**REPORT**

**COMPREHENSIVE MAPPING OF COMMUNITY HEALTH VOLUNTEERS (CHVS) AND COMMUNITY HEALTH STRUCTURES IN ALL HEALTH DISTRICTS OF LIBERIA**

**COMMUNITY HEALTH SERVICES DIVISION**

**Ministry of Health and Social Welfare** 

**SUBMITTED TO: Dr. Bernice T. Dahn**

**Deputy Minister of Health/ Chief Medical Officer, MOHSW**

**CONGO TOWN,**

**MONROVIA LIBERIA**

Contents

[LIST OF TABLES 4](#_Toc358560922)

[ACRONYMS 5](#_Toc358560923)

[Acknowledgements 7](#_Toc358560924)

[Executive Summary 8](#_Toc358560925)

[INTRODUCTION 10](#_Toc358560926)

[OBJECTIVES 11](#_Toc358560927)

[METHODOLOGY AND MATERIALS 11](#_Toc358560928)

[Materials 11](#_Toc358560929)

[Training survey workforce 12](#_Toc358560930)

[Data Collection 12](#_Toc358560931)

[Data entry and analysis 12](#_Toc358560932)

[FINDINGS 13](#_Toc358560933)

[Community Health Volunteers 13](#_Toc358560934)

[Types of CHVs enumerated 13](#_Toc358560935)

[gCHVs by gender 15](#_Toc358560936)

[Education level of gCHV 16](#_Toc358560937)

[Age distribution of gCHVs and TTMs 17](#_Toc358560938)

[Distribution of CHVs by year of selection 18](#_Toc358560939)

[Method of selection of gCHV by counties. 18](#_Toc358560940)

[Training received by general Community Health Volunteers (gCHVs) 19](#_Toc358560941)

[Training received by TTMs 22](#_Toc358560942)

[Various gear and supplies received by gCHVs 24](#_Toc358560943)

[gCHV community coverage 25](#_Toc358560944)

[Estimation of number of gCHVs required as per policy 26](#_Toc358560945)

[Community Health Structures 30](#_Toc358560946)

[Distribution of enumerated communities by distance from health facility 30](#_Toc358560947)

[Community health committees 31](#_Toc358560948)

[Community water and sanitation situation 32](#_Toc358560949)

[LIMITATIONS 34](#_Toc358560950)

[REFERENCES 36](#_Toc358560951)

[APPENDIX – A: Community Health Volunteer (CHV) Profile Form 37](#_Toc358560952)

[APPENDIX-B: Community Profile 38](#_Toc358560953)

[APPENDIX-C: Community Health Focal Points 39](#_Toc358560954)

[APPENDIX D: List of Health Districts in Liberia 41](#_Toc358560955)

# LIST OF TABLES

|  |  |
| --- | --- |
| Tables | Page number |
| Table 1: Number of different types of CHVs enumerated |  |
| Table 2: gCHVs by gender |  |
| Table 3: Education levels of gCHVs by gender |  |
| Table 4: Age distribution of gCHV and TTM |  |
| Table 5: Distribution of selection of CHVs by period of years |  |
| Table 6: Methods of selection of gCHVs |  |
| Table 7: Percentage of gCHVs who have been trained on various subjects |  |
| Table 8: Percentage of TTMs who are trained on various training |  |
| Table 9: Status of ever receiving of various gear and supplies by gCHVs |  |
| Table 10: Distribution of gCHVs and TTMs by communities |  |
| Table 11: Distribution of communities by population size, distance from facility and population covered |  |
| Table 12: Estimation of gCHV requirement based on population to be covered by a gCHV |  |
| Table 13: Distribution of enumerated communities by distance from health facility |  |
| Table 14: Distribution of enumerated communities by distance from health facility |  |

# ACRONYMS

ARI Acute Respiratory Infection

CBD Community Based Distributor

CBD-FP Community Based Distribution of Family Planning

CCM Community Case Management

CDD Community Directed Distributor

CHC Community Health Committee

CHDC Community Health Development Committee

CHDD Community Health Department Director

CHEST Community Health Education Skill Training

CHSD Community Health Services Division

CHV Community Health Volunteer

CHFP Community Health Focal Person

CLTS Community Lead Total Sanitation

DHO District health officer

DOTS Direct Observed Treatment

ENA Essential Nutrition Action

EPI Expanded Program on Immunization

FP Family Planning

gCHV General Community Health Volunteers

EPHS Essential Package of Health Services

HBLSS Home based Life Saving Skills

HHP Household Health Promoters

HP Health promotion

HIV/AIDS Human Immune Virus/Acquired Immune Deficiency Syndrome

ITN Insecticide Treated Net

MCH Maternal & Child Health

MOHSW Ministry of Health and Social Welfare

MDG Millennium Development Goal

NGO Non-Governmental Organization

ORS Oral Rehydration Salt

NHPP National Health Plan and Policy

PS Peer Supervisor

TTM Trained Traditional Midwife

TM Traditional Midwife

RBHS Rebuilding Basic Health Services Project

UNICEF United Nations International Children Emergency Fund

WASH Water Sanitation and Hygiene

# Acknowledgements

The Community Health Services Division (CHSD) of the Ministry of Health and Social Welfare extends its sincere thanks and appreciation on behalf of the Department of Health Services to the Honorable Minister Dr. Walter T. Gwenigale and his deputies, in person of Dr. Bernice T. Dahn Deputy Minister and Chief Medical Officer, the Assistant Ministers for Preventive and Curative services, Hon. G. Tolbert Nyenswah and Dr. Saye Dahn Baawo for their support, leadership and oversight roles played during the planning and implementation of the entire exercise. The Division also recognizes the immense contributions of the HMIS Division, especially Mr. Luke Bawo in the development of the data collection tools and analysis of the data. Thanks also to the Community Health Volunteers and stakeholders who contributed their views. Many thanks and profound gratitude goes to all the programs of the MOHSW for their contribution as it relates to time and logistical support.

The guidance of the assessment staff and partners of the 88 health districts in the fifteen counties was crucial to the development of these activities. The Division is grateful to the entire community health services department and providers in the districts who have provided us with access to programmatic information and insights, especially the District Health Officers (DHOs) for their support.

The CHSD also thanks UNICEF and RBHS for technical assistance of this survey, as well as the Assessment Technical Working Group on Monitoring and Evaluation, consisting of Mentor Initiative, IRC, Clinton Health Access Initiative, CHSD (MOH), Mental Health (MOH), Merlin, MERCI, AHA, Africare, RBHS, Save the Children, for constructive inputs.

Special thanks go to the reviewers of this report: Dr. Bangboye M. Afolabi and Mr. Thomas K. Nagbe from the MOHSW, Dr. Theo Lippeveld and Mr. Bal Ram Bhui from RBHS.

# Executive Summary

The CHV mapping survey in Liberia was done in the period of November 2012 to February 2013 covering entire 88 health districts in 15 counties. The Community Health Division of MOHSW in collaboration with HMIS division and with funding from GAVI and technical assistance from UNICEF, RBHS and other partners conceived the survey methodology, developed tools and conducted the survey. Three data collection instruments namely 1) CHV profile form, 2) community profile form, and 3) community health focal person form were developed. The CHV profile collected data on location, training received, and logistics status of CHVs. The community profile form collected data on location of the communities, community health structures and their functionality, and the water, hygiene and sanitation situation in the community.

Survey training was done at all levels. 15 central MOHSW technical staff working in various ministry departments and divisions were trained at national level and worked as national survey coordinators assigned to a county. The national survey coordinators in their respective counties trained and mobilized the county team and district health officers, who then in turn trained health facility community health focal persons in the data collection. 401 facility community health focal persons collected the data by visiting CHVs and communities.

The survey enumerated 8,052 CHVs including 3,727 gCHVs, 2,856 TTMs, 586 TMs, 238 HHPs, and 645 CDDs. They were resident in 2,217 communities. Among the gCHVs, 79% were males and 21% were females. 96% of them had some level of education. However, among the gCHV with some level of education, only 19% were females. In terms of age of gCHVs, 34% are aged 18-34 years old while among TTMs, only 3% are of that age. 68% of gCHVs were elected by community. The survey found that 89% of gCHVs had received orientation during selection.

In terms of training received, 58% of gCHV ever got training in diarrhea prevention and case management, 30% got training in ARI case management and 65% in malaria case management. 30% and 17% of CHVs got training in CHEST Kit and in Journey of Hope kit respectively. Among the TTMs, 85% of them got an orientation of the job and 41% of them got training in HBLSS. gCHVs are supposed to receive certain gear and supplies to help them perform effectively. The survey showed that only about one third of them ever got bicycles, boots and raincoats. Most of them did not receive drugs for iCCM.

Besides information on communities with resident CHVs, the survey enumerated all communities irrespective of the fact that a CHV is residing in it or not. It was very important to reach all communities to know important characteristics of those communities as relevant to the community health program such as the population size and how far those communities are from nearest health facility, as well as presence of community structures and water, sanitation and hygiene situation in the communities. In total, 4,418 communities were enumerated in the 15 counties. Out of the 4,418 communities enumerated, the survey found that 57% of communities are 5km or more from the nearest health facility.

The national policy on gCHV to population ratio states that there should be one gCHV per 250 to 500 population. Using the survey data on population size and distance, an estimate of gCHVs requirement to cover the entire country has been worked out and compared to the current inventory of gCHV. Two estimation methods are presented. The first method recognizes the fact that there should be a differential gCHV/population ratio approach between accessible and remote areas. For remote areas, a population of 250 per gCHV is used and for accessible communities, a population of 500 per gCHV is used. The second method uses a general approach of 500 persons per gCHV irrespective of communities being accessible or remote.

