Health Pooled Fund
South Sudan

HEALTH POOLED FUND LEGACY BRIEF

Supporting Community-based Health Services in Fragile and Conflict-affected Settings

Authors: To come

Supporting Community-based Health Services in Fragile and Conflict-affected Settings

In 2012, the government of the United Kingdom (UK) launched the first iteration of the Health Pooled Fund (HPF) which was designed to improve health outcomes in South Sudan. HPF was a consortium of partners led by Crown Agents and included International Procurement Agency (IPA), Royal Tropical Institute (KIT), and Montrose International. As it was originally conceived, the HPF was designed to increase access to quality health services particularly among women, children, and other vulnerable groups.

With support from other country governments (Government of Canada, the Swedish International Development and Cooperation Agency, the United States Agency for International Development, Global Alliance for Vaccines and Immunisation, and the European Union), the UK Foreign Commonwealth and Development Office (FCDO) -led HPF programme supported the delivery of South Sudan's health strategy by comprehensively funding the delivery of a basic package of health services covering health units and facilities up to the county hospital level. The third phase of HPF, which began in late 2018 and largely operated in eight states, aimed to reduce maternal and child mortality rates in South Sudan through the continued delivery of a basic package of health and nutrition services, promoting community engagement in health as a public good, and through the stabilization of the local health system

Operating Context.

HPF has operated within a context of immense population health needs, a weak health system, and sustained turmoil. War in South Sudan devastated health care infrastructure in conflict areas and resulted in high levels of internally displaced populations, multitudes without medical care, and a population dependent on humanitarian aid for their survival. Conflict exacerbates rates of morbidity and mortality through flight of healthcare workers and interruption to delivery of drugs and medical supplies. Also hindering access to health care was the fact that about 56% of the population lived more than five kilometres away from a health facility. Because of limited access to care, standard health metrics were weak (e.g., the maternal mortality rate in the country is high and children, especially those under the age of five, suffer from poor health and nutritional status).

" DESPITE THE PREVAILING CHALLENGES, SOUTH SUDAN HAS THE POTENTIAL TO IMPLEMENT COMPREHENSIVE HEALTH PROMOTION EFFECTIVELY. THE BOMA HEALTH INITIATIVE PROVIDES A CONDUCIVE PLATFORM AND OPPORTUNITY TO FULLY EMBRACE AND IMPLEMENT HEALTH PROMOTION INTERVENTIONS AT [THE] COMMUNITY LEVEL THAT WILL CONTRIBUTE TOWARDS ACHIEVING THE UNIVERSAL HEALTH COVERAGE AND HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS."

MR EVANS LIYOSI,
WHO REPRESENTATIVE
TO SOUTH SUDAN

Against these difficult operating conditions, each of the three HPF phases, which collectively spanned over a decade (2012-2024), successively expanded their efforts to improve the public health care system. Essential to this effort was creating strong linkages between remote and under-resourced communities to primary health care services. With this understanding, HPF and partners supported the Ministry of Health (MoH) to launch a community-based health strategy in 2017 called the "Boma Health Initiative (BHI)" whose main goal was to provide accessible and free health care to communities across South Sudan with a special focus on hard-to-reach areas and vulnerable populations including women, girls, and children. The BHI had the following objectives:

- develop a community health structure as a formal component of the national health system at the Boma level,
- provide leadership for the implementation of the BHI through inter-sectoral collaboration and community participation,
- increase access to quality health promotion, disease prevention, and selected curative services through community engagement and trained community health workers, and
- formalize the role of community-level health workers, called Boma health workers (BHWs), in South Sudan.

In 2018, the second phase of the FCDO Integrated Community Case Management (iCCM) programme, which funded the training and supervision of community health workers to treat children under-five in hard-to-reach areas, was transitioned to HPF and incorporated into the BHI. The BHI began in earnest in 2019 when 1,840 BHWs were trained along with 91 supervisors to deliver child health services across 23 counties. The programme then expanded into an additional 32 counties in early 2020 with another wave of recruited BHWs totalling around 4,400 in 55 counties across8 States. These BHWs are permanent members of their communities, selected by the community, and willing to serve their community with near constant availability.

