The third community health workers' symposium, Liberia, 2023: What are the implications for South Sudan's Boma Health Initiative?

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ABSTRACT

Community health workers (CHWs) are defined by the International Labour Organization (ILO) as healthcare workers who 'provide health education, referral and follow-up, case management, basic preventive health care and home visiting services to specific communities. This paper is a synthesis report on the third CHWs' symposium held in Monrovia, Liberia in March 2023 and its implications for the South Sudan version, the Boma Health Workers (BHWs). It documents the notes on the conference deliberations supplemented by literature on the Boma Health Initiative in particular and CHWs in general. The key thematic areas were institutionalization and integration of CHW programmes into the health system, human resource recruitment, training and retention, CHWs in conflict and complex emergencies, effect of gender, and measuring performance. The Symposium was a platform for sharing information on best practices and challenges facing CHW programmes across nations. In the Monrovia Call to Action, the Symposium urged stakeholders to invest in country-led strategies, professionalize and integrate CHWs into the national human resources and health sector plans, galvanise political support and track progress.

Key words: community health, workers, boma, Monrovia, South Sudan

Introduction

Community health workers (CHWs) are defined by the International Labour Organization (ILO) as healthcare workers who 'provide health education, referral and follow-up, case management, basic preventive health care and home visiting services to specific communities. They provide support and assistance to individuals and families in navigating the health and social services system'.[1] They are also described as service extenders, social change agents and cultural brokers.[2] Community health programmes are recognized as important strategies for accelerating progress towards universal health coverage and achieving global goals such as the Sustainable Development Goals (SDGs), and CHWs are becoming increasingly critical in responding to current and emerging pandemics.[3] For

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instance, they have been credited for robust response to the Ebola epidemic in West Africa and the COVID-19 Pandemic around the world.[4]

The community health variant in South Sudan, is known as the Boma Health Initiative (BHI), a homegrown innovation guided by the BHI policy launched by the national Ministry of Health (MOH) in 2017.[5] BHI aims to offer basic health services to 56% of South Sudanese living at more than 5 kilometres from a health facility.[5]

This paper is a synopsis of the reflections during the 3rd International CHWs' Symposium held in Monrovia, Liberia, in March 2023 and discusses its implications for South Sudan's BHI programme using a comparative lens to the global practice.

Setting

The 5-day symposium was held from 20th to 24th of March 2023 under the theme "Advancing community health workers programmes to build resilient and equitable health system that accelerates primary health care for universal coverage." The event provided an opportunity for magnifying CHW voices and CHW led advocacy among more than 700 delegates from over forty entities including countries, organizations, researchers and UN Agencies. The workshop took stock of bold policy reforms and renewed commitment to develop a professionalized community health workforce capable of driving health outcomes and realizing the 'health for all' agenda.

Two days of the pre-symposium period focused on funding mechanisms for Global Fund, country level reflections, interaction with countries to foster experience sharing and learning between countries. Following the opening ceremony, a series of corresponding sessions of presentations, panel discussions, and plenaries as well as marketplaces for poster presentations, institutional engagement, sponsorship, and sales by accredited local vendors, were unveiled.

Symposium deliberations

During the Symposium, focus was drawn to five issues thought to be critical for CHW programmes and services across countries. Through a series of plenaries and break up groups, the following thematic areas were covered:

Institutionalization and integration of CHW into national health systems

Delegates compared notes on the foundational role played on primary health care (PHC) by established community-level health care but noted that it continues to struggle to be prioritized within the PHC systems because governments focus mainly on facility-based care. In some countries the results of lack of prioritization manifest in:

1. Under funding and inadequate support to CHWs, supply chain, and information systems;
2. Poor institutionalization and integration of CHW programmes;
3. Inadequate political will to provide an enabling policy environment for CHW progress;
4. Relegation of CHW programmes to partners, instead of government, in most countries (Table1).

Despite these observations, in countries such as Liberia, Rwanda, Uganda, Kenya and Ghana, where strong CHW programmes are established, it was reported that:

1. Government leads priority-setting and this is backed by strong alignment within the MOH, key non-governmental partners, and donors;
2. Strong linkage between health facilities and community health programmes exist;
3. Policies, strategies, and programmes with focus on improving the delivery of integrated, comprehensive, and quality community health services were developed and operationalized;
4. Data management and information sharing were prioritized and were seen as critical for success and
5. Bold mechanisms for resource mobilization and management were devised.

