

ADVANCING PARTNERS & COMMUNITIES

Post-Ebola Recovery: Strengthening Community Health Services
Baseline Facility Assessment Report
October 2016



Advancing Partners & Communities

Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

In Sierra Leone, the project works through a USD \$17 million grant from USAID's "Ebola Response and Preparedness" funds, to support the Ministry of Health and Sanitation (MOHS) in the implementation of its 2015–2020 Health Sector Recovery Plan (HSRP) in five districts. The project's goal is to strengthen critical community-based non-Ebola health services, with emphasis on reproductive, maternal, newborn, and child health (RMNCH) services.

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Photo Credit: Joshua Yospyn

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**POST-EBOLA RECOVERY: STRENGTHENING COMMUNITY HEALTH
SERVICES**

BASELINE FACILITY ASSESSMENT REPORT

OCTOBER 2016

EXECUTIVE SUMMARY

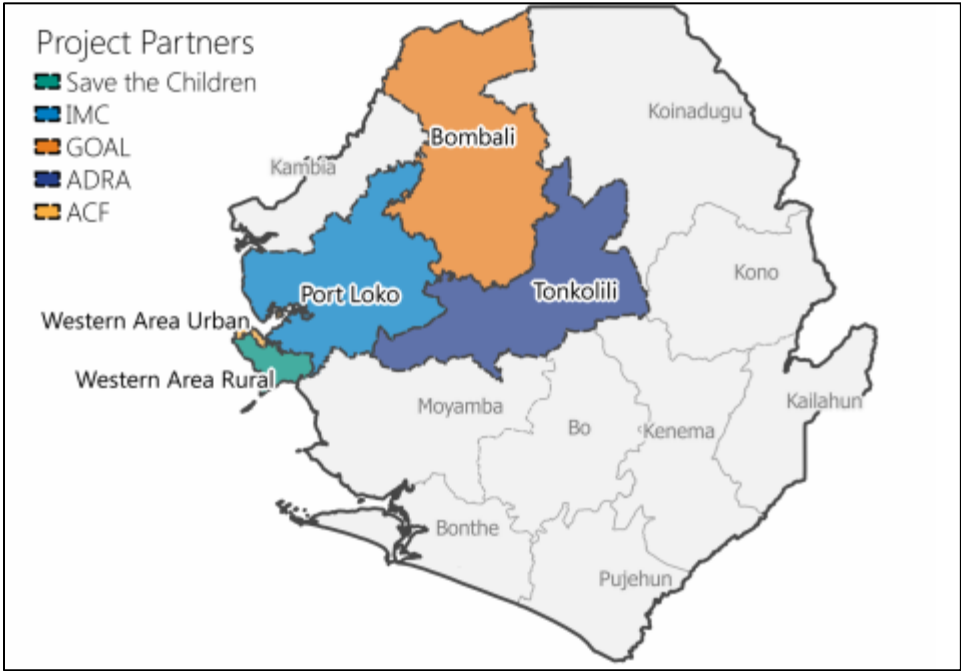
Background

Sierra Leone’s health system was severely affected by the Ebola virus disease (EVD) epidemic that plagued the country from May 2014 through December 2015. In 2014, a survey of health facilities by the United Nations Children's Fund (UNICEF) categorized gaps in four major areas (UNICEF 2014):

- Inadequate training of health facility personnel
- Lack of necessary medical equipment
- Weakened diagnostic capability at the facility level
- Stockouts of essential medicines at peripheral health units (PHUs).

To address these gaps, Advancing Partners & Communities is supporting recovery activities carried out by the Ministry of Health and Sanitation (MOHS), focusing on reproductive, maternal, neonatal, and child health (RMNCH) at the levels of maternal and child health posts (MCHP) and community health posts (CHPs). This project is being implemented in five U.S. Agency for International Development (USAID) priority districts in Sierra Leone (Bombali, Port Loko, Tonkolili, Western Area Urban (WAU), and Western Area Rural (WAR)) in association with five implementing partners: Action Against Hunger, Adventist Development and Relief Agency, International Medical Corps, GOAL, and Save the Children.

