HEALTH SYSTEMS STRENGTHENING ACCELERATOR

MINISTRY OF HEALTH
Republic of Liberia

Community-Level Mental Health Services in Liberia: Programs, Learnings, & Challenges

The USAID Health Systems Strengthening Accelerator

May 2022

USAID FROM THE AMERICAN PEOPLE
RESULTS FOR DEVELOPMENT
HEALTH STRATEGY AND DELIVERY FOUNDATION
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Contents

List of Acronyms

ANC	Antenatal care
CETA	Common Elements Treatment Approach
CH	Community Health
CHA	Community Health Assistant(s)
CHC	Community Health Committee
CHSD	Community Health Services Division of the Liberia MOH
CHTWG	Community Health Technical Working Group
CHV	Community Health Volunteer(s)
CHW	Community Health Worker(s) [either CHAs or NGO workers]
CMH	Community Mental Health [alternatively, mental health services delivered through CHWs]
COVID	COVID-19
DDI	USAID Bureau for Democracy, Development, & Innovation
DHIS	District Health Information Systems
EVD	Ebola Virus Disease
GOL	Government of Liberia
HFDC	Health Facility Development Committee
HMIS	Health Management Information System
IRC	The International Rescue Committee
JISS	Joint Integrated Supportive Supervision tool
KII	Key Informant Interview
LAPS	Liberia Association of Psychosocial Services
MH	Mental Health
MHC	Mental Health Clinician(s)
MHPSS	Mental Health and Psychosocial Support Services
MHU	Mental Health Unit
MNS	Mental, Neurological, and Substance Abuse Disorders
MOH	Ministry of Health (Liberia)
MSF	Médecins Sans Frontières
NCHS	National Community Health Services Strategic Plan 2016-2021
NGO	Non-Governmental Organization
PHC	Primary Healthcare
PIH	Partners in Health
USAID	United States Agency for International Development

Introduction

With funding from the Victims of Torture Fund, USAID's Bureau of Development, Democracy, and Innovation (DDI) has engaged the Health Systems Strengthening Accelerator[1] (Accelerator) to support the Government of Liberia (GOL) in expanding the provision of high-quality mental health and psychosocial support (MHPSS) services.

One of the core components of the Accelerator's scope of work in Liberia is to support the MHU in strengthening community-level mental health programming. Community-level mental health services are neither fully functioning nor well-resourced in Liberia. In order to better understand the challenges and best practices observed in previous and ongoing local initiatives, the Accelerator conducted a rapid desk review of salient community-level mental health interventions in Liberia. This output will be utilized by the MHU, Community Health Services Department (CHSD), and local stakeholders as they revise the training module for MHPSS delivery at the community level informed by the learnings and promising approaches identified herein.

Background

Liberia has developed an array of community health policies and programs that enable community workers to play a large role in the implementation and provision of health activities. Liberia's MOH revised the National Community Health Services Strategic Plan 2016-2021 (NCHS) in the wake of the Ebola outbreak in recognition of the essential functions that communities and community health volunteers performed in responding to health needs. The plan aims to "extend the reach of the country's primary health care system via an integrated and standardized national community health model that can provide a package of essential life-saving primary health care services and epidemic surveillance within communities and to households on an equitable basis."[i] A key element of the NCHS is the institution of the Community Health Assistants (CHAs) program—a formal and standardized cadre of community health workers (CHWs).

CHAs are selected by their respective communities and trained to deliver an integrated and standardized service delivery package, which includes promotive, preventive, and curative services and epidemic surveillance, to households located more than 5 km from the nearest health facility. Mental health is included in one of the program's training modules; CHAs are trained to raise awareness on stigma and discrimination, in addition to identifying, referring, and monitoring patients in their communities with signs and symptoms of mental health disorders. By early 2020, the CHA program had become active in 14 of 15 counties (except Montserrado) and was slated to be expanded to all targeted communities in all 15 counties.[ii]

The National Mental Health Policy 2016-2021 similarly indicates an intended investment in mental health at the community level. The policy aims to substantially increase the number of Community Health Assistants who are trained to provide MHPSS services, including identification of persons with signs and symptoms of mental health conditions, referrals, and follow-up visits. Furthermore, the policy's sixth objective is to "Desensitize communities about mental health and illness and modify

