



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

FACILITY MANAGEMENT COMMITTEE OPERATIONAL GUIDELINES

ACKNOWLEDGEMENTS

The Directorate of Primary Health Care (DPHC) within the Ministry of Health and Sanitation (MOHS) works to ensure that every man, woman, and child in Sierra Leone can access high-quality primary health care services. In the years that have followed the Ebola outbreak, the DPHC has, with support from other MOHS Directorates and development partners, made an enormous effort to ensure supportive policies that respond to evolving health priorities, build on lessons learned, and sustain the health gains that have been achieved.

Among its efforts to improve community engagement in health, the DPHC led the process for developing the Facility Management Committees (FMC) Operational Guidelines and Training Manual. This was a collaborative effort between the MOHS and the United States Agency for International Development (USAID)-funded Advancing Partners & Communities project implemented by JSI Research & Training Institute, Inc. in collaboration with FHI 360 and partners Action Against Hunger, the Adventist Development and Relief Agency, GOAL, the International Medical Corps, and Save the Children.

The two documents are based on national policies and guidelines related to community engagement, the MOHS' vision for the role of FMCs; and the experience of the Advancing Partners & Communities project in Sierra Leone, which developed and implemented a community engagement implementation strategy for FMC strengthening. This strategy was developed through workshops and field testing in close collaboration with the MOHS and the district health management teams (DHMTs) from Bombali, Port Loko, Tonkolili, and Western Areas (Rural and Urban).

The documents could not have been written without the leadership of Dr. Joseph Kandeh, Director of Primary Health Care, Mr. Lansana Conteh, Manager of the Health Education Division (HED) within the DPHC, Dr. SAS Kargbo Director of Policy, Planning and Information; and Dr. Santigie Sesay, Director of Reproductive and Child Health.

A special thanks the District Medical Officers, District Social Mobilizers, other DHMT members, local council members, health facilities staff, FMC members, and community members who contributed their time and ideas to develop these guidelines and tools.

FOREWORD

Actively engaging communities is a key ingredient to improving the quality, accessibility, and utilization of health services in Sierra Leone. It is also a necessary aspect of emergency response preparedness, building a more resilient health system, and reaching global health targets such as the Sustainable Development Goals. Community engagement is critical for the achievement and sustainability of Sierra Leone’s strategy for “Getting to and Maintaining a Resilient Zero,” which includes restoring confidence and trust in health services; building relationships between communities and service providers; and improving community-based surveillance.

Supporting facility management committees (FMCs) will ensure community ownership of health, which is one of the five pillars of Sierra Leone’s 2015 Health Sector Recovery Plan. FMCs comprise community members, leaders, and service providers who oversee facility operations and maintenance, promote health, and strengthen links between communities and facilities. FMCs have been present in Sierra Leone for many years, and the Ministry of Health and Sanitation (MOHS) revitalized and reoriented them in Sierra Leone’s 14 districts as part of the Free Health Care Initiative in 2010 to improve access to care for women and children.

Experience has demonstrated that FMCs are capable and active structures that strengthen relationships between community members and facility staff, support improvements in the day-to-day function of community-level health facilities, and promote positive health-seeking behaviours and emergency preparedness in their communities.

An array of policies, including the National Community Health Worker Policy (2016–2020), the National Health Promotion Strategy of Sierra Leone (2017–2021), and the forthcoming Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy, mention FMCs but there is not yet an explicit or consistent definition of their roles and responsibilities.

With the present FMC Operational Guidelines and Training Manual, the MOHS has developed a harmonized, national strategy for promoting community ownership in health. The strategy officially defines FMCs, outlines their roles and responsibilities, and provides tools that will help them reach national and global health objectives in years to come.

It is my recommendation that all stakeholders use this guidance and training manual when working with communities and FMCs to improve the quality and uptake of community-level health services.



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CONTENTS

Acronyms	vi
I. Introduction	1
II. What is AN FMC?	2
III. Who SUPPORTS FMCs?	5
Key FMC stakeholders, roles, and responsibilities	6
IV. How ARE FMCs Implemented?	10
Phase I: FMC Establishment	12
Phase II: FMC Strengthening	14
Phase III: Supervising and Monitoring FMCs	15
V. Tools for FMC Implementation	16
VI. References	17

ACRONYMS

BPEHS	Basic Package of Essential Health Services
CHW	community health worker
DHMT	district health management team
DPHC	Directorate of Primary Health Care
FMC	facility management committee
HED	Health Education Division
IP	implementing partner
MOHS	Ministry of Health and Sanitation
PHU	peripheral health unit
USAID	United States Agency for International Development
VDC	village development committee
WDC	ward development committee

I. INTRODUCTION

Community engagement is a key to optimizing Sierra Leone's transition from emergency response to recovery, and is an essential component for sustainability. Since 2011, the aim of facility management committees (FMCs) has been to support community engagement in health by improving the quality and community acceptability of services. The following key government documents have mentioned community engagement:

- The Sierra Leone Ministry of Health and Sanitation (MOHS) Health Sector Recovery Plan 2015–2020, which includes “community ownership” among its five priority areas of focus.
- The National Ebola Recovery Strategy for Sierra Leone: 2015–2017.
- Basic Package of Essential Health Services.
- The National Community Health Worker Policy 2016–2020.
- The planned nursing and midwifery policy.
- The National Human Resources for Health Strategic Plan 2012–2016.