Figure 1. Map of Advancing Partners & Communities Implementation Districts



This baseline facility assessment was conducted in January and February 2016 to better understand the capacity and infrastructure of the PHUs in the five priority districts, and to establish a benchmark against which improvements made throughout the course of the project can be measured.

The project objectives are as follows:

Objective #1: Improve regulatory and policy environment to enable increased service delivery access, focusing at health posts (MCHPs and CHPs) and community levels, supporting:

- The revision of the national community health worker (CHW) policy and its subsequent implementation
- A review and update of the water, sanitation and hygiene (WASH) standards and guidelines for healthcare facilities
- Development of operational guidelines for the functioning of the Facility Management Committees (FMC)

Objective #2: Increase the capacity and effectiveness of the health workforce and community platforms to provide quality RMNCH services, in line with infection prevention and control (IPC) and WASH guidelines, by:

- Providing training for staff at the health post level, state enrolled community health nurses (SECHNs), maternal and child health aides and for CHWs
- Improving facility-to-community engagement by strengthening facility management committees.

Objective #3: Improve physical and operational conditions of CHPs and MCHPs to enhance the quality, safety, and access to health services by:

- Renovating health posts—both major (expanded) and minor (limited) renovations, with focus on WASH and IPC improvements
- Procuring minor medical equipment (MME) to support RMNCH services, including providing installation of solar-powered lightning systems
- Improving access to water by developing hand-dug wells and drilling boreholes.

Methodology

In collaboration with the MOHS, four tools were developed (General Facility Overview; Infrastructure Assessment; Minor Medical Equipment Assessment; and Health Staff Survey) to capture information on health facility management and staffing, physical infrastructure, available equipment at each facility, and staff knowledge. The tools were implemented in a total of 268 of 351 (76 percent) of PHUs, including CHPs and MCHPs, across the five districts, and in community health centers (CHCs) in WAU. The remaining 24 percent of facilities failed to meet the initial PHU selection criteria (being owned and managed by the MOHS, and having no renovation in the past five years). Data collection was conducted by each of the partner organizations within their respective districts.

Results

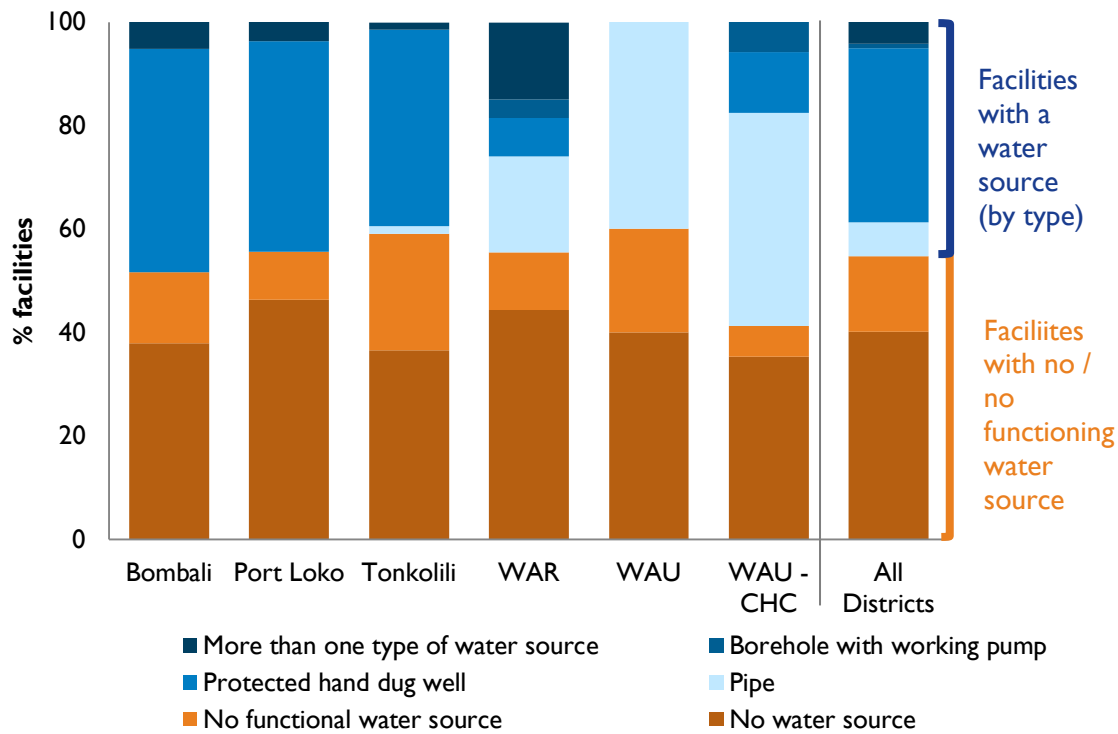
The results from the baseline assessment are highlighted in the order of the topics covered in the report.