[1] The Health Systems Strengthening Accelerator is a global, USAID Cooperative Agreement to strengthen institutions and processes, and build local expertise, to ensure that health systems can tackle future challenges and weather shocks with less reliance on external support.

negative perceptions about the mentally ill" through anti-stigma campaigns; early identification, prevention and treatment; and community protection networks, among others.[iii]

Several key administrative bodies influence and support community-level service delivery. The Community Health Services Division (CHSD) of the MOH develops community health guidelines and curricula at the national level, coordinates the CHA program, and monitors community-based interventions implemented by partners and collaborating programs and divisions within the MOH. The community health technical working group (CHTWG) provides strategic and technical guidance to the CHSD. At the county level, Community Health Departments coordinate all community-level activities.

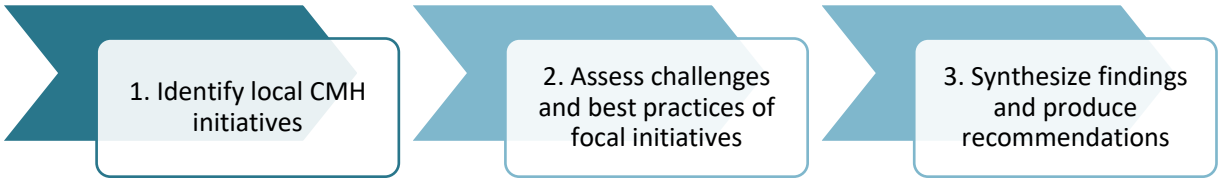
Liberia's landscape of community health strategies, related health worker platforms, and local CMH initiatives are robust, and have yielded positive results. However, several key challenges restrict access to quality MHPSS services at the community level, including a) limited resources, b) insufficient training and implementation, c) limited availability of psychotropic drugs, d) insufficient supervision and monitoring, e) weak referral systems, and f) pervasive mental health stigma and discrimination.

Desk Review Approach and Methodology

The Accelerator's rapid desk review of CMH services in Liberia was structured according to the step-wise process depicted in Figure 1 below, and aimed to answer two broad research questions:

1. What is the current role of the CHA program in providing mental health services and how may it evolve?
2. How can the proposed mental health role of the CHAs be implemented in an integrated and coordinated manner?

Figure 1: Desk Review Exercise Three-step Process



The Accelerator identified CMH initiatives with previous and ongoing activities in Liberia, and selected four focal initiatives to investigate during the desk review:

1. MH in 2016-2021 CH Strategy: Implementation of CH Module 4
2. Partners in Health (PIH): CETA in Maryland County
3. Médecins Sans Frontières (MSF): implementation of CMH activities in Montserrado County
4. Liberian Association of Psychosocial Services (LAPS)

Through a review of program data and literature as well as Key Informant Interviews (KIIs), the Accelerator assessed these initiatives across several dimensions: the roles and responsibilities of their respective community health workers (CHWs) that pertain to mental health, the relationships between the CMH initiatives and primary health care (PHC) facilities, modalities for training of CHWs for mental health activities, and monitoring and oversight mechanisms. A summary of the KIIs conducted is listed in Figure 2 below. The Accelerator systematically documented learnings from KIIs, data, and documents gathered in order to produce an analysis and corresponding recommendations for revising CH Strategy

Module 4 (Module 4) and broadly enhancing implementation and coordination of CMH in Liberia. Further information about the desk review methodology is located in Annexes 1-2.