Building on these guidelines and lessons from implementing partner (IP) and project approaches to FMC strengthening, the FMC Operational Guidelines define stakeholder roles and responsibilities in promoting FMC functionality and sustainability, and recommend implementation approaches and tools. The intended users of the guidelines are district health management teams (DHMTs) and IPs.

The *FMC Training Manual and Tools* is the accompanying document to these FMC Operational Guidelines. To ensure FMC sustainability and continued support, it is recommended that these documents be integrated into future MOHS policies and strategies, such as DHMT routine supportive supervision and the forthcoming Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy, and used by donors and partners supporting their implementation.

II. WHAT IS AN FMC?

The primary focus of the FMC is to ensure the functionality of the peripheral health unit (PHU), including day-to-day operations, drug supply, infrastructure, general sanitation, equipment management, and human resources. FMCs were created to manage the cost-recovery agenda of the Bamako Initiative and its role in facility infrastructure and operations management, and revitalize it to ensure access to the Free Health Care Initiative by its intended beneficiaries: pregnant women, lactating mothers, and children under five years of age. The FMC must also take community feedback on facility-based health services within its catchment area and convey it to the DHMT, although the community perspective on the quality of services has been less emphasized in recent years.

The MOHS expects that FMCs will help give communities ownership of the PHUs they serve and intends to establish an FMC for each of the 1,100 PHUs in the country to ensure health worker accountability to communities. The National Community Health Worker (CHW) Policy 2016–2020 defines the FMCs as the key community structure for health.

Table I below outlines the composition, roles, and responsibilities of stakeholders on FMCs.

Table I. FMC Composition, Roles, and Responsibilities

FACILITY MANAGEMENT COMMITTEE	
Composition	
Executive leadership	<ul style="list-style-type: none"> • Five elected positions: <ul style="list-style-type: none"> ○ Chair ○ Vice chair ○ Secretary ○ Assistant secretary ○ Treasurer ○ Auditor/monitor • The FMC is preferably led by a female chair, as PHU reproductive, maternal, newborn, and child health issues largely pertain to women.

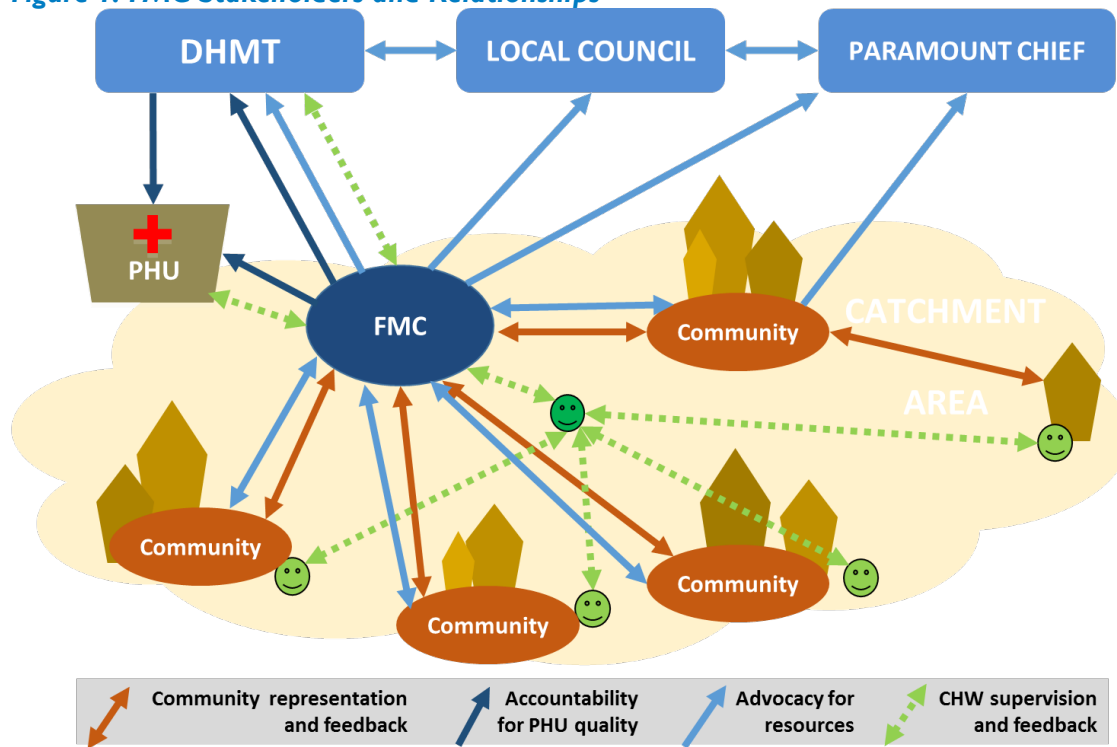
FACILITY MANAGEMENT COMMITTEE	
General membership	<p>General and elected members should not exceed 15. Members should be drawn from:</p> <p>Community:</p> <ul style="list-style-type: none"> • Village chief/headman • Imam • Pastor • Women’s representative • Men’s representative • Youth representative • Children’s representative • Mammy queen • Village development committee (VDC) member • Teacher • CHW or peer supervisor • Representatives from hard-to-reach catchment communities, preferably a CHW • Representatives from populations with special health needs, such as disabled persons and/or Ebola survivors <p>Facility:</p> <ul style="list-style-type: none"> • PHU staff in-charge • Peer supervisor of CHWs across the catchment area
Roles and responsibilities	
Community representation and feedback	<ul style="list-style-type: none"> • Organize quarterly meetings (with possibility of additional monthly or ad hoc meetings) with catchment community members (as represented by the village or ward development committee) to provide updates on achievements, challenges, and suggestions, and to solicit feedback from all communities within the catchment area. • Facilitate/promote mobilization of community resources through the VDC. • Identify and engage key community members such as CHWs and traditional birth attendants (TBAs). • Ensure that PHU staff conduct community outreach.
Accountability for PHU quality	<ul style="list-style-type: none"> • Be accountable to the DHMT through the submission of monthly/quarterly meeting minutes (compiled by the PHU in-charge and the FMC secretary) to provide information (e.g., non-functioning facility because staff is absent, negative attitudes of staff toward clients, drug stockouts) about the facility to district and national levels for action. The CHW peer supervisor communicates directly with the CHW coordinator at the DHMT. • Provide facilities with feedback from community and vice versa. • Clearly communicate health policies to community members. • Work with health facility staff to prevent theft or misuse of drugs supplied to health facilities. • Report anything that is affecting health service provision and use among catchment population.