Infrastructure (with focus on WASH and IPC)

The infrastructure assessment included questions about water and sanitation, waste disposal, electricity, and structural integrity. The expectation is that health centers with these basic amenities are in a better position to provide improved services, especially in situations where IPC needs to be maintained while patients are being treated.

Fifty-five percent of facilities lacked a functional water source within the compound (Figure 2). While 40 percent of all facilities did not have a source of water at all, water to one-third of the facilities could be provided through repair or rehabilitation of a water source in disrepair.

Figure 2. Functional Water Source Available within the Facility, by District (%)



Fourteen percent of facilities in all districts did not have a toilet (Figure 3). Among those with functional toilets, however, 64 percent were in need of renovations. About half the facilities in all districts did not have a working incinerator or a general solid waste pit. Even fewer had a pit for sharps or for medical waste. Seventy nine percent of PHUs surveyed in the five districts lacked power (Figure 4). Arrangement for power supply is particularly needed in Bombali and Tonkolili, where more than 90 percent of facilities had no form of power available. While nearly half of facilities in the project area were in need of some building rehabilitation (at least one structural component), need ranged substantially by district, from one-third of facilities (WAU) to three-fourths of facilities (Port Loko). Renovations for all structural components were needed in 9 percent of facilities.

Figure 3. Sanitation Type Available at the Facility, by District (%)

