TECHNICAL BRIEF

Communities Support Health Facilities in Sierra Leone

BACKGROUND

A number of devastating events have affected Sierra Leone, a small West African country with a population of just over 7 million people. These events include a 10-year civil war and more recently, the largest and deadliest Ebola virus disease (EVD) outbreak ever recorded. As a result, the country has some of the worst health indicators in the world; according to the World Health Organization, Sierra Leone's maternal mortality rate (1,360/100,000 live births) is the highest in the world (WHO 2015).

As Sierra Leone continues to recover from the effects of the EVD outbreak and rebuilds its health system, it is important to understand the importance of community engagement. Community engagement contributed to the end of the EVD outbreak and needs to be part of health system strengthening to promote community ownership of health facilities and to strengthen health system resilience. Community involvement can improve the quality of health services by aligning health care worker capacity-building priorities with community needs and demand for services.

The USAID-funded Advancing Partners & Communities project, under the Sustaining Health Facility Improvements (SHFI) program, worked with the Ministry of Health and Sanitation and District Health Management Teams in Sierra Leone to support community engagement in Bombali, Port Loko, and Tonkolili Districts. The program was implemented by JSI Research & Training Institute, Inc., with NGO partners Care International, RODA, and MADAM. The support focused on maintenance and preventive maintenance (M/PM) of infrastructure and water, sanitation, and hygiene at peripheral health units (PHUs), which include maternal and child health posts (MCHPs) and community health posts (CHPs).

The SHFI program worked with Facility Management Committees (FMCs), community-based structures that represent PHU catchment communities and are the link between the community and the PHU. The FMCs support the PHU with maintenance and preventive maintenance and help address community concerns as a way to ensure accountability for health services.

FMC member Morlai and his family, and the facility in-charge who delivered his newborn at the Mawoma MCHP.

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Members of the Mafoimara CHP in Port Loko receive training on masonry and carpentry.

INTERVENTIONS

The primary role of the FMC is to ensure PHU functionality in all areas. The FMC, which includes the facility officer-in charge, creates a facility improvement action plan (FIAP) to detail and prioritize M/PM activities needed at the PHU. The FIAPs are sent to their respective communities for discussions on how they can mobilize resources to support FIAP activities. By determining whether and how to invest in the PHU, the community gains a sense of ownership of and commitment to its PHU.

As part of this effort, FMCs brought communities together to determine what support communities are willing and able to provide for their PHUs. Through this consultative process, most communities have become aware of the importance and value of their PHUs and their role in maintaining them. This in turn encouraged communities to mobilize resources to support their PHUs.

SHFI program activities also included trainings for the FMC and communities on resource mobilization, livelihood interventions, and trade skills like masonry and carpentry that communities can use to better themselves and support the PHUs. Below are descriptions of the various resource mobilization interventions undertaken by communities in the SHF program.

1. Community in-kind Support

To gain support from communities, FMCs discuss implementation of the FIAPs with village development committees (VDCs), mother-to-mother (M2M) groups, youth leaders, and mammy queens. NGO partners facilitate these discussions and give communities guidance and tools so they can plan and implement their locally identified initiatives. During these discussions, communities identify ways to support the PHUs, including the feasibility of various in-kind contributions. Communities have been able

Community members constructed staff quarters at Kabonka CHP in Bombali.

FMC and VSLA members in Mawoma repair the PHU water tap.

to mobilize resources like sand, stones, cement, sticks, and labor for PHU repairs and renovations. These in-kind contributions were the most common form of resource mobilization. Forty of 70 facilities in APC-supported areas had their communities mobilize in-kind contributions between February and April 2019, showing the communities' commitment to their PHU and empowering communities to be self-reliant.

These efforts can be seen all around the facilities that APC supported, in each of the three districts. In Wonkibor MCHP in Tonkolili District, eight villages helped build a perimeter fence for the PHU. Each community constructed a portion of the fence with local materials and sent representatives to build it. The community also built a waiting hut for patients and walls for the health worker staff quarters. The SHFI program is supporting high-performing FMCs with materials to compliment the communities' work, and provided roofing material to complete the staff quarters.