FACILITY MANAGEMENT COMMITTEE	
Advocacy for resources	<ul style="list-style-type: none"> • Advocate for the PHU at the DHMT/district level. • Develop a sustainable mechanism for FMC functionality, including community contributions to facility maintenance.
CHW supervision and feedback	<ul style="list-style-type: none"> • Ensure a strong relationship between the CHW and PHU. • Peer supervisors represent CHW perspectives on the FMC and share feedback from community-based FMC representatives to CHWs. • Oversee the CHW program, ensure peer supervisor and CHW representation on the FMC. • With the PHU in-charge, support the selection, performance appraisal, and replacement of CHWs.

III. WHO SUPPORTS FMCS?

Based on document review and consultation with partners, communities, facility staff, and across the MOHS, this section describes the roles and responsibilities of the stakeholders in community engagement. It includes the DHMT, the local council, the facility staff, the facility-based governance structures that represent the communities within a facility’s catchment area, and the community-based practitioners who are accountable and report to the public health system (i.e., CHWs). Based on available national documentation and conversations within the MOHS, DHMT, technical and implementing partners, and others, the following FMC stakeholders and relationships at the district, facility, and community levels are recommended, as illustrated in Figure 1.

Figure 1. FMC Stakeholders and Relationships



KEY FMC STAKEHOLDERS, ROLES, AND RESPONSIBILITIES

CENTRAL LEVEL

Within the MOHS:

- The Directorate of Primary Health Care (DPHC) and the division of Health Education (HED) oversee and facilitate district implementation of these guidelines and any updates to the guidelines and training manual and tools. The DPHC will liaise with current and future IPs working in health and community engagement to ensure they adhere to the guidelines and use the accompanying tools.
- The Directorate of Reproductive and Child Health will promote adherence to these guidelines and use of the tools to strengthen FMCs in order to improve access to and quality of reproductive, maternal, newborn, and child health services.
- All MOHS departments will consult these guidelines in the development of future policies and operational guidelines that refer to FMCs and when they implement activities related to FMCs.

DISTRICT LEVEL

District health management teams

DHMTs represent the MOHS at the district level. According to MOHS documentation, the 14 DHMTs across Sierra Leone are broadly responsible for the tasks below.

Table 2. DHMT Tasks

Task	Illustrative activities
<i>Implementing national health policies, strategies, and service delivery packages</i>	Implementing the Basic Package of Essential Health Services (BPEHS)
<i>Managing and planning health activities</i>	Developing, updating, and costing a district-level plan to implement the BPEHS Recruiting and deploying health staff Managing an ambulance service Liaising with local councils and central-level ministries about resource allocation and budget requests Ensuring CHW program functionality, including supervision of all CHWs in the district
<i>Monitoring and reporting of facilities</i>	Monitoring health waste management and health worker protection through provision of protective equipment Routine surveillance Reporting indicators as defined by the national M&E framework, which includes CHW indicators
<i>Engaging with key community stakeholders</i>	Quarterly meetings with paramount chiefs and religious leaders to solve community problems.

