

ENSURING ACCESS TO ROUTINE AND ESSENTIAL SERVICES DURING COVID-19 THROUGH COMMUNITY-BASED SERVICES IN LIBERIA

COVID-19 PROMISING PRACTICES

EXECUTIVE SUMMARY

- Liberia is a low-income country in the process of strengthening their health system through the establishment of essential and routine services in the community through its National Community Health Assistant Program.
- In 2014, the country suffered from an Ebola outbreak which led to 25,515 cases and 10,572 deaths. This outbreak disrupted essential health services, and weakened the health system's overall capacity
- The first local case of COVID-19 in Liberia was confirmed in March 2020, and led to the activation of the country's Incident Management System.
- To ensure continuous access to both COVID-19 and non-COVID-19 health services, community health workers, specifically Community Health Volunteers (CHVs), Community Health Assistants (CHAs) and Community Health Services Supervisors (CHSS) are being trained on outbreak preparedness, surveillance and management.
- For CHAs and CHSS, routine community-based services will also shift to a "no-touch" policy to guarantee the safety of both patients and health care providers
- This adapted approach to community-based services has demonstrated government commitment to continuity of primary health care services at the community level, the training and upskilling of health workers on COVID-19, and clear protocols for supporting patients when there is a suspected or confirmed case at the community level

COVID-19 IN LIBERIA



As of 26 June 2020

684

TOTAL CONFIRMED CASES

285

RECOVERIES

34

DEATHS

17 MAR 20

1ST CONFIRMED LOCAL TRANSMISSION

22 MAR 20

DECLARATION OF NATIONAL HEALTH EMERGENCY

20 APR 20

INSTITUTION OF LOCKDOWN

Liberia has focused their COVID-19 response efforts on travel restrictions and implementation of lockdown measures. Capitalizing on lessons from the past Ebola epidemic, Liberia was able to implement cross-border coordination and rapid contact-tracing in Monrovia, where the majority of cases currently are. The Incident Management System (IMS), was activated to coordinate direct outbreak response, maintain national supply chains, and put in place COVID-19 surveillance & laboratory capacity. At the community level, the Ministry of Health is working closely with local authorities to conduct community awareness and mobilization to address fear and stigma around COVID-19. Additionally, the Ministry of Health is in the process of supporting and equipping frontline health workers with the necessary PPE to ensure they can stay safe while serving their communities.

LIBERIA PHC AT A GLANCE



Population: 4.82 M
GDP/Capita: \$677.32 (current USD)
Human Development Index: 0.47
Life Expectancy at Birth: 63.7 Years

- Liberia's health system has been in the process of recovery from past civil conflict that lasted a few decades and ended in 2003, at which point only 30 physicians remained in Liberia and 83% of the public health facilities were non-functional. Through the establishment of the Basic Package of Health Services (BPHS), the health status of the population has been slowly improving.
- The Ebola virus disease (EVD) outbreak of 2014 and 2015 led to weakening of the Liberian health system and economy. During the outbreak, delivery of routine health services was disrupted, primarily because of community distrust, fear leading to decreased care seeking behavior, stigma and lack of adequate PPE and initially a lack of training in how to continue services safely.
- Health facilities are divided into primary health care clinics, district health centers, district hospitals, county hospitals, regional hospitals, and the national referral hospital.
- Primary health care accounts for 68% of total health expenditure. The majority of this is sourced out from out-of-pocket spending and funding from donors and international NGOs. However, primary health care facilities are underfunded, as compared to the large hospitals in urban areas.
- 29% of the population lives at least one hour away from the nearest health facility. Referral linkages between the different levels remain weak and dysfunctional. Many patients tend to bypass primary care clinics and go straight to secondary and tertiary facilities causing unnecessary burden in higher-levels of care.
- Currently, malaria is the leading cause of morbidity and mortality in Liberia, with 42 percent of outpatient consultations and 44 percent of inpatient deaths attributable to malaria.
- Community Health Assistants (CHAs), play a critical role in engaging the communities for essential health services. This includes provision of community-based services such as health education, disease surveillance, and diagnosis and treatment of malaria, diarrhea, pneumonia, screening for malnutrition and provision of family planning services.