Based on the first method, the country needs a total of 9,213 gCHVs of which 5,369 gCHVs would be needed for remote communities and 3,844 for accessible communities. Using the second method, 6,529 gCHVs are needed to cover entire country. Liberia has currently 3,727 functional gCHVs. However, the exact number of gCHVs required in counties will have to be determined by further work at the grassroots level to examine the sizes and spatial distribution of communities. Under either estimation method, there is a shortage of gCHVs to expand the community health in each corner of the country. The country needs from 2,902 to 5,486 additional gCHVs. The findings call for meticulous micro planning at grassroots level to get the appropriate number and distribution of gCHVs required to cover entire population with essential package of health at community level.

In terms of presence of community health structures in these communities, the survey found out that 54% have a CHC and 48% of them are aware of the existence of a facility based CHDC. Adequate sanitation and safe water and hygiene practices could help prevent a number of communicable diseases such as diarrhea. The survey found out that 58% of communities have a hand pump but only 50% have functional hand pumps. 42% of communities reported to have community latrine.

Based on the survey findings, two important recommendations for MOHSW and more specifically for the CHSD are (1) to define a community clearly so that it is applied by all counties in standard way; and (2) to fine tune the notion of gCHV catchment community so that one or more nearby communities can be assigned to a gCHV. The data collected as a part of this survey can be used further in grouping the communities to a number of gCHV catchment areas.

Other important recommendations are

* To establish and update a CHV database at all levels
* To improve the competence and functionality of gCHVs and TTMs by providing appropriate training, equipment and commodities
* To revitalize the community structures in each health facility catchment area
* To expand the community water, sanitation and hygiene program coverage

# INTRODUCTION

The Ministry of Health and Social Welfare has developed a ten year National Health Plan and Policy (2011-2021), and revised the Basic Health Package to the Essential Package of health Services (EPHS). The ten-year plan adapts the WHO health systems framework and includes seven building blocks: financing, governance and leadership, human resources, information systems, management and organization, medical products and technology, and network infrastructure. Decentralization and the primary health care (PHC) approach are used to achieve the goal and objectives of the policy and plan.

Community-based services are vital to the primary health care goal of achieving maximum participation in decision-making and focus on preventing common conditions, health promotion

and education, providing basic services that can be easily delivered in the community and linking communities to facility-based services. Community Health Activities are implemented using community health volunteers (CHVs).

In an effort to increase access to health promotion and case management, the Ministry of Health and Social Welfare through the Community Health Services Division (CHSD) developed a number of key documents to include the National Community Health Services Policy, the National Community Health Services Strategic Plan, Operational Guidelines for Community Health Committees (CHCs) and Community Health Development Committees (CHDCs), and General Community Health Volunteers (gCHVs) training modules for Diarrhea, Malaria, and ARI. Community case management (ICCM) is a strategy with broad global endorsement in which a health system trains, supplies and supervises front-line workers in communities to identify and treat children with common, serious infections: diarrhea, pneumonia and malaria. (*One Million Community Health Workers: Technical Task Force Report The Earth Institute: Colombia University 2011).*

Despite these strides, the division is faced with many challenges which include the lack of coordination of community health services program, limited functional community health structures, and many partners not adhering to the revised community health services policy and strategy when implementing community health activities. Furthermore, capacity building for Community Health Volunteers (CHVs), and the communities themselves, through awareness raising activities needs to be scaled up, thereby leading to behavioral change, and providing better access to prompt and evidence based treatment for endemic diseases. Currently, the conditions contributing the most to childhood mortality (malaria, ARIs and diarrhea) are only being treated at 59%, 70% and 53% respectively *(MOHSW, National Strategy for Child Survival in Liberia, 2008-11*). Only 60% of children with a fever or cough are taken to health facilities for treatment, meaning that others are dying without even having sought care (Liberia DHS, 2007). Chronic malnutrition is another major problem in Liberia, affecting more than 40% of children under 5.

In order to address the challenges mentioned above, it was prudent to do an assessment of community health program plans and implementation. As a first step, CHSD has conducted a comprehensive study in all health districts of Liberia to map CHVs and Community Structures. The outcome of this exercise will inform the division, partners and County Health Teams to properly plan and implement community health programs in Liberia that are community driven, cost effective and achievable.

# OBJECTIVES

The objective of the study was to conduct a comprehensive mapping and profiling of community health volunteers and mapping of community health structures to assess the implementation status of community health policy and strategies.

Specifically the Community Health Services Division conducted the assessment to achieve the following:

* Inventory of various community health cadres including general community health volunteers (gCHV) and Trained Traditional Midwifes (TTM).
* Understanding the socio demographic characteristics of CHVs.
* Inventory of training sessions offered to gCHVs and TTMs.
* Identification of community structures (CHC, CHDC) that support the delivery of community health activities.
* Establishment of CHV and communities database for support of community health program

# METHODOLOGY AND MATERIALS

The survey method is a census of all community health volunteers (CHVs) except the traditional midwives (TTMs) for which up to 3 TTM/TMs per community were included. The methodology was developed with technical assistance from HMIS/MOHSW, UNICEF and RBHS. All subjects were interviewed and a picture taken of gCHVs. The survey collected information on individual profile of CHV, on the communities they serve and on staff at health facility who provide support to CHVs-community health focal person.

## Materials

The survey used three tabular data forms: 1) CHV Profile Form, 2) Community Profile Form, and 3) Facility Community Health Focal Person for CHV. CHV profile form collects information on each and every CHV as to age, sex, education level, training received, and various gear and supplies received. The Community Profile Form collects information on each community enumerated as to population, and distance from facility, presence of community health committee, community health development committee, and water and hygine and sanitation situation. The third form collects information on name, title and contact phone number of community health focal person in the health facilities.

To facilitate the data entry in computer, MS Excel based Spreadsheets were developed and given to the survey coordinators. An instruction guide in support of each data collection form was developed in which the answer codes and other details were provided. The pre testing exercise was done in two districts (Careysburg and Todee) in Montserrado County, Liberia. The questionnaire was then finalized and printed after incorporating feedback from the pre-test exercise.

## Training survey workforce

The survey workforce included a group of national survey coordinators, all district health officers and one focal point in each facility in all 15 counties. A total of 88 DHOs and 401 health facility community health focal persons were trained.

The training of participants was done at three levels: national, county and district. At the national level, fifteen (15) staffs working in various central MOHSW offices were selected as national coordinators for the survey. They had a good level of prior knowledge and experience working with community health program. A 2-days training was provided to the survey coordinators on the use of the instruments (CHV profile, community profile and contacts) and supervision of the field work. They were also trained on the use of the PDA phones for picture profiling of gCHVs.

At the county level the National Coordinators in collaboration with the county Community Health Department Directors (CHDD) trained the District Health Officers (DHOs) in the use of the instruments and how to provide support to the health facility focal persons. DHOs were also trained to double check data submitted to them by the data collectors.

Lastly, the DHOs brought together all community health focal persons from each health facility at a location in their district for one day training in the use of the instrument, and how to cross-check the data before submission.

## Data Collection

Data collection took place mainly in December 2012. 401 functional health facilities as well as 4,418 communities were visited. The primary data collectors in this survey were the community health focal persons in the health facilities. In each facility catchment area, the data collector visited communities and interviewed CHC members or local leaders to collect information on community profile. Likewise, they met each CHV in person, took a picture, and collected information on the individual CHV profile. The data was collected by using the standard data collection forms and procedures. The national coordinator and district health officer supervised the data collection process. The data collector then submitted the data to DHO and the DHO, in turn, submitted all the facility data to the national survey coordinator in the county health office. The national coordinator compiled the data in the dedicated MS Excel Spreadsheet and forwarded it to HMIS director who compiled all county level data in a national database.

## Data entry and analysis

The data was entered in MS Excel Spreadsheet in each county. The county spreadsheet data was combined to form a national database. The final database included a data set for CHV profile, data set for community profile and data set of community health focal person at facility.

For data analysis, the MS Excel spreadsheet data was converted into pivot tables that allow a simple and easy aggregation of data. Additional calculations such as percentages/ratios or other measures included in this report were done as usual spreadsheet functions.

# FINDINGS

The CHV mapping survey in Liberia was done in the period of November 2012 to February 2013 covering entire 88 health districts in 15 counties. The findings reported here have been arranged under two main areas: (1) the Community Health Volunteers; and (2) the Community Health Structures. The report does not describe information on facility community health focal person because it will be used only in database.

# Community Health Volunteers

## Types of CHVs enumerated

Community Health Volunteers (CHVs) are the main providers of community health services in Liberia. Mostly, CHVs are members of the communities that they serve and are unpaid. They are knowledgeable about the cultural setting in which they work. They therefore can develop trusting, one-on-one relationships with consumers/clients and providers. The concept of using community members to render certain basic health services to the communities which they come has at least a 50-year history. (*Community health workers: What do we know about them? School of Public Health University of the Western Cape Lehmann U, Sanders, D (2007)*

The following cadres of Community Health Volunteers (CHVs) have been recognized by MOHSW to cover the community health activities stated in the Essential Package of Health Services (Revised National Community Health Services Policy 2011):

* General Community Health Volunteers (gCHVs)
* Trained Traditional Midwives (TTMs)
* Community Health Support Groups
	+ Household Health Promoters (HHPs)
	+ Community Directed Distributors (CDDs)
	+ Mass Drug Distributors (MDD)
	+ Community Based Distributors (CDBs)

CHVs have been recruited and trained by various entities. NGOs involved in community health services over the past several years have developed a number of new cadres in areas where they work- mostly limited to health promotion roles. Various vertical programs within the MOHSW have also implemented community level activities using community level volunteers or workers.

