

NATIONAL COMMUNITY HEALTH WORKER POLICY 2016–2020



**MINISTRY OF HEALTH
AND SANITATION**
THE REPUBLIC OF SIERRA LEONE



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Acronyms

BPEHS	Basic Package of Essential Health Services
CHW	Community Health Worker
DFID	Department for International Development (U.K.)
DHMT	District Health Management Team
DPHC	Directorate of Primary Health Care
FMC	Facility Management Committee
FP	Family Planning
HIV	Human Immunodeficiency Virus
iCCM	Integrated Community Case Management
IGC	International Growth Centre
IP	Implementing Partner
IPC	Infection Prevention and Control
JSI	John Snow, Inc.
JSS	Junior Secondary School
KRA	Key Result Area
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MNCH	Maternal, Newborn, and Child Health
MOHS	Ministry of Health and Sanitation
MUAC	Mid-Upper Arm Circumference
NGO	Nongovernmental Organization
NMCP	National Malaria Control Programme
PHU	Peripheral Health Unit
PIH	Partners In Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SAM	Severe Acute Malnutrition
SOW	Scope of Work
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VDC	Village Development Committee
WASH	Water, Sanitation, and Hygiene

MINISTER'S FOREWORD



The entire development landscape in Sierra Leone is changing and with each policy my Ministry makes, we take one bold step in the improvement of health outcomes of the people of Sierra Leone. When we were faced with the Ebola virus disease outbreak, we fought so hard and made tremendous progress within a short space of time to recover the health care system and restore essential health care services. It was not business as usual. Community Health Workers (CHWs) were part of this “not business as usual” approach. CHWs, many of whom had been working within their communities for years, stepped up to meet the enormous challenge and acted as contact tracers and members of burial teams, and helped to spread messages of caution and hope to their communities.

It is very important that after Ebola we do not go back to business as usual. The President’s Recovery Priorities set ambitious targets for the country, including saving the lives of 600 women and 5,000 children by 2018, as outlined in Key Result Area (KRA) 1. Strengthening the National Community Health Worker Programme is a KRA1 initiative. The Programme will contribute by identifying Sierra Leoneans who are sick or at risk of being sick, especially expectant and new mothers and their children, and providing basic treatment in the community for the country’s greatest killers through Integrated Community Case Management (iCCM) while also providing referral and linkage to care. As Sierra Leone continues to face the world’s highest maternal and child mortality rates, reaching every child and woman with essential, life-saving interventions is key, and requires active participation of the community. CHWs bridge the gap between the health facilities by bringing the clinic to communities and communities to the clinic.

The revised National CHW Programme, as outlined in the 2016 National CHW Policy and Strategy, employs a government-led, health- and community- systems strengthening approach that aims to make the CHW Programme stronger and better integrated with the overall health system. The changes relate to governance, programmatic details, and support to the CHWs themselves. For the first time, there is a structure within the Ministry of Health and Sanitation (MOHS) that is fully dedicated to overseeing the Programme, including direct fundraising, with funds flowing directly through the MOHS. This is aligned with the numerous partnership agreements that Sierra Leone has signed, including the Paris Declaration and the Abuja Accord.

The details of what we want to achieve, and how we want to achieve it, are outlined in the 2016 National CHW Policy and Strategy. We are cognizant of the fact that what we aim to achieve is ambitious. We have a big appetite for change, and know that achieving this will not be easy. But we are confident that we can do it if we resist returning to “business as usual” and continue to work together and quickly. Doing so will mean that more Sierra Leoneans, particularly mothers and children, will receive the care they need in their homes and communities, and will trust and seek services at health facilities that the MOHS and our partners are working to strengthen across Sierra Leone. I urge all stakeholders to implement the strategies outlined in the 2016 CHW Policy and Strategy, thus contributing to His Excellency’s Agenda for Prosperity.

A handwritten signature in blue ink, likely belonging to Honourable Dr Abu Bakarr Fofanah. The signature is stylized and cursive, written over a horizontal line.

Honourable Dr Abu Bakarr Fofanah, Minister of Health and Sanitation
11 October 2016

CHIEF MEDICAL OFFICER'S REMARKS



As we all know, there is ample international evidence, including our own experience before and during the Ebola epidemic in 2014/15, that a robust focus on strengthening community health is essential to achieving the Sustainable Development Goals. CHWs are one of the most cost-effective ways to reduce maternal and child mortality and work toward 'resilient zero.' By making community ownership a pillar of the Health Sector Recovery Plan and the Basic Package of Essential Health Services, CHWs will become an even more prominent feature of our health landscape.

CHW work in this country has progressed over the decades, from a series of vertical, primarily nongovernmental organization (NGO)-led programmes to one overseen by the MOHS with ambitions for high-quality coverage across the country. The Ministry developed the 2016 National CHW Policy and the associated National CHW Strategy, which outline the goals and ambitions of the revised National CHW Programme.

Led by the newly formed CHW Hub within the Directorate of Primary Health Care and supported by Technical Experts, Health Development Partners, Implementing Partners, MOHS Directorates and District Health Management Teams (DHMTs), the Ministry reviewed the 2012 CHW Policy, Strategy, and Programme and considered best practices from around the world to formulate an appropriate and ambitious revised policy framework.

The National CHW Programme aims to align with and complement the overall health workforce. It strives to meet Sierra Leoneans' biggest health needs in an efficient, equitable way, with all Sierra Leoneans receiving the same package of health care services, while focusing on areas that need the most care. This would not have been possible without the hard work that this Ministry, our Health Development Partners, and CHWs themselves have done for many years preceding this document and today's Programme. We are where we are today because of the road paved by those before us.

I would also like to commend the collaborative and transparent manner with which this policy has been developed, with an underlying commitment to creating an evidence-based programme that meets the needs of the health service, and therefore improves health outcomes among Sierra Leoneans. I am proud to have overseen this process, and proud to be launching a revised and strengthened CHW Programme today.

This policy document and the strategy that accompanies it are just the beginning. We know that a singular, harmonized national Programme will only be followed with strong commitment from all stakeholders. In an effort to save the lives of Sierra Leoneans, the MOHS assures all stakeholders of its commitment to work in a collaborative effort to realize the goals and objectives of the CHW policy.