There were some challenges with community-led interventions and FMC meetings, primarily related to the distance between some catchment communities and their PHUs. At times, this meant that communities closest to the PHU did most of the work. This led some communities to impose cash penalties on communities that did not finish the required work. In other communities, the FMC agreed to cook lunch for the people who travelled longer distances to ease their burden and show appreciation for the extra effort they took to help.

2. Village Savings and Loan Associations

A Village Savings and Loan Association (VSLA) is a group of 10–25 people who save money, take small loans from those savings, and pay the money back with interest in roughly a one-year cycle. One member is selected to manage the account. At the end of the year, the VSLA distributes the money in proportion to members' deposits.

NGO partners supported the training of VSLA members, but never managed them. Members put in money through the purchase of "shares" (between 1 and 5 at every meeting). The share value is decided by members at the beginning of each cycle. Each member has the right to borrow up to three times the value of his/her shares and most repay within three months. Most VSLAs institute social funds that members can use for a variety of reasons; FMCs have encouraged VSLAs to use some of their social funds for M/PM at their PHU.

The VSLA at the Mawoma MCHP in Port Loko District comprises 15 men and 15 women from 13 villages. They deposited Le 970,000 and created a social fund of Le 420,000. This VSLA has provided four loans to support small business, and has used some of its social funds to repair doors and locks at its PHU.

During the SHFI program, 30 new VSLAs were formed between the three districts and many were revisited and supported with additional training. Before the formation of the VSLAs, NGO partners met with community stakeholders and other community groups such as FMC, VDC, and M2M on the functionality of existing VSLAs, their interest in forming new ones, and willingness to use social funds to support implementation of M/PM activities.

The distance of some catchment communities from their PHUs and the associated cost of transportation to meetings deterred some people from participating in VSLAs. This could be alleviated by changing meeting locations regularly

VSLA members at Mawoma.

or restricting VSLA membership to people from nearby villages. The latter is preferable because it improves cohesion, attendance, and loan re-payment. It also facilitates the monitoring of VSLA activities.

The VSLAs are a great economic development initiative for communities because they improve household livelihood and can support the larger catchment population too, including through PHU maintenance.

3. Income-generation Activities

When discussing different types of resource mobilization with communities, income-generation activities (IGA) were considered a potentially valuable method for communities to support their livelihoods. Communities were excited about IGA as a longer-term and renewable form of support to maintain their facilities, which did not depend on increasing the financial contribution of their communities.

As part of the FIAP disseminations, the FMCs talked with communities about using some of the IGA revenue for M/PM. These discussions included resource mobilization, livelihood interventions, reasons for selection of a particular activity, availability and seasonality of needed resources, cost implications, community contributions, and market for product including proximity to market outlets.

The SHFI program set IGA support selection criteria favoring FMCs that: 1) were already taking actions to support M/PM activities; 2) were meeting at least every other month; 3) had identified an IGA and had begun moving forward; and 4) agreed to use some funds or goods to support PHU maintenance.

The FMC at Rochen Malal in Tonkolili was one selected for SHFI support. FMC members had agreed on a farming IGA to raise money to support their PHU. Since the rainy season was fast approaching and seeds were needed to start the activity, FMC members each contributed 2–3 cups of seeds for ground nut, which they harvested. They used a portion of the proceeds to buy nails for PHU repairs, food for volunteer fence-builders, and block molds for constructing staff quarters. This FMC said that IGAs are important because they minimize community contributions to the FMC, especially during the rainy season when things are difficult.

The Mawoma FMC, another one supported by SFHI, planted cassava as an IGA for its PHU on land given by the chief. The FMC purchased cassava clippings and community members planted them. It will use some of the cassava proceeds for health facility improvement. The SHFI program provided Mawoma FMC with equipment to process cassava into garri, which they can sell at the nearby market.