Since the focus of the community health program is on general Community Health Volunteers (gCHVs), the survey did a full census only of the gCHVs. Only up to 3 TTM/TMs were included per community due to time constraints. The Community Directed Distributor (CDD) is a special cadre who is involved in mass distribution of drugs. They are present in all counties. The Household Promoter (HPP) is a type of community volunteer found in Grand Cape Mount and Gbarpolu. This particular concept of volunteer was developed by MTI, one of the NGO partners supporting the counties. Some of the gCHVs are also community based distributors or other types of community volunteers. In this survey, CHVs were classified by his/her major volunteer status. For example, a CHV who is a gCHV as well as a CDD is listed as a gCHV.

A total of 8,052 CHVs were interviewed from 15 counties. The 8,052 CHVs interviewed included: 645 CDDs, 3,727 gCHVs, 238 HHP, 586 TM and 2,856 TTM (Table 1). The table shows that the distribution of various cadres by counties reflects the relative size and the urban/rural nature of the counties. For example, Nimba has the highest number of gCHVs as it is the second most populous county. Although, Monteserrado is the most populous county with the national capital, it has a relatively smaller number of gCHVs because the county is mostly urban and health care is highly accessible. Bong and Lofa are the next largest counties which have correspondingly high numbers of gCHVs. River Gee and Bomi have 84 and 97 gCHV and are the ones with least number of gCHVs.

|  |  |  |
| --- | --- | --- |
| **Table 1: Number of different types of CHVs enumerated** |  |  |
| **County** | **gCHV** | **TM** | **TTM** | **CDD** | **HHP** | **Grand Total** |
| Bomi | 97 | 8 | 59 | 5 | 6 | 175 |
| Bong | 367 | 9 | 945 | 150 | 0 | 1,471 |
| Gbarpolu | 110 | 0 | 39 | 0 | 43 | 192 |
| Grand Bassa | 291 | 340 | 145 | 68 | 9 | 853 |
| Grand Cape Mount | 238 | 0 | 88 | 115 | 179 | 620 |
| Grand Gedeh | 122 | 9 | 202 | 23 | 0 | 356 |
| Grand Kru | 112 | 0 | 104 | 17 | 0 | 233 |
| Lofa | 333 | 1 | 69 | 38 | 0 | 441 |
| Margibi | 287 | 0 | 0 | 13 | 0 | 300 |
| Maryland | 165 | 88 | 89 | 8 | 1 | 351 |
| Montserrado | 265 | 0 | 107 | 1 | 0 | 373 |
| Nimba | 887 | 81 | 624 | 20 | 0 | 1,612 |
| River Gee | 84 | 1 | 49 | 126 | 0 | 260 |
| Rivercess | 137 | 47 | 56 | 10 | 0 | 250 |
| Sinoe | 232 | 2 | 280 | 51 | 0 | 565 |
| Grand Total | 3,727 | 586 | 2,856 | 645 | 238 | 8,052 |

While the MOHSW currently recognizes the presence of various types of community health volunteers, the policy in the long run is to have the gCHVs and TTMs as the only designated community health volunteers. The remaining part of the analysis of this survey report will focus primarily on gCHVs and TTMs.

## gCHVs by gender

According to the National Community Health Services Policy 2011, both men and women are encouraged to become gCHVs. The results from our study found that male gCHVs far outnumber females; 79% of gCHV were Male compared to 21% female. This can be attributed to the 2008 National Community Health Services Policy that required a certain level of literacy as a prerequisite in order to qualify as a gCHV, meaning at least a 6th grade education. During the period of the implementation of the 2008 policy, many women did not have a 6th grade education. This became a barrier in the recruitment of female volunteers leading to the increased number of male workers presently serving as gCHVs in the community as seen by the findings. The 2011 revised National Community Health Services Policy has excluded education as one of the criteria. Therefore it is assumed that in the future, more female CHVs will be recruited.

Table 2 gives the breakdown of gCHVs by county and by gender. County wise variation shows that Montserrado, Nimba and Margibi counties have better proportion of female gCHVs with 37%, 35%, and 30% respectively.

|  |  |  |
| --- | --- | --- |
| **Table 2: gCHVs by gender** |  |  |
| **County** | **gCHV** |
| **Male** | **Female** | **Total** |
| Bomi | 91% | 9% | 97 |
| Bong | 89% | 11% | 367 |
| Gbarpolu | 85% | 15% | 110 |
| Grand Bassa | 80% | 20% | 291 |
| Grand Cape Mount | 82% | 18% | 238 |
| Grand Gedeh | 84% | 16% | 122 |
| Grand Kru | 91% | 9% | 112 |
| Lofa | 94% | 6% | 333 |
| Margibi | 70% | 30% | 287 |
| Maryland | 88% | 12% | 165 |
| Montserrado | 63% | 37% | 265 |
| Nimba | 65% | 35% | 887 |
| River Gee | 79% | 21% | 84 |
| Rivercess | 88% | 12% | 137 |
| Sinoe | 88% | 13% | 232 |
| Grand Total | 79% | 21% | 3,727 |

##

## **Education level of gCHV**

Table 3 shows the education level of gCHVs. Overall only four percent of gCHVs do not have any level of education. Ten percent of gCHV have an elementary level of education. One third of them have junior high school and 52% of them have senior high school level education. Among the gCHVs with some level of education, only 19% are females (compared to 21% in the total group of gCHVs), showing the lower levels of education of female gCHVs.

Findings from this study indicate that out of the 15 counties of the country, 6 (40%) counties do not have illiterate gCHVs. Nimba has substantially high proportion (11%) of illiterate gCHVs who are primarily women. A substantial proportion of gCHVs have senior high level of education in all counties. Margibi has 74% of gCHVs who have senior high school level education followed by Bomi with 72%. River Gee and Rivercess are remote counties which are also reflected in having lower proportion gCHVs having higher level of education.

|  |
| --- |
| **Table 3: Education levels of gCHVs by gender** |
| County | Total gCHV | Level of Education | gCHV with some level of education |
| None | Elementary | Junior High | Senior High | College | # of gCHV | Female | Male |
| Bomi | 97 | 2% | 2% | 20% | 72% | 4% | 95 | 8% | 92% |
| Bong | 367 | 1% | 4% | 34% | 60% | 1% | 363 | 11% | 89% |
| Gbarpolu | 110 | 0% | 11% | 28% | 61% | 0% | 110 | 15% | 85% |
| Grand Bassa | 291 | 0% | 14% | 41% | 40% | 5% | 290 | 20% | 80% |
| Grand Cape Mount | 238 | 1% | 11% | 30% | 57% | 2% | 235 | 18% | 82% |
| Grand Gedeh | 122 | 5% | 14% | 31% | 49% | 1% | 116 | 14% | 86% |
| Grand Kru | 112 | 0% | 11% | 49% | 40% | 0% | 112 | 9% | 91% |
| Lofa | 333 | 1% | 15% | 43% | 41% | 0% | 329 | 5% | 95% |
| Margibi | 287 | 0% | 9% | 13% | 74% | 5% | 287 | 30% | 70% |
| Maryland | 165 | 1% | 14% | 43% | 42% | 0% | 164 | 12% | 88% |
| Montserrado | 265 | 5% | 6% | 22% | 63% | 4% | 251 | 36% | 64% |
| Nimba | 887 | 11% | 6% | 29% | 54% | 0% | 788 | 27% | 73% |
| River Gee | 84 | 0% | 24% | 36% | 39% | 1% | 84 | 21% | 79% |
| Rivercess | 137 | 1% | 28% | 42% | 28% | 0% | 136 | 13% | 88% |
| Sinoe | 232 | 0% | 15% | 38% | 44% | 3% | 231 | 13% | 87% |
| Grand Total | 3,727 | 4% | 10% | 32% | 52% | 2% |  3,591  | 19% | 81% |

The education and gender characteristics of gCHV population have implications on motivation and attrition of gCHVs. The former national community health policy required higher level of education to be a gCHV. As a result more men who have higher levels of education compared to women were recruited as gCHVs. Since most of gCHV have a good level of education and are mostly males, they could more easily get a paid job in formal or informal sector. It was learnt that many male gCHVs had high expectations that as a gCHV they would receive a good monetary compensation. This most likely explains the high rate of attrition of gCHVs. As a matter of fact, the MOHSW gCHV program is purely a volunteer program. In the recently revised policy, the requirement on education has been relaxed so as to attract more women to become gCHV.

## Age distribution of gCHVs and TTMs

The Government of Liberia has laws to protect children from the worst forms of child labor. It is unlawful for any person to employ or hire any under age child during the hours when he or she is required to attend school in any portion of any month when school is in session (Government of Liberia, Labor Law (Title 18 and 184). (1956), section 74). Therefore the Community Health Services only accept CHVs who are 18 years of age and above.

The age of gCHVs and TTMs are grouped in two age groups (18-34 years and 35+ years) to reflect young or older CHV population (Table 4). Two-thirds of gCHVs are in upper age bracket. Among the TTM, 97% of them are in upper age bracket. For a TTM to be recognized in the community, one needs a lot of experience and therefore an older age.

The age variation in counties shows that counties namely Grand Cape Mount, Montserrado, Margibi and Grand Bassa have close to 50% of gCHVs in lower age groups.