Human resource recruitment, training, and retention

Further deliberations captured information on best practices and the modus operandi regarding CHW recruitment, training and retention. Country reports indicated that all CHWs are selected from within the community according to written terms of reference and each country presented tailored curriculum for training CHWs. Such curricula showed varying training durations from as short as 2 weeks in South Sudan to as long as 3 years in Ghana. Across all the countries, a mix of practical and in-class learning models were used during training. In Ghana for instance, there is a clear career development pathway for the CHWs. Some CHWs can advance to medical or paramedical courses. As an example, a former Ghanaian CHW was at the conference as a PhD scholar

Table 1. Thematic areas of discussion during the Symposium, challenges and success steps

Thematic area	Challenges across countries	Success steps in some countries
Institutionalization and integration of CHW into national health systems	• Under funding and inadequate support to CHWs, supply chain, and information systems • Poor institutionalization and integration of CHW programme • Inadequate political will to provide an enabling policy environment for CHW progress; • Relegation of CHW programmes to partners, instead of government	• Government leads priority-setting backed by strong alignment within the MOH and partners • Strong linkage between health facilities and community health programmes • Policies, strategies, and programmes focus on improving delivery of integrated, comprehensive, and quality community health services • Bold mechanisms for resource mobilization and management
Human resource recruitment, training, & retention	• Financial insecurity and unfairness in fund use • High attrition rates attributed to low payments • Lack of recognition • Unclear career pathway	• Improved supportive supervision • Payment of incentives to complement government pay • Recruitment into the public service and clear career ladder
Impact and influence of gender	• Chronic gender underrepresentation • Cultural taboos such as barring women from riding bicycles • Domestic responsibilities • Education disparities between boys and girls	• Gender sensitive recruitment • Deliberate preference for female CHWs to provide women related community health services • Addressing wider gender gaps
CHW programmes in conflict and complex humanitarian context	• Insecurity • Access constraints	• Use of mobile phones for reporting • Negotiation skills to ensure access to supplies • Use of women to transport and preposition supplies since they are less targeted by conflicting parties
Measuring performance for community health programmes	• Inadequate use of standard matrices for measuring CHW performance • Inadequate supportive supervision and appraisal of CHW work • Insufficient capacity of CHW to use data for decision making and poor records of recruitment and training • Parallel recruitment by some CSOs doing vertical programmes	• Improved supportive supervision • Use of mobile phone reporting • Data management and information sharing are prioritized and were seen as critical for success • Integration of CHW programmes into the health system

from Johns Hopkins University to attest to this. He was a very special inspiration for the CHW fraternity as his presence was a litmus test for the future of the career. Remuneration also varied remarkably from as little as 45 US dollars in South Sudan to 150 US dollars in Ghana. The mode of payment included performance-based approaches, although this was marred with irregularities such as financial insecurity and unfairness in using the funds. High attrition rates attributed to low payment, lack of recognition, unclear career pathways were raised as

bottlenecks to CHW programmes across countries.

Impact and influence of gender

As a cross-cutting issue of global concern, a gender lens was applied to CHW programmes and delegates reported key milestones such as gender sensitive recruitment and deliberate preference for female CHWs to provide women related community health services to curb chronic under representation of women in the CHW workforce. Given that female CHWs have strong commitment to remain in their jobs longer than their male counterparts, delegates agreed to pay attention to issues that discourage women participation such as barring women from riding bicycles which undermines their mobility, and social responsibilities which curtail career advancement among females.

CHW programmes in conflict and complex humanitarian context

Given the prevailing conflict environment in many less developed countries, delegates shared experiences and adjustments made to ensure continuity of essential community based PHC services in such contexts. In the face of conflict and complex emergencies, CHWs are usually the main service providers and this ensures continuity of services such as community-based treatment of cases, vaccinations, hygiene promotion and distribution of essential high impact health commodities. Maintenance of the supply chain for health commodities was reported as one of the key areas where CHWs supported essential services. It was reported that CHWs use mobile phones reporting, negotiation skills to ensure access to supplies, and women to transport supplies and preposition buffer stock because they are less targets of conflicting parties.

In many countries it was reported that CHWs are critical during emergencies as they are the key cadres who provide critical risk communication messages to the community, promote hygiene during disease outbreak and carry out patient centred services such as screening, dispensing and referral.

Measuring performance for community health programmes

Institutionalization and integration of effective and sustainable community health systems is currently being challenged by inadequate use of standard matrices for measuring CHW performance and the systems they work within. Strategies such as developing robust measurement techniques for tracking the performance of CHWs, appraisal of CHWs and recruitment were examined. Delegates also identified gaps in supportive supervision and appraisal of CHW work, insufficient capacity of most CHWs and their communities to use data generated for decision making, poor records of recruitment, training of CHWs and parallel recruitment and training by some CSOs doing parallel programmes.

