Partner' approach rolled out in counties with the following output:

- USAID/International Rescue Committee (Bong, Grand Kru, Lofa and River Gee)
- Global Fund/PLAN International (Bomi, Margibi, Maryland, Nimba and Sinoe)
- Co-Impact/Last Mile Health (Grand Bassa, Grand Gedeh and Rivercess)
- World Bank/MoH (Cape Mount and Gbarpolu)

Community Engagement

Community engagement

Priorities (2021-2022)

- Remap all community health structures in line with the new policy by 2022

Roadmap Implementation: Costs and resource gap

Total cost of the National Community Health Assistant Programme (FY 2021-2024): US$53 million

Liberia has estimated its total cost of implementing the NCHAP over a four-year period at US$53 million (Figure 1). These costs include scale-up to 4,368 CHAs and 440 CHSS and transitioning to a fully-led government programme. Currently, the programme is funded exclusively by partners. Human resources (including CHA and CHSS salaries) and training represent 63% of programme costs (Figure 2).

Figure 1.
Cost (in US$) of National CHA Programme, Fiscal Year 2021-2024

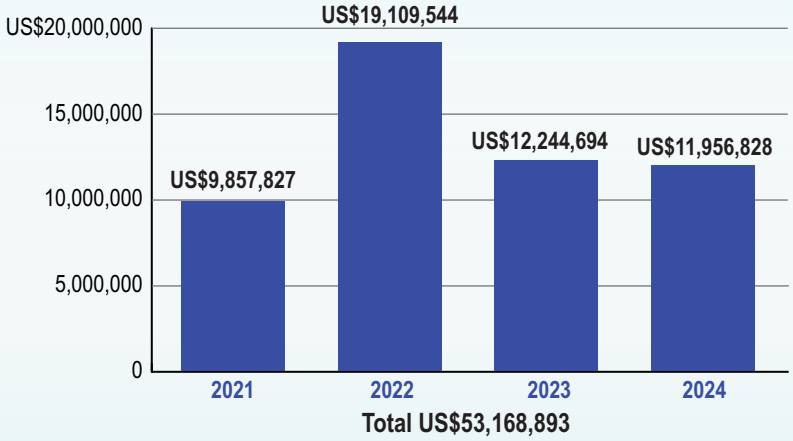
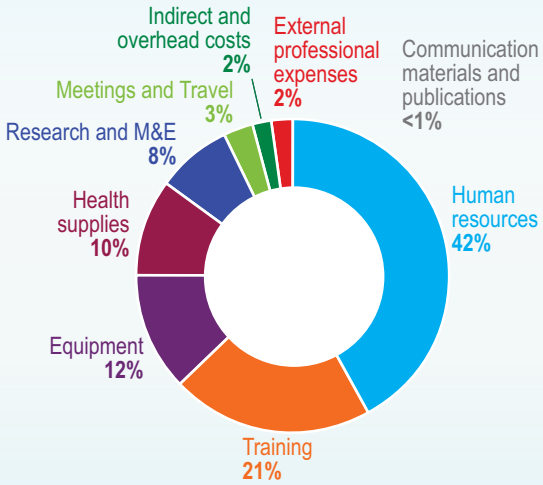


Figure 2.
Breakdown of National CHA Programme costs (%)



Development Partners and Coordinating Mechanisms

Funders:

Bill and Melinda Gates Foundation
Co-Impact
Gavi
Global Financing Facility
The Global Fund
USAID
The World Bank

Implementing Partners:

International Rescue Committee
Last Mile Health
PLAN International
Partners In Health
County health teams

Coordinating Mechanisms:

- Community Health Services Division Steering Committee
- National Community Health Coordination Committee
- Technical working groups (supply chain, M&E, continuing clinical education)
- Quarterly review meetings at national and county levels

Acronyms

Acronyms:

CBIS	community-based information system
CBV	community-based volunteers
CHA	community health assistants
CHC	Community Health Committee
CHP	community health promoter
CHSS	Community Health Services Supervisor
DHIS2	District Health Information System, version 2
eJISS	electronic Joint Integrated Supportive Supervision
HFCD	Health Facility Development Committee
HMIS	Health Management Information System
IFI	Implementation Fidelity Initiative
MoH	Ministry of Health
PHC	primary health care
TBA	traditional birth attendant
TTM	trained traditional midwife

Sources:

Original country roadmap at www.communityhealthroadmap.org and subsequent versions.

Ministry of Health, *National Community Health Services Policy (Revised), 2016-2021,* Government of the Republic of Liberia, Monrovia, 2015.

Mortality: Liberia Demographic and Health Surveys, 2013 and 2019

Population: Primary Health Care Performance Initiative, https://improvingphc.org/indicator/population#?loc=&viz=0&ci=false, accessed 20 August 2021.