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 4: Age distribution of gCHV and TTM** |  |  |  |
| **County** | **gCHV** | **TTM** |
| **18-34** | **35+** | **Total** | **18-34** | **35+** | **Total** |
| Bomi | 40% | 60% | 97 | 3% | 97% | 59 |
| Bong | 20% | 80% | 367 | 2% | 98% | 945 |
| Gbarpolu | 35% | 65% | 110 | 5% | 95% | 39 |
| Grand Bassa | 43% | 57% | 291 | 4% | 96% | 145 |
| Grand Cape Mount | 50% | 50% | 238 | 6% | 94% | 88 |
| Grand Gedeh | 35% | 65% | 122 | 3% | 97% | 202 |
| Grand Kru | 25% | 75% | 112 | 3% | 97% | 104 |
| Lofa | 41% | 59% | 333 | 4% | 96% | 69 |
| Margibi | 47% | 53% | 287 |  |  | 0 |
| Maryland | 30% | 70% | 165 | 10% | 90% | 89 |
| Montserrado | 50% | 50% | 265 | 5% | 95% | 107 |
| Nimba | 26% | 74% | 887 | 3% | 97% | 624 |
| River Gee | 20% | 80% | 84 | 4% | 96% | 49 |
| Rivercess | 34% | 66% | 137 | 4% | 96% | 56 |
| Sinoe | 31% | 69% | 232 | 4% | 96% | 280 |
| Grand Total | 34% | 66% | 3,727 | 3% | 97% | 2,856 |

## Distribution of CHVs by year of selection

The distribution of gCHVs by year of selection was analyzed in 3 categories: (1) before 2000; (2) between 2000-2009; and (3) 2010 to 2013. The study found that the majority of gCHV (59%) were selected during the period of 2010-2013.

The study also showed that majority of TTMs (59%) began serving their communities during the period of 2000-2009. It shows that the TTM program scale up started earlier than the gCHV program.

|  |
| --- |
| **Table 5: Distribution of selection of CHVs by period of years** |
|  | **gCHV** | **TTMs** |
| **County** | **before 2000** | **2000-2009** | **2010-2013** | **# gCHV** | **before 2000** | **2000-2009** | **2010-2013** | **# TTM** |
| Bomi | 1% | 49% | 49% | 97 | 22% | 64% | 14% | 59 |
| Bong | 1% | 59% | 39% | 367 | 29% | 59% | 12% | 945 |
| Gbarpolu | 0% | 0% | 100% | 110 | 0% | 15% | 85% | 39 |
| Grand Bassa | 3% | 54% | 43% | 291 | 34% | 57% | 9% | 145 |
| Grand Cape Mount | 0% | 17% | 83% | 238 | 10% | 67% | 23% | 88 |
| Grand Gedeh | 2% | 57% | 41% | 122 | 13% | 77% | 10% | 202 |
| Grand Kru | 0% | 1% | 99% | 112 | 0% | 60% | 40% | 104 |
| Lofa | 1% | 34% | 65% | 333 | 17% | 75% | 7% | 69 |
| Margibi | 1% | 32% | 67% | 287 |   |   |   | 0 |
| Maryland | 0% | 20% | 80% | 165 | 6% | 71% | 24% | 89 |
| Montserrado | 1% | 18% | 81% | 265 | 32% | 24% | 44% | 107 |
| Nimba | 13% | 48% | 40% | 887 | 30% | 66% | 3% | 624 |
| River Gee | 1% | 42% | 57% | 84 | 2% | 33% | 65% | 49 |
| Rivercess | 0% | 9% | 91% | 137 | 16% | 23% | 61% | 56 |
| Sinoe | 0% | 41% | 59% | 232 | 2% | 47% | 51% | 280 |
| Grand Total | 4% | 37% | 59% | 3,727 | 22% | 59% | 19% | 2,856 |

## Method of selection of gCHV by counties.

The Community Health Services Policy states, inter alia, that CHVs should always be chosen from the communities they will serve and that communities should have a say in the selection of their CHVs. This is a non-negotiable decision in that neither health nor other officials should make this choice.

Findings from this study show that 68% of gCHVs in all 15 counties were elected according to the Community Health Services policy, while members of the community appointed 32% (Table 6). Looking at county variation gives mixed findings. 6 of 15 counties have over 80% of gCHVs who were elected. They include Sinoe (100%), Gbarpolu (88%), Grand Kru (88%), Montserrado (86%) and Lofa and Margibi with 84%. Some of counties that have low % of gCHVs selected by election are Grand Cape Mount (8%), River Gee (18%), and Grand Bassa (22%). The finding clearly shows that the policy is not adhered during selection of gCHVs. While the policy of selecting/ electing CHVs from local communities is widely accepted, not all communities had direct and meaningful participation in the selection process. This could be due to the fact that community health structures such as CHC and CHDCs are not strong and functional.

|  |  |
| --- | --- |
| **Table 6: Methods of selection of gCHVs** |  |
|  | **gCHVs** |
| **County** | **Appointed** | **Elected** | **Total** |
| Bomi | 57% | 43% | 97 |
| Bong | 36% | 64% | 367 |
| Gbarpolu | 12% | 88% | 110 |
| Grand Bassa | 78% | 22% | 291 |
| Grand Cape Mount | 92% | 8% | 238 |
| Grand Gedeh | 29% | 71% | 122 |
| Grand Kru | 12% | 88% | 112 |
| Lofa | 31% | 69% | 333 |
| Margibi | 16% | 84% | 287 |
| Maryland | 16% | 84% | 165 |
| Montserrado | 13% | 86% | 265 |
| Nimba | 17% | 83% | 887 |
| River Gee | 82% | 18% | 84 |
| Rivercess | 45% | 55% | 137 |
| Sinoe | 0% | 100% | 232 |
| Grand Total | 32% | 68% | 3,727 |

## Training received by general Community Health Volunteers (gCHVs)

General Community Health Volunteers (gCHVs) are provided training on various areas of health that they need to know for the provision of adequate and appropriate health services at community level. The gCHVs received training sessions on preventive and curative health services. They were also trained on health promotion and behavioral change. The Community Health Policy recommends training of gCHVs in far flung areas (more than 5km from a health facility) on some of curative services such as diarrhea, pneumonia and malaria. This Policy is in line with WHO/UNICEF joint statement about Integrated Community Case Management, that the correct treatment of childhood pneumona, diarrhea and malaria is one of the most powerful intervention to reduce mortality. The training package given to the gCHVs also includes other technical areas.

The findings from the survey showed that 89% of gCHV had orientation during their selection process as gCHV in the community. The process of selecting gCHVs involves community meetings, getting nominations and informing the community and the aspirant gCHVs on community health and their roles.

Otherwise, the findings from the study revealed that 65% of gCHV received malaria case management training while, 58% received diarrhea case management training and 30% received ARI training. While the survey documented the various case management training sessions given to the gCHVs, many of them are not really practicing case management, mainly because of the poor quality of the training and also because no treatment drugs are available.

General Community Health Volunteers (gCHVs) are expected to contribute to improved nutritional status of women and children in the community through identification, counseling and referral. Currently, only 29% of gCHVs received ENA training. The Essential Nutrition Action (ENA) program puts emphasis on nutrition for pregnant women and children under two.

One of the most important tasks of gCHVs is health promotion and behavioral change. The CHEST Kit (community health education skills training) is a health education tool kit with job aids that gCHVs can use in giving health knowledge. The tool kit covers all preventive and health promotion issues. The Journey of Hope Kit is a health education kit on HIV/AIDS. Table 7 indicates that only 20% and 17% of gCHVs are trained in CHEST Kit and Journey of Hope respectively. The training coverage is quite low because most of the counties have not provided this training.

The responsibility of gCHVs includes provision of various sexual and reproductive health services to women of child-bearing age. The gCHVs provides counseling on family planning (FP), distributes condoms, re-supplies pills and provides other support as appropriate. Table 7 shows that only 37% of gCHV have so far been trained on FP awareness and only 17% of them were trained on community-based distribution of contraceptives. A total of 72% of gCHVs have been trained in Mass Drugs Distribution such as Vitamin A, Ivermetin, and de-worming campaigns.

