ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: LIBERIA

DECEMBER 2016

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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.

Recommended Citation
Kristen Devlin, Kimberly Farnham Egan, and Tanvi Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Liberia*. Arlington, VA: Advancing Partners & Communities.

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ACRONYMS

APC	Advancing Partners & Communities
CBIS	community-based information system
CDD	community-directed distributor
CHA	community health assistant
CHC	community health committee
CHS	community health system
CHSD	Community Health Services Division
CHSS	community health services supervisor
CHT	county health team
CHTWG	community health technical working group
CHV	community health volunteer
DHO	district health officer
DHT	district health team
FP	family planning
gCHV	general community health volunteer
HFDC	health facility development committee
HHP	household health promoter
IDSR	integrated disease and surveillance response
IUD	intrauterine device
MOH	Ministry of Health
NGO	nongovernmental organization
OIC	officer in charge
RMNCH	reproductive, maternal, newborn, and child health
TB	tuberculosis
TM	traditional midwife
TTM	trained traditional midwife
USAID	Unites States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

LIBERIA COMMUNITY HEALTH OVERVIEW

Between 2014 and 2015, Liberia was one of several countries in West Africa devastated by Ebola outbreak. The epidemic brought heavy social and economic losses, with the death of 4,810 of the 10,678 people infected (CDC 2016). The country's already precarious health system was also stricken. Routine health service provision and utilization declined due the redirection of health workers to handle the outbreak, fears about contracting the virus, and health facility closures. At 30-times greater risk of becoming infected than the general population, health workers were disproportionately affected by the virus. Further, health worker training institutions across the country closed during this period, resulting in a smaller health workforce in the current post-Ebola context.

Liberia's Ministry of Health (MOH) has since developed policies to guide efforts to rebuild its health system, including at the community level, recognizing the critical role that communities play in addressing their own health needs. The *Investment Plan for Building a Resilient Health System in Liberia 2015 to 2021* aims to restore gains made in strengthening the country's health system prior to the outbreak. The plan emphasizes greater community engagement in health activities to re-establish trust in health authorities, a better trained and standardized workforce, and systems improvements for health surveillance and response. Liberia established its first formal and standardized cadre of community health providers after observing the successes of a well-supported and trained community health workforce during the response to the 2014 Ebola outbreak.

Table 1. Community Health Quick Stats

Main community health policies/ strategies	*Essential Package of Health Services: The Community Health System*	*Investment Plan for Building a Resilient Health System in Liberia 2015 to 2021*	*Liberia Health Workforce Program*	*National Health and Social Welfare Policy and Plan 2011–2021*	*Revised National Community Health Services Policy 2016–2021*	*Revised National Community Health Services Strategic Plan 2016–2021*
Last updated	2011	2015	2016	No date	2015	2015
Number of community health provider cadres	2 main cadres					
	Community health assistants (CHAs)			Community health volunteers (CHVs)		
Recommended number of community health providers	4,467 CHAs			3,844 CHVs		
Estimated number of community health providers	*Information not available in policy*[1]			8,052 CHVs		
Recommended ratio of community health providers to beneficiaries	1 CHA : 40-60 housholds[2]			1 CHV : 40-60 households[2]		
Community-level data collection	Yes					
Levels of management of community-level service delivery	National, regional, district, health facility, community					
Key community health program(s)	CHA Program; Integrated Disease Surveillance and Response (IDSR) Program; various national health-focused programs (e.g., HIV and AIDS, malaria)					

[1] The CHA is a new cadre established per policies developed in 2015–2016. To date, there is no record of the number recruited and trained.
[2] Or up to 350 people. Some CHVs, however, may have a different recommended ratio based on their job description.

The *Liberia Health Workforce Program (FY 2015–2021)* was developed partially to mitigate Ebola's toll on the health workforce. One component of the program introduces community health assistants (CHAs) as an accredited, professional cadre. Previously, a number of fragmented cadres collectively known as community health volunteers (CHVs) provided an array of health services. During the Ebola outbreak, the government of Liberia and development partners trained and deployed 10,000 CHVs and other health workers to conduct social mobilization, case detection, and contact tracing in communities. These efforts led to increased awareness about prevention and to earlier detection of suspected cases, which helped ultimately halt the spread of the virus. The experience demonstrated that health providers can have a positive effect on community health when provided with the necessary, coordinated technical and operational support – a lesson that the CHA program builds upon.

Liberia established its first formal and standardized cadre of community health providers after observing the successes of a well-supported and trained community health workforce during the response to the 2014 Ebola outbreak.

The *Revised National Community Health Services Policy 2016–2021* aims to improve primary health care through an integrated and standardized national community health model. The objectives are to strengthen community engagement, increase access to and utilization of a high-quality standardized package of essential interventions and services, strengthen support and governance systems, build human resource capacity, and develop a robust community-based surveillance system and information system. The policy also provides further details about the CHA program to help reach these objectives. The accompanying *Revised National Community Health Services Strategic Plan* provides a framework for the policy and lays out operational guidance for its implementation.

Recent community health guidance aligns with policies and strategies developed before the Ebola outbreak. The *National Health and Social Welfare Policy and Plan 2011–2021* aims to make health care and social protection available to all Liberians by increasing access to and utilization of a comprehensive package of high-quality services. It also intends to transfer management and decision making to lower levels of the health system to better respond to the population's needs. This document also builds on lessons learned from the country's previous health plan, which the MOH developed in 2007 as part of the country's post-conflict reconstruction efforts after what had been more than two decades of civil unrest and violence. Finally, the *Essential Package of Health Services* developed in 2011 describes a comprehensive package of health services with a strong emphasis on reproductive, maternal, newborn, and child health (RMNCH), service integration, and standardization of protocols, guidelines, and procedures.

Table 2. Key Health Indicators, Liberia

Total population[1]	4.6 m
Rural population[1]	50%
Total expenditure on health per capita (current US$)[2]	$46
Total fertility rate[3]	4.7
Unmet need for contraception[3]	31.1%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	19.1%
Maternal mortality ratio[4]	725
Neonatal, infant, and under 5 mortality rates[3]	26 / 54 / 94
Percentage of births delivered by a skilled provider[3]	61.1%
Percentage of children under 5 years moderately or severely stunted[3]	31.6%
HIV prevalence rate[5]	1.1%

[1]PRB 2016; [2]World Bank 2016; [3]Liberia Institute of Statistics and Geo-Information Services, Ministry of Health and Social Welfare [Liberia], National AIDS Control Program [Liberia], and ICF International 2014; [4]World Health Organization 2015; [5]UNAIDS 2015.

These documents, in addition to other health-area specific policies, guide community health in Liberia. Together, they cover health areas such as FP, HIV and AIDS, and WASH, and key components of programs supporting community health providers, such as selection, scope of service, supervision, and incentives. However, existing policies do not articulate information about the CHA selection or recruitment process well. Also, information on CHVs is limited since they generally operate through vertically-oriented programs for which there is less clear and available guidance. The Human Resources for Health section provides information on CHAs and CHVs as it is available.

According to policies, community groups play a large role in community health in Liberia. Civil society, faith-based organizations, and nongovernmental organizations (NGOs) support implementation of community health activities, such service provision at government facilities and by community health providers. To help ensure CHA program sustainability, policies also designate these organizations to be advocates for local pooled funds[1] and for ensuring the MOH and other stakeholders fulfill their respective obligations in implementing community health programs.

The community health committee (CHC) coordinates all health-related activities in each catchment community. The CHC reports to a health facility development committee (HFDC), which mobilizes communities, links them with the health facility, and provides operational and management support to the health facility.

Liberia's policies integrate gender as a cross-cutting topic in community health. They task the Ministry of Gender, Children & Social Protection with ensuring that women are represented and engaged in community health leadership positions and decision-making processes. Furthermore, the *Liberia Health Workforce Strategy* states that recruitment for the CHA program specifically targets underemployed youth and women. For example, women are supposed to be given preference during CHA selection. Policies also integrate gender-based violence issues into programming.

Liberia has an array of community health programs that span various health areas, like malaria, tuberculosis (TB) and RMNCH. Some are more cross-cutting, such as the Integrated Disease Surveillance and Response (IDSR) program, which was developed in response to the Ebola outbreak to ensure greater emergency preparedness, including identifying priority disease and event triggers in communities. Generally, the MOH heads these programs and implements them with the support of international donors and NGOs. Many programs are linked to other sectors, like education, finance, and agriculture, and have been active for over a decade. Most intend to reach nationwide coverage and operate in urban, rural, and peri-urban areas.

1 Liberia has documented success using pool funds to align and coordinate donors and other health actors to help finance the MOH's health priorities, such as those outlined in the 2007 *National Health Policy and Plan*. This mechanism for financing and coordination has been linked to health outcome improvements preceding the Ebola outbreak (Hughes, Glassman, and Gwenigale 2012).

LEADERSHIP AND GOVERNANCE

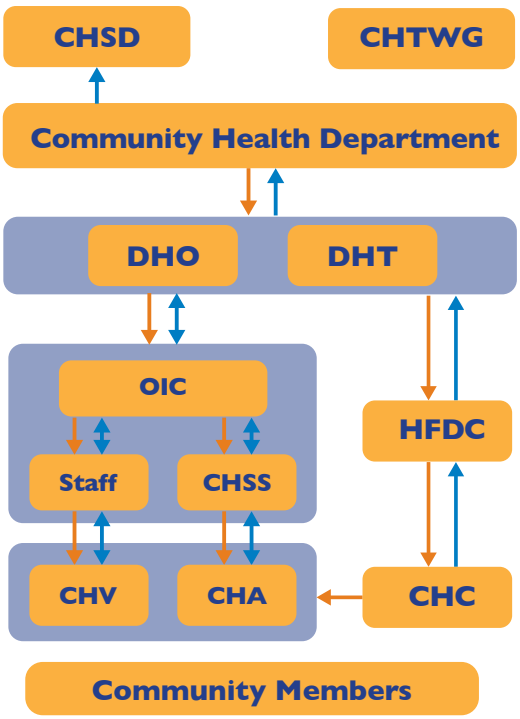
Community-level service delivery in Liberia is managed and coordinated across the national, county, district, health facility, and community levels. Each has a distinct role in supporting policy and program efforts.

- The Community Health Services Division (CHSD) of the MOH develops community health guidelines, tools, and curricula at the **national level**. It coordinates and monitors the *Revised National Community Health Service Policy* and community-based interventions implemented by partners and collaborating programs and divisions within the MOH. There are plans for the CHSD to maintain a community-based information system (CBIS) and conduct other monitoring and evaluation activities and operational research. The community health technical working group (CHTWG) provides strategic and technical guidance to the CHSD. It will also coordinate the CHA component of Liberia's health workforce program, guiding CHA training, supervision, remuneration, supply chain management, and monitoring and evaluation.
- At the **county level**, the community health department within the county health team (CHT) coordinates community health activities. The department's director and focal person oversee implementation at the district and health facility levels; facilitate recruitment and selection of CHAs, their supervisors, and CHCs; conduct supportive supervision; facilitate training; and distribute health commodities. In addition, the director and focal person participate in program planning, review, and evaluation.
- At the **district level**, the district health officer (DHO) and the district health team (DHT) oversee coordination, collaboration, and supervision of services and activities in facilities and communities. They also collect and review monthly activity reports from the clinics before submission to the CHT. The DHO holds regular meetings with health facility staff.
- There are several key actors at the **health facility level**:
  - The governing body for all CHCs in the facility catchment area is the HFDC, which facilitates linkages between the district, health facility, and community levels. It meets monthly to discuss health activities and identifies priorities for action, and oversees facility operations; service quality monitoring; quarterly health facility reviews; annual reviews of district health plans; planning and forecasting health needs and resources; and community mobilization to support facility activities.
  - The officer in charge (OIC) coordinates all health activities in the catchment communities of each facility.
  - The community health services supervisor (CHSS) provides oversight, supervision, and mentorship to CHAs; technical support in planning and implementation of community programs; and guidance as communities select CHAs and CHCs.
- At the **community level**, the CHC coordinates health activities, supports community health providers, mobilizes communities for health actions, and reports to the HFDC. The CHC also oversees and assists in the selection of community health providers. CHAs and CHVs deliver services in communities. CHAs report to the CHSS, and CHVs report to other clinic staff based on their specific job descriptions.

Figure 1 summarizes Liberia's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships
National	CHSD CHTWG	Regional Hospital	
County	Community Health Department	County Hospital	
District	DHO DHT	District Hospital Health Center	
Health Facility	HFDC OIC	Clinic	
Community	CHC	CHA CHV	



HUMAN RESOURCES FOR HEALTH

CHAs and CHVs are the two main community health provider cadres in Liberia.

The "CHV" is a catch-all term for a number of cadres that have been providing health-related education and services in Liberia for many years. They include but are not limited to:

- Community-based distributors (CBDs) of FP.
- Traditional midwives (TMs).
- Trained traditional midwives (TTMs).
- Natural leaders who support communities to become open defecation-free.
- Household health promoters (HHPs).
- Community-directed distributors (CDDs) to fight neglected tropical diseases.
- Peer educators for HIV and AIDS.

- General community health volunteers (gCHVs) who have been trained to conduct a variety of interventions, such as health promotion, behavior change, and integrated community case management.

Although CHVs are often ingrained in Liberian communities, the programs and systems that support them are not always standardized or well-coordinated.

CHAs are expected to implement many of the formerly CHV-implemented interventions, among others, through a standardized approach that is integrated into national health programming under the MOH. After being selected, trained, and deployed, CHAs will provide promotional, preventive, and curative services in communities related to IDSR; disease prevention; RMNCH, including FP; nutrition; first aid; and mental health.

Some CHVs may be trained to become CHAs, but policies do not discuss if or how CHVs might be phased out or replaced by CHAs. Moreover, policies do not define a relationship between CHVs and CHAs, e.g., how they should coordinate responsibilities within their respective areas.

Table 3 provides an overview of CHAs and CHVs.

Table 3. Community Health Provider Overview: CHAs and CHVs

	CHAs	CHVs
Number in country	A new cadre established per policies developed in 2015–2016. To date, there is no record of the number that have been recruited and trained.	8,052 This includes 3,727 gCHVs; 2,856 TTMs; 586 TMs; 238 HHPs; and 645 CDDs. These estimates were calculated before the CHA cadre was established.
Target number	4,467	3,844 This is an estimate of the number of CHVs needed after the deployment of the CHA cadre.
Coverage ratios and areas	1 CHA : 40–60 households, or up to 350 people in communities beyond 5 kilometers from the nearest health facility. Ratios may be adjusted in sparsely or heavily populated areas to ensure each community has an appropriate number of CHAs. Will operate in urban, peri-urban, and rural areas.	1 CHV : 40-60 households, or up to 350 people in communities within 5 kilometers of the nearest health facility. Guidance may vary by type of CHV: 2 TTMs : 40–60 households (up to 350 people) 1 CDD : 100 people 1 HHP : 10 households Operate in urban, peri-urban, and rural areas.
Health system linkage	CHAs will be linked to the formal health system by receiving technical support and supervision from health clinic staff; making referrals to health clinics; and collecting and submitting community health data to clinics through a health management information system. They will be accredited and nationally recognized.	CHVs are linked to the formal health system by receiving technical support and supervision from health clinic staff; making referrals to health clinics; and collecting and submitting community health data to clinics through a health management information system.
Supervision	CHAs will be supervised by the CHSS who may be a physician's assistant, community midwife, registered nurse, or environmental health technician. The CHSS will receive specific training to provide mentorship, supportive supervision, and oversight to up to 10 CHAs. Supervision will be field-based. The CHC based in each community will also supervise and provide support to CHAs. Once CHAs are recruited, trained, and deployed, implementing NGOs will share oversight of CHAs, though policy does not provide details about how.	At the health facility level, clinic staff supervises CHVs. The type of staff member depends on the CHV cadre. For example, certified midwives at the health facility supervise TTMs. The CHC based in each community also supervises and provides support to CHVs. Implementing NGOs may share oversight of CHVs, though policy does not provide details about how.
Accessing clients	On foot Bicycle	On foot Bicycle

Table 3. Community Health Provider Overview: CHAs and CHVs

	CHAs	CHVs
Selection criteria	Permanent resident in the community in which s/he serves 18–50 years old Trustworthy and respected Interested in health and development Good mobilizer and communicator Available to perform assigned tasks Physically, medically, mentally, and socially fit to provide required services Past involvement in community project/s Demonstrated ability to add, subtract, and multiply, and read and write in English Passes a literacy test Fluent in village or town dialect where s/he is serving Liberian Female candidates given preference CHVs may be trained to be CHAs, but it is not clear whether they are given preference in selection.	Permanent resident in the community in which s/he serves Speaks local language Willing and able to serve the position and likely to continue in role long-term Well-respected and of sound moral character Male or female, but female candidates given preference Available and committed to voluntary work Other criteria vary by type of CHV.
Selection process	CHAs will be identified by community members during community meetings. The recruitment and selection processes will be overseen by CHCs using the established selection criteria. To become a CHA, candidates must undergo and complete the MOH training.	CHVs are identified by community members during community meetings. Selection processes vary by CHV cadre.

Table 3. Community Health Provider Overview: CHAs and CHVs

	CHAs	CHVs
Training	CHA training will be phased over a 6-month period, with each session lasting 2 weeks. The MOH and partners will provide refresher trainings based on outcomes from supervisory field visits and training needs assessments. They will take place twice a year.	CHVs receive training in community engagement and mobilization; health promotion and education; and referral. Specialized programs working with different CHV cadres use standardized training modules within their health area in coordination with the relevant MOH divisions. For example, gCHV trainings are phased over time by training module. The training emphasizes integrated community case management with a focus on diarrhea (2 days); malaria (5 days); and acute respiratory infections (3 days). Some gCHVs receive training on community-based family planning (5 days). Additional trainings for gCHVs and other CHVs may be on community health education skills; providing HIV and AIDS education; mass drug distribution; WASH promotion; community-led total sanitation; nutrition; and directly observed treatment for TB.
Curriculum	*National Community Health Assistant Curriculum 2016–2021* (2016). Includes 4 modules: disease prevention and control; reproductive, maternal, and newborn health; child health; and special services, including HIV and AIDS, tuberculosis, leprosy, first aid, and mental health.	There are many training curricula for different types of CHVs. For example, modules for gCHVs include: *Community-Based Management of Acute Respiratory Infections in Childhood* (2011); *Community-Based Management of Diarrhea in Childhood* (2011); and *Community-Based Management of Malaria in Childhood* (2012).
Incentives and remuneration	Financial incentives include per diems and cash payments, such as stipends equivalent to $70 US per month. They will be provided by the MOH, NGOs, and international donors. Nonfinancial incentives may include t-shirts; umbrellas; vests; boots; raincoats; cloths/lappas; identification cards; bicycles; formal social recognition; and opportunities for career advancement. They will be provided by the MOH, NGOs, and the community. The MOH and partners plan to design and implement a system of performance-based incentives linked to national monitoring and evaluation systems.	Financial incentives include per diems and cash payments. The Revised National Community Health Services Policy offers guidance to programs for incentivizing CHVs and includes: – $5 US per day not exceeding 10 days per month for health campaigns. – A flat rate of up to $50 US per month (commensurate to workload) for ongoing specialized or routine activities, or compensation at rates established prior to 2015. Amounts should not exceed those for CHAs. Financial incentives are provided by the MOH, NGOs, and international donors. Nonfinancial incentives may include t-shirts; umbrellas; vests; boots; raincoats; cloths/lappas; identification cards; bicycles; formal social recognition; and opportunities for career advancement. They are provided by the MOH, NGOs, and the community. The MOH and partners plan to design and implement a system of performance-based incentives linked to national monitoring and evaluation systems.

HEALTH INFORMATION SYSTEMS

CHAs and CHVs are expected to routinely collect health service data related to the health promotion, prevention, and care services that they provide in communities. They complete forms and ledgers that track indicators to assess the quality, access to, and efficiency of community services as well as health status indicators of their catchment population. They submit forms to their supervisors at clinics monthly.

Liberia is developing a community-based information system which will be integrated into its national health management information system so community data can inform planning and implementation at all levels.

Supervisors at the health facility compile the data, but there is not yet a system in place to integrate the community and health facility data before they are submitted to the district and county. Currently, only facility-level data are sent to the higher levels of the health system on a monthly basis through the national health management information system. Community health providers and their supervisors use these data to identify and respond to local needs and priorities, but the process is not specified.

However, recent policies like the *Revised Community Health Services Policy* and the *Liberia Health Workforce Program* outline plans to better integrate community data into the national health management information system through a CBIS. Managed by the CHSD and the national body for health monitoring and research, the CBIS would allow community data to be accessed at various levels; e.g., by CHAs for targeting interventions, CHA supervisors for management, and the CHSD for health workforce decision making.

The blue arrows in Figure 1 indicate the intended flow of community data through the country's health system.

HEALTH SUPPLY MANAGEMENT

Community health providers in Liberia must order the commodities, educational materials, and supplies they need from the health facility in their catchment area on a monthly basis. They complete a drug and supply requisition form and submit it to their supervisors.

Policies do not detail how community health providers can access back-ups if there are stockouts. However, they indicate that committees at different levels of the health system need to focus on strengthening supply chains to prevent stockouts. There is no guidance on how providers should dispose of medical waste generated through their services.

Table 4 offers information about selected medicines and products included in Liberia's *Essential Package of Health Services* (2011).

Table 4. Selected Medicines and Products Included in Liberia's *Essential Package of Health Services* (2011)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☐	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☐	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☐	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☐	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

SERVICE DELIVERY

Liberia's *Essential Package of Health Services* describes the primary care services to be delivered in communities and in clinics. These include interventions related to RMNCH, FP, adolescent health, infection prevention and control, communicable and non-communicable diseases, neglected tropical diseases, eye health, emergency health, and mental health.

Table 5 outlines the modes through which clinical services, health education, and community mobilization are delivered in communities.

Policies do not define a referral mechanism in which lower level community health providers refer to those at higher levels. Instead, community health providers refer cases they cannot treat to the nearest health care facility—usually a clinic or a health center. Facilities are expected to counter refer clients for follow-up care by community health providers.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Using FP as an example, CHVs and CHAs may provide condoms, oral contraceptive pills, and information on the Standard Days Method, CycleBeads, and lactational amenorrhea method.[2] They may also refer clients to:

- **Clinics** for the methods that CHAs and CHVs are able to provide as well as injectable contraceptives, intrauterine devices (IUDs), and emergency contraceptive pills.
- **Health centers** for methods available at clinics and implants.
- **District and county hospitals** for methods available at health centers and permanent methods.

Table 6 details selected interventions delivered by CHAs and CHVs according to policy in the following health areas: FP, RMNCH, TB, HIV, malaria, and WASH.

2 Policies indicate that before the establishment of the CHA cadre, certain types of CHVs were trained to administer injectable contraceptives and emergency contraceptive pills. The CHA curricula do not include the current method mix for community-level distribution, but indicate that CHAs may be trained to administer injectable contraceptives in the future.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	CycleBeads®	CHA, CHV	CHA[1], CHV	CHA, CHV	CHA, CHV
	Emergency contraceptive pills[2]	CHV	CHV	CHV	CHV
	Implants	CHA, CHV	No	CHA, CHV	CHA, CHV
	Injectable contraceptives	CHA, CHV	CHA[3], CHV	CHA, CHV	CHA, CHV
	IUDs	CHA, CHV	No	CHA, CHV	CHA, CHV
	Lactational amenorrhea method	CHA, CHV		CHA, CHV	CHA, CHV
	Oral contraceptive pills	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	CHA, CHV	No	CHA, CHV	CHA, CHV
	Standard Days Method	CHA, CHV		CHA, CHV	CHA, CHV
Maternal health	Birth preparedness plan	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	Iron/folate for pregnant women	CHA, CHV	No	CHA, CHV	CHA, CHV
	Nutrition/dietary practices during pregnancy	CHA, CHV		CHA, CHV	CHA, CHV
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Unspecified	Unspecified	Unspecified
	Recognition of danger signs during pregnancy	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	Recognition of danger signs in mothers during postnatal period	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
Newborn care	Care seeking based on signs of illness	CHA, CHV			CHA, CHV
	Chlorhexidine use	CHA	CHA	CHA	CHA
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	CHA		CHA	CHA
	Nutrition/dietary practices during lactation	CHA, CHV		CHA, CHV	CHA, CHV
	Postnatal care	CHA, CHV	CHA	CHA, CHV	CHA, CHV
	Recognition of danger signs in newborns	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CHA, CHV	CHA, CHV[4]	CHA, CHV	CHA, CHV
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	CHA	CHA[5]	CHA	CHA
	Exclusive breastfeeding for first 6 months	CHA, CHV		CHA, CHV	CHA, CHV
	Immunization of children[6]	CHA, CHV	No	CHA, CHV	CHA, CHV
	Vitamin A supplementation for children 6–59 months	CHA	CHA[5]	CHA	CHA
HIV and TB	Community treatment adherence support, including directly observed therapy	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	Contact tracing of people suspected of being exposed to TB	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	HIV testing	CHA, CHV	No	CHA, CHV	Unspecified
	HIV treatment support	CHA, CHV	CHA, CHV	CHA, CHV	CHA
Malaria	Artemisinin combination therapy	CHA, CHV	CHA, CHV[7]	CHA, CHV	CHA, CHV
	Long-lasting insecticide-treated nets	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
	Rapid diagnostic testing for malaria	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV
WASH	Community-led total sanitation	CHV	CHV		
	Hand washing with soap	CHA, CHV			
	Household point-of-use water treatment	CHA, CHV			
	Oral rehydration salts[8]	CHA, CHV	CHA, CHV	CHA, CHV	CHA, CHV

[1] Policies indicate that some CHAs may be trained to provide CycleBeads. Others may refer clients to a health facility to learn how to use them.
[2] Liberia's *National Guidelines for Initiating and Managing Community-Based Family Planning Distribution Services*, which predates the creation of the CHA cadre, mentions emergency contraceptive pills. Under the guidelines, CHVs trained to distribute FP in communities may provide emergency contraceptive pills. The CHA curriculum, however, does not mention emergency contraception.
[3] The CHA curriculum indicates that CHAs may be trained to administer injectable contraceptives (Depo Provera) in the future, but currently it is not part of their method mix.
[4] It is not clear if CHVs will still be allowed to conduct integrated community case management after the deployment of the new CHA cadre.
[5] CHAs provide this intervention during special campaigns. The CHA curriculum does not clearly state if they are allowed to provide this intervention routinely.
[6] Includes newborns.
[7] CHAs and CHVs may provide artemisinin combination therapy to children under 5 years old if they test positively for malaria using a rapid diagnostic test. If no rapid diagnostic test is available, they must refer the client to the health facility for testing.
[8] There is policy guidance for this intervention only in children under 5 years as part of integrated community case management.

KEY POLICIES AND STRATEGIES

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