



NATIONAL POLICY AND STRATEGY ON COMMUNITY HEALTH SERVICES

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 **BASICS**

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ACRONYMS

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BPHS	Basic Package of Health Services
CBO	Community Based Organization
CCM	Community Case Management
CH	Community Health
CHC	Community Health Committee
CHS	Community Health Services
CHT	County Health Team
CHV	Community Health Volunteer
CHV	Community Health Worker
EPI	Expanded Program of Immunization
FCHV	Female Community Health Volunteer
gCHV	General Community Health Volunteer
HC	Health Center
HF	Health Facility
HW	Health Worker
INGO	International Non-Governmental Organization
IPT-SP	Intermittent Presumptive Therapy – Sulfadoxine-Pyrimethamine
ITN	Insecticide-Treated Net
LDHS	Liberia Demographic and Health Survey
MCHV	Maternal Child Health Worker
MNH	Maternal Neonatal Health
MoH&SW	Ministry of Health and Social Welfare
NIDS	National Immunization Days
NN	Neonatal
OIC	Officer-in-Charge
OR	Outreach
TB/DOTS	Tuberculosis – Directly Observed Treatment, Short-Course
TM	Traditional Midwife
TTM	Trained Traditional Midwife
VDC	Village Development Committee
VHW	Village Health Worker

National Policy and Strategy on Community Health Services

I Background

a) *The Liberian Context*

Recent health surveys in Liberia show significant improvements in some areas, for example in child mortality, which now stands at 110/1000,¹ but maternal mortality remains very high, at 994/100,000, and malaria affects much of the population, with under-5 prevalence standing at 74%.² From the LDHS, among married women, 47% had a need for birth spacing or limiting but only ¼ of that need was met.

The Ministry of Health and Social Welfare (MoH&SW) has mobilized to rebuild the health sector and is following the blueprint elaborated in the National Health Plan and Policy (2007) and in the Basic Package of Health Services (2007). Clinics and health centers are being rebuilt and expanded, but remain constrained by staff shortages and many of the existing positions are filled on an interim basis by NGO partners. EPI vaccinators are to be integrated into clinic/health centers as nurses' aides. Many traditional midwives, trained before the war, are still active, supported by members of their communities.

Community health workers (CHW) trained before the war, are largely gone but a wide variety of new CHWs have been recruited and trained by various entities. NGOs involved in community health services over the past several years have developed a number of new cadres in areas where they have been working – mostly limited to health promotion roles. Various vertical programs have had community-level activities using community-level volunteers or workers, for example to support onchocerciasis, and malaria programs. Although this community level work has been contributing to improve health conditions in the country, these efforts are not yet optimally coordinated. As Liberia transitions from humanitarian response to development, there is a need for a rationalized approach to community health services.

b) *Global Experience with Community Health Workers/Community health volunteer*

There are thousands of examples of small scale CHW programs implemented by NGOs across the world and many cases of larger scale programs with community-level cadres linked to government health services. There are many instances of disappointing experiences with CHW programs but there are also examples of successful programs, operating at scale, continuing to play an important role in improving health status – particularly child health – over the long-term. Lehmann and Sanders recent review³ is an excellent summary of the global experience with such programs. Several key findings of their review are:

- CHWs can improve access, coverage, and outcomes but are not a panacea. They are not a replacement for professional health workers
- Effective CHW programs at scale are not cheap or easy; they require a considerable and sustained effort.
- Key issues for successful implementation include selection, training, support (from health sector and community)
- Community ownership/ linkages – although some individuals will certainly be able to do so, CHWs as a group cannot be expected to take the lead in mobilizing communities; but mobilized communities are necessary for effective CHWs. It is important to effectively *institutionalize* community participation (Brazilian example – Macinko,⁴ 2006 – & Nepal's Health Facility Management Committees and Mothers Groups)
- Motivation of CHWs is critically important. If not effectively addressed, attrition will fundamentally weaken a CHW program. With a view to developing an effective national cadre, approaches to incentives need to be *scaleable* and *sustainable*.
- Volunteers or remunerated – as a rule programs with no material incentives do not continue to perform on a sustained basis and relying on community financing generally doesn't work.
- Role – in many cases the community has expectations with regard to a treatment role and is less supportive of CHW programs that only do health promotion work.

Lehmann doesn't provide coverage of Nepal's successful experience with community volunteers,⁵ who can take much of the credit for improved child survival in that country. Nepal gives a good example of a national program relying on community health *volunteers* whose motivation remains strong due to an

effective mix of incentives. Bhattacharya's 2001 review⁶ provides useful program learning (summarized later) from many CHW programs worldwide on what is required to sustain CHV motivation.

II Vision

A coherent coordinated national community health system, at the center of which is an active motivated national cadre of community health volunteers – fully integrated with peripheral health facility services – sustained on a long-term basis and significantly contributing to improve the health status of Liberians, especially the most vulnerable.

III Overall Goal

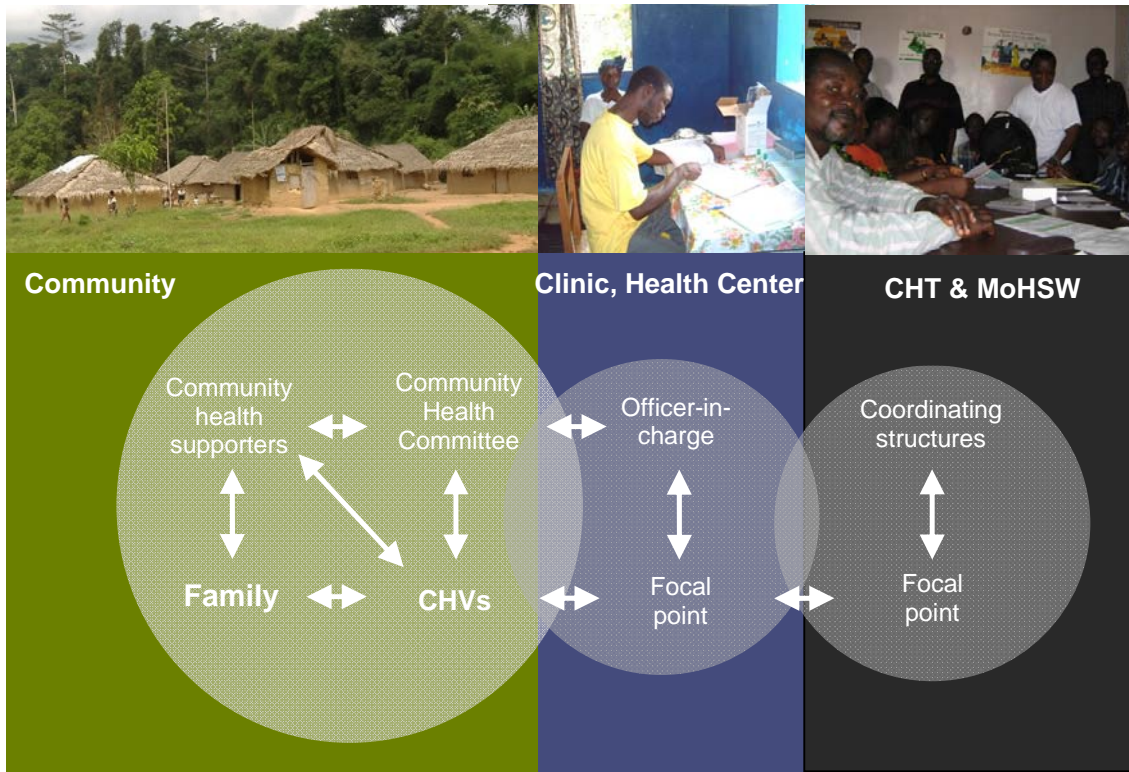
To develop a sustainable national system of community health services characterized by:

