TECHNICAL BRIEF

Supporting Sierra Leone's Community Health Worker Policy 2016–2020

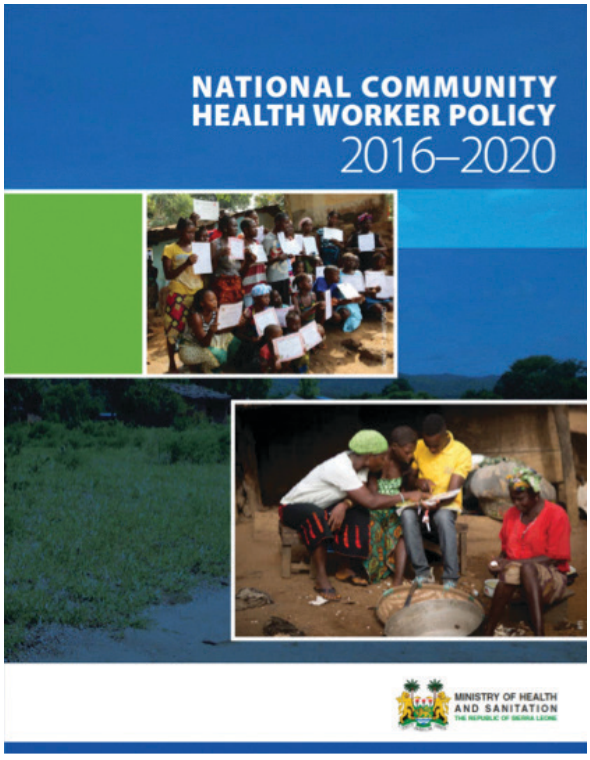
This technical brief describes the Advancing Partners & Communities project concept, context, and process for improving community health systems in Sierra Leone through the adoption and roll-out of the National Community Health Worker (CHW) Policy 2016–2020.

The updated policy–

- Revises the scope of work and defines the minimum service package to be provided by CHWs, as well as the inputs required to support this service package.
- Calls for a nationwide CHW program that is accountable to those it serves and improves the health of all Sierra Leoneans.
- Supports the development of a resilient national health system.

BACKGROUND

In 2012, the Ministry of Health and Sanitation (MOHS) of Sierra Leone launched the first National Community Health Worker Policy. This was a crucial step toward improving health access in a country with one of the highest maternal and child mortality rates, and weak staffing capacity at the community health posts. The 2012 National CHW Policy emphasized the concept of volunteerism for CHWs and brought volunteers, thought to be in excess of 15,000, from different health programs under one umbrella. Alongside the policy, a 10-day training curriculum was developed, highlighting health education messages, integrated community case management (iCCM)



Cover of the CHW Policy.

[1] The WHO, 2015, estimates Sierra Leone's maternal mortality rate as 1,360/100,000 live births, the highest rate globally and over twice the regional average of 542/100,000 (http://apps.who.int/gho/data/node.sdg.3-1-viz?lang=en).

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and water, sanitation, and hygiene (WASH) as the main areas of CHWs' engagement, with limited involvement in surveillance, reproductive and maternal health care, malaria, and other diseases. However, the implementation of the UNICEF-funded and guided policy was interrupted by the Ebola virus disease (EVD) outbreak, and became incomplete and fragmented.

Despite that, CHWs were indispensable during the EVD crisis. They conducted community social mobilization on behavior change and early-care seeking; traced contacts and reported suspect cases; and participated in the burial teams. Their versatility, combined with the poor indicators[1] for reproductive, maternal, newborn, and child health (RMNCH), inspired the revision of the national CHW policy, which addresses these essential community health needs and builds upon the expanded roles that CHWs playing during the crisis. Implementation of the improved 2016–2020 policy, which included the essential components of surveillance, reproductive and maternal health care and malaria, became a national priority and was a key initiative of President Koroma's 10–24 Month Recovery Plan.

INTERVENTIONS

In July 2015, the MOHS and stakeholders began to revise the CHW policy and strategy. The USAID-funded Advancing Partners & Communities, as well as UNICEF, International Growth Centre, London School of Economics, Partners in Health, International Rescue Committee, Save the Children, and World Vision provided valuable technical assistance. Revisions were based on global evidence adapted to Sierra Leone's context and aimed to harmonize and integrate all community efforts under one national CHWs program. The 2016–2020 policy formally recognizes CHWs as an integral part of the health system, with the goal that CHWs become an essential part of the continuum of care, linking the community to the health facility. They will also complement the provision of health services in hard-to-reach disadvantaged areas.

Advancing Partners & Communities support to the CHW policy revisions and roll-out are summarized in the following thematic areas:

Revised CHW policy and strategy: The project provided direct technical assistance and support for a series of policy/strategy development workshops, providing the ministry leadership with analyses of population coverage; costing; monitoring and evaluation (M&E) structures; supportive supervision, and recommendations for appropriate service mixing. Key services envisioned include treatment of diarrhea, pneumonia, and malaria through the iCCM approach; distribution of family planning commodities (condoms and re-supply of pills); promoting healthy lifestyles and appropriate health-seeking behaviors; counseling caregivers in households; and referring cases that need special clinical attention—ultimately improving access to and use of health care services.

Revised CHW training: The project was a leading member of the technical working group tasked with improving the training curriculum for CHWs and peer supervisors and providing input and TA on development of the program and accompanying materials. In December 2016, the final drafts of the three core training modules (community health basics, iCCM, and RMNCH) were completed, as was a supervision module for CHW peer supervisors. The four complementary registers (household, community-based surveillance, iCCM+, and RMNCH) and CHW job aids were also completed. The training materials were validated by technical experts from the MOHS, UNICEF, Advancing Partners & Communities, and other NGOs. All materials were field tested prior to training roll-out in early 2017.