THE ROLE OF COMMUNITY-BASED SERVICES IN ENSURING CONTINUED ACCESS TO HEALTH SERVICES DURING COVID-19

AN INTERVIEW WITH MALLIKA RAGHAVAN & DR. AMI WATERS



Mallika Raghavan (left), MPH is the Director of Country Engagement for Last Mile Health (LMH); and Dr. Ami Waters (right) serves as their Co-Medical Director. LMH has been partnering with the Liberian government to recruit, train, and support community health workers since their founding in 2007. Through their work, community health workers -- known locally as community health assistants -- are equipped to carry out home visits, manage community illnesses, and identify potential epidemic events. We interviewed them to learn more about their experiences in building the capacity of community health workers during the COVID-19 pandemic. Responses have been edited for length and clarity.



Question: How did COVID-19 impact access to primary health care services? What were some changes seen in the different facilities?

Answer: At present, COVID-19 is predominantly limited to urban centers in Liberia. In these areas, some patients are hesitant to seek care because of the fear of transmission in the clinics and there have been intermittent closures and discontinuation of services. Interruptions to routine and essential care-- including a decrease in deliveries by skilled birth attendants, antenatal care visits, and vaccination coverage-- have been most marked in the two counties of Montserrado and Margibi where the COVID-19 case burden has been highest, but some other counties have seen similar worrisome trends. Primary health clinics find it hard to refer suspected COVID-19 cases to larger facilities that are not willing to accept cases or where services are disrupted. In rural areas where LMH works, there hasn't been significant discontinuation of services at this time but there has been some impact on care-seeking behavior. In addition, we are implementing procedural changes in community-based services that rely on close contact (e.g. vaccination and family planning) to diminish risk of transmission to health workers in anticipation of COVID-19 spreading to rural areas. In the event of active cases in the community, there would be a significant shift in the daily tasks of the community health workers (CHWs) to include support of surveillance and isolation of COVID-19.

Question: Were these changes also observed in the recent Ebola outbreak in Liberia? What lessons have you learned from that prior experience?

Answer: During Ebola, a lot of the larger health facilities were closing because of health worker infections, and a lack of protective equipment or training that made health workers feel unsafe in continuing services. Despite this surge in cases, many CHWs were able to continue the provision of pneumonia, malaria and diarrhea treatment beyond the facilities. In areas where Last Mile Health worked, there was also no significant decrease in the number of cases being seen by CHWs for sick child visits, and facility-based deliveries only decreased by around 3%. This success in maintaining access to essential and routine health services is associated with the community's trust in the CHWs, and the efficient linkage of the primary care facilities to the greater health system.

Question: What is the role of community-based services in maintaining access to primary health care during COVID-19?

Answer: Since 2016, the National Community Health Assistant (CHA) Program has expanded primary health care to around 1.2 million Liberians in marginalized settings through hiring and supervising community and frontline health workers. As the COVID-19 pandemic spreads in Liberia, these frontline health workers are being mobilized to provide continuing access to essential health care services.

Community health services supervisors (CHSS'), who are in the field at least once a week to supervise CHAs (known globally as community health workers), are also critical in the monitoring and surveillance of COVID-19 events on the ground. Regular reporting from the CHSS will allow policy makers to get an idea of what is happening at the facility level, and inform the development of infection control protocols both locally and nationally.

Capitalizing on the existing training platforms for the community health workforce, LMH collaborated with the Ministry of Health to develop a comprehensive training package on COVID-19 that is being implemented nationally. CHAs are being trained on the impact of COVID-19 on the community, proper infection prevention and control, outbreak communication, community surveillance and reporting, and strategies to assure the continuation of routine health care during the COVID-19 pandemic. Through building the capacity of CHAs, Last Mile Health, in support of the Ministry of Health, aims to ensure continuity of primary health care services, limit health worker infections, and eliminate transmission from known COVID-19 cases.

CHAs were advised that, despite the pivot to COVID-19 response, patients are still at risk of complications from malaria, pneumonia, diarrhea, and malnutrition. The priority will be to continue providing community health services to the population in the safest way possible by using Personal Protection Equipment (PPE), proper social distancing measures, and avoiding mass gatherings. Community-based services will shift to a “no-touch policy” to ensure the safety of both the patients and health care providers. For example, the usual mid-upper arm circumference (MUAC) screening for severe acute malnutrition will be replaced by asking the mothers to check their children for signs of edema and then to report the findings to the CHAs from a distance. Family planning methods will also shift from injectables (i.e. Sayana Press) to oral contraceptive pills to limit direct patient contact.

In addition to typical primary health care activities, CHAs conduct community COVID-19 screening as an adjunct function to existing disease surveillance practices. During sick-child visits and community-based surveillance monitoring, CHAs also screen for

COVID-19 symptoms for suspect cases and close contacts. For COVID-19 suspects with no respiratory symptoms, rapid diagnostic tests (RDTs) for malaria will still be completed for those who have fever. This helps to minimize risks to overtreatment for malaria of those who do not screen positive for COVID-19.

