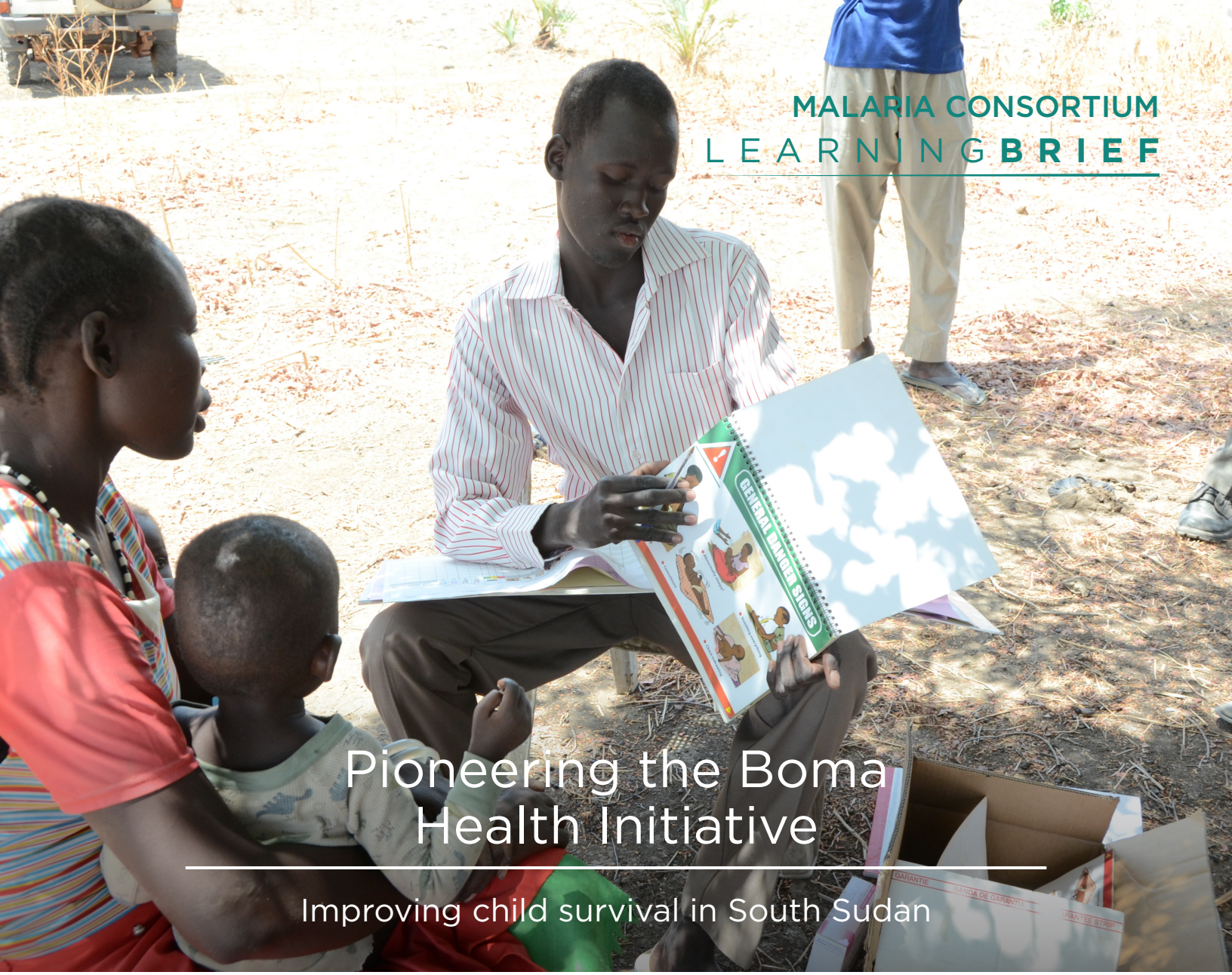

MALARIA CONSORTIUM

LEARNING **BRIEF**

Pioneering the Boma Health Initiative

Improving child survival in South Sudan

Key learning

- With appropriate training, supervision and resources, community members can provide an integrated package of essential health services to hard-to-reach populations, promoting healthy behaviours and helping to prevent and treat diseases.
- To ensure that women are not excluded from delivering this package of services to their communities, educational recruitment requirements should be gender equitable and provision made for women to attend training with their children if desired.
- Adaptive learning will be crucial to the tailoring of human resource capacity for the delivery and effectiveness of the BHI.

Background

Improving child survival remains a major challenge in the Republic of South Sudan. It has one of the highest under-five mortality rates in sub-Saharan Africa – 96 per 1,000 live births in 2017[1] – and has made slow progress towards achieving universal health coverage[i] and the Sustainable Development Goals. The burden of preventable illness for children under five remains extremely high, with pneumonia, malaria and diarrhoea the leading causes of morbidity and mortality, and malnutrition the underlying cause of around half of all deaths.[2]

Community-based primary healthcare – whereby trained community health workers provide basic and essential health services, such as integrated community case management (iCCM) of childhood illnesses, to underserved communities – is key to tackling these illnesses and, ultimately, to achieving universal health coverage.