- a particular focus on high impact public health problems,
- strong coordination with partners and across programs having a community component, and
- meaningful participation by community members in positive actions for health, including helping direct the services of their local health facilities

IV Guiding Principles

- *Impact & equity* - ensure the greatest possible coverage of key health services, particularly striving to reach the most marginalized and vulnerable
- *Quality* - services are of good technical quality and are delivered in a respectful humane way
- *Sustainability* - services are delivered using approaches that can be effectively sustained
- *Quick visible results* – although strong emphasis is needed on building effective sustainable systems over the *long term*, at the same time – to maintain confidence in the sector – community health services need to be rolled out in a way that yields visible and important impact over the *short to medium term*.
- *A tight technical focus* – the chances of achieving population impact are increased by prioritizing a limited number of key interventions addressing the highest burden public health problems.
- *Managing for performance* - monitor actual performance of the system, making adjustments as necessary depending on how well things are working out
- *Adopting new technologies, as appropriate* – continually review current global best-practices in community-based interventions, making revisions to the content of community-level services adopting new technical approaches suitable to the Liberian context
- *Task-shifting* - make available potentially high impact interventions that would otherwise not be available to more remote populations because they are normally only provided by more senior level health cadres, by delegating functions to peripheral level cadres.
- *Worker and volunteer motivation* – to ensure delivery of effective services on a sustained basis, the Ministry of Health and Social Welfare (MoH&SW) and its partners will give continuing attention to ensure that health facility staff and community health volunteers (CHV) remain active and motivated.

V National System of Community Health Services: Conceptual Framework



It is important to recognize that achieving sustained high coverage of quality services requires that *each* element in this *system* is working effectively and that the interactions and support between each of the elements are fully functional. This in turn requires that planning and management *integrate across system elements*.

To explain some of the details – at the bottom left we have *families* whose well-being we are seeking to improve by ensuring that they get certain services and whose conditions can be improved by appropriate household practices and care-seeking. Community Health Volunteers (CHV) – including Trained Traditional Midwives (TTMs) and the planned general Community Health Volunteers – can play a key role in helping achieve these objectives. But CHVs cannot do this alone. Many other individuals and groups in the community can play a helpful role. Here, they are referred to as *Community Health Supporters*. This can include a wide range of players, notably: women’s and youth groups, household health promoters, local religious leaders and traditional healers, churches, Red Cross members, school teachers, local officials in the political and administrative structure, service clubs, and other community-based organizations. For CHVs to be effective, an active community helps a great deal. The Community Health Committee (CHC) can help in this mobilization. They can also help mobilize local support for the health facility (HF), and hold HF accountable to the community for providing a good service. The CHC or some other appropriate local body should have the primary responsibility for selecting their local CHVs.

Within the health facility, it is important that there is a *focal point* with the primary responsibility for support to CHVs (including supportive supervision, training, re-supply of materials and supplies). This could be the officer-in-charge (OIC), although in several other national CHV programs (e.g. Ethiopia and Nepal) this responsibility rests with the locally hired extension worker. In Liberia, this responsibility could be given to the nurses’ aides (former vaccinators). Oversight and coordination for community health services (CHS) are also needed at County Health Team (CHT) and MoH&SW levels, in each of which focal points are needed, as well as structures ensuring smooth coordination with NGO partners and vertical programs having community components.

In a number of counties there are *lead NGOs* playing a very important role in health-facility and community level service delivery. Such NGOs will have a key role in further developing community health services, notably:

- supporting CHS-related training and orientation at various levels including local representative bodies, CHVs, nurses' aides/ extension workers, professional health workers and county-level supervisors;
- building the capacity of CHTs as related to managing CHS and helping enable them to more effectively fill their supervisory functions;
- helping to ensure strong oversight and support from HF for outreach and CHV functions;
- building the capacity of Community Development Committees, catchment-area Community Health Committees and other local representative bodies; and
- encouraging and supporting Community Health Supporters.

VI Policy Areas

a) Geographic Coverage

i Issues

Community health services can play several different functions within the broader health system. One important function is to improve *access* to a limited set of simple high impact interventions. This is a particularly important function for those segments of the population living at some distance from the closest health facility.

ii Policy Orientations

1. *This Policy and Strategy primarily addresses service delivery requirements in rural areas of Liberia.**
2. *MoH&SW will support community health volunteers based in communities lacking a functional 24 hour/ 7 day-a-week service and lying beyond 1 hour's walk of a community with such service.*
3. *Generally, as the new community health services are rolled out, officially recognized TTMs and general CHVs will have essentially uniform functions regardless of location. However there will be some flexibility, allowing an approach appropriately tailored to the setting. Furthermore, certain novel functions or technical approaches will be piloted in a limited number of districts before being more widely adopted.*

b) CHV Cadres

i Issues

The generic nomenclature for those playing this role has been 'community health worker'. Continuing to use this term to designate officially recognized community cadres has the advantage of familiarity. There are disadvantages however. First, because the term is used generically, covering a wide variety of workers, using this term to refer specifically to a government recognized cadre could create a bigger challenge in clearly differentiating this cadre from other community health workers. A second potential disadvantage with using this term is that, at least in some people's minds, the title 'worker' may imply that this is a paid function. Use of this term could reinforce unrealistic expectations for remuneration on the part of community cadres. An alternative would be to designate the officially recognized government cadre as 'community health volunteers.' From this point in the document forward, the official government community cadre will be referred to as *community health volunteers*.

