Republic of Liberia

MINISTRY OF HEALTH

NATIONAL COMMUNITY HEALTH PROGRAM POLICY

2023–2032

March 2023

Forward

The Government of the Republic of Liberia has been championing the cause of the Sustainable Development Goals (SDGs) to ensure it achieves Universal Health Coverage (UHC) for all in Liberia through its different layers of the health care systems in collaboration with global actors. The community health program of Liberia currently serves as the foundation of the health care delivery system. This revised Policy (2023–2032) will provide coverage to communities that are accessible within 5 km to facilities that still lack basic health-seeking behavior and to communities beyond 5 km from the nearest health facilities with basic life-saving skills and health-seeking behavior change opportunities. The Community Health workforce is a crucial driver for health systems strengthening and disease outbreak preparedness and response.

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

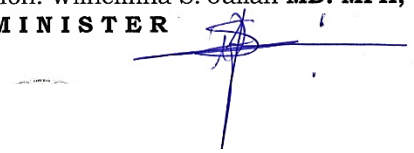
This Policy aims to achieve its specific objectives by harmonizing and coordinating the implementation of the seven thematic areas of community health services to include well-coordinated leadership, governance, and community engagement structures; a fit-for-purpose community health workforce; a well-defined community health service delivery by the community health workforce to improve health outcomes and strengthen active surveillance; a standardized training mechanism, and supervision processes; sustain and sufficient resources to fully fund community health service delivery; an efficient supply of commodities; and a national community-based information system, monitoring,

evaluation and research to provide evidence and strengthening referral mechanisms.

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

This policy shall be styled and known as the **National Community Health Program Policy (2023–2032)**. This guide to the one Community Health Program has two approaches: **the CHA Strategy and the CHP Strategy**, for a robust implementation that will harness the achievement of Universal Health Coverage in Liberia. Therefore, we urge all donors, implementing partners, collaborating MOH programs and divisions, line ministries, and agencies to duly align to this policy for the smooth implementation of community health in the Republic of Liberia.

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



Acknowledgment

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

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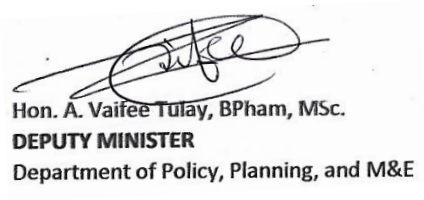
Special thanks and gratitude to the senior management of the Ministry of Health under the stewardship of the Hon. Minister Dr. Wilhemina S. Jallah for creating the enabling environment for implementing community health services in Liberia.



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List of Acronyms

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CAHW	Community Animal Health Workers
CBIS	Community-Based Information System
CBO	Community-Based Organization
CEBS	Community Event-Based Surveillance
CHA	Community Health Assistant
CHC	Community Health Committee
CHO	County Health Officer
CHFP	Community Health Focal Person
CHP	Community Health Promoter
CHS	Community Health Services
CHSD	Community Health Services Division
CHSS	Community Health Services Supervisor
CHT	County Health Team
CHV	Community Health Volunteer
CHW	Community Health Worker
CLTS	Community-Led Total Sanitation
CM	Certified Midwife
CSA	Civil Service Agency
DHO	District Health Officer
DHT	District Health Team
DOTS	Directly Observed Therapy Short course

DPC	Disease Prevention and Control
eMTCT	Elimination of Mother-to-Child Transmission
EPHS	Essential Package of Health Services
EVD	Ebola Virus Disease
FBO	Faith-Based Organization
gCHV	General Community Health Volunteer
HFDC	Health Facility Development Committee
HIV	Human Immunodeficiency Virus
HPD	Health Promotion Division
HMER	Health Monitoring, Evaluation, and Research
iCCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education, and Communication
iHRIS	Integrated Human Resources Information System
IPC	Infection Prevention and Control
ITN	Insecticide-Treated Net
km	kilometers
MGCSP	Ministry of Gender, Children and Social Protection
MOA	Ministry of Agriculture
MIA	Ministry of Internal Affairs
MOE	Ministry of Education
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
MYS	Ministry of Youth and Sports
NCHP	National Community Health Program
NEHP	National Eye Health Program
NGO	Non-Governmental Organization
OIC	Officer-in-Charge
ORS	Oral Rehydration Solutions

PA	Physician Assistant
PLHIV	People Living with Human Immune Virus
RDT	Rapid Diagnostic Test
RM	Registered Midwife
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
RN	Registered Nurse
SCMU	Supply Chain Management Unit
SOP	Standard Operating Procedures
SQS	Safe, Quality Health Services
TB	Tuberculosis
TTM	Trained Traditional Midwives
UHC	Universal Health Coverage
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background and Rationale of Policy

In 2015, Liberia began an ambitious journey to rebuild a resilient health system, learning from the devastating Ebola virus outbreak. The introduction of the National Community Health Assistant Program in the health care delivery system and the critical role that communities played in addressing their own health needs and changing their health-seeking behaviors was a driving force. Thus, a fit-for-purpose, productive and motivated community health workforce that would provide essential lifesaving services to the country's most remote communities in a standardized package, consistent with *the National Health and Social Welfare Policy and Plan 2011–2021* (National Health Plan) and the *Essential Package of Health Services* (EPHS), was designed to render services along three levels of care: primary, secondary, and tertiary. The EPHS aims to provide more comprehensive services to the Liberian people while focusing on strengthening certain key areas that continue to perform poorly in the current system.

At the time, approximately 29% of Liberians, and 60% of rural Liberians, lived more than one hour's walk (5 kilometers (km)) from the nearest health facility[1] and community-based services are vital to the health and wellbeing of these communities.

The Community Health Services Division (CHSD) of the Ministry of Health (MOH), was made functional and given the responsibility to develop and implement policies, guidelines, and

[1] Liberia Demographic and Health Survey, 2013

strategic roadmaps for ensuring access to basic health services at the community level. To provide these services, the Division advocates, coordinates and collaborates with all development partners, MOH programs and divisions, as well as County and District Health Teams (CHTs and DHTs) and communities to scale up community health activities in Liberia's 15 counties in a standardized formation. Therefore, all partners and other programs implementing community health activities in Liberia shall adhere to this revised policy by fully collaborating with the National Community Health Program.

1.2 Policy Development Processes

This National Community Health Services Policy has been led by the Ministry of Health through the Community Health Services Division and the Department of Policy and Planning. This process was initiated in November of 2020 with the Comprehensive Desk Review (CDR) of the previous National Community Health Services Policy and Strategy (2016–2021). The CDR was followed by several stages of engagement and consultation:

1. **Formation of TWGs and Steering Committee**
   In January 2021, in Montserrado County, a wide range of stakeholders met at a one-day technical workshop on the formation of seven thematic policy priority areas and a steering membership to support coordination and technical compilation.

2. **Validation and Adoption of Comprehensive Desk Review, WHO Guidelines, and CHP Pilot Report**
   To complement the review process, key documents needed to be adopted and validated; as such, in March 2021 in Grand Bassa County, MOH, stakeholders, and partners met for a three-day working session to validate recommendations from the comprehensive desk review and CHP Pilot report from

Maryland County to be used in policy change and to adopt the WHO guideline on health policy and system support to optimize community health worker programs, keying on the fifteen recommendations. This gave rise to the development of the first zero drafts of the new policy.

3. **First TWG Meetings Held in Gbarnga with Stakeholders**
   The MOH did a thematic mapping of stakeholders and experts looking at seven key policy objectives in a three-day working retreat from April 27–29, 2021 to dissect different views and recommendations based on lessons learned during implementation. Reports were summarized and incorporated in the first drafted policy write-up.

4. **Second Thematic TWG Meetings Held in Monrovia with Stakeholders**
   As a continuation of the process, a four-day working session was held in Monrovia from May 25–28, 2021 using the same thematic pattern involving all key stakeholders including MOH, partners, and government institutions. The first draft of the Strategy was developed, building on the inputs and recommendations made from the Policy to improve the implementation of the national community health services program.

5. **Steering Committee Meeting Held in Ganta**
   A two-day meeting was held in Ganta, from June 8–9, 2021 with improved recommendations for the Policy. The NCHP presented work to the Steering Committee on progress made and recommended the expansion of service delivery areas for endorsement. The Steering Committee comprises key decision-making members of the senior MOH leadership and directors from relevant programs.

6. **County Health Teams Participation in Consensus Building**

In September 2021, all 15 CHTs were represented by their CHOs and CHFPs in a three-day working session in Margibi County to review and make inputs into the policy and strategy documents to ensure sub-national buy-in and advocacy.

7. **Second Steering Committee Meeting**

   Upon completing the compilation of all inputs and recommendations for all stakeholders, the NCHP presented the fourth draft of the documents to the Steering Committee in September 2021 for further guidance and made needed changes based on recommendations and inputs made by the committee members.

8. **After Action Review and Activation of the Curriculum Development Team**

   Upon the successful completion of all the policy review processes on October 15, 2021, the NCHP policy review committee organized a final After-Action Review meeting from November 10–12, 2021 to validate the new ten-year National Community Health Program Policy (2022–2031) and the new five-year National Community Health Program Strategy (2022–2026). The NCHP Curriculum Development Committee was activated on October 15, 2021.

Chapter 2: Situation Analysis

2.1 Overview of Community Health Systems

The community health landscape in Liberia reflects efforts to work towards universal health coverage by enhancing access to essential life-saving services within the country's most remote communities. For over a decade, community health programs have been shaped by iterative policy reform and the intervening Ebola outbreak.

The 2008 National Policy and Strategy on Community Health Services was a post-conflict step towards coordinating community health workforce (CHW) initiatives in Liberia, although gaps persisted. In late 2011, a pilot project was undertaken to evaluate a community-based HIV treatment model that relied on salaried, supervised, and trained CHWs to treat HIV. The pilot provided Liberia with both a model and advocacy tool for community health programming and commitments to upgrading community health programs. The reinvigorated Ministry of Health (MOH) officials were afforded—in part through the international community—the opportunities, network, guidance, and tools needed to restructure and scale the CHW program which ultimately informed the 2016 Revised National Community Health Services Policy and led to the preparation of a Community Health Roadmap to outline a path to scale for CHW programs in Liberia.

Notwithstanding, Liberia's experience with the Ebola outbreak highlighted the critical role that communities play in addressing their own health needs. In 2015, with significant political will and an immense sense of urgency to invest in a strengthened health workforce, the MOH began to mobilize a larger coalition of

stakeholders in community health with an expanded Community Health Technical Working Group (TWG). Despite challenges around the alignment of differing agendas and priorities of the diverse stakeholders, the coalition ultimately developed the Revised National Community Health Services Policy and Plan for validation and endorsement in 2016.