Question: What factors have supported the development and rollout of these guidelines to date, and which do you think would be critical in the event that community spread in rural areas begins to increase?

Answer: As previously mentioned, there are a lot of lessons and materials from the previous Ebola response. The majority of the CHAs and patients are already familiar with the “no-touch policy”, and understand its value for COVID-19. The previous outbreak also gave us an idea of the best ways to tailor messaging and health education in the community (e.g. using jingles, local translation of content).

The investment and prioritization of the National Community Health Assistant Program over the last four years and its deployment of nearly 4,000 CHAs has created a strong foundation for the response to COVID-19. Community mobilization and activities for community sensitization to COVID-19 are implemented through existing structures and a planned training cascade. Additionally, the activation by the Liberia Ministry of Health of pillars to create a more integrated and coordinated response with the support of partners in a responsive fashion is a reflection of lessons learned during the Ebola crisis, as a coalition of actors came together alongside the Ministry of Health.

Question: What have been the challenges related to implementing these guidelines nationally?

Answer: The initial challenge has been in planning for procurement and distribution of adequate PPE for the frontline health workers. During Ebola, some health workers just abandoned posts because they felt that they were not adequately protected. Unfortunately, these worries have carried over to the current pandemic, and some CHAs and frontline health workers have expressed their apprehensions in shifting to COVID-19 work. This reiterates the urgent need for training and mentorship to address these issues. On the other end, we are concerned that people won't take COVID-19 seriously since it

isn't perceived to be as bad as Ebola. In effect, this might lead to more cases in the communities if social distancing and PPE measures aren't taken seriously. There were also misconceptions on the negative effects of the Ebola vaccine which caused a decrease in vaccination rates following the outbreak. This distrust of vaccines has emerged again with the talk of a new vaccine in the future and has led to temporary cessation of immunization outreach.

Another challenge for implementation is balancing which interventions should be provided utilizing a "no touch" protocol, and which ones require care with direct touch of patients. Organizing face-to-face COVID-19 training for CHAs is important because it allows us to immediately cascade protocol changes needed in the field but it also brings a set of risks and decreased social distancing, emphasizing the need for safety protocols for the training itself. This has emphasized a need for innovation and changes in protocol to safely facilitate training. Lastly, another unique challenge is the difficulty of returning to "touch protocols" after an outbreak. For example, in Liberia, laboratory tests (i.e. rapid diagnostic tests for malaria) and screening for malnutrition with MUAC in the community were not routinely done in the community long past the last case of Ebola in Liberia.

Question: What lessons have you learned from this new approach of shifting the roles of community health assistants? Do you think these changes in practice will go beyond the COVID-19 pandemic?



*The Liberia Ministry of Health holds a training of trainers on infection prevention and control measures for COVID-19 in Monrovia. Participants completing this course are responsible for training County and District Health Teams, health facility staff, and community and frontline health workers - including nurses and physician assistants.
(April 2020, Photo Credit: Last Mile Health)*

Answer: This new approach reiterates the value of community health workers as a cornerstone to the COVID-19 response and as a critical member of the health workforce more broadly. During this important time in keeping a health system strong and resilient, CHAs play a critical role in outbreak response and ensuring essential services are maintained. For urban areas impacted by COVID19 like Montserrado County, where CHWs are less formally established, there is a potential initiative to recruit CHVs to conduct risk communication and COVID-19 surveillance work. After the outbreak, this has the potential to create a longer term strategy in urban areas to sustain more routine primary health care services, and connect primary care units to the larger health system.

RELEVANT RESOURCES



RELEVANT IMPROVEMENT STRATEGIES

- [Primary Health Care Policies](#)
- [Quality Management Infrastructure](#)
- [Workforce, Funds, and Safety](#)
- [Population Health Management](#)
- [Team-based Organization](#)

GLOBAL LEARNING TOOLS AND RESOURCES

- WHO Resources
 - [COVID-19 Operational guidance for maintaining essential services during an outbreak](#)
 - [Operational considerations for case management of COVID-19 in health facility and community](#)
 - [Considerations in adjusting public health and social measures in the context of COVID-19](#)
 - [Webpage on Community Health Workers](#)
- [PATH Resources to support COVID-19 in LMICs](#)
- [STRATIS - Community-based Care Coordination – A Comprehensive Development Toolkit](#)