Community Health Systems Strengthening: Boma Health Teams Training at Jonglei State, South Sudan

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Abstract

The Boma Health Teams training report was part of my capstone project. South Sudan like other developing countries has critical skilled human resources for health (HRH) challenges that have dramatically impeded timely delivery of basic health care services. The country is characterized by sparse population settlements, semi mobile communities, few qualified health workers and poor health seeking behavior among some communities and social groups which has hampered effective delivery of health services to all citizens. Only 44% of the population has access to health care services as a result the maternal, new-born and child health indicators are amongst the worst in the world. The training of Boma Health Teams (BHTs) was conducted to address the skilled health personnel gaps by having community owned resource person to deliver health services within reach to increase access and create demand for health care service utilization. The participants were identified and selected within the community by the community. The training was designed and offered through 30% of the time for modified lectures, 20% of the time on skills demonstration and return demonstration using models and Mankins in the training hall and 50% of the time for supervised skills practice at a health facility and community settings. Learning was assessed through written and practical pre-and post-tests.

Keywords*: Boma health team, community health system strengthening, human resource for health.*

Introduction

The Republic of South Sudan is characterized by sparse population settlements, semi mobile communities, few qualified health workers and poor health seeking behavior among some communities and social groups has hampered effective delivery of health services to all citizens' especially rural communities and some social groups (Human Resources for Health Strategic Plan, 2017-2021).

About 56% of the communities have no access to health services in South Sudan. Where the health services exist for the 44%, they are not within easy reach of most communities, not of good quality, not age and gender sensitive or not sought by the communities due to a myriad of other factors (National Health Sector Development Plan, 2016-2021). The maternal, new-born and child health indicators are amongst the worst in the world. Maternal mortality ratio (MMR) of 789 per100, 000 live births, newborn mortality rate (NMR) of 39 per 1,000 live births, infant mortality rate of 75 per 1000 live births and under five mortality rates of 106 per 1000 live births (UNFPA,2018).

The recurrent armed conflict in South Sudan has exacerbated public health challenges, which were already evident. The six building blocks of the health systems (governance, health financing, human resources for health, health information systems, logistics and pharmaceuticals, and service delivery) were greatly affected during these armed conflicts. The National Health Policy (2016-2026) priority is the rehabilitation of the health sector to address the immediate health needs of the South Sudanese population. In particular, the country is moving towards restoring or establishing (where they did not exist before) a package of essential health services as well as rehabilitating of the health systems as a whole (Boma Health Initiative Strategy, 2016).

The training of Boma Health Teams was conducted to address the skilled health personnel gaps by having community owned resource person trained to deliver health services within reach to increase access and create demand for health care service utilization. The participants were identified and selected within the community by the community and trained at local setting. This is in line with the

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National Health Policy (2016-2026) objective two (2) that prioritize the scale up the production of human resources for health and strengthen health services management and effective delivery of the Basic Package of Health and Nutrition Services (BPHNS). The BHTs training was conducted as part of my capstone project. The purpose of training community owned resource persons is to create access to skilled health provider, access to health care service, create demand and service utilization while improving community life style through behavior change and best practices through health promotion and disease prevention activities.

The training was designed and offered through 30% of the time for modified lectures, 20% of the time on skills demonstration and return demonstration using models and Mankins in the training hall and 50% of the time for supervised skills practice at a health facility and community settings. A total of 30 participants (21 males and 9 females) drawn from the ten (10) Bomas of Jonglei State were trained. The participant were mainly primary school leavers and a few secondary school dropouts. Learning was assessed through written and practical pre-and post-tests.

General training objective

The general objective of the training was to produce adequate and competent community health workers (Boma Health Teams) with basic literacy, numerical and health skills required for the delivery of the Basic Package of Health and Nutrition Services (BPHNS) at community (Boma) level in Jonglei State.

Specific training objectives

1. To equip the BHTs with better understanding of the BPHNS to be delivered by them to individuals, families and the community.
2. To prepare work-plans (weekly and monthly) for the BPHNS services delivery in the Boma
3. To conduct home visits and community mobilization for health promotion activities.
4. To assess, classify, treat, counsel and refer patients and clients who requires specialized skills in the various health facility levels.
5. To conduct disease surveillance, prepare and submit timely reports to the appropriate health authorities.

Training packages

Table 1. Boma health initiative training packages and content.