With a concentrated population, the *population/ CHV ratio* can be higher than for more scattered populations. The population/ CHV ratio needs to be realistic. While it is true, all else being equal, that

* Community level services are certainly also important in urban areas but approaches required differ in significant respects, so the needs for such services for urban populations warrants separate treatment.

access and coverage will tend to be better with higher population/ CHV ratio, cost and management burden will vary directly by number of CHVs. Setting numbers needs be done taking into account that ultimately the government of Liberia will have to take full responsibility.

In the LDHS 2007, it is evident that the role of traditional midwives (TMs) in antenatal care has been much less significant (23% in rural areas) than for delivery care. However TTMs could take on additional functions during the antenatal period, complementary to HF-based ANC. TTMs have potential to play an important role in further reducing *neonatal deaths* through:

- neonatal resuscitation,
- counseling on essential newborn care (warmth, hygiene, immediate breast-feeding) and recognition and appropriate response in the case of danger signs;
- treating umbilical cord stump with chlorhexidine,⁷ and
- dispensing vitamin A (50,000 UI) to children from 6 months.

Interventions that could improve *maternal* outcomes that could be delivered by the TTM include immediate post-partum misoprostol (600ug) for preventing post-partum hemorrhage⁸ and iron supplements for the post-partum period (30-45 days). However, the long-term objective is to progressively shift away from use of TMs in performing delivery, encouraging delivery with professional midwives. The approach used over the short to medium term needs also to be supportive of long-term goals, i.e. progressively de-emphasizing the TM role as the primary provider of intrapartum care and transitioning TMs to new roles.

TTMs could assume an advocacy role related to family planning and referral.

ii Policy Orientations

4. *Under this Policy and Strategy, it is the government's intention to form an officially recognized cadre of Community Health Volunteers that will be able to cover at least some of the functions served by the current diverse mix of workers and volunteers. This new cadre will consist of two categories of community volunteers: 1) TTMs, and 2) General CHVs.*
5. *CHVs are an integral part of the MoH&SW system*
6. *To ensure, at the same time, optimal population coverage as well as affordability and manageability, the numbers of CHVs will be controlled and target populations/ CHV ratios will be established . Overall TTM: population ratio – 1:2000, gCHV: population ratio – 1:1000. In rural areas, there will be scope for local level adjustments based on how concentrated or dispersed the population is. Within 1 hour of functional 24/7 health facilities (i.e. hospitals and HCs), lower priority for CHVs.*
7. *Those recognized by MoH&SW as official CHVs will be given an identification card documenting their status. HFs and CHTs will maintain an up-to-date official list of MoH&SW CHVs working in their catchment areas.*

c) CHV Roles & Programmatic Focus

i Issues

The global literature on CHVs reports that generally there is an expectation from the community that CHVs have some capacity to provide treatment services.³ When the community health worker role is confined to health education/ health promotion, often the community is less satisfied and this has consequences for CHV motivation and retention. In the Liberian context, expanding the CHV role to include some dispensing and case-management functions can increase coverage of key public health interventions and contribute to reducing maternal and child mortality.

Possible CHV roles in the Liberian context (reflecting the C-IMCI framework):

- *Linking the community and health facility* – notably through mobilization for/ support to outreach services (with assistance from CH Supporters) – EPI, TB/DOTS, special campaigns/ days (vitamin A supplement distribution, NIDS, child health days, national HIV/AIDS day); antenatal services could also achieve higher coverage with some use of OR clinics.
- *Health promotion* (creating awareness, demonstrating desired behaviors, etc.) – group and individual level.
- *Service delivery*
 - *Distribution and dispensing of pills/ condoms; antenatal iron/ folate, deworming tabs, intermittent presumptive therapy (IPT), and ITNs* (given fairly high ANC visit coverage, CHV distribution of these commodities may only be necessary for more remote populations with poorer ANC coverage); *post-natal* – provided by TTMs – routine preventive Misoprostol,⁹ immediately post-partum; post-partum iron supplementation; immediate post-natal application of chlorhexidine to umbilical stump⁷ and administration of vitamin A to children 6 months and above; under-5 twice semiannual vitamin A and de-worming;
 - *Case-management – conditions for which dispensing will be considered:*
 - diarrhea – ORS & zinc;
 - pneumonia – including cotrimoxazole;
 - malaria – presumptive ACT for febrile under-5s & pre-referral rectal artemether for severe cases;⁹
 - neonatal sepsis – assessment and treatment initiating with cotrimoxazole, facilitating HF referral for injectable gentamicin;¹⁰
 - pregnancy-related night-blindness – low-dose vitamin A.
- *Documentation* – key community-level HMIS indicators, support for civil registration, monitoring maternal and child deaths.

It is important to give some indication to prospective CHVs and the community what kind of *time commitment* this represents.*

ii Policy Orientations

8. *The MoHS&W agrees in principle that selected community-based distribution and community case management functions will be delegated to CHVs, under close supervision by HF staff. A working group, consisting of key stakeholders – including representatives of the medical and pharmacist professions, and others – will be tasked with determining which functions will be included and in what circumstances. Any new tasks or functions will be rigorously piloted at county-wide scale, using approaches that are realistic for scale-up. Expansion decisions will be made based on observed performance under the pilots.*

* In Nepal, where FCHVs have a similar set of functions, and where they typically cover 100-150 households, they generally put in about 5-6 hours per week on related duties, working 2 or 3 days a week. Perhaps ~15 days per year, they are putting in full days, either on training/ review meetings or major outreach activities like vitamin A supplement distribution.

d) Selection Criteria & Process

i Issues

There needs to be meaningful community input on selection, to ensure acceptability and a sense of ownership and accountability. CHV selection should be at community level – i.e. town/ village – from which the CHV is being drawn and where service is to be provided. Village development committees could be suitable bodies for this function. Those tasked with selection need a clear idea of the expected role and working conditions of the CHV.