Discussion

This report highlights key issues relevant to the development and progression of CHW programmes across countries which dominated discussions during the Symposium. It also reveals how variable CHW programmes are in different settings and countries. This variability oscillates around four main themes identified as selection criteria, roles or tasks, training and remuneration.[6] These issues resonated through the symposium's major topics which were; institutionalization and integration into the health system, recruitment, training and retention, impact and influence of gender, CHW in conflict and complex emergencies and measuring performance. In line with this thinking, South Sudan's BHI programme aims at institutionalizing BHWs through formal recruitment into the public service at the entry grade 17.[5] They are nominated by the communities, based on community membership, minimum education level, personal character, age between 21 – 45 years, readiness to work for at least one year, numeric skills for reporting, knowledge of the local language and gender considerations, for a competitive recruitment into the public service.[5] Except for age requirements in BHI, these recruitment criteria align with WHO recommendations which list community membership, minimum education levels appropriate to the tasks to be performed, membership of and acceptance by the local community, promotion of gender equity, personal attributes and capacity of the candidates as key requirements for selection of a CHW.[7]

With regards to training, BHWs are trained for a period of two weeks, a wide variation from the three years' training period for Community Health Extension Workers in Nigeria.[8] Training may be as short as a few days in some settings depending on the intention of the cadres.[8] To address these variations, the Symposium recommends professionalization of CHWs with a clear career path. Scholars have suggested that training of CHWs should aim at professionalizing, monitoring performance and scaling up as this workforce takes shape with several tiers of the workforce having varying training levels necessary for placement and progression at different grades in the

public service scales.[8]

The role of CHWs in conflict and complex humanitarian emergencies such as the Ebola Outbreak in West Africa, COVID-19 and several disasters such as flooding, wars and famine cannot be overemphasized. The BHI mid-term evaluation report noted that they played crucial roles providing preventive messages on COVID-19 vaccination, distribution of IEC materials, and health education to local authorities, religious leaders, and the management committees of healthcare facilities.[9] They are equally engaged in detection and management of HIV and tuberculosis, management of chronic diseases and palliative care.[10] Their community embeddedness is their strength because it enhances their acceptability and effectiveness.[2] Evidence also shows that tasks such as community mobilization, health promotion, preventive services, offering selected clinical services, epidemiological surveillance and record keeping as well as referral to health facilities have traditionally been carried out by CHWs.[4]

The gender gap continues to bite the CHW programme. Despite obvious advantages of women performing key roles in their communities, and deliberate efforts by countries to preferentially recruit women, their numbers were still wanting across countries. Evidence from the BHI mid-term evaluation report also showed that the programme lags behind on gender representation; 83% of BHWs and 90% of BHW supervisors were males.[9] This is surely an area that requires special efforts to close the gap.

Measuring performance and tracking the progress of CHW programmes is a critical area that requires the attention of countries. BHI could benefit from innovative platforms such as the open data kit and incorporation of the indicators into DHIS 2 reporting system. It is critical to measure the performance of the individual CHWs, the community outcomes and processes in order to track progress.[11] The mid-term evaluation of BHI conducted in 2022 is a right step in the right direction; it highlights activities such as monitoring and supervision visits conducted by the BHI partners using MOH National BHI Supportive Supervision Checklist, assessment of quality of care, alignment to MoH treatment guidelines and protocols, supply chain, training, implementation and data reporting; analysis of monthly community data submitted by the implementing partners, use of visual dashboards for monitoring progress of counties, and progress on community health information management system (CHIMS) indicators tracked, as uploaded on DHIS-2 every month by county health authorities. Moreover, donors have also noted regular audits and data quality assessments for funds management, submission of quarterly reports by the implementing partners to the fund managers and use of third-party monitoring mechanisms.[9]

Conclusion

The 3rd International Community Health Workers' Symposium held in Monrovia, Liberia in March 2023 provides an invaluable learning experience among countries in general and South Sudan in particular. Key lessons were learnt and the gathering responded with a resounding 'yes' to the development, support and institutionalization of CHWs by all partners in order to accelerate the delivery of essential PHC services across countries. South Sudan's Boma Health Initiative is bound to benefit from the key lessons learnt from the gathering especially addressing local shortcomings identified during the event.

This report therefore recommends several actions to strengthen the implementation of BHI. First, there is a need for more advocacy to galvanize strong political will for BHI. There also needs to be improved resource allocation for BHI, led by domestic resource mobilization and supplemented by partners (UN agencies, CSOs and donors) to ensure ownership and sustainability. Coordination mechanisms should be strengthened at all levels of BHI implementation with involvement of BHW representatives in the coordination of activities. Additionally, the digitalization of CHIMS in South Sudan, such as use of open data kits for data collection and storage, should be prioritised.

To enhance motivation and retention, remuneration, including salaries and incentives, need to be improved. Human resources for BHI should also be strengthened, through supporting recruitment, training and retention of BHWs. This includes adopting at least a six months training curriculum with hands on job training and collaborating with the education sector to provide evening classes to improve BHWs' skills. Ultimately, this should lead to clear career pathways for BHWs being developed, as enshrined in the Monrovia Call to Action.[12]

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