Figure 2: Key Informant Interviews

KII Group	Target KII	# Interviews	# Resources Shared
Module 4 Implementation	Last Mile Health	3	0
	Director of National Community Health Program	1	7
Common Elements Treatment Approach (CETA)	PIH	2	5
Implementing CMH	MSF, IRC	3	1
Use of training modules	LAPS	1	2
County Mental Health Coordinators & CHSSs	Regional coordinators	4	0
Misc. MH Stakeholders	Former National Clinical Coordinator, Director MH Unit, etc.	2	0
Total		16	15

Findings

1. Roles and responsibilities of CHWs pertaining to mental health

The desk review findings indicated that the Mental Health component of the community health training Module 4 is very limited compared to more expansive services provided from NGO-led initiatives (the latter being either layered on top of CH strategy work or parallel interventions). Community mental health in Module 4 of Community Health Strategy is quite limited: covering basic information and use of screening tool for onward referral for mental illness and epilepsy and side effects of medication; techniques to support acute situations (de-escalation; suicide containment). On the other hand, NGO-led initiatives offer much more expansive services, including psychosocial support from counseling and behavioral therapies to community reintegration, and all report significant promotional (prevention) components and active and tracked referral pathways. This limitation in the public sector package (Module 4) is compounded by a lack of public ownership and resources that are urgently needed to drive forward implementation and better account for the mobilization of MH roles and responsibilities amongst Module 4 trainees operating in communities. This has meant that there has been very limited actual implementation (discharge) of CMH roles under CH Strategy Module 4, with quite an overt focus only on referrals to facilities for medication. In contrast, NGO implementers report robust implementation of programmed community (mental) health worker roles and responsibilities.

Task shifting[2] among CHWs is limited across the CMH initiatives investigated and is not an explicit objective of the CH Strategy. Based on KIIs, it seems that the initial hopes for CHAs to perform MH activities previously only delivered in facilities (e.g., supporting a higher volume of identification and

[2] Task shifting involves the redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health.

referrals, medication adherence, and reintegration into family/community) have not been realized. This has been attributed to the fact that CHAs already have considerable responsibilities other than MH and lack adequate training to take on traditionally facility-based activities, thereby constraining overall bandwidth of CHAs and opportunities for task shifting. The only observed task shifting amongst focal initiatives occurs within NGO-led programs, where dedicated psychosocial workers are deployed in communities to deliver counseling and therapy (e.g., LAPS).

In line with the CH Policy, CHAs are not trained to prescribe and refill of psychotropic medications for clients. Instead, CHA roles and responsibilities involve referrals of persons with MH issues (including to help them obtain and refill psychotropic medications), treatment adherence, and monitoring of side effects. Given the focus on medication under Module 4, these responsibilities are inherently tied to drug availability at facilities. Hence frequent stock-outs undermine the ability of CHAs to carry out associated tasks. CHA performance of these duties is also not tracked systematically (there is little to no data on the implementation of this responsibility—except anecdotally—or even record of referrals and counter referrals), thus limiting their visibility, so it is unclear the extent to which they are carried out. Given the frequency of medication stockouts, it seems adding medication refills to the set of CHA responsibilities will potentially deepen the focus on medications in the CH Strategy and be challenging to implement. NGO implementers reported stronger performance on monitoring and intervention around side effects, counseling and support to promote adherence, and proper administration.

The prevalence of stigma and misinformation about MNS disorders were widely acknowledged in KIIs. NGO-led initiatives demonstrated robust implementation of promotion and prevention activities (such as community stakeholder engagement, peer group education, interventions to prevent abuse, and awareness campaigns), and reiterated that such activities have enhanced their operations in communities. For instance, LAPS conducts a pre-entry phase dedicated to mass sensitization and community engagement, which enables CHWs to build awareness and trust within the community, and ground future work in local experiences. However, such prevention and promotion activities are not systematically defined and delivered in line with Module 4. As such, CHA performance in this area is assumed to be negligible, although trained PHCs and MHCs may be carrying out such programming. This represents an important and neglected area of programming and likely low-hanging fruit to strengthen the public sector community health platform.

Overall, there remain key opportunities to expand and improve upon the existing scope of CHW roles and responsibilities related to MH, including by leveraging: 1) Trained CHAs, Community Health Service Supervisors (CHSS), and volunteers under EVD & COVID as well as PHC and MHC workers to mobilize MH in the CH Strategy; 2) The CH platform for prevention and promotion, by learning from the existing reservoir of NGO experience with community entry, engagement, and implementation.