4. Household Contributions

During FIAP development and dissemination to community members, household contributions were discussed as a way to finance M/PM activities. The communities that

> **"I am a stakeholder in my community and one of my responsibilities is to provide care and sacrifice for my people for the health facility to function. I will use my personal motorbike to collect monthly household contributions from all the 13 catchment communities as my own support to the health facility maintenance. Whether the PHU or other FMC members support me with fuel or not, I am going to continue."**
>
> **–Osman Saccoh, VDC chair, Tonkolili District**

agreed on this initiative based the final amounts for monthly household contributions on average community income and perceptions of affordability. Monthly contributions vary by community, from Le 500 ($0.06) to 5,000 ($0.59). Funds are collected by FMC, CHW, VDC, or town heads, who record and track contributions in a ledger. The collection box and ledger are usually kept at the PHU for safekeeping. A committee of 5–7 community members manage the funds to assure prompt allocation decisions and to strengthen accountability and provide constant feedback to the wider community. The committee signs off on the ledger before disbursing any of the collected funds.

At the Manumtheneh MCHP in Port Loko, the community aimed to collect Le 2,000 per household for M/PM. Since February 2019, it has collected Le 396,000, some of which it used to pay for small repairs at the PHU. A number of the women in the community, who participated in SHFI program trainings, have become involved in cleaning and repairing things at the facility, including cleaning the water tank.

In Kolisokoh in Bombali District, the FMC and VDC convened the nine catchment communities to discuss the faulty pump at the PHU. All agreed to contribute Le 2,000 per household, and a total of Le 340,000 was collected. The PHU staff contacted a technician from Makeni to provide an estimate for the work. When the amount collected was not enough for the repair, the VDC and FMC approached the VSLAs in the catchment areas, and they agreed to contribute the final Le 200,000 from their social funds. The repair was made and the pump fixed. The FMC has initiated another collection to repair the PHU's main door.

For many FMCs and communities, the concept of collecting household contributions is not new; some have been doing this since 2017. What has changed is the level of information given to the community before collecting contributions for improvements at the facilities. For example, in Mawoma community in Port Loko, household contributions were collected for several months in 2017. FMC members said contributions were not easy to collect initially; many households did not want to pay because they did not know where their money was going and did not see the value of contributing. When the FMC stopped meeting at the end of 2017, the treasurer kept the money and the financial records for safekeeping. When it began meeting again in early 2019, the money was still there—it had not been misappropriated, stolen, or lost even after more than a year of inactivity. This built community trust that their contributions would not go missing. In addition, when the FMC resumed meeting

The FMC meets with the communities of their catchment area to discuss the FIAP in December 2018.

and wanted to collect household contributions again, the members went to every single community in the catchment area to discuss the FIAP they had committed to, and outlined a budget for each repair. Household members could see precisely where their contribution would go, and could follow up to ensure the repairs were made. This boosted transparency and accountability of the FMC.

Now, most communities report that regular household contributions are not difficult to collect, except at the end of the dry season/beginning of farming season (also called "the hungry time") when people designate resources for planting. FMC resource mobilization must be coupled with consistent activity and clear communication, and the FMC executive must maintain trust through transparent record keeping.

