

# **REVISED NATIONAL COMMUNITY HEALTH SERVICES POLICY**



**MINISTRY OF HEALTH**  
Monrovia, Liberia

**2016 - 2021**

## **ACKNOWLEDGEMENTS**

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## ACRONYMS

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ARV	Anti-retro viral
BCC	Behavior Change Communication
BLSS	Basic Life-Saving Skills
CBIS	Community-Based Information System
CBO	Community-Based Organization
CDC	Community Development Council
CDD	Community Directed Distributor
CEBS	Community Event-Based Surveillance
CHC	Community Health Committee
CHDD	Community Health Department Director
CHP	Community Health Promoter
CHS	Community Health Services
CHSD	Community Health Services Division
CHSS	Community Health Services Supervisor
CHT	County Health Team
CHTWG	Community Health Technical Working Group
CHV	Community Health Volunteer
CHW	Community Health Worker
CLTS	Community-Led Total Sanitation
CM	Certified Midwife
CSA	Civil Service Agency
CSO	Civil Society Organization
DPC	Disease Prevention and Control
DHO	District Health Officer
DOTS	Directly Observed Therapy Short course
EHT	Environmental Health Technician
eMTCT	Elimination of Mother-to-Child Transmission
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
EVD	Ebola Virus Disease
FBO	Faith-Based Organization
HFDC	Health Facility Development Committee
HIV	Human Immunodeficiency Virus
HMER	Health Monitoring, Evaluation and Research
iCCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
iHRIS	Integrated Human Resources Information System
IPC	Infection Prevention and Control
ITN	Insecticide-Treated Net
KMC	Kangaroo Mother Care
MDD	Mass Drug Distributors

MFDP	Ministry of Finance and Development Planning
MGCSP	Ministry of Gender, Children and Social Protection
MIA	Ministry of Internal Affairs
MOE	Ministry of Education
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
MYS	Ministry of Youth and Sports
NCHCC	National Community Health Coordinating Committee
NHPD	National Health Promotion Division
NGO	Non Governmental Organization
OIC	Officer-in-Charge
ORS	Oral Rehydration Salts
PA	Physician's Assistant
RDT	Rapid Diagnostic Test
RM	Registered Midwife
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RN	Registered Nurse
SCMU	Supply Chain Management Unit
TB	Tuberculosis
TOT	Training of Trainers
TTM	Trained Traditional Midwife

## Background

Consistent with the National Health and Social Welfare Policy and Plan 2011– 2021 (National Health Plan), the Essential Package of Health Services (EPHS) is designed to render services along the three levels of care: primary, secondary and tertiary. It 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 focuses on strengthening certain key areas that continue to perform weakly in the current system.

In 2015, it became prudent to revise the National Policy on Community Health Services so that it reflects the community health components of the National Health Plan. The revised National Community Health Services Policy also reflects the community health components of the Investment Plan for Building a Resilient Health System in Liberia 2015 – 2021 (Investment Plan) which aims to restore the gains lost due to the Ebola Virus Disease (EVD) crisis, provide health security by reducing risks due to epidemics and other health threats, accelerate progress towards universal health coverage by improving access to safe and quality health services, and narrow the equity gap for the most vulnerable populations.

Approximately 29% of Liberians, and 60% of rural Liberians, live more than 5 kilometers from the nearest health facility<sup>1</sup>. Community-based services are vital to the primary health of communities located more than a one-hour walk (>5km) from the nearest health facility. Additionally, the recent Ebola epidemic in West Africa, including Liberia, highlighted the critical role of involving communities in their own health-seeking behavior.

The Community Health Services Division (CHSD) of the Ministry of Health (MOH) is tasked with ensuring 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.

This revised policy institutes a new cadre of Community Health Workers (CHWs). Through established criteria, individuals will be selected by their respective communities to undergo and successfully complete integrated and standardized training modules in order to be certificated as community health workers (CHWs). Once trained, CHWs will be supervised to deliver an integrated and standardized service delivery package, which includes curative, preventive, promotive, rehabilitative and palliative services, to households located more than one hour walk (more than 5km) from the nearest health facility. For households located within 5km of a health facility, a tailored package of services will be delivered by other community cadres.