Dr Brima Kargbo, Chief Medical Officer
Ministry of Health and Sanitation
11 October 2016

ACKNOWLEDGMENTS



The Directorate of Primary Health Care is responsible for all health care services provided at Community Health Centres and at levels below that in the health system. With the unwavering support of the Deputy Minister of Health and Sanitation II, the Directorate has made significant progress in ensuring that lower levels of care are of the highest quality and reach every Sierra Leonean in the country. The 2016 CHW policy is one of the outputs of the Ministry of Health and Sanitation, supported by Health Development Partners and others.

Over the past year, many contributed to the development of this policy document as well as the revitalization of the National CHW Programme. From across the country and the world, MOHS staff, technical experts, Health Development Partners, donors, and Implementing Partners came together to review the 2012 National CHW Programme and consider what revisions were needed. I hope and believe that this document reflects the contributions of all of those who gave their time and input. This document would not have been possible without the contributions indicated above.

While there are too many to thank, a few deserve particular note. The review process was supported both financially and technically by the United Nations Children's Fund (UNICEF), one of the strongest allies of the Ministry of Health and Sanitation and the CHW Programme. I would also like to acknowledge the significant support of the Health System Strengthening Hub within the MOHS, as well as the significant technical, financial, and personnel support that came from the International Growth Centre (IGC), London School of Economics; Partners In Health (PIH); the U.S. Agency for International Development (USAID), through John Snow, Inc. (JSI); International Rescue Committee; Save the Children; and World Vision, among others. I thank USAID and JSI in particular for their final editing, layout, and printing support, and UNICEF, USAID and IGC for their support for the official re-launch.

Implementing Partners who have long supported the Programme offered valuable feedback from the field, helping the Ministry to understand how changes would effect on-the-ground implementation. Particular thanks should be given to Save the Children, Concern Worldwide, World Hope International, and the International Rescue Committee, all of which provided significant feedback both through the Technical Working Group and smaller meetings. Furthermore, I would like to thank our DHMTs, Local Councils, Civil Society, and all other organizations for their time and valuable contribution.

Special thanks to our donors, The World Bank, Global Fund to Fight HIV, TB and Malaria, USAID, and the Department for International Development (DFID), for their continued and generous support. I also would like to thank the District CHW Focal Persons and staff of the CHW Hub, who, despite the challenges, have worked tirelessly as a team through this difficult but important process. Finally, I would like to thank my MOHS colleagues and our leadership, especially the Hon. Minister, the Hon. Deputy Minister II, and the Chief Medical Officer, who have been instrumental to the creation and sustaining of the National CHW Programme. I know that if we continue to work together, we can move forward and go far. To all those not mentioned, I express my deep appreciation for contributing in diverse ways.

A handwritten signature in dark ink, appearing to read 'Dr. Joseph Kandeh'.

Dr. Joseph Kandeh, Director of Primary Health Care
Ministry of Health and Sanitation
11 October 2016

INTRODUCTION

Sierra Leone's National CHW Programme has been in formal existence since 2012, when the MOHS, supported by partners, developed the first national CHW policy focused on providing a basic package of services at the community level. This national programme was built on decades of efforts to bring essential services to communities across the country through a variety of vertical community-based programmes, such as Traditional Birth Attendants (TBAs), Community Drug Distributors through the Neglected Tropical Diseases Programme, Community-Based Providers through the National Malaria Control Programme (NMCP), and Blue Flag Volunteers diagnosing and treating diarrhoea. Additionally, many NGOs promoted community-based care through Community-Based Workers and volunteers. These programmes demonstrated the importance of providing care at the community level.

Until the Ebola outbreak, the implementation of the 2012 National CHW Policy was on track to achieve results for mothers and children in Sierra Leone. However, the support to CHWs during the Ebola outbreak was significantly affected by less supportive supervision and decreased stock of supplies. In addition, the CHWs were called to perform additional tasks during the outbreak, including contact tracing, Community Event-Based Surveillance, and social mobilization on Ebola related messages. In some instances, CHWs even served as burial team members. In order to take into account the lessons learned from the 2012 Programme and from CHWs work during the Ebola outbreak, the MOHS and partners embarked on revising the 2012 policy.

The 2016 CHW Policy builds on the historic efforts to strengthen and harmonize different community-based programmes to provide comprehensive primary health care at the community level. This revised and updated policy provides further guidance on coordination, implementation, and monitoring and evaluation of the National CHW Programme; CHWs' revised Scope of Work (SOW); geographical coverage; selection criteria and processes; supervision; incentives and remuneration; expanded standardized training curriculum; supplies; and reporting. The National CHW Programme aims for national scale so that all hard-to-reach communities receive a basic but comprehensive package of services.

The 2016 National CHW Policy provides guidance on the minimum package of services to be provided by CHWs and the minimum package of inputs required to support those CHWs. All Ministry programmes and directorates, partners, and donors working to implement and support the National CHW Programme must meet the minimum standards outlined in this policy.

The National CHW Programme looks forward to working with other MOHS programmes, Implementing and Technical Partners, and communities over the coming years to build a strong National CHW Programme that serves the needs of communities, is accountable to those it serves, and improves the health of all Sierra Leoneans.

Policy revision process

The MOHS, led by the Directorate of Primary Health Care (DPHC), with support from the Health Systems Strengthening Hub and UNICEF, began revising the National CHW Programme in March 2015. This included a series of consultations

The 2016 CHW Policy builds on the historic efforts to strengthen and harmonize different community-based programmes to provide comprehensive primary health care at the community level.

with the MOHS, other line ministries, Technical Partners and Implementing Partners (IPs), as well as a workshop with key stakeholders such as Local Councils, partners, and civil society and international representatives to consider evidence and best practices. A series of small working groups were later created to discuss key areas, and consisted of partners and MOHS staff. The National CHW Technical Working Group (TWG) contributed to these discussions throughout the policy revision process. Based on evidence gathering and discussions, draft recommendations were written in November 2015 and presented to the TWG and MOHS directorates, programmes, and leadership. A final policy was drafted in February 2016 by the National CHW Hub and Technical Advisors. The policy was reviewed by the Steering Committee and validated by all key stakeholders before being finalized in August 2016.

Vision, mission, guiding principles, and Programme objectives

Vision

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

Mission

CHWs contribute to the Agenda for Prosperity: Road to Middle-Income Status (2013–2018) and socio-economic development by promoting access to high-quality health care, including reproductive health care and nutrition services, for the population of Sierra Leone.