2. Relationship between CMH and PHC systems

In an ideal scenario, CMH initiatives will have strong ties to PHC systems, wherein associated health workers benefit from in-service training, mentoring, and supervision by PHC workers; referral pathways are established and functional; and data is shared between platforms. In Liberia, CHAs are to be trained and supervised by CHSS. However, the relationship between Liberia's CH platform and PHC systems is broadly weakened by insufficient governance and coordination, limited funding dedicated to CH budget lines, limited availability and geographic distribution of CHAs, fragmented training and incentives, and infrequent supportive supervision.

We observed that supportive supervision relationships for mental health between CHAs and PHC workers (i.e., mhGAP-trained PHC workers and trained MHCs) are largely inoperative in the public sector. There is a particular disconnect between the CHA platform and PHC systems when it comes to mental health: one key informant noted that "[A] check of referral and counter-referral forms will show that [joint] CMH service provision between CHAs and PHC is low." More robust supervision support and training—as well as referral and follow-up activities—were observed among NGO implementers, although practices were inconsistent and non-standardized across projects. The relationship between MHCs and PHC systems is more established and functional, indicating that extensive curriculum rollout and trainings is a pathway to success. The presence of trained PHC workers—the majority of which are trained in mhGAP—emerges as an untapped opportunity for scaling up supportive supervision of CHAs and ensuring CHA services are continuously delivered. This highlights the need for standardized tool for PHC systems to monitor mental health at the community health level. As one informant said, "The system already exists, we just have to make it work better."

Data sharing between CMH and PHC facilities is also strained. According to CH Module 4, data should flow from CHAs, who capture it on paper-based templates and submit it to the CHSS. Collected data is then sent to the county level, entered into the DHIS2, and aggregated for the use of the MOH CHSD. However, weak implementation of this component of Module 4 translates into poor data exchange on clients and their needs. Data sharing practices and tools between CMH and PHC are largely under-developed, a reality which has been attributed in part to the general under-prioritization of CMH. As a result, the demand for data exchange and coordinated services from the PHC system is underwhelming. Based on our findings, it appears likely that the weak CMH-PHC relationship is another inhibiting factor at play, further undermining investment in service delivery preparedness at the facility level. Meanwhile, NGO implementers use their own data collection tools, mainly geared towards tracking project-level outputs and outcomes and conducting monitoring and evaluation activities. However, NGO implementers do not report their formal data sharing arrangements with public sector PHC facilities, nor integrate their data into the public sector HMIS.

Additional data systems issues persist, including that a) referral and counter-referral forms are the main data exchange tools in the public sector CMH-PHC ecosystem, but CMH data is not coming up through the DHIS2; b) there is no systematic data collection, no space on a home-based mother card or an ANC card for "mental status"; and c) mental health is not included on the Joint Integrated Supportive Supervision tool (the JISS) for monitoring PHC facilities. As a result, important questions remain unanswered. For instance, do users go to facilities on the basis of CHA referrals? Do facilities accept referral forms and log or record them? Do they maintain that data and loop back to the CHAs to report who made it to the facilities?

Data exchange and more robust service tracking/measurement are important components of joint PHC-CMH programming and to momentum for CMH implementation overall. As such, more robust aggregation and analysis is needed. Data from NGO implementers may serve as a window into community-level programming experiences and needs if integrated.

3. Modalities for training CHAs/CHWs for mental health

Training modalities vary across public and NGO initiatives both in terms of resource intensity and approach. The tools for training CHAs under Module 4 as well as CHWs under NGO initiatives are well-developed. NGO implementers use bespoke organizational resources for training CHWs on CMH

including through CETA, mhGAP, a mental health curriculum at PIH, and in-house manual developed to train psychosocial workers at LAPS. While Module 4 necessitates a job aid, a facilitator's guide, and evaluation materials, the *utilization* of such tools in the CH Strategy rollout is limited and superficial. Key informants noted that CMH was not rolled out in an "organized and consistent way" by CHA implementing partners in counties, and that resulting trainings were too short and light on technical content. In contrast, the project-based tools used by NGOs are better utilized and (presumably) updated. Findings suggest that there needs to be greater consensus among central policymakers, clinicians, and county-level coordinators on the next set of training materials to help determine whether the scope of the module's content and associated competency assessments are sufficient. For example, from a mental health programmatic perspective: is the CH Strategy Module 4 information too narrow and basic? Do CHAs have enough information on detecting MH conditions? Are there decision support tools available for referral decisions? Have MHCs reviewed the information in training materials? Overall, the differences on training materials also reflect a lack of agreement on priority CMH services among MH actors in the public and stakeholder sectors.