Several key selection criteria include long-term residence in the community (and expectation that this will continue), capacity to competently execute the functions of a CHV, and respect and stature in the community. But there also needs to be flexibility to adapt to local circumstances. For example, in predominantly Muslim communities, male CHVs may be less acceptable if their role involves service delivery to women. A few key areas where decisions will need to be made are: *age, marital status, sex, literacy/level of education*. Note that in some instances there may be trade-offs to be made; for example if a higher level of schooling is required, this can result in younger CHVs who may not be able to command the respect that older CHVs would.

The CH Sub-Committee on CHV Training Materials has recommended the following selection criteria: literate, permanent resident and expectation that they will remain, good moral conduct, respected by the community, selected by the community, self-sustainable/ volunteer, 25-55 years and speaks the local language.

ii Policy Orientations

9. *CHVs will be selected by and held accountable to their communities (through local Village Development Committees or some other suitable local body)*
10. *Selection criteria for general CHVs – certain standard criteria will apply, with scope for adding others per the local situation. In communities where there is an active TTM who is willing and who is judged able to effectively take on this expanded role and is acceptable to the community, first preference would be to offer the role to her. In the event that such a TTM is not available, standard criteria will be:*
 - *permanent resident of the community (speaking the local language), judged likely to continue to actively and effectively serve in this role long-term*
 - *judged to have qualities enabling her/him to be effective in their required roles*
 - *well respected/ of sound moral character*
 - *gainfully employed and not expecting this role to result in any significant income supplementation*
 - *female or male, female preferred especially in localities with large muslim population*
 - *literacy: 6 grades and above for only General CHV and so not applicable to TTM.*

e) Incentives/ Motivation

i Issues

Bhattacharyya and colleagues have reviewed the global literature on CHV motivation. Their findings on key motivating and de-motivating factors are summarized in the table below.

	Incentives	Disincentives
<i>Monetary</i> factors that motivate individual CHVs	<ul style="list-style-type: none"> • Satisfactory remuneration/ material Incentives/ financial incentives • Possibility of future paid employment 	<ul style="list-style-type: none"> • Inconsistent remuneration • Change in tangible incentives • Inequitable distribution of incentives among different types of community workers
<i>Non-monetary</i> factors that motivate individual CHVs	<ul style="list-style-type: none"> • Community recognition and respect of CHV work • Acquisition of valued skills • Personal growth and development • Accomplishment • Peer support • CHV associations • Identification (badge, shirt) and job aids • Status within community • Preferential treatment • Flexible and minimal hours • Clear role 	<ul style="list-style-type: none"> • Person not from community • Inadequate refresher training • Inadequate supervision • Excessive demands/ time constraints • Lack of respect from health facility staff
<i>Community-level</i> factors that motivate individual CHVs	<ul style="list-style-type: none"> • Community involvement in CHV selection • Community organizations that support CHV work • Community involvement in CHV training • Community information systems 	<ul style="list-style-type: none"> • Inappropriate selection of CHVs • Lack of community involvement in CHV selection, training, and support
Factors that motivate <i>communities</i> to support and sustain CHVs	<ul style="list-style-type: none"> • Witnessing visible changes • Contribution to community empowerment • CHV associations • Successful referrals to health facilities 	<ul style="list-style-type: none"> • Unclear role and expectations (preventive versus curative care) • Inappropriate CHV behavior • Needs of the community not taken into account
Factors that motivate <i>MOH</i> staff to support and sustain CHVs	<ul style="list-style-type: none"> • Policies/ legislation that support CHVs • Witnessing visible changes • Funding for supervisory activities from government and/or community 	<ul style="list-style-type: none"> • Inadequate staff and supplies

There is no simple formula for ensuring effective CHV incentives; maintaining good motivation long-term has been an Achilles heel in many CHV programs. However, giving continued serious attention to motivation, using a mix of incentives, and avoiding de-motivating factors can help ensure that CHV cadres remain active, effective and motivated. *Consistency on material benefits* for CHVs will be important, e.g. standardize conditions under which allowances are paid (for example – they could be provided for training activities and for special campaigns – e.g. NIDS, but not for regular review meetings – for which modest refreshments could be provided instead; performance-based incentives could be used in some instances, e.g. on completion of TB treatment, for community-based DOTS oversight). In a Liberian context, efforts should be made to ensure greater standardization of use of CHV *training allowances* across programs: what they're called, conditions under which they're given (full day/ part day, local resident/ non-local resident) and amount per day. These conditions should be settled taking into account *scaleability* and *sustainability* – i.e. have to be careful not to break the bank or – alternatively – demoralize CHVs by changing the rules of the game later. Some specific measures that could be useful in this context include: ID cards/ badges (using official government of Liberia logo), sign to post outside their home, certificates for training successfully completed, bags with program logo

ii Policy Orientations

11. *CHVs are unsalaried volunteers.*
12. *MoH&SW, with support from partners and the community will ensure provision of a variety of types of material support, on an uninterrupted basis.*
13. *As a critical condition for continued effective delivery of community health services, CHV motivation will be monitored and any necessary adjustments will be made to minimize attrition and maintain motivation.*

f) Health Sector Support

i Issues

Government focal point staff at central and county level need to be empowered to coordinate inputs involving CHVs, for example to ensure that CHVs in any particular county don't have their time overloaded with training activities sponsored by different vertical programs or INGOs.

The CHV knowledge/ skill base and functions need to be seen as a dynamic not static thing. The technical state-of-the-art in community-based interventions is always moving. So we need to build in provision for continual review and revision. At the same time, there is a need to developing modalities for delivery updates that are efficient with regard to money and time. Training can be a major motivator for CHVs but this needs to be balanced against time demands. Time spent in training is not available for service delivery or for any of the CHVs' other family and work obligations.

To be effective and remain motivated, CHVs need to be adequately supported and managed. In Nepal, at the level corresponding to a Liberian district, there are ~7-20,000 people. For that population, there are 2 more-or-less fulltime, literate, locally-hired extension workers (with about 4 months training) – one Maternal Child Health Worker (MCHV) and one Village Health Worker (VHW). They are able to give injections (e.g. vaccinations, Depoprovera[®], and antibiotics for more severely ill sick children). They oversee a minimum of 9 (and up to 25-30) unpaid part-time CHVs – called Female Community Health Volunteers* (FCHV), who each cover an average of 100-150 households (i.e. ~500-1000 population). Health Extension Workers in Ethiopia have similar functions to Nepal's MCHVs and VHWs, including oversight of community volunteers. In Liberia, the clinic-level Nurses Aides under the BPHS (former vaccinators) also have a similar profile and could be suitable for an expanded role as extension workers, including service delivery functions beyond EPI, as well as supervision of CHVs.