The table also provides the training status by counties. As can be seen, counties differ in percentage of gCHVs having received training in various functional areas. As for the ARI case management training, Bomi, Grand Bassa, Grand Gedeh, Maryland have less than 5% of gCHV trained. A number of counties such as Bomi, Grand Bassa, Grand Gedeh, Grand Kru, Maryland, Rivercess and Sinoe have not trained gCHVs in CHEST Kit and Journey of Hope.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 7: Percentage of gCHVs who have been trained on various subjects** |  |  |  |  |  |  |  |  |  |  |
| County | **Number of gCHV** | **Percentage of gCHVs who got training in** |
| **Orientation** | **Diarrhea-CCM** | **ARI-CCM** | **Malaria-CCM** | **ENA** | **HBLSS** | **Fistula** | **CBD-FP** | **FP Awareness** | **DOTS** | **CLTS** | **WASH** | **Journey of Hope** | **CHEST Kit** | **Mass Drugs Distribution** |
| Bomi | 97 | 95% | 80% | 1% | 62% | 66% | 5% | 0% | 35% | 74% | 1% | 12% | 56% | 0% | 0% | 30% |
| Bong | 367 | 91% | 73% | 54% | 77% | 62% | 5% | 5% | 20% | 34% | 24% | 19% | 18% | 22% | 35% | 75% |
| Gbarpolu | 110 | 100% | 99% | 99% | 99% | 59% | 19% | 12% | 47% | 60% | 71% | 83% | 73% | 16% | 22% | 95% |
| Grand Bassa | 291 | 85% | 46% | 1% | 51% | 2% | 0% | 8% | 2% | 18% | 2% | 5% | 36% | 0% | 1% | 67% |
| Grand Cape Mount | 238 | 57% | 43% | 44% | 36% | 16% | 13% | 13% | 29% | 33% | 36% | 10% | 17% | 37% | 39% | 53% |
| Grand Gedeh | 122 | 89% | 61% | 2% | 47% | 48% | 2% | 2% | 16% | 34% | 8% | 2% | 14% | 0% | 1% | 68% |
| Grand Kru | 112 | 79% | 46% | 46% | 69% | 0% | 0% | 0% | 35% | 69% | 26% | 0% | 9% | 0% | 0% | 91% |
| Lofa | 333 | 93% | 67% | 36% | 41% | 15% | 15% | 2% | 20% | 54% | 15% | 26% | 46% | 20% | 28% | 85% |
| Margibi | 287 | 88% | 26% | 18% | 63% | 12% | 15% | 2% | 14% | 35% | 7% | 5% | 32% | 16% | 14% | 82% |
| Maryland | 165 | 51% | 5% | 5% | 64% | 1% | 5% | 2% | 8% | 13% | 5% | 7% | 18% | 0% | 2% | 66% |
| Montserrado | 265 | 95% | 43% | 7% | 50% | 9% | 4% | 3% | 17% | 47% | 18% | 9% | 20% | 8% | 8% | 55% |
| Nimba | 887 | 96% | 72% | 20% | 76% | 54% | 2% | 1% | 10% | 26% | 4% | 14% | 15% | 35% | 34% | 75% |
| River Gee | 84 | 95% | 67% | 61% | 52% | 51% | 5% | 0% | 45% | 65% | 6% | 30% | 18% | 15% | 46% | 35% |
| Rivercess | 137 | 97% | 41% | 39% | 86% | 0% | 0% | 1% | 3% | 39% | 1% | 0% | 28% | 0% | 1% | 72% |
| Sinoe | 232 | 100% | 76% | 76% | 97% | 0% | 1% | 0% | 23% | 39% | 21% | 13% | 27% | 0% | 0% | 92% |
| Grand Total | 3,727 | 89% | 58% | 30% | 65% | 29% | 6% | 3% | 17% | 37% | 14% | 14% | 25% | 17% | 20% | **72%** |

## Training received by TTMs

The survey collected information on various training sessions received by trained traditional midwives (TTMs) in the communities. Table 8 shows that 85% of TTMs received formal community orientation. The primary job of trained traditional midwives (TTMs) is to help pregnant women in the community to seek antenatal care at the health facility, plan for the delivery of the baby in health facility, and refer or accompany pregnant women to the health facility in case of obstetric emergencies. She should be knowledgeable in identification of emergency signs and symptoms during pregnancy, labor and after birth. Home Based Life Saving Skills (HBLSS) training is designed for TTMs to perform their duties diligently and most appropriately. In all, only 41% of TTMs have received any form of training in HBLSS with Rivercess county having the highest percentage (91%) followed by Bomi county at 68%. Only Grand Kru did not record any TTM trained in HBLSS while Maryland, Montserrado, Gbarpolu, Grand Kru and River Gee recorded very low percentages of trained TTMs in this regard. Fistula is an obstetrical complication primarily found among women who deliver at home. For this reason, training TTMs on prevention of fistula is important. However, as shown in Table 8, only 10% of TTMs have been trained on fistula prevention.

One other responsibility of TTMs is promotion of adequate antenatal and postnatal nutrition of mothers, as well as encouraging postpartum women to initiate baby’s breastfeeding immediately after delivery and exclusively for the next six months. Despite its importance, only 10% of TTMs have been trained in ENA in all the counties with River Gee having the highest percentage (39%) of trained TTMs and 5 counties – Grand Bassa, Grand Kru, Maryland, Rivercess and Sinoe - not having trained TTMs in ENA. Another vital function of the TTMs is to educate women on postpartum contraception and provide adequate support for them. However, only 24% of TTMs received training in FP awareness, ranging from 64% in Grand Kru county to 2% in Nimba and 0% in Maryland counties.

These findings raise pertinent questions regarding the minimum training package that TTMs should receive.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 8: Percentage of TTMs who are trained on various training** |  |  |  |  |  |  |  |  |  |  |
| County | **Number of TTMs** | **Percentage of TTMs who got training in** |
| **Orientation** | **HBLSS** | **Fistula** | **CBD-FP** | **FP Awareness** | **ENA** | **Diarrhea-CCM** | **ARI-CCM** | **Malaria-CCM** | **DOTS** | **CLTS** | **WASH** | **Journey of Hope** | **CHEST Kit** | **Mass Drugs Distribution** |
| Bomi | 59 | 88% | 68% | 5% | 2% | 63% | 14% | 17% | 5% | 8% | 0% | 8% | 5% | 0% | 0% | 0% |
| Bong | 945 | 82% | 37% | 15% | 3% | 19% | 12% | 7% | 1% | 4% | 2% | 7% | 6% | 1% | 0% | 3% |
| Gbarpolu | 39 | 72% | 3% | 0% | 8% | 8% | 3% | 0% | 0% | 0% | 3% | 3% | 8% | 0% | 0% | 0% |
| Grand Bassa | 145 | 79% | 55% | 13% | 0% | 30% | 0% | 6% | 0% | 6% | 0% | 0% | 17% | 0% | 0% | 17% |
| Grand Cape Mount | 88 | 73% | 42% | 0% | 2% | 9% | 3% | 13% | 7% | 8% | 2% | 0% | 2% | 0% | 0% | 18% |
| Grand Gedeh | 202 | 82% | 48% | 1% | 11% | 37% | 3% | 12% | 0% | 42% | 3% | 1% | 7% | 0% | 0% | 1% |
| Grand Kru | 104 | 79% | 0% | 0% | 32% | 64% | 0% | 44% | 44% | 64% | 17% | 0% | 13% | 0% | 0% | 88% |
| Lofa | 69 | 83% | 19% | 6% | 29% | 54% | 3% | 4% | 0% | 4% | 1% | 10% | 14% | 1% | 22% | 29% |
| Maryland | 89 | 28% | 9% | 0% | 0% | 0% | 0% | 0% | 1% | 7% | 0% | 0% | 2% | 0% | 0% | 10% |
| Montserrado | 107 | 75% | 9% | 8% | 21% | 28% | 15% | 31% | 13% | 30% | 17% | 12% | 17% | 8% | 7% | 21% |
| Nimba | 624 | 96% | 50% | 17% | 0% | 2% | 17% | 9% | 1% | 8% | 0% | 0% | 0% | 1% | 0% | 5% |
| River Gee | 49 | 98% | 10% | 6% | 8% | 35% | 39% | 27% | 10% | 22% | 2% | 22% | 4% | 8% | 2% | 10% |
| Rivercess | 56 | 86% | 91% | 0% | 0% | 14% | 0% | 0% | 0% | 11% | 0% | 0% | 2% | 0% | 0% | 7% |
| Sinoe | 280 | 99% | 59% | 0% | 11% | 56% | 0% | 20% | 18% | 25% | 1% | 7% | 7% | 0% | 0% | 3% |
| Grand Total | 2856 | 85% | 41% | 10% | 6% | 24% | 10% | 11% | 5% | 14% | 2% | 5% | 6% | 1% | 1% | 9% |

## Various gear and supplies received by gCHVs

The national community health policy recommends that gCHVs are provided with a set of essential work gears, drugs and supplies as well as tools to perform their work efficiently. Table 9 illustrates responses from interviewed gCHVs on commodities, tools and drugs supplied to them to perform their duties efficiently after they have been recognized and chosen. Out of the 3,727 gCHVs that were interviewed, only 32% reported receiving a bicycle each. Grand Bassa reported only 2% of gCHV receiving a bicycle while Gbarpolu reported the highest figure (97%) on this indicator. This signifies that the majority of gCHVs walk to communities they serve or to the health facilities. The study also found that 48% of gCHVs reported receiving backpacks and one-third receiving boots and raincoats, indicating that only about one third of gCHVs ever got their essential gear that will help them reach out in their catchment communities.

In addition, the gCHVs were asked if they received the necessary drugs or tools to aid case management. Only 21% and 24% of the interviewed gCHVs received an ORS set and ARI Timer respectively. This shows that even though many gCHVs were trained in case management of diarrhea and ARI, majority of them did not receive the necessary drugs and tools to treat patients. No information has been obtained on receiving drugs such as Cotrimoxazole and ACTs.

|  |
| --- |
| **Table 9: Status of ever receiving of various gear and supplies by gCHVs** |
| **County** |  | **Number of gCHVs who have** |
| **Number of gCHVs** | **Bicycle** | **Boots** | **Raincoat** | **Vest** | **Ledger** | **Backpack** | **ORT Set** | **ARI Timer** |
| Bomi | 97 | 42% | 0% | 0% | 62% | 65% | 45% | 9% | 0% |
| Bong | 367 | 30% | 13% | 29% | 61% | 72% | 65% | 35% | 47% |
| Gbarpolu | 110 | 97% | 97% | 97% | 99% | 99% | 97% | 83% | 98% |
| Grand Bassa | 291 | 2% | 2% | 2% | 8% | 9% | 20% | 2% | 0% |
| Grand Cape Mount | 238 | 26% | 26% | 29% | 12% | 29% | 25% | 16% | 32% |
| Grand Gedeh | 122 | 46% | 8% | 6% | 31% | 22% | 21% | 19% | 2% |
| Grand Kru | 112 | 35% | 46% | 46% | 46% | 46% | 38% | 46% | 46% |
| Lofa | 333 | 28% | 54% | 55% | 57% | 63% | 63% | 18% | 28% |
| Margibi | 287 | 15% | 28% | 28% | 23% | 29% | 18% | 10% | 9% |
| Maryland | 165 | 41% | 50% | 44% | 4% | 48% | 35% | 2% | 2% |
| Montserrado | 265 | 19% | 35% | 36% | 38% | 35% | 25% | 8% | 2% |
| Nimba | 887 | 35% | 33% | 34% | 43% | 68% | 65% | 16% | 13% |
| River Gee | 84 | 38% | 21% | 26% | 60% | 67% | 58% | 19% | 60% |
| Rivercess | 137 | 35% | 35% | 35% | 40% | 45% | 37% | 23% | 31% |
| Sinoe | 232 | 59% | 66% | 67% | 61% | 70% | 67% | 55% | 61% |
| Grand Total | 3,727 | 32% | 33% | 35% | 41% | 53% | 48% | 21% | 24% |

## gCHV community coverage

The survey identified 2,217 communities in all 15 counties with a resident CHV who could be a gCHV, TTM, TM, CDD. Table 10 gives the information on distribution of gCHVs in these communities. The distribution of the gCHVs is such that 1,254 (57%) communities have one (1) gCHV each, while 616 (28%) communities had 2 or more gCHVs each. Findings from this survey lead to some pertinent questions as to why more than one fourth of communities have more than one gCHV. Otherwise, 15% of communities had no resident gCHV. This may be due to the fact that some of the gCHVs who are resident in other nearby communities could be serving in adjacent communities.