A major reform under the 2016 policy was the launch of the National Community Health Assistant (CHA) Program in July 2016, with remuneration for CHAs, a standardized approved MOH training package, and supervision by a health professional called Community Health Services Supervisors (CHSSs). However, there were major challenges during implementation according to the Comprehensive Desk Review Report of December 2020 of the National Community Health Assistant Program which included: the lack of commodity needs assessment at the onset that impacted the supply chain; the lack of MOH advocacy to increase government funding to the MOH to include support for community health workforce; the extended salary delays in MOH in directly run counties of the programs— leading to attrition; the lack of recruitment of more female CHAs to correct the male gender bias; the partial inclusion of district health teams and health facility staff in the NCHAP implementation; the design of the government plan (not clearly articulated) to take over the funding of the NCHAP; the lack of a replacement plan for staff leaving; the poor quality of improvement activities by generating more data to assess quality through the development of supervision processes and tools for District Health Team and health facility and the protracted stock outs of CHAP commodities.

2.2 Reproductive, Maternal, and Child Health

Despite the odds, Liberia has made significant progress in improving the health status of its population, particularly in the

indicators of infant and under-five mortality. Over the years, health facility births increased steadily from 37% in 2007 to 80% in 2019–20.[2] Conversely, home births dropped during this period, from 61% to 19%, and births delivered by traditional midwives decreased from 48% to 15%.[3] While the total fertility rate in Liberia of 4.2 children per woman[4] remains higher than the global average, the unmet needs for family planning decreased from 35.7% in 2007 to 31.1% in 2013 but increased to 33.4% in 2019–20.[5] In addition, infant mortality rates reduced from 71 deaths per 1,000 live births in 2007 to 63 deaths per 1,000 live births in 2019–20.[6] Under-five mortality has also slightly changed from 94 deaths per 1,000 live births in 2013 to 93 deaths per 1,000 live births in 2019–20[7]. During this period, maternal mortality also dropped from 913 per 100,000 live births over the period of seven (7) years to 742 per 100, 000 live births in 2019–20.[8]

Immunization coverage also increased dramatically from 39% of children ages 12–23 months in 2007 to 65% in 2019–20, with only 5.8% of children aged 12–23 months not receiving any vaccinations.[9] According to the LDHS (2019), vaccination coverage among children aged 12-23 months and 24-35 months shows that 65% of children aged 12-23 months have received all basic vaccinations, while only 40% have received all age-appropriate vaccinations. Six percent of children aged 12-23 months have not received any vaccinations. Among children aged 24-35 months, 31% have received all age-appropriate vaccinations. For children aged 12-23 months, basic vaccination

[2] Liberia Demographic and Health Survey, 2019–20
[3] Ibid
[4] Ibid
[5] Ibid
[6] Ibid
[7] Ibid
[8] Ibid
[9] Ibid

coverage is higher among boys than among girls (67% versus 63%). Additionally, basic coverage is higher in urban than rural areas (66% versus 63%) and lowest in the Southeastern A region (54%) but highest in the Northwestern region (72%). By county, basic coverage is highest in Lofa (78%) and lowest in Sinoe (46%). In the case of multi-dose vaccines, coverage rates are highest for the first dose and decline for subsequent doses.

With these significant gains made, major public health challenges remain, primarily in preventable communicable diseases, maternal and under-five morbidity, and malnutrition. In Liberia, malaria, acute respiratory infections, diarrheal diseases, and malnutrition remain the leading causes of under-five mortality.[10] non-communicable diseases' magnitude and relevance have also been on the rise. While the proportion of pregnant women receiving a postnatal care visit in the first two days after birth increased from 70% in 2013 to 80% in 2019–20, there was still an estimated 29% of women who did not receive any post-natal care in 2013. Liberia had one of the highest maternal mortality rates globally (913 per 100,000), with the major causes of maternal deaths attributable to preventable and treatable complications, such as hemorrhage, hypertension, unsafe abortion, and sepsis. Moreover, about 30% of children under age 5 are stunted and 10% are severely stunted, 3% are wasted with 1% being severely wasted while 11% of children are underweight and 3% are severely underweight.[11]

From the launch of the program in July 2016 to March 2021, CHAs have treated nearly 700,000 cases of malaria, diarrhea, and pneumonia and conducted over 800,000 malnutrition screenings and over 5.4 million home visits. As of December 2020, there

[10] Liberia Demographic and Health Survey, 2019–20
[11] Ibid

have been 3,430 CHAs and 388 CHSSs trained, equipped, deployed, and incentivized in communities across Liberia in 14 of the 15 targeted counties that are fully implementing the National CHA Program. However, there remains a diverse number of CHVs across MOH programs for which this policy shall harmonize into a new cadre called the Community Health Promoters (CHPs) and fully address the TTMs' roles in collaborating with CHAs and CHPs.

Several initiatives which were supported to improve the coverage of community-based services included the Child-Friendly Communities Initiatives which was piloted in Grand Gedeh and is an initiative that supports governments and local communities in realizing the rights of children (in the areas of exploitation, violence, and abuse, health, nutrition, WASH, Education, play and a fair chance regardless of their ethnic origin, religion, income gender or ability) at the community level using the UN Convention on the Rights of the Child as its foundation.

To further strengthen the Community Health Care delivery services, improved data collection, and management of real-time data collection using digital technology were also employed and showed that this remains a promising platform for monitoring the Community Health programming.

2.3 Gender Mainstreaming

According to the 2008 Population and Housing Census of Liberia, women make up 50% of the overall population in Liberia and 49.1% of the rural population. There is still high illiteracy among the rural population with women mainly affected due to many reasons ranging from cultural background, access to school and education, early marriage, teenage pregnancy, etc. that lead to inadequate female participation in developmental activities, especially those that are health and health-related.

During the implementation of 2016–2021, only 18% of female was recruited to serve as CHA that need serious gender sensitivities. Pointing out gender-specific services and clearly defining the role of women in the recruitment processes for the participation of the community health workforce and structures are key to addressing gender equity. Confidentiality and privacy are also key to women in the provision of certain health-related services and are often missing due to the unbalanced gender health workforce. Thus, these should be given attention to address discrimination in the service provision of the National Community Health Program of Liberia to meet the needs of clients' desires for a particular service.

This policy shall address various approaches to render gender-sensitive services and increase awareness of gender barriers in communities. Services accessible to women and girls should be monitored for any obstacle, deterrence, and disenchantment. Facilities utilization will also be identified and addressed on an ongoing basis.

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

Chapter 3: Policy Foundation

3.1 Policy Mission

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

3.2 Policy Vision

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

3.3 Policy Goal

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

3.4 Policy Objectives

3.4.1 General Objective

To achieve a sustainable and integrated community health program that serves all communities through a **national standardized package** of health services.

3.4.2 Specific Objectives

The specific objectives of the policy are described below:

1. Specific Objective One: Leadership, Governance, and Community Engagement

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

2. Specific Objective Two: Capacity development and motivation

2.1: To build the human resource capacity of community health workers through the institutionalization of the NCHP training curriculum in health training institutions for career advancement, pre-service training, refresher training (competency-based modular training package), and mentorship for technical capacity-building skills transfer.

2.2 To ensure that all training modules are digitized, and blended learning processes are incorporated.

2.3 To improve Community Health Workers' retention package

3. Specific Objective Three: Community Health Service Delivery

To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based interventions and services with an emphasis on RMNAH+N.

4. Specific Objective Four: Community Health Supervision

To institute mentorship, and coaching through routine supervision of community health workers, to ensure the

delivery of quality health services and adherence to the policy, guidelines, and protocols.

5. Specific Objective Five: Monitoring, Evaluation, Research, and Technology

To develop robust community health information and monitoring systems to generate real-time quality data and information for evidence-based decision-making.

6. Specific Objective Six: Community Health Supply Chain Systems

To ensure the availability of commodities and logistics at the community level by improving procurement, distribution, and accountability of supplies.

7. Specific Objective Seven: Community Health Financing

7.1 To mobilize domestic resources through innovative ways for the sustainability of community health services.

7.2 To ensure partners align their resources and interventions with the national strategy and priorities for the improvement and sustainability of the program.

3.5 Policy Priorities

This policy prioritizes the reduction of maternal, neonatal, infant, child, and adolescent morbidity and mortality; the prevention and control of both communicable and non-communicable diseases; strengthening community engagement and behavior change; disease surveillance; vaccine-preventable disease and malnutrition. The following approaches will be used to address these priorities:

1. Strengthening community structures: through standardization of identification and orientation processes as well as active engagement and mobilization to support the community health workforce and ensure a safe community.
2. Provision of quality preventative health services—including health promotion, education, and risk communication activities for attainment of behavior change.
3. CHW capacity development: Trained, equipped, deployed, incentivized, supervised, digitally empowered, supported, motivated, and fit-for-purpose community health cadres of CHSSs, CHAs, CHPs, and TTMs.
4. Strengthening community event-based surveillance: through integrated disease surveillance and an efficient response system.
5. Specialized community-based curative services: to close the gap in health equity.
6. Community empowerment: individuals, households, and communities engage in safe family and environmental health practices.
7. Gender mainstreaming and participation: emphasizing the participation of females at all levels of community health.
8. Institutionalizing the National Community Health Program into health training institutions: through incorporating tools and training modules in the national health system including pre-service education programs as career ladder opportunities for the community health workforce.
9. Resource mobilization and stakeholders' engagement: Advocating with national stakeholders,

the private sector, and developmental partners for the prioritization of resources to sustain and fully fund community health service delivery.

10. Evidence-based decision-making real-time reporting and monitoring of community health services and interventions.

3.6 Key Policy Statement

To address gaps identified in access and utilization of health services and to maintain sustainable, cost-effective, and resilient health systems across the country, the Ministry of Health has institutionalized the National Community Health Program as a fourth tier of the national healthcare delivery system. The institutionalization of this tier will be achieved through:

1. Expansion and deepening of the service delivery package of the community health workforce to address gaps in community engagement; surveillance; reproductive, maternal, newborn, child, and adolescents health; NTDs; communicable diseases including HIV and TB; and NCDs including eye, mental health, and healthy lifestyle, while strengthening the quality improvement frameworks to facilitate ongoing implementation fidelity to achieve clinical impact and health equity for those who live within and beyond 5 km of health facilities.
2. Maintain the current community health governance structures of CHCs and HFDCs, and cadres of CHSSs, CHAs, and TTMs and the introduction of a new cadre, the CHPs; transforming all CHVs to CHPs to uniformly focus on services in communities within the 5 km radius of health facilities.
3. Addressing gender disparity in the community health workforce and ensuring gender-responsive program design in all aspects of the community health policy,

strategic planning, standard operating procedures, and curriculum design.

