The Republic of South Sudan

The Community Health System in South Sudan:

"The Boma Health Initiative"

A community anchored health system for sustainable health sector development

5th *Draft*, October 2015

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Acronyms

BCC	Behaviour Change Communication
BHC	Boma Health Committee
BHI	Boma Health Initiative
BHT	Boma Health Teams
BHW	Boma Health Worker
BPHN	Basic Package for Health & Nutrition
CBD	Community Based Distributors
CBOs	Community Based Organizations
CCM	Community Case Management
CHDO	County Health Department Office
CHWs	Community Health Workers
HHPs	Home Health Promoters
HSSP	Health Sector Strategic Plan
ISDP	Integrated Service Delivery Program
MCHIP	Maternal and Child Health Integrated Program
MCHWs	Maternal and Child Health Workers
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PSI	Population Services International
SCI	Save the Children International
WHO	World Health Organization

Glossary of Terms

1. **Advocacy is** the act of pleading for public support on ownership of Boma Health Initiative [BHI],
2. **Basic Packages of Health and Nutrition services [BPHNS]** These are evidenced based and cost effective health intervention services for reduction of burden of diseases as defined by the Ministry of Health of the Republic of South Sudan and made available at health facilities and in communities.
3. **Boma** the smallest geographical area and administrative unit in South Sudan consisting of villages and households.
4. **Boma Health Teams:** a team of three members selected by the community of a Boma, recruited to provide community health services to the community.
5. **Community action,** is generally understood to mean any activity undertaken by a community to effect change.
6. **Community is a** group of individuals that identify themselves by common characteristics such as territory/ geographic locations, culture/language, religion, ethnicity, work, social interaction, power relationships, communication, behaviours**.**
7. **Community ownership in health** refers to mechanisms, systems and processes that empower members of Boma communities to influence policies, planning, operation, use and benefits of health services.
8. **Empowerment is a** continual process whereby individuals and/or communities gain the confidence, self-esteem, understanding and power necessary to articulate their concerns, ensure that action is taken to address them and, more broadly, gain control over their lives.
9. **Health** is a complete state of physical, mental, social wellbeing and not merely the absence of disease or infirmity;
10. **Involvement** is a term often used synonymously with participation and implies being included as a necessary part of something.
11. **Participate is** a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.
12. **Primary health care** is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
13. **Community capacity-building is** development work that involves training and providing access to support and resources; recognizes existing capabilities and strengthens the ability of community organizations and groups to build structures, systems and skills that enable them to participate and take community action.
14. Community Resource Persons: Member of that community equipped with skills to serve the same community under a project or program arrangement.

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The Ministry of Health extends its special gratitude to all organizations, and individuals involved in the development of the Boma Health Initiative implementation guideline. This guideline is the product of intensive work by several players who made different contributions, and in many forms. It took commitment, time, technical knowledge and financial resources to produce this document since the preliminary discussions and efforts since 2012 and 2014, for which we are highly indebted.

We are particular about the hallmarks of health systems strengthening in the guideline. Which includes;

- Primary health care principles of health promotion and disease prevention,
- universal coverage though the service package and geographical coverage,
- Sustainable development through government ownership and involvement of people in service delivery and governance of the Boma Health Initiative.

The Ministry of Health recounts the contributions made by its own Departments, programs and its partners through the Behaviour Change Communication Technical Working Group. The ministry singles out WHO, Jhpeigo, South Sudan Red Cross, Swiss Red Cross, Health Pooled Funds, UNICEF, MCHIP/ISDP, Population Services International (PSI), save the children international and Management Sciences for Health (MSH) for the significant technical and financial contributions during the review process.

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Dr Makur M Kariom

Undersecretary ministry of Health

Forward

The government of the Republic of South Sudan is committed to strengthen the national health system to improve quality and increase access to the BPHNS to its citizens. Thus, Policy reviews, structural reforms, clarity on partnerships, processes, roles, and responsibilities to harmonize implementation of health actions becomes urgent.

To this end the ministry of health updated the National Health Policy (2015-2024), developed the Health Sector Strategic Plan (2015-2019), to provide the long term strategic framework for strengthening the health system. The two documents strongly recommend establishment of a community health system (the reform) as a means to equitably engage communities in health promotion at household level. This reform has come to be known as the *Boma Health Initiative.*

Through consultations with countries in the African region and beyond, we have finally conceptualized the Boma Health Initiative tailored to our circumstances, shaped by local experience, with invaluable inputs from partners in the field as laid down in this implementation guideline.