FMCs and VDC/ward development committees (WDCs) are the main committees that ensure community engagement. The DHMT is responsible for holding these committees accountable as they work with the PHU to address community health issues. The DHMTs are also responsible for responding to health issues identified through the '117' health information telephone line.¹

Specific DHMT members support community engagement, notably the CHW and social mobilization focal persons. As the DHMT and IPs collaborate to conduct community engagement activities, it is recommended that any support they provide FMCs conform to national standards (i.e., maintain the national daily sustenance allowance).

The DHMT community engagement tasks are to:

- Identify and train CHWs in community mobilization skills and techniques.
- Conduct a community needs assessment, which involves identifying existing health hazards and risky behaviors and presenting them to communities for collective actions to mitigate them.
- Community organization by facilitating the formation of health-related structures.
- Conduct community meetings for feedback, decision making, and planning.
- Work with FMCs to raise community awareness through sensitization and education.
- Attend district-level meetings and report progress of community-level engagement activities.
- Report district activities to national level.

Table 3. Recommended roles and frequency of tasks of stakeholders in FMC strengthening

STAKEHOLDER	ROLES	TIMEFRAME
DHMT	Supervise and support FMC community engagement activities	Quarterly
Local council	Jointly supervise CHWs and community-level engagement activities with the DHMT	Quarterly
Paramount chief	Provide input in community engagement activities through engaging with FMC members and traditional leaders.	Ongoing
PHU in-charge	Jointly conduct community-level assessment of hazards/risky behaviors and involve community stakeholders in initiatives with CHWs and report to district-level focal persons	Routinely
	Monitor and supervise CHWs at PHU catchment level	Monthly
	Attend FMC meetings	Monthly
	Follow up community action plans	Per the schedule
	Report progress of community engagement activities to district-level focal persons	Monthly
WDCs/VDCs	Liaise with FMC to report to local council on facility and community health issues	Routinely
	Attend and play leading roles in all community engagement meetings	Per the schedule
	Report progress of community-level engagement activities to council	Monthly

¹ Dr. SAS Kargbo, personal communication, January 13, 2016. The national '117' telephone line was originally intended for FMCs to provide feedback and hold accountable their respective DHMTs. With a call center in Kono, the MOHS introduced the line to promote efficiency in triage. When the Free Health Care Initiative was launched, it became a general information line, particularly for mothers and children seeking care. When Ebola broke out, the line was transferred to the Ebola Response Team to receive reports of suspected cases and coordinate the response. It is anticipated that as the country shifts from emergency to recovery, this line will resume its former roles.

Local councils

The 19 local councils in Sierra Leone are sub-divided into 392 wards, each of which is headed by an elected councilor. Local councils work closely with the MOHS and the Ministry of Local Government and Rural Development to coordinate health activities, including implementation of the BPEHS and allocating district-level resources across the public sector and collaborating with the DHMT to optimize resource allocation. A health committee within each local council works with the DHMT. This body ensures that DHMTs are supported and deliver services in line with national standards, protocols, and plans.

CHIEFDOM LEVEL

Paramount chiefs

Sierra Leone's 14 districts are divided into 149 chiefdoms, each of which is headed by a paramount chief. Paramount chiefs have both administrative and traditional roles; they are government representative focal points within the country's decentralized system, custodians of traditional laws and customs, and represent the people in their chiefdoms. Paramount chiefs are responsible for safety and security of their chiefdoms and advocate for the economic interest of their people. Chiefs at the village and ward levels report to the paramount chief.

Paramount chiefs are encouraged to take an advisory role in community engagement activities through pre-established communication channels. For example, they may facilitate community entry process; provide input in FMC member selection; discuss chiefdom health and development priorities with FMCs; and help enforce FMC bylaws. FMCs should engage paramount chiefs as appropriate.

Catchment community structures

Village/ward development committees

VDCs and WDCs are the key community development structures. VDCs/WDCs represent the interests of their constituencies across a range of development areas, including health. Some VDC/WDCs have acted as FMCs, overseeing day-to-day PHU operations. VDCs were also designated to take community engagement leadership in the Ebola response.

VDCs/WDCs within a catchment area should be represented on the FMC to ensure that feedback represents the entire community that the PHU is supposed to serve. If there are proper accountability channels, the representatives of the VDCs/WDCs who serve on the FMCs should communicate feedback to their own committees and to the community. This communication system and the coordination among community and facility-level stakeholders should be strengthened to respond to MOHS objectives.

PHU staff/health workers

Health care staff at PHUs—maternal and child health posts, community health posts, and community health centers—are responsible for providing high-quality care that corresponds with the national BPEHS:

- Serve on the FMC or participate in facility-specific activities of the VDC/WDC.
- Be well-informed about all PHU activities and communicate them to the FMC and VDCs/WDCs and communities through outreach.
- Understand the community's health priorities (two-way communication).
- Listen to community needs/problems/complaints and help manage and resolve them.
- Take PHU-level health issues that cannot be resolved by PHU staff to the DHMT.
- Meet monthly with peer supervisors and quarterly with the FMC.