MHCs are (often) not leveraged for CHA training purposes, which appears to be a missed opportunity. **Integrating the CMH training module into overall CH strategy roll out is an efficient course of action**. However, there are several interrelated obstacles to doing so. First, community mental health (CMH) training module is largely de-prioritized compared to other training modules. And, with limited resources allocated, the cost of holding multi-module trainings over the course of several days is substantial enough[3] to create hesitation about a more intensive CMH package. Whereas NGO implementers are able to budget for and use staff, expatriates, and clinical trainers, as well as meals and transportation, Module 4 trainings are more fragmented, inconsistent, and light by comparison. A more integrated and basic but better supervised and enforced training approach may be advisable. Importantly, it appears that greater collaboration between the CHSD and Ministry of Health's Mental Health Unit is needed in order to facilitate the CHA training roll-out.

Mental health providers and managers within the health system are also not adequately involved in CHAs/CMH trainings. Module 4 trainings for CHAs are usually run by two master trainers from the county, who train across the entire curriculum and may not have the mental health expertise necessary. Similarly, county mental health coordinators are out of the loop on Module 4 trainings, leaving them responsible for implementing the MH strategy but disconnected from the rollout of the CMH approach. Overall, respondents called for much closer CHSD and MHU collaboration on the planning and rollout of CMH training at the grassroots level.

4. Coordination, monitoring, and oversight mechanisms

Community health planning and implementation is led at the county level but excludes mental health stakeholders in the system. Planning processes are widely recognized by respondents as good opportunities to better integrate mental health into the community program strategy. However, broadly speaking, CMH is not well-integrated nor prioritized within these processes, which respondents noted as "a major issue." In fact, it was observed that county MH coordinators are excluded from CH training and

[3] Respondents reported a number of days [4-7] of didactic/classroom training on CHA Strategy Module 4; two master trainers from each county (may occasionally/incidentally include an MHC); printing of flipcharts, handouts, visual aids needed to physically carry materials to remote locations; trainings can be conducted in communities in "palava huts" (informal community centers) though, which can be cost-effective

review meetings. Overall, the national CMH approach does not appear to perform systemically unless integrated into county-level planning of community health programming. An underlying assumption is that only programs with adequate funding become CH priorities in practice. Respondents noted that a "lack of funding for running the system is a key constraint" for CMH. For instance, while key partners supported rollout (materials, training, coordinating, monitoring, and oversight) for the TB and HIV components of Module 4, there was no systematic partner support for CMH. Furthermore, communities often lack enough resources and support to carry out functions stipulated within the national policy.

There is a disconnect in coordination at the subnational level between mental health and community health structures. These persistent breakdowns in coordination have resulted in a lack of integrated CMH implementation at the local level and contribute to the lack of emphasis for CMH in the PHC model in Liberia. This furthermore has opened the door to ad hoc and verticalized community level programs implemented by partners. Coordination among these partners is limited to sharing project-level good practice (co-location of services, sharing of routine data and reporting, etc.).

Yet some promising opportunities to improve CMH planning with implementation already exist or are emerging: 1) the Community Health Promoter Strategy will standardize CHWs, formalize community-facility link, and feed information into the DHIS2; and 2) some partners (PIH, LAPS) have experience mobilizing CMH as well as relationships with CHTs to facilitate integrated planning. Trained PHC and MHC workers also represent an opportunity to monitor and oversee CHWs, but institutional mechanisms at the community level (e.g., MHCs in DHTs or trained personnel in CHCs/HFDCs) will need to be made functional. A stronger and more inclusive roll-out of CMH through the CHA strategy will help to a) directly link the MHU and CMH platform, b) better link CMH with PHC facilities

Fragmentation in health planning and data collection processes is a major challenge for integration of CMH in routine health systems. In general, the collection and aggregation of CMH data are not integrated in routine mechanisms: data collection practices for CH Strategy implementation are inconsistent across CH program modules and fragmented from the DHIS2 (which does not capture CMH information). The CH strategy approaches and expertise of NGO partners can facilitate more integrated MH and CH planning and implementation, if prioritized. CH data collection and reporting (including for MH) in general needs to be better integrated with DHIS2.