4. Increasing the government's oversight and management of all programmatic aspects of the National Community Health Program by ensuring adherence to the 'One County, One Partner Strategy' while ensuring and increasing domestic financial contribution over time to ensure sustainability and government ownership of the program through implementation of a National Community Health Program transition plan.

3.7 Guiding Principles

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

1. Health equity—to ensure access and utilization of quality health services for vulnerable, far and hard-to-reach, key, and disadvantaged populations.
2. Promotion of safe quality health services (SQS)—with emphasis on ongoing community-based disease surveillance, and infection prevention and control (IPC).
3. Decentralization and coordination—networking and integration of services at all levels of the healthcare system, as a means of increasing the effectiveness and efficiency of public service provision and the responsiveness of services to local needs by stepping down management responsibilities from the central level to county, district, and community levels.
4. Community engagement and ownership—a people-focused approach that acknowledges the fact that people's knowledge, attitudes, and practices are important driving forces for social and behavior change

and utilization for planning and implementation of community health services.

5. Gender equity—affirmative actions to promote gender mainstreaming for increasing the quota of female CHWs will be the hallmark of the policy with a focus on a multi-sectoral approach, integration, and more collaboration and partnership with state and non-state stakeholders for advancing gender equality, and collaboration with adult formal and informal learning and educative programs using teaching and learning methods for non- and semi-literate.
6. Advocacy—for consensus building, resource mobilization, and political prioritization at all levels of the health care delivery system.
7. Community-focused services – contextualization of community health interventions.
8. Evidence-based cost-effective interventions and decision making.

Chapter 4: Policy Orientations

4.1 Leadership, Governance, and Community Engagement

***Specific Objective 1**: To strengthen community leadership and governance systems through community mobilization, engagement, and training to support the implementation of all community health services.*

4.1.1 Community Leadership and Governance Structure

The community health leadership and governance structures shall be established through the active participation of the community members with guidance from the CHSS and the OIC of the catchment facility. The Community Health Committee (CHC) shall be the foundation of these structures and shall govern all community health-related developments and activities in each community and serve as a liaison structure between the community and the facility with support from the Health Facility Development Committee (HDFC) who shall coordinate health activities at the facility level. The SOPs of the NCHP and Decentralization and Governance provide more details.

4.1.1.A Community Health Committees (CHCs)

4.1.1.A.1: Introduction

The Community Health Committee forms the basis of community interaction and participation in managing the community's health. CHCs shall be formed in all communities within and beyond 5km from the health facilities. CHCs shall be formed before the selection of CHAs and CHPs. Community Health Services Supervisors at these health facilities will support and work with CHCs.

4.1.1.A.2: Roles and Responsibilities

Community Health Committees (CHCs), representing the communities, are:

- Responsible for coordinating and supporting community health cadres, as well as mobilizing communities for health actions.
- Oversee and assist in the selection of CHAs and CHPs.
- Elect a CHC Representative to the Health Facility Development Committee who shall coordinate and provides an interface between CHCs and the HFDC.
- Provide administrative support for health activities in the community including safety and security of drugs and supplies.
- Mobilize community members' periodic support of farming for their CHAs and CHPs.
- Support the work of the Community Animal Health Worker (CAHW)

4.1.1.A.3: Membership and Compositions

Community Health Committees shall comprise six or more members depending on the size of the community. The Committee is expected to encourage gender equity and diversity in its composition. The Chair, Co-chair, Secretary, and Treasure will be elected by the community; CHAs and CHPs shall serve as Recording Officers by default and cannot be elected for any leadership positions due to their outstanding responsibilities. The Town Chief in each community must by default serve as a member of the CHC unless otherwise indicated. Additionally, each CHC will elect a CHC Representative as the liaison and member of HFDC.

Community Health Committee (CHC) members are elected by the community with guidance from the catchment health facility and

the District Health Team (DHT). All the above members have voice and voting rights. If any of these members cannot attend the meeting and send a proxy, the proxy shall not count for quorum and shall have a voice but no voting rights.

4.1.1.A.4: Orientation

The CHCs shall be established in all communities of each health facility catchment community. Community Health Services Supervisors at the health facility shall work and provide technical support to their CHCs. The CHC Chairman shall not by default serve as the CHC Representative to the HFDC unless he or she is selected by many of the elected members. Each CHC shall serve a tenure of two years with an opportunity for reelection for a second term. After two consecutive tenures of service, the member shall honorably retire.

4.1.1.B Health Facility Development Committee (HFDC)

4.1.1.B.1: Introduction

Like other county health governance boards, Health Facility Development Committee (HFDC) plays a major role in integrating citizens' participation in the health and well-being of their communities. They serve as conduits to strengthen community voices in health decisions through advocacy, and monitoring of services provided at the health facility thereby improving the facility-community relations. HFDCs are formed in all public health facilities; each facility shall have one HFDC. Community Health Services Supervisors and the OIC at the health facility shall support and work with HFDC members.

4.1.1.B.2: Roles and Responsibilities

Shall advocate and assist the health facility and community health cadres in resolving health-related issues arising from the facility and communities.

- Shall serve as the health facility board (this excludes all hospitals)
- Monitor and ensure that quality, equitable services, and support are provided for the CHAs, CHPs, and TTMs as per policy across the health facility catchment.
- Provide oversight responsibility for facility operations, including regular monitoring of service quality, such as resource management, client satisfaction, and flow of surveillance information.
- Assist in the mobilization of communities through the CHCs to support health facility development (e.g., the building of placenta pits, clinic fencing, etc.).
- Participate in annual reviews of District Health Plans and implementation.
- Mobilize communities to provide lodging for facility health workers.
- Provide performance feedback to the facility using the community scorecard system.
- Serve as the liaison between the health facility and the CHCs and provide regular updates from and to the CHCs.

4.1.1.B.3: Membership and Compositions

The Health Facility Development Committees shall comprise at least six (6) members including the CHC liaison from each facility's catchment. For example, if there are ten communities within a health facility's catchment, the HFDC will have 15 members (five members plus ten CHC Representatives). The Board is expected to encourage gender equity and diversity in its composition. The Chair, Co-chair, and Secretary will be elected;

by default, the OIC and the CHSS are members of the HFDC but have no voting rights and CHSS shall serve as the Recording Officer.

4.1.1.B.4: Orientation

The HFDCs shall be established in all public health facilities to serve catchment communities within and beyond 5km of the health facility. All HFDC meetings shall be conducted by the Chairmen or Co-Chairman (*when designated by the Chairman*) and minutes taken by the Recording Officer (*in the absence of the CHSS, the OIC may proxy, or someone designated by the CHSS*). The Community Health Services Supervisors at the health facility shall work and provide technical support to their HFDCs in consultation with the OICs. Each HFDC member (*excluding the OIC and CHC*) shall serve a tenure of two years with an opportunity for reelection for a second term. After two consecutive tenures of service, the member shall honorably retire.

4.1.2 Community Engagement and Community Support

The cornerstone for community engagement shall be mobilization and communication with an emphasis on dialogue between communities and stakeholders, partners, and donors in the provision of health services. Community engagement shall emphasize practices that are evidence-based, gender-sensitive, people-centered, professionally developed, multichannel, service-linked, and efficiently monitored.

The relationship between community health cadres (CHAs, CHPs, and TTMs) and the community is critical. Accordingly, these cadres of individuals must come from and reside in the communities where they serve. Therefore, community engagement is the first step for the recruitment and deployment

of community health cadres and is vital to ensuring that community health achievements are sustainable. Community engagement and support require an inter-sectoral and collaborative effort at all levels, especially with the private and public sectors. Thus, all communities shall be engaged, mobilized, and orientated during the planning and implementation of the community health programs to

- Identify socio-cultural and gender barriers and prioritize evidence-based health interventions for effective change in attitudes and behavior of their community.
- Participate in and take ownership of community health interventions, including IPC and community-led total sanitation (CLTS).
- Mobilize local resources to support health interventions.
- Participate in planning, implementing, monitoring, and community feedback process using the community scorecards and digital technology.
- Participate in risk communication and health education and promotion.

4.2 Community Health Workforce

Specific Objective 2: *To strengthen human resource capacity for the community health workforce to improve service delivery through pre-service training; institutionalization of the NCHP training curriculum in training institutions for career advancement; in-service training; refresher training (competency-based modular training package) and mentorship for technical capacity building skills transfer.*

4.2.1 Overview of the Community Health Workforce (CHW)

4.2.1.A. Introduction

The World Health Organization (WHO) defines Community Health Workers (CHWs) as "any members of the community 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 but not necessarily a part of its organization, and have shorter training than professional workers."

According to the **World Health Organization (WHO) Guideline on Health Policy and System Support to Optimize Community Health Worker Program (2018),** "Community Health Workers have been acknowledged as a vital component of primary care since the Alma Ata Declaration in 1978. Forty years later, we now have compelling evidence demonstrating the valuable contribution of community health workers in delivering basic and essential life-saving health services." Yet, they are often operating at the margins of the health system, without being duly recognized, integrated, supported, and rewarded for the crucial role they play (WHO 2018). Therefore, support for community health must stand from an investment point of view which represents good value for money.

This revised policy maintains the previous CHWs and introduces a new cadre of CHWs called Community Health Promoters (CHPs)—transforming all current CHVs into CHPs. The National Community Health Program shall achieve a minimum of 50% gender quota in alignment with the World Health Organization target for all cadres of the National Community Health Program.

In the context of the Liberian National Community Health Program, a Community Health Worker called Community Health Workforce is defined as:

1. Anyone who lives in a community, selected by the community through an interactive community engagement process, trained in the NCHP competency-based curriculum, equipped, supervised, and incentivized by the Ministry of Health through its Community Health Services Division to provide the essential package of community health service in their community as outline in this policy.

   OR

2. A professionally trained and licensed health care provider (Physician Assistant, Nurse, or Midwife) who is recruited and trained by the Ministry of Health through its Community Health Services Division, in the NCHP competency-based curriculum, equipped, deployed, incentivized, and supervised by the Ministry of Health to supervise and deliver the essential package of community health service as outline in this policy.

No community members actively serving key positions in a community (for example City Mayor, Commissioner, Chief, Teacher, etc.), shall be recruited to serve as a CHW in the first and second categories.
The Liberian Community Health Workforce shall therefore include **Community Health Assistants (CHAs), Community Health Promoters (CHPs), Trained Traditional Midwives (TTMs),** in the first category and **Community Health Services Supervisors**

(CHSSs) in the second category. Females shall be prioritized for all CHW recruitment according to this policy.

4.2.1.B Coverage

The policy seeks to define the geographical coverage for three cadres (CHAs, CHPs, and TTMs) to provide an integrated package of preventive, promotive, and curative services in Liberia. It addresses the community health workforce within and beyond 5km and in partnership with CAHWs, where applicable.