The findings by county are interesting. The counties that have higher percentage of communities with no resident gCHV have lower percentage of communities with more than one gCHV. Otherwise, counties that have lower percentage of communities with no resident gCHV have higher percentage of communities with more than one gCHV. The findings suggest clustering of gCHVs in number of counties such as Bomi, Margibi, Grand Cape Mount, Grand Gedeh, Maryland and Rivercess. These findings probably are related to the size and number of communities. Sinoe and Grand Bassa seem to have smaller communities and perhaps sparsely populated and therefore reported more communities with no resident and fewer communities with more than one gCHV. Bomi and Margibi communities appear to be larger and fewer and therefore have more communities with more than one gCHV.

|  |  |  |
| --- | --- | --- |
| **Table 10: Distribution of gCHVs and TTMs by communities** |  |  |
| **County** | **Total community** | **gCHVs** |
| **# of communities with no gCHV** | **# of communities with 1 gCHV** | **# of communities with 2 or more gCHVs** |
| Bomi | 35 | 0% | 43% | 57% |
| Bong | 346 | 8% | 80% | 12% |
| Gbarpolu | 99 | 9% | 74% | 17% |
| Grand Bassa | 318 | 31% | 51% | 18% |
| Grand cape mount | 35 | 3% | 9% | 89% |
| Grand Gedeh | 104 | 4% | 81% | 15% |
| Grand Kru | 123 | 18% | 75% | 7% |
| Lofa | 108 | 12% | 35% | 53% |
| Margibi | 23 | 0% | 0% | 100% |
| Maryland | 129 | 4% | 71% | 26% |
| Montserrado | 162 | 9% | 57% | 34% |
| Nimba | 389 | 9% | 40% | 52% |
| River Gee | 20 | 10% | 10% | 80% |
| Rivercess | 60 | 3% | 63% | 33% |
| Sinoe | 266 | 40% | 49% | 11% |
| Total | 2,217 | 15% | 57% | 28% |

This raises questions as to what extent the definition of a community is standardized across the counties. A definition has to be worked out that is applicable for all counties. As data showed, there are a substantial number of large communities that need more than one gCHV, based on the minimum gCHV-population ratio.

## Estimation of number of gCHVs required as per policy

Besides information on communities with resident CHVs as in table 10, the survey tried to enumerate all communities irrespective of the fact that a CHV is present in it or not. It was very important to get to all communities to know important characteristics of those communities such as the population size and how far those communities were from the nearest health facility, the presence of functional community structures, and water, sanitation and hygiene situations in the community. 4,418 such communities of varying sizes were enumerated in the 15 counties. This information helped to understand the current level of gCHV-population coverage and to project the number of gCHV required to ensure the full coverage of community health interventions.

Table 11 shows the distribution of these 4,418 communities by population size in remote and accessible areas. The national policy recognized two categories of communities in terms of their accessibility to the nearest health facility. One set of communities are within 5 km distance from the nearest health facility. These communities are considered to be “accessible” to health services. The other set of communities are 5 km or more from the nearest health facility. The latter are referred to as “remote’ communities. The survey identified the enumerated communities by “within 5km” or “5 km or more”. The 4,418 communities cover a total population of 3,264,302. Of this 2,530 (57%) communities are located in remote areas while a total of 1,888 (43%) communities are located in accessible areas. The set of remote areas covers a population of 1,342,215 and those accessible ones covers a population of 1,922,087.

There are communities as small as having less than 50 people in both areas. In remote areas, 49% of communities have population size less than 250 people while in accessible areas only 40% of communities have similar population size. However, if the total population covered is examined, this category in remote areas covers 10% of the population while in accessible areas it is 4%, which suggest that remote communities could really be smaller and sparsely distributed. Looking at the population size 500 plus, 33% of communities this size are in remote areas and they cover 79% of the population, while 43% of communities that size are in accessible areas and cover 91% of population. This shows that accessible communities are larger and more clustered than the ones in remote areas. But it is obvious that even in remote areas; there are a substantial number of larger communities for which a gCHV could serve more people.

|  |  |  |
| --- | --- | --- |
| **Table 11: Distribution of communities by population size, distance from facility and population covered** |  |  |
|  | **Communities 5km or far from facility** | **Communities within 5 km from facility** | **Total** |
| **Population size** | **# of communities** | **% communities** | **Population** | **Population %** | **# of communities** | **% communities** | **Population** | **Population %** | **# of communities** | **% communities** | **Population** | **Population %** |
| <50 |  356  | 14% |  8,938  | 1% |  213  | 11% |  5,512  | 0% |  569  | 13% |  14,450  | 0% |
| 50-99 |  318  | 13% |  23,426  | 2% |  212  | 11% |  15,631  | 1% |  530  | 12% |  39,057  | 1% |
| 100-249 |  559  | 22% |  89,046  | 7% |  347  | 18% |  56,368  | 3% |  906  | 21% |  145,414  | 4% |
| 250-499 |  454  | 18% |  162,803  | 12% |  312  | 17% |  111,210  | 6% |  766  | 17% |  274,013  | 8% |
| 500-999 |  437  | 17% |  311,136  | 23% |  335  | 18% |  240,546  | 13% |  772  | 17% |  551,682  | 17% |
| 1000+ |  406  | 16% |  746,866  | 56% |  469  | 25% |  1,492,820  | 78% |  875  | 20% |  2,239,686  | 69% |
| Grand Total |  2,530  |   |  1,342,215  |   |  1,888  |   |  1,922,087  |   | 4,418  |   |  3,264,302  |   |

Table 12 shows an estimation of the number of gCHVs required to cover the entire country for community health as per the national community health policy of Liberia. The national policy on gCHV to population ratio states that there should be one gCHV per 250 to 500 population. This suggests that in remote areas and sparsely populated areas, a gCHV could serve communities as small as 250 people.

Concerning the estimated number of gCHVs for the country, two methods are presented. The first method recognizes the fact that there should be different gCHV/population ratios between accessible and remote areas. For remote areas, a population of 250 per gCHV is used. For accessible communities, a population of 500 per gCHV is used. The second method uses a general approach of 500 persons per gCHV irrespective of accessible or remote communities.

Based on the first method, the country needs a total of 9,213 gCHVs of which 5,369 gCHVs would be needed for remote communities and 3,844 for accessible communities. Using the second method, the conservative method of one gCHV for a population of 500, 6,529 gCHVs are needed to cover the entire country. The number of gCHVs required by county is related to the size and proportion of remote and accessible communities of a county (see table 12).

Liberia has currently 3,727 functional gCHVs. In either scenario of estimation, there is a shortage of gCHVs to expand the community health to each corner of the country. Considering the differential gCHV/population ratio approach for remote and accessible communities, an additional 5,486 gCHV will be needed, and if a general approach of one gCHV for 500 population is used, an additional 2,802 gCHVs will be needed. However, the exact number gCHVs required in counties will have to be determined by further work at the grassroots level to examine the sizes and spatial distribution of communities. Even though 57% of communities are reported to be remote, some of the communities could be so large that the gCHV/Population ratio of 1/500 can be used instead of 1/250.