Community health workers

CHWs link the community to the health facility. They represent both the community and the PHU, and may include former TBAs and other lay cadres that have been recruited from and who are considered part of the community. CHWs should serve between 100 and 500 people, although in some places they serve more.

To date, 13,000 CHWs in Sierra Leone have completed the MOHS 10-day training with UNICEF support. Geo-mapping undertaken by the MOHS and UNICEF, in collaboration with other partners and CHWs, revealed that 75 percent of CHWs are female; literate; own a mobile phone; and earn their livelihoods primarily through farming. Ninety percent originate from the community in which they serve.

According to National CHW Policy 2016–2020, CHWs and their peer supervisors are “encouraged to contribute to the strengthening of local structures that exist in their community, as well as their formation where they do not exist.” CHWs and their peer supervisors should encourage VDCs/WDCs to focus on community health issues.

The relationships of these community engagement stakeholders are illustrated in Figure 1.

IV. HOW ARE FMCS IMPLEMENTED?

FMC implementation, whether initiated by the DHMTs or an IP, should be harmonized with the MOHS vision for community engagement and with the national health sector recovery plan and related policies.

Community engagement is critical to Sierra Leone's transition from emergency response to recovery, and is an essential component of sustainability. The *FMC Training Manual and Tools* that accompany this guidance are designed to improve the effectiveness and sustainability of FMC strengthening efforts, as well as to inform future national community engagement approaches.

For community engagement to be effective at health facilities, these questions must be asked:

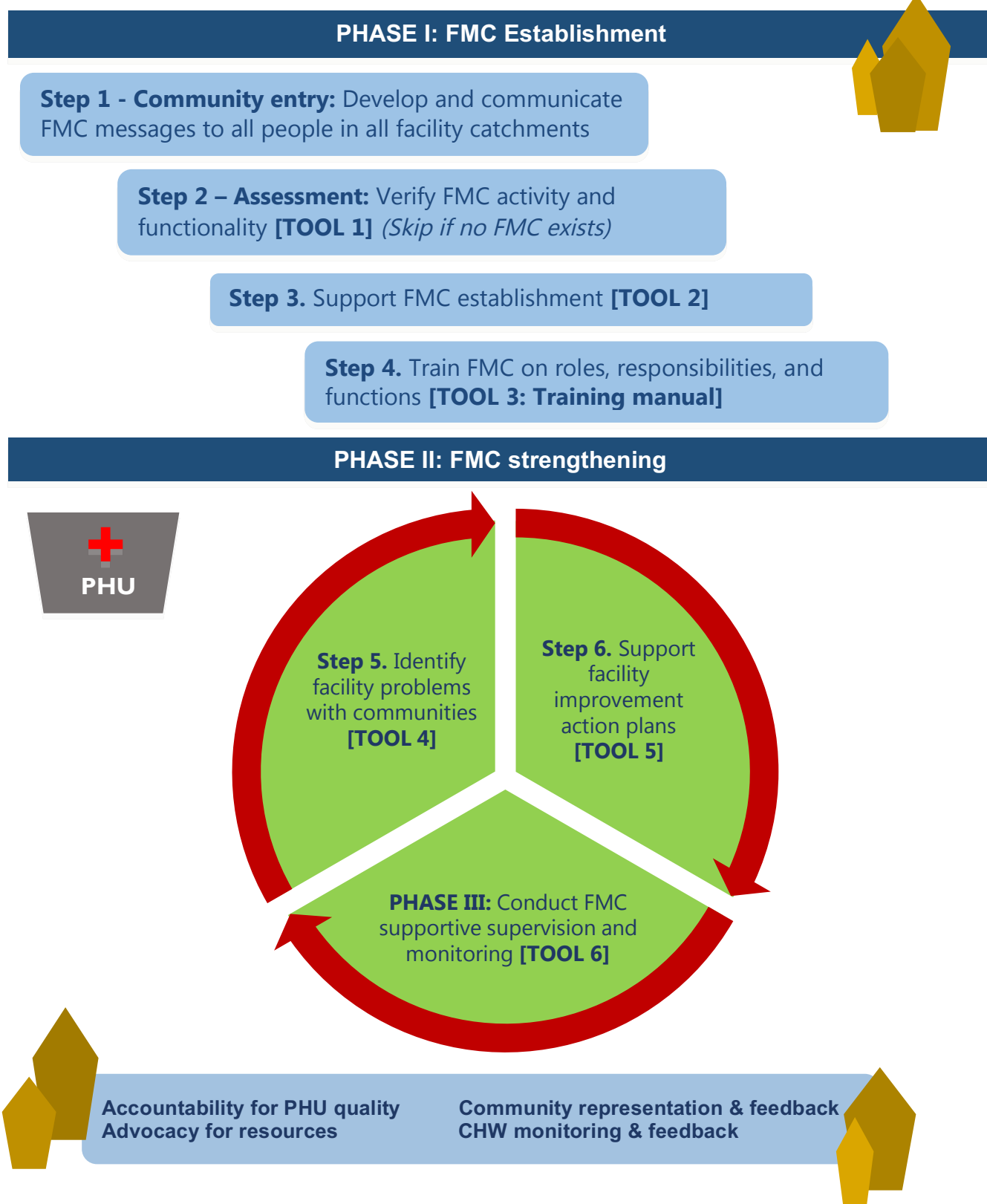
“Where are the community people? How can the community people be involved?”
« *Wae de pipul dem na dis ton? Aw di ton pipul dem go dae pan dis wok?*” *Krio translation*