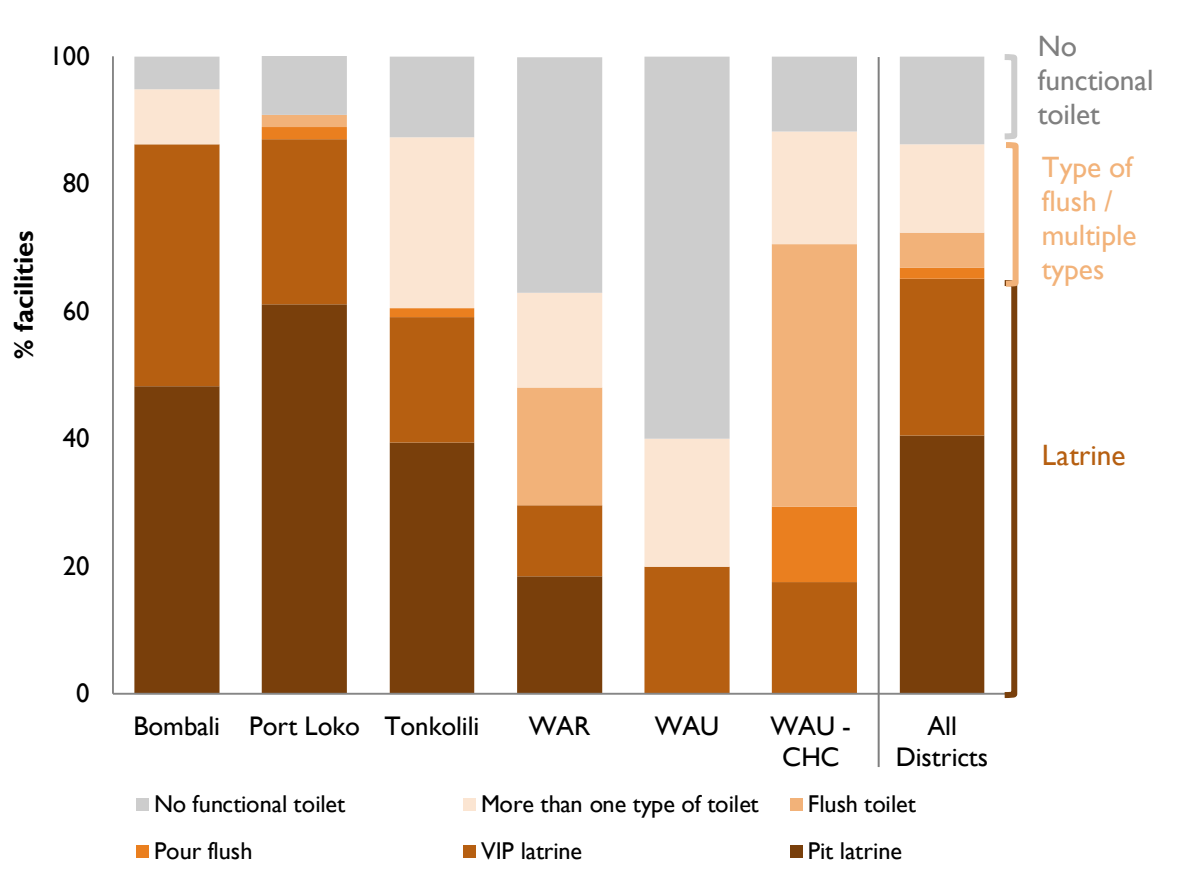
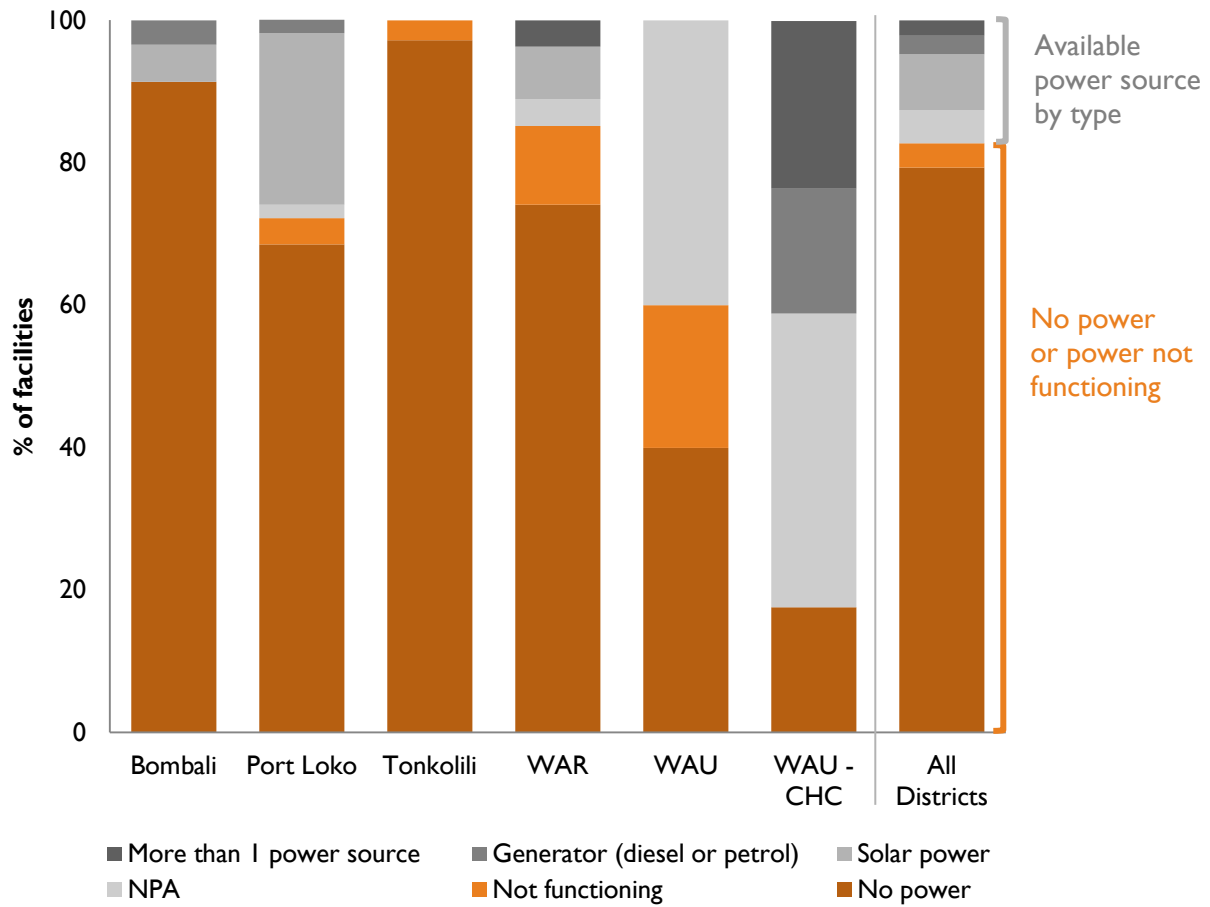