To achieve geographical coverage, the CHAs and TTMs will serve the catchment communities beyond the 5km or one hour or more walk to the nearest health facility, whilst the CHPs and TTMs (where available) will serve catchment communities within the 5km radius respectively.

The goal of the geographical coverage is to expand access to evidence-based and high-impact health interventions and services. To ensure efficiency, health facilities and their catchment communities shall be mapped periodically to identify communities that are 5km and beyond and the size of the population in which the CHA and CHP strategy can be implemented.

The community health workforce to population ratio will be based on the following three (3) criteria: **a**. Densely populated, **b**. Sparsely populated and **c**. Communities that are far and hard to reach. However, the population ratio for CHWs shall be determined on a county-specific basis in consultation with the Community Health Services Division. Moreover, geographical landscape and topography may be used in considering the coverage for each CHW.

The established ratios for the community health cadres shall be:

- One CHA shall be assigned to 200 to 350 population (40 to 60 households)
- One CHP shall be assigned to 300 to 400 population (60 to 80 households)
- One TTM shall be assigned to 100 to 150 population (20 to 30 households)
- One CHSS shall be assigned to at most 10 CHAs and at least 5 CHPs

According to the LDHS report 2019–20, a household is defined as, "a person or group of related or unrelated persons who live together under the same dwelling unit, who acknowledge one adult male or female as the head, who share the same housekeeping arrangement and who are considered as a single unit".

4.2.1.C Remuneration

Compensation or incentive for each cadre of the CHW shall be based on this policy through a consultative process involving major stakeholders during strategy revisions. The approved rates or incentives[12] shall be officially released by the MOH through its Community Health Services Division and shared with all County Health Teams and relevant partners.

Performance-based incentives, linked to community health performance evaluation systems, shall be designed, and implemented by the MOH through its Community Health Services Division and partners. The goal of these schemes will be to

[12] Reference the implementation SOP

identify mechanisms to improve and direct CHWs' performance and provide consideration for specialized functions. Performance-based incentive schemes for CHWs shall be piloted, adapted, and scaled up based on results and lessons learned, and shall be complementary to the base compensation policy. MOH shall ensure the continuity of any such incentive provisions. All pilots will follow the process outlined in the **NCHP Innovation and Quality Improvement SOP**.

The CHWs may also receive other forms of motivation, both monetary and non-monetary–such as transportation, gifts-in-kind, advancement opportunities, involvement in national health-related campaigns, and recognition at national and sub-national events based on commitment and performance. Furthermore, communities through the Community Health Committee shall seek ways to recognize and actively encourage the efforts of the community health workforce.

All stakeholders including partners are required to use the recognized national community health workforce to provide all related community health services in their community, including national health-related campaigns.

Any service outside of the approved standardized essential package will not be implemented by the CHWs unless otherwise indicated by negotiation with the Community Health Services Division which shall follow the NCHP Human Resources for Health and Training SOP.

4.2.1.D Career Development

The Ministry of Health (MOH) through the Community Health Services Division (CHSD), shall work with relevant stakeholders

and partners to develop career paths and implement opportunities for advancing the community health workforce.

4.2.1.E Motivation/ Retention

As part of motivation, the involvement of communities and their leaders plays a critical role in empowering and retaining the community health workforce. The community health workforce shall be given the first preference to national campaigns and all other health services in the communities and advocacy for the community health workforce shall be considered among the following:

- Priority seeking healthcare
- Community work exemption
- Making communion farms for CHWs
- Training opportunities
- Timely incentive payments
- Provision of requisite tools
- Professional development opportunities inclusive of career pathways

4.2.2 Community Health Assistant (CHA)

4.2.2.A: Roles and Responsibilities

Community Health Assistants (CHAs) shall provide preventive, promotive to all within the community and curative and diagnostic services for all children under five years of age as well as children 6–11 years of age (for malaria services only) in far and hard-to-reach communities (beyond 5km). The CHAs shall be the community-based link to the health system, providing other services in the community, assisting individuals and groups to access health services, and educating community members on health issues.

Since CHAs are an integral part of the community, it is imperative that the communities are involved and or engaged in the identification, recruitment, and performances of the CHA. Accordingly, a community ***must*** have a functional CHC to oversee the identification and recruitment of the CHA.

4.2.2.B: Selection Criteria

The selection criteria for a CHA shall be:

- A resident of the community aged 18 to 65 years
- A trustworthy, respected with good morals in the community
- Interested in the health and development of the community
- A good mobilizer and communicator
- Available to perform the roles and responsibilities of a CHA
- Capable of walking long distances (an hour or more) to provide health interventions and services to people in their designated assigned area
- Having been involved in community projects in the past could be an added advantage
- Must pass a pre-selection standardized test, proving basic literacy and numeracy competency skills.
- Fluently speaks the local language (dialect) of the community
- A Liberian national

Females with these qualifications shall be encouraged to participate and given preference.

4.2.2.C: Geographic and Household Coverage

One CHA shall cover 40–60 households (200 to 350 population), however, in sparsely populated areas with walking distances greater than one hour between villages and or with a population of less than 350, the minimum number of households will be reduced to ensure each community has at least one CHA available.

4.2.2.D: Incentives / Payment Mechanisms

To commit CHAs to remain in their communities and dedicate a portion of their everyday time to performing their role (an expected average of at least four hours per day), CHAs shall receive monthly remuneration that commensurate with the job demands. This shall be determined by the MOH through its Community Health Service Division. Additionally, compensation may be provided to CHAs as a form of performance-based incentive to improve community health indicators. CHAs are not civil servants and will not receive any compensation that is higher than a professional staff assigned at a health facility.

4.2.2.E: Work Hours

CHAs shall be expected to work for at least four hours per day, five days a week, for a maximum of 80 hours per month.

4.2.2.F: Benefit

CHAs shall be granted leave by the **Decent Work Act** as a program benefit. During these times, CHSSs will work with the concerned CHA in arranging support from a nearby CHA to cover that community. This process ***must*** be in full consultation with the implementing partner and the Community Health Focal Person of the CHT.

4.2.2.G: Assets Management

CHAs are expected to maintain all the NCHP logistics and assets assigned to them and ensure that they are always functional. In the case of loss or damage of assigned logistics or assets proven by the negligence of the CHA, the CHA shall be charged the depreciated cost at the point of loss or damage. The charge may be deducted from the CHA's net compensation package using a phased approach (25% per pay period).

The MOH shall recommend to partners the disposal of used assets after a fixed life span.

4.2.2.H: Disciplinary Action

Disciplinary action for CHAs will be by the guidelines of the MOH policy for contractors.

4.2.3 Community Health Promoter (CHP)

4.2.3.A: Roles and Responsibilities

Community Health Promoters (CHPs) shall serve communities within 5km (near-facility communities) and provide promotive and preventive services only with an emphasis on identification and referrals of diseases and conditions. CHPs shall provide all services and interventions provided by CHAs except curative services (iCCM, and Family Planning injectable). CHPs shall be the community-based link to the health system, providing health-related services in the community, assisting individuals and groups to access health services, and educating community members on health issues.

4.2.3.B: Selection Criteria

Like CHAs, CHPs are an integral part of the community, therefore it is imperative that the communities are involved and engaged in the identification, recruitment, and performance of CHPs. Accordingly, a community ***must*** have a functional CHC to oversee the identification and recruitment of the CHP. The selection criteria for a CHP shall be the same as of a CHA as indicated above.

4.2.3.C: Geographic and Household Coverage

For all communities within 5km of the health facility, CHPs shall provide the approved MOH integrated and standardized service delivery package to 300 to 400 population (60–80 households). However, in densely populated areas (urban and semi-urban communities) with walking distances of less than one hour between households with a population of more than 450, the maximum number of households shall be increased to 90 households.

4.2.3.D: Incentives / Payment Mechanism

To commit CHPs to remain in their communities and dedicate a portion of their everyday time to performing their role (an expected average of at least four hours per day), CHPs shall receive remuneration for their work that is commensurate with the job demands, complexity, number of hours, training, and roles that they undertake. This shall be determined by the MOH through its Community Health Service Division. Additional compensation may be provided to CHPs as a form of performance-based incentive to improve community health indicators. CHPs are not civil servants and will not receive any compensation that is higher than a professional staff assignment at a health facility.

4.2.3.E: Work Hours

CHPs shall be expected to work for at least four hours per day, five days a week, for a maximum of 80 hours per month. CHPs must be willing to work extra hours based on the needs of their community.

4.2.3.F: Benefits

CHPs shall be granted leave by the **Decent Work Bill** as a program benefit. During these times, CHSSs will work with the concerned CHA in arranging support from a nearby CHP to cover that community. This process ***must*** be in full consultation with the implementing partner and the Community Health Focal Person of the CHT.

4.2.3.G: Assets Management

CHPs are expected to maintain all logistics and assets assigned to them and ensure that they are always functional. In the case of loss or damage of assigned logistics or assets proven by the negligence of the CHP, the CHP shall be charged the depreciated cost at the point of loss or damage. The charge may be deducted from the CHP's net compensation package using a phased approach (25% per pay period).

4.2.3.H: Disciplinary Action

Disciplinary action for CHPs will be by the guidelines of the MOH policy for contractors.

4.2.4 Trained Traditional Midwives (TTM)

4.2.4.A: Roles and Responsibilities

The functional roles and responsibilities of Trained Traditional Midwives (TTMs) shall include, but are NOT limited to

identification, encouragement, referral, and or accompaniment of pregnant women for ANC visits and skilled-facility delivery in collaboration with their CHAs and CHPs.

4.2.4.B: Selection Criteria

The criteria for a TTM shall be:

- A resident in the community in which she serves and is linked to a health facility
- A woman aged 25 years and above
- Someone trustworthy, respected with good morals.
- Someone interested in health matters (RMNCAH) of their community
- A good mobilizer and communicator
- Available to perform TTM roles and responsibilities
- Capable of walking long distances up to one hour or more to provide RMNCAH health services to people in her designated assigned communities
- Fluently speak the local language (dialect) of the community
- A Liberian national

4.2.4.C: Geographic and Household Coverage

TTMs shall work within 5km with CHPs and beyond 5km with CHAs to provide integrated standardized service delivery packages to 20–30 households (100 to 150 population). Two TTMs shall collaborate with one CHA whilst three TTMs shall collaborate with one CHP.

4.2.4.D: Incentives / Payment Mechanism

TTMs shall receive compensation (in cash or kind) either through the government of Liberia, development partners, or an innovative mechanism. However, TTMs are not civil servants and

will not receive any compensation that is higher than CHP, CHA, or a professional staff assignment at a health facility. This shall be determined by the MOH through its Community Health Service Division.