The BHI training curriculum consists of multiple modules packaged into three phases including (phase 1) child health, which encompasses iCCM; (phase 2) safe motherhood, family planning, and gender-based violence; and (phase 3) communicable diseases, first aid, and vital statistics; which are all aimed at addressing the most pressing health concerns across the country. Additionally, and in collaboration with the national MoH, HPF developed BHI supervision guidelines and tools to address the supervision of BHWs. Specialists within HPF collaborated with master trainers from the MoH to provide technical trainings on the above-mentioned modules. Furthermore, HPF's deeply rooted relationship with the MoH contributed to an effective and efficient roll-out of the BHI programme. Through HPF3's implementing partners, the programme provided the necessary equipment and tools to the trained BHWs inclusive of commodities for treatments and monthly incentives.

The BHI on the dignity, worth, and rights of people

Convention on child rights: The BHI delivered community-based health services such as referral for immunizations, nutrition assessments for children, and treating childhood illnesses such as diarrhoea, pneumonia, and malaria. BHI also promoted referral of pregnant women, birth spacing, etc.

Convention on the Elimination of All forms of Discrimination against Women: The BHI addressed aspects of gender such as inclusion of both males and females in communities across South Sudan as BHWs and their supervisors, and in the planning of community health programmes and efforts to curb gender-based violence, of which women and children are the most affected.

Human rights of persons with disability and mental health conditions: HPF3 continuously carried out community sensitisation/awareness sessions on disability and mental health inclusion to reduce cultural, environmental, and institutional barriers; promote an understanding of disability and mental health issues; and mobilise support for the rights, dignity, and well-being of persons with disabilities and mental health conditions. Guidance materials and tools have been provided to BHWs to integrate disability into their community engagement activities, including promoting the health needs of people with a disability and mental health conditions, and service referral.

Key Accomplishments

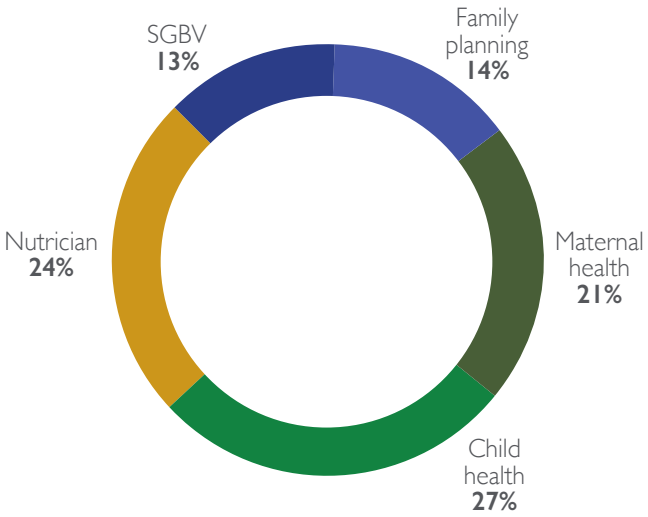
The BHI was designed to expand the reach of the health system by establishing a formal health structure at the Boma level to deliver an integrated package of promotional, preventive, and selected curative interventions. The BHI contributed to a systems' strengthening approach by building local capacities and enhancing the ability of trained BHWs to address community-level health issues.

BHI-related activities increased access to health care; health facility births; treatments received for malaria, uncomplicated pneumonia, and diarrhoea; and mobilization of the communities for immunizations, defaulter tracing (i.e., finding children who missed their scheduled immunization), and subsequent referral to the nearest health facility. Thanks in part to the MoH and HPF's work to ensure access to health care, BHI contributed to the improvement of universal health care coverage. With increased push to eliminate neonatal tetanus and polio among children under-5, there was an overall reduction in associated morbidity and mortality rates. These efforts can be directly linked to Sustainable Development Goal 3: "Ensure healthy lives and promote well-being for all at all ages" by 2030.