Approaches for DHMTs and IPs might include:

- Supporting a strong community entry process when FMCs are established to ensure awareness of community engagement activities and a wide range of stakeholders.
- Cultivating good working relationships between the FMC and the DHMT to promote local ownership and sustainability. For instance, establishing a formal process of introducing new PHU staff to communities may help ensure a positive relationship.
- Encouraging the FMC and the community to take the responsibility for the functionality of PHUs and encourage community ownership by drawing on the volunteer spirit of groups and individuals.
- Encouraging and supporting functional FMCs, CHWs, VDCs and other groups that are concerned with family health.
- Strengthening links between communities and health providers (facilities and outreach activities) and links between FMCs and CHWs, VDCs, and other local groups.

Figure 2 outlines the recommended phases and steps for promoting FMC functionality and sustainability.

Figure 2. FMC Strengthening Activities by Phase



PHASE I: FMC ESTABLISHMENT

The DHMT and IPs should support community entry by developing and disseminating a harmonized communication strategy with community input. The strategy should present the roles, responsibilities, and value of an FMC and describe the process by which a PHU catchment community can establish or re-establish one.

IPs may support DHMTs in community engagement activities, including community entry, but should make the terms of support clear to each entity.

Step 1. Develop and communicate messages to all people in all catchment communities

Community entry is the process of visiting communities to meet people who live in and are familiar with the locality in question. At the meeting, the DHMT and IPs should communicate the proposed FMC strategy and guidelines to the PHU-in-charge and village chief/head, who in turn should explain expectations on health stakeholder roles and responsibilities to people in the PHU catchment area.

Considerations:

- Some catchment communities may have a difficult or distrustful relationship with PHU staff. In such cases, hold preparatory meetings (one with PHU staff only, and a second only with communities) so that attendees feel comfortable speaking openly. This will help the DHMT and IPs understand the staff-community relationship so that any issues can be addressed before all stakeholders are convened in subsequent meetings.
- All stakeholders involved in establishing an FMC—DHMTs, IPs, local council members, paramount chiefs, PHU staff, and community leaders and members—should ensure transparency and representation of entire catchment area in the FMC. Ideally, community members and their VDCs/WDCs will be represented on the FMC.

Verifying Step 1 outcomes: The DHMT and IPs can systematically track date(s) of community entry meetings held.

Step 2. Verify FMC and assess functionalities (skip to Step 3 if no FMC exists)

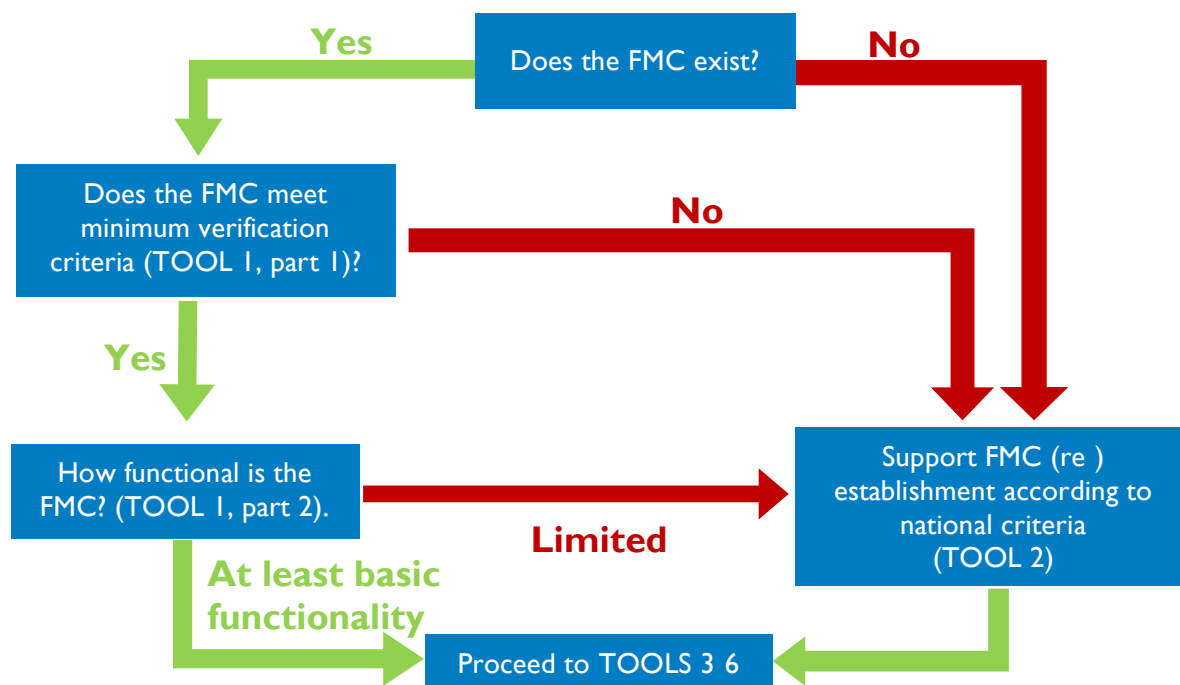
At the start of community engagement activities, the DHMT and partners should use TOOL 1, Part 1: Verification of the FMC (included in the *FMC Training Manual and Tools*) to ascertain if an FMC already exists, is active, has adequate membership, representation, and attendance.