Guiding principles

The National CHW Programme, which is led by the Government of Sierra Leone through the MOHS, is guided by the following key principles:

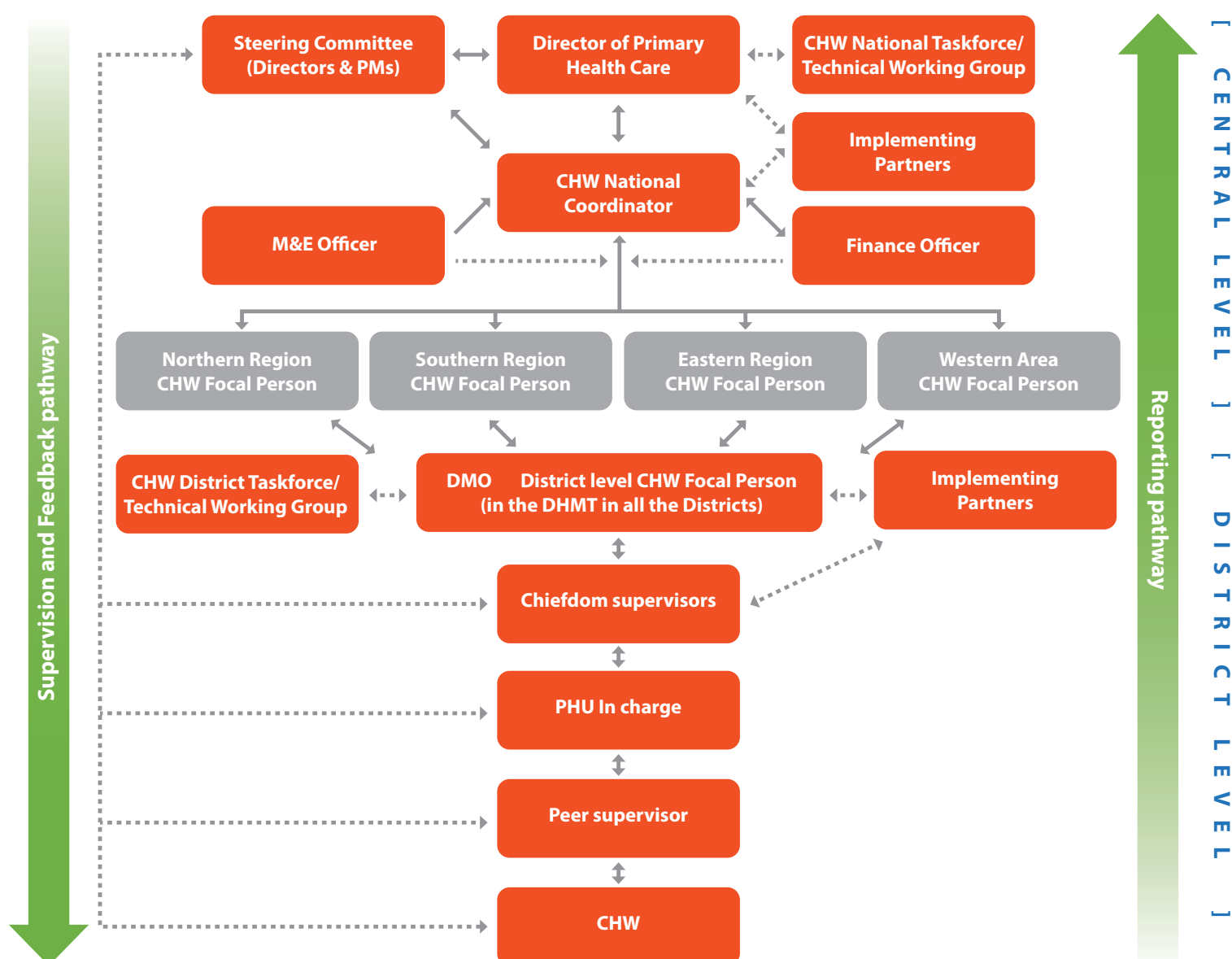
1. Save lives, particularly those of pregnant and post-natal women, newborns, and children under five. This will be achieved by ensuring that the National CHW Programme provides complimentary services as part of an overall health system strengthening approach that seeks to deliver high-quality preventive and curative services at the community level while making referrals as needed.
2. Create an ongoing, evidence-based learning and policy environment that can influence programmatic changes that reflect the national and international health landscape while responding to potentially changing local situations.
3. Encourage community engagement and ownership to ensure that the National CHW Programme meets the needs of and is accountable to the communities it serves. Foster individual and community health care service utilization and ownership of health outcomes.
4. Foster partnership, coordination, and mutual respect among all stakeholders from Community Members and CHWs to Donors and Development Partners. Commit to strong communication, transparency, accountability, and iterative learning throughout the Programme.
5. Ensure complementarity—not duplication—of services and efforts at community, district, and national levels. Ensure joint and proper planning of the Programme with other MOHS structures and Health and Development Partners.
6. Ensure that community-based services are equitably offered and accessed across Sierra Leone.

Policy review and update

The MOHS, with support from partners, commits to reviewing and updating this policy as needed. The National TWG and Steering Committee will review this policy and the associated strategy at least annually. Any changes will be formally adopted by the MOHS and included as an addendum.



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



Key stakeholders

Ministry of Health and Sanitation

Directorate of Primary Health Care

The National CHW Programme is part of the MOHS. Within the MOHS, the DPHC, through the National CHW Hub, oversees and is responsible for ensuring that the policy and strategy are implemented and in place. The DPHC must also ensure coherence and complementarity between the National CHW Programme and other programmes within the MOHS.

Within the DPHC, the National CHW Hub is the coordinating body for CHW activities nationwide and is responsible for:

- Overseeing implementation and monitoring of the CHW Programme
- Overseeing Programme quality
- Overseeing coordination between key stakeholders, including other MOHS programmes and non-MOHS partners
- Fundraising and allocation of resources
- Supporting an enabling environment for CHWs and the Programme
- Ensuring alignment of the CHW Programme with health and development goals, strategies, and policies
- Identify research needs and oversee operational studies and evaluations\

CHW Steering Committee

The CHW Steering Committee is chaired by the Director of Primary Health Care, with the National CHW Hub serving as the Secretariat. Members include all MOHS Directors and Programme Managers whose programmes are implicated in the National CHW Programme, including but not limited to the National Malaria Control Programme (NMCP), Disease Surveillance Control Programme, Food and Nutrition Directorate, Reproductive and Child Health Directorate, National TB/ Leprosy Control Programme and National AIDS Control Programme, and the Directorate of Human Resources for Health. The Steering Committee is responsible for overseeing implementation of the National CHW Programme, ensuring that goals and timelines are met, as well as finding solutions to implementation, funding, and governance difficulties. The Steering Committee is also responsible for developing and ensuring implementation of an integration strategy, and supports coherence and complementarity between the CHW and other MOHS programmes.