The findings of this survey call for meticulous micro planning at grassroots level to determine the number and distribution of gCHVs required to cover the whole population with an essential package of health at community level. It is important to make sure that gCHVs are not clustered into one location. Two important recommendations for the MOHSW are pertinent based on the survey findings. First is to define a community in clear terms so that it is applied in all counties in community health mapping. The second is to come up with a standard for gCHV catchment community/population area. In addition, community mapping can use Geographic Information System (GIS) maps and social mapping to group communities and assign gCHVs to them. This will make sure each health facility will have adequate number of gCHVs and they are strategically placed in various locations so as to cover all communities and populations.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 12: Estimation of gCHV requirement based on population to be covered by a CHV** |  |  |  |  |
|  | **Method I: Using different gCHV/population ratio for accessible and in-accessible communities** | **Total population of communities enumerated** | **Method II: Using 1gCHV/500 population** | **Number of gCHV already working** | **Additional gCHV needed for county based on method I** | **Additional gCHV needed for county based on method II** |
| **County** | **Communities that are 5km or more from health facility** | **Communities within 5km of health facility** | **Estimated number of gCHV required for county** |
| **Total Population** | **# of gCHV needed at 1 gCHV/250 population** | **Total Population** | **# of gCHV needed at 1 gCHV/500 pop** |
| Bomi |  39,358  |  157  |  37,002  |  74  |  231  |  76,360  |  153  |  97  |  134  |  56  |
| Bong |  225,797  |  903  |  161,370  |  323  |  1,226  |  387,167  |  774  |  367  |  859  |  407  |
| Gbarpolu |  59,974  |  240  |  15,527  |  31  |  271  |  75,501  |  151  |  110  |  161  |  41  |
| Grand Bassa |  169,869  |  679  |  108,204  |  216  |  896  |  278,073  |  556  |  291  |  605  |  265  |
| Grand Cape Mount |  30,152  |  121  |  20,930  |  42  |  162  |  51,082  |  102  |  238  | - 76  | - 136  |
| Grand Gedeh |  47,289  |  189  |  52,582  |  105  |  294  |  99,871  |  200  |  122  |  172  |  78  |
| Grand Kru |  16,934  |  68  |  37,786  |  76  |  143  |  54,720  |  109  |  112  |  31  | - 3  |
| Lofa |  90,652  |  363  |  112,360  |  225  |  587  |  203,012  |  406  |  333  |  254  |  73  |
| Margibi |  101,150  |  405  |  93,593  |  187  |  592  |  194,743  |  389  |  287  |  305  |  102  |
| Maryland |  46,726  |  187  |  96,424  |  193  |  380  |  143,150  |  286  |  165  |  215  |  121  |
| Montserrado |  114,713  |  459  |  715,247  |  1,430  |  1,889  |  829,960  |  1,660  |  265  |  1,624  |  1,395  |
| Nimba |  282,643  |  1,131  |  327,295  |  655  |  1,785  |  609,938  | 1,220  |  887  |  898  |  333  |
| River Gee |  26,600  |  106  |  47,175  |  94  |  201  |  73,775  |  148  |  84  |  117  |  64  |
| Rivercess |  44,869  |  179  |  23,059  |  46  |  226  |  67,928  |  136  |  137  |  89  | - 1  |
| Sinoe |  45,489  |  182  |  73,533  |  147  |  329  |  119,022  |  238  |  232  |  97  |  6  |
| Grand Total |  1,342,215  |  5,369  |  1,922,087  |  3,844  |  9,213  |  3,264,302  | 6,529  |  3,727  |  5,486  |  2,802  |
|  |  |  |

# Community Health Structures

As pointed out earlier, the survey tried to enumerate all communities irrespective of the fact that CHV is present in it. This was not only important to measure coverage of the communities, but also to examine the presence of community structures and their functionality, as well as the water, sanitation and hygiene situation in the community. 4,418 communities of varying sizes and locations were enumerated.

## Distribution of enumerated communities by distance from health facility

According to Liberia Demographic and Health Survey (DHS) 2007, 41% of the Liberian population have access to basic health services. As part of the health sector reform, CHSD was re-organized to increase access to basic health services at the community level. In doing this, CHSD coordinates and collaborates with County Health Teams and partners to scale up community health activities in the counties. The overall goal of CHSD is to improve the health and social welfare status of the population of Liberia on an equitable basis at community level. The goal of CHSD is to increase access to all communities, by providing out-reach services, health promotion and referral services through case management to communities that are 1 hour (5km) away from health facility.

Therefore, this survey was designed to investigate the number of communities that are currently more than 1 hour walk (5km) from the nearest health facility.

The study found that out of the total of 4,418 communities assessed in the 15 counties, a significant proportion (57%) are more than 1 hour or more than 5 km walk from the nearest health facility. The study also shows that 79% of communities in Grand Cape Mount are 1 hour or more than 5 km away from the nearest health facility, compared to 25% in Grand Kru.

|  |
| --- |
| **Table 13: Distribution of enumerated communities by distance from health facility** |
|  | **# of communities** |  |
| **County** | **5km or more from facility** | **within 5km from facility** | **Total communities** |
| Bomi | 59% | 41% | 410 |
| Bong | 65% | 35% | 499 |
| Gbarpolu | 59% | 41% | 128 |
| Grand Bassa | 67% | 33% | 485 |
| Grand Cape Mount | 79% | 21% | 240 |
| Grand Gedeh | 51% | 49% | 106 |
| Grand Kru | 25% | 75% | 104 |
| Lofa | 48% | 52% | 328 |
| Margibi | 66% | 34% | 346 |
| Maryland | 52% | 48% | 183 |
| Montserrado | 32% | 68% | 209 |
| Nimba | 58% | 42% | 418 |
| River Gee | 73% | 27% | 130 |
| Rivercess | 73% | 27% | 366 |
| Sinoe | 30% | 70% | 466 |
| Grand Total | 57% | 43% | 4418 |

## Community health committees

The Community Health Committee (CHC) is elected by the community with guidance from the catchment health facility and the County Health Team. Members of this committee form the basis of community interaction and participation in improving and setting up priority agendas for managing its own health. A member from each CHC is to serve on the Community Development Committees (CHDC) which provides a mechanism for coordination and participation at the health facility level. The CHC oversees and assists in the selection of CHVs and provides administrative support. CHC are to be formed in all communities to provide these functions.

Findings from the study show that 54% of communities have an established CHC and 88% are holding meetings as per CHSD policy (Table 14). When asked if the community is aware of their catchment facility CHDC, the study found that only 48% of communities are aware of establishment of the CHDC. This can be interpreted that majority of communities have not well understood the objective and roles of the CHDC.

**Table 14: Distribution of enumerated communities by distance from health facility**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County** | **# of communities** | **% communities with a CHC established** | **% CHCs that hold meeting** | **% of communities aware of local facility CHDC** |
| Bomi | 410 | 17% | 93% | 27% |
| Bong | 499 | 76% | 95% | 60% |
| Gbarpolu | 128 | 90% | 85% | 76% |
| Grand Bassa | 485 | 26% | 35% | 15% |
| Grand Cape Mount | 240 | 33% | 96% | 9% |
| Grand Gedeh | 106 | 91% | 100% | 77% |
| Grand Kru | 104 | 55% | 0% | 73% |
| Lofa | 328 | 55% | 90% | 57% |
| Margibi | 346 | 21% | 97% | 34% |
| Maryland | 183 | 68% | 75% | 52% |
| Montserrado | 209 | 55% | 99% | 55% |
| Nimba | 418 | 70% | 94% | 38% |
| River Gee | 130 | 55% | 94% | 65% |
| Rivercess | 366 | 69% | 94% | 57% |
| Sinoe | 466 | 80% | 98% | 86% |
| Grand Total | 4418 | 54% | 88% | 48% |

## Community water and sanitation situation

Inadequate and unsafe water, poor sanitation, and unsafe hygiene practices are the main causes of diarrhea, and are also linked to many other diseases that kill children or stunt their development. These diseases includehelminth infections, dracunculiasis, trachoma, cholera, fluorosis and arsenicosis. Children (and adults) living with HIV/AIDS, because of their weakened immune systems, are especially susceptible to the debilitating effects of persistent bouts of diarrhoea (UNICEF water, sanitation and hygiene strategies, 2006-2015).There is also emerging evidence linking better hand-washing practices with reduced incidence of acute respiratory infections. Therefore, water of the highest quality and in sufficient quantity needs to be provided for drinking.

The Ministry states, as its mission, “the reform of the health sector to efficiently deliver quality health services to the people of Liberia through equitable accessible and sustainable health promotion and protection and the provision of comprehensive and affordable health and social welfare services”. Water Supply and Sanitation are closely linked to the efforts to achieve the Millennium Development Goals (MDG). MDG target 7 is to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation (Water Supply And Sanitation Policy, Ministry of Lands, Mines, And Energy, Republic of Liberia).

As stated above, MOHSW expects community health volunteers to contribute to the improvement in water, sanitation and hygiene situations in the communities. The survey collected information on number of community water pumps and latrines. The survey found that in the 4,418 communities, 7,122 hand pumps were installed but only 4,669 were functional. Some communities have a number of hand pumps while some have none. In terms of community coverage of hand pumps, 58% of community reported to have hand pumps, but only half of the communities have a functional hand pumps (see table 15).

14,159 community latrines were reported. Some communities have a number of latrines while some of them have none. 42% of communities reported to have community latrines. The study is limited in knowing if number of community latrines they have is adequate to cover the entire community population.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Table 15: Community water and sanitation situation |  |  |  |  |  |
| County | Number of communities | Number of hand pumps | Number of functional hand pumps | % of communities with hand pump | % of communities with functional hand pump | Number of community latrines | % of communities with a community latrine |
| Bomi | 410 | 515 | 323 | 69% | 56% | 294 | 31% |
| Bong | 499 | 1,078 | 508 | 56% | 47% | 1,274 | 37% |
| Gbarpolu | 128 | 165 | 94 | 59% | 43% | 106 | 40% |
| Grand Bassa | 485 | 456 | 345 | 52% | 46% | 448 | 35% |
| Grand Cape Mount | 240 | 234 | 140 | 48% | 41% | 57 | 13% |
| Grand Gedeh | 106 | 356 | 247 | 84% | 80% | 1,448 | 86% |
| Grand Kru | 104 | 160 | 122 | 60% | 59% | 202 | 45% |
| Lofa | 328 | 616 | 365 | 69% | 61% | 1,490 | 64% |
| Margibi | 346 | 461 | 369 | 55% | 52% | 411 | 32% |
| Maryland | 183 | 407 | 307 | 70% | 63% | 1,646 | 58% |
| Montserrado | 209 | 369 | 271 | 47% | 43% | 197 | 31% |
| Nimba | 418 | 1,433 | 932 | 94% | 84% | 4,562 | 80% |
| River Gee | 130 | 290 | 229 | 65% | 58% | 1,154 | 67% |
| Rivercess | 366 | 175 | 116 | 29% | 23% | 166 | 22% |
| Sinoe | 466 | 407 | 301 | 40% | 32% | 704 | 32% |
| Grand Total | 4,418 | 7,122 | 4,669 | 58% | 50% | 14,159 | 42% |

# LIMITATIONS

This was the first experience in trying to measure coverage of the population in Liberia by community health services. The survey has documented a number of limitations pertaining to the findings and constraints faced during the field work. These are listed below. This documentation will hopefully contribute to improve the methodology and quality of the field work in follow-on work to monitor and evaluate the community health program in Liberia

* The time allotted for this survey was insufficient
* The survey may have left out some CHVs due to inability of survey team to meet them or unavailability of CHVs during survey period
* The survey data did not link names of communities enumerated with a designated gCHV. This limits the analysis ability to find out a proper distribution of gCHVs with respect to the number of communities and population covered by a given gCHV.
* Information collected on training obtained by CHV does not discriminate technical training from orientation or awareness raising sessions.
* Late arrival of data of TM/TTM’s for Margibi led to data not been included in this report
* Limited PDA’s and inability of some supervisors to use them delayed the photographing of some gCHVs.
* Logistic issues such as delay in transferring funds, vehicle breakdown, and bad road conditions affected the survey process.