The Boma Health Structure is not a project, but an integral structure of the health system, governed by Boma health Committees, staffed and managed by salaried Boma Health Teams (3), technically supervised by Payam Health Office, Supported by the HHP, referring cases to health facilities and sending reports to the Payam Health office.

Health education for health promotion and provision of selected treatment services constitutes the service package delivered by the Boma Health Teams and HHPs to the communities and households. In addition, a community based HMIS, Community based Surveillance, and registration of Births and Deaths in the Boma shall be part of the routines of the BHT in collaboration with the HHPs.

We are convinced that the Boma Health Initiative will significantly reduce ill health and deaths at a lower cost, increase service uptake and participation of communities in health activities, and promote ownership and sustainability of the community health structure.

I call upon all partners to support the Boma Health Initiative as the official structure for service delivery at community level. Let us continue to join hands to develop the Training Manuals, BHT Hand Books, and other tools as we develop *a community anchored health system for sustainable health sector development.*

Dr Riek Gai Kok

Hon Minister of Health, Republic of South Sudan

Preamble

Historical and political basis of the strategy

Inspired by the vision of Gen Dr John Garang De Mabior (RIP), the founder leader of the Liberation Movement; “Taking towns to Villages,” and convinced that the main health conditions in the Republic of South Sudan are preventable at individual, house hold and community level as alluded to in the National Health Policy (2015-2024) and National Health Sector Strategic Plan (2015-2019); the Minister of Health, Dr Riak Gai Kok, directed that a home grown model to deliver the Basic Package of Health and Nutrition Services to families and communities through community health action be developed.

The Boma Health Initiative.

This model, the Boma Health Initiative, comprising Boma Health Committees, Home Health Teams (3 Community health Workers) is constituted as a formal structure of the health system to close the gap between health facilities and the communities to deliver an integrated package of health promotion and disease prevention activities supported by volunteer Home Health Promoters. The Boma Health Teams shall be the entry point for all community level health activities for all health programs in that community (Boma).

1. Introduction:

1.1.Background, Context, Justification, policy goal

The context of the health system under the Unitary Government of the Sudan of that time and the decades of independence war in the south could not allow the development of community health structures to the disadvantage of the Republic of South Sudan.

Various attempts have been made to engage communities in health service delivery in South Sudan from the times of liberation movement through the period under the Comprehensive Peace Agreement (CPA) till now. During the liberation movement, community structures were established in the liberated areas to reach communities with basic health services with the help of Non-Governmental Organisations. Since the CPA, Community Resource Persons have continued to serve on an ad hoc basis despite efforts to formalise or recognise the structure as an integral part of the national health system.

The Ministry of Health Policy Framework (2013-2016), Basic Package of Health and Nutrition Services for South Sudan (2011) and Health Sector Development Plan South Sudan, (2011 – 2015) have elaborated a health service delivery structure that is suitable for curative services. A community level health structure is provided for, with limited practical steps to its realisation.

The current attempts at establishing community health structures have largely been partner-led or diseases specific, duplicative, fragmented and existing in different names and different incentive packages. It is not uncommon to find an individual doing different tasks under different names within the health sector resulting in resource wastage in the absence of a harmonised structure.
There is lack of clarity in the structure, composition, roles and responsibilities, benefits, harmonisation within the existing community health initiatives and commitment of resources for selection, training, and operations of the structures.

Ineffective programing is among some of the challenges. It was observed in some states that community interventions stop at training of community resource persons who are not facilitated to reach the households with the key health messages and interventions [Discussions]. Some interventions are fragmented, shallow and not reaching the root causes of the health problems (SSHHS 2010).

Most trained health workers' time is taken up providing clinical services leaving little time for preventive and promotion services in the communities. This partly explains the low indices for preventive interventions; e.g. low pit latrine coverage (7%), low immunisation coverage DPT3 (33%), frequent outbreaks of epidemics and vaccine preventable diseases (measles, cholera, etc.), high maternal (2,054/100,000 LB) and infant mortality (102/1000LB) rates, low health facility based deliveries (11.6% in 2012), poor health seeking behaviour (OPD Utilisation rate 0.38 HMIS 2012) among others, related to the low associated risk perception.