It is fundamentally important for any CHV dispensing role (and the same applies for key services provided in clinics and health facilities) that *stock-outs* of key program commodities are minimized. Stock-outs not only result in service delivery gaps, they undermine confidence in the service providers. Robust procurement and sound logistics management, including monitoring through a logistics management information system, are needed for key program commodities. This requires developing and sustaining suitably strong systems, capable of reliably providing key program materials and commodities on an uninterrupted basis.

ii Policy Orientations

14. *CHVs will be provided robust support by their local HF and CHT, including in-service training, supportive supervision and consistent resupply of any needed materials (e.g. job aids, reporting forms, medicines or other consumables).*
15. *District health officers will ensure implementation of CHV programmes in their districts*

* Nepal's FCHVs have more limited functions than the MCHVs and VHWs but because of how numerous they are, for a number of national programs they are the key service providers (~½ of public sector condoms/ pills distributed, more than ½ of antenatal iron/ folate, more than ½ of public sector outpatient treatment of child pneumonia, virtually all under-5 vitamin A supplements and de-worming, virtually all polio/ NIDS). Note that annual attrition of this cadre is only ~3%.

16. *Supervisory support from the local HF will be regular (at least monthly contact) and will be the responsibility of a specific focal point, usually the nurses aide/ extension worker for gCHVs, and the certified midwife for TTMs. CHV support will be a major work responsibility of these HF staff. This support will include collecting of reports, review and action on performance issues, re-supply of materials.*
17. *MoH&SW, with its own resources and assistance from partners, will endeavor to assure certain material benefits for CHVs, e.g. for time spent in training – transport allowances, using standardized rates. Special incentives may be provided for specialized functions, e.g. support for special campaigns, TB-DOTS. Recognizing that irregularity of such incentives can be very demotivating to CHVs and damaging to programs, MoH&SW will endeavor to ensure continuity of any such incentive provisions.*
18. *A standardized core package will be used, consisting of training curricula, job-aids, MIS forms/ registers. This can be supplemented per local circumstances.*
19. *Appreciating that implementing effective sustainable community health services is complex and challenging, the MoH&SW approaches this task in the expectation that performance will need to be continuously monitored and adjustments in approach made both to optimize quality and coverage and to reflect evolving global best practices.*
20. *The Community Health Services Division will ensure coordination in delivery of services through CHVs, including activities of other MoH&SW departments and divisions and of partners. In each County Health Team, a supervisor will be assigned responsibility for Community Health Services, and will ensure coordination within the county, among partners working on community health services. This position should have a full-time or nearly full time focus on Community Health Services.*

g) Community support

i Issues

Local Representative Bodies

Relations between CHV and the community are critical. One key selection criterion must be that CHVs come from the community where they serve (as discussed above). There needs to be meaningful participation by the community in their selection.

CHVs are more likely to be effective in active, mobilized communities; it is not realistic to expect that CHVs, by themselves, can activate or empower a community that isn't already. Where, at the *village or town level*, there are active Village Development Committees (VDC) or some similar structure present they are the suitable body to work with in selection of CHVs. In their absence village chiefs and elders can play this role, identifying suitable candidates and finalizing selection together with staff from the County Health Team. VDCs should also be empowered to remove non-performing CHVs. At the level of *catchment area*, Community Health Committees can play a key liaison role with the health facilities. Support for capacity-building of both community and catchment area-level committees could be a helpful role for INGO partners to play.

One key consideration for effective CH services is enhancing the credibility of the CHV among members of the community they serve. Involvement of the community in selection is the first step. At the time of completing certain trainings, there can be ways of presenting the CHV to the community, e.g. on completing training for pneumonia community case management, mothers can be called together to bring their young children to be examined by CHVs for signs of pneumonia and then treated on the spot by CHVs. On completion of training, HF OICs and supervisors from CHT can meet with community leaders to have them decide on and commit to an action plan to support CHV activities. These local bodies can be tasked with organizing special days on an annual basis to recognize and honor the contribution of CHVs in some locally appropriate way, perhaps in connection with some other annual festival or event (World Health Day...), and perhaps with some material tokens of appreciation.

Community Health Supporters

Concerning the desire of certain partners to maximize the number of community members exposed to CH knowledge and the number that can play a CHV role, the difficulty is that beyond a certain number, it can become unmanageable and unaffordable to provide the necessary continued support for a large number of CHVs (for training, supervision, commodity logistics, etc.). An alternative is to conceptualize *CH supporters* who may not have a continuing formalized role but who can be drawn on, on an ad hoc basis. Subject to availability of resources, materials could be prepared with such ‘supporters’ in mind, including suggested roles. Possible supporters could include: officials within the local political and administrative structure, Red Cross, other youth groups, local women’s groups, service clubs like Rotary, interested school teachers, church leaders/ imams/ local traditional leaders, black-baggers and traditional healers, members of local health or development committees, CBOs, etc. But, in each locality, there should be a primary support group identified. This will generally be the VDC. Possible roles for supporters include:

- mobilizing for community actions for health, e.g. securing protected water sources, digging/ building latrines,
- disseminating health messages,
- helping mobilize for outreach activities, including special campaigns and routine outreach from the HF (like EPI),
- could assume some CHV functions in remote or small villages without a resident CHV,
- mobilize periodic CHV appreciation events.

It can also be appropriate to direct outreach to engage spiritualists and herbalists who may be sought out for conditions that could require urgent referral. And they should continue as a valuable resource for signaling instances of reportable illnesses.