If the minimum criteria are met, the DHMT and any partners may assess additional FMC functions using TOOL 1, Part 2: Functionality of the *FMC Training Manual and Tools*, which include questions about community feedback, meeting organization, financial documentation, CHW monitoring, advocacy and resource mobilization, accountability for PHU quality, and trainings and other capacity building. If the FMC does not meet the criteria, an FMC will be established or re-established (Step 3).

FMCs can respond to a wide range of community needs, including:

- *Raising funds to build a nurse's quarters at the PHU.*
- *Resolving conflict between health workers and community members to make the PHU a more welcoming environment.*
- *Promoting services available at the PHU, such as family planning counseling and methods.*
- *Participating in community dialogue and planning to prevent harmful practices, such as domestic violence.*
- *Asking nongovernmental organizations to partner in constructing a new PHU well.*
- *Creating a plan to respond to late-night emergency labor in a distant PHU catchment village.*

Figure 3. Verification and Functionality Process



Verifying Step 2 outcomes: The DHMT should document:

- The date that the FMC verification and functionality assessment tools were administered.
- FMC functionality assessment outcome (yes/no).

Step 3. Support FMC (re-) establishment according to national criteria

In catchment areas where no FMC exists, or where an FMC has limited engagement and/or functionality, the DHMT should work with the PHU, communities, and the VDC/WDC to (re)establish an FMC according to the process and criteria outlined in [TOOL 2: FMC \(Re-\) Establishment Guide](#) of the *FMC Training Manual and Tools*.

In some cases, this may mean reactivating an FMC that has been dormant in recent months or years. These communities will require the most intensive approach. At the start of revitalization, sensitize and engage all communities in the catchment area, reviewing the composition of the previously established, non-active FMC and validate it based on the membership and representation criteria outlined in Table 1.

Verifying Step 3 outcomes: The DHMT and partners should document:

- Date(s) of meeting(s) held to establish the FMC and select/elect members according to national criteria.
- Number of female FMC members selected/elected.
- Number of male FMC members selected/elected.
- Total number of communities contained within the PHU catchment area.
- Number of communities represented by the FMC.
- The FMC’s local name (to promote ownership and distinguish its identity).

Step 4. Train FMC on roles, responsibilities, and functions

The DHMT and IPs should use the standard content in [TOOL 3: FMC Orientation and Strengthening Guide](#) of the *FMC Training Manual and Tools* to orient FMC members to their roles and responsibilities. It is likely that these meetings will take place at the chiefdom, facility, or community level, and should include all FMC members for each catchment area when possible.

The training manual sessions include:

- Introduction: What is an FMC?
- FMC selection criteria
- FMC roles of executive and general members
- FMC community feedback mechanisms (PHU exit interview)
- Facility improvement action plan
- FMC meeting organization
- Advocacy and resource mobilization
- Financial management (*treasurers and secretaries only*)
- Monitoring and reporting (*executive members/secretary only*)
- Replacing members who leave or underperform

Verifying Step 4 outcomes: The DHMT and IPs should document:

- Date(s) that FMC training took place.
- Total number of FMC members (female and male) completing training.

PHASE II: FMC STRENGTHENING

In this phase, IPs and DHMTs will help FMCs develop and implement a facility improvement action plan. As illustrated in Figure 2, the steps of phase II happen on a routine (monthly) basis, and may be coordinated with other project or program interventions. Depending on the FMC's level of functionality, the approach to phase II activities may vary in intensity. The DHMT and IPs should schedule and coordinate FMC trainings to minimize the staffing gaps of PHU health workers and promote rotational trainings.

FMC functionality: It is expected that the FMC will be active and meet monthly or quarterly. Using the questions on FMCs for the DHMTs Integrated Supportive Supervision Checklist (TOOL 6 in the *FMC Training Manual and Tools*), at each visit the DHMT should record whether or not an FMC meeting took place during the last quarter.

Step 5. Identify communities' facility priority problems

Each month, the FMC should use [TOOL 4: PHU Exit Interview Form](#) to administer 12–20 exit interviews with clients after they receive PHU services. The FMC should also review the results each month. The DHMT and partners should provide technical support the FMC to use this standard approach to identify the facility's priority problems.