District Health Management Teams

DHMTs are responsible for district-level planning, implementation and monitoring of the National CHW Programme in line with the National CHW Policy. This may be in the form of direct implementation through the DHMT staff and MOHS structures, and/or collaborating with IPs to do so. The DHMT maintains a database of all active CHWs in the districts, officially certifies and registers them, and ensures that they have the support needed to fulfil their roles.

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 Local Government; the Ministry of Social Welfare, Gender and Children's Affairs; the Ministry of Trade and Industry; and the Ministry of Education, will be essential.

Local governance

Traditional leaders

Chiefs and other traditional leaders help CHWs to promote healthy and health-seeking behaviours in their communities. They are responsible for ensuring community ownership and functionality of community level structures. They need to make sure that CHWs and/or their Peer Supervisors are represented in the community structures so that CHWs will report their challenges and successes to initiate appropriate actions.

Local and District Councils

Local and District 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.



Adam Parr/USAID

Local and District Councils must also support Programme financing.

Community structures

Community ownership is a key component of the President's Recovery Priorities and the Basic Package of Essential Health Services (BPEHS). Traditional and health- and development-oriented community structures ensure community ownership of health outcomes and support CHWs. The most common structures are Facility Management Committees (FMCs) and Village Development Committees (VDCs), but given the diversity of communities in Sierra Leone, other structures may be relevant as well. Community structures are responsible to collaborate with the Peripheral Health Unit (PHU) and DHMT in selecting and recruiting CHWs based on the criteria set in this policy. They are also responsible to collaborate with the Peer Supervisor, the PHU staffs and DHMT in conducting annual performance appraisal of the CHWs. The CHWs and/or their Peer Supervisors will need to be members of these structures.

Technical Working Groups

National TWG

The National TWG advises the National CHW Programme. It participates in and facilitates the process of reviewing, updating, and implementing the CHW Policy and Strategy. It helps the MOHS harmonize and standardize the CHW Training Curriculum, manual, job aids, and monitoring tools. It also helps MOHS mobilize sufficient resources—financial, human, and material—to implement a high-quality and comprehensive Programme at national and district levels equitably. The National TWGs ensures collaboration and coordination among current and potential Programme partners.

The DPHC chairs the National TWG. Members include MOHS programme Technical Officers, UN agencies and other Development Partners, and NGOs.

District TWG

Each district must have a TWG that is responsible for ensuring full implementation of the National Programme at the district level. The District TWG helps the DHMT maintain an accurate database of all CHWs working in the district; identifies and addresses implementation challenges, including stock issues; and develops and monitors implementation of district annual, quarterly, and monthly plans with clear activities and timelines. The District TWG regularly reviews district-level Programme implementation, including routine Programme monitoring data, to identify and address issues. The District Medical Officer chairs the District TWG, and the District Council co-chairs. The District CHW Focal Person acts as secretary. Members include District CHW Focal Persons of associated programmes (malaria, nutrition, the Expanded Programme on Immunisation, etc.), the District Monitoring and Evaluation Officer, and the District Logistics Officer. All IPs in the district are required to be members, regardless of whether or not they are directly implementing the national program.

Development Partners, Implementing Partners, and Donors

Partners have supported the National CHW Programme and other vertical CHW programmes, for decades. Although the MOHS is committed to greater leadership, coordination, oversight, fundraising, governance, and implementation of the Programme in the short-term while the government of Sierra Leone plans to assume its full implementation and funding in the long-term, the MOHS will continue to work with partners at all levels of the health system. Particular support will

be needed in the first few years of implementation, and technical support will be needed in the short-, medium-, and long-terms. In the short-term, donors will continue to provide financial support; development partners will continue to provide technical, coordination, and financial assistance; and IPs will continue to assist with implementation, primarily at the district level.

Civil Society and faith-based organizations

Civil Society and faith-based organizations, including disease-specific organizations, are key to monitoring the activities and programmes of the MOHS, including the National CHW Programme. Such organizations can promote the Programme's accountability while fostering an enabling environment for CHWs and as well as community ownership of health outcomes.

CHW roles and responsibilities

Definition of a CHW

In accordance with the BPEHS, a CHW is a community-based Lay Health Worker who:

- Is selected in coordination with the DHMT and is officially recognized by the MOHS
- Meets the selection criteria outlined in this policy document
- Is trained in the National CHW Training Programme
- Implements the services in the SOW outlined in this document

All DHMTs and the National CHW Hub are responsible for keeping an up-to-date database of all CHWs operating in each district. IPs must consult and agree with the respective DHMT and National CHW Hub before training and supporting a CHW.

While the National CHW Programme aims to be singular and harmonized, the CHW Hub and the MOHS recognize the long history and continued importance of other community-based individuals in health promotion and behaviour change, linkage to care, and simple curative care that falls outside the National Programme. Community-based programmes may only work outside the official National Programme if:

- Their work is aligned with and does not duplicate the National CHW Programme content or target audience.
 - Partners that implement one component of the National CHW Programme (e.g., maternal and newborn health promotion) without any intention of including the full Programme are not implementing the National CHW Programme. However, the MOHS recognizes that some activities included in the SOW, such as health promotion and community-based surveillance, may be needed outside the National CHW Programme, especially given the revised coverage guidance.
 - Community-based programmes may work outside the official National CHW Programme if they are implementing services that are not included in the National CHW Programme SOW (e.g., community directly-observed treatment short course, injectable contraceptives). Such activities must be coordinated by the National CHW Programme, other affected and implicated MOHS programs as necessary, and the respective DHMT.
 - The National TB/Leprosy Control Programme and National AIDS Control Programme are the only programmes that should maintain and use their CHWs alongside the National Programme (vertical integration). However, the programmes should share necessary information that could lead to future full integration in the future. The decision for vertical integration will be reviewed annually by the CHW TWG, Steering Committee, CHW Hub, National TB/Leprosy Control Programme, and National AIDS Control Programme.