To further improve overall vaccination rates, HPF3 conducted a pilot programme that intentionally increased the frequency of coordination meetings between vaccinators and BHI supervisors. Vaccinators would compile the list of children who defaulted, BHI supervisors would disseminate to the BHWs, and the BHWs would follow up with the children to ensure that they were referred to the health facility for vaccination. The pilot observed increased accountability and as a result, the average defaulter rate, which was 34.1% in May 2023 before the pilot, reduced to 10.3% in October 2023 when the pilot ended.

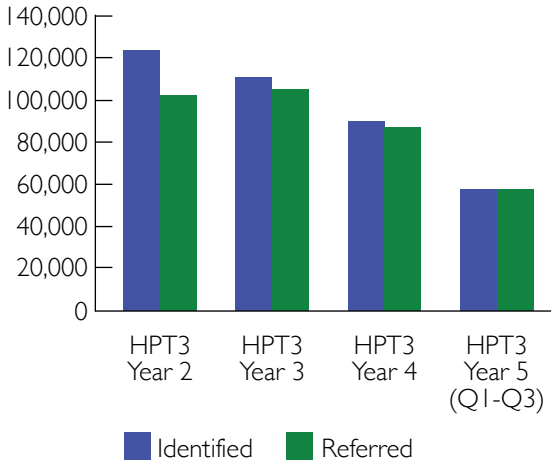
The progressive performance in figure 2 resulted from various strategies that were used. For example, by working closely with the health facility in-charges and community leaders, the BHWs and boma chiefs facilitated and enabled outreach and mobile immunisation services in location with high defaulters and zero dose children to be strengthened. Access to information and direct services were increased, making it easier for caregivers to not just access vaccination sites, but gain an understanding of the benefit of their children receiving vaccinations as well as their vital involvement in this process.

Figure 1. Distribution of family health sessions given during the final two years of HPF3. A total of 7.2 million sessions were dispensed between April 2022 and December 2023.



The HPF programme also developed a gender equality and social inclusion strategy which was integrated into all stages of the programme cycle. Additionally, HPF ensured provision of guidance materials and tools to BHWs to integrate disability into their community engagement activities, including promoting the health needs of people with a disability and service referral. The actions of the BHWs also contributed to addressing the six pillars of safe motherhood (antenatal care, childbirth, postnatal care, both maternal and child nutrition, and child spacing) and enhanced health seeking behaviour of people in South Sudan.

Figure 2. Number of children in the community below one year who have been identified as immunisation defaulters and referred to health facilities for follow-up.



Key BHI achievements across HPF-supported states

- **382,260** children in the community below one ear were identified as immunisation defaulters and **92%** were referred to a health facility for follow-up.
- **5,925,136** treated cases of diarrhoea, pneumonia, and malaria for children under the age of five years at the community level.
- Over **12 million** community health sessions were delivered by BHWs including **3,921,181** related to child health, **3,379,587** on nutrition, and **2,783,011** on maternal health.
- Survey data from late 2022 showed that most household members were aware that the BHI had been initiated in their localities. These data also showed that **96%** of household respondents knew the BHW in their communities and that **95%** of surveyed people reported to have accessed health care services through their BHW.

BHI County focal persons were trained on the HPF3 demand creation strategy which they cascaded to supervisors and BHWs in their counties. This training provided BHI-affiliated workers an opportunity to improve their knowledge and skills and to ultimately increase the health literacy of the communities they serve. One of the many topics covered by BHWs during their community health sessions was family planning. HPF3 attributes a comparatively better performance in contraceptive coverage among HPF-supported states thanks to these sensitization activities alongside HPF3 facilitation of last mile delivery of family planning commodities, and continued capacity building of staff to administer contraceptives, among other factors. Additionally, the work of BHWs across HPF-supported counties created demand for nutrition services via health nutrition sessions and through screening for malnutrition at the Boma level. HPF was able to meet the demand for nutrition-related services through rigorous screening and active case finding as well as orientation of nutrition assistants on community management of acute malnutrition at all public health care centres and hospitals. HPF3 also credits improved health seeking behaviour for facility-based deliveries to the implementation of the BHI demand creation strategy.