Figure 4. PHU Power Sources, by District (%)

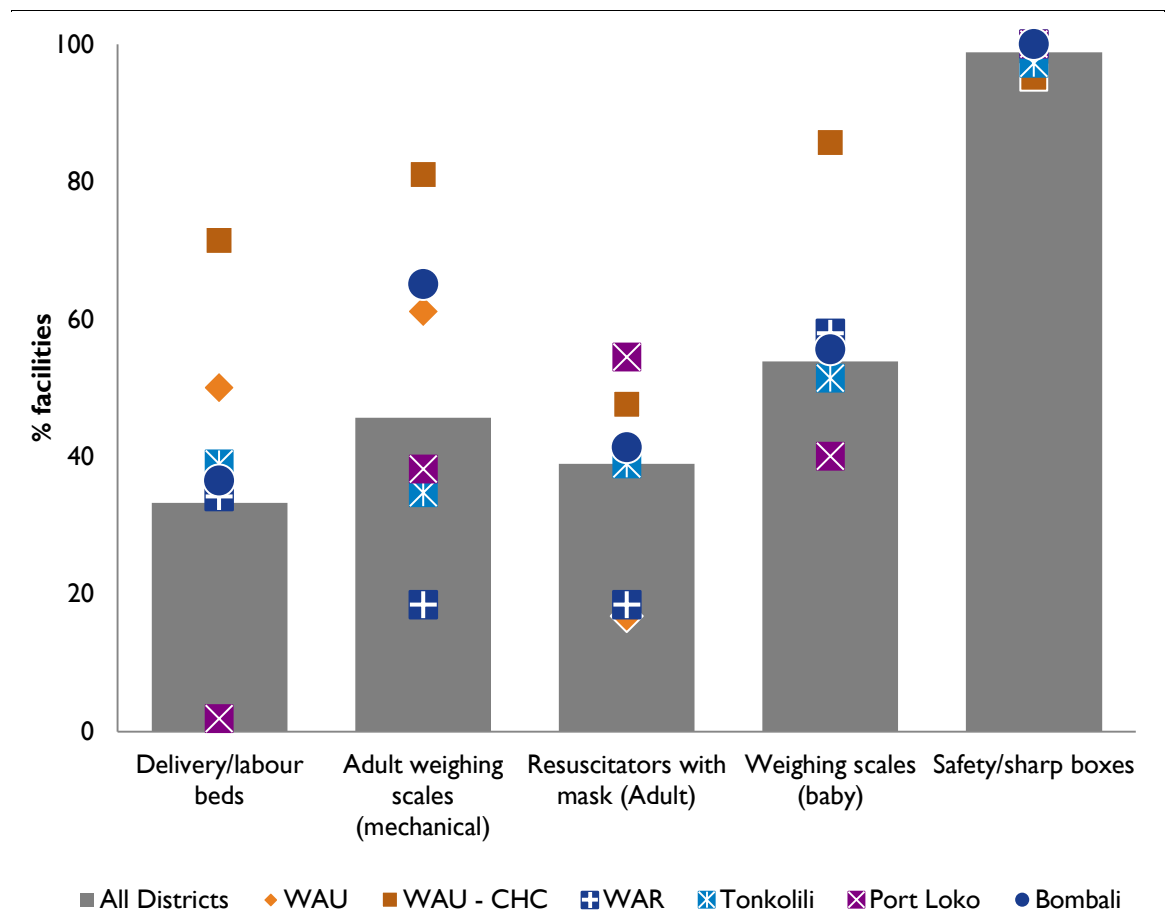


Note: All PHUs in each district are MCHP/CHP unless otherwise specified.

Minor Medical Equipment

Facilities have a strong need for minor medical equipment. Less than half the facilities had functional RMNCH equipment (Figure 5). Delivery/labor beds were not present in more than half the facilities in all districts. A majority of MCHPs/CHPs in all districts did not possess adult weighing scales or resuscitators with masks for adults, and close to half the facilities do not have a baby weighing scale. Although a majority of facilities had a functioning fetoscope, stethoscope, and sphygmomanometer for example, no facility had a fully functioning delivery kit. Only about half the facilities had a functional sterilizer with lower availability, particularly in MCHPs/CHPs in Tonkolili, WAR, and WAU.

Figure 5. Available and Functioning RMNCH and IPC Equipment, by District (%)

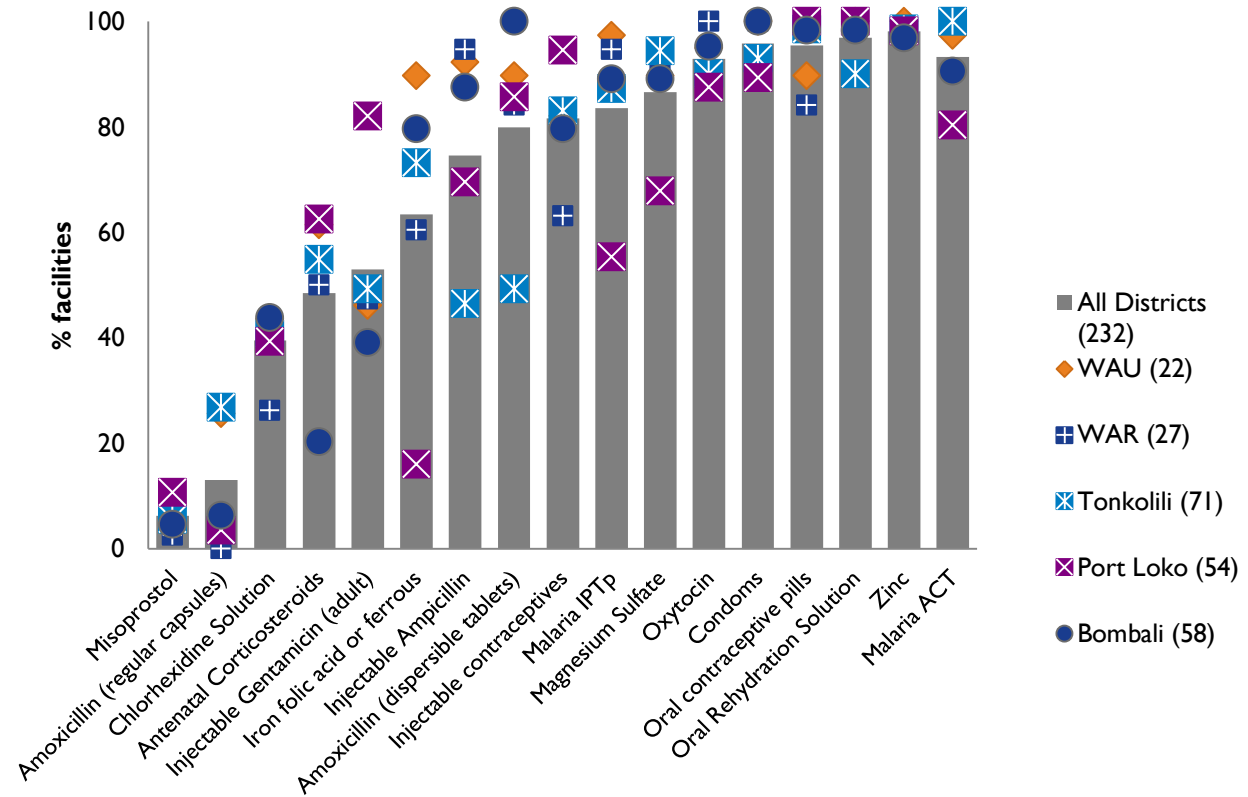


Note: All PHUs in each district are MCHP/CHP unless otherwise specified.

Drugs and Supplies

Availability of amoxicillin, chlorhexidine and misoprostol were consistently very low in all districts, and needed to be replenished. Availability of other drugs varied by district, and need to be monitored (Figure 6).

Figure 6. Available (Not Expired) Drugs and Supplies, by District (%)



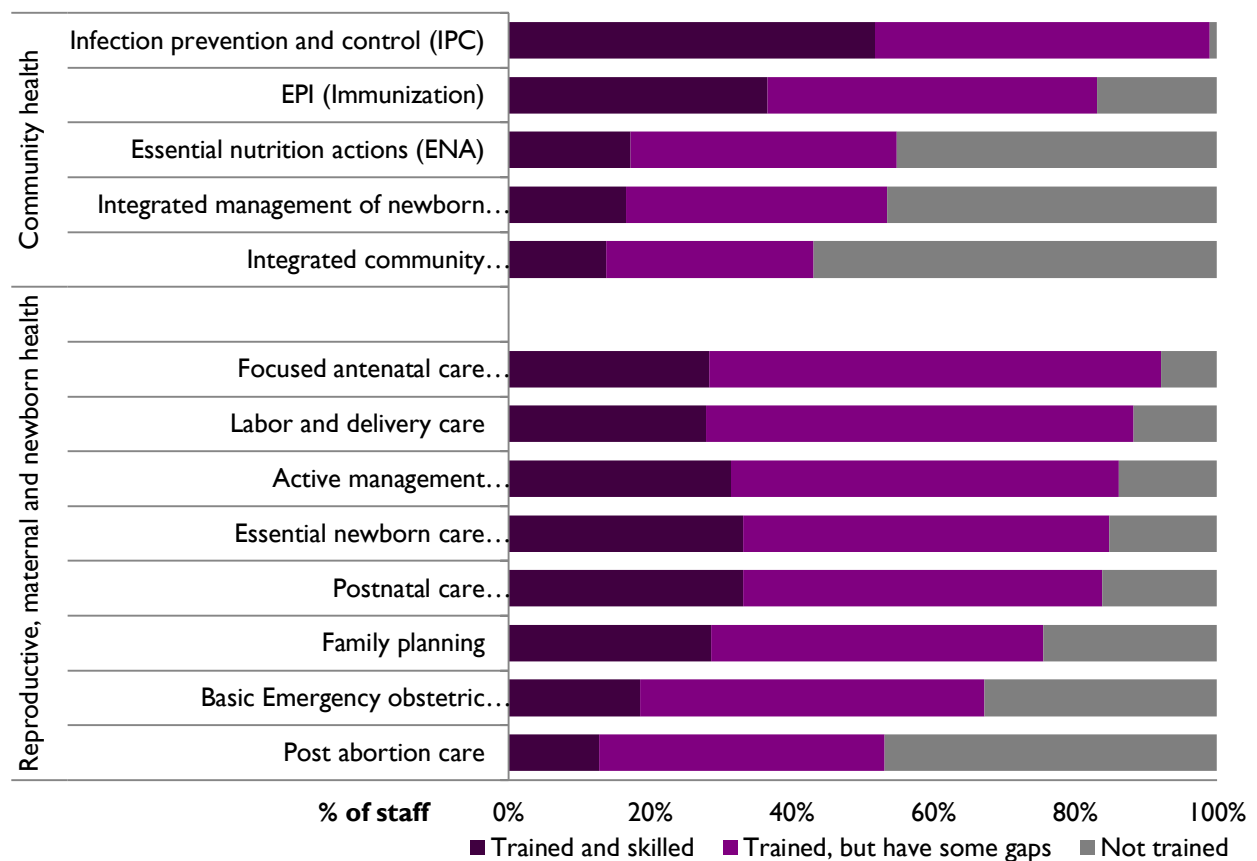
Note: All PHUs in each district are MCHP/CHP unless otherwise specified.

Health Staff Capacity

The non-availability of paid staff is evident across all districts, the exception being CHCs in WAU. Overall, clinical staff available in facilities are often voluntary and non-salaried.

Training in areas such as essential nutrition action (ENA) and integrated management of newborn and childhood illnesses (IMNCI) were reported only by about half the staff interviewed (Figure 7). Although a high percentage of staff reported being trained in various areas of health, such as IPC, focused antenatal care (FANC), and labor and delivery, for example, gaps in knowledge in many technical areas persisted. Scores across the area of child health were particularly low in all districts.

Figure 7. Percentage of Staff Trained and Skilled by Technical Area, Based on Self-Reporting



NOTE: technical areas split into a) community health b) reproductive, maternal and newborn care. Denominator is 290. Out of 300 MCH Aides and SECHNs, 10 respondents did not have data for trained and skilled questions.

Community Engagement and Governance

Three fourths of facilities reported receiving support or supervision for CHWs from district health management teams (DHMTs), nongovernmental organizations (NGOs), or facility staff, with limited community health worker (CHW) support by senior CHWs, especially in WAR and WAU districts (Table I). A little over half of facilities reported regular meetings with the facility and health management committees (FMC/HMCs) in the last three months, with lower levels in Bombali.

Table I. Technical Support and/or Supervision for CHWs, by District (%)

	Bombali	Port Loko	Tonkolili	WAR	WAU	WAU	All Districts		Total %	Number of PHUs
						CHC	MCHP/CHP	CHC		
CHW support or supervision provided by DHMT, NGO, or facility level staff	92.2	73.2	83.1	44.7	68.4	95.0	76.2	95.0	77.6	208
CHW support or supervision provided by more senior CHW/peer supervisor	85.9	66.1	63.4	21.1	26.3	50.0	60.5	50.0	59.7	160
Total number of PHUs	64	56	71	38	19	20	248	20	100	268

Note: All PHUs in each district are MCHP/CHP unless otherwise specified

Referral Practices

On average, almost three-fourths of the facilities had a system of informing the referral facility of a patient referral. Poorer referral practices were evident in WAR and WAU.



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