Support for such community level work could be an appropriate role for INGO partners.

ii Policy orientations

- 21. Consistent with the valuable role CHVs are to play in their communities, it is expected that CHVs will receive encouragement and support from their communities.*
- 22. In addition to their responsibility for CHV selection, community health committees will be responsible for mobilizing community action for health, overseeing and supporting local CHVs and liaising with the local HF.*
- 23. This Policy is not intended to restrict or prohibit partners from doing more intensive local-level work with community health supporters or other community level cadres. However, partners required to adhere to policy.*

h) Outreach services

i Issues

Outreach can be categorized as follows:

- *One-off campaigns*, e.g. polio-NIDS, which in some cases may be repeated several times.
- *Periodic, infrequent*, e.g. twice annual vitamin A supplement distribution/ child health days (as done in some other countries); ivermectin dosing.
- *Periodic, frequent*, e.g. monthly outreach clinics for EPI or other MCH/FP services.
- *Continuous/ as needed*, e.g. household-level TB-DOTS, FP commodities

For all of these, CHVs are expected to play various roles, including:

- Mobilizing community members to take advantage of these services, helping to achieve highest possible coverage. This can be done by making, putting up posters, door-to-door visits, etc. Explaining the benefits, giving information on time and place.
- Preparing and organizing a venue.
- Approaching specific individuals or households to encourage them to make use of a service (e.g. for an EPI outreach clinic), in some cases accompanying individuals to service delivery sites.
- Dispensing, e.g. vitamin A or polio drops, or TB meds to a DOTS patient; distributing ITNs during a Child Health Day, ORS, FP commodities

For such outreach services, CH supporters should be mobilized to support the functions listed above for CHV.

Other cadres also have important roles to play in outreach (OR) services. Although it can certainly be appropriate for this to involve professional cadres in the peripheral health facility or staff from the CHT, this extension function would be a suitable role for the clinic-level cadre now designated *Nurses' aides* (former Vaccinators). Rather than having this cadre primarily involved in support functions at the health facility, more can be achieved if their focus is on outreach activities and CHV support. Outreach services provided by these nurses aides/ extension workers should be broader than EPI and can include family planning, post-partum and other technical areas. For outreach and support for CHV functions, health centers also need to have a similar staff person able to give full-time attention.

Outreach services should be managed along *micro-planning* lines (as done for EPI), based on distribution of population and adapting in response to measured program performance. For some OR activities, advantage can be taken of recurring local events, e.g. weekly markets, feasts.

ii Policy orientations

24. At the level of each catchment area, associated with each clinic and health center, there will be one locally hired staff person with a primary focus on outreach services and support to CHVs. This would correspond to the clinic-level 'Nurses Aide' currently reflected in the BPHS; many of these may be former Vaccinators. Certified midwives will provide technical oversight of TTMs working within their catchment areas.

VII Strategic Approach

It is important that CHS not be seen as a stand-alone function. For community services to make an important contribution they need to be developed in tandem with associated developments in HF-based services. For example planning for further evolution of the role of the TTM needs to be done in the context of broader planning on maternal-neonatal health services at community and health facility level. Recalling the conceptual framework, the community and peripheral health facility and each of their components can, together, be considered the *catchment-area health system*. Further planning and development of community health services needs to be done working out in detail not only the roles of those based *outside* the health facility but staff and functions of the *health facility* as well.

a) Phased Introduction

For several reasons, *phased* introduction of community health services is prudent. First, incorporation, from the very beginning, of too many elements – particularly novel elements – is more likely to *overwhelm* the systems and workers responsible for delivering services. Second, important *visible gains* need to be evident over the short to medium term to sustain motivation of CHVs and confidence of the population in the capacity of the health sector to improve health conditions in Liberia. So the Ministry, with its partners, will proceed with an initial focused and relatively simple package, designed to be scaleable and sustainable, maintaining provider motivation and having scope to deliver important and visible improvements in population health status.

In 2009, piloting of the new package will begin in 5 counties (still to be selected). A monitoring and evaluation plan will be developed, looking at a variety of aspects of program performance, particularly population coverage for key interventions, quality of service, and CHV motivation and retention. After a year of implementation, there will be a detailed review and any necessary changes in approach will be made. In 2010, the package will be expanded to 5 new counties, bringing geographic coverage up to 10 counties. In 2011, it is expected that 1) the final 5 counties will be reached with the phase I package and 2) the phase II package will be initiated in the 5 counties where phase I was first implemented. As with the case of phase I, after one year of phase II implementation in the first 5 counties, there will be a detailed review of performance and any necessary changes in approach will be made.

b) Choice of Programmatic Elements, by Phase

Those items marked in the table below in *italics* are not reflected in the current version of the Basic Package of Health Services. Those activities that are underlined> are in BPHS but not yet definitively assigned for community-level delivery. Note that this is *illustrative* content only; *actual* content needs to be determined based on further technical discussions.

Illustrative Content	Phase I	Phase II
Maternal – Neonatal Health		
<ul style="list-style-type: none"> • Counseling to pregnant women on birth preparedness, danger sign recognition and response and essential newborn care 	TTM	
<ul style="list-style-type: none"> • <i>Routine misoprostol immediately post-delivery, for prevention of post-partum hemorrhage⁹</i> 	<i>TTM</i>	
<ul style="list-style-type: none"> • Shift in TTM role, emphasizing antenatal and post-natal care and de-emphasizing intrapartum care* 	TTM	TTM
<ul style="list-style-type: none"> • <i>Antenatal dispensing of ITNs, IPT, iron, deworming or facilitating receipt through HF, depending on local circumstances – ensuring every pregnant woman gets ITN and IPT</i> 	<i>TTM</i>	
<ul style="list-style-type: none"> • Postnatal home visit – counseling, dispensing iron to the mother, assessment of mother and NN for danger signs, referral 	TTM	
<ul style="list-style-type: none"> • Dispensing family planning commodities like condoms and pills 		

* This will be a complex ongoing challenge and relates in part to further development of HF maternity services and community-level demand creation for HF delivery. Evolution of the TTM role needs to be handled carefully to maintain TTM motivation and community support.