Overarching takeaways

Within these findings, several overarching and key takeaways emerged:

First and foremost, implementation of MHPSS under CH Strategy Module 4 (CH4) is inconsistent and broadly lacking. Interviewees noted that when it comes to MHPSS, the CH Strategy and CH Module 4 function in actuality as more of a framework than a coherent program, and implementation is not guaranteed. Considerable discretion is exercised around which components are implemented and where (making programming very "divisible"), largely due to external funding and partner-led implementation. Mental health often loses out in the implementation of community health programs to other health priorities because of a lack of funding, interested partners, and inclusion in programming.

Second, an enabling environment is crucial to improving implementation. For instance, there is a clear agenda of tools in which to include mental health at the community and facility (PHC) levels; establishing and maintaining supervisory relationships (especially in terms of MHC involvement for

carrying out drug refills); and integrating CMH in county and district level health planning to operationalize well-aligned MH and CH strategies from the outset.

Third, MH stigmas and discrimination are pervasive, and degrade the potential for CMH initiatives to make an impact. As such, stigmas reduction and awareness raising is fundamental to the success of CMH activities. Furthermore, CHWs require robust and continual training to ensure competency in MH issues as well as compassion for people with mental illness. Interviewees noted that even trained CHAs may have misperceptions about MH issues, which limits their ability to adequately identify symptoms, make referrals to PHC facilities, and conduct the scope of their MH duties with adequate sensitivity towards community stigmas. This indicates an important opportunity to better integrate awareness not only into Module 4, but into other health service areas. For instance, addressing mental health in the context of care for HIV, maternal health, and NCDs.

Fourth, the presence of trained PHC workers, MHCs, county MH coordinators, and CHAs/CHVs (MH training as part of with EVD and COVID response) provides synergies and opportunities to operationalize joint planning, monitoring and supportive supervision, better training, and data sharing for mental health at the community level.

Finally, given that the earlier CMH package (CH Strategy Module 4 over 2016-2021) was not well-delivered, adding to it without requisite funding and operational preparation appears unlikely to work out better than the implementation experience and performance in the past. Additional funding and operational preparation, therefore, is necessary to make improvements in implementation.

Recommendations

In light of these findings, the following recommendations emerged for **a) revising the package and training module for MHPSS delivery at the community level**, and **b) sustainably improving how community mental health is implemented and coordinated** by integrating certain strategic and promising approaches observed in the Liberian initiatives under review.

Revising Module 4 package and training materials for Community Mental Health

1. Integrate training on stigma reduction and awareness raising activities, including through outreach to community stakeholders, religious and traditional institutions, schools, etc.
2. Prioritize training on identifying mental health conditions for referral and conducting follow-up visits, particularly for assisting with treatment adherence and monitoring medication side effects.
3. Prioritize training on conducting psychosocial education and counseling, either in individual or group formats.
4. Ramp up task sharing, especially in the area of MH medication (and revise guidelines as needed)
5. Include additional indicators for demonstrating knowledge on MH in the Module 4 Pre- and Post-Test and Skills Check Evaluation, especially on identifying symptoms of mental illness, making referrals, de-escalation, and raising community awareness.
6. Consider building a pre-intervention phase into the protocol for community entry, focused on initiating connections in the community and identifying potential clients.
7. Consider additional training in family support and care for persons with MH issues, such as methods for communicating with family members and local authorities to prevent harmful activities and improve their response.

8. Include MHPSS policymakers, clinicians, and county-level coordinators in the CH4 training module revision process as well as training and routine planning processes.