**RECOMMENDATIONS**

Based on the survey findings the following recommendations were formulated for use by the MOHSW and more specifically by the Community Health Services Division (CHSD):

1. *Develop a conceptual approach on gCHV catchment communities*

At present, there is lack of a well defined assignment of communities to a gCHV. This poses problems as to knowing the workload for a gCHV and hence identifying coverage gaps, and to improve management and accountability of community health programs.

Based on the survey findings, two important recommendations for MOHSW are (1) to define a community clearly so that it is applied in all counties in standard way; and (2) to fine tune the notion of gCHV catchment community so that one or more nearby communities can be assigned to a gCHV. The data collected as a part of this survey can be used further in grouping the communities to a number of gCHV catchment areas.

1. *Establishment of CHV database at all levels*

The data collected by this survey shall be used to set up a community health database by county to help counties to review its community health program coverage and develop a strategic plan. The database should contain CHV profiles including training and equipment received, as well as catchment communities. CHSD will coordinate the establishment of this database and train the concerned program staff at county level to use and update it.

1. *Updating the CHV database*

As the survey has missed some CHVs and communities in the data collection, it is recommended that an effort is made to complete the baseline data. It could be done by sending out list of CHVs and communities from the survey database to each health facility to update it. As part of this effort, it is recommended that CHDC is involved in the community mapping of the facility catchment area so that complete information is collected. The county health team shall update the data from each facility.

1. *Improving the competence and functionality of gCHVs and TTMs*

The CHSD and county teams should collaborate to ensure that all gCHVs and TTMs receive relevant and adequate quality training. This includes regular updating of the CHV database. Also gCHVs and TTMs shall be given policy recommended gear and supplies to ensure effective functioning. gCHVs living in communities at 5km and more from the health facilities should be given adequate stocks for iCCM.

1. *Revitalizing community structures*

Coverage of health facility catchment areas by community health structures such as CHCs and CHDCs is low and their level of functionality is even lower. Hence, efforts to form or revitalize the existing structures need to be taken as a priority to ensure ownership and sustainability of the community health program.

1. *Expanding the Community Led Total Sanitation (CLTS) program*

The community water, sanitation and hygiene program coverage is not adequate and hence need to be expanded and improved.

# REFERENCES

1. Essential Package of Health Services, Ministry of Health and Social Welfare, 2011.
2. UNICEF water, sanitation and hygiene strategies, 2006-2015)
3. Demographic and Health Survey, Liberia Institute for Geo-Information Services, 2007.
4. WHO/UNICEF Joint Statement Integrated Community Case Management: An equity-focused strategy to improve access to essential treatment services children – Technical Task Force Report; The Earth Institute Columbia University 2011.
5. One Million Community Health Workers: Technical Task Force Report The Earth Institute: Colombia University 2011.
6. Community Health Services Policy and Strategy-Revised, Ministry of Health and Social Welfare; 2011.
7. Operational Guidelines for Community Health Development Committees Ministry of Health and Social Welfare, 2010.
8. Government of Liberia, Labor Law (Title 18 and 184). (1956), section 74; available from http;/www.ilo.org/dyn/natlex\_browse.details?p\_lang=en&p\_country=LBR&p\_Classification 01.02&p\_origin
9. Community health workers: What do we know about them? School of Public Health University of the Western Cape Lehmann U, Sanders, D (2007)
10. . MOHSW, National strategy for child survival in Liberia, 2008
11. National Community Health Services Strategy and Plans; 2011-2015
12. Water Supply And Sanitation Policy, Ministry of Lands Mines, And Energy, Republic of Liberia

# APPENDIX – A: Community Health Volunteer (CHV) Profile Form

**Community Health Services**

**Assessment & Mapping of Community level Health Workers – CHV Profile**

**County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Community: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Vital Data** |  | **Training** | **Supplies** |
| **No.** | **Name** | **Status** | **Age** | **Sex** | **Qualification** | **Year selected** | **How selected** |  | **Orientation** | **Diarrhea-CCM** | **ARI-CCM** | **Malaria-CCM** | **ENA** | **CBD-FP** | **DOTS** | **WASH** | **FP Awareness** | **Journey of Hope** | **CHEST Kit** | **Mass Drugs Distribution** | **CLTS** | **HBLSS** | **Fistula** |  | **Bicycle** | **Boots** | **Raincoat** | **Vest** | **Ledger** | **Backpack** | **ORT Set** | **ARI Timer** | **Photo number** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

# APPENDIX-B: Community Profile

**Community Health Services**

**Assessment & Mapping of Community level Health Workers – Community Profile**

**County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Community Details** |  | **Services in Community** |  |
| **No.** | **Community** | **Population**  | **Within 5km** | **No. of Hand pumps** | **No. of functional hand pumps** | **No. of functional latrines** | **CHC Established** | **CHC Meeting** | **CHDC Established** | **CHDC Meeting** | **CHV Present?** | **Diarrhea-CCM** | **ARI-CCM** | **Malaria-CCM** | **CBD-FP** | **DOTS** | **WASH** | **HP** | **Growth Monitoring** | **FP Awareness** | **Mass drug distribution** | **CLTS** | **MCH Awareness** | **Vital registration** | **Health****Partner/NGO** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

# APPENDIX-C: Community Health Focal Points

**Community Health Services**

**Assessment & Mapping of Community level Health Workers – Contacts**

**County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **No.** | **District** | **Facility** | **Name**  | **Position** | **Phone number** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

# APPENDIX D: List of Health Districts in Liberia

|  |  |  |
| --- | --- | --- |
| 1. **MONTSERRADO COUNTY**
2. CAREYSBURG
3. ST. PAUL
4. TODEE
5. MONROVIA
 | 1. **BONG COUNTY**
2. ZOTA
3. JORQUELLEH
4. SUAKOKO
5. SANOYEA
6. KOKOYAH
7. SALALA
8. PANTA/KPAAI
9. FUAMAH
 | 1. **GBARPOLU COUNTY**
2. Gbarma
3. Belle
4. Bopolu
5. Bokomu
6. Kongba
 |
| 1. **NIMBA COUNTY**
2. GBEHLAY- GEH
3. YARWIN MEHSONNAH
4. SACLEPEA - MAH
5. TAPPITA
6. SANNIQULLIE-MAH
7. ZOE-GEH
 | 1. **LOFA COUNTY**
2. ZORZOR
3. VAHUN
4. FOYA
5. VOINJAMA
6. KOLAHUN
7. SALAYEA
 | 1. **RIVERGEE COUNTY**
2. GBEAPO
3. SARBO
4. TIENPO
5. CHEDEPO
6. POTUPO
7. WEBBO
 |
| 1. **SINOE COUNTY**
2. KPANYAN
3. TARJUOWON
4. GBLONEE
5. JEDOEPO
6. TRASUE
7. DUGBE
8. PYNES TOWN
9. BOKON JAEDAE
10. BUTAN
11. GREENVILLE
 | 1. **GRAND GEDEH COUNTY**
2. B'HAI
3. GBAO
4. CAVALLA
5. PUTU
6. TCHIEN
7. KONOBO
 | 1. **MARYLAND COUNTY**
2. KARLUWAY #1
3. KARLUWAY #2
4. WHOJAH
5. HARPER
6. PLEEBO-SODOKEN
 |
| 1. **GRAND KRU COUNTY**
2. FARJAH
3. JRAOH
4. TREHN
5. DORBOR
6. BARCLAYVILLE
7. BUAH
 | 1. **MARGIBI COUNTY**
2. GIBI
3. KAKATA
4. MAMBAM KABA
5. FIRESTONE
 | 1. **GRAND CAPE MOUNT COUNTY**
2. SENJEH
3. SUEHN MECCA
4. TEWOR
5. GOLA KONNEH
6. GARWULAR
7. PORKPA
 |
| 1. **RIVERCESS COUNTY**
2. TIMBO
3. JOWEN
4. JO-RIVER
5. DOEDAIN
6. CENTRAL C
7. YARNEE
 | 1. **GRAND BASSA COUNTY**
2. CAMPWOOD
3. #4
4. OWENSGROVE
5. BUCHANAN
6. # 1
7. # 2 A
8. # 3 A
 | 1. **BOMI COUNTY**
2. KLAY
3. DEWOIN
4. SENJEH
5. SUEHN MECCA
 |