4.2.4.E: Disciplinary Action

Disciplinary action for TTMs will be by the Annual National Maternal Health Conference Resolution

4.2.5 Community Health Services Supervisor (CHSS)

4.2.5.A: Roles and Responsibilities

CHSSs shall serve all communities beyond and within a 5km radius and supervise all CHWs in their assigned catchment communities and likewise community within where applicable based on a ratio. They shall be either a Physician Assistant, Nurse, or Midwife. All CHSSs must always maintain a current and valid professional license as supervisors in the execution of their duties.

4.2.5.B: Selection Criteria

The selection criteria for a CHSS shall be:

- A professionally trained health worker who graduates from a health regulatory body-approved training institution (*Liberian Board for Nursing and Midwifery and Liberia National Physician Assistant Board*)
- With a current and valid professional license to practice
- Willing to travel about 80%–90% of their work time in assigned communities
- Willing to lead, train, mentor, and coach supervisees
- A trustworthy and respected member of the community; upholding high moral standers and building trust with their communities.

- Willing to live and work around the area of assignment
- Can ride a motorbike

A qualified woman who meets the selection criteria shall be prioritized during the selection process to meet the program gender quota.

4.2.5.C: Geographic and Household Coverage

CHSSs shall serve all communities within and beyond the 5km radius of the facility, and shall supervise all CHAs, CHPs, and TTMs in the facility catchment communities as per the assigned ratio indicated in this policy.

4.2.5.D: Incentives / Payment Mechanism

CHSSs shall receive a monthly salary through the Government of Liberia or development partners. Salary payment and benefits for CHSSs shall be subject to the approved Ministry of Health standards for professional health care providers.

4.2.5.E: Work Hours

CHSSs shall work 40 hours per week with 90% of time spent supporting CHAs, CHPs, and TTMs at the community level and only 10% of the time spent at the health facility *(please reference the TOR for details of the workload of CHSSs at the community and facility levels).*

4.2.5.F: Leave

Leave for CHSSs shall be per the Standing Orders of Civil Service for CHSS who civil servants are and the MOH policy for contractors for CHSS who contractors are.

4.2.5.G: Disciplinary Action and Asset Management

Disciplinary action for CHSSs shall be by the MOH HR Handbook. CHSS are expected to maintain high moral standards and trust with the communities. All CHSSs are expected to manage and maintain all logistics and assets assigned to them and ensure that they are always functional. In the case of loss or damage of assigned logistics or assets proven by the negligence of the CHSS, the CHSS shall be charged to pay the depreciated cost at the point of loss or damage. The charge may be deducted from the CHSS's net compensation package using a phased approach (25% per pay period).

4.3 Community Health Service Delivery

Specific Objective 3: To reduce disease burden by increasing access to and utilization of a high-quality, standardized, and cost-effective package of essential community-based interventions and services.

4.3.1 Essential Health Services for Community Health Workforce

The community health workforce shall be supervised, monitored, and mentored to deliver an integrated and standardized service delivery package (*Essential Package of Community Health Services – EPCHS*), which includes **preventive, promotive, curative, diagnostic, rehabilitative, palliative services, and surveillance for disease and public health events to all households located in all communities**. There shall be standardized core services for each cadre of the community health workforce. The Ministry of Health through its Community Health Services Division shall initiate innovation and research activities for new services for community health. *The comprehensive details of all community services are available in the* ***NCHP Strategy.***

4.3.1.A: Community Engagement and Empowerment

The key role of the community health workforce shall be the **promotion of health through education, risk communication, community engagement,** and **social mobilization**; by empowering individuals, families, and communities to enable them to take control of their health through positive behavior change. The community health workforce will **conduct door-to-door, mass, and small group awareness** activities to sensitize community members and caregivers about various interventions to prevent and promote good health, including IPC measures, and to roll out health messages, actions, and other interventions. The community health workforce shill also mobilizes their communities to **create demand and promote health** through community participation and ownership of the prevention of diseases for the promotion of healthy lifestyles and a child-friendly community. CHAs and CHPs shall conduct annual **profiling** of their respective communities. Based on emerging evidence, the Ministry of Health shall develop and adopt guidelines articulating the threshold and frequency for community engagement activities

CHAs and CHPs shall conduct health promotion activities on Water, Sanitation, and Hygiene (WASH) to include protecting water sources, home water treatment, safe water storage, proper hand washing, proper use of latrines, waste disposal, vector control, and the use of safe storage for household utensils.

The National Community Health Program shall promote self-care interventions including self-screening, early detection of health problems, and early care-seeking for confirmation within a healthcare setting. CHAs and CHPs will engage and mobilize communities for self-care—appropriately tailored to the different

needs of individuals to be in control of some self-care interventions such as using condoms, Sayana Press self-administration, breast examination, self-glucose testing, home-based self-care for lymphoedema; while others, such as a positive HIV self-test, self-sampling of HPV, screening for TB, self-Mental Health identification of sign, symptom, and others will require confirmation and testing within a healthcare setting. These dynamic interactions between individuals and the health system can also change over time in line with the needs and choices of individuals.

4.3.1.B: Integrated Disease Surveillance, Emergency Preparedness, and Response

The community health workforce plays a key role in strengthening early case detection and reporting of priority diseases and other event triggers, as they occur in the community through active case finding and contact tracing in the context of the One Health Approach. CHAs and CHPs shall notify the CHSS at the health facilities of any reportable disease encountered within their area of work according to the Community Event Base Surveillance (CEBS) and eIDSR guidelines. They shall work in:

- Human Health (Integrated Disease Surveillance and Response – IDSR)
- Animal Health (Disease Surveillance and Response - ADSR)
- Environmental Health

4.3.1.C: Reproductive, Maternal, Newborn, and Adolescent Health (RMNAH)

The community health workforce (CHAs, CHPs, and TTMs) shall be trained and capacitated to provide selected community-based RMNAH services. CHAs shall provide reproductive, maternal,

newborn and adolescent services and interventions to contribute to the reduction of maternal and newborn morbidity and mortality. These services shall be provided by CHAs, CHPs and TTMs and shall include:

- Family planning inclusive of OCPs, injectable provision (Sayana Press), and barriers
- Maternal and newborn services including HBMNC
- Provision of IPTP for the prevention of malaria in pregnant women
- Adolescent Sexual Reproductive Health (ASRH)+ Nutrition
- Nutrition services for pregnant women, lactating mothers and adolescents including supporting mother groups for nutrition interventions
- Using the Big Belly Business integrated community health service provision guide
  to improve maternal and child interventions

4.3.1.D: Child Health

The community health workforce (CHAs and CHSS) shall be trained and capacitated to provide Integrated Community Case Management (iCCM) services in areas beyond 5 kilometers. This is the hallmark function of the CHA. CHAs shall assess, diagnose, and treat for malaria, pneumonia, and diarrhea in children between the ages of 2 to 59 months and refer for any complications or severity related to any of these and other childhood conditions. Additionally, CHAs will operationalize community-based testing (using mRDTs only) and treatment for malaria in children 6 to 13 years. CHAs shall provide other childhood services for the prevention and control of childhood illnesses and improve health outcomes through community-based interventions. CHAs shall conduct defaulter tracking and referral for children 0 to 59 months and notify their CHSS for immunization services. Additionally, nutrition services including

MUAC screening shall be provided by CHAs. These services shall include:

- Integrated Community Case Management (iCCM)
- Diagnosis and treatment of children 6 to 13 years for malaria
- Immunization; defaulter tracking, referral and community mobilization for vaccination
- Nutrition inclusive of routine MUAC screening for all children under 5 years
- Nutrition counseling and referral for danger signs of severe acute malnutrition
- Provision of micronutrient powder, deworming and vitamin A supplementation for all children under 5 years.

4.3.1.E: Communicable Disease (Human Immunocompromised Virus and Tuberculosis)

To reduce the burden of HIV and TB diseases, including stigmatization and discrimination against the general and vulnerable populations, CHAs and CHPs shall support the provision of these services through strengthening community involvement and participation. Their focus shall be the following:

- Mobilization and conducting community counseling and testing for HIV
- Identification, follow-ups, and referrals
- Treatment buddy for PLHIV
- Create awareness for HIV and TB, active case search and screening for TB,
- Contact investigation, and default tracking,
- TB Sputum collection and transporting
- Community Direct Observation Therapy (DOT) for TB

4.3.1.F: Non-Communicable Diseases (Mental Health, Eye Health, Diabetes, Neglected Tropical Diseases, and First Aid)

Given the disease burden of NCDs in Liberia, community health workers (CHAs and CHPs) shall be capacitated to deliver evidence-based interventions using a task-sharing model. For communities to live a healthy lifestyle, CHAs and CHPs shall be trained to create awareness and sensitization on NCDs—including risk factors, signs, and symptoms, and supporting prevention, screening, and referrals at the community level. CHAs and CHPs shall also be empowered to provide community-based promotion including risk factors, identification, prevention, treatment, and referrals for mental health, neurological, and substance use disorders. CHAs and CHPs shall provide NTDs and Eye Health services within their respective communities. NTD services shall include the identification, referral, and provision of preventive chemotherapy, home-based self-care for lymphoedema, prevention of disability (POD), and rapid testing for yaws at the community level. Eye Health services shall focus on the dispensing of appropriate reading glasses following simple near vision acuity testing using appropriate testing tools.
These services shall include the following:

- Education, sensitization, counseling, and mobilization for behavior change
- Screening, and accompaniment as a treatment buddy
- Follow-ups, treatment adherence, refill, and referrals
- Identification, treatment, and management
- Screening and dispensing of appropriate reading glasses

CHAs and CHPs shall also provide **First Aid** services within their respective communities by adhering to the principles of First Aid—including prevention and basic response to identifying the four common accidental injuries (road traffic accidents, burns,

falls and animal bites or scratches) and provide first aid case management. The focus of these services shall be:

- Identification and management
- Education and sensitization
- Follow-ups and referrals

4.4 Community Health Training and Supervision

Specific objective 4a: *To build human resource capacity for community health services via pre-service and in-service training (definition and description are outlined in NCHP Training and Supervision SOP), ensuring that all training modules are digitized, and blended learning processes are incorporated.*

Specific Objective 4b: *To institute mentorship, coaching, monitoring of accuracy, utilization of drugs and medical supplies, referrals, surveillance, and adherence to guidelines and protocols to ensure quality improvement of community-based information systems (CBIS).*

4.4.1 Pre-Service Training, In-service, and Refresher Training

The Ministry of Health will advocate with training institutions to incorporate the Community Health Service Supervisors (CHSS) training modules into their curriculum. The MOH and partners shall utilize the standardized training package as a pre-service training to train newly recruited CHSSs, CHAs, CHPs, and TTMs while in-service training, and refresher training will be focused on knowledge gaps as identified from findings from supportive supervisory, field visits, as well as training needs assessments.