Although such strategies have been implemented in South Sudan by international development and humanitarian partners over the last few decades, these have often been short term and limited in scope due to gaps in the country's health system. Since South Sudan gained independence in 2011, recognition of the need to strengthen the Ministry of Health's (MoH) ownership of iCCM services and their integration with primary healthcare systems has increased. Indeed, the country's National Health Policy 2016-2026 and Health Sector Strategic Plan 2016-2021 make clear the need for a formal community health system that ensures equitable, country-wide access to healthcare.

To this end, in 2016 the government launched its flagship strategy for community-based primary healthcare – the Boma Health Initiative (BHI). This outlines how communities will be reached with an integrated package of health promotion, disease prevention and treatment through a formal delivery system at *boma* (village) level. The BHI envisages community health workers being selected by their communities to form Boma Health Teams (BHTs) that would deliver this package of services – and register births and deaths – under the supervision of *payam* (the second lowest administrative unit) health officials and with the support of home health promoters (village-based volunteers who would promote positive health behaviours).

Pilot overview

Since 2017, Malaria Consortium has worked with the MoH in South Sudan and with state and county authorities and health departments in Warrap and Twic to pilot and roll out the BHI. Running April to September 2018, the pilot aimed to trial the feasibility of the structures and processes outlined in the BHI and, in so doing, to identify any adaptations required before the planned national scale-up.

Core stakeholders – from state, county, *payam* and *boma* levels, as well as non-governmental organisations, other implementing partners and local media – were engaged from the outset to ensure clarity on roles and responsibilities and to foster support for the pilot and eventual rollout of the BHI. This included meetings to assess the acceptability of BHTs to community leaders and health facilities.

The pilot saw BHTs recruited by communities and then trained by the MoH to: screen under-fives for malnutrition and refer cases onto health facilities, manage uncomplicated cases of diarrhoea, pneumonia and malaria in under-fives, provide safe maternal and newborn care, give advice on birth spacing, prevent, identify and treat communicable diseases, foster community surveillance of disease, register births and deaths, and deliver basic first aid. Although a voluntary undertaking, BHT members received incentives for their work.

It was intended that BHTs would be supervised by *payam* health officials, via group and individual supervision meetings and observation of household visits. This would highlight any challenges BHTs might have been facing, ensure their compliance with standards of practice and that quality care was being provided to community members, and assist the restocking of drugs and commodities (e.g. mosquito nets). To standardise monitoring of BHTs' progress and facilitate state-level decision making, it was planned that data on BHTs' activities would be submitted monthly to the District Health Information System and county health departments for inclusion in MoH reporting.

This brief outlines learning and recommendations from the pilot.

Activities

Malaria Consortium's contribution to the pilot included:

- assisting the MoH to build capacity to support the trial and eventual rollout of the BHI strategy
- establishing and leading meetings for the BHI technical working group
- reviewing BHTs' training guidelines, scope of work and reporting tools
- supporting the cascading of MoH training in Juba down to *payam* and *boma* levels
- providing supportive supervision of BHTs (via its Twic-based field officer).

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i Universal health coverage would see all people, including the poorest and most marginalised, able to access quality health services without suffering financial hardship.

Lessons learnt

The following lessons were identified during the pilot.

- Focus group discussions revealed high levels of **stakeholder engagement** with the pilot and awareness of its purpose and BHTs' roles. Participating communities reported being appreciative of the treatment offered by BHTs and, during meetings with their leaders, requested that services were extended beyond the pilot. This is promising for the rollout.

- Low levels of numeracy and literacy rendered many women ineligible for recruitment to a BHT, resulting in just 23 receiving training (compared with 41 men). This **gender skew** was problematic because male BHTs reported feeling uncomfortable discussing key issues – particularly those surrounding care during pregnancy – with female community members, which may have adversely impacted the quality of care and advice provided.

- It was not possible to recruit sufficient numbers of county-level BHT **trainers**, meaning that trainers had to be flown in from Juba at great expense. Not only was this cost-inefficient, but it also prevented BHTs from receiving the post-training support that would have been provided by county-level trainers.

- Facilitators of training sessions for BHTs chose to use participants' **training manuals** rather than their own as they felt the former had more content. Facilitators' manuals were also missing information on job aids and tools, as well as instructions on the post-training support that they should provide to trainees. This resulted in some key training content being omitted from sessions and may have affected the quality of training delivered and follow up provided to BHTs.

- **Training guidelines** did not include a checklist against which BHTs' skills could be assessed during training, which rendered standardisation of their performance challenging. To address this, Malaria Consortium developed skills checklists that were used during BHT members' visits to health facilities.

- **Training sessions** were too short, leaving insufficient time for participants to practise each skill under supervision.

- Despite receiving transport, food and accommodation **allowances** to attend training, additional costs of participation were not covered. This prevented some female BHTs with children from attending.