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

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<sup>1</sup> Liberia Demographic and Health Survey, 2013

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

## **Vision**

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

## **Overall Goal**

The overall goal of the community health services policy shall be to extend the reach of the country's primary health care system via a standardized national community health model that can provide a package of essential, life-saving primary health care services and epidemic surveillance within communities and households on an equitable basis.

## **Guiding Principles**

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

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

## **Priorities of the Policy**

The policy prioritizes objectives and approaches that aim to achieve the following:

- Reduction of maternal, newborn and child morbidity and mortality;
- Health promotion;
- Motivated, fit-for-purpose cadre of community health workers;
- Prevention of communicable diseases, epidemic and diseases related to malnutrition and poor living conditions; and
- Ensuring safe family and environmental health conditions.

## **Policy Objectives**

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

1. Strengthen community engagement and build the capacity of households to contribute to the reduction of maternal, newborn and child morbidity and mortality and to address issues of public health concern;
2. Increase access to and utilization of an improved quality of a standardized package of essential interventions and services including, Infection Prevention and Control (IPC) interventions;
3. Strengthen support and governance systems for implementation of community health services;
4. Build human resource capacity for community health services via pre-service and in-service training, including IPC; and
5. Develop robust Health Monitoring, Evaluation and Research (HMER) systems, including community-based surveillance and information systems.

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

#### **A. Community Engagement and Community Support**

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

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

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

- Identify socio-cultural barriers and prioritize evidence-based Reproductive, Maternal, Neonatal and Child Health (RMNCH) and adolescent health interventions for effective change in attitudes and behaviors in the communities;
- Identify, refer and report suspected diseases of epidemic potential utilizing MOH surveillance and reporting protocols;
- Participate and take ownership of community health interventions, including infection prevention and control and community-led total sanitation (CLTS);
- Support treatment adherence and stigma reduction for priority diseases;
- Mobilize local resources to support health interventions; and
- Participate in planning, implementing, monitoring and feedback.



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

## **B. Health Promotion**

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

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

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

**Policy Objective 2:** Increase access to and utilization of an improved quality of a standardized package of essential interventions and services including, Infection Prevention and Control (IPC) interventions.

## **A. Community Health Cadres**

The Ministry of Health recognizes the following community health cadres:

**Community Health Volunteers (CHVs),** including:

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

## **Community Health Workers (CHWs)**

As indicated above, this policy institutes a new cadre of Community Health Workers (CHWs). WHO defines a community health worker as follows:

*Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the*

*communities for their activities, should be supported by the health system<sup>1</sup>*

Community Health Workers (CHWs) shall be community-based workers and shall assist individuals and groups, at the household level, to access health and social services, and educate community members on health issues. Therefore, communities must be highly engaged in the work of CHWs from the start. Before CHW selection can begin, Community Health Committees (CHCs) must be activated in order to participate fully in the selection process.

The general selection criteria for Community Health Worker shall prefer those with prior work experience with community health program and shall include the following:

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

## **B. Roles and Responsibilities of Community Health Workers**

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

The roles and responsibilities of Community Health Workers shall include:

1. Household visits on a regular basis, ensuring each household in the catchment area is visited at least once a month;
2. Referral of cases requiring further management to health facilities and follow up;
3. Integrated disease surveillance and response (IDSR) – including Community Event-Based Surveillance (CEBS) – and disease prevention and control (DPC) activities;
4. Home-based services in:
  - a. Reproductive health services, including family planning, antenatal health, neonatal health, post natal health;
  - b. Child health services;
  - c. Nutrition services;

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<sup>1</sup> World Health Organization (2007), Geneva. Community Health Workers: What do we know about them.  
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5. Integrated Community Case Management (iCCM) for malaria, acute respiratory infection (ARI) and diarrhea with bi-directional referral system;
6. First aid and Basic Life Saving Skills (BLSS);
7. Prevention, health education and promotion, and referral for communicable and non-communicable diseases;
8. Mental health; and
9. Health and hygiene promotion, and environmental sanitation.

A full description of the CHW Service package appears in Annex 1.

In addition to the direct service package described above, CHWs and their supervisors must be fully integrated into outreach services at the following levels:

- **Health Facility:** Under the supervision of the Officer in Charge (OIC) of the health facility, the Community Health Services Supervisor (CHSS) and the Certified/Registered Midwife and any other relevant staff shall jointly plan and implement EPHS-mandated outreach services within the catchment communities located in remote and hard-to-reach areas.
- **Community:** CHWs shall be engaged to mobilize the community for outreach services.