4.4.1.A Pre-service Training Requirements

To become a certificated CHA or CHP, candidates must undergo and complete the MOH integrated and standardized training

modules. Before deployment, CHAs and CHPs must demonstrate a minimum level of core competency, as measured by established skills check tools that are included in the training package and administered by the CHSS. Similarly, CHAs and CHPs will not progress to the next training module without demonstrating mastery, via supervision tools with competency-based assessments, of the full content and skills for which they have been previously trained. ***All CHSSs, CHAs, and CHPs must successfully pass one module to progress to the next. This process must be strictly adhered to throughout the training.*** Each module will begin and end with pre-test and post-test evaluations. All CHSSs, CHAs, CHPs, and TTMs shall be provided with allowance during the training to cover accommodation, safety, and transportation.

All specialized programs working through the community health platform shall adhere to these standardized training modules and avoid duplication. The Community Health Services Division shall be solely responsible for all CHWs' training in collaboration with all relevant partners, MOH programs and units, and the National Public Health Institute.

4.4.1.A.1 Community Health Services Supervisor (CHSS) Training Package

A specialized integrated competency modular training package, with emphasis on special services (*maternal health, immunization, HIV, TB, Infectious Disease, and IPC*), leadership, operations, supply, supervision, monitoring, and supervisory functions shall be developed to provide additional essential skills for successful program management and coordination with planned outreach services.

The CHSS will be trained in the competency-based curriculum and taught to identify gaps in competency and quality of care that will be addressed through mentorship, coaching, and routine supportive supervision. CHSS training will also include sessions on facilitation skills and relevant technical content for CHA, CHP, and TTM level service provision, as CHSSs will serve as trainers of all CHAs, CHPs, and TTMs. Each modular training will be inclusive of theoretical and practical sessions followed by a competency-based assessment.

Relevant county and district level supervisors including health facility staff shall also undergo the CHSS training to enable them to provide oversight of the National Community Health Program implementation. Community Health Focal Persons and OICs shall receive additional training that empowers them to effectively undertake their leadership and management roles in the program. These supervisors will also receive training in quality assurance and improvement to allow for improved data use, design, and implementation of activities to address gaps during the implementation.

The MOH, through its Community Health Services Division, shall coordinate with health training institutions to institutionalize CHSS competency-based curriculum.

4.4.1.A.2 Community Health Assistant (CHA) Training Package

An integrated and standardized competency-based modular training package shall be used for the training of CHAs. The package shall include promotive, preventive, curative, diagnostics, and palliative services as stipulated in this policy as an essential package of community

health services for CHAs. Each module will be inclusive of supportive services on logistics (as appropriate), monitoring, data collection and reporting, and digital systems. The package shall include COVID-19 and other infectious diseases information and IPC. Each modular training will be inclusive of theoretical and practical sessions followed by a competency-based assessment. Post-training will have a period of intensive supervision to address gaps in competency through mentorship and coaching before proceeding to subsequent modules. Each module will begin and end with pre-test and post-test evaluations.

4.4.1.A.3 Community Health Promoters (CHP) Training

An integrated and standardized competency-based modular training package shall be used for the training of CHPs. The package shall include promotive, preventive, and palliative services as stipulated in this policy as an essential package of community health services for CHPs. Each module will be inclusive of supportive services on logistics (as appropriate), monitoring, data collection and reporting, and digital systems. The package shall include COVID-19 and other infectious diseases information and IPC. Each modular training will be inclusive of theoretical and practical sessions followed by a competency-based assessment. Post-training will have a period of intensive supervision to address gaps in competency through mentorship and coaching before proceeding to subsequent modules. ***CHPs training package shall not be inclusive of the integrated community case management for Malaria, Diarrhea, and Pneumonia*.** Each module will begin and end with pre-test and post-test evaluations.

4.4.1.A.4 Traditional Trained Midwife (TTM) Training

The training of TTMs shall base on the revised Big Belly Business module for TTMs. It will focus on simplified, easy-to-use job aids that will build the knowledge and skills of TTM. The package shall include COVID-19 and other infectious diseases information and IPC.

4.4.1.B: In-service and Refresher Training

In Service and Refresher, Training interventions shall be focused on findings from supportive supervisory, field visits, as well as training needs assessments. These periodic training interventions shall be conducted to appropriately address identified gaps and reinforce quality improvement and evidence-based best practices. **A full course of training shall be conducted every five (5) years after the mid-term review of the National Community Health Program Policy and Strategy.**

4.4.1.C: Certification and Identification of Community Health Workforce

All community health workforce (CHSS, CHA, CHP, and TTM) shall receive a certificate and identification card upon completion of the approved MOH standardized training package in a formal certification program before deployment.

4.4.2 Supervision

Supervision is critical for ensuring an acceptable level of performance and motivation for CHSSs, CHAs, CHPs, and TTMs as well as for strong linkages between community and facility-based services. National, county, and district level supervision shall be conducted as per the Joint Integrated Supportive Supervision (JISS) Guidelines.

Community Health Services Supervisors (CHSSs) shall be assigned to health facilities where they will be supervised by OICs. CHSSs shall provide regular field-based supervision to CHAs, CHPs, and TTMs working in the catchment communities of health facilities. **One CHSS shall supervise up to 10 CHAs, 5 CHPs, and their TTMs**.

Supervision shall focus on those activities and tasks that are most important for the CHAs, CHPs, and TTMs—as well as the health of the communities they serve. Supervision is intended to facilitate improved quality of service delivery by CHAs, CHPs, and TTMs to their respective communities. Supervision shall also enable continuous monitoring, mentoring, coaching, and data collection and serve as a mechanism for other critical support functions such as re-supply of commodities for service provision. Supervision shall be conducted twice a month. Each CHA and CHP shall receive at least one supervisory visit per month. The health facility assigned Reproductive Health staff shall support the CHSS to conduct periodic visits for TTMs.

Integrated and standardized competency-based supervisory checklists and tools shall be used for the supportive supervision of all community health activities. The CHSD shall ensure strict adherence to the utilization of these checklists and data collection tools. No collaborating programs, divisions, implementing partners, CHTs, or other supportive partners shall develop parallel supervision and or data collection tools for use by CHAs, CHPs, and TTMs. Quality assurance and improvement activities will be permitted under the QI framework.

4.5 Monitoring, Evaluation, Research, and Technology

***Specific Objective 5**: To develop robust digital health tools and systems that will use community-based surveillance, information, and M&E systems to report high-quality data for use to improve program implementation fidelity at the community level and to engage in operational research and innovations to enhance the continued quality improvement of the program.*

4.5.1 Monitoring and Evaluation

Monitoring will be a continuous process and information will be collected on activities implemented and results achieved by community health workers (CHSS, CHA, CHPs, and TTMs). Data generated through the monitoring process shall be used for informed programmatic decision-making at all levels. The NCHP implementation fidelity initiatives shall be carried out by CHSD and partners every quarter as mechanism to measure the program quantitatively.

Adherence to the utilization of integrated and standardized monitoring and evaluation tools shall be enforced to ensure quality management. Data flow, analysis and validation will be carried out per the protocols jointly defined by HMER, CHSD, and other stakeholders. Furthermore, HMER and CHSD will monitor and ensure adherence to the overall implementation standards set in this policy and appropriate action will be taken to address identified deviations from national standards. Standardized program indicators shall be used by all partners and collaborating programs. No parallel NCHP (programmatic) indicators will be introduced or used by any stakeholders. CHSD shall be the final determinate of all community health indicators after a comprehensive engagement process.

The HMER, in collaboration with CHSD, shall ensure an integrated and functioning electronic community-based information system (eCBIS) that is standardized across the program and integrated with the Health Management Information System (HMIS).

The CHSD, ICT, and HMER Units shall leverage mobile health interventions for community health workers and digitize key community-level information systems—including eCBIS, CEBS, and tools used for community-level supply chain and HRH management.

All reporting information systems used by the community health workforce are mandated to interoperate with the central Health Management Information System (HMIS), in which key data is warehoused within the HMIS and all key indicators are reportable within the HMIS.

4.5.2 Technology and Digital Health

As a supplement to clinical care, digital health holds tremendous potential to benefit Liberian community health programs to improve health systems and health outcomes. Globally, "digital health" refers to the widespread use of mobile telecommunication and multimedia technology involved in the delivery of health services and distribution of health information.

Technological innovations that are proposed to be used by CHSSs, CHAs, or CHPs must align with existing systems and must be approved by the Ministry of Health (CHSD, ICT, and HMER Units) before being permitted to implement by members of the Liberia Community Health Workforce. The CHSD, ICT, and HMER Units shall set standards for digital health platforms for CHSSs, CHAs, and CHPs for all community health services, continued clinical education, surveillance, community-level supply chain, and HRH management.

Health surveillance and digital health reporting initiatives used by the community health workforce must be reviewed by the MOH (CHSD, ICT, and HMER Units) and be approved for implementation.

CHSD shall collaborate with NHPD for the development of digital continued education content deployed to the community health workforce. Continue education content must be tested, reviewed, and approved before deployment to the workforce.

The ICT Unit shall be responsible for national-level warehousing, tracking, troubleshooting, and distribution of all NCHP digital health equipment and assets to counties. All hardware used by the Liberia community health workforce must be approved by the MOH (CHSD, ICT, and HMER Units) and must be registered within the ICT Unit's inventory management systems.

Each County Health Teams will be responsible for the county-level management, warehousing, tracking, troubleshooting, and distribution of the NCHP digital health equipment to the community health workforce. All CHSSs, CHAs, and CHPs must sign asset designation forms and take responsibility for appropriately managing their designated assets.

4.5.3 Operational Research

The MOH shall promote a culture of inquiry, documentation, dissemination, and publishing. Community health research shall endeavor to explore strategies, interventions, tools, and knowledge that can enhance the quality, coverage, effectiveness, and performance of the health system at the community level. CHSD and its partners shall conduct parodic qualitative perception studies to assess community perception of the program.

The CHSD and HMER shall also collaborate with other autonomous institutions to create, organize, and conduct community-based research. All parties wishing to conduct community-health-related research must consult and receive authorization through documented communication from the MOH (Research Unit) and approval from the National Ethics Review Board.

MOH and partners will support national, county, and community health service providers to participate actively in sub-regional, regional, and global exchanges to further the community health interests of the country, learning from the best practices of others, as well as sharing and documenting its own experiences.

