POLICY BRIEF:

COMMUNITY HEALTH INTERVENTIONS IN SOUTH SUDAN

Despite the conflict in South Sudan, community health programmes such as integrated community case management for communicable diseases and neglected tropical diseases have been successful.

South Sudan has experienced significant levels of fragility, conflict, and violence for nearly half a century. It is estimated that over 400,000 lives have been lost since 2013 due to conflict and millions more have been displaced. With very limited access to basic health services, South Sudan has some of the worst health indicators in the world, with mainly women and children affected. The health system is underdeveloped and non-governmental organisations (NGOs) provide nearly 80 per cent of the services. Where they function, health services are particularly constrained, poorly aligned and lacking in coordination, meaning access by the community is limited.

Crown Agents is the managing agent of the Health Pooled Fund (HPF), which strengthens the government's capacity to meet basic needs, providing approximately 10 million people with health care services. The HPF is now the single largest provider of life-saving healthcare in 80 per cent of the country, supporting at least 800 health facilities.

In March 2017, the Ministry of Health (MoH) launched the Boma Health Initiative (BHI), a community health system strengthening initiative intended to bridge the gap between health facilities and communities. It is designed to increase equitable access to community health services, and the participation of communities in promoting ownership and sustainability of the health services.

To achieve the BHI goal, trained and full-time salaried community health workers (CHWs) would be responsible for delivering a standard, integrated basic package of promotional, preventive, and selected curative health services, focusing on:

1. Child health
2. Maternal and infant health
3. Control of communicable and non-communicable diseases
4. Disease surveillance
5. Reporting of service delivery data and vital statistics.

The MoH has taken steps to roll out the BHI strategy (but this is hampered by inadequate funding and ongoing conflict) and established a secretariat to oversee the overall implementation and a technical working group to provide advisory support. The MoH conducted introductory meetings on the strategy, developed training packages and reporting tools for Boma health workers (BHWs), and conducted a costing and investment analysis to guide resource mobilisation.

As the BHI is new and lacks documented evidence of its practice, KIT Royal Tropical Institute, a consortium partner of HPF, undertook a study to guide its implementation in a more resilient and sustainable manner. The findings of the study will be used by the HPF programme to enhance community engagement and to improve health outcomes across the country.

APPROACH

The study was designed to explore the characteristics, barriers and facilitators to implementation of community health interventions in the areas supported by the HPF programme, and to inform further scale-up. It covered eight out of the ten states with participants from the MoH, HPF implementing partners, UN Agencies, and other NGOs. The participants were selected based on their current or previous experience in the health sector, specifically in implementing community health programmes.

SUMMARY OF FINDINGS

Given the challenges accessing services in the country, the provision of community health programmes is very important, as is community participation in the selection of CHWs, the intervention areas, and the supervision of health activities. Using CHWs to provide the services has made them acceptable to the community members, and therefore played an important role in community mobilisation and the promotion of service utilisation.

Community health programmes have improved access to health services because the communities selected and trusted the CHWs to provide services within their reach. CHWs can cover areas where no health workers based at health facilities are able, and therefore identify warning signs among mothers and children allowing for early referral.

The use of simple pictorial training materials and reporting tools facilitated both learning and reporting, and the sensitisation meetings held with various community stakeholders before services were introduced in the community were critical.

Quarterly review meetings held by implementing partners and other stakeholders provided good avenues for disseminating information to and getting feedback from communities. Supportive supervision, on-the-job mentoring, and the provision of incentives also had a significant effect on motivation. The community health programmes have generally been successful, for example, the community surveillance system, in which CHWs play an important role, has meant that Guinea worm, once endemic, is now nearly eliminated.

Where integrated Community Case Management (iCCM) has been implemented, there has been improved access to malaria, pneumonia and diarrhoea treatments for children under five, leading to a presumed reduction in child deaths and improvements in health education activities.

Community dialogue sessions and advocacy meetings have helped to improve the uptake of maternal and child health services and where they exist. Boma Health Committees (BHCs) contributed to improved WASH activities and supported health campaigns such as the construction of pit latrines and the organisation of national immunisation days. Working with communities helped in the organisation of regular integrated outreach services in hard-to-reach areas, coupled with improvement in uptake of family planning services and addressing issues related to the prevention of gender-based violence.

RECOMMENDATIONS

Community participation:
Implementing partners should work closely with the county health department and local authorities to validate the existing BHCs, dormant BHCs should be reactivated, and where they do not exist, partners should work with the local leadership to guide their formation, taking the local power context into consideration. Every BHC must be trained in their roles and responsibilities.

Mapping of the intervention areas:
The implementation of community health services must be rooted in a thorough understanding of contextual needs. For this purpose, a mapping of the local geography and population distribution, including hard-to-reach areas and communities, local morbidity trends and available human resources has to be made. This will help in understanding the vulnerabilities of communities and the priorities for the allocation and distribution of resources.