Enhancing Implementation and Coordination of CMH

1. Make a concerted case and effort for limited piloting.
2. Conduct experimentation, data collection, and implementation research to ensure continuous improvement and surface evidence for future advocacy and resource mobilization purposes.
3. Activate and operationalize the CHW-PHC-MHC collaboration in terms of referrals, counter-referrals, supportive supervision, follow-up communication and/or visitations, and data exchange.
4. Enhance advocacy to leverage the current window of policy revision and openness, especially to activate more joint planning and coordination at the county and district level.
5. Pursue the agenda to improve for the CH program as a whole (e.g., on making CH-PHC data flow, PHC support and supervision of CHAs, better collaboration between CHSD and health programs).
6. Advocate for the integration of mental health awareness into other training modules, including HIV, maternal care, and NCDs.
7. Strive for more equal gender representation among CHAs. At present, only 20% of CHAs are women. Recruiting more women CHAs for CMH training is a key opportunity to shore up women's mental health (esp. maternal mental health) as a component of prevention.

Conclusions

Although Liberia's community health policies and programs enable communities to play a large role in the implementation and provision of health activities, community-level mental health services are neither fully functioning nor well-resourced. Still, there is much to learn from the successes and challenges of existing CMH initiatives in how to sustainably strengthen CMH programming. We hope for these findings to be utilized by the MHU, Community Health Services Department (CHSD), and local stakeholders as they revise CH Module 4, create a corresponding roadmap for rolling out a pilot, and continue working to strengthen CMH in Liberia in the future.

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Annex 1: Methodology

Assess examples, describe findings, and develop recommendations around two questions:

I. What may be the CMH role of the CHA program?
II. How to implement in an integrated and coordinated manner?

- Describe the roles and responsibilities of CHWs: service packages, esp. approach to (1) task shifting, (2) medication mgmt, (2) self-care and empowerment of service users and carers, (3) stigma reduction and preventing discrimination, abuse, and social exclusion
- Call out links between CMH and PHC: tools, training, referral, follow-up, data and confidentiality
- Review modalities for training of CHWs for MH: (1) tools (e.g. module), (2) human and financial resources, (3) process (length, classroom and/or practical), and (4) responsibilities of various actors, e.g. IPs, CHTs & DHTs, and national actors
- Explain monitoring and oversight mechanisms: vertical and horizontal flow of authority and information (esp. integration into routine public sector mechanisms)

Once key CMH interventions of interest are identified:

1. Develop questionnaire for KII perspectives, data, & materials
2. Develop template for capturing/describing findings
3. Introductions and outreach to implementers in Liberia
    - Conduct KIIs
    - Obtain data and resources
4. Document learnings to produce analysis and recommendations

Annex 2: Questionnaire for collecting key informant perspectives and relevant data and documents

The rapid desk review of selected community mental health (CMH) initiatives in Liberia will seek to answer two broad questions for the purposes of the MOH Mental Health Unit (MHU) and the Community Health Services Department (CHSD) as they embark upon a policy review of the community and mental health strategies. These are:

5. What is the current role of the Community Health Assistants (CHA) program in providing mental health services and how may it evolve?
6. How may the proposed CMH role of the CHAs be implemented in an integrated and coordinated manner?

The Accelerator team will gather and review the following information in order to produce learnings on best practices and challenges:

The roles and responsibilities of community health workers (CHWs)

For the respective CHWs under each initiative, overview the following:

7. Enumerate discrete mental health service package delivered by the CHWs/CHAs
8. Describe the treatment of the following:

i. **Approach to task shifting in community mental health**: What services are devolved to CHWs as lay health workers, which training modules or guidelines are used (mhGAP), and how are CHWs trained (in facilities, in communities, in classrooms?)?

ii. **Responsibilities regarding medication management**: are CHWs/CHAs trained on medication management? Are CHWs/CHAs prescribing or delivering medications to clients for any MNS disorders? Are they referring clients for medication/follow up visits? Are they following up with clients to check for medication adherence/side effects/adverse effects?

iii. **Responsibilities and activities around stigma reduction and preventing discrimination, abuse, and social exclusion**: please enumerate responsibilities and corresponding activities—e.g., anti-stigma messages/awareness, reporting of abuse or rights violations of persons with mental illness, exclusion of persons with mental illness in community activities, etc.

iv. **Interventions to promote self-care and empowerment of service users and carers**: For example, are CHWs trained and provided any guidelines for promoting self-care strategies like maintaining positive relationships, coping, employment, creative and physical activities, healthy living etc.? [This may be a high bar, but useful to check if CHWs touch upon it]

9. Were the responsibilities in (a) and (b)i-iv fully operationalized?
10. What facilitated or enabled the discharge of these functions?
11. Where not, why not?
12. What were the main challenges encountered in delivering the above roles and responsibilities?