Verifying Step 5 outcomes: Using the questions on FMCs for the DHMTs Integrated Supportive Supervision Checklist (TOOL 6 in the *FMC Training Manual and Tools*), the DHMT should record:

- If PHU exit interviews have been compiled and shared with the FMC during this month (Yes/No).

Step 6. Support FMC facility improvement action plans

A key function of the FMC is to develop facility improvement action plans using [TOOL 5: Facility Improvement Action Plan](#). In this plan, the FMCs defines facility and community health problems and develop solutions in a participatory manner. The action plan specifies actions the FMC will take to address community and facility health priorities. FMCs, PHU staff, DHMTs, and IPs should make efforts to ensure that the plan targets health priorities identified by the communities in an inclusive, participatory manner. The action plans will help FMCs demonstrate measurable facility improvements and take steps toward greater community ownership.

FMCs may consider generating a special fund to support the implementation of their facility improvement action plans. The FMC Training Manual suggests ways to do this.

To build the confidence of newly established FMCs, it is recommended that they begin by targeting easily solved, tangible community health priorities.

Verifying Step 6 outcomes: Using the questions on FMCs for the DHMTs Integrated Supportive Supervision Checklist (TOOL 6 in the *FMC Training Manual and Tools*), the DHMT should record:

- If FMC facility improvement action plan is developed/updated during this month (Yes/No).

PHASE III: SUPERVISING AND MONITORING FMCS

It is recommended that stakeholders establish a process for storing and transmitting copies of FMC-related documents, such as PHU exit interview forms and facility improvement action plans, from the PHU to the DHMT and other relevant stakeholders.

For example, these forms might be printed on carbon paper so that PHU staff can simply tear off and submit copies to DHMTs during quarterly supervision visits. The original copy can remain at the PHU in a designated file cabinet.

In phase III, the DHMT and IPs should provide catchment area-level mentoring to promote individual empowerment and ensure that community leaders have the knowledge, skills, finances, resources, and commitment to sustain community health efforts. In contrast to the revitalization and skill-building activities of phase II, phase III activities will be led by the FMC with less support from the IP and the DHMT. FMCs should continue to solicit regular community feedback (TOOL 4); meet regularly to discuss issues and implementation progress on facility improvements (TOOL 5); replace members who leave or underperform (e.g., persistent failure to attend meetings) subject to

review by the DHMT; and report action plan progress to the DHMT and community. The DHMT and IPs can facilitate discussions among the committees and catchment area stakeholders to review action plan items and mitigate bottlenecks. In particular, the DHMT and IPs should create peer-to-peer support mechanisms across a district or chiefdom by pairing active and effective FMCs with less-developed FMCs.

FMC achievements can be celebrated at local festivals. Knowledge-exchange events can allow FMCs to reflect on success and challenges, propose solutions, support each other, and get guidance from project partners or the DHMT. IPs are encouraged to document and report community engagement success that they observe at PHUs and with community stakeholders.

Phase III Outcomes: Using TOOL 6: Questions on FMCs for the DHMTs Integrated Supportive Supervision Checklist (included in the *FMC Training Manual and Tools*), the DHMT should record:

- Any FMC facility improvement action plan items that have been achieved in the past month (Yes/No, and details if possible).
- Any supervision or mentoring visits that have conducted by DHMT/IPs in the past month.

V. TOOLS FOR FMC IMPLEMENTATION

Six tools were developed to support implementation of these guidelines. These can be found in the *FMC Training Manual and Tools* document, which is available from the MOHS DPHC and HED.

TOOL 1: FMC Verification and Functionality Assessment

This tool is intended for use by DHMTs and/or IPs to assess the status of FMCs at PHUs (whether they are established, active, and performing their key functions). This tool can also be used by the FMCs as a self-assessment tool.

TOOL 2: FMC (Re-) Establishment Guide

This tool is intended for use by DHMTs and/or IPs that are establishing or re-establishing that do not meet national standards. This tool advises on the process of community entry, FMC member selection, and election of executive members.

TOOL 3: FMC Training Manual

This tool outlines the methods and content for a three-day interactive FMC member training. It covers FMCs roles, responsibilities, key activities, and how they are managed. The training manual reflects the MOHS's standard approach to FMCs outlined in these guidelines and can be used by anyone supporting FMCs.

TOOL 4: PHU Exit Interview Form

This tool is to be used by FMC members to interview patients/client after they have used services at the PHU. It is meant to help the FMC monitor service quality and identify problems that it can help solve.

TOOL 5: Facility Improvement Action Plan

This tool is meant to be used by FMCs to plan actions that will help improve the PHU based on community priorities. FMCs use the tool to list priorities, plan actions, identify resources needed, specify a timeline for the actions, and track progress.

TOOL 6: Questions about FMCs for the DHMT Integrated Supervision Checklist

This tool has five questions that DHMTs can ask about FMCs during routine supervision visits to PHUs. The questions are formatted and scored to match the existing supervision checklist. IPs can also use this tool to monitor their support to FMCs.

VI. REFERENCES

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