Community members and stakeholders expressed excitement about the BHI project to the extent that most community leaders have taken ownership by participating in BHW supervision activities and providing feedback on the performance of each BHW under their jurisdiction.

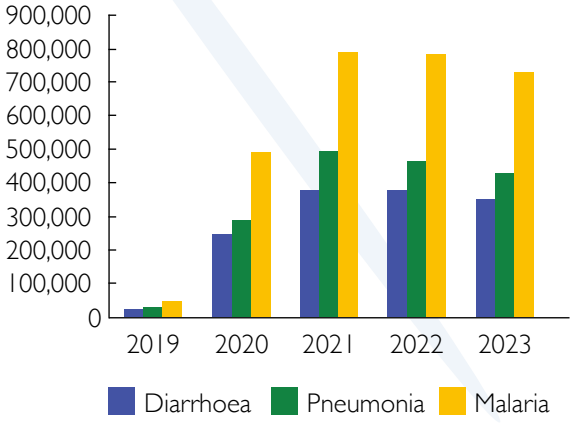
Increasing trust from the community in the work done by BHWs has similarly contributed to the achievement of child health treatment milestones. Because of this early initiation of treatment, some health workers and community members reported drastic decreases in cases of severe disease conditions in children in both community and peripheral health facilities.

It is also worth noting that community health reporting through the BHI has shown tremendous improvement (from 54% in Year 1, to 85% in Year 2, to virtually 100% of all supported Bomas in Years 3-5). This progress was attributed to HPF3 working in close collaboration with humanitarian and state actors which ensured that reporting areas were included in the health management information system and that appropriate training on data collection was provided to BHWs and their supervisors.

Way Forward

In 2021, the MoH conduced an analysis to determine the number of BHWs and supervisors required for national implementation of the BHI. The number of households requiring services far exceeds current BHW capacity. BHWs are often required to cover well over 300 households within their Boma, compared with the expected 40 household allocation. To address this challenge, HPF3 has continued to advocate for additional resources to add more BHWs on the ground and increase the quality and scale of the programme. Currently, there is also a lack of strategy within the BHI to reach disadvantaged communities such as nomads, fishing communities, urban poor, and internally displaced populations. HPF is actively advocating with the MoH to amend the strategy to include a selection of BHWs for these populations and in these locations, with a revised service package.

Figure 3. Number of children under 5 receiving treatment in the community for diarrhoea, pneumonia and malaria.



At the end of HPF, 92% of BHWs and their supervisors were male. Feedback from HPF's implementing partners suggested that the gender imbalance (male/female representation) amongst BHI programme staff was attributed to low female literacy levels, meaning that during recruitment, most of the applicants were male. Throughout implementation, HPF3 actively worked with implementing partners to encourage the recruitment of more female staff.

Recommendations

- Additional operational research needs to be conducted to better understand what the optimum ratio of BHW to population should be.
- The State MoH and county health department officials including health facility staff need to embrace the BHI as an extension of the formal health system in the community. The Health Committees are encouraged to support the BHWs in providing awareness to community members to lessen the workload associated with health promotion.
- The MOH to revise the BHW recruitment guidelines/procedures to allow for females with lower educational qualifications/ standards to be recruited and then later enrolled in an adult education program specifically designed for them in collaboration with the Ministry of Education and the relevant partners. Fostering opportunities for women to become BHWs and BHI programme staff, enabling clear prospects for career progression will not only benefit individual girls and women, but also communities and the economy.
- Due to the wear and tear of BHI working equipment, funding to be set aside for the repair and or procurement of these necessary items.

References

1. GFATM/UNDP. (2016). Global Fund Project for South Sudan, 2016 Annual Report.
2. HPF (2013). Business Case: Integrated Community Case Management (ICCM) South Sudan
3. HPF (2018) HPF Annual Report (2017-2018)
4. NTEGRITY. (2018). Evaluation of South Sudan Health Pooled Fund Final Report.
5. HPF3. (2021). HPF3 Annual Report 2020-2021.
6. WAP (2023). Mini-Household Health Survey using LQAS in four Health Pooled Fund supported States

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