### **C. Geographic Coverage for Community Health Workforce**

Beyond 5km from health facilities, Community Health Workers (CHWs) shall provide an integrated package of preventive, promotive and curative services. Efforts shall be made to upgrade eligible, qualified CHVs living in these communities. CHVs not eligible for upgrade, shall continue to provide services beyond 5km and will be coordinated by the CHW that is working in their catchment area. Within 5 km from health facilities, CHVs will continue to provide services under the supervision of the health facility staff as part of their normal outreach activities.

Community health cadres play several different functions within the broader health system.

**Remote Health Access:** One important function is to improve access to a limited set of evidence-based and high-impact interventions for the nearly 1.2 million persons living in households<sup>1</sup> located more than 5 km away or one hour walk from the closest health facility. These efforts are intended to complement a range of community-based initiatives, such as iCCM, CLTS and CEBS, which aim to extend access to basic health services and promote ownership and mobilization around health-related matters.

**Urban and Peri-Urban Settings:** Community Health Volunteers can extend the continuum of care from the facility level to the household level via bi-directional referral mechanisms, surveillance, health promotion, outreach and accompaniment of specified patient populations located within 5km of a health facility.

### **D. Household Coverage for Community Health Cadres**

The established ratios for the community health cadres are:

1. One CHW to 40 – 60 households (up to 350 Population)

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<sup>1</sup>Placeholder for [SOURCE]

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

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

In urban and peri-urban areas, it is at the discretion of the county and district health team to adjust the ratio of households to community workers as needed.

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

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

- Supplied with the necessary equipment, medicines and other tools to perform their duties;
- Supervised and mentored for continuous quality improvement and assurance;
- Provided with appropriate remuneration and motivation or incentives; and
- Encouraged to continue their participation in the health workforce via career pathways and retention schemes.

#### **A. Incentive**

In contrast with other community health cadres, Community Health Workers are expected to provide ongoing, continuous access to a standardized, integrated primary care package at the level of the household. To commit CHWs to remain in their communities and dedicate a portion of every day to performing their role, CHWs shall receive a base monthly incentive of seventy United States Dollars (USD70)<sup>1</sup>. While CHWs are entitled to a monthly incentive, they are not considered civil servants.

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

#### **B. Motivation**

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

Certain cadres of community workers, such as CHVs (TTMs and others) are not entitled to any fixed, monthly compensation from the government. However, when

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<sup>1</sup>Or its Liberian Dollar Equivalent

CHVs are engaged in project-specific initiatives [directly observed therapy short course (DOTS), immunization campaigns, Insecticide Treated Nets (ITNs) distribution, and response to emergency outbreaks etc.] monetary and non-monetary mechanisms of motivation may be considered. For programs wishing to incentivize community health cadres for mass campaigns, daily disbursement for activities lasting up to and including 10 days shall amount to \$5 per day. For programs wishing to incentivize community cadres for mass campaigns lasting beyond 10 days, community cadres shall receive a flat rate of up to \$50 per month<sup>1</sup>.

In keeping with MOH policy, partners and projects wishing to motivate specialized cadres must operate in line with the Community Health Services Policy and seek input from the CHSD and the relevant national programs. They must also collaborate with CHTs to avoid duplication and ensure clear plans for sustainability with the government.

### **C. Performance-Based Incentives**

For all cadres, performance-based incentives, linked to monitoring and evaluation systems, shall be piloted by the MOH and its implementing partners to explore mechanisms to improve and direct CHW and CHV performance and provide consideration for specialized functions. MOH shall endeavor to ensure continuity of any such incentive provisions.

### **D. Career Development and Retention**

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

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

### **E. Supply Chain and Logistics**

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

The Community Health Services Division of the MOH shall therefore:

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<sup>1</sup>For community cadres providing ongoing, specialized services, such as DOTS, these cadres may continue to be motivated at pre-established rates not exceeding those of CHWs.