4.6 Community Health Supply Chain Systems

Specific Objective 6*: To strengthen community health commodity availability and accountability at all levels— using standardized approaches in the supply of community health commodities; ensuring timely reporting of logistics data (consumption, stock on hand, losses, and adjustment, days stock out) and linking CHWs' restock and logistics data with the eLMIS at the health facility, district, county, and national levels.*

4.6.1 Supply Chain and Logistics

Providing adequate quality-assured medicines, supplies, and logistical support is critical for ensuring the integrity and quality of community health services without interruption and facilitating attaining desired health outcomes at the community level. Once community health cadres are trained and deployed, they must be supplied with the necessary equipment, medicines, and other tools to perform their duties as prescribed by this

policy. The supply of drugs and essential commodities for use by CHWs must be evidence-based on logistics data.

The DPS in collaboration with CHSD shall ensure that national supply chain and commodity documents are reflective of the latest international guidelines and protocols for community health programs and, similarly, that the training curriculum and SOPs for CHWs align with national supply chain management protocols.

DPS and CHSD shall ensure that all key pharmaceutical policy documents incorporate CHW supply chain requirements and design innovative approaches for the safe and timely delivery of medicines and products to CHWs.

DPS shall ensure that oversight responsibilities for rational utilization of commodities are clearly outlined to the responsible pharmaceutical arm of the MOH and in coordination with county-level administration.

CHSD in collaboration with DPS shall advocate with the national government, partners, and donors to allocate resources/budget for the procurement of commodities for community health programs.

The DPS and CHSD shall revise the existing CHAP Supply chain SOP to align with the new NCHP Policy.

The DPS in collaboration with CHSD shall ensure that all national quantification shall incorporate the needs of the CHWs and the procurement of such needs shall be informed by the national quantification output irrespective of who is funding the procurement.

4.7 Community Health Financing

***Specific Objective 7**: To develop a costed plan or roadmap for advocacy and sustainability of community health services, ensuring that partners align needed resources with national strategy and priorities for the continuity of the services.*

4.7.1 Health Financing Approach

The community health financing approach is the foundation of the community health systems strengthening and a well-designed costing method is needed at all levels to advocate for proper resources.

- The MOH shall advocate with the national government, stakeholders, and donors to commit financial resources to meet the objectives of this National Community Health Program Policy.
- The County Health Teams shall adopt program-based budgeting and commit a prescribed percentage of the health budget to meet the objectives of the National Community Health Program.
- The MOH shall develop a costed roadmap to guide development partners for investment into the National Community Health Program.

4.7.2 Health Financing Function

Liberia's commitment to Universal Health Coverage requires a carefully considered and equitable approach to financing the community health system. The MOH has embarked on a path to ensure universal access to health through core health financing functions:

1. **Resource mobilization**: The NCHP is presently reliant on donor funding to support the existing policy and strategy. Longer-term financial sustainability for all community-based service delivery requires a systematic and well-planned transition to domestic sources of funding, at a pace that does not degrade the significant gains made by the NCHP at the community level. The MOH intends to increase government contributions to the program over time and to explore mechanisms that may help to increase sustainability through domestic resource mobilization to support adequate, affordable, and equitable service delivery at the community level.

2. **Resource pooling**: Across the 15 counties, resources are allocated by donors through their prime implementing partners, meaning that resources are pooled based on geographic coverage. The Liberia Health Equity Fund (LHEF) represents the MOH's most significant reform objective and will be the longer-term basis of domestic resource mobilization, including for the community health system.

3. **Purchasing of health services**: The MOH is the main purchaser of community health services at present. It defines the benefit packages, service delivery standards and payment rates, and mechanisms for community health services providers. Over time, it is anticipated that services will be purchased via a public entity, which will contract the public health sector (as well as the private sector), leading to more efficient resource allocation on an output basis.

3.7.3 Transparency of the NCHP Costs

Thorough awareness and understanding of the full costs of the NCHP are necessary to move toward equitable access to affordable, appropriate, and high-quality health services for all communities. As a crucial aspect, MOH must bring all community health services donors and implementing partners together to ensure that ongoing and planned investments of the NCHP are aligned with the MOH's longer-term vision of sustainable financing for community health.

The MOH shall lead NCHP donors and implementing partners to develop a common approach and common tools for costing the NCHP at all levels. The MOH shall insist on full transparency of the program costs and will endeavor to ensure that program components in all counties are aligned with this policy.

Chapter 5: Partnership and Stakeholders Coordination

5.1 Partnership

Multi-sectoral and inter-governmental collaboration and teamwork shall be encouraged to ensure optimal use of resources for health services to communities. Oversight and coordination are also needed at all levels, as well as structures to ensure smooth coordination with partners and vertical programs.

5.2 Coordination

All programs and units of the Ministry of Health and NHPIL as well as all partners shall collaborate with the CHSD to implement community health activities including meetings, training, monitoring, supervision, community engagement, etc. The CHSD shall coordinate closely with focal persons of these programs, units, and institutions to ensure that policies, strategies, and plans are shared and harmonized to avoid duplication and facilitate the efficient and effective utilization of available resources. Program alignment shall also be carried out at counties, districts, and community levels. The MOH shall ensure the alignment of all partners to the One County, One Partner Strategy of the NCHP *(see this strategy in the annex of the NCHP Strategy).*

CHSD shall maintain active coordination of the NCHP through the following mechanism but not limited to:

1. NCHP Technical Working Group:

Primary Function:

The primary function of the NCHP TWG is to take responsibility for and address major topics associated with the implementation of all community health services and interventions, including the scope, strategy, design, assumptions, and risks. This TWG will function as the regular coordinating mechanism of CHSD and ensure the following:

- Strengthen advocacy for NCHP, to influence policies and developments in community health within the Ministry of Health, Government of Liberia and donor community
- Share information, experience, best practices, and challenges related to community health amongst key stakeholders to develop solutions bottlenecks during implementation.
- Recommendations implementation strategies and facilitate the development and harmonization of the NCHP across all 15 counties.
- Support CHSD to minimize duplicate and create efficiencies and accountability of resources
- Support in development and quality improvement of long-term planning in line with the NCHP policies, and strategies
- Promotion and strengthen collaboration and linkages between CHSD and various units within the Ministry of Health and technical implanting and NGO partners
- Report on the NCHP progress to those responsible at senior management level- including the Assistant Minister of Preventative Services, Chief Medical Office/Deputy Minister, and Minister of Health
- Addressing strategic questions that arise regarding the NCHP Policy and Strategic Plan
- Understand the significance of all major stakeholders and consider their interests

- Support CHSD develop the NCHP annual operational plan as set forth by the Ministry of Health
- Accept responsibility for deliverables as puts forward by CHSD Director
- Unless otherwise indicated, CHSD shall remain the chair of the TWG

Membership:
Membership of the NCHP TWG includes but not limited to all collaborating MOH divisions, units, and programs, as well as partners and donors. A need based TWG may be formulated at any given time.

Frequency:
The TWG shall meet on the last Wednesday of each month. Unless otherwise agreed, meetings shall commence at 10:00 A.M Liberian time and last not more than two hours.

Venue:
Unless otherwise indicated by the CHSD Director, the venue of this TWG meeting remains virtual (zoom, teams, google meet and other platform).

Agenda:
Agenda items must be forwarded to all members by close of business one working day prior to the next scheduled meeting. The agenda must accompany the previous meeting minutes.

Minutes:
The TWG secretariat shall document the meeting minutes and achieve using the CHSD google drive. Full copies of the minutes, including attachments, shall be provided to all members no later than three working days following each meeting.

2. NCHP Steering Committee

Primary Function:

- Established small technical committee to move forward with special projects or to make an emergency decision.
- Provide technical support to CHSD to move forward with key projects and address time-sensitive challenges that are negatively impacting the quality of the NCHP.
- To provide emergency technical guidance/support to CHSD for the smoothe operation of the NCHP.
- Ensure that key major challenges and issues of serious concern are resolved in a timely manner.
- To advise the CHSD Director on emergency decisions needed for quick response.

Membership:

Members of a NCHP Steering Committee is made either by volunteer from the NCHP TWG or are decided by the CHSD Director.

Frequency:

Meetings of the NCHP Steering Committee will be held quarterly (March, June, September, and December); however, the CHSD Director will convene an ad hoc meeting in consultation of members as needed.

Venue:

The venue of a NCHP Steering Committee meeting will be decided by the CHSD Director.

Agenda:

The agenda of the meeting will be decided at the NCHP TWG or by the CHSD Director with support from a technical assistant.

Minutes:

Minutes and updates of the Steering Committee will be shared at the next meeting. CHSD Director must ensure minutes are documented and achieved.

3. NCHP Bi-Annual Review Meetings

Primary Function:

- To review analyzed data elements and indicators of the NCHP.
- To address key areas of weakness and challenges experienced over the reporting period.
- Share learnings, best practices and challenges experienced during implementation across all 15 counties in community activities.
- Update all stakeholders on new innovations or changes relevant to the implementation of the NCHP
- Document key challenges hampering the program and follow up on action to be taken to overcome such barriers.
- To provide all stakeholders with updates on action points from previous BRM.
- Ensure follow-up on action points arising from meeting in specific areas as assigned.

Membership:

Participants of the NCHP BRM includes but not limited to all collaborating MOH departments, divisions, units, and programs

as well as CHWs, partners, donors, county health teams and local authorities.

Frequency:

The NCHP BRM shall take place twice each year; each meeting will cover one of the following time periods: January to June, and July to December. To ensure the completeness of all data for the reporting periods, each BRM will take place within three weeks after CBIS reports have been entered. Thus, the first BRM shall be held in the fourth week of July (to review January to June) and the second shall be held in the fourth week of January (to review July to December).

Venue:

The venue of the NCHP BRM shall be decided by the CHSD Director in consultation with partners.

Agenda:

The agenda must be forwarded to all those invited at least one week prior to the event. Presentations to be made at BRM by those invited and listed on the agenda must be submitted to CHSD or a designated email address at least three days before the meeting for review and setup.

Minutes:

Minutes and presentations should be shared within two weeks after each meeting. CHSD with support from partners shall be responsible to document and disseminate meeting minutes, presentations, and Action Points from the BRM

4. NCHP Donor Coordination

Primary Function:

- To provide implementation updates to all NCHP donor representatives and challenges related to scaling and sustaining a high-quality National Community Health Program.
- Serve to advocate for sustain funding mechanism of the NCHP.
- To identify areas for improvement for coordination and collaboration between the MOH and implementing partners and donors
- To address larger challenges related to the long-term sustainability of the NCHP
- Support the NCHP One County One Partner strategy to ensure transparency, accountability and avoid duplication of services and resources.