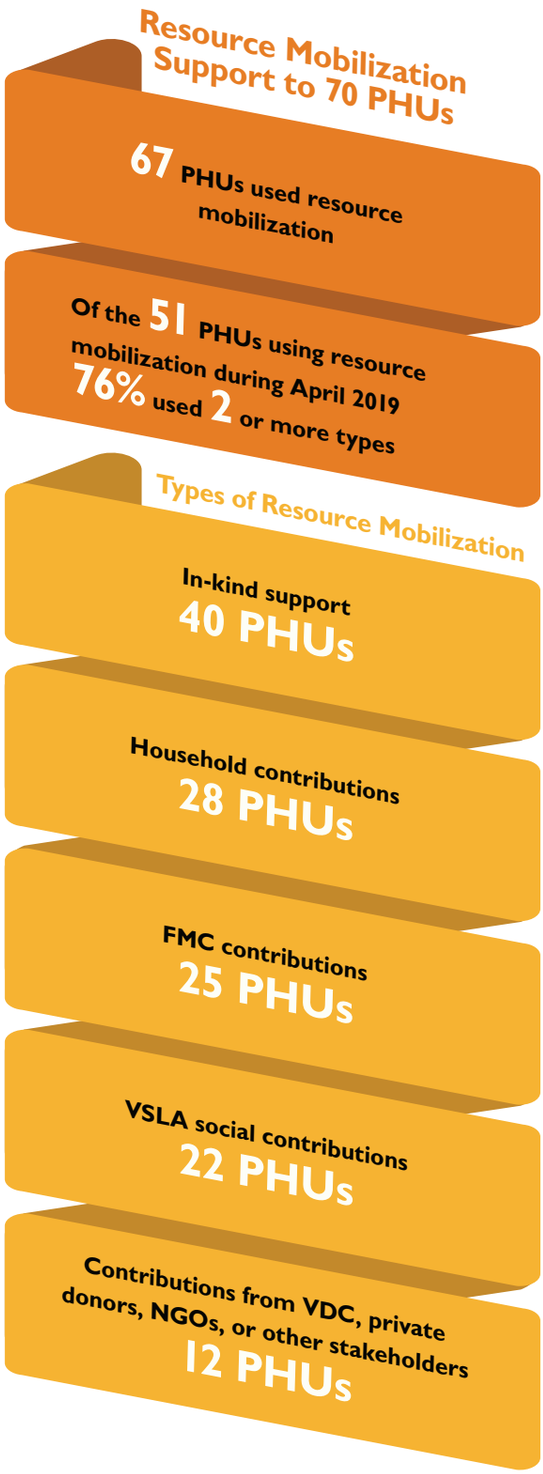
LESSONS AND RESULTS

While the Ministry of Health and Sanitation is committed to continued support and improvement of the health sector, it has to rely not only on the public sector and its donors and partners, but also on the users of the health facility. At the same time, communities must be invested in the upkeep of their health facility and feel proud of having a well-maintained and thriving health facility. Health is important to everyone; it is everyone's business.

The SHFI program helped communities understand the importance of the PHU and increase their willingness to support and provide resources to improve the quality of care. The catchment communities of the 70 PHUs supported in Bombali, Port Loko, and Tonkolili are contributing to the improvement of the health sector and their PHUs through their community resource mobilization. They understand that these facilities are not only the responsibility of the in-charge.

"When I am sick, I can come [to the PHU]. When my child is sick, I can bring them here. Why shouldn't I help to make it be the best it can be?" said Thaimu Koroma, FMC chair, Mabayo PHU in Bombali. "We spend so much money taking our sick to Makeni. Why not invest that in improving this facility so we don't need to pay to go far away?"

The most common type of resource mobilization that communities provide is in-kind support. Most communities are making a real effort to support the PHU by providing time and materials from their community to the work needed at the PHU. The second-most common resource mobilization method was household contributions, which



indicated willingness of the community leadership to decide with the community on feasible contributions for PHU maintenance. Contributions made by households, FMCs, VSLAs, and other cash collected by FMCs ranged from Le 80,000 ($9) to 2,500,000 ($295) a month per PHU, with a median monthly collection of 250,000 ($30).

> "Now, with or without anyone else, we can do something. We can showcase our health facility, and we can maintain our facility."
>
> –Ali Kanu, FMC member, Workinbor

In total, 67 PHUs received community financial resources in just a few months during the SHFI program. Of the 51 FMCs that collected resources in April 2019, 76 percent conducted two or more forms of resource mobilization.

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