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

## **F. Supervision**

Supervision is critical for ensuring an acceptable level of performance and motivation for Community Health Workers, as well as for ensuring strong linkages between community and facility-based services. A Community Health Services Supervisor (CHSS), a professionally trained health worker (RN, PA, CM/RM, EHT), shall be assigned to the health facility and supervised by the Officer-in-Charge (OIC). The CHSS shall provide field-based supervision to CHWs working in the catchment communities of the health facility. One CHSS shall supervise up to 10 CHWs. For catchment areas with more than 10 CHWs operating, additional CHSS shall be recruited. As stated above, community health volunteers providing services within 5km of the health facility shall fall under the supervision of health facility staff.

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

Integrated and standardized Supervisory Check-Lists and Tools shall be developed and used for the supportive supervision of all community health activities. The Community Health Services Division shall ensure strict adherence to the utilization of the integrated and standardized Supervisory Check-lists and Tools for the supportive supervision of all community health activities.

## **G. Institutional Framework for Policy Implementation**

1. **Central Level:** The Ministry of Health has the stewardship role for the implementation of the National Community Health Services Policy. The Community Health Services Division (CHSD) at the central level is responsible for coordinating the implementation and monitoring of the Policy. The CHSD will be tasked with:
  - a. the development and dissemination of the policy, strategies, guidelines, standardized training package, protocols and reporting tools ,

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- b. Ensuring that the implementation of all community health services and activities complies with the standards laid out by the Ministry of Health.
  - c. Coordinating all community-based interventions implemented by partners and stakeholders including other programs/divisions and units within the MOH under the National Community Health Coordinating Committee (NCHCC) and Community Health Technical Working Group (CHTWG). Terms of reference for these two bodies are outlined in the Community health Strategic Plan and Guidelines for implementation.
  - d. Identifying priorities and gaps in the implementation of the policy and resource mobilization to address the needs
2. **County Level:** The Community Health Department shall be responsible to integrate all community health activities into the county operational plan. The Community Health Department Director (CHDD) shall be responsible for coordinating and overseeing the implementation of all community health activities captured under this policy in consultation with the County Health Officer. The Community Health Focal Person, assigned by the CHT, shall work under the supervision of the CHDD to coordinate all community health activities in the county.
  3. **District Level:** At the district level, the District Health Officer (DHO) along with the District health teams shall ensure the coordination, collaboration and supervision of community health services and activities at facility and community level.
  4. **Health Facility Level:** The Officer-in-Charge (OIC) is responsible to coordinate all health related activities in all catchment communities for each health facility. Health Facility Development Committees (HFDCs), formerly known as Community Health Development Committees, shall meet monthly at the health facility to discuss community health activities and facilitate strong links between the health facility and the catchment community. HFDCs shall report to the applicable community development structure, as specified by the Ministry of Internal Affairs.
  5. **Community Level:** Community Health Committees (CHCs), which exist in each catchment community, are responsible to coordinate all health related activities for each catchment community and report to the HFDC. CHCs and community members shall also engage with and encourage health activities.
  6. **Other Line Ministries, Development Partners and Civil Society Organizations;**
    - a. Ministry of Internal Affairs (MIA): In accordance with Liberia's move towards decentralization and intersectoral collaboration for development, the Community Health Structures will be accountable to the Community Development Council that will be under the direct supervision of the local authority of the Ministry of Internal Affairs.
    - b. Ministry of Education (MOE): Along with training institutions, the MOE shall take the lead in providing quality education, with a particular focus on girls' education, so that potential community health cadres are able to read and write and function in their roles. Furthermore, MoE shall support the

integration of community health content in existing, pre-service health training programs as well as potential, subsequent accreditation of Community Health Workers.