The top ten or so diseases in South Sudan are communicable diseases which are preventable. Acute watery diarrhoea, acute bloody diarrhoea, measles, acute respiratory infection, malaria, jaundice syndrome, meningitis, tetanus, epidemic-prone diseases such as cholera, hepatitis E, shigellosis and HIV/AIDS are among the most common communicable health conditions in South Sudan.

Three diseases constitute 77% of the OPD diagnoses for children, with the remaining 23% constituted by others. Malaria alone contributes 50%, while diarrhoea and pneumonia account for 17% and 10% respectively of the total diagnosis (HMIS 2012). In addition, severe and moderate malnutrition contributes 3.5%, STI 1%, typhoid fever 0.6%, and Suspected TB, 8,581 cases to the total diagnosis of the year.

The high infant and maternal mortality rates in the country are largely due to preventable conditions. It is imperative that the health system targets and engages individuals, households and communities to communicate health risks and related costs for health action to improve health outcomes.

Most of the NTD which are amenable to Preventive Chemotherapy and Case Management are endemic in South Sudan; Visceral Leishmaniasis (Kala-azar), brucellosis, Leprosy, Lymphatic Filariasis, Trypanosomiasis, Plague and Rabies, Soil Transmitted Helminths, Bilharzia, Trachoma. Mobilisation of communities for mass treatment and screening is dependent on the community structures for successful program implementation.

The majority of South Sudanese people live in rural areas and have different settlement patterns; agricultural, pastoral and nomadic. Low population, scattered over vast country with 90% in rural areas. The country is prone to malnutrition resulting from frequent floods, prolonged dry seasons leading to low production and chronic food

insufficiency, and malnutrition related to food shortage and poor nutritional habits. Successful nutrition program interventions for promotion of good nutrition, prevention and management of malnutrition, will require community level intervention premised on a strong community health system.

Communities are active consumers of health services and play different roles in the health system. For example communities have played governance roles in the health system and as health service financiers. Communities have served as intermediaries (service providers) to deliver health services where the formal health system cannot effectively reach them. This may take the form of mobilising communities for health promotion, prevention and selected curative services as is the case with Home Health Promoters in different parts of the country for Mass Drug Administration for NTDs.

Poor health status and health inequities are underpinned by poor health determinants and access barriers to healthcare which ordinarily are beyond the primary jurisdiction of the ministry of health. These include among others; Education, Food and Agriculture, Employment, Water and sanitation, Traffic and Road Safety, social and community networks and support, individual lifestyles etc. A comprehensive health promotion program is required through inter-sectoral collaboration to improve determinants of health.

Some cultural practices are known to promote and hurt health. Negative practices around sexual and reproductive health, child health, communicable and non-communicable diseases constitute a formidable barrier to accessing health services manifesting into poor utilisation of available services. Local and specific community action is required to overcome these barriers.
In this context, a community health structure – the Boma Health Initiative is critical to increasing access to health promotion, disease prevention and community case management interventions.

1.2. Health system Priority is;

The establishment of a formal structure of the health system;

i) at the Boma level,
ii) dedicated to deliver an integrated package of health Promotion and disease prevention and selected treatment services,
iii) to individuals, families and communities,
iv) using trained, equipped and salaried Community Resource Persons (CHW),

v) to contribute to reduction of morbidity and mortality,

vi) Due to preventable health conditions.

2. Goal & Objectives

2.1. Goal,

A strengthened health system that efficiently delivers components of the BPHNS at community level to achieve universal coverage.

2.2. Objectives

1) Develop community health structures as a formal component of the national health system at the Boma level.

2) Increase access to quality delivery of health promotion, disease prevention, and selected curative services through community engagement.

3) Provide leadership for the implementation of the BHI through inter-sectoral collaboration and community participation.

3. Implementation Guidance

Successful implementation of the Boma Health Initiative is dependent on clear structures for implementation, the commitment and efficient use of resources, skills, tools and support supervision. The initiative needs to fit within the wider government structure and the health system for ownership and sustainability. The resources particularly human resources numbers, skills, tools, motivation and technical support should match the expected out comes for assurance of quality.