Selection of community health workers:
BHWs should be selected based on the guidelines listed in the BHI strategy documents. Given the low literacy levels for women in the country, the education requirements should be adjusted to avoid gender disparities among the BHWs, and special consideration should be given to people living with disabilities who are willing to participate.

Training:
Training should be based on the newly developed curricula, and the materials should be in a language understood by the community members, preferably with pictographic illustrations. The training should be competency-based rather than being theoretical, allowing participants to gain the necessary technical and social skills. Training should be done in phases in the environment where the trainees will be working and followed by practice under the supervision of a qualified health worker from the nearest health facility. Refresher training should be used to reinforce knowledge and skills, and to include new developments in the programme.

Supportive supervision:
Regular supportive supervision must be provided with clearly defined objectives for measuring knowledge, skills, competencies, motivation and adherence to the standards provided in the Boma Health Team handbook. Supervision should also provide opportunities for learning, problem-solving, community feedback, and quality assurance. To ensure embedding into the health system, the nearest health facility should take a leading role in the first line of supervision.

Motivation and remuneration:
When BHWs are recruited and trained, they should be provided with appointment letters, job descriptions, and be included on the government payroll. As the BHI is meant to harmonise all the community health activities in the country, the incentives should be standardised to ensure retention.

Performance management and career development:
The MoH should develop standard guidelines for regular performance appraisal. The BHWs should have job descriptions with specific roles and responsibilities, working conditions, reporting lines, remuneration and rights, and a career pathway should also be created to legitimise their work and improve retention.

Community health information management system:
The MoH should develop user-friendly reporting tools and registers that include pictographic illustrations. During training and supervision, sufficient time should be dedicated to recording and reporting data. This will improve the completeness and quality of data collected, and reporting can be used as one of the standards for measuring performance, the payment of incentives, and making informed decisions.

Availability of medical commodities:
The HPF supply chain management of medical commodities has been efficient in supporting the distribution of drugs. Until the government develops its capacity, this same supply chain route should be used to supply drugs for the BHWs. The BHW supplies should be pre-positioned at the nearest health facility where BHWs work and to serve as a replenishment centre for the community activities. This will also facilitate supportive supervision on usage and reporting as well as improve linkages between the health facilities and the BHWs. For BHI to succeed, there is a need for uninterrupted supply of drugs and other medical commodities. Currently, nearly all drugs are procured by the donors, therefore, the MoH should allocate funds to support the procurement and supply of medical commodities in their annual national budget.

Funding mechanisms:
The MoH should provide more resources to support the BHI strategy. Funding from the government may be incremental, but this commitment is required to ensure sustainability. The government can also lobby for more material support from other countries and private sector organisations as part of their corporate social responsibility.

Coordination, linkages, and inter-sectoral collaboration:
The MoH, through the BHI secretariat, should take a leading role in coordinating with those working or supporting the health sector, at national and state levels to provide their input by engaging in policy dialogues, exchanging information, participating in joint decision-making and mobilising resources for the implementation of BHI. This coordination within the health system should cascade from the national level down.

To ensure that BHWs are fully embedded into the health system, there should be linkages to between CHWs and the nearest health facilities. This will enhance appropriate supervision, the supply chain for drugs and commodities, referral of clients, and accountability. This will also contribute to the sustainability of the community health programme in the country. The involvement of the communities in preventive services could reduce cultural and other barriers to using services.

KEY TAKEAWAYS

Tailored Interventions
A situational analysis and mapping should be done to tailor interventions to the actual context.

Training
Adequate time should be allowed for training. The training activities should be done in phases based on the programme packages, and the materials should be simplified.

Supervision and Reporting
Supervision should be strengthened by making it regular and supportive and that the reporting tools should be simplified.

Motivation
Incentives for community health workers should be harmonised across all community health programmes.

Coordination and linkages
The coordination of community health activities should be improved at all levels.

Funding for community initiatives
The government should lobby donors for more funding for community health programmes.

CONCLUSIONS

The majority of the barriers to effective implementation were the result of insufficient coordination mechanisms. Other important issues, such as poor infrastructure, and outbreaks of violence, and the unsustainable nature of health programmes, which are funded entirely by donors, are beyond the scope of the programme.

In general, community members are happy to participate in the implementation of health initiatives that will benefit them, and community health programmes of any kind can thrive when community members are engaged in every step of the implementation process.

If the BHI strategy is going to be effectively implemented, robust coordination efforts are required to build connections and cooperation among stakeholders, but it is clear that community health programmes can be successfully implemented in a conflict situation if local human resources are leveraged, engaged, and nurtured.

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