<ul style="list-style-type: none"> • Neonatal vitamin A dispensing • Chlorhexidine for immediate post-natal application to the umbilical cord stump 		TTM TTM
<p>Child Health – Malaria</p> <ul style="list-style-type: none"> • Health education on cause of malaria, ITN use, danger sign recognition & prompt treatment seeking; community mobilization for malaria campaign activities (e.g. ITN distribution) • Case-management of fever in under-5s using ACT – on a piloting basis • Case-management of malaria with danger signs, using rectal artemether and facilitating transfer 	gCHV gCHV (+TTMs?) gCHV	
<p>Child Health – Pneumonia</p> <ul style="list-style-type: none"> • Health education on danger sign recognition, referral for treatment • Case-management by CHVs, using cotrimoxazole 	gCHV	gCHV
<p>Child Health – Diarrhea</p> <ul style="list-style-type: none"> • Health education on prevention – especially water & sanitation and hand-washing with soap; on household management of diarrhea – including continued feeding and fluids, use of SSS, convalescent feeding and danger sign recognition and response • CHV case-management/ dispensing – ORS, Zn 	gCHV	gCHV
<p>Child Health – Nutrition</p> <ul style="list-style-type: none"> • Health education on breast-feeding – immediately post-natally and exclusively through 6 months; developing community champions for continued exclusive breast-feeding • Recognition & referral of severe malnutrition (MUAC) • Biannual vitamin A distribution* and de-worming 	TTM TTM, gCHV	gCHV
<p>Child Health – EPI</p> <ul style="list-style-type: none"> • Health education/ sensitization and community mobilization for outreach activities, including special campaigns like NIDS 	gCHV	
<p>Family Planning</p> <ul style="list-style-type: none"> • <u>Health education/ counseling & community based distribution of oral contraceptive pills</u> 		TTM, gCHV
<p>Other program areas</p> <ul style="list-style-type: none"> • <u>HIV – health education on prevention and stigma; condom distribution</u> • TB/leprosy – defaulter tracing • <u>TB – community-based DOTS</u> • <u>Family planning –</u> • Community mobilization for periodic ivermectin dosing 	TTM, gCHV gCHV gCHV gCHV	
<p>Documentation</p> <ul style="list-style-type: none"> • Birth recording to facilitate civil registration • Very basic documentation on services provided – to feed into MoH&SW HMIS 	TTM TTM, gCHV	

* Countries with the highest U5 vitamin A coverage have achieved this using semi-annual campaign-style outreach. This should be considered for Liberia

Note that any changes to the role of TTMs need to be made based on a broader review of Liberia's approach to safe-motherhood. Linked with planning and preparations for roll-out of CHS, there should be further refining of plans for antenatal and intrapartum care, specifying the roles and functions of certified midwives and other professional staff involved in maternal health care at clinic, health center and county hospital levels as well as among traditional midwives. This planning needs to address continued wide-scale use of TMs who have received *no* training and whose current practices may be at variance with recommended practices. Community-level antenatal and intrapartum care (including provisions for transport) are important elements of CHS and will require a substantial planning and preparation effort over the coming months, together with other aspects of CHS and maternal health program planning.

c) Functions to be Developed

For each of the two phases, there are a number of functions that will need attention by program planners and managers. For phase I, it is a matter of some urgency to proceed with this planning work. Once this planning and preparatory work is complete, implementation of phase I activities can begin and planning work can begin for phase II, with implementation of phase II work to begin 1-2 years later.

i. Policy, Planning and Management

CHV *focal points* will be assigned at MoH&SW, CHT and HF levels, with the responsibility for management of the program and coordination with partners – i.e. line program managers, INGOs, WHO, UNICEF, USAID, etc. A technical working group will be formed at central level, chaired by the Deputy CMO for Preventive Services with secretariat support from the program manager of the Community Health Services Division and with participation by partners. Similarly, at county level, there will be a coordinating committee for community-level services chaired by the County Health Officer with secretariat support from the CHS focal point (generally the Community Health Services director) and with participation from NGOs and other relevant local partners. This function could be consolidated within an existing relevant committee or structure, providing due attention is given to community services. At the district level, the district health officers will ensure supervision.

Detailed *guidelines* will be developed on the *CHV role* under the leadership of the director of the Community Health Services Division, with active support and participation by key stakeholders (specialized programs, clinical/ technical experts – e.g. from medical and nursing professions, INGO partners, UNICEF, WHO, etc.). This will include a detailed listing of functions, activities, and related competencies (see the section on Strategic Approach).

Various specific details of the phase I package need to be finalized based on detailed technical discussions led by relevant MoH&SW divisions and with participation by key stakeholders. In some instances, for example those involving important commitment of resources or task-shifting functions normally resting only with professional cadres, additional policy approval steps will be needed.

Overall coordination and planning for phase I implementation will be under the leadership of the Chief Medical Officer and the Community Health Services Division and will be supported and advised by a technical committee with representation from key implementing partners. Once county selection has been done, the County Health Officers and designated CHS focal points will be thoroughly oriented and will assume planning and coordination responsibilities, with support from INGOs and other partners active in their counties.

TTMs will continue to be referred to by this designation. A second cadre will also be included as official MoH&SW CHVs. They will be designated as “general CHVs”. Together these two cadres will be referred to as MoH&SW “community health volunteers”. An attractive and effective logo will be developed for CHVs and the CHS program.

Commodities and dugs for CHVs shall be integrated into regular distribution system of the county

ii. Training

A *core training package* corresponding to the defined functions of the general CHV needs to be developed (and the TTMs training package will need to be revised to reflect changes in their role). The

package will be competency-focused, relating to the CHV functions. Training approaches, materials, and job-aids will draw on international and local best practices; and there will be provision for regular review and updating, keeping the content current.

Once there has been finalization of the content of the Phase I package, a set of training modules will be developed for TTMs and general CHVs. A common curriculum will be used by partners supporting phase I implementation. The content will be limited to the identified priority areas and will focus on the CHVs expected tasks. Training will include all key functions – health education/ counseling, dispensing & case-management, and documentation.

Supervisors from CHT can be drawn on as trainers. Local HF staff should be used as trainers for those CHVs working in their catchment area, i.e. health workers who will have an ongoing role supervising these CHVs. However, a national pool of *expert trainers* should be developed, who have full mastery of the content and training approaches. To ensure quality, for *every* training batch there should be at least one outside expert trainer (other than for very straightforward orientations, which can be handled through a conventional cascade approach).

To the extent appropriate, *similar training approaches* should be used each time a new area of competency is being introduced to CHVs. Familiarity with the training approach will help CHVs more readily acquire new knowledge and skills. The training will be hands-on and practical, with any necessary theory integrated into practical sections, rather than being presented separately. Methods should include use of models and visual aids (harmonized with job-aids and IEC materials to be used by CHVs in their program work); role-plays/ simulations; songs; hands-on observed practice. Training will be competency-based, ensuring that each participant has achieved mastery of the needed skills and associated knowledge before they are certified to provide the related service.