Membership:

Membership of the NCHP Donor Coordination shall include all NCHP Donors and heads of Implementing partners (as non-voting member). The NCHP DC shall be chaired by the Chief Medical Officer RL/Deputy Minister of Health Services and the CHSD Director shall serve as the secretary.

Frequency:

The NCHP DC shall meet once every four months; first Wednesday of April, August, and December of each year.

Venue:

Unless otherwise indicated, the NCHP DC shall be held in person at the Ministry of Health. CHSD will be responsible for securing a conference room and communicating the location to all members.

Agenda:

The agenda, along with the last meeting minutes, must be shared with each member two working days prior to the next scheduled meeting.

Minutes:

CHSD is responsible for maintaining the minutes with support from technical assistants. Full copies of the minutes, including attachments, shall be provided to all members within one week following each meeting and shall be achieved on the CHSD Google Drive.

5. NCHP Inter-Ministerial Coordination Committee (IMCC)

Primary Function:

- To update representatives from across the Government of Liberia on the progress and challenges related to scaling and sustaining a high-quality National Community Health Program.
- To ensure that the NCHP remains a national priority and is integrated and institutionalized throughout the GOL ministries and agencies.
- To provide a steer on how the GOL can sustain and scale the NCHP and increase access to basic community base services and interventions
- To identify areas for coordination and collaboration between the MOH and other line ministries.
- To address larger challenges related to the long-term sustainability of the NCHP

Membership:

Membership of the IMCC shall include but not limited to MOH Department of Health Service, Department of Planning, Community Health Services Division, National Health Promotion Division, the National Public Health Institute of Liberia (NPHIL), the Ministry of Education, Ministry of Finance, Ministry of Youth and Sports, Ministry of Gender, Ministry of Internal Affairs, and the President's Delivery Unit. The NCHP IMCC shall be chaired by the Assistant Minister for Preventive Services and the CHSD Director shall serve as the secretary.

Frequency:

The IMCC shall meet once every four months; last Tuesday of April, August and December of each year.

Venue:

Unless otherwise indicated, the NCHP IMCC shall be held in person at the Ministry of Health. CHSD will be responsible for securing a conference room and communicating the location to all members.

Agenda:

The agenda, along with the last meeting minutes, must be shared with each member two working days prior to the next scheduled meeting.

Minutes:

CHSD is responsible for maintaining the minutes with support from technical assistants. Full copies of the minutes, including attachments, shall be provided to all members within one week following each meeting and shall be achieved on the CHSD Google Drive.

Chapter 6: Implementation Arrangement, and Partnership

6.1 Implementation Arrangement

6.1.1: Central Level

The MOH maintains the stewardship role for the implementation of the NCHP Policy. At the central level, CHSD is solely responsible for managing, coordinating, and monitoring the implementation of the NCHP Policy with key functions including:

1. Developing and disseminating the NCHP policies, strategies, training packages and guidelines, SOPs, and reporting.
2. Shall be the custodian of this policy, ensuring that implementation of all community health services and activities comply with the standards laid out by the MOH
3. Coordinating and directing all community-based interventions implemented by partners and stakeholders, as well as all MOH community health collaborating programs, divisions, and units, and NPHIL
4. Identifying priorities and gaps in the implementation of the policy and mobilizing resources to address these needs
5. Ensure that community health services and interventions are implemented in all communities (urban, semi-urban, and remote) throughout the republic.

6.1.2: Regional Level

The Reginal Desk Officers (RDOs) shall be the primary staff to ensure the effective implementation of the NCHP in each county, focusing on the managerial and technical components of the

program for quality improvement and assurance. RDOs shall serve as the direct link between CHSD and the County Health Teams and they shall coordinate and supervise program implementation in their respective regions to ensure the proper functionality of the program. RDO shall ensure the fidelity of the program, i.e., that CHSS supervise each CHA at least twice monthly using the approved checklist and other tools to ensure program quality and that CHFPs conduct regular routine IFI supervision, and is maintaining active engagement with all CHWs, CHT Supervisors, partners and other county level collaborators.

6.1.3: County Level

The Community Health Department of each County Health Team shall be responsible for integrating all community health activities into their county operational plan. The Community Health Department Director (CHDD) shall be responsible for coordinating and overseeing the implementation of all community health activities as outlined in this policy, in consultation with the County Health Officer (CHO). The Community Health Focal Person (CHFP), assigned by the CHT, shall work under the supervision of the CHDD and the CHFP shall liaise with the Regional Desk Officer of the CHSD to coordinate all community health activities in the county. *See the Terms of Reference (TOR) for the CHFP in the annex of the National Community Health Program Strategy.*

6.1.4: District Level

At the district level, District Health Officers (DHOs), shall ensure the coordination of all community health services and interventions at the community level. Supervision and oversight

of the implementation of the program shall be the responsibility of the District Community Health Focal Point *(or designated District Reproductive Health Supervisor).*

6.1.5: Health Facility Level

The OIC is responsible for coordinating all health-related services and interventions in all catchment communities for each health facility. The CHSS shall be responsible for the implementation of all community health services and interventions in the facility catchment communities. Health Facility Development Committees (HFDCs) shall serve as the board and meet monthly at the health facility to discuss community health activities to facilitate strong links between the health facility and catchment communities through advocacy. Gaps in access and quality of service delivery will be monitored to inform quality assurance and improvement activities for the catchment communities. HFDCs shall report to the District Health Board. *See the TOR for the CHSS and HFDC in the annex of the NCHP Strategy.*

6.1.6: Community Level

The CHC Leadership is responsible for coordinating and monitoring all health-related functions within their communities and reporting to the HFDC. ***See the TOR for the CHC in the annex of the NCHP Strategy.***

6.2 Partnerships

The MOH shall endeavor to work closely with all relevant GOL line ministries and agencies, development partners, and civil society organizations:

6.2.1: Ministry of Internal Affairs (MIA)

With Liberia's move towards decentralization and interpectoral collaboration for development, community health leadership and governance structures (CHCs and HFDCs) will be accountable to the applicable local authority of the MIA.

6.2.2: Ministry of Education (MOE)

The MOE shall take the lead in providing quality education to the Liberian people so that potential community health cadres can read and write, function in their roles, and access further training in the health sector. Emphasis shall be placed on women's and girls' education to narrow gender gaps in terms of literacy, access, and retention. Furthermore, MOE shall work with relevant training institutions to support the integration of community health content in existing, pre-service health training programs as well as potential, subsequent accreditation of the Community Health Workforce.

6.2.3 Ministry of Youth & Sport (MYS)

As the lead Ministry involved in youth empowerment, the MYS will collaborate with MOH in integrating the Community Health Workforce with the National Youth Empowerment Program.

6.2.4. Ministry of Gender Children and Social Protection (MGCSP)

The MGCSP shall work to ensure that women are represented and engaged in leadership positions and decision-making processes related to community health. MGCSP shall also work in collaboration with MOE and MOH to encourage the recruitment and retention of females within the community health cadres.

6.2.5. National Legislature

The National Legislature shall declare health equity as a national development priority and ensure the sustainability of community health activities through allocation for NCHP at national and subnational levels—including the possibility of a pooled funding mechanism. They shall also support the enactment of legislation that promotes the implementation of the NCHP as a Flagship program of the GOL.

6.2.6. Civil Society

Civil Society—including Community-Based Organizations (CBOs), Faith-Based Organizations (FBOs), and local Non-Governmental Organizations (NGOs)—shall advocate for the establishment of a pooled fund for sustaining the NCHP. The Civil society shall also function as an accountability mechanism to ensure the Ministries and other stakeholders fulfill their respective obligations. They shall work closely with community health cadres to facilitate the implementation of community health activities, strengthen community health structures, and promote linkages between the community and health facility.

6.2.7. Donors and Development Partners

To promote and ensure the sustainability of the NCHP, donors and development partners shall advocate and support the Government of Liberia to establish innovative financing mechanisms. Donors and partners shall also provide continuous technical and financial assistance for this policy and the program implementation.

Chapter 7: Policy Enabling Environment

7.1 Legal Framework

This Policy is drawn from and shall be guided by relevant global and national legal instruments and focus areas. Globally, the Policy is anchored and draws upon the following instruments: WHO Guideline for Community Health Workers Programs (2018), the Declaration for UHC 2030, the Sustainable Development Goals (2016), and the 1989 Convention on the Rights of the Child. Nationally, the NCHP Policy aligns with the Pro-Poor Agenda for Prosperity and Development (PAPD – 2019), Liberia Rising 2030 (Vision 2030), MOH National Health Plan (2021), the National Health Promotion Policy and Strategic Plan, the Roadmap for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia, the Decentralization Leadership Management and Governance Operational Guideline (2020), the Public Health Law of Liberia (2022), the Community Health Assistant Program policy (2016 – 2021) and other Government of Liberia instruments related to community health.

If any of the provisions of this NCHP Policy conflict with any provisions of any of the said national and or global instruments, the provisions of the subject parent instrument will prevail.

7.2 Innovation

There shall be room to explore innovation as the need arises with approval from the National Community Health Program. This will be done through the identification of gaps in service delivery quality and access through quarterly data review and quality improvement initiatives. A standardized review process for innovation pilot proposals will be outlined in the annex. All pilots will require co-design, review, and final approval by CHSD. The

division shall also develop a new strategy to address Community Nursing in urban communities and seek to skill up based on lessons learned through a pilot in Montserrado.

7.3 Regulation

The CHSD, under the MOH, may promulgate regulations for the effective implementation of this Policy; provided that such regulations shall not impair the spirit and intent of this Policy and are in line with relevant legal instruments.

7.4 Enforcement

The CHSD, in conjunction with the Policy Planning, Monitoring and Evaluation Department, and the Office of General Counsel (OGC), shall monitor and enforce the provisions of this Policy. The Ministry of Health will promote the monitoring and enforcement of this Policy in line with existing national laws, regulations, and other policies. Modalities shall be established with the Senior Management Team of the MOH to ensure compliance with existing community health regulations, policies, standard operating procedures, protocols, and guidelines.

7.5 Risks and Assumptions

7.5.1 Risks

- Possible outbreak of a public health epidemic (like Ebola and COVID-19) that leads to overwhelming government systems
- Natural disasters (drought, floods)
- Political insecurity
- General Inflation
- Increased demand for social services especially in urban areas

7.5.2 Assumptions

- This policy shall serve as the main agenda and will provide the main thrust for community health programming in the country
- Government ownership and commitment to community health through a partnership is sustained
- No major humanitarian situation will overwhelm the health sector and other relevant sectors
- The National Community Health Program is sustained to ensure that community health services and interventions are available and accessible in all communities
- Advocacy efforts toward strengthening the policy architecture are successful
- All stakeholders are committed and proactively collaborate to advance the community health agenda through the existing coordination mechanisms

References

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