Specifically, to MOH, ask for opinion on the feasibility of CHAs delivering medications to clients/refilling mental health clients' prescription? Respondents may include pharmacist John T. Harris (director of pharmaceutical services), Mr. Olasford Wiah (director for community health program), Ms. Angie Tarr (director of MHU), etc.

Relationship between CMH initiatives and primary health care service delivery systems

Describe and evaluate the connections between CHWs/CMH platform and the PHC system (likely public but document private PHC links as well for initiatives fully in the private/donor space). Specifically:

a. Are PHC workers involved in training and overseeing CHWs for the mental health services delivered by the latter? What role(s) do they play?
b. How does information flow between the CMH and PHC platforms if there are such data relationships? These data may relate to screenings and services, referrals, and follow-up.
c. Enumerate and describe the tools used for such data sharing. Are there (well-enforced) protocols for maintaining data confidentiality?
d. Are the responsibilities in (a)-(c) fully operationalized? What facilitated/enabled/hindered the discharge of these functions?
e. Summary views on main challenges encountered: seek informant perspectives and any formal evaluations and reports.

Modalities for training of CHWs for mental health

a. What tools (e.g. the CHA Program Module 4 Facilitators Guide, Job Aid, and Evaluation Materials) were used for training CHWs and assessing their competencies?
b. What human and financial resources were involved in the training? For instance, what were the cost items for training (venues, stipends, travel, meals and lodging)? How were the trainers sourced (local, foreign) and how were they compensated (by public or donor project funds)?
c. What was the process and modality of training? For instance, what was the length, pedagogical or practical focus (classroom vs. practical in facilities and/or communities), etc.?
d. What was the engagement with and responsibilities of various health system actors, e.g., implementing partners, CHTs & DHTs, and national government actors?
e. What facilitated/enabled/hindered the discharge of these functions?
f. Summary views on main challenges encountered: seek informant perspectives and any formal evaluations and reports (ask if these touch upon the experience of CHW training and roll-out of the CMH initiative).

Note: CHAs are supervised by community health services supervisors (CHSSs). The CHSSs are in turn supervised by PHC workers, officers in-charge (OICs) in health facilities. As part of 2 and 3 above, when speaking with CHSSs and OICs, ask about:

- Their capacities and training in mental health service provision,
- Experience in training CHAs on Module 4,
- Reporting of mental health cases by CHAs,
- How CHAs handle confidentiality in dealing with mental health clients

Mechanisms for coordination, monitoring, and oversight

a. Describe planning/implementation processes and actors: bodies/platforms set up, actors engaged?
b. Describe coordination relationships and platforms (locally and across levels of the health systems)
c. Describe monitoring and oversight relationships
d. Describe integration into routine public sector mechanisms for reporting/information
e. What facilitated/enabled/hindered the discharge of these functions?
f. Summary views on main challenges encountered: seek informant perspectives and any formal evaluations and reports

Endnotes

References

[i] Liberia Ministry of Health (2016). National Community Health Services Strategic Plan 2016-2021. pp 8. Monrovia, Liberia.
[ii] Healey, J., Wiah, S. O., Horace, J. M., Majekodunmi, D. B., & Duokie, D. S. (2021). Liberia's Community Health Assistant Program: Scale, Quality, and Resilience. Global health, science and practice, 9(Suppl 1), S18–S24. https://doi.org/10.9745/GHSP-D-20-00509
[iii] Liberia Ministry of Health (2016). National Mental Health Policy 2016-2021. pp 26. Monrovia, Liberia.