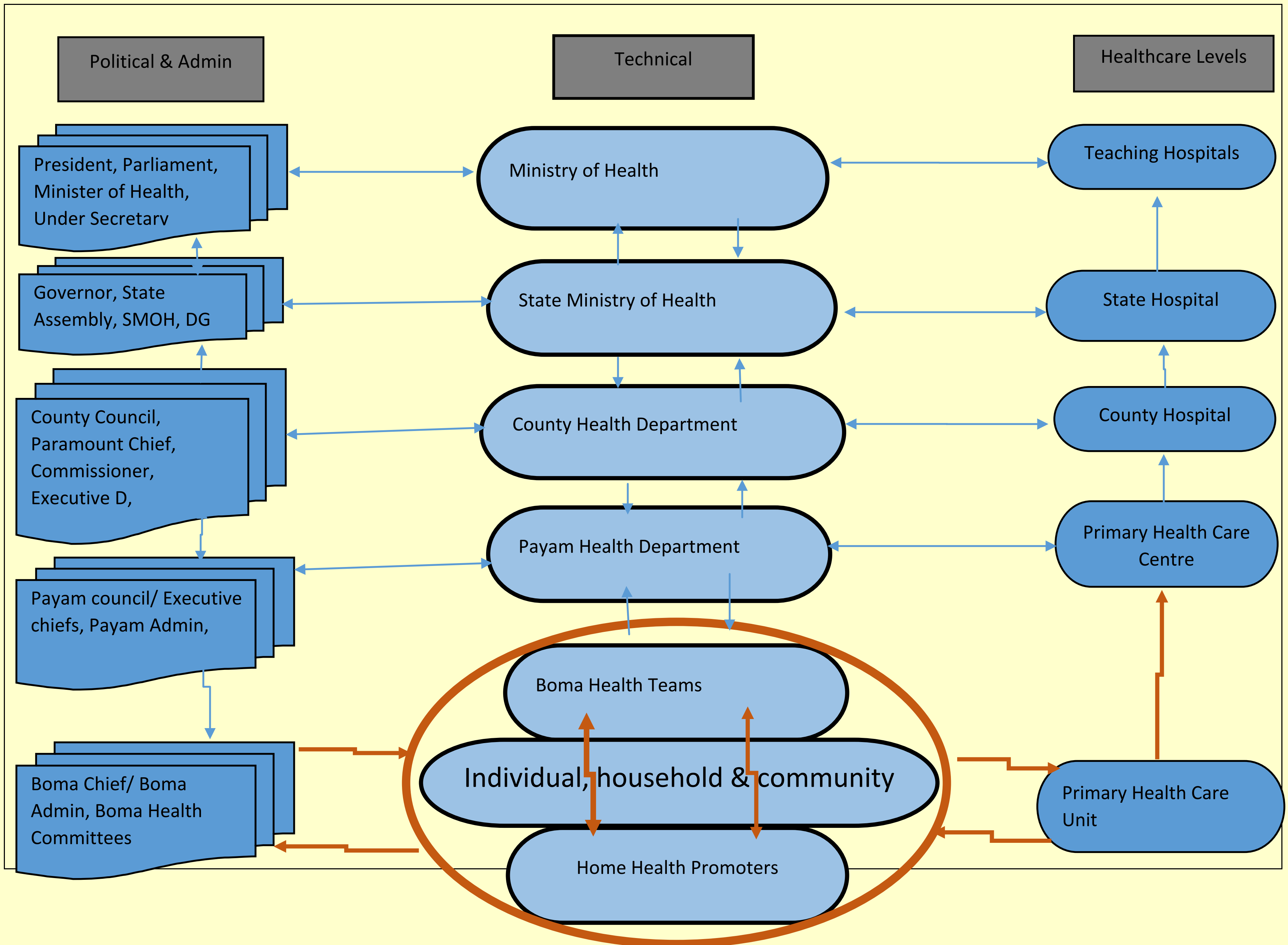
3.1 Structure

The smallest administrative unit of government in South Sudan nearest to the communities is the Boma. Bomas are made up of a number of villages which do not have a structured presence of government institutions. A number of Bomas form a Payam, which in turn form a County then State; which are statutory units with decentralised powers of government.

3.1.1 The Structural context of the Boma Health Initiative

The organogram depicts the placement of the Boma health Initiative in the wider context of decentralisation, the health system and the referral system, governance,

supervision, service delivery and reporting. It places the Boma Health initiