MINISTRY OF HEALTH
AND SANITATION
THE REPUBLIC OF SIERRA LEONE

National Community Health Workers' (CHW) Policy

2021-2025

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
BECE	Basic Education Certificate Examination
BPEHS	Basic Package of Essential Health Services
CBO	Community-based Organization
CBS	Community-based surveillance
CHIS	Community Health Information System
CHC	Community Health Centre
CHP	Community Health Post
CHW	Community Health Worker
CSO	Civil Society Organization
DDMS	Directorate of Drugs and Medical Supplies
DHMT	District Health Management Team
DMO	District Medical Officer
DOT	Directly Observed Treatment
DPHC	Directorate of Primary Health Care
DPPI	Directorate of Policy, Planning and Information
ECD	Early childhood Development
EPI	Expanded Programme on Immunization
ETR	Easy-to-reach
FBO	Faith-based Organization
FCDO	Foreign, Commonwealth & Development Office
FHCI	Free Health Care Initiative
FMC	Facility Management Committee
FP	Family planning
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HTR	Hard-to-reach
iCCM	Integrated Community Case Management
ICT	Information and Communications Technology
IPC	Infection Prevention and Control
ISSV	Integrated Supportive Supervision Visit
JSI	John Snow Institute
LLIN	Long-lasting insecticidal net
LMIC	Low- and middle-income country
MAM	Moderate acute malnutrition
MCH	Maternal and Child Health
MCHP	Maternal and child health post
MDA	Ministries, Departments, and Agencies
M&E	Monitoring and Evaluation
MoHS	Ministry of Health and Sanitation
MSG	Mothers' Support Group
MTNDP	Medium-Term National Development Plan
MUAC	Mid-upper arm circumference

NCD	Non-communicable disease
NEML	National Essential Medicines List
NHSSP	National Health Sector Strategic Plan
NGO	Nongovernmental organization
NMCP	National Malaria Control Programme
NMSA	National Medical Supplies Agency
PHC	Primary Health Care
PHU	Peripheral health unit
RDT	Rapid diagnostic test
RMNCAH-N	Reproductive, maternal, newborn, child, adolescent health and nutrition
SAM	Severe acute malnutrition
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SOW	Scope of Work
STG	Standard Treatment Guideline
TB	Tuberculosis
TOR	Terms of Reference
TP	Teenage pregnancy
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
VDC	Village Development Committee
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

1.0 Introduction

1.1 Overview

Sierra Leone, like many low- and middle-income countries (LMICs), is grappling with serious deficits in human resources, posing a critical constraint to health system performance. Low and Middle Income Countries face challenges to train, retrain, and distribute health workers, threatening individual and community health outcomes.[1] While a range of global strategies have been used to resolve the human resources crisis by promoting staff retention and retraining, another widely used strategy has been task-shifting, which involves delegating as many tasks as possible away from doctors, nurses, and pharmacists to non-clinical staff. Task-shifting enables clinical staff to concentrate on their specific areas of expertise and establishes new cadres to extend workforce capacity.[2] It is within the context of task-shifting that the concept of using community health workers (CHWs) to carry out certain basic health services in their communities has regained currency. CHWs are members of the communities where they work, selected by their communities, and accountable to them. They are supported by the health system, as they perform a wide range of preventive and curative tasks. However, they have less training than professional workers. Worldwide, it has been demonstrated that CHWs can contribute significantly to improving the health of the population[3] by providing a critical link between their communities and the health and social service systems. Based on the good body of evidence supporting the significant role of CHWs in promoting community health outcomes, countries have been encouraged to consider integrating CHWs fully into their national human resources for health (HRH) plans and health systems.[4]

Since 2012, Sierra Leone has included CHWs as a key workforce in the delivery of community health services. The first National CHW Policy was developed in 2012 to ensure that programme-specific CHWs and other volunteers were well-managed. The second National CHW Policy was developed in 2016, building on the historic efforts to strengthen and harmonize various community-based programmes in order to provide comprehensive primary health care (PHC) services at the community level. In 2017, the programme was rolled out nationwide with 15,000 CHWs trained to provide a basic package of essential health and nutrition services at the community level, including

[1] Lehmann U, Sanders D. Community health workers: what do we know about them? Geneva: World Health Organization; 2007 (https://www.who.int/hrh/documents/community_health_workers.pdf).
[2] Celletti F, Wright A, Palen J, Frehywot S, Markus A, Greenberg A, et al. Can the deployment of community health workers for the delivery of HIV services represent an effective and sustainable response to health workforce shortages? Results of a multicountry study. AIDS. 2010;24(suppl 1):S45–S57. doi: 10.1097/01.aids.0000366082.68321.d6.
[3] Wringe A, Cataldo F, Stevenson N, Fakoya A. Delivering comprehensive home-based care programmes for HIV: a review of lessons learned and challenges ahead in the era of antiretroviral therapy. Health Policy Plan. 2010;25(5):352–362. doi: 10.1093/heapol/czq005.
[4] Global Health Workforce Alliance, World Health Organization. Integrating community health workers in national health workforce plans. Geneva: World Health Organization; 2010 (https://www.who.int/workforcealliance/knowledge/resources/CHW_KeyMessages_English.pdf?ua=1).

reproductive, maternal, newborn, and child health, Integrated Community Case Management (iCCM) of sick children, and community-based surveillance (CBS) of diseases and events.

The 2021-2025 National CHW Policy builds on the recommendations of the 2019 National CHW Programme assessment led by the John Snow Institute (JSI), and the report of the joint mission to Sierra Leone by the United Nations (UN) and other development partners in November 2019, as well as other national and international considerations. This policy provides further guidance on the coordination, implementation, and monitoring and evaluation (M&E) of the National CHW Programme. It also provides guidelines on the CHWs' revised Scope of Work (SOW), programme integration, geographic coverage, selection criteria, training and deployment, supervision, incentives and remuneration, performance management, programme M&E, and reporting.

The 2021-2025 National CHW Policy aims at contributing to the attainment of the goals of the National Health Policy (2021-2025), the Medium-Term National Development Plan (2019–2023), and the Universal Health Coverage (UHC) Roadmap (2021–2030) by ensuring increased and equitable access to quality and affordable health care services and health security by all people in Sierra Leone.

1.2 Purpose of the CHW Policy

The 2021-2025 National CHW Policy serves two primary purposes. First, the Policy will ensure a standardized and well-coordinated CHW programme at all levels. The Policy takes into consideration the key findings and recommendations of the independent JSI-led assessment and lessons learned from implementing the previous Policy in order to promote the integration of CHWs into the national health systems and manage the operations and performance of the programme and its staff. Second, the Ministry of Health and Sanitation (MoHS) has developed the revised National Health Policy and UHC Roadmap for Sierra Leone in the countdown to 2030. In this context, the National CHW Programme plays a foundational role in the community component of PHC, which is the cornerstone of a sustainable health system and crucial for achieving UHC. A well trained, supervised, motivated, equitably distributed, and sustainable CHW workforce can be a game-changer in the Sierra Leonean context, considering the current inadequacies and poor distribution of the health workforce. The revised Policy, therefore, provides a framework to ensure that the CHW programme contributes to the attainment of the goals laid out in the National Health Policy, MTNDP, and UHC Roadmap, and other health-related targets in the Sustainable Development Goals (SDGs).

2.0 Context analysis of the PHC system

The health sector has adopted an integrated approach to the delivery of health interventions. The access, quality, and coverage of health services, preventive care, clinical care, and emergency services are important aspects of the health service delivery system. Through an integrated approach, public health interventions are packaged and delivered as part of community health interventions and outreach at the community, district, and national health care delivery levels.

Sierra Leone has a three-tier pyramidal health care system, structured by the primary, secondary, and tertiary levels. The PHC level is the subdistrict level, involving peripheral health units (PHUs) and the extended community-based services implemented by CHWs. The district health system encompasses public and private hospitals, PHUs, and community health programmes. Each district has a hospital that provides secondary care services and serves as a referral centre for the PHUs. The District Health Management Team (DHMT) is responsible for implementing the national health policies and carrying out the planning, coordination, and management of health service delivery in collaboration with stakeholders. The tertiary level consists of referral and teaching hospitals, including the regional hospitals situated in regional headquarter towns. They serve as the referral facilities for secondary care and are run by general practitioners and specialists.

First-line PHUs are further subclassified into three levels: maternal and child health posts (MCHPs), community health posts (CHPs), and community health centres (CHCs). These facilities are situated in small villages and chiefdom headquarters. All levels of PHUs extend select essential health and nutrition services to the households and communities in hard-to-reach areas through the CHW network across the country.

3.0 Policy analysis

Guided by global strategies and guidelines[5], the general orientation of the 2021 National CHW Policy revolves around some important national documents and reports, which are described briefly below.

3.1 National Health Sector Strategic Plan (2017–2021)

With the end of the 2014–2015 Ebola outbreak and the President's recovery priorities, the health sector shifted from recovery to a more stable and functional environment. In this context, the 2017-2021 National Health Sector Strategic Plan (NHSSP) was developed to organize the tremendous outpouring of energy and resources in different

[5] Guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf); Declaration of Astana on Primary Health Care. Geneva: World Health Organization; 2018 (https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf); and the Cotonou Declaration on Community Health in the Context of PHC, 2019.

areas across the sector into a coherent, prioritized, and efficient plan to drive coordination in the health sector. The strategy provided the opportunity for the MoHS to begin thinking about its longer term goals and objectives, including the revision of the National Health Policy to articulate a proactive vision for the MoHS in relation to a set of longer term goals for the health sector, the SDGs for health, and the long-term promise of UHC.

3.2 Sierra Leone's Medium-Term National Development Plan (2019–2023)

The Government of Sierra Leone's long-term socioeconomic development agenda is guided by the MTNDP, which charts a clear path towards achieving middle-income status by 2039. The Plan recognizes the importance of investing in education and health to ensure sustainable economic transformation and optimal poverty reduction.

3.3 National Health Policy (2021–2025)

The health sector's focus is to improve the health status of all people in Sierra Leone and to ensure that populations have access to affordable, quality health care services and health security, without suffering undue financial hardship and social risk in the process of accessing health care at any level of the health care delivery system. However, a number of factors have posed challenges to the provision of high-quality, affordable, and accessible care for all in Sierra Leone, including inadequate financing, weak HRH, poor maternal and child health (MCH) outcomes, high prevalence of infectious diseases, the emerging burden of non-communicable diseases (NCDs), and weak health systems leadership and governance.

3.4 Universal Health Coverage Roadmap for Sierra Leone (2021–2030)

UHC is a national priority for Sierra Leone. UHC, as defined in target 3.8 of the UN SDG, is the provision of equitable access to quality and affordable health care for all without undue financial hardship. Sierra Leone is in the process of expanding health coverage and uptake, particularly among people working in the informal sector and other vulnerable groups, and providing financial protection. In Sierra Leone, despite the importance policymakers and health managers have attached to efforts to improve the quality of health care, significant deficits persist in the populations' access to quality health services. Such deficits are anticipated to compromise efforts towards the achievement of UHC.

3.5 National CHW Programme assessments and labour market analysis

In the context of developing the 2021 National CHW Policy and with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria, JSI (in partnership with FOCUS1000) conducted an assessment of the National CHW Programme. The assessment focused on three main components: a process evaluation of the CHW reporting system, a process evaluation of CHW service quality, and a cost-efficiency analysis of the CHW programme. In 2019, a labour market analysis, which included the

CHW workforce, was conducted with technical assistance from the Global Fund and World Health Organization (WHO).

The Directorate of Primary Health Care (DPHC) of the MoHS, with technical support from Living Goods, also conducted a self-assessment using the Community Health Systems Change Maturity Model tool. The aim of this assessment was to identify elements of success for institutionalization and challenges/gaps for improvement in order to achieve the policy goals of sustainability, scalability, and impact. Key findings from these assessments include:

1. **Repeated stock out** of lifesaving commodities
2. **Low capacity**: literacy/untrainable
3. **Operational Challenges/gaps**: data quality, infrequent reporting delays, incentive payments delays, performance management and accountability
4. **Sustainability:** costly due to programme size/CHW numbers, competing CHW cadres (TB, HIV, Malaria etc), funding/financing
5. **International best practice:** scope of work, coverage area and population, gender balance

The findings of these assessments yielded recommendations, notably related to the following: coordination of fragmented CHW programmes, funding and sustainability, CHW deployment, remuneration and payment method, selection process, and integration into national human resources and health systems. These findings and recommendations have informed the revised CHW Policy and CHW Strategic Plan.

4.0 National CHW Policy orientation

The National CHW Policy seeks to promote and sustain community health services that reduce maternal, neonatal, and child mortality rates and improve the health and well-being of the populations. The Policy also aims at contributing to the achievement of the Sierra Leone UHC Roadmap in the countdown to 2030 and ultimately the attainment of other health-related SDGs. Such achievements will enable the entire population of Sierra Leone to contribute to the country's sustainable development agenda.

The vision, mission, goal, objectives, and guiding principles of the National CHW Programme are as follows:

4.1 Vision

The National CHW Policy aims to provide guidance to operationalize a functional CHW programme that is part of a resilient and responsive national health system. The National CHW Programme aims to provide efficient, effective, and high-quality services that are accessible and affordable to everybody, especially people living in hard-to-reach areas.

4.2 Mission

The National CHW Programme will contribute to the overall human capital development through equitable deployment and management of a competent, responsive, gender-sensitive, and sustainable community health workforce, while creating an enabling environment for maximizing their performance.

4.3 Goal

To contribute to improved health promotion and delivery of essential services in Sierra Leone through an adequately trained, motivated, and equitably distributed community health workforce in order to achieve the goals set in the UHC Roadmap and other health-related SDGs by 2030.

4.4 Objectives

The main objectives of the National CHW Policy include:

- Providing policy guidance and a framework for the selection, recruitment, training, Scope of Work (SOW), and deployment of CHWs in Sierra Leone;
- Strengthening the management and supervision structures, and ensuring that sustainable remuneration, supply of essential commodities, and performance management systems are in place for CHWs; and
- Further promoting the integration of CHWs into the national health systems.

4.5 Guiding principles

The National CHW Programme's guiding principles are the shared rules and ethical standards that underpin its work and its relationships with communities and other stakeholders. The guiding principles are:

Cost-effective, people-centred, integrated care based on the holistic needs of the populations. The interventions are high-impact and demand-driven to meet the health needs of individuals, delivered through an integrated approach.

Equity and access: Equity will be assured across gender and urban–rural geographic locations, adhering to the principle of leaving no one behind in the attainment of UHC. The CHW programme will include innovative mechanisms to provide poor, highly vulnerable, and hard-to-reach communities and individuals with access to basic essential health services.

Community ownership: The CHWs' SOW acknowledges the needs of the communities, and interventions are designed to be demand-driven. A bi-directional dialogue between CHWs and communities, along with other community participatory approaches, will be used at all stages of CHW programme operations.

Inclusive and coordinated partnership: The national CHW programme is led by the MoHS through the DPHC and supported by numerous stakeholders and partners at the national and district levels. Harmonized joint actions by all partners supporting the CHW Policy implementation will ensure that all efforts and related resources are employed as efficiently and effectively as possible, thereby reducing duplication.

Accountability and transparency: The MoHS, partners, and stakeholders will be accountable for their commitments and responsibilities to the beneficiaries.

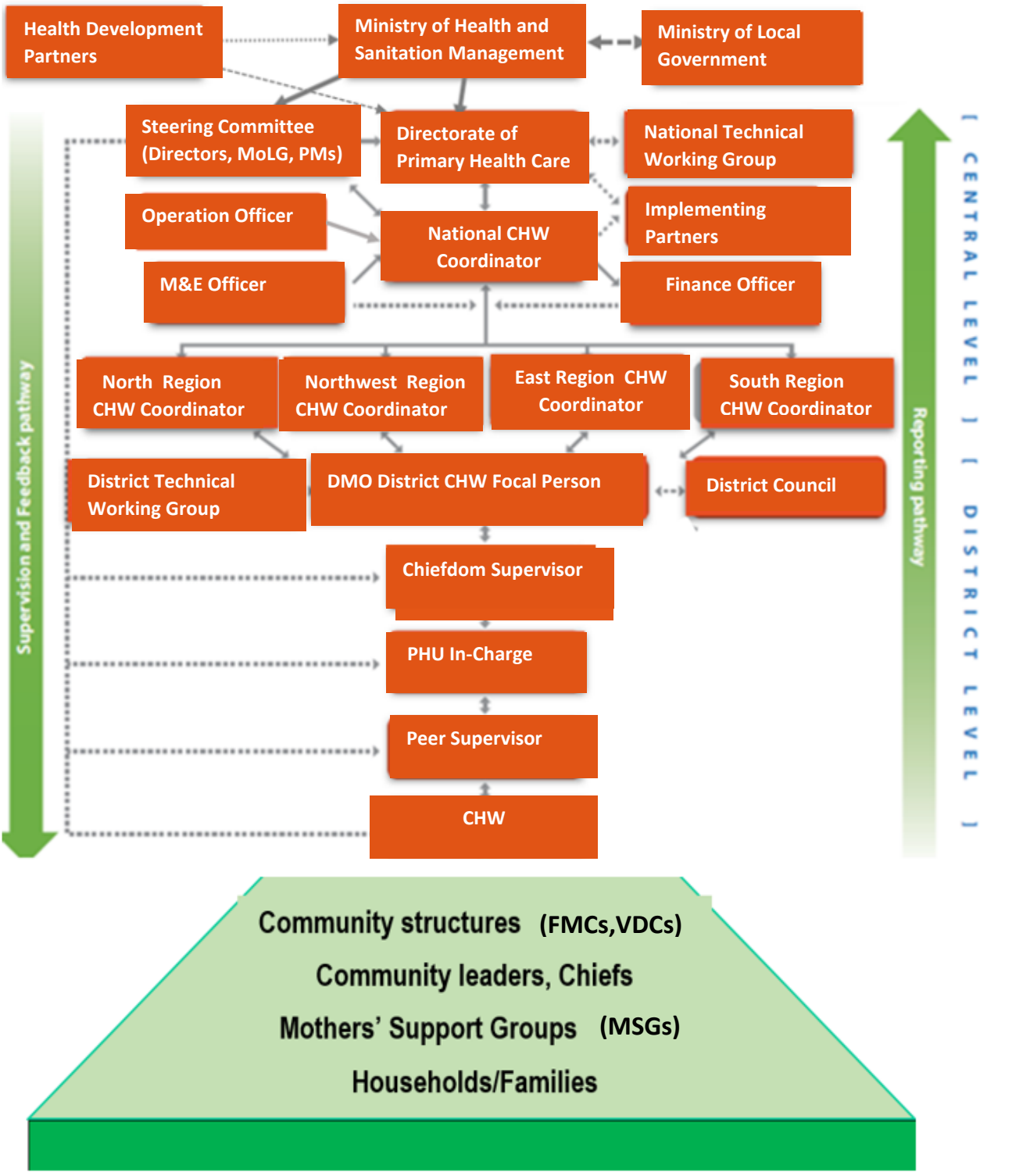
Results-oriented and evidence-based management: The CHW programme will create ongoing, evidence-based learning platforms to influence programmatic changes that reflect the national and international health landscape and respond to potentially changing local situations. With strong performance management of CHWs in place, the CHW programme must achieve the most effective and efficient use of resources and ensure rapid action with a strong feedback loop.

5.0 National CHW Programme governance framework

5.1 Programme organization and management

The national CHW programme is integrated into the national health systems at all levels. The relationships among CHW stakeholders at the national and district levels are schematically presented in Figure 1 below.

Figure 1: Organogram of Sierra Leone's National Community Health Worker Programme



5.2 Management and stewardship

The functions of the national and district levels of the MoHS are as follows: At the national level, the MoHS is responsible for the governance of the health sector and for developing policies, strategies, guidelines, etc. for all health initiatives. The implementation of policies and strategies occurs at the district level through the DHMTs. Led by the District Medical Officer (DMO), the DHMT is in charge of overseeing the implementation of policies and strategies for all national programmes.

The roles and responsibilities of the respective stakeholders of the National CHW Programme are as follows:

National-Level Stakeholders

Ministry of Health and Sanitation

The MoHS through the DPHC and National CHW Hub:

- Oversees and is responsible for ensuring that the policy and strategy are in place and are implemented;
- Ensures the effective coordination of and collaboration on CHW strategies with other relevant ministries, donors, development partners, DHMTs, and local councils;
- Advocates for and ensures sustainable funding for the implementation of the CHW Policy and Strategic Plan; allocates a part of the MoHS annual budget to the management and operation of the National CHW Programme;
- Ensures the integration of the CHW programme into the existing MoHS strategic plans and programmes;
- Ensures that all community health interventions implemented by partners comply with MoHS directives and guidelines;
- Ensures quality control of training and supervisory activities;
- Conducts periodic reviews of integrated CHW training packages, guidelines, and supervision tools;
- Ensures a constant supply of the life-saving commodities and tools (registers, reporting forms, etc.) that are necessary for implementing the strategy;
- Supervises implementation in collaboration with the DHMTs and implementing partners, and conducts regular supportive supervision and quality assurance;
- Ensures coherence and complementarity between the National CHW Programme and other programmes within the MoHS; and
- Identifies research needs, and oversees operational studies and evaluations.

Ministry of Local Government and Rural Development

- Ensures the participation of local community structures in the selection process, deployment, and performance management of CHWs;
- Oversees and supports national-, district-, and community-level CHW engagements as appropriate; and
- Supports sustainable funding initiatives for the National CHW Programme. This includes apportioning a budget to the local councils for managing the CHW programme.

Other line ministries

As the Government of Sierra Leone increases ownership of the National CHW Programme, the involvement of other line ministries, such as the Ministry of Finance; the Ministry of Social Welfare, the Ministry of Gender and Children's Affairs; the Ministry of Trade and Industry; and the Ministry of Basic & Secondary School Education (MBSSE), will be essential.

CHW Steering Committee

The CHW Steering Committee is chaired by the Chief Medical Officer, with the National CHW Hub serving as the Secretariat. Members include all MoHS Directors and Programme Managers of associated programmes in the National CHW Programme, other ministries, departments, and agencies (MDAs), and health development partners, including the following:

- *National Malaria Control Programme (NMCP)*
- *Directorate of Disease Prevention & Control*
- *Food and Nutrition Directorate*
- *Reproductive and Child Health Directorate*
- *National TB/Leprosy Control Programme*
- *National AIDS Control Programme*
- *EPI/Child Health Programme*
- *Directorate of Non-Communicable Diseases*
- *Directorate of Policy, Planning and Information*
- *Directorate of Nursing & Midwifery*
- *Directorate of Training & Research*
- *Directorate of Human Resources for Health*
- *Directorate of Decentralization and Local Governance*
- *Directorate of Health Security and Emergencies*
- *Chief CHO's Office*
- *Health Development Partners*

The Steering Committee is responsible for:

- Overseeing the implementation of the National CHW Programme, ensuring that goals and timelines are met, and finding solutions to performance, funding, and governance difficulties; and
- Developing and ensuring implementation of an integration strategy and supporting coherence and complementarity between the CHW programme and other MoHS programmes.

National Technical Working Group (TWG)

The DPHC chairs the National TWG. Members include MoHS programme Technical Officers, technical experts from UN agencies and other development partners, and NGOs. The National TWG plays the following roles:

- Advises the National CHW Programme;
- Participates in and facilitates the review, update, and implementation of the CHW Policy and Strategic Plan;
- Helps the MoHS to harmonize and standardize the CHW Training Curriculum, guides, job aids, and monitoring, recording and reporting tools;
- Helps the MoHS to mobilize sufficient resources (financial, human, and material) to implement a high-quality and comprehensive CHW programme at the national and district levels equitably; and
- Ensures collaboration and coordination among current and potential CHW programme partners.

District-Level Stakeholders

District Health Management Team

DHMTs are responsible for district-level planning, implementation, and monitoring of the National CHW Programme in line with the National CHW Policy. Specifically, the DHMTs should:

- Ensure the effective coordination of the programme at the district level in line with the CHW Policy and Strategic Plan;
- Coordinate and harmonize with the District Council on the planning, resource mobilization, allocation, and M&E of the CHW programme;
- Advocate for local support for the implementation of the CHW programme in districts;

- Ensure that all community-based organization (CBO), civil society organization (CSO), and NGO partners work in line with the National CHW Policy and Strategic Plan to avoid misalignment and duplication of activities;
- Oversee the selection, training, and deployment of CHWs in their respective communities as per the National CHW Policy and Strategy;
- Map villages to show the coverage of each health facility and CHW;
- Maintain a database of the CHWs in each district by name, contact address, location, and training undertaken;
- Train CHWs and ensure that norms, standards, and quality assurance are adhered to;
- Collate monthly and quarterly data, validate, analyse, summarize, provide feedback to the PHU in-charge and supervisors, and disseminate to all stakeholders; and
- Document lessons learned and communicate these to ensure improvement in the quality of CHW programme implementation.

Other line ministries

As the Government of Sierra Leone increases ownership of the National CHW Programme, the involvement of other line ministry representatives at the district level, such as the Ministry of Finance, Ministry of Local Government, Ministry of Social Welfare, Gender and Children's Affairs, Ministry of Trade and Industry, and Ministry of Education, will be essential.

Peripheral health unit in-charge

The PHU in-charge is the person responsible for the management of the CHW programme within his/her catchment area. The PHU in-charge is responsible for**:**

- Directed by the DHMT leadership, coordinating and facilitating the selection, training, and deployment of CHWs in the catchment area as per the criteria stipulated in the National CHW Policy and Strategy;
- Keeping a database of CHWs by name, gender, village, contact address, and training, and updating it regularly;
- Managing the planning, implementation, and monitoring of CHW programme activities in the catchment;
- Providing essential medicines and supplies to CHWs, and ensuring their proper use;
- Supervising and guiding peer supervisors, CHWs, and Mothers' Support Groups (MSGs) in the catchment;

- Organizing monthly meetings with CHWs, peer supervisors, and MSGs; reviewing and validating activity reports and supplies; and providing mentoring/coaching as needed;
- Regularly reviewing CHW programme implementation using CHW programme monitoring data to identify and address issues or seek support from the DHMT;
- Compiling, validating, and reporting data to the DHMT using the community health information system (CHIS) and the District Health Information Software 2 (DHIS2); and
- Applying performance-based management to each CHW and peer supervisor; and tracking and reporting their functionality and performance to the DHMT. This links to any financial or non-financial incentives or corrective measures.

Local councils

Local Councils (District and City Councils) are responsible for supporting implementation of the National CHW Programme at the district level, including ensuring that the Programme interacts with other local structures, particularly local governance structures to:

- Prioritize and support the CHW programme as a vehicle for human capital development in Sierra Leone;
- Provide leadership and coordination for the timely planning and M&E of the CHW programme;
- Participate in the selection of community members to be trained and deployed as CHWs; local council authorities are expected to coordinate among traditional leaders, Facility Management Committees (FMCs), Village Development Committees (VDCs), and other community structures in the selection of CHWs;
- Lead the mobilization of local resources for sustainable financing of the CHW programme; District Councils should allocate budget to support the management of the CHW programme in their districts;
- Undertake community sensitization on the roles and responsibilities of CHWs and ensure compliance; and
- Formulate by-laws governing the provision and use of health care services in the communities.

Community and its governance structures

Families, individuals, and their organizations (e.g., women's groups), community leaders (political and religious), and health and social structures (FMCs, VDCs, and PHUs) are crucial partners for CHWs for:

- Prioritizing, promoting, and/or providing prompt and adequate treatments, particularly for high-risk groups, and immediate referral in the case of non-response or danger signs;
- Prioritizing preventive measures to protect the family and the community with particular emphasis on high risk groups; and
- Providing oversight of CHWs.

Chiefs and other traditional leaders help CHWs to promote healthy behaviours and appropriate care-seeking in their communities. They are responsible for ensuring community ownership and functionality of community-level structures. They must make sure that CHWs and/or their peer supervisors are represented in the community structures so that CHWs are able to report their challenges and successes in order to initiate appropriate actions.

Community ownership is important for the success of any community-based programme. Several community structures exist in the context of Sierra Leone, and all of them have key roles in the implementation of the CHW programme. The most common structures are FMCs and VDCs, but given the diversity of communities in Sierra Leone, other structures may also be relevant. Community structures are responsible for collaborating with the PHUs and DHMTs in selecting CHWs based on the criteria set in this Policy. They are also responsible for collaborating with the peer supervisors, PHU staff, and DHMTs to conduct annual performance appraisals of the CHWs and peer supervisors. The CHWs or their peer supervisors will need to be members of these structures.

District Technical Working Group

Each district must have a TWG that is chaired and co-chaired by the DMO and District Council, respectively. The District TWG is responsible for:

- Ensuring full implementation of the National CHW Programme at the district level;
- Helping the DHMT to maintain an accurate database of all CHWs working in the district;
- Identifying and addressing implementation challenges, including stock issues, and developing and monitoring the implementation of district annual, quarterly, and monthly plans with explicit activities and timelines; and
- Regularly reviewing district-level CHW programme implementation, including routine monitoring of CHW programme data to identify and address issues.

Members include district focal persons from associated programmes (CHW, malaria, nutrition, tuberculosis [TB], HIV, disease surveillance, etc.), the M&E Officer, District Logistics Officer, and District Council representative. All implementing partners in districts

are required to be members, regardless of whether or not they are directly involved in implementing the national programme. The District CHW Focal Person acts as secretary of the District TWG.

Partner-Level Stakeholders: Donors, NGOs, CBOs, and FBOs

Partners at both national and district levels are expected to:

- Provide financial support for the implementation of the CHW programme;
- Provide technical guidance on the execution, monitoring, and evaluation of CHW implementation;
- Support quality assurance of all aspects of implementation;
- Comply with MoHS directives and circulars regarding CHWs, community health interventions, and community case management;
- Ensure all community health activities are channeled via CHWs;
- Coordinate activities with the DHMTs and other partners to ensure effective coverage of interventions and avoid duplication;
- Ensure that the content of all key messaging, training, and supervision packages is in line with MoHS directives and guidelines;
- Report activities and data, as defined by the MoHS, in a format that is compatible with the health management information system (HMIS) in a timely and complete manner;
- Ensure the quality of services according to national treatment guidelines; and
- Participate in the National and District TWGs.

5.3 Partnership and Coordination

The Government of Sierra Leone is working towards ownership of the National CHW Programme by integrating CHWs into the national health systems. The implementation of the current National CHW Policy involves numerous stakeholders at the national, district, and community levels. At the national level, the MoHS through the DPHC will coordinate and provide leadership for implementation. The MoHS will advocate with other MDAs, notably the Ministry of Local Government and Rural Development, for community ownership of the CHW programme, and the Ministry of Finance for resource allocation to CHW Policy implementation. Other key MDAs include the Ministry of Social Welfare, Gender and Children's Affairs, Ministry of Economic Planning and Development (MoPED), and Ministry of Basic and Senior Secondary Education (MBSSE). The MoHS will also advocate with development partners and other agencies to mobilize resources and acquire technical support for the CHW programme.

The DHMTs, with clear guidance and support from the MoHS/DPHC, will coordinate CHW Policy implementation at the district level. The PHUs, with clear mandates, guidance, and support from the DHMT, will oversee the coordination at the community level. As the PHUs form the link between the DHMT and the community, the capacity of these health facilities to coordinate CHW activities needs to be developed so that they can lead, supervise, and support communities and other organizations implementing health projects at the community level. In addition, the PHUs will need sufficient support from the DHMTs to be nurtured into a position where they can perform their coordinating and collaborating duties well.

The overall coordination of CHW Policy implementation is well-integrated within the health system coordinating structures, with explicit policy direction on what partners can do in response to community health needs. The National CHW Programme coordinating structure articulates a shared vision with stakeholders and provides clearly defined roles at the district level, thus promoting commitment to the national goals of not only the CHW programme, but also the National Health Policy and strategic plans.

6.0 CHWs' roles and responsibilities

6.1 Definition of a CHW

A community-based Lay Health Worker trained and deployed by MoHS to provide promotive, preventive, limited basic curative and referral services in relation to reproductive, maternal, newborn, child, adolescent health, and nutrition (RMNCAH-N), communicable and non-communicable diseases to his/her community

A person serving as a CHW must:

- Be a member of the community where he/she works;
- Be selected in coordination with the DHMT, local council, and community structures, and be officially recognized by the MoHS;
- Meet the selection criteria outlined in this policy document;
- Be trained on the National CHW Training Curriculum; and
- Implement the services in the SOW as outlined in this document with satisfactory performance.

6.2 Scope of Work

The CHWs' SOW prioritizes high-impact, cost-effective, and evidence-based interventions that will reduce maternal and child morbidity and mortality and improve RMNCAH-N outcomes. It also addresses prevention and control of select prominent infectious diseases and NCDs. The SOW aligns with the continuum of care in the Sierra Leone health systems. It complements the roles of other PHC workers, while equally using a 'demand-driven' approach to meet the needs and preferences of the communities served.

The SOW will be reviewed periodically by the MoHS with the support of partners. The review of the SOW can be undertaken at any time as needed, considering national and international evidence, experience with implementation, country health priorities, disease burden, and the financial landscape.

The harmonized SOW of the National CHW Programme is as follows:

General

- Conduct community mapping, household registration, and community entry meetings to understand communities and the demographic structure, and to identify the CHW target populations.
- Actively participate and lead community mobilization and engagement for the health and nutrition of the populations. This includes participation in key community and national campaigns and meetings of local community structures, such as the FMCs and VDCs.
- Identify and promptly refer cases and conditions that are beyond his/her mandate to health facilities.
- Conduct bi-monthly (every two months) routine home visits to all households in the catchment area to:
  - Update the community mapping, including demography;
  - Reinforce key healthy behaviours and practices for families and households, including early care-seeking when one is sick, through effective interpersonal communication skills;
  - Assess the social and health situation of households, including the availability of water, sanitation, and hygiene (WASH) facilities, use of health and nutrition services, and practice of health-promoting behaviours, and identify gaps;
  - Conduct dialogue with families and communities, help identify solutions to fulfil health needs, monitor and support the implementation of such solutions; and
  - Identify pregnant women, children, and women of childbearing age who are eligible for RMNCAH-N interventions, including the uptake of family planning (FP) methods, tetanus toxoid vaccination, and iCCM for sick children.

Reproductive, maternal, newborn, child, adolescent health and nutrition

- Provide pre-pregnancy counselling on the importance and availability of FP methods, including distribution of condoms and refills of oral contraceptive pills to all women of childbearing age. This includes teaching adolescent girls about the importance of deferring childbearing.
- Identify pregnant women as early as possible through (i) self-reporting of mothers or their family members; (ii) active surveillance through routine house visits; and (iii) notification by PHUs and other stakeholders in the community.
- Conduct monthly antenatal home visits: first visit early in pregnancy (2–4 months), second visit during mid-pregnancy (5 months), third visit (at 6 months), fourth visit (at 7 months), fifth visit (at 8 months), and sixth visit (at 9 months) to:
    - Educate and counsel women and their spouse/family on:
        - ✓ The importance of antenatal care and delivery at PHUs by skilled health workers. The CHWs must ensure that pregnant women visit the PHU for antenatal care between the first and second trimesters;
        - ✓ Maternal nutrition;
        - ✓ Essential newborn care (exclusive breastfeeding, hygienic cord care, thermal care, immunization);
        - ✓ Promotion of early childhood development (ECD) through responsive stimulation (play, communication, and early learning) during the first 1,000 days of a child's life, starting from pregnancy;
        - ✓ Promotion of care, psychosocial, and emotional support to caregivers, mothers, fathers, and guardians to create an enabling environment for successful ECD;
        - ✓ Preventive and promotive behaviours for maternal, newborn, and child health, including WASH, infant and young child feeding, FP, and immunization;
        - ✓ The importance of the use of long-lasting insecticide-treated bed nets (LLINs);
        - ✓ HIV testing and prevention of mother-to-child transmission of HIV, as needed;
        - ✓ Handwashing with soap at critical times and use of toilets;
        - ✓ Use of modern FP methods and referral to the closest facility.
    - Screen for danger signs (bleeding, oedema, fever, persistent headache, etc.) during pregnancy and refer to PHUs if one is identified.
    - Educate women on birth preparedness and planning for delivery at the health facility.
    - Provide intermittent preventive treatment in pregnancy for malaria,

specifically Sulfadoxine-pyrimethamine, at each visit (at least three doses during pregnancy).

- Where possible, accompany labouring women to the nearest PHU for delivery and facilitate birth registration.
- Conduct three postnatal home visits for both mother and baby on the 1st, 3rd, and 7th day after delivery to:
    - Educate and counsel the mother and her family/spouse on:
        - ✓ Essential newborn care practices (including early initiation of breastfeeding, exclusive breastfeeding for up to six months, thermal care, skin-to-skin contact, delayed bathing, and hygienic cord care including application of chlorhexidine gel);
        - ✓ The importance of using modern FP methods (e.g., condoms, oral contraceptives, injectable contraceptives, implants, and intrauterine devices);
        - ✓ Maternal nutrition, including postnatal vitamin A supplementation;
        - ✓ Danger signs for mothers and newborns and the need for immediate PHU treatment if one occurs;
        - ✓ Handwashing with soap at critical times and use of a toilet;
        - ✓ Vaccination for the baby.
    - Educate and screen for danger signs in both the mother (excessive or offensive lochia, fever, etc.) and the newborn (fever, inability to breastfeed, etc.), and refer to a PHU if identified.
    - Follow up to ensure the implementation of essential newborn care practices and adherence to vaccination schedules.
    - Supervise mothers in administering chlorhexidine for appropriate cord hygiene as needed.
- Conduct a fourth postnatal home visit for low birth weight (small) babies in order to provide the services listed above, including kangaroo mother care.
- Assess breastfeeding practices for young infants (0 to 2 months) and reinforce appropriate breastfeeding practices as needed.
- Screen children 6–59 months for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM), using the mid-upper arm circumference (MUAC) measurement and detection of oedema in both feet, and refer to the health facility.
    - Provide support and follow-up for MAM and SAM referrals to the health facility.
    - Provide support for adherence to the supplementary feeding programme and ready-to-use therapeutic feeding.
    - Provide follow-up counselling and support after the supplementary feeding programme and after discharge from the treatment of MAM

and SAM.

- Conduct five promotional young child home visits during the first 1,000 days (i.e., at 1, 5, 9, 12, 15, 18, 20, and 24 months) to ensure optimal ECD and nurturing, emotional support and care for the caregiver, appropriate infant and young child feeding, and vaccination.
- Report births, and maternal and under-5 deaths in the community.
- Provide Vitamin A supplementation for children 6–59 months in hard-to-reach communities, including tracing defaulters and supplementing or linking them to the PHU for supplementation.
- Tracing zero-dose children and defaulters of vaccination, reporting and linking them to the PHU. In addition, the CHW receives the names of defaulters in his/her village from the PHU in-charge to trace and ensure vaccination of these children.
- Work with MSGs for health promotion and prevention activities particularly for maternal, infant and young child feeding and screening children for acute malnutrition .
- Conduct social mobilization for programme-specific, national, and subnational campaigns in the community (e.g., MCH Week, National Immunization Days, and LLIN distribution) and routine integrated outreach services by the PHUs.

Integrated Community Case Management (iCCM 'Plus')

- In hard-to-reach areas, identify and treat pneumonia with a first-line oral antibiotic, diarrhoea with ORS-zinc, and malaria with a first-line antimalarial (following a positive rapid diagnostic test [RDT] result) in children ages 2 to 59 months. Refer cases with danger signs as outlined in the National CHW Protocol. Immediately refer diarrhoea cases to the PHU during an outbreak of acute watery diarrhoea diseases (Cholera). Identify (using RDTs) and treat malaria in older children and adults (all ages) as per the National CHW Protocol.
- Identify and provide oral rehydration salts for children over 5 years with diarrhoea and refer them to the PHU.
- In easy-to-reach areas, identify and refer sick children and older people for care to the next-level health facility (PHU).
- Provide follow-up care for patients who are on treatment, as well as those who have finished treatment, with a referral if necessary, through appropriately scheduled home visits as per the National CHW Protocol.

Disease surveillance, prevention, and control

- CHWs Conduct CBS of any event related to the following diseases and conditions:

- acute flaccid paralysis (AFP)-Polio
- acute watery diarrhoea
- Guinea worm
- measles
- neonatal tetanus (NNT)
- acute viral haemorrhagic fever (AVHF)
- yellow fever
- cluster of death

- Report any unusual events or rumours affecting the health of community members. CHWs will be expected to report immediately to their peer supervisors by phone (or other means if contact by phone is not available) when any of the above occur. They will also be required to document all events in a paper register to be kept at home. Additionally, CHWs will be expected to support community engagement activities in response to outbreaks, especially in areas of contact-tracing and social mobilization, among others.

Newborn and Maternal Death Surveillance;

The death of a woman during pregnancy or labour or 42 days after delivery due to pregnancy related causes is a reportable event. The CHW should collaborate with communities to ensure the following events are reported immediately to the PHU;

- *Maternal death*
- *Neonatal death*

Tuberculosis (TB) and HIV/AIDS

The National CHW Hub should work very closely with the TB and HIV/AIDS Programmes in designing the Training Curriculum and SOW for CHWs, and in conducting pre-service and refresher training.

CHWs are expected to fulfil the following:

- Conduct community sensitization to increase the level of awareness and create demand for TB and HIV prevention and care services.
- Conduct dialogue with families of TB and HIV patients and communities to address the stigma and discrimination related to the diseases.
- Screen household contacts of confirmed TB patients; identify and refer presumptive TB cases to the health facility for diagnosis and management.
- Educate and counsel TB patients and their family members on basic TB infection control practices at the household and community level.

- Follow up patients in their respective homes through home visits, and ensure that patient education is given on side effects, TB and HIV issues, adherence counselling, and prevention.
- Identify presumptive TB cases in the community and refer them to the nearest health facility for further investigation and diagnosis.
- Educate the community on HIV prevention measures.
- Identify and trace patients who have interrupted treatment and defaulters and bring them back into care, in collaboration with the in-charges at the DOT/antiretroviral therapy (ART) sites.
- Refer TB and HIV patients on treatment for follow-up medical appointments, including for sputum smears, collection of medicines, viral load testing, CD4 count tests, and adverse side effects.
- Complete the follow-up register for patients on anti-TB medicines and ART in the catchment area.
- Complete the integrated TB/HIV monthly summary form and report to the facility in-charge.
- Participate in periodic review meetings organized by the CHW and TB/HIV District Focal Persons, or facility in-charges.

School and adolescent health

- Map all schools in the CHW catchment area.
- In collaboration with the PHU staff, support the establishment of school health clubs at the community level, especially in primary and junior secondary schools.
- Provide outreach to primary and junior secondary schools and communities to prevent teenage pregnancy (TP), sexual and gender-based violence (SGBV), and child marriage.
- Conduct focus group discussions in school and communities on the use of adolescent-friendly health services, especially for FP, and TP and SGBV prevention.
- Provide support and feedback to traditional leaders, tribal heads, and religious leaders in communities on the use of school clinics, and TP and SGBV prevention.

Expanded Programme on Immunization (EPI) services

- Promote uptake of immunization services through community sensitization
- Educate pregnant and nursing mothers on the importance of immunization.
- Support mothers to remember the dates their children are due for vaccination.
- Trace zero-dose and started but defaulted children and link them to the PHU

for immunization (at outreach or facility-based).
- Report to the PHUs on any vaccine-related complications including that of COVID 19 vaccine

Non-communicable diseases (NCDs)

With the increased burden of NCDs, CHWs' tasks have evolved from mainly focusing on the prevention and promotion of communicable diseases to fulfilling more supportive roles for chronic lifelong conditions at the family and community level.[6] As the country faces a shortage of health staff at all levels of service delivery, CHWs will have to expand their work to support the management of NCDs, mainly hypertension, diabetes, and cancers, in addition to their prevention and promotion efforts for communicable diseases. CHWs provide the following services:

- Use simple clinical signs to identify hypertension and diabetes in the community.
- Identify high-risk individuals using simplified protocols and refer them to the PHU.
- Promote a healthy lifestyle, physical exercise, and avoidance of alcohol and smoking.
- Ensure adherence to the treatment advice of health workers.
- Provide counselling services to enhance care-seeking from a health facility provider.
- Provide support for the management of mental health patients in the community
- Facilitate support groups for the prevention and management of chronic conditions.

Infection prevention and control (IPC) practices

In all their work, CHWs are expected to practice IPC measures to ensure their own safety and to protect their communities. As part of pre-service training, CHWs will learn about community IPC protocols and be provided with the necessary supplies. They are expected to promote IPC practices in their communities.

Innovation and research

The CHW programme will be open to benefiting from any evidence-supported innovations to improve the feasibility, effectiveness, and efficiency of the programme in delivering

[6] Tsolekile LP, Puoane T, Schneider H, Levitt NS, Steyn K. The roles of community health workers in management of non-communicable diseases in an urban township. Afr J Prm Health Care Fam Med. 2014;6(1). doi: 10.4102/ phcfm.v6i1.693.

quality services. Therefore, the DPHC/MoHS will support partners who conduct relevant operational research as part of the CHW programme implementation and M&E.

6.3 Geographic Coverage

It is recognized both nationally and internationally that geographic access is a key factor in limited health-seeking behaviour and poor health outcomes. The National CHW Programme aims to attain nationwide coverage, while focusing efforts on geographically hard-to-reach areas (e.g., that require crossing of rivers and canals, or mountainous settings). Each CHW will serve a given catchment population that will be determined by distance (plus access challenges) to a community, as outlined in Table 1.

Table 1: Coverage of CHWs

Coverage Dimensions	**Easy-to-Reach (ETR)**	**Hard-to-Reach (HTR)**
Distance (Radius from the nearest PHU)	Between 3km and 5 km	Over 5km (or between 3km and 5 km with difficult terrain)
Catchment population	500-1,000 (100-170 households)	300–350 (50–60 households)
Service package	• Provide all services as per SOW • Provide TB and HIV services	• Provide all services as per SOW • Provide iCCM Plus services • Provide TB and HIV services

CHWs differ in their SOW as per this policy: CHWs in hard-to-reach communities will provide all the services in the CHW package, including iCCM Plus, TB and HIV services. CHWs in easy-to-reach communities will provide all services with the exception of iCCM Plus (treatments); however, they will identify and refer sick persons to health facilities for treatment and provide TB and HIV services as per the SOW.

6.4 CHW selection criteria

6.4.1 CHW selection process

New CHWs must be selected fairly and transparently, with equal opportunity given to all qualified and interested candidates in a community. Selection is a joint effort between the community structures and local community health facility (PHU), as appropriate.

There should be a committee consisting of:

- PHU in-charge, serving as the coordinator of the selection process

- DHMT representative (such as the CHW Focal Person, TB and HIV Coordinators/supervisors)
- Local leader
- Local council representative (e.g., the elected councilor)
- Mamie Queen/women's representative
- Others, such as representatives of CSOs and CHW implementing partner, to play a watchdog role.

To ensure community ownership but dissuade undue influence, local political structures (for example, chiefs and councilors) should not be in charge of the selection process. External observers, such as CSOs and implementing partners, should play a watchdog role. Any undue influence should be reported immediately to the District CHW Focal Person, who will take action as necessary with support from the DHMT and local council. The PHU in-charge is required to inform the entire community and/or catchment area of existing vacancies for CHW recruitment.

Recruitment is open to both men and women; however, priority should be given to women to meet the recommended ratio of 6 women to4 men in the PHU catchment.

6.4.2 Qualifications

The selection of CHWs is based on minimum standard criteria. Whereas the previous CHW Policy does not put literacy as a requirement for a community member to serve as a CHW, the 2021 National CHW Policy emphasizes the attainment of a high-school education or its equivalent. CHWs with higher educational qualifications could learn and enhance their skills in identifying common illnesses[7] and thereby deliver a higher quality of care to the community.

CHWs should be selected based on the following criteria:

- Must be educated to a high-school standard, minimum Basic Education Certificate Examination (BECE) or its equivalent; in cases where BECE graduates are not available among female candidates, this requirement should be relaxed to National Primary School Examination (NPSE) or its equivalent, especially in hard-to-reach areas;
- Must be a permanent resident of the community to be served
- Should be able to perform specified CHW tasks, as outlined in the SOW;
- Should be exemplary, honest, trustworthy, and respected;

[7] Ande O, Oladepo O, Brieger WR. Comparison of knowledge on diarrheal disease management between two types of community based distributors in Oyo State Nigeria. Health Education Res. 2004;19(1):110–113. doi: 10.1093/her/cyg004.

- Should be willing, capable, and motivated to serve his/her community and dedicated to helping others;
- Should be interested in community health and development;
- Should have experience in past community work with satisfactory records;
- Should be a good mobilizer and communicator;
- May already be a high-performing community health volunteer or youth trained in life skills who meets the educational requirement;
- Must be between 20 and 45 years old; and
- Must be accepted by the community.

6.4.3 CHW Terms of Reference (TOR)

Any person serving as a CHW under the National CHW Programme is expected to carry out the following roles and responsibilities:

- Fulfil the SOW outlined in the National CHW Policy.
- Provide services as outlined in the SOW to the designated catchment area.
- Meet the health and nutritional needs of the community.
- Provide high-quality services in a respectful, compassionate, and non-discriminatory manner.
- Attend monthly meetings at the PHU.
- Report to the peer supervisor.
- Submit reports on time to the peer supervisor or the PHU in-charge (monthly and immediately for notifiable diseases).
- Participate in meetings of local community structures (FMCs, VDCs, etc.).
- Support and liaise with MSGs to health facilities.

6.4.4 Removal and replacement of CHWs

CHWs will be removed from their position and replaced if they are not fulfilling their responsibilities under the TOR above. A CHW can be classified as active, inactive, or dropped-out. The following considerations will inform decisions on whether to remove or replace a CHW based on where he/she falls in this classification at any given time during his/her service to the programme:

Active CHW:
A CHW is actively engaged in community work: Has attended in-service training, facilitated community events, done home visits, attended to clients.

Inactive CHW:

A CHW has not done any home visits or attended to clients (iCCM, counselling referral) in the last three months, but has attended activities such as monthly meetings or community events. The peer supervisor should contact the CHW on month two of inactivity to understand the reasons. The PHU in-charge should also notify the peer supervisor of the CHW's inconsistent performance. a) If there is willingness to continue serving as a CHW, provide the necessary support to ensure the CHW resumes home visits (pregnancy registrations, assessments, and newborn visits); b) If there is no willingness to continue fully executing all duties as required, terminate the CHW agreement as guided in the **"Removal and Replacement"** process.
Dropped-out CHW: A CHW has not done any home visits, not attended to any client, and not attended an activity such as monthly meeting or community event for the last three months or more. Such a CHW is considered to have left, even though he/she has not returned any assigned property. The peer supervisor should contact the CHW on month two to understand the reasons for dropping the assigned roles and responsibilities. The following action is required as appropriate: a) If there is willingness to return to service, provide the necessary support to ensure the CHW resumes work (pregnancy registrations, assessments, and newborn visits); b) If the exit decision is confirmed, communicate and engage with the PHU in-charge to terminate the CHW agreement as guided in the **"Removal and Replacement"** process.

Causes for removal or replacement include:

- Poor quality of services that do not meet the minimum standards and do not improve with continued coaching and support;
- Misconduct, such as repeatedly failing to report to or attend monthly meetings at the PHU;
- Accepting fees for service, or selling medicines and health commodities that are intended to be provided for free to the populations;
- Inappropriate or offensive behaviours, including any form of harassment such as sexual harassment;
- Being absent from the community without justifiable excuse for three months consecutively, or cumulatively for four months within a 12-month period;
- Providing services outside of the SOW or his/her mandate.

6.5 Selection criteria for peer supervisors

6.5.1 Selection process

Peer supervisors must be selected fairly and transparently in order to give equal

opportunity to all qualified candidates. Peer supervisors will no longer perform CHW functions. They should focus on providing supportive supervision and mentoring to the CHWs. Peer supervisors serve as a bridge between the PHU (PHU in-charge) and the CHWs. Recruitment is open to both men and women, but priority should be given to women.

The selection process should be overseen by a committee consisting of:

- PHU in-charge, serving as the coordinator of the selection process;
- DHMT representative (such as the CHW Focal Person, TB and HIV Coordinators/supervisors);
- Paramount Chief or representative;
- Local council representative (e.g., the elected councilor);
- Mamie Queen/women's representative; and
- Others, such as representatives of CSOs and implementing partners, to play a watchdog role.

As in the selection process for CHWs, efforts should be made to prevent any undue influence from community elites in the selection of peer supervisors.

6.5.2 Qualifications

Peer supervisors must meet the following minimum standard criteria. Any person meeting these qualifications may be considered by the community and the MoHS for selection as a peer supervisor under the National CHW Programme:

- Must be qualified to serve as a CHW (see criteria for CHW above);
- Must have served as a CHW for at least one year, with a demonstrated record of high-quality performance; if it is impossible to find a candidate with a CHW background, candidates who perform particularly well during CHW training may be considered. Either way, the candidate must demonstrate competency in all CHW areas of work;
- Higher educational qualification beyond BECE is required for new peer supervisors without a year of CHW experience; this requirement should be relaxed to BECE or its equivalent in cases where graduates above BECE level are not available among female candidates, especially in hard-to-reach areas;
- Is a permanent resident of a community within the PHU catchment area, or is a former resident who is willing to return to live in the catchment area;
- Is between 20 and 45 years old;
- Is a good mobilizer and communicator;
- Is willing and able to provide the required services;
- Is willing and able to travel frequently to provide in-community supervision;

- Is able to compile data.

6.5.3 Peer supervisor TOR

Peer supervisors within the National CHW Programme are expected to carry out the following roles and responsibilities:

- Supervise all CHWs in their catchment area at least once per month.
- Attend monthly meetings at the PHU.
- Encourage CHWs to attend monthly meetings at the PHU.
- Provide reports to the PHU. This includes but is not limited to:
    - Compiling CHW reports and submitting them monthly to the PHU in-charge;
    - Informing the PHU of findings from in-community supervision and working together to define actionable priorities, such as recommendations for further training or need for replenishing stock based on these findings.
- Ensure that CHWs perform their SOW.
- Ensure that CHWs receive the support they need, as outlined in this Policy.
- Provide on-the-job mentoring and support to ensure that the services CHWs are providing are of acceptable quality.
- Participate in community structures (FMCs, VDCs, etc.).
- Ensure a strong working relationship between the CHWs and the PHU.
- Identify and report stockouts to community structures and the PHU.
- Conduct performance appraisals of the CHWs together with the PHUs and community structures.
- Promote a healthy working relationship with the CHWs.

6.5.4 Removal and replacement of peer supervisors

The following would be reasons to consider removing and replacing a peer supervisor:

- Not performing adequately;
- Misconduct, such as repeatedly failing to report to or attend monthly meetings at the PHU;
- Accepting fees for service, or selling medicines and health commodities that are intended to be provided for free;
- Inappropriate or offensive behaviour, including sexual harassment;
- Being absent from his/her community without justifiable excuse for three months consecutively, or for four months cumulatively within a 12-month period.
- Providing services outside of the SOW or his/her mandate.

7.0 CHW programme pillars

7.1 Integration of CHWs

There are various CHW designations in the country, which are often linked to disease-specific programmes (for example, malaria, TB, and HIV). This means that CHWs are trained to focus on specific disease programmes, and there are lots of different CHWs to be managed. The 2021 National CHW Policy emphasizes the integration of all CHWs, including the TB/HIV and malaria CHWs, into the National CHW Programme. The job description, training, supervision, and performance management of all CHWs will be harmonized to ensure well-coordinated and quality service delivery. This integration also means that CHWs will gradually be recruited into the national health workforce to improve the sustainability of the programme.

7.2 Supervision of CHW activities

Supervision is the backbone of any successful CHW programme. CHWs need regular supportive supervision to provide high-quality services and timely, high-quality reports. Supportive supervision is also a key factor in sustaining CHWs' motivation. In addition to giving CHWs feedback, supervision links CHWs with the PHUs, implementing partners, and DHMTs to which they are attached. The supervision of CHW activities takes place at different levels and involves a range of stakeholders as described below:

Peer supervisors: The MoHS acknowledges that Sierra Leone has a limited health workforce. At some health facilities, there is not enough staff to provide regular, in-community supervision. In this situation, peer supervisors who have more education and skills than the CHWs can also fulfil supervisory roles. Their supervisory support does not replace PHU supervision.

PHU staff: PHU staff are ultimately responsible for conducting and ensuring the proper supervision of CHWs. The PHU staff supervises the CHWs who are attached to their facility.

DHMT: Supervision by the PHU in-charges and peer supervisor is also supported by DHMT officials, chiefdom supervisors, CHW Focal Persons, and the Regional CHW Coordinators from the National CHW Hub to provide district-level supervision. Joint supervision involving DHMT staff, National CHW Programme, and implementing partners is also encouraged.

National: The National CHW Programme will also be included in the national Integrated Supportive Supervision Visits (ISSVs). In addition, supervision undertaken by other MoHS programmes and activities that are involved with the National CHW Programme should work with the CHW Hub to coordinate supervision whenever possible in order to support the integration of programmes and efficient use of resources.

7.3 Incentives and motivation for CHWs

CHWs perform an essential, life-saving role in the health system. This role requires a substantial amount of time. CHWs must be motivated for this work, both by recognizing its importance and by being compensated for the time lost from other income-generating activities. The various forms of incentives for CHWs are described below:

Financial incentives*:* The incentives included in the 2021 National CHW Policy are meant to cover day-to-day work. In the current policy, the financial incentive is provided to both CHWs in hard-to-reach (HTR) areas (*at a distance of over 5km radius from the nearest PHU*) and CHWs in easy-to-reach (ETR) areas (*within a 3–5 km radius of the nearest PHU)*. Peer supervisors also receive financial incentives. The minimum monthly incentive for CHWs is shown in Table 2.

Table 2: Minimum standard support package for CHWs

Role	Amount (in Leones)
CHW in ETR	**100,000**
CHW in HTR	**200,000**
Peer Supervisor	**250,000**

If campaigns or other activities require more time than that required for routine CHW activities or detract from other activities in the person's SOW, the programme responsible for the activity must provide adequate compensation. The amount of compensation is to be agreed upon with the DHMT and National CHW Programme.

Non-financial incentives: This covers a range of non-financial support in recognition and appreciation of CHWs (in both ETR and HTR areas). Non-financial incentives may include the following:

- Awards for outstanding work given by implementing partners or the MoHS;
- Provision of identification cards;
- Provision of rain gear;
- Career prospects; CHWs' aspirations do influence their performance, and lack of career prospects has been shown to be a reason for significant drop-out of CHWs. Therefore, career prospects along with financial incentives are strong incentives in

both retaining CHWs and enhancing their performance.[8] CHWs will have access to a promotion pathway to the peer supervisor role. High-performing peer supervisors and CHWs alike who have the requisite qualifications to enter into formal training in health (e.g., as an MCH Aide, state-enrolled community health nurse [SECHN], etc.) will be encouraged to do so.

- Community leaders may encourage communities to support CHWs or exempt them from communal work. This will be negotiated on a community basis.

7.4 Training

The National CHW Programme recognizes that robust training, frequent mentoring and coaching, and follow-up support are essential to a strong programme. High-quality, regular, and interactive training is also a key motivator for CHWs, since well-trained CHWs feel empowered to do their job well.[9] The National CHW Hub is responsible for ensuring that all CHWs receive pre-service training. Refresher training should be conducted every two years. Representatives from the MoHS (i.e., directorates and programmes relevant to the thematic focus of the training), DHMTs, chiefdom supervisors, PHU staff, and the CHW Hub must attend all pieces of CHW training.

The National CHW Training Curriculum is competency- and skills-based, and focuses extensively on providing hands-on, practical experience. Training is not effective without frequent, high-quality supportive supervision during and immediately following the training, when CHWs are most likely to make mistakes and can most easily correct them.

All peer supervisors must go through the same training components as CHWs so that they understand the roles and competencies required of the people they supervise. Supervisors will also undergo additional training that focuses on effective communication, data collection, reporting, spot-checks to test the quality of the CHWs' work, mentoring, and coaching. Peer supervisors should also receive refresher training every 2 years.

The National CHW Programme is also responsible for ensuring that PHU staff and chiefdom supervisors are oriented on the CHW programme, with particular attention to their roles in implementing and overseeing the programme and providing supportive supervision.

Key components of the CHW training include:

- Community health basics
- Integrated community case management (iCCM) Plus

[8] Scott G, Wilson R. Community health worker advancement: a research summary. Boston: SkillWorks; 2006 (https://jfforg-prod-prime.s3.amazonaws.com/media/documents/CHWressumm.pdf).

[9] Developing and strengthening community health worker programs at scale. A reference guide and case studies for program managers and policymakers. Baltimore: Jhpiego; 2014 (https://chwcentral.org/resources/developing-and-strengthening-community-health-worker-programs-at-scale-a-reference-guide-and-case-studies-for-program-managers-and-policymakers/).

- RMNCAH-N
- CBS
- TB
- HIV
- NCDs, including mental health.
- Vaccine-preventable diseases
- Community preparedness for emerging disease prevention and control including preparedness for COVID 19 vaccination.

Details of the respective training components are provided in the CHW Training Curriculum. Peer supervisors will receive all the above plus supervisory and communication skill training.

The CHW Hub, with support from the DHMTs and implementing partners, is responsible for identifying any training gaps and performance improvement needs of CHWs, developing and implementing refresher training on those topics, and integrating those topics into the National Curriculum during the subsequent review.

7.5 Certification

A key component of quality care delivery is CHW standards. This implies defining professional roles, SOW, responsibilities, and tasks, along with educational standards and minimum competency requirements for the delivery of different health services. After successful completion of pre-service training, CHWs are provided with certification. Certification may also be considered for periodic refresher trainings that are completed successfully. The certification process verifies that the CHWs have not only successfully completed their pre-service training, but also demonstrated that they possess the technical and soft skills required to carry out their roles and responsibilities.

Additionally, the certification provides a formal recognition awarded to those meeting pre-determined standards. A certificate represents another form of non-financial incentive that may increase the motivation and sense of self-esteem among CHWs. Evidence of certification can be used as part of the admissions criteria for further education.

7.6 CHW logistics: Medicines and supplies

Uninterrupted availability of the essential medicines and supplies that CHWs are mandated to have (e.g., a first-line antibiotic, first-line antimalarial, RDTs, and ORS-zinc), treatment protocols, and counselling tools is critical to delivering life-saving interventions to the people in need at their doorsteps. Access to supplies greatly affects CHWs' motivation, knowledge, skills, performance, and retention. When CHWs have the medicines, commodities, and other supplies they need to do their jobs, they are

empowered and more confident in their work. When they are able to practice what they have learned, they gain experience. However, when there are stockouts, CHWs are not able to perform their roles and their skills may deteriorate. Moreover, such issues contribute significantly to demotivation and lack of trust among communities and clients in both the CHWs and the overall health systems.[10]

The National CHW Programme provides all services, including medicines and medical supplies, free of charge. Clients must never be asked to pay for any of the services or products provided by CHWs. The National CHW Programme maintains a zero-tolerance policy towards CHWs who sell services, medicines, or commodities, and will closely investigate any reports of such behaviour. Any CHW found to be selling medicines or other commodities or charging service fees will be removed from the programme at the discretion of the DHMT and the community structures responsible for overseeing him/her.

Quantification, procurement, and distribution

Informed by the BPEHS, Standard Treatment Guideline (STG), and National Essential Medicines List (NEML), and guided by the national essential supply procurement list, the quantification of essential medicines and commodities is done nationally in an integrated manner. Quantification of these products takes place annually as part of the prioritization and quantification of national Free Health Care Initiative (FHCI) commodities and essential malaria medicines and commodities. This process is led by the Directorate of Drugs and Medical Supplies (DDMS) with the involvement of the relevant directorates and programmes. The national health systems currently follow a mixed approach, using both morbidity and consumption data for quantification. The CHW Register serves as a primary source of consumption rates and informs the quantification of the medicines and supplies required by the CHW programme. The National CHW Programme and the Directorate of Policy, Planning and Information (DPPI) should work closely with the DDMS to provide the data and other inputs required so that consumption data inform the quantification.

The procurement of most essential commodities is done as part of the procurement of national FHCI commodities and overall malaria essential commodities. The National Medical Supplies Agency (NMSA) of the MoHS leads the procurement, storage, and distribution of all the commodities. Distribution is done quarterly to the first mile (district medical stores) and to the last mile (health facilities). The PHUs are responsible for

[10] Brunie A, Wamala-Mucheri P, Otterness C, Akol A, Chen M, Bufumbo L, et al. Keeping community health workers in Uganda motivated: key challenges, facilitators, and preferred program inputs. Glob Health Sci Pract. 2014;2(1):103–116. doi: 10.9745/GHSP-D-13-00140.

supplying CHWs with malaria, pneumonia, and diarrhoea essential commodities based on consumption, reporting, and availability every month.

According to the revised SOW in this Policy, only CHWs in hard-to-reach areas will provide iCCM services (i.e., treatment of malaria, pneumonia, and diarrhoea). Therefore, first-line antimalarials and first-line antibiotics (as defined in the national iCCM STG) will be distributed only to those CHWs serving in hard-to-reach areas.

Buffer stocks

Due to frequent stockouts in the national supply chain system, many partners have historically procured and provided buffer stocks of medicines and medical supplies directly to CHWs. This practice may continue until the national supply chain has been sufficiently strengthened. Partners must consult with the DHMT, National CHW Programme, and NMSA to coordinate and agree upon any buffer stocks they intend to provide in their programme area. Partners must use programme data to quantify CHWs' buffer supplies and report all information on supply needs and supplies ordered to the district medical store to guide quantification. The buffer supplies must be distributed in coordination with the NMSA and the DHMT through the district medical store to the PHUs, and from the PHUs to the CHWs. However, partners can provide support (transport, logistics) as needed and agreed upon by the DHMT.

Other supplies that enable CHWs to deliver their services include rain gear, T-shirts, hats, and backpacks that are procured periodically as needed. In addition, different registers, referral tickets, locally appropriate pictorial counselling tools, and digital equipment to ease recording and reporting will be supplied as needed.

Ensuring appropriate use of essential commodities

Regular capacity improvement, quality assurance, and strict monitoring of CHWs is critical to ensure that essential medicines and supplies are kept safe and used for the intended beneficiary according to the standard CHW guideline. CHWs should also report on consumption and any remaining balance at the monthly PHU meetings.

7.7 Community health information system (CHIS)

The MoHS recognizes the vital role played by health information systems (HIS) in measuring the performance of the health care delivery system and generating data to support programme M&E. Sierra Leone's HIS includes a CHIS designed to be integrated with the HMIS. The CHIS and HMIS utilize identical digital platforms, tools, and human resources, and have aligned governance mechanisms and approaches. The HIS dataflow has been built to ensure that CHIS data flow seamlessly into the HMIS. Data management responsibilities are coordinated to support data availability, completeness, and timely

reporting. However, the quality of data produced by the CHIS and HMIS remains low. Therefore, the development and use of Standard Operating Procedures (SOPs) at the national, subnational, and community levels will be critical to improving data quality, as will the institutionalization of CHIS data analysis and use. Information and communications technology (ICT) has also been identified as a key enabler of increased access to the quality data needed for tracking UHC results. Significant investments have been made in the use of technology to improve the access to and quality of health care delivery to citizens. Such investments are manifested in the various HIS and platforms deployed across the country, including DHIS2, eCBDS, eIDSR, RapidPro, and IHRIS.

Despite these investments, the use of ICT at the lowest level of health care service delivery continues to be limited. Health care provision in the MoHS begins at the community level, spearheaded by the CHWs who offer services directly to individual households. The process of reporting data from the community level to the national level through DHIS2 remains largely paper-based, rendering it inefficient, unreliable, and prone to data quality issues. These limitations ultimately hinder the optimal use of community-level data to inform the subnational and national public health response, resource allocation, and ability to monitor progress towards UHC.

The UHC Roadmap and identification of community health services as a top priority of the MoHS and its partners have made it necessary to ensure that quality data are generated and reported from frontline CHWs into DHIS2 for national and DHMT use. Updating the design and customizing the country's primary HMIS platform (DHIS2) to directly capture community data below the facility level will significantly increase the availability of community data for use at all levels. Investment in the CHIS to conduct the day-to-day business of community service delivery and to generate and capture information coming from the transaction data stored in the system is also crucial for the accurate and timely collection, reporting, tracking, and use of CHW programme data and results.

7.8 Functional linkage of CHWs with PHUs

This Policy emphasizes the integration of the various designations and harmonized job descriptions of CHWs to ensure quality and coordinated service delivery in alignment with the National Health Policy and the UHC Roadmap. Efforts must be made to strengthen the relationships between CHWs and PHU staff in order to maximize the health gains of the beneficiary communities. The following focus areas need to be addressed in setting up a strong link between the CHWs and PHUs:

- Providing coaching and mentoring;
- Encouraging and supporting career-building;
- Ensuring uninterrupted supplies;

- Ensuring an effective referral and counter-referral system;
- Fostering a respectful relationship between the CHWs and PHU staff;
- Providing psychosocial support to ~~frontline~~ CHWs who face a wide range of challenges on their own.

7.9 Community ownership and engagement

Community ownership is a vital component of any functioning CHW programme. The National CHW Programme is committed to promoting strong local health structures, strengthening those structures as part of the CHW Programme, and promoting linkages between CHWs and community structures.

The National CHW Programme provides guidance on which community structures CHWs should engage with. The decision is decentralized to each PHU, with oversight from the Chiefdom Supervisor and District CHW Focal Person, given the diverse realities of communities across Sierra Leone.

Community structures such as FMCs and VDCs are expected to support the CHW programme's functionality in their community. If neither an FMC nor VDC exists, CHWs must work with other community groups applicable to the local context. Regardless of the existence of FMCs and/or VDCs, CHWs and peer supervisors are encouraged to work closely with other community health-focused groups, such as WASH committees, MSGs, and community advocacy groups, to educate and promote health information.

7.10 CHW programme performance management, monitoring & evaluation

7.10.1 Performance management

CHWs play a foundational role in health systems and communities. They are an integral part of health programmes, communities, and health systems that are interconnected and dynamic. The overall performance of a health system (how well it meets the needs of the populations it is meant to serve) depends on the effective functioning of all of its parts as they interact. As a result, design choices or the performance of particular elements can have significant consequences.

The management of CHW performance requires sustainable support from and integration into the district and national health systems and plans. It also requires:

i. **Supportive supervision:** Supportive supervision needs to be established for sustainable CHW functioning, with supervisors having the requisite skills and training. Supervision should be guided by quality management frameworks. and should focus on solving problems and improving the skills of CHWs. Follow-up supervisory visits should be built in and supported by a strong data

system, such as the CHIS, with well-trained users.

ii. **Adequate pre-service and refresher training:** Ensuring that CHWs have the right training is critical for performance. Follow-up refresher training, especially on new interventions and protocols/treatment guidelines, will help to build the CHWs' confidence in their skills and ultimately improve their performance.

iii. **Performance management system for quality assurance:** The supervision of CHWs should be guided by performance targets and standard indicators that are linked to an incentive payment. Performance-based contracts may be considered to drive the motivation of CHWs to achieve better performance, and to rationalize decisions for sanctions, including removal for non-performance. Annual performance appraisals linked to certification should also be considered for the performance management of CHWs and peer supervisors.

Optimizing the value and impact of the CHW programme requires appropriate planning, implementation, and measurement of performance, and adequate resources and supplies.[11] It is therefore important that efforts be made to understand the reasons for CHWs' non-performance at any given time, especially when minimum performance indicators determine incentives. A CHW might be unable to meet some performance indicators due to stockouts of commodities or lack of support from PHU staff, among other challenges. However, when non-performance is linked to the CHW, then the conditions stated under section ***6.4.4 Removal and replacement of CHWs*** should be reviewed to inform the programme's next action.

7.10.2 M&E

Data for decision-making and operational research

The National CHW Programme is committed to regular and robust M&E to track the functionality, quality, and effectiveness of the programme, and to guide programme design, changes, and implementation. The CHW programme is also committed to operational research to explore innovations that could strengthen the programme and to promote those that prove successful and feasible at scale. Partners conducting operational research must collaborate with the MoHS and align with official government policy and research objectives. This means, for example, that research questions, objectives, and study design must be discussed with the MoHS through the Sierra Leone Ethics and Scientific Review Committee (SLESRC); all findings must be shared with the MoHS and its partners.

[11] WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018 (http://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf).

Integrated CHW data

To ensure that CHW data are used coherently, cohesively, and effectively, the National CHW Programme collects data through a singular, harmonized data collection and reporting system in line with the national M&E system. The National CHW Hub works with the DPPI to design user-friendly reporting tools that are aligned with the CHWs' SOW, fully integrated with the national HMIS, and complementary to their daily work.

CHW data in the CHIS must be included in the national reporting system and shared with partners upon request. Implementing partners supporting the DHMTs should have access to district data and support the DHMTs in compiling, reviewing, and analysing those data. All implementers (MoHS and implementing partners) must report progress based on the National CHW M&E Framework using National CHW Programme tools. This framework defines a comprehensive list of indicators with targets to monitor the results that the National CHW Programme expects to achieve. This framework encompasses CHW service delivery and operationalization of the National CHW Programme. Each tool will be reviewed and updated as needed.