Partners who would like to support community-based interventions must:

- Approach and receive agreement from the National CHW Programme and other affected and implicated programmes as necessary, as well as the respective DHMT, before work begins
- Align their work with other programmes in the locality in which they work

- Be part of the District TWG
- Support and utilize MOHS structures (supply chain, supervision, etc.) as much as possible
- Report to the National CHW Programme through the DHMT

Nomenclature and identification

Individuals who work outside the National CHW Programme, as defined and outlined in this document (SOW, training, enabling environment, etc.) should not be referred to as CHWs, which is reserved strictly for those implementing the National Programme. The MOHS will provide guidance for the naming of those individuals or programmes.

DHMTs must provide certificates and ID cards for CHWs who fall within the National Programme.

Scope of work¹

Minimum standards for reproductive, maternal, newborn, and child health (RMNCH)

The CHW SOW prioritizes high-impact, cost-effective and evidence-based interventions that will reduce maternal and child morbidity and mortality and improve maternal, newborn and child health (MNCH) outcomes. It also addresses selected prominent infectious disease concerns. The SOW aligns with the continuum of care in the Sierra Leone health system and complements the roles of other health workers (particularly Maternal and Child Health [MCH] Aides), while equally using a 'demand-driven' approach to meet the needs and the preferences of the communities served.

The SOW will be reviewed and if necessary updated annually by the MOHS with the support of partners. The review and potential update must consider the roles and responsibilities of formal primary health care staff, particularly MCH Aides and State-Enrolled Community Health Nurses (SECHNs); national and international evidence; experience with implementation; country health priorities; disease burden; and the financial landscape.

The full Scope of Work is included in Annex 1.

Integrated Community Case Management (iCCM)

CHWs are expected to assess and treat pneumonia, malaria, and diarrhoea in children between the ages of two to 59 months. In addition, CHWs will test and treat for malaria in people older than five years.

IPC

In all their work, CHWs are expected to practice infection prevention and control (IPC) measures for their own safety and for the protection of their communities. IPC is a cross-cutting component of the implementation of all elements of the SOW. As part of pre-service training, CHWs will learn community IPC protocols and be provided with the necessary supplies.

Innovations

Additional services may be added to this minimum standard under a particular programme in a particular geographic area by a DHMT and/or an IP (in conjunction with the DHMT). This could be in response to a localized disease burden, or a pilot study to test the feasibility, effectiveness, and/or effect of a proposed intervention. However, all justifications for additions to the SOW must be discussed with and agreed to by affected communities, CHWs² who will implement the service(s), the National CHW Programme, the DHMT, and relevant programme(s) within the MOHS. For example, a pilot study of CHWs providing injectable contraceptives would have to be approved by the Directorate of Reproductive and Child Health in addition to the National CHW Programme, the DPHC, and the DHMT.

Coverage

Sierra Leone faces poor health indicators across the country, regardless of whether a community is urban, peri-urban, or rural, and regardless of the community's proximity to a health facility. However, it is recognized both nationally and

¹ As of the time of writing (October 2016), the National CHW Programme, in consultation with the National TB / Leprosy Control Programme, National AIDS Secretariat, and National AIDS Control Programme, decided that while National CHWs will do HIV and TB sensitization, separate community cadres will be trained in more extensive HIV and TB care, such as adherence support and contact tracing. This vertical integration will be reviewed annually by the Steering Committee.

² Before deciding to add services, talk with CHWs about whether there is adequate demand and acceptability for the service within their communities, whether the CHWs feel confident in their capacity to implement the service, and the inputs they would require to do so.



internationally that geographic access is a key factor for limited health-seeking behaviour and poor health outcomes. The National CHW Programme aims to attain national reach while equally focusing efforts on geographically hard-to-reach areas.

All CHWs, regardless of location, will perform the same SOW and will be attached and report to a PHU.

Selection criteria

CHWs

Selection process

New CHWs must be selected in a fair and transparent manner that gives equal opportunity to all qualified and interested candidates in a community. Selection is a joint effort between the community structure – the FMC, VDC, and/or other local community health structure as appropriate – and PHU staff to which the CHW will be attached. To ensure community ownership but dissuade undue influence, local political structures (Chiefs, Councillors, etc.) may participate in but should not be in charge of the selection process. External observers, such as Civil Society Organizations and IPs, should provide a watchdog role. Any undue influence should be reported immediately to the District CHW Focal Person, who, with support from the DHMT and Local Council, will take action as necessary.

Qualifications

CHWs will be selected based on the following minimum standard criteria. Any person in a community who meets these qualifications may be considered by the community and the MOHS for selection as a CHW under the National CHW Programme. S/he:

- Should be exemplary, honest, trustworthy, and respected
- Should be willing, able, and motivated to serve his/her community and dedicated to helping others
- Must be a permanent resident of the community and willing to work in it
- Should be able to perform specified CHW tasks as outlined in the SOW
- Should be interested in community health and development
- Should have experience in past community projects
- Should be a good mobilizer and communicator
- May already be a community health volunteer, TBA, condom distributor, or youth trained in life skills
- Must be at least 18 years old
- Must be accepted by the community

When all things are equal, preference will be given to women, especially those who have worked with pregnant and new mothers. Literacy and basic numeracy is highly valued and preferable, but is not strictly required, especially in the case of female candidates³ for now. This is subject to change in the near future and will be communicated via addenda.

CHW terms of reference

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

- Fulfil the SOW outlined in the National CHW Policy
- Provide the SOW to their designated catchment area
- Meet community health needs
- Provide high-quality services in a respectful manner
- Attend monthly meetings at the PHU
- Report to the Peer Supervisor as required (per this policy)
- Submit reports on time to the Peer Supervisor or the PHU In-Charge (monthly and more frequently for notifiable diseases)
- Participate in local community structures (FMCs, VDCs, etc.)

Removal and replacement of CHWs

CHWs may be removed from their position and replaced if they are not fulfilling their responsibilities under the terms of reference above. Cause for removal includes poor quality of service that does not improve with continued coaching and support. CHWs may also be removed for misconduct such as repeatedly failing to report to or attend monthly meetings at the PHU, accepting fees for service, selling drugs and health commodities that are intended to be provided for free, inappropriate or offensive behaviour including sexual harassment, and repeated or extended absence without notice and/or to the extent that the community cannot access CHW services.

Peer Supervisors

Selection process

New Peer Supervisors must be selected in a fair and transparent manner that gives equal opportunity to all qualified candidates.

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:

- 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, candidate must demonstrate competency in all CHW areas of work.
- 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 18 years or older.
- Is literate (able to read and write in English) and has basic numeracy. Has completed basic education through junior secondary school (JSS) 3 or equivalent.
- Is able and motivated to serve the community and help others.
- Is a good mobiliser and communicator.
- Is willing and able to provide required services.