Package	Content
Introduction to Boma Health Imitative (BHI and Boma Health Initiative	Basic packages of health and nutrition services at community level (BHI service package), Communication skills, Ethical code of conduct, Roles of BHTs, Community mobilization skills, Community Based Health services organization and management skills
Child Health	Introduction and General Danger sings, Malaria in children, Pneumonia in children, Diarrhea in children, Childhood preventable diseases, Food and childhood nutrition
Safe motherhood	Components of safe motherhood, Antenatal care safe and clean child birth, Postnatal care, Child spacing and family planning, Adolescent and Sexual Reproductive Health and Gender-based violence
Communicable diseases	Malaria, HIV and AIDS, Tuberculosis, Acute Watery Diarrhea, Meningitis, Neglected Tropical Diseases (NTDs)
First aid	Introduction to first aid, Principles of first aid, Referral system and linkages
Community based health management information system (CBHMIS)	Community Based Surveillance, Vital Statistics, Family Information Register, Boma Health Initiative Monthly Reporting Form, Payam BHI monthly Reporting Form and Payam/ County BHI Month Performance Assessment Form

Training methodology

The trainings were for six days, it was co facilitated by qualified facilitators on community health systems strengthening from IMA World Health and the Ministry of Health (MoH). Participatory and interactive approaches such as brain storming, questions and answers; small group discussions, group works and plenary presentations, role plays, audio visual aids and videos translated into local language, case studies, supervised practice at health facilities and community filed works, pre- and post- tests; and course evaluation were used. Wall posters and illustrations, quotations, cartoons, poems, drawings and videos, etc. helped in setting the scene. Facilitators were encouraged to be creative with flipcharts, including the use of drawings and icons and role plays whenever possible. Facilitators Guide, Participant Hand Books and illustration charts were available and used on day to day handling of the course units.

The training materials

The reference materials developed by the ministry of health, Republic of South Sudan were used (Boma Health Initiative Facilitators Guide and Boma Health Teams Hand Books, illustration charts, Boma Health Initiative registers and Reporting tools June 2017).

Training outcome

Skills practice

The participants demonstrated skills on models and Mankins before supervised practice in the health centers and Primary Health Care Units. The participants also demonstrated skills on community field visits to identify community health needs at household level, conducted household registration and provided health education on health promotion and specific common diseases prevention as shown in Figure1.

Figure 1. Participant conducting household registration

The participants practiced skills in the health facilities under the supervion of the facilitators. Figure 2 shows a participant withdrawing blood sample from a patient at Panyagor Primary Health Care Unit (PHCU).

Figure 2. Participant drawing blood sample for malaria test using rapid diagnostic test learning outcome

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Generally, there was a positive change in knowledge and skills practiced as shown in Figure 3. The pre-test results show, the lowest participant with 18% and the highest with 64% compared to 56% and 96% for the post-test. The lowest and highest knowledge gains were 12% and 42% respectively and an average of 20.6% change in knowledge. This implies that the methodologies used during the training were relevant for knowledge and skills acquisition especially for participants of low educational background and adult learning.

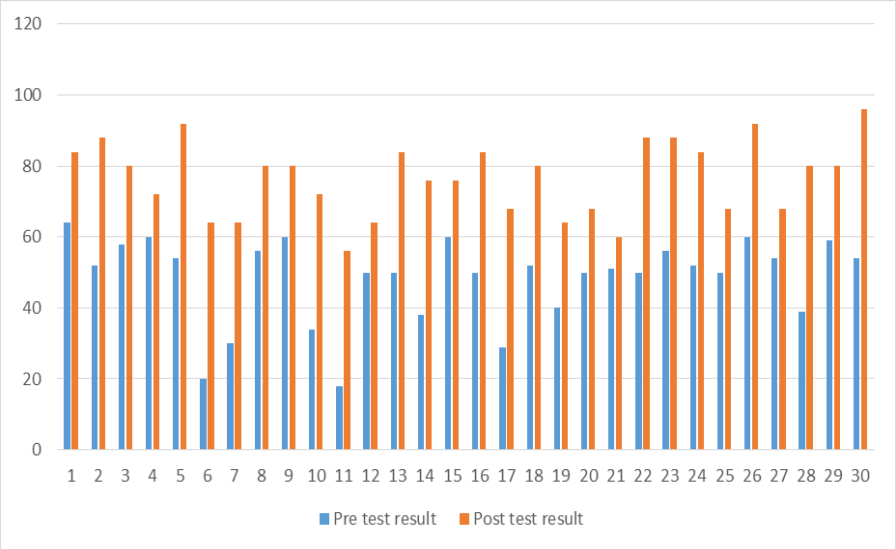

Figure 3. Pre and post test results

Follow up after the training

The participants developed three months action planned to be followed up by the supervisors during the monthly supervisory visits.

Training limitation

The varying educational background of the participants made it difficult for the facilitators to finish the training content on the prescribed time. Hence, the facilitators have to help those with little understanding after dinner every evening. There was challenge in getting some of the teaching aids such as respiration rate counting times, and beats on time therefore making learning of skills on this area being rushed. The training duration is too short for training a beginner with low educational background in low resource setting.

Conclusion

From the training outcome it could be concluded that basic community health care services for common conditions, creation of demand for service utilization and identification of danger signs in children and mothers can easily be done by community own resource persons with low educational background. However, the knowledge and skills gain during the training needs to be maintained and improved further through on job training, coaching and mentorship during regular and frequent support supervision and guidance.

Recommendations

The state and national ministry of health could consider expanding such training nationwide for easy access to health care services and improve lives of the population.

The state and national ministry of health in collaboration with other health actors could consider increasing the BHTs training period from six days to fourteen days during curriculum review.

The BHTs supervisors should visit each BHT on weekly bases to provide technical support and guidance.

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