Training was divided into two phases, with seven districts undertaking CHW training in each to allow adequate oversight and supervision from the CHW Hub during the training process. The training of the master trainers was conducted in December 2016, with a refresher training in January 2017 before the district training-of-trainers for Phase 1 districts in February. The cascade training in the Phase 1 districts to the CHWs commenced in February/March 2017, with Advancing Partners & Communities supporting the DHMTs in three priority districts: Western Area Urban (through Action Against Hunger); Western Area Rural (Save the Children); and Bombali (GOAL in partnership with World Hope International).

A CHW learns to use a job aid at a CHW training.

Updated the monitoring and evaluation framework: The project co-hosted the annual CHW program review; led the technical committee that developed the revised M&E framework; supported the development of data collection tools; successfully advocated for the inclusion of CHW program data in the MOHS quarterly health bulletin; and continued efforts to advocate for the inclusion of CHW data in the national and district health management information system (the DHIS2) and human resources for health information system (the iHRIS), which built on previous USAID-funded health system strengthening work.

Supported the National CHW Hub: The National CHW Hub is the Directorate of Primary Health Care unit tasked with the oversight and implementation of the national CHW program. Support from Advancing Partners & Communities' included using geo-mapping tools to mobilize resources from the World Bank and the Global Fund; a series of trainings (IT, M&E); and operational assistance for three key CHW Hub national staff members and the district focal persons in USAID-supported districts (Western Area [Urban and Rural], Port Loko, Bombali, and Tonkolili).

RESULTS

The 2016–2020 CHW policy was officially launched in February 2017. The Phase 1 cohort of CHWs have been trained and will graduate in June/July 2017.

Advancing Partners & Communities supported the training of 1,491 CHWs and peer supervisors in three districts (see Table 1), as part of the seven-district Phase 1 training roll-out (February–July 2017). Complementing the USAID efforts, DFID is funding UNICEF and its partners to support the training of a further 718 CHWs and peer supervisors in Bombali and 4,390 in the four other Phase 1 districts (Bo, Kambia, Kono, and Tonkolili), yielding a total of more than 6,500 trained CHWs.

District (implementing partner)	Number of district TOTs	Number of CHWs trained		
		Female	Male	Total
Western Area Urban (Action Against Hunger)	20	295	255	550
Bombali (GOAL)	24*	86	312	398
Western Area Rural (Save the Children)	21	273	270	543
TOTAL	**65**	**654**	**837**	**1,491**

**in partnership with World Hope International*

CHW peer supervisor training at Kamaranka, Bombali District.

The remaining seven Phase 2 districts will begin roll-out in July 2017, with funding support from DFID, Global Fund, and World Bank.

Overall, the introduction of the new policy and roll-out of training has been a great success, with the expectation that by the end of 2017 CHWs in all districts will have received training on the three core modules, and communities across the country will be benefitting from an improved and strengthened primary health service. CHWs report that they have found the new training materials easy to use and understand, and are enthusiastic about providing services within their communities.

CHW training in Wilberforce, Western Area Urban District.

Lessons and Way Forward

The roll out of training for the Phase 1 districts highlighted a number of challenges. The National CHW Hub played a key role in their resolution:

- Districts struggled with rapid planning, resource mobilization, and coordination, which led to sporadic absenteeism among facilitators and little clarity on processes and responsibilities for the intra-modular supervisors. More attention and advance planning is needed at the district level.
- National-level delays in printing and distribution of training materials, as well as shortages of supplies in the district, at times resulted in sites not having the necessary training materials. Supplies of training materials and CHW medication and test kits must be ordered well in advance of district roll-out.
- Efforts to integrate CHWs in the formal health system were perceived negatively by some PHU staff. PHU staff must be made aware in advance about the CHW roles and responsibilities, and PHU staff responsibilities to them to ensure that CHWs have access to the supplies they needed to do their job effectively, particularly for iCCM+ services.

As the national CHW program evolves, districts will take greater responsibility for creating annual plans, which will include determining district coverage, training, and disbursement of supplies and job aids. They will also be responsible for fundraising, budgeting, financial planning, overseeing CHW incentive disbursements, reporting, and annual updating of district-level geo-mapping databases, which previously fell to implementing partners and district health management teams (DHMTs). Training, technical assistance, and secondments to support this transition of responsibility and longer term program implementation will be necessary.

Annual reviews of the national CHW programs have identified local solutions and should continue. Performance reviews of CHWs and peer supervisors through DHMT supervision and community meetings will be useful to strengthen program implementation and monitoring.

Annual refresher training should be provided to CHW and peer supervisors. DHMTs should work with the National CHW Hub and partners to continuously assess their training needs and determine key areas of support. Some refreshers could focus on integrating CHWs with volunteers from other MOHS-led programs, such as malaria and EVD survivor care.

Strengthening CHW data is a program priority. National CHW program data will be integrated into the HMIS, and CHW district data quickly fed to central level, providing the CHW Hub with essential data for decision making. District M&E teams should be provided with further training to PHU staff and M&E officers and secondments as needed.

Finally, CHW program's success depends on ongoing support of the National CHW Hub, the Government of Sierra Leone, MOHS, and partners. They must ensure that the DPHC unit has the financial and technical support to maintain the oversight, implementation, and development of this program.

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