³ Selected candidates who have limited literacy and numeracy should be supported by their local communities, DHMTs, and IPs to gain these skills.

- Is able and willing to travel frequently to provide in-community supervision.
- Is able to compile data.
- Is accepted by the community and by the CHWs s/he will supervise.

Terms of reference

Peer Supervisors within the National CHW Programme are expected to fulfil the following roles and responsibilities:⁴

- Supervise all CHWs in their catchment area at least twice 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:
 - Compile CHW reports and submit monthly to PHU in-charge.
 - Inform PHU of findings from in-community supervision and work 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 services CHWs are providing are of acceptable quality.
- Participate in community structures (FMC, VDC, etc.).
- Ensure strong working relationship between CHWs and the PHU.
- Identify and report stockouts to community structures and the PHU.
- Conducts performance appraisal of CHWs together with the PHUs and community structures.

Removal and replacement of Peer Supervisors

Supervision is a key component of the revised Programme, and Peer Supervisors will be required to provide supportive supervision to their CHWs. Peer Supervisors who do not perform adequately should be removed.

CHW Programme pillars

Supervision

Supervision is the backbone of any successful CHW programme. CHWs need regular supportive supervision to provide high-quality services and report on time and in a high-quality manner. Supportive supervision is also a key factor in CHWs' motivation. In addition to giving CHWs feedback, supervision links CHWs with the PHUs, IPs, and DHMTs to which they are attached.

PHU staff supervise the CHWs who are attached to their facility. However, the MOHS acknowledges, that Sierra Leone has a limited health work force. At some health facilities there are not enough staff to provide regular, in-community supervision. In these situations, supervision by Peer Supervisors, well-trained community members who have more education and skills than CHWs, supports but does not replace PHU supervision. PHU staff are ultimately responsible for conducting and ensuring proper supervision of CHWs.

Supervision from PHU in-charges and Peer Supervisors is additionally supported by chiefdom supervisors, IP staff, DHMT CHW Focal Persons, and Regional CHW Coordinators from the National CHW Hub. Programme-specific supervision from the National CHW Hub will be conducted on a quarterly basis. The CHW Programme will also be included in the national Integrated Supportive Supervision Visit. Additionally, supervision undertaken by other MOHS programmes and activities

⁴ The 2016 National CHW Programme does not require Peer Supervisors to act as CHWs themselves; they are instead solely responsible for providing a supportive supervisory role. This is a significant change from the 2012 CHW Programme, in which Peer Supervisors were responsible for providing CHW services and conducting supervision. This change has been made in recognition of the importance of supportive supervision for an effective CHW Programme, and in recognition and respect for Peer Supervisors' limited time.

that are involved with the National CHW Programme, such as the NMCP, the Expanded Programme on Immunisation, and the Directorate of Food and Nutrition, should work with the CHW Hub to coordinate supervision whenever possible to support integration of programmes and efficiently utilize resources.

Incentives and motivation

CHWs perform an essential, life-saving role in the health system. This role requires a substantial amount of time. CHWs must be financially motivated for this work, both in recognition of its importance and in compensation for time lost for other income-generating activities.

The current minimum standard support package, including financial incentives, logistics support, and job aids, is described in Annex 2 of this policy, with incentives outlined in the accompanying strategy. Each year, the MOHS through the National CHW Programme with support from the Steering Committee and the TWG, will assess and update as necessary the minimum standard that all CHWs receive. Any updates to the incentive or other support package will be included as an addendum to this policy.

Training

The National CHW Programme recognizes that robust and frequent training is 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 jobs well.^{5,6}

The National CHW Hub is responsible for ensuring that all CHWs receive pre-service and annual refresher training. Any CHW training not included in the national pre-service and refresher training must be agreed upon by the National CHW Hub. Representatives from the MOHS, such as DHMT, Chiefdom Supervisors, PHU staff, and the CHW Hub, must attend all CHW trainings.

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

5 Perry, H. and Crigler, L. (2013). "Developing and strengthening community health worker programs at scale. A reference guide and case studies for programme managers and policymakers."

6 Strachan, D. L., Källander, K., ten Asbroek, A. H. A., Kirkwood, B., Meek, S. R., Benton, L., ... Hill, Z. (2012). Interventions to Improve Motivation and Retention of Community Health Workers Delivering Integrated Community Case Management (iCCM): Stakeholder Perceptions and Priorities. *The American Journal of Tropical Medicine and Hygiene*, 87(5 Suppl), 111–119. <http://doi.org/10.4269/ajtmh.2012.12-0030>



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All Peer Supervisors must go through the same trainings 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 and reporting, spot-checks to test the quality of CHWs' work, mentoring, and coaching. Peer Supervisors should also receive annual refresher trainings.

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 supportive supervision.

An outline of the full pre-service CHW and Peer Supervisor Training Curriculum is included in Annex 3, and will be reviewed and updated as necessary by the MOHS and partners. The CHW Hub, with support from DHMTs and IPs, is responsible for identifying training gaps and performance improvement needs of CHWs, developing and implementing supplementary trainings on those topics, and integrating those topics into the national curriculum during the next review.

CHW supplies

Access to supplies greatly affects CHW motivation and knowledge and skills retention. When CHWs have the drugs, commodities, and other supplies they need to do their jobs, they are empowered and more confident in their work; by practicing what they have learned, they gain experience. When there are stockouts, CHWs are not able to perform their roles; their skills deteriorate if they are unable to practice what they are taught. This contributes significantly to their demotivation and to community and client lack of trust in both the CHW and the overall health system.⁷

The National CHW Programme provides all services, including drugs and medical supplies, free of charge. Clients must never be asked to pay for services or products provided by CHWs. The National CHW Programme maintains a zero-tolerance policy toward CHWs selling services, drugs, or commodities, and will closely investigate any reports of this behaviour. Any CHW found to be selling drugs 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

The CHW Register is the primary source for consumption rates and informs the quantification of drugs and supplies required by CHWs. While the national health system currently uses an informed push system for drug supply and distribution, the National CHW Programme is committed to working with the national supply chain to provide the data and other inputs required, and to use consumption data to inform quantification and distribution planning.