Training will be delivered in short blocks (generally no more than 4 days at a time), with each such module including new skills that can be immediately applied. At the time of subsequent training blocks, there will be review of previous material and CHVs' experience applying it.

At suitable points in training, when CHVs have been equipped to play a significant new role, they will be presented to the community, doing real-life demonstration of their new skills/ roles (e.g. assessing and treating children with fever).

In addition to training for CHVs, various other key players in CHSs will need orientation to their expected roles, particularly nurses aides/ extension workers as well as other CHS focal points and supervisors and CHC members. The orientation process is an important opportunity to communicate to these various players the rationale and content of community health services. At community level, it will be appropriate that the orientation process engage *local opinion leaders*, securing their full understanding and commitment.

Support from NGO partners for training TTMs, gCHVs and nurses aides/ extension workers would be welcomed.

iii. Logistics

For phase I, all materials and commodities, including any drugs or other health-related supplies to be dispensed by CHVs, will be determined and, for each, quantification and procurement planning will be done. Provision of key program materials and commodities will be assured to the level of CHVs, with no interruptions in supply. To achieve this, in each county involved, necessary arrangements for transport and storage will be made and an adequate information system will be put in place allowing peripheral level workers to signal to the center their re-supply needs and secure shipments on a timely basis, avoiding any stock-outs at the point of service. The same process will be implemented for phase II once key functions and needed material and commodities are definitively determined.

iv. Supervision

Effective supervision is needed at multiple levels, from the center, from CHT and particularly from HF level, providing oversight and support to CHVs. For health facility level, suitable supervisors will be identified. It would be appropriate for supervision for TTMs to be provided by the Certified Midwife.

General CHVs will be supervised by the Nurses Aide/ extension worker. There will be flexibility to reassign this supervisory function subject to what positions are actually filled, but this role will be written into the job descriptions of the selected staff and will be an important part of their duties. Those serving as supervisors generally should participate as trainers for any CHV training activities provided to the CHVs they are supervising. Materials will be developed to help facilitate supportive supervision, including checklists. Generally contacts with CHVs should happen at least monthly. These contacts can be used to do follow-up reinforcement related to recent training and on any programmatic area where CHV performance is less than optimal. They will review stock status of all key program commodities and ensure any needed resupply. They will collect MIS reports. They will provide support and encouragement to CHVs, reflecting their valued role as community volunteers. INGO support to facilitate supervisory functions would be useful, in counties where they have a presence.

v. Community Participation

A fleshed out plan and supporting materials are needed to ensure that the community component is adequately addressed. The Community Health Committee will be the principal focus of this work at the level of the catchment area. As the CHV package is first introduced in a county, there will be orientation meetings with CHC members, at which time the objectives, implementation modalities, and CHV roles will be presented and discussed. At that time, the role of the CHC will also be explained, including: CHV selection (or endorsement, e.g. of existing TTMs or CHVs), CHV encouragement and support, liaison with the health facility, and mobilization and coordination of Community Health Supporters of all kinds. Commitment of CHC members to play such a role will be sought. Before training begins, CHCs will need to recommend who should be selected as their GCHVs and TTMs.

MoH&SW and partners will assess what kinds of support in building the capacity of CHCs and VDCs may be effective and feasible for sustainable implementation at scale. Such support would be a suitable role for NGO partners.

vi. Behavior Change/ IEC

With leadership from the Health Promotion Division, behavior change goals related to the selected priority public health areas will be identified. Communication and non-communication related behavioral interventions will be selected and *standard key messages and approaches* will be determined corresponding to the content for each of the two phases. All partners will be encouraged to use *standardized graphics* (e.g. mother giving ORS to sick child) for training materials, HW and CHV job-aids and IEC materials aimed at the general public (e.g. posters).

For CHV behavior change/ IEC functions, to the extent possible just two sets of tools will be used, one for TTMs and one for general CHVs, covering all the core technical areas for which they are responsible. These tools need to be of a form that allows addition of new materials and substitution or replacement of obsolete material, for example, some kind of binder with removable pages.

vii. CHV Motivation

Under leadership by the Community Health Services Division, a task group will develop a standardized incentive package, including non-material incentives like:

- recognition through events like a national CHV day,
- official badges or ID cards,
- presenting CHVs who have successfully completed key trainings to the community

and material incentives like:

- meals or transport allowances for days spent in training,
- items like rain gear, special items of clothing, flash-lights, agricultural tools, etc.,

specifying under what conditions these incentives will be provided. It is very important that:

- the package of incentives be implemented in a standardized way,
- that it be consistently available, and
- that it be clearly communicated to CHVs (and CHCs).

The task group will also review factors that can potentially be *de-motivating* to CHVs and will ensure that implementation is done in ways that minimize such effects. Communities will be expected to provide meaningful support to their CHVs, although community financing is not expected.

CHV attrition will be monitored and any necessary modifications will be made to keep it to a minimum.

The question of incentives for TTMs is somewhat complicated. On the one hand traditional midwives have a well understood and valued role in the community and are generally given some compensation for delivery services by the family. This has resulted in them remaining relatively active even in the absence of inputs from government or partners. If they are to be transitioned to a somewhat different role including more antenatal and postnatal support and facilitating delivery at the health facility level, this would involve forgoing the material incentives they have been receiving from the community for their delivery services. For this to be viable, substitution of some kind will be needed. Along with other issues with regard to a realignment of TTM functions, this issue of incentives needs explicit attention.

viii. Monitoring and Evaluation

A detailed M&E plan will be developed for each phase. This plan will address a variety of issues including:

- *Formative research* needs will be defined, e.g. a *maternal death verbal autopsy study* would be very helpful, to better define causes and circumstances of maternal death. This can help to orient planning for future work both with traditional midwives and HF-based service providers – identifying the most widespread barriers to receipt of timely definitive care.
- Key aspects of program performance issues will be assessed, *piloting* new programmatic approaches and technical innovations. Planning will be done how these pilots will be evaluated, for example determining what kind of *baseline* performance measures are needed and whether or not to plan from the beginning to also track indicators *in non-intervention* areas for purposes of *comparison*.
- Key indicators will be selected for monitoring quality, coverage, CHV retention and other important dimensions of program performance and decisions will be made on the most appropriate ways of collecting such information both for service delivery and household practices (routine information collected from service providers, representative household surveys, sentinel surveillance systems, etc.).
- Mechanisms will be put in place to ensure that performance monitoring data is actively used at all levels for program management.

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