- Evaluation revealed that training built **knowledge and skills**. The majority of participants (83 percent) retained essential information and/or demonstrated core competencies and skills. However, a minority (11 percent) were found to have lower levels of related knowledge and skills. This could potentially be due to some female trainees having missed parts of the training while breastfeeding.

- The large **geographical areas** that some BHTs were required to cover precluded them from being able to complete household registration within the allocated timeframe as they had to balance this activity with the timely provision of treatment. That they also had to travel between locations via MoH-supplied bicycles, for which no maintenance provisions had been made, further hampered their attainment of household registration targets.

- **Communities' access** to BHTs' services was also affected by competing livelihood priorities and entrenched sociocultural norms. While BHT members often provided services early in the morning or in the evening, frequently their other livelihood commitments prevented them from being available during the day. Sociocultural norms further restricted communities' access to BHTs' services during adverse weather as these precluded non-family members from entering private spaces (i.e. seeking shelter).

- Links between health facilities and BHTs for drugs and other commodity-related support were not well defined in the BHI. As a result, when BHTs experienced **stock-outs**, they waited for new commodities from implementing partners rather than collecting these from local health facilities that had ready supplies. To strengthen these links and avoid stock-outs (particularly in hard-to-reach areas), Malaria Consortium responded by pre-positioning commodities in some health facilities.

- Despite the BHI charging the MoH with recruiting and remunerating *payam* health officials to support and monitor BHTs, this did not take place during the pilot period. As a result, BHTs' were left without immediate **supervision** and *payam*-level monitoring and reporting was incomplete.

Recommendations

Based on these lessons, Malaria Consortium compiled the following recommendations. We presented these – along with our findings and lessons learnt – to the MoH, the UK Department for International Development, the BHI technical working group and the National BHI Coordinator. They agreed to adopt recommendations three, four, five, six and eight (the latter had already been under discussion), and to partially adopt recommendation two..

1. Further scale-up of the BHI strategy should be underpinned by **adaptive learning**[ii] practices that are embedded into MoH and implementing partners' plans and budgets. This will strengthen the MoH's capacity to lead an effective rollout and ability to oversee timely, context-specific modifications.

2. As more BHTs are required to support the timely and effective delivery of BHI activities, the MoH should undertake a review of **human resource capacity** before scale-up commences. This should explore the potential of transitioning community health workers – particularly those already delivering iCCM (e.g. in Warrap state) – into BHTs, and expanding home health promoters' roles to also include some BHI activities. This would build capacity and, potentially, reduce BHTs' workloads.

3. As indicated in the BHI strategy, *payam*-level supervisors should be recruited as early as possible in the scale-up to avoid gaps in BHTs' **supervision**, effective mentorship and on-the-job training, and ensure that high quality services are provided by BHTs.

4. The BHT **training programme** should be revised to address identified gaps. Increasing the training period from one to two weeks, with an additional week for practical sessions at local health facilities, would be beneficial. Staggering and punctuating training modules with periods of implementation that are monitored closely by supervisors would also be prudent as it would ensure that new content and skills are mastered before trainees proceed to the next module.

5. A full review of the **training guides and tools** should be undertaken by the BHI technical working group. This should include addition of a skills checklist to standardise assessment of trainees and help promote their self-assessment and continuous improvement, as well as provide clarification of appropriate next steps for participants following training.

6. In order to increase sustainability, BHT training should be undertaken by **county trainers** with support from *payam* supervisors. This will help to reduce training costs, maintain a pool of support for BHTs at county and *payam* levels and, ultimately, improve the quality of services provided by BHTs.

7. The MoH should address the BHI's identified **gender** constraints before commencing scale-up. The educational requirements for the post of a BHT member should be gender equitable so that more women are eligible to be recruited. To achieve this, female and/or adult literacy could be promoted as part of the BHI strategy. The MoH and donors should also increase the budget for BHT training so that it covers the costs of mothers who wish to attend BHT training with their children.

8. Drugs should be pre-positioned at health facilities quarterly and the role of health facility staff within **supply chain management** plans should be clearly defined (by the MoH) in the BHI strategy. This will enable BHTs to acquire supplies when required and health facilities to manage BHT drugs and other commodities effectively.

9. The MoH should ensure that all bicycles distributed to BHTs include a repair and service kit to enable community-level **maintenance**.

10. Further **evidence** around the cost-effectiveness of the multi-component integrated package of the BHI and sustainability, as well as the BHI's contribution to strengthening health systems, community resilience and gender transformation, is needed. Malaria Consortium aims to generate this as implementation continues into the next phase.

ii Adaptive learning describes a systematic approach to learning from experience, making iterative course corrections and adapting plans in response to new knowledge.

References

1. United Nations Children's Fund. South Sudan country profile. New York: Unicef; no date. Available from: https://data.unicef.org/country/ssd/.
2. Rice AL, Sacco L, Hyder A, Black RE. Malnutrition as an underlying cause of childhood deaths associated with infectious diseases in developing countries. Bulletin of the World Health organization. 2000; 78:1207-21.

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Cover image: Community health worker uses a job aid to explain the danger signs that caregivers should look for, South Sudan

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