Buffer stocks

Due to frequent stockouts in the national supply chain system, many IPs have historically procured and provided buffer stocks of drugs and medical supplies to CHWs. This may continue until the national supply chain is strengthened sufficiently. IPs must consult with the DHMT and National CHW Programme to coordinate and agree upon any buffer stocks they intend to provide in their programme area. IPs must use programme data to quantify CHW buffer supplies, and must report all information on supply needs and supplies ordered to the District Medical Store to guide quantification. IP-provided buffer supplies must be distributed through the District Medical Store to PHUs, and from PHUs to CHWs, although IPs can provide support (transport, logistics) as needed and agreed upon by the DHMT.

Community ownership and engagement

Community ownership is a key 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 (and IPs where applicable), given the varying realities of communities across Sierra Leone.

⁷ Brunie, A., Wamala-Mucheri, P., Otterness, C., Akol, A., Chen, M., Bufumbo, L., & Weaver, M. (2014). Keeping community health workers in Uganda motivated: key challenges, facilitators, and preferred program inputs. *Global Health: Science and Practice*, 2(1), 103–116. <https://doi.org/10.9745/GHSP-D-13-00140>

Community structures such as FMCs and VDCs are expected to support the functionality of the CHW Programme in their community. If neither an FMC nor VDC exists, CHWs must work with other community groups as 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 water, sanitation, and hygiene (WASH) committees, mother-to-mother support groups, and Community Advocacy Groups, to educate and promote health information.

Monitoring & Evaluation and reporting

Data for decision making and operational research

The National CHW Programme is committed to regular and robust monitoring and evaluation to track the functionality, quality and effectiveness of the Programme, and to guide Programme design, changes, and implementation. The Programme is also committed to operational research to explore innovations that could strengthen the Programme, and promote those that prove successful and feasible at scale. Partners conducting operational research must collaborate with the MOHS and be in line with official government policy and research objectives. This means, for example, that research questions, objectives, and design must be discussed with the MOHS and that all findings must be shared with the MOHS.

Integrated CHW data

To ensure that CHW data is 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 monitoring and evaluation (M&E) system. The National CHW Hub works with the Directorate of Policy, Planning, and Information to design reporting tools that are user-friendly, aligned with CHW SOW, fully integrated with the national Health Management Information System, and support their daily work.

CHW data must be included in the national reporting system, but the National CHW Programme ultimately owns the data. National data must be shared with partners upon request. IPs supporting DHMTs should have access to district data and support the DHMT in compiling, reviewing, and analysing it.

All implementers (MOHS and IPs) must report 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 the CHW Programme expects to achieve. It encompasses CHW service delivery and operationalization of the national CHW Programme. Each will be reviewed and updated as needed.



ANNEX 1.

CHW Scope of Work

The harmonized, official SOW of the National CHW Programme is as follows. Please refer to the National CHW Training Curriculum for details.

General

- Conduct community mapping, household registration, and community entry meetings to understand communities, the demographic structure, and to identify the CHW target population.
- Actively participate and potentially lead community mobilisation and engagement for health. This includes participation in key community and national campaigns and involvement in local community structures, such as FMCs and VDCs.
- Identify and promptly refer cases and conditions that are life threatening and/or beyond their mandate for management at health facilities.
- Conduct quarterly routine home visits to all households in the catchment area to:
 - Update the community mapping, including demography.
 - Apply interpersonal communication skills to reinforce key healthy behaviours and practices for families and households, including early care-seeking when one is sick.
 - Assess the health situation of households including availability, use, and/or practice of healthy behaviours and identify gaps.
 - Conduct dialogue with families and communities, help identify solutions to address needs, and monitor and support implementation of such solutions.
 - Identify pregnant women early as well as children and women of childbearing age who are eligible for RMNCH interventions, including uptake of family planning (FP) methods and iCCM for sick children.

Reproductive, maternal, newborn, and child health

- Provide pre-pregnancy counselling on the importance and availability of FP methods, including distribution of condoms and refill 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: 1) self-reporting of mothers or their family members; 2) active surveillance through routine house visits, and; 3) notification by PHUs, TBAs, and other stakeholders in the community.

- Conduct three antenatal home visits: first early in pregnancy (2–4 months), second during mid-pregnancy (5–6 months), and third late in pregnancy (7–9 months) to:
 - Educate and counsel the woman and her spouse/family on:
 - The importance of focused antenatal care at PHUs by skilled health workers. The CHW must ensure that the pregnant women visit PHU for antenatal care.
 - Maternal nutrition.
 - The importance of the use of long-lasting insecticide-treated bed nets.
 - HIV testing and prevention of mother to child transmission of HIV, as needed.
 - Hand washing and use of toilets.
 - Use of FP methods and referral to closest facility.
 - Essential newborn care (exclusive breastfeeding, hygienic cord care, thermal care, immunisation).
 - Preventive and promotive behaviours for MNCH, including WASH, infant and young child feeding, FP, immunisation.
 - Screen for danger signs (bleeding, oedema, fever, persistent headache, etc.) during pregnancy and refer to PHUs if one is identified.
 - Educate woman for birth preparedness and planning for delivery at health facility.
 - Provide intermittent preventive treatment in pregnancy for malaria—specifically, sulfadoxine-pyrimethamine—at each visit.
- Conduct a fourth visit to women identified and/or referred by the PHU as having vulnerable pregnancies (e.g., women with previous obstetric complications, HIV-infected women, adolescents).
- Where possible, accompany labouring women to the PHU for delivery and facilitate birth registration.
- Conduct three postnatal home visits for both the mother and the 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 feeding the colostrum, exclusive breastfeeding for up to 6 months, thermal care, skin-to-skin contact, delayed bathing, and hygienic cord care)
 - The importance of using FP methods (e.g., condoms, oral contraceptives, injectable contraceptives, implants, and intrauterine devices)
 - Maternal nutrition
 - Danger signs for mothers and newborns and the need for immediate PHU treatment if one occurs
 - Hand washing 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 PHUs if identified.
 - Follow up to ensure implementation of essential newborn care practices and vaccination schedule.
 - Supervise mothers in administering chlorhexidine for appropriate cord hygiene.
- Conduct a fourth postnatal home visit to low birth-weight (small) babies to provide the services listed above, including kangaroo mother care.
- Assess breastfeeding practices for younger infants (0 to 2 months) and facilitate appropriate breastfeeding practices as needed.