- c. Ministry of Youth and Sports (MYS): As the lead ministry involved in youth empowerment, MYS will collaborate with MOH in integrating Community Health Workers with the National Youth Empowerment Program.
- a. Ministry of Finance and Development Planning (MFDP): As the lead ministry that coordinates government spending, the MFDP shall ensure adequate budgetary allocation to MOH to promote equitable access to quality health care to all Liberians irrespective of their location.
- d. Ministry of Gender, Children and Social Protection (MGCSP): Shall work to ensure women are represented and engaged in leadership positions and decision-making processes related to community health. MGCSP shall also work in collaboration with MOH to encourage the recruitment and retention of females within the community health cadres.
- e. Legislature: Shall declare health equity as a national development priority; ensure the sustainability of community health activities through the allocation of county and national budget support – including the possibility of a pooled funding mechanism. They shall also support the enactment of legislation that promotes improvements in the health of communities.
- f. Civil Society: Civil society, including community based organizations (CBOs) faith-based organizations (FBOs), local non-governmental organizations (NGOs), shall advocate for the establishment of a pool fund for sustaining Community health worker program. Civil Society shall also function as an accountability mechanism to ensure the Ministries and other stakeholders fulfill their respective obligations. Finally, Civil Society shall work closely with community health cadres to facilitate implementation of community health activities.
- g. Donors and Development Partners: To promote and ensure sustainability of community health program, donors and development partners shall advocate and support the GoL to establish innovative financing mechanisms. Donors and partners shall also provide technical and financial assistance for policy and program implementation.

## **H. Integration**

All vertical programs of the ministry shall collaborate with the Community Health Services Division to implement activities including meetings, trainings, monitoring, supervision, behavior change communication (BCC) activities, etc. The CHSD shall coordinate closely with focal persons of these vertical programs to ensure that strategy and plans are shared and harmonized to avoid duplication and facilitate the efficient utilization of available resources. Program alignment shall also be carried out at county level.

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

### **A. Pre-Service Training**

**CHW Training Package:** An integrated and standardized training package shall be developed and used for training of Community Health Workers. The package shall include promotive, preventive and curative services as well as modules on operations, monitoring and surveillance.

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**CHW Training Requirements:** In order to become a Community Health Worker, candidates nominated by their communities using the established selection criteria, must undergo and successfully complete the MOH integrated and standardized training modules regardless of their previous functions or trainings as Community Health Volunteers.

**CHSS Training Package:** Community Health Services Supervisors must be a professional health worker (RN, RM, PA, CM, EHT) with training in community health in order to serve in this role. A specialized training package, with emphasis on supply, operations, monitoring and supervisory functions shall be developed to provide additional essential skills for successful program management and quality supervision.

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

## **B. In-Service/Refresher Training**

In-Service/Refresher training interventions will be based on findings from the supportive supervisory field visits, as well as training needs assessments. These periodic training interventions will be conducted to appropriately address identified gaps and reinforce evidence-based best practices.

**Policy Objective 5:** Strengthen Health Monitoring, Evaluation and Research (HMER) systems to integrate community-based surveillance and information systems.

## **A. Monitoring and Evaluation**

Monitoring will be a continuous process and information will be collected with regards to activities implemented by CHWs as well as the result/s attained following the implementation of these activities.

Data generated through the monitoring process shall be used for informed programmatic decision-making at all levels. .

The Community Health Services Division, together with Health Monitoring, Evaluation and Research (HMER) Unit shall:

1. Update and maintain an integrated and functioning community-based information system (CBIS);
2. Strengthen and maintain functioning of monitoring and review mechanism;
3. Ensure timely and ongoing integration with the Human Resources Information System (iHRIS) in order to capture community health workforce information;
4. Initiate appropriate corrective actions, including mentoring and coaching, where data indicate a gap in the delivery of services.
5. Strengthen the set-up of the community-event based surveillance system as part of IDSR activities;
6. Document best practices and lessons learned during implementation; and
7. Conduct ongoing evaluation of programmatic effectiveness.

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Integrated and standardized Community Health Services Monitoring and Evaluation Tools will be developed and used for the monitoring and evaluation of all community health activities including community based surveillance activities and compliance with IPC standards. The Community Health Services Division shall ensure adherence to the utilization of the integrated and standardized Monitoring and Evaluation Tool for the monitoring and evaluation of all community health activities. Data flow, analysis and validation will be carried out in accordance with the protocols jointly defined by CHSD and HMER in collaboration with the Disease Prevention and Control (DPC) unit.

The Community Health Services Division (CHSD) and the Health, Monitoring, Evaluation and Research (HMER) Unit shall ensure adherence to the implementation standards set in this policy will also be monitored and appropriate action will be taken to address identified deviations.

## **B. Operational Research**

The Ministry of Health shall promote a culture of inquiry, documentation and dissemination. Community health research shall endeavor to look into strategies, interventions, tools or knowledge that can enhance the quality, coverage, effectiveness and or performance of the health system at the community level. To achieve this and ensure coordination of community research activities, the Community Health Services Division will work closely with the existing Health Monitoring, Evaluation and Research (HMER) Unit of the MOH to carry out operational, programmatic and result-oriented research.

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

The National Ethics Board for research will apply approved ethics guidelines and internationally accepted standards to determine the appropriateness of all community health related research. MOH 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.

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## **ANNEX 1**

### **Community Health Worker (CHW) Service Package**

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

#### **PART ONE: CORE SERVICES (CORE PACKAGE)**

##### **1. General Services**

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

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

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

##### **3. Reproductive, Maternal, Newborn and Child Health**

###### **A. Reproductive Health**

- i. Family planning promotion, counseling, distribution and dispensing of family planning commodities; referral for family planning services where needed

###### **B. Maternal and Neonatal Health**

- i. Antenatal Care (ANC)
  - a. ANC education and promotion and referral to health facilities for ANC visits
  - b. Identification of danger signs in pregnancy and referral to health facilities
  - c. Referral to facilities for deworming tabs, pre-natal vitamins and Insecticide-Treated Nets (ITNs)
  - d. Birth planning and preparedness, including education on items needed for delivery and birth spacing
  - e. Awareness on elimination of Maternal-to-Child Health Transmission of HIV (eMTCT) and referral to facilities for identified HIV positive mothers (collaborate with HIV/eMTCT officers where available)
  - f. Treatment of malaria
- ii. Home-based Maternal and Newborn Care

- a. Immediate and subsequent post-partum home visits
- b. Well-being check for mother and newborn
- c. Identification and referral for maternal danger signs including excessive bleeding, headache, fits, fever, feeling very weak, breathing difficulties, foul smelling discharge, painful urination, severe abdominal or perianal pain.
- d. Identification and referral for neonatal danger signs including not feeding well, reduced activity, difficult breathing, fever or feels cold, fits or convulsions.
- e. Counsel about danger signs for mother and newborn, the need for prompt recognition and care-seeking, and advise on where to seek early care when needed
- f. Promotion of essential care of the newborn and essential nutrition actions, including exclusive breastfeeding, Supportive counseling and troubleshooting of breastfeeding problems, referral when needed
- g. Promote hygienic umbilical cord care, including chlorhexidine application, and skin care
- h. Support for Kangaroo Mother Care (KMC) application
- i. Identify and support newborns who need additional care (e.g. Low birth weight, sick, HIV positive mother)
- j. Provide birth spacing and family planning counseling
- k. Promote birth registration and timely vaccination

### **C. Child Health**

- i. Integrated Community Case Management (iCCM) of:
  - a. Diarrhea including provision of ORS and zinc
  - b. Pneumonia including provision of Amoxicillin and pediatric paracetamol
  - c. Malaria: referral of suspected cases if RDTs are not available; confirmed case management with ACT for children under-5 and pre-referral rectal artemether for severe cases; provision of pediatric paracetamol
- ii. Community-based bi-directional referrals, particularly for newborns, for severe dehydration, malaria, acute respiratory infections (ARIs), and other emergency cases
- iii. Integrated outreach services including:
  - a. Vaccination drop out tracing for all under-fives;
  - b. Under-5 vitamin A administration and de-worming during campaigns

### **D. Nutrition**

- i. Mid-upper arm circumference (MUAC) screening and referrals for malnourished children
- ii. Nutrition education for caregivers and households, including: optimal nutrition for women, exclusive breastfeeding up to 6 months for infants, optimal complementary feeding starting at 6 months with continued breastfeeding to 2 years of age and beyond, nutritional care for the sick and malnourished

## **PART TWO: ADDITIONAL SERVICES (FULL PACKAGE)**

### **1. First aid and Basic Life Saving Skills (BLSS)**

- i. Principles of First Aid including prevention and basic response
- ii. Basic Life Saving Skills

## **2. Communicable Diseases**

- i. HIV/AIDS education and prevention messaging
- ii. Tuberculosis education and prevention messaging, counseling for treatment adherence
- iii. Leprosy education, counseling and referral
- iv. Awareness on stigma and discrimination

## **3. Mental Health**

- i. Identification, referral and monitoring of patients in the community with signs and symptoms of mental health disorders

