MINISTRY OF HEALTH AND SANITATION
THE REPUBLIC OF SIERRA LEONE

**Strengthening Health Services as Part of the
Post-Ebola Transition in Sierra Leone**
Advancing Partners & Communities | Sierra Leone

Community Engagement Implementation Strategy
OCTOBER 2016

Contents

Acronyms

ACF   *Action Contre la Faim* /Action Against Hunger
BPEHS   basic package of essential health services
CHP   community health post
CHW   community health worker
DHMT   district health management team
DPHC   Directorate of Primary Health Care
DPPI   Directorate of Policy, Planning and Information
EVD   Ebola virus disease
FMC   facility management committee
HED   Health Education Division
HP   health post
HR   human resources
HRH   Human Resources for Health
HSRP   Health Sector Recovery Plan
IMC   International Medical Corps
IPC   infection prevention and control
JSI   JSI Research & Training Institute, Inc.
MCH   maternal and child health
MCHP   maternal and child health post
MOHS   Ministry of Health and Sanitation
MME   minor medical equipment
PHU   peripheral health unit
RMNCH   reproductive, maternal, newborn, and child health
SBCC   social and behavior change communication
USAID   United States Agency for International Development
VDC   village development committee
WASH   water, sanitation, and hygiene
WAR   Western area rural
WAU   Western area urban
WDC   ward development committee

Acknowledgements

The Advancing Partners & Communities / Sierra Leone project team developed the Community Engagement Implementation Strategy through workshops and field testing in collaboration with the Ministry of Health and Sanitation (MOHS) and the District Health Management Teams (DHMTs) from Bombali, Port Loko, Tonkolili, and Western Area, along with project implementing partners: *Action Contre la Faim*, the Adventist Relief and Development Agency, GOAL, the International Medical Corps, and Save the Children. In addition, the strategy benefitted from the consultation of other national health partners, including Concern, several Northern region PHUs, the Johns' Hopkins University HC3 project, the London School of Economics International Growth Centre, and UNICEF.

I.   Introduction and Project Scope

Sierra Leone has experienced the worst Ebola virus disease (EVD) epidemic in history, with 14,124 confirmed cases and 3,956 deaths (WHO 2016). Diminished "community confidence" in the post-Ebola health sector resulted in a one-quarter reduction in institutional deliveries, 39 percent fewer children treated for malaria, and one-fifth reduction in basic immunization (MOHS 2015a). In addition, a documented 296 health workers were infected with EVD, of whom 211 perished, including 11 specialized doctors (MOHS 2015a).

The USAID-funded Advancing Partners & Communities project advances and supports community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. With the aim of strengthening Sierra Leone's health system as part of its post-Ebola response, the Advancing Partners & Communities project scope of work has three main objectives: 1) community health worker (CHW) policy and maternal and child health (MCH) guidelines development; 2) capacity building and community engagement; and 3) health post infrastructure/rehabilitation improvements.

Specifically, objective 2 seeks to "Increase capacity and effectiveness of the health workforce and community platforms to improve quality of reproductive, maternal, newborn, and child health (RMNCH) services, including infection prevention and control (IPC), at the primary health care and community levels." The project objectives and proposed community engagement strategy seek to align with and support:

- The Sierra Leone Ministry of Health and Sanitation (MOHS) Health Sector Recovery Plan (HSRP) 2015–2020, which includes "community ownership" among its five key priority areas of focus (MOHS 2015b).
- The National Ebola Recovery Strategy for Sierra Leone: 2015-2017 (GOSL 2015).
- Basic Package of Essential Health Services (MOHS 2015a).
- The National Community Health Worker Policy 2016-2020, the planned nursing and midwifery policy, and the national Human Resources for Health (HRH) Strategic Plan 2012–2016 (MOHS 2011).
- The United States Agency for International Development (USAID)'s Local Systems Framework for sustainable development (2014), and its Acting on the Call: end preventable child and maternal deaths (2014).

The project's geographic zone is the Western urban and rural areas, and Bombali, Port Loko, and Tonkolili of the Northern region (Figure 1). A total of almost 300 facilities are being supported by the project, intervening in 50 to 70 facilities per district.

The project's five implementing partners are *Action Contre la Faim* (ACF), Adventist Development and Relief Agency (ADRA), GOAL, the International Medical Corps (IMC), and Save the Children. Each partner has a one-year grant of approximately US $1.6 million to intervene in 20–40 facilities per district, with facility-level support for one of three intervention packages:

Figure 1. Advancing Partners & Communities – Sierra Leone implementing partners by district
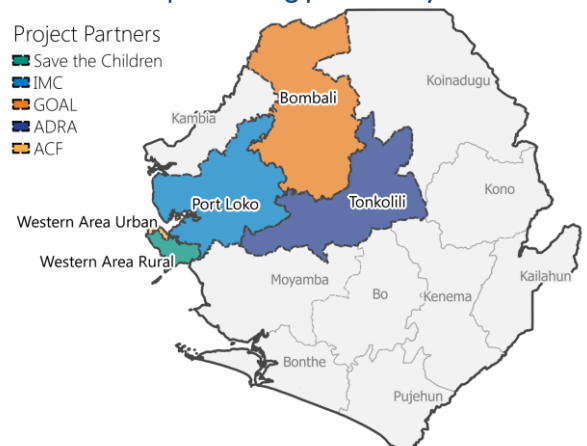
a. **Full package.** A total of 100 sites will receive support for WASH/IPC renovations:
    a. infrastructure/rehabilitation, of which about half (50) are "expanded" renovations, and the other half (50) are "limited".
    b. facility capacity building, performance improvement, and supportive supervision support for health post staff
    c. CHW program support (training and supervision of CHWs)
    d. community engagement support
    e. minor medical equipment, including focused training on equipment use and maintenance.

b. **Training & equipment package.** One hundred and thirteen (113) health posts (HPs) will receive capacity building, CHW program support, community engagement, and minor medical equipment (MME) (components b, c, d and e above).

c. **Minor medical equipment only package.** Seventy-two (72) health posts will receive the MME component only.

Thus, there are a total of 213 health posts receiving community engagement support.

In addition, the harmonized community engagement approach for the Advancing Partners & Communities project complements other community health interventions. Notably:

- UNICEF is helping MOHS geo-map all CHWs in Sierra Leone. This information will increase supportive supervision of and capacity building for district-level CHWs.
- Existing and forthcoming World Bank and Global Fund financing strategies in support of the MOHS Health Sector Recovery Plan and CHWs.[1]
- The USAID-funded Health Communication Capacity Collaborative (HC3) project, led by the Johns Hopkins Center for Communication Programs.[2]

Strategy purpose

Community engagement is at the foundation of the Advancing Partners & Communities project goals. It should thus be part of every project activity. The purpose of this document is to define a harmonized community engagement implementation strategy that is aligned with: a) national health guidance, strategies, and policies; and b) all implementing partners across the project's five districts. It seeks to define community engagement, the roles and responsibilities of key stakeholders in community health, and to recommend approaches and tools for implementation. Community engagement is a key to

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[1] According to an update at the MOHS, CHW Hub coordinator Meredith Dyson reported that the World Bank project for MCH in Sierra Leone is expected to start mid-2016 and would include provisions for covering CHW incentives, with the Western Area possibly among their intervention zone. In addition, the Global Fund may support integrated CHW programming under its health systems strengthening component (personal communication, January 12, 2016).

[2] HC3's objectives are to: 1) improve quality, targeting, and scale of social and behavior change communication (SBCC) activities (to change behaviors at the level of the facilities, communities, and individuals); 2) to improve national and sub-national coordination, planning, and integration of SBCC activities (creating a supportive environment); and 3) improve capacity to design, implement, and evaluate high-quality SBCC activities among institutions. HC3's role in community engagement is primarily from the demand side in the same five districts as the Advancing Partners & Communities project. The project will intervene in five facilities per district, in all communities within the facility catchment area. In Bombali district, GOAL is the implementing partner for both HC3 and Advancing Partners.

optimizing Sierra Leone's transition from its emergency response to a recovery phase, and is an essential component for sustainability.

As the Advancing Partners & Communities project goals are to strengthen the health system on the supply side, the community engagement strategy will focus on district- and facility-level interventions with attention on the role of the facility management committee (FMC), the community health worker and the guiding role of the District health management teams (DHMT) to in support of other community-based interventions.

For community engagement to be streamlined into every project activity, these two key questions should always be asked when working at a facility:

"Where are the community people? How can the community people be involved?"

« Wae de pipul dem na dis ton ? Aw di ton pipul dem go dae pan dis wok?"   ~ Krio translation

II.   What is Community Engagement?

In the post-Ebola context, the Government of Sierra Leone identified "deepening community engagement through social mobilization, psychosocial interventions, and linkages between communities and formal systems" among the immediate recovery strategies

The Advancing Partners & Communities defines community engagement **as a coordinated series of activities that take place at a health facility or in a community and contribute to building community ownership of health issues and services.**

Community ownership increases the likelihood that donor-funded public sector health activities will continue when programs end. The Government of the Republic of Sierra Leone's national strategic health documents describe community ownership in the following ways:

- "…promoting community trust, engagement, and participation in delivering the BPEHS, and building back better through effective and efficient community health work." – *BPEHS (MOHS 2015a, page 19).*
- "…foster[ing] communities that engage the health system to improve trust, take ownership of their own health, demand accountability, and access essential health services" – *HSRP (MOHS 2015b, page 28).*
- "Community participation… dialogue, formalizing community-based approaches to health service delivery, improving linkages between communities and facilities, including empowering communities to hold the health system accountable for accessible and high-quality service delivery." – *HSRP, (MOHS 2015b, page 46).*
- The CHW program's guiding principles are expected to include fostering community engagement and community ownership in order to ensure that the National CHW Program ultimately meets the need of and is accountable to the communities it serves (MOHS, 2016).

The MOHS and UNICEF (n.d.) defined the objectives of community engagement in the context of EVD to: report sick and death alerts at the chiefdom and section levels; and strengthen/create ownership among traditional leaders and community, including developing preparedness plans at chiefdom, section, and village levels for an emergency response in the case of EVD, as well as community action plans against Ebola at the village level.

In the post-Ebola recovery phase, the question should be asked: "community engagement for what?" The Advancing Partners & Communities project objective 2 aims to increase capacity and effectiveness of the health workforce and community platforms to improve quality of RMNCH services, including IPC, at the primary health care and community levels.

As previously noted, this strategy focuses on the facility-based or supply-side community engagement activities rather than those at the grassroots levels. Key activities relating to community engagement under this objective aim to:

1) Increase capacity and effectiveness of community health workforce to promote and support high-quality RMNCH services, water, sanitation, and hygiene (WASH) practices, and institutionalized IPC guidelines and procedures, and to gain essential technical, managerial, and leadership skills.

2) Increase capacity and effectiveness of community platforms to support the provision of high-quality responsive services, including new IPC guidelines/procedures, by CHPs and maternal and child health posts (MCHPs).

Recommended implementation approaches, processes and standard tools to achieve these defined community engagement aims are described in the accompanying project Community Engagement Implementation Toolkit.

Within the project's performance monitoring plan, the desired outcomes specific to community engagement activities are:

- **OP10:** #/% of health posts that receive capacity-building and community engagement support.
- **OP14:** #/% of health posts with functional community governance structures attached (facility management committee, village development committee) that are supported by the project.
- **OP15:** #/% of health posts with staff conducting quarterly community engagement activities (meetings with community leaders, support to Mothers 2 Mothers, active engagement with VDCs/WDCs, outreach).

It is hypothesized by the project and partners that with greater community engagement, there will be greater uptake of health services. Additional outcome indicators sought by the project include:

- **OC2:** % change in utilization rates of priority RMNCH service at HPs receiving substantial USAID support.
- **OC3:** % change in patients seeking care at HPs receiving substantial USAID support.

III.   Who Does Community Engagement?

Based on document review and consultation with partners, communities, facility staff, and the MOHS, this section of the document describes the roles and responsibilities of the stakeholders that are involved in community engagement. It includes the district health management team (DHMT), the facility staff, the facility-based governance structures that represent the communities within the facility's catchment area, and the community-based practitioners who are accountable and report to the public health system (i.e., CHWs). Based on available national documentation and conversations with the MOHS[3], DHMT, technical and implementing partners, and others, the following directives for community engagement staff at the district and facility levels were established.

On January 13, 2016, a catchment-level community engagement mapping of stakeholders and relationships was elaborated upon by Advancing Partners & Communities' partners (see Annex 2). The roles and responsibilities of these stakeholders and the community structures were elaborated upon During project partner meetings on April 14, 2016 and July 7, 2016 as well as field visits in September 2016, the mapping was further updated, as illustrated in Figure 2.

Figure 2. Community engagement conceptual framework: stakeholders and relationships

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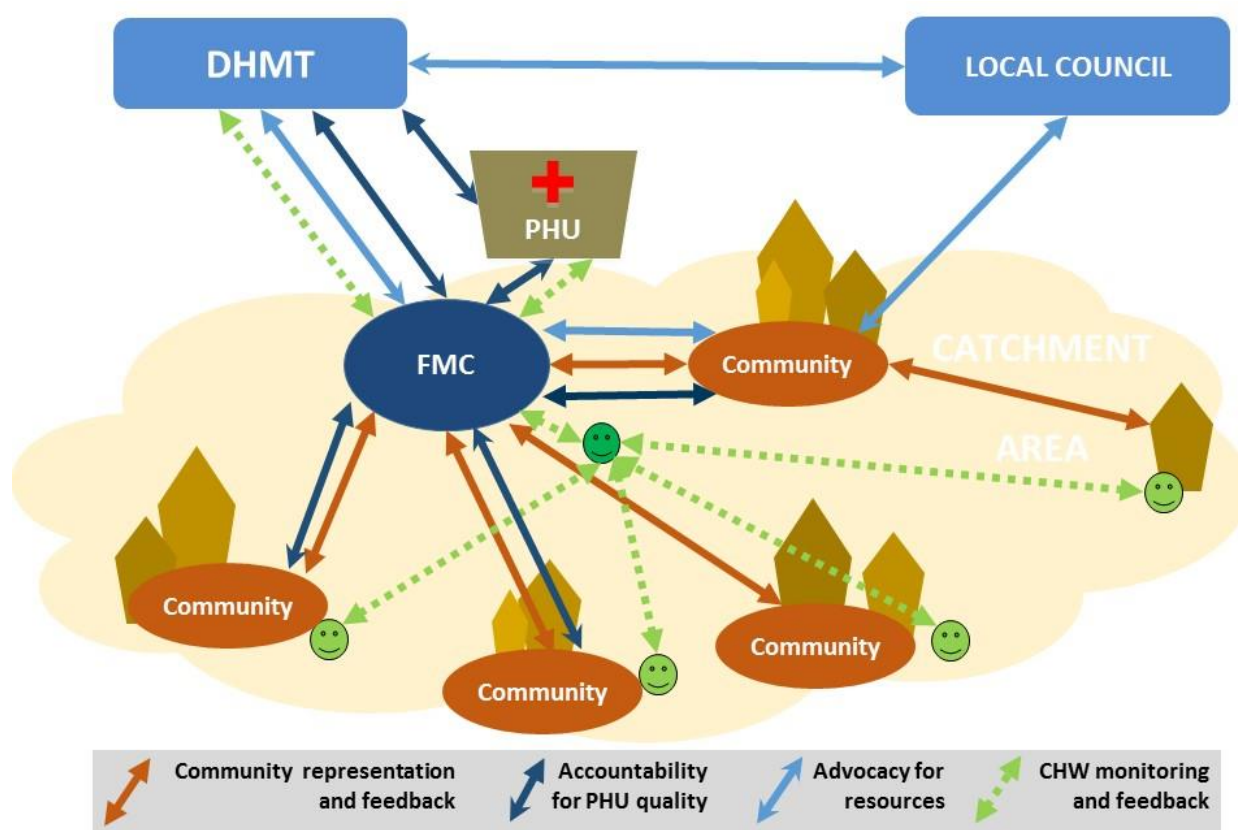
[3] Including PowerPoint presentations by UNICEF/MOHS, *no date*, and H4+ Initiative, *no date.*

Key community engagement stakeholders, roles, and responsibilities

District health management teams

DHMTs represent the MOHS at the district level. The 13 DHMTs across Sierra Leone are responsible for:

- *Implementing:* "…implement national health policies and manage health service delivery" (MOHS 2015b, p 15). "Implement the BPEHS through direct service provision – i.e., the '*how'* of the BPEHS and coordinate with partners to ensure the collective implementation of the BPEHS" (MOHS 2015a, p 27).

- *Managing:* "develop its own health plan as a collaborative effort between the DHMT, district hospital superintendent, and the district council." (MOHS 2015a, p 27) The DHMT is responsible for developing, updating, and costing a district-level plan to implement the BPEHS. This costed planning process was last completed in March 2015 (MOHS 2015a, p 14). The DMHTs with oversight from MOHS, are responsible for recruiting and deploying staff, making staffing allocations according to need (MOHS 2015a, p 52) and managing an ambulance service (MOHS 2015a). Concerning resource allocation and budget requests, the DHMTs liaise with their respective local councils and central-level ministries. The DHMTs are responsible for ensuring that the CHW program functions, which includes supervision of all CHWs in the district (MOHS 2016).

- *Monitoring and reporting:* "…all facilities as part of routine supervisory systems," including health waste management and health worker protection through provision of protective equipment (PPE) (MOHS 2015b, p34). In addition, with the coordination of the Directorate of Disease Control and Prevention, the DHMTs work to institutionalize robust, real-time surveillance (MOHS 2015b, p 51). Through the monitoring and evaluation (M&E) officers, the DHMT reports regularly the indicators as defined by the national M&E framework (MOHS 2015b) and contributes to the district health information system (DHIS) (MOHS 2015a). Reporting includes data on and service indicators of CHWs. The DHMT is accountable to the central level MOHS.

- *Engage:* "initiate quarterly community meetings with paramount chiefs, religious leaders, and community stakeholders… [to] provide an opportunity for community members to identify gaps and propose solutions" (MOHS 2015b, p 47), where the FMCs and VDC/WDCs are the primary committees to ensure community engagement. The DHMT is thus responsible for holding accountable the FMCs and VDC/WDCs that are working with the PHU on community health issues. The DHMTs are also responsible for responding to health issues identified through the '117' health information telephone line[4] (Dr. SAS Kargbo, personal communication, January 13, 2016).

  o There are specific roles on the DHMT that support community engagement, notably the CHW and social mobilization focal persons. As implementing partners and the DHMT collaborate to conduct community engagement activities, it is recommended that any support provided conform to national standards (i.e., maintain the national daily sustenance According to the Tonkolili DHMT, their scope of work and tasks are to:

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[4] The national '117' telephone line was originally a line for all FMCs to provide feedback and hold accountable their respective DHMTs. With a call center in Kono, the MOHS introduced the line to promote efficiency in triage. When the Free Health Care Initiative was launched, it became a general information line, particularly for mothers and children seeking care. When Ebola broke out, the line was transferred to the Ebola Response Team to receive reports of suspected cases and coordinate the response. However, it is anticipated that as the country shifts from emergency to recovery, this line will resume its role as a coordinating center for the Free Health Care Initiative, and possibly for FMCs.

- Identify and train CHWs in Community mobilization skills and techniques
- Conduct a community needs assessment, which involves identifying existing health hazards and risky behaviors and presenting them to communities for collective actions to address them
- Community organization through facilitating the formation structures such as Chiefdom Task Forces, FMCs, HMCs, VDCs, Mothers' Clubs, and others
- Conduct community meetings for feedback, decision making and planning
- Promote community awareness raising through sensitization and education
- Attend district-level meetings and report on progress of community-level engagement activities
- Report to national-level on district based activities

Local councils

The 19 local councils in Sierra Leone are sub-divided into 392 wards. Each ward is headed by an elected councilor (MOHS 2015a). They work closely with the MOHS and the Ministry of Local Government and Rural Development "to improve coordination of devolved health and sanitation functions" (MOHS 2015a, p6). They are responsible for supporting the implementation of the BPEHS (MOHS 2015a, p9) and allocating district-level resources across the public sector, responding to and collaborating with the DHMT to optimize resource allocation. A health committee within the local councils works with the DHMT and maintains linkage with the councils. This body ensures that DHMTs are supported and deliver services in line with national standards, protocols, and plans.

Recommended roles and frequency of tasks of stakeholders in community engagement

STAKEHOLDER	ROLES	TIME FRAME
DHMT	Supervision of CHWs and community level engagement activities	Monthly
	Attend community level engagement meetings for action planning	As per schedule
	Follow-up community level engagement activities as planned during meetings	As per schedule
Local Council	Jointly supervise CHWs and community level engagement activities together with the DHMT	Monthly
	Attend community level engagement meetings	As per schedule
	Jointly follow-up community level engagement activities as planned during meetings	As per schedule
PHU	PHU Staff jointly carry out community level assessment of hazards/risky behaviors and involve community stake holders in action taken initiatives together with CHWs and report to district level focal persons	Ongoing
	Monitor and supervise CHWs at PHU Catchment level	Monthly
	Attend community engagement meetings	As per schedule
	Follow-up community action plans	As per schedule
	Report to district level focal persons on the progress of community engagement activities	Monthly
WDCs/VDCs	Carry out regular health needs assessment within wards and PHU Catchments and facilitate total action taken initiatives	Ongoing
	Attend and play leading roles in all community engagement meetings	As per schedule
	Report to Council on the progress of Community level engagement	Monthly

	activities	

Source: Tonkolili District Health Management Team

COMMUNITY STRUCTURES

Facility management committees

The primary focus of the facility management committee (FMC) is to ensure the functionality of the PHU, including day-to-day operations, drug, infrastructure, general sanitation, and equipment management, and human resources (HR). According to Dr. SAS Kargbo of the MOHS, FMCs were created to manage the cost-recovery agenda of the Bamako Initiative (personal communication, January 13, 2016) and its role in facility infrastructure and operations management, and further revitalize it to ensure access to the Free Health Care Initiative by its intended beneficiaries: pregnant women, lactating mothers, and children under five years of age. However, the FMC must also take community feedback on facility-based health services within its catchment area and convey it to the DHMT, although the community perspective on the quality of services has been less emphasized in recent years (H4+ n.d.).

The MOHS envisions that the FMCs will help give PHU ownership to the people and intends to establish an FMC for each of the 1,100 PHUs in the country to ensure that health workers are accountable to the communities they serve (Kargbo, 2012). The MOHS has outlined terms of reference for FMCs, which the project built upon to operationalize the FMC role within the community engagement strategy. National CHW Policy 2016-2020 defines the FMCs as the key community structure for health (MOHS 2016).

Village development committees

The village development committee (VDC) and ward development committees (WDCs) represents the interests of its constituency across a range of development areas, including health. Anecdotally, some VDC/WDCs have played the role of FMCs, overseeing day-to-day PHU operations. Village development committees were also designated to take community engagement leadership in the Ebola response (UNICEF and MOHS, n.d.). The VDC/WDC is the key community development structure, and health is one of the areas in which VDCs/WDCs engage (MOHS 2016).

The VDC(s)/ WDC(s) within a catchment area should be represented at the FMC ensure feedback that is representative of the entire community that the PHU is supposed to serve, and too help manage. If there are proper accountability channels, the representatives of the VDCs/WDCs at the FMCs should give feedback to the VDCs/WDCs and then to the community. This system and the coordination among community and facility level stakeholders should be strengthened to respond to the Advancing Partners & Communities project objectives.

Based on the triangulation of available documentation on FMCs and VDCs/WDCs and consultations with the MOHS, DHMT and their various partners, the distinctions between the composition, roles, and responsibilities of stakeholders on the FMCs and VDCs/WDCs for community engagement are outlined in table 1 below:

Table 1. FMC and VDC/WDC Composition, Roles, and Responsibilities

	Facility management committee	Village development committee or ward development committee
Composition		

Executive leadership	• Four elected positions
	  o Chair
	  o Vice chair
	  o Secretary (PHU in-charge)
	  o Treasurer
	• The FMC is preferably led by a female chair, as the PHU RMNCH issues are most pertinent to women as consumers of health care services (Dr. SAS Kargbo, personal communication, January 13, 2016).
		• Elect through a transparent process the following executive members: chairperson, vice chair, secretary, treasurer, mammy queen, and auditors/monitor. Define functions for each.
		• The FMC executive leadership is part of the VDC/WDC to provide feedback and linkages between the community and PHU.

General membership	General and elected members should not exceed 12. Members have the following individual responsibilities:[5] **Community representation** • Town chief • Religious leaders (imam/pastor) • Women's representative • Men's representative • Youth leader/representative • Children's representative • Mammy queen • Teacher • Community health worker • Other representatives from hard-to-reach catchment communities, preferably a CHW • Other representatives from sub-populations with special health needs, such as disabled persons and/or Ebola survivors **Facility representation** • PHU staff in-charge • Peer supervisor of CHWs across the catchment area. • Community health monitor to encourage timely utilization of PHU service; promote WASH and hygiene.	Eleven to thirteen members who reside in the community and are willing to dedicate their time to working in the village's best interests and development. In the event that there are more villages in the catchment PHU to form the VDCs/WDCs, it is recommended to have more members. If representation of all VDC/WDC catchment villages pushes membership to more than 25, two VDCs should be formed. **Community representation** • Village/section chief • Religious leaders (imam/pastor) • Community health worker • Women, men, and youth leaders • Community health groups • Child welfare committee • School management committee • Traditional birth attendants (TBAs) • Traditional healers • Secret society heads • One person (preferably a woman) from the larger towns and communities in the PHU catchment area.

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[5] Based on project consultation with partner NGOs and JICA, 2015.

	Facility management committee	Village development committee or ward development committee
Roles and responsibilities		
<u>Community representation and feedback</u>	- Organize quarterly meetings (with possibility of additional monthly or ad hoc meetings) with catchment. Community members (as represented by the VDC/WDC) to provide updates on achievements, challenges, and suggestions, and to solicit feedback from all communities within the catchment area. - Facilitate/promote mobilization of community resources through the VDC - Identify key community members such as CHWs and TBAs. - Ensure PHU staff are conducting community outreach.	- Organize monthly meetings with members to discuss community issues, including an assessment of the PHU facility quality (through use of the toolkit's community scorecard, TOOL 4). - Ensure adequate community representation. - Document meetings and develop action plans based on meeting discussions. ***Where there is an established/active FMC,** all VDCs/WDCs within the catchment area must work together with the PHU's FMC.* ***Where there is no active/functional FMC,** the project will work with the PHU and existing community structures to lead the establishment of an FMC that represents all communities within the catchment area. CHWs must work with the existing local structure.*
<u>Accountability for PHU quality</u>	- Accountable to the DHMT through the submission of monthly/quarterly meeting minutes (compiled by the PHU in-charge and the FMC secretary) to provide information (i.e., non-functioning facility because staff is absent, stock-out of drugs) about the facility to district and national level for action. The CHW peer supervisor communicates directly with the CHW coordinator at the DHMT. - Liaise between the community and the health facility, providing facilities with feedback from community and vice versa. - Clearly communicate health polices to community members. - Work with the health facility to prevent theft or misuse of drugs supplied to health facilities. - Report anything that is affecting health service provision and utilisation within catchment population.	Accountable to the local council to respond to community health needs, as well as other local development needs.
<u>Advocacy for</u>	Advocate for the PHU to the	Advocate to local councils.

	Facility management committee	Village development committee or ward development committee
resources	DHMT/district level. • Develop sustainable mechanism for FMC functionality, including community contributions to facility maintenance.	• Mobilize community resources. • Monitor community engagement efforts to demonstrate ownership.
CHW supervision and feedback	• Ensure a strong relationship between the CHW and PHU. • Peer supervisors represent the CHW perspectives on the FMC and community feedback delivered by community-based FMC representatives to CHWs. • Oversee CHW program, ensure peer supervisor and CHW representation on the FMC. • With the PHU in-charge, support the selection, performance appraisal, and replacement of CHWs.	• Ensure a strong relationship between the CHW and PHU. • Peer supervisors represent the CHW perspectives on the VDC/WDC, and community feedback delivered by community-based FMC representatives to CHWs. • With the PHU in-charge, support the selection, performance appraisal, and replacement of CHWs.

PHU staff / health workers

Health care staff at PHUs[6]— MCHPs, and community health posts (CHPs)—are responsible for providing high-quality care that corresponds with the national Basic Package of Essential Health Services:

- Full engagement and participation on the FMC, or within the facility-specific activities of the VDC/WDC.
- Be well-informed about all PHU activities and communicate them to the FMC and VDCs/WDCs and communities through outreach.
- Understand the community's health priorities (two-way communication).
- Listen to community needs/problems/complaints and help manage and resolve them.
- Take PHU-level health issues that cannot be resolved by PHU staff to the DHMT.
- Meet monthly with peer supervisors and quarterly with the FMC.

Community health workers

Community health workers link the community to the health facility. According to National CHW Policy 2016-2020 (MOHS 2016), CHWs and their peer supervisors are "encouraged to contribute to the strengthening of local structures that exist in their community, as well as their formation where they do not exist." CHWs and their peer supervisors should encourage VDCs/WDCs to focus on community health issues. They represent both the community and the PHU, and may include former TBAs and other lay cadres that have been recruited from the community, and considered part of the community.[7]

CHWs should serve between 100 to 500 individuals, although in some places they serve more (UNICEF 2016). To date, 13,000 CHWs in Sierra Leone have completed the MOHS 10-day training with UNICEF support. Geo-mapping undertaken by the MOHS and UNICEF, in collaboration with other partners and CHWs, revealed that 75 percent of CHWs female; are literate; own a mobile phone; and earn their

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[6] The project may engage with a limited number of community health centers in the Western Area Urban (WAU).

[7] NB: community groups, Mother advocacy groups, mother-to-mother care groups, and community mobilizers will engage with the HC3 project by supporting community champions (SMAC CLEA approach – HC3). This approach has a defined community entry process with VDCs and leadership.

livelihoods primarily through farming. Ninety percent originate from the community in which they serve. The relationships of these community engagement stakeholders are illustrated in Figure 2.

IV.   How is Community Engagement Implemented?

The project seeks to support partners to implement community engagement by documenting their experiences to provide recommendations to harmonize the MOHS's FMC and VDC/WDC model with the national health sector recovery plan and related policies.

Community engagement is a key strategy to optimize Sierra Leone's transition from its emergency response to a recovery phase, and an essential component for sustainability. Community engagement is also at the foundation of the Advancing Partners & Communities project goals, and should thus be part of every project activity. This toolkit intends to provide standard tools and guidance to improve the effectiveness and sustainability of broader project efforts, as well as to help inform future national community engagement approaches. This toolkit takes forward the project's harmonized community engagement implementation strategy that is aligned with: a) national health guidance, strategies and policies, and b) all implementing partners across the project's five districts. It seeks to develop a common definition of community engagement, the roles and responsibilities of key stakeholders in community health.

For community engagement to be streamlined into every project activity, these key questions should always be asked when working at a facility:

"Where are the community people? How can the community people be involved? When should they be involved?"

"Wae de pipul dem na dis ton ? Aw di ton pipul dem go dae pan dis wok?"   ~ Krio translation

Through the April and July 2016 partners' meetings, some key implementation approaches were identified:
- A strong community entry process is important to ensure awareness of community engagement activities and a wide range of stakeholders
- Cultivate good working relationships with the DHMT to promote local ownership and sustainability
- Engage the FMC and the community to take the responsibility for ensuring the functionality of PHUs and encourage the community to take ownership by drawing up on the volunteer spirit of groups and individuals in communities
- Encourage and support functioning FMCs, CHWs, VDCs and other local groups that addresses family health issues
- Strengthen the linkages between communities and health providers (facilities and outreach activities) as well as linkages between CHWs, VDCs and other local groups

Possible challenges, opportunities, and mitigating measures

The Advancing Partners & Communities project team has anticipated challenges to the implementation of its community development strategy and proposed solutions.

- **Limited project time to shift from emergency response to recovery**. Sierra Leone's resilient but sometimes fragmented communities have experienced fluxes of humanitarian initiatives and development aid. Many have grown responsive to and in some cases dependent on the varied materials distribution, allowances, and other incentives of emergency aid. The project may struggle to transform attitudes and cultivate greater community engagement, particularly when community transformation to ownership and empowerment can take several years.
    - In response, we recommend that the project use "win-win" activities for the systems and the individuals that the project wants to involve. For example, using mobile technologies for committee reporting would not only improve project monitoring functions, but it could encourage participation of members who were previously motivated by refreshments or entertainment.
    - Another tactic could be "gamification" to create awards and friendly competition among catchment areas, or introducing participatory learning games within skill-building activities. The project might reposition 'entertainment' by having MOHS and DHMTs record simple messages that convey project objectives. Community and committee members could record video responses or take pictures and record attendance at community meetings.
    - Certain data points on PHU-level activities and status updates (once verified) could be made available on a map of Sierra Leone, in a similar but simplified manner at http://www.fbrcameroun.org/
- **Reliance on the paucity of health workers to lead key community engagement activities.** The PHU staff in-charge plays a pivotal role in the project's community engagement strategy. The absence of this person could hinder project results. Further, where HR shortages are already acute, the project's training schedule for health workers is expected to be intense and would prevent existing staff from conducting community outreach.
    - To mitigate this, trainings must be coordinated. PHU in-charges should delegate the FMC representation responsibility to another staff member to maintain representation. Where health workforce shortages are especially acute, implementing partners and the DHMT might initiate a partnership with local health professional training schools and recruit students interested in gaining practicum experience. Facilities and communities may be able to sponsor these students.
- **Limited commitment of qualified FMC/VDC/WDC members.** Concern about the qualifications and capacity of these committees, particularly in the most remote and underserved areas, has been raised.
    - While all committees will need at least some literate members, members' commitment to their community is the primary criteria and qualification. When needed, tasks requiring literacy can be delegated to another member.
- **Availability of DHMT management and PHU for supportive supervision**. Too often, the DHMT and PHU staff may be under-resourced and over-burdened, which inhibits their key role in accountability, management, and resource mobilization.
    - Given that a large proportion of CHWs have mobile phones, the new CHW registers could support a CommCare-style database for each community to provide feedback. Simple response forms could reduce the steps between the feedback and the recipient (the current

approach with the 117 line, which is channeled through the central call center), unless this would require more effort for the DHMTs to respond. Data mapped on Open Street map / Open Data Kit– might give DHMTs and PHUs more /better information.

- **A disease outbreak or other emergency.** While it is hoped that Sierra Leone will move into a strong recovery phase, it is possible that an urgent event or pandemic could push it back into emergency response and any community ownership gains would be lost.
  - A new case of EVD was confirmed in Sierra Leone in January 2016, and project staff observed high district level IPC compliance and strong communication to keep Ebola transmission rates low.

Next steps

The Advancing Partners & Communities project and partners will:
- Support partners to integrate community engagement strategy interventions in their workplans, including the adaptation of the proposed community engagement tools referenced in the annexes.
- Integrate the national CHW policy and supervision measures into the community engagement approach, as pertains to the strengthening of the community health workforce and their linkages between the facility and community.
- Use the results of the project's baseline survey, including information about the existence of active FMCs and VDCs/WDCs, to develop district, facility, and community-level implementation plans
- Participate in the weekly MOHS Health Promotion/Social Mobilization meetings (Wednesdays at 3pm) at the Central Medical Stores / UNICEF building.
- Coordinate at district level with HC3 to ensure the joint implementation of the community entry strategy and coordinate monthly meetings within individual communities.
- Support the MOHS, UNICEF, and other partners for national community engagement consultations to document activities, contribute to discussions, and inform and adapt future implementation based on emerging strategies, best practices, and lessons, particularly related to the post-Ebola recovery phase
- Document how the implementation toolkit is used, including adaptations and evaluate how effective it is across the project zone's diverse contexts
- Consider how the MOHS and DHMT can take the community engagement process forward after the project implementation period, develop sustainable motivation strategies, and to scale up efforts within additional PHU catchment areas.

V.   References

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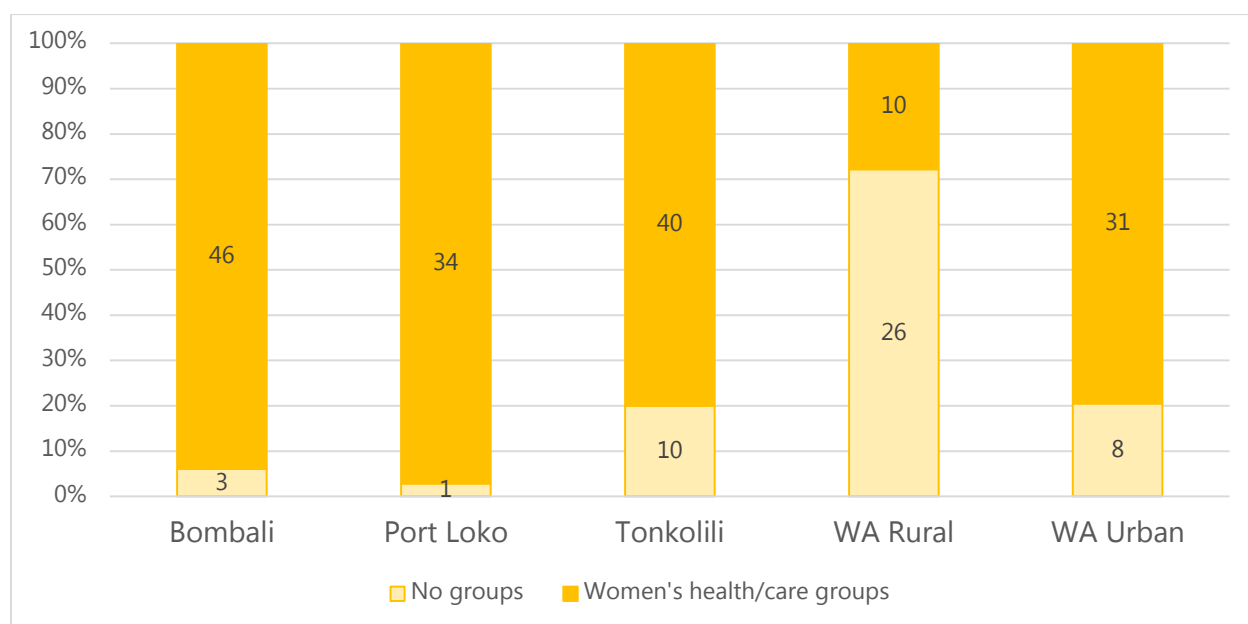
VI.   Annexes

Annex 1. Project baseline survey results on community structures

Figure A. Presence of community-based organizations for PHU linkages by district
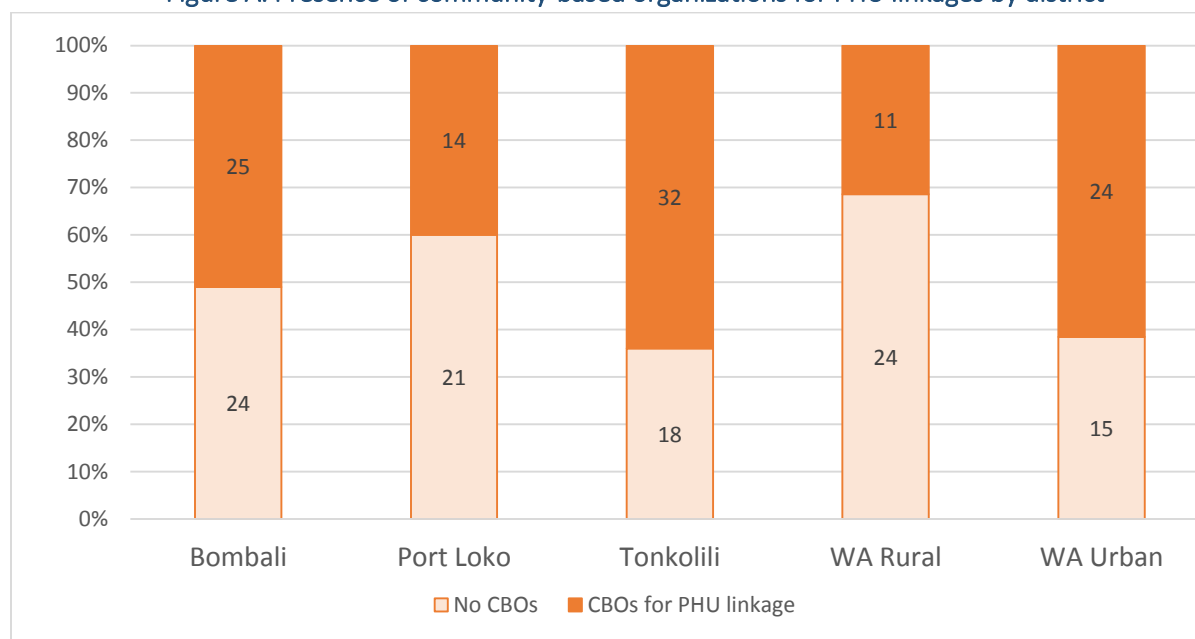
Source: Advancing Partners & Communities baseline survey, February 2016.

Figure B. Presence of women's health/care groups for improved MNH by district

Source: Advancing Partners & Communities baseline survey, February 2016.

Figure C. Bombali District – FMC existence by chiefdom and intervention type

Legend:
- Renovation, FMC exists
- Renovation, No FMC
- No renovation, FMC exists
- No renovation, No FMC
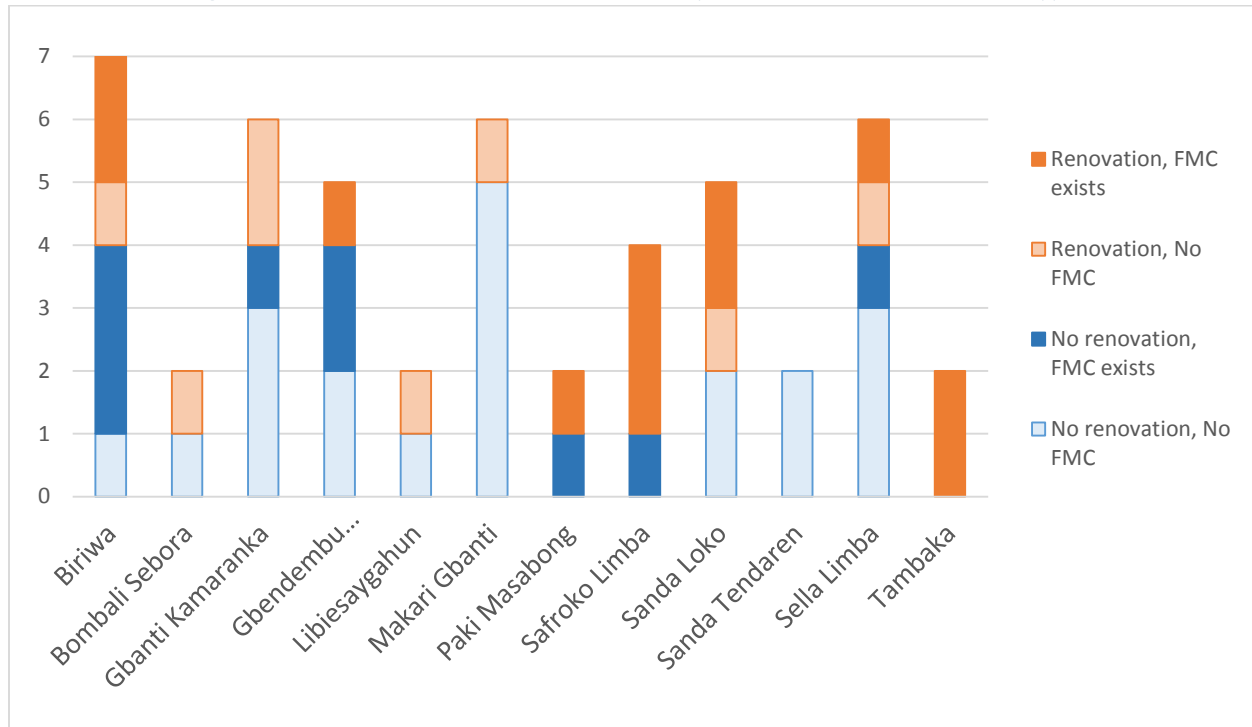
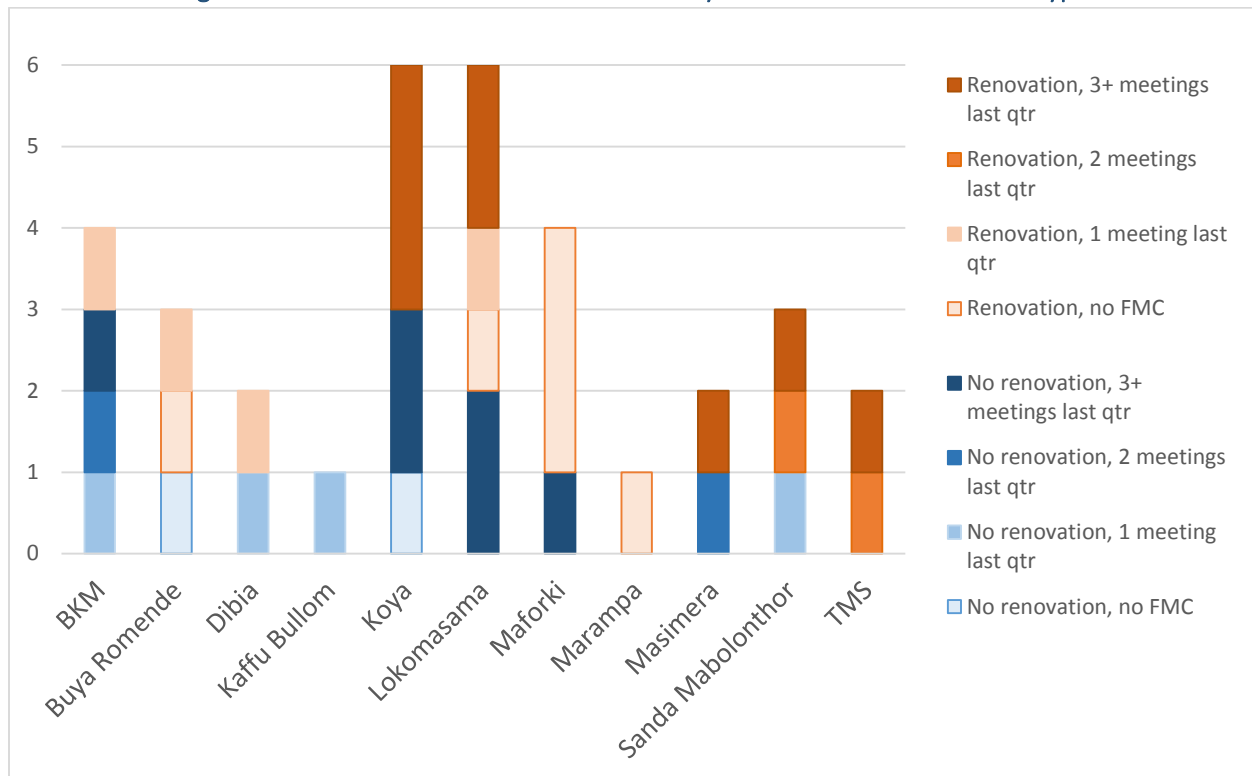*Source: Advancing Partners & Communities baseline survey, February 2016.*

Figure D. Port Loko District – FMC existence by chiefdom and intervention type

Legend:
- Renovation, 3+ meetings last qtr
- Renovation, 2 meetings last qtr
- Renovation, 1 meeting last qtr
- Renovation, no FMC
- No renovation, 3+ meetings last qtr
- No renovation, 2 meetings last qtr
- No renovation, 1 meeting last qtr
- No renovation, no FMC

Chiefdoms: BKM, Buya Romende, Dibia, Kaffu Bullom, Koya, Lokomasama, Maforki, Marampa, Masimera, Sanda Mabolonthor, TMS

Source: Advancing Partners & Communities baseline survey, February 2016.

Figure E. Tonkolili District – FMC existence by chiefdom and intervention type
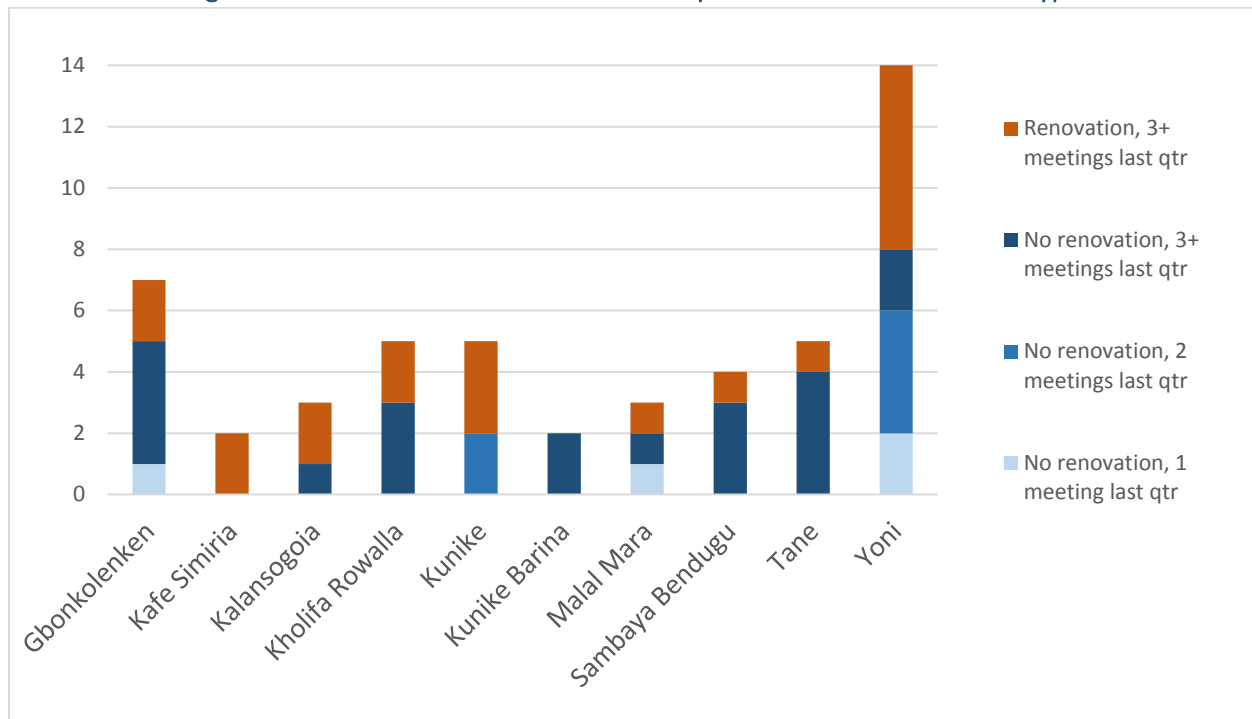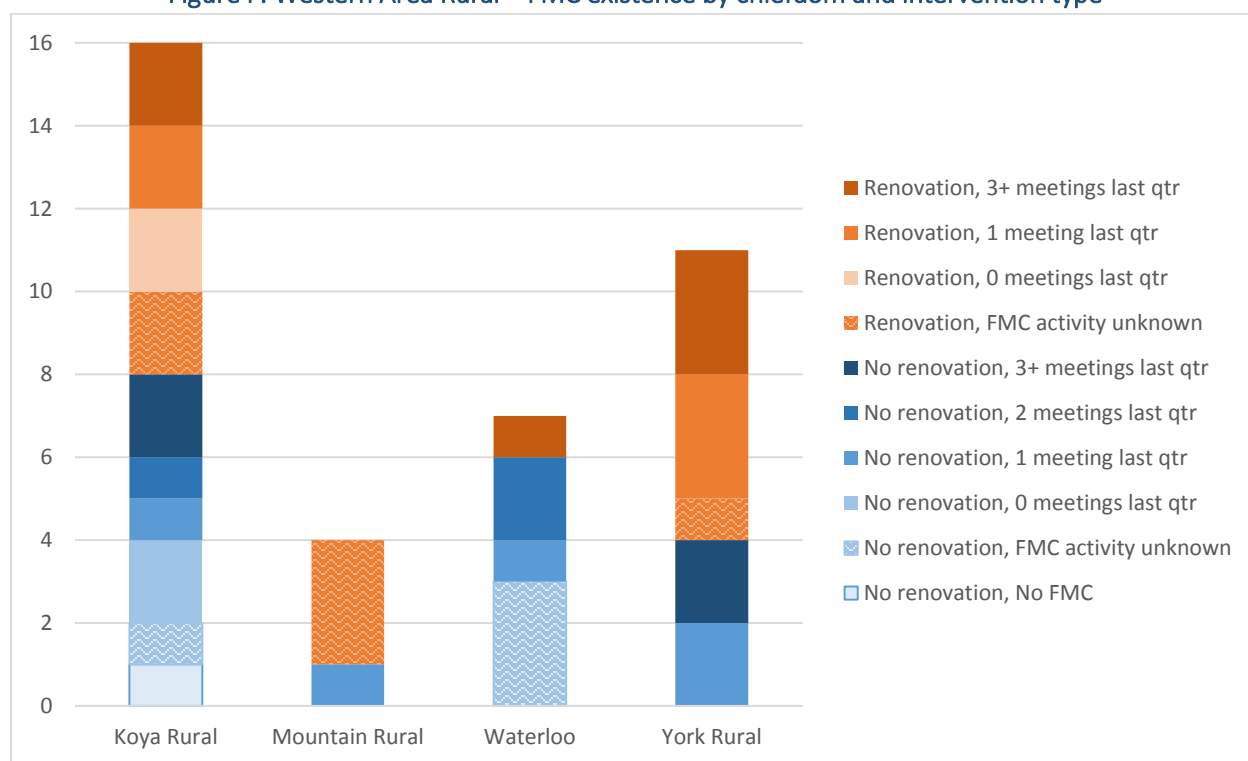

Source: Advancing Partners & Communities baseline survey, February 2016.

Figure F. Western Area Rural – FMC existence by chiefdom and intervention type

Legend:
- Renovation, 3+ meetings last qtr
- Renovation, 1 meeting last qtr
- Renovation, 0 meetings last qtr
- Renovation, FMC activity unknown
- No renovation, 3+ meetings last qtr
- No renovation, 2 meetings last qtr
- No renovation, 1 meeting last qtr
- No renovation, 0 meetings last qtr
- No renovation, FMC activity unknown
- No renovation, No FMC

Source: Advancing Partners & Communities baseline survey, February 2016.

Figure G. Western Area Urban – FMC existence by chiefdom and intervention type

Legend:
- Renovation, 3+ meetings last qtr
- Renovation, 2 meetings last qtr
- Renovation, FMC activity unknown
- No renovation, 3+ meetings last qtr
- No renovation, 2 meetings last qtr
- No renovation, 1 meeting last qtr
- No renovation, 0 meetings last qtr
- No renovation, FMC activity unknown
- No renovation, no FMC

X-axis: Freetown

Source: Advancing Partners & Communities baseline survey, February 2016.

Annex 2. Participatory mapping of community engagement

**Participatory Mapping of Community Engagement Stakeholders
in a Hypothetical Catchment Area, January 13, 2016**