- Screen children 6–59 months for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) (e.g., through the use of mid-upper arm circumference [MUAC] measurement) and refer to health facility.
 - Provide support and follow-up for MAM & SAM referrals to health facility.
 - Provide support for adherence to supplementary feeding programmes and ready-to-use therapeutic feeding doses.
 - Provide follow-up support after supplementary feeding programme and after discharge for treatment of MAM.
- Conduct five infant home visits during 1st, 5th, 9th, 12th, and 15th months to ensure vaccination and appropriate feeding.
- Report births, maternal and under-five deaths in the community.
- Conduct social mobilization for specialized campaigns and PHU outreach services in community (e.g., MCH Week, National Immunisation Day).

iCCM 'Plus'

- Identify and treat pneumonia, diarrhoea, and malaria (using rapid diagnostic testing) in children ages 2 to 59 months, and refer cases with danger signs as outlined in the National CHW Training Programme. Diarrhoea cases should be immediately referred during outbreak of diarrheal diseases.
 - Plus: Identification and treatment of malaria (using rapid diagnostic testing) in older children and adults (entire population /over-fives) as outlined in the National CHW Training Programme.
 - Plus: Identification and provision of oral rehydration salts for over-fives with diarrhoea and refer to the PHU.
- Provide follow-up care for patients who are on treatment, as well as those who have finished treatment, with referral if necessary, through appropriately scheduled home visits as outlined in the National CHW Training Programme.

Disease prevention and control

Community-based surveillance and reporting of any events related to the following diseases/conditions based on community-level case definitions for:

- Acute flaccid paralysis (polio)
- Acute watery diarrhoea (cholera)
- Clustered deaths
- Guinea worm
- Maternal death
- Measles
- Neonatal tetanus
- Neonatal death
- Suspected Ebola
- Yellow fever
 - Additionally, the CHW is required to report any unusual events or rumours affecting the health of community member(s).

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 occurs. They will also be required to document all events in a paper register to be kept at home. They will be expected to provide treatment for uncomplicated cases of illnesses that they have been trained to

manage (such as acute watery diarrhoea without dehydration in children under five years, except in the case of outbreak when referral is needed). If unable to treat, refer the patient immediately to the closest facility.

Additionally, CHWs will be expected to support community engagement activities in response to outbreaks.

Community sensitization to HIV and TB

- TB risk factors, signs, and symptoms
- HIV risk factors, signs, and symptoms

ANNEX 2.

Financial and Non-financial Incentives for CHWs and Peer Supervisors

Financial incentives

All CHWs must receive Le100,000 per month.

All Peer Supervisors must receive Le150,000 per month.

The incentives included in this policy are meant to cover day-to-day volunteer work. If campaigns or other activities require more time than this or detract from other activities in their SOW, the Programme responsible for the activity must provide adequate compensation. The amount is to be agreed upon with the DHMT and the National CHW Programme.

Logistics support

All CHWs in easy-to-reach areas (defined as within a 3 km radius of a PHU) must receive Le50,000 to cover transport, phone top-up, and other logistical support (cumulative) per month.

All CHWs in hard-to-reach areas (defined as outside a 3 km radius of a PHU) or in an otherwise difficult geographical area as determined by the DHMT must receive Le80,000 to cover transport, phone top-up, and other logistical support (cumulative) per month.

All Peer Supervisors, regardless of where they are located, must receive Le100,000 in transport and top-up support (cumulative) per month.

Non-financial incentives

- Awards for outstanding work given by IPs or the MOHS.
- Encouragement to pursue career pathways in the health system for those who meet the minimum training requirements for other cadres such as MCH Aides and State-Enrolled Community Health Nurses. High-performing Peer Supervisors may be encouraged to pursue career pathways into MOHS civil service positions. CHWs will have access to a promotion pathway into the Peer Supervisor role, and possibly into the MOHS after that.
- Community leaders may encourage communities to support CHWs, or exempt CHWs from communal work. This will be negotiated on a per-community basis.

ANNEX 3.

CHW Pre-service Training Model

Module 1	Module 2	Module 3
For CHWs and Peer Supervisors		
Community health basics <ul style="list-style-type: none"> • CHW roles and ethics • Effective communication • Negotiation for behaviour change • Community entry and profiling • Household registration • Community-based surveillance: reporting births, deaths, and notifiable conditions • Routine household visits: assess households every 3 months and advocate: <ul style="list-style-type: none"> - Improved sanitation and waste disposal - Safe water and food storage - Handwashing • Preventive care for children: <ul style="list-style-type: none"> - Vaccinations - Nutrition practices - Vitamin A supplementation - Deworming • Screen for Acute Malnutrition (MUAC) • Referral/refill for FP • Identify pregnant women 	Integrated community case management 'plus' <ul style="list-style-type: none"> • Assess a sick child for: <ul style="list-style-type: none"> - General danger signs - Cough and fast breathing - Fever - Diarrhoea - Acute malnutrition • Refer sick children with danger signs or acute malnutrition • Treat and counsel for the sick child • Feeding during illnesses • Provide follow-up care and support for the sick child • Provide follow-up care in the home for the child with acute malnutrition • Assess adults for Malaria. Provide treatment and follow-up care. 	Reproductive, maternal, newborn, and child health <ul style="list-style-type: none"> • The RMNCH continuum of care • Healthy timing and spacing of pregnancies • Overview of the RMNCH home visit • Pregnancy visits 1, 2, 3, and 3+: nutrition, home care, promoting antenatal care, birth preparation, birth spacing, assessment for danger signs and referral, additional visits (3+) for high-risk pregnancies • Newborn visits 1, 2, and 3 (on days 1, 3, and 7) and additional visits 3+ for small babies (low birth-weight newborns on day 15): essential newborn care, initiation of breast-feeding, care for the mother, assessment of danger signs in newborn and mother and referral, caring for the small newborn • Child visit 1 (at 1 month): <ul style="list-style-type: none"> - Exclusive breastfeeding - Routine care for the child; vaccinations, bed net use - Care-seeking for illness - Birth spacing for mother • Child visits 2–5 (at 5, 9, 12, and 15 months): <ul style="list-style-type: none"> - Routine care for the child - Child feeding and development
Duration of training Classroom: 6 days Field practical / Clinical: 1 days	Duration of training Classroom: 6 days Field practical / Clinical: 2 days	Duration of training Classroom: 8 days Field practical / Clinical: 2 day
Additional training for Peer Supervisors: Basics of supervision and supervision and reporting tools (4 days)	Additional training for Peer Supervisors: Supervision tailored to Module 2, including supervision and reporting tool (1 day)	Additional training for Peer Supervisors: Supervision tailored to Module 3, including supervision and reporting tool (1 day)
Community training and supervision Minimum 2 weeks	Community training and supervision Minimum 2 weeks	Community training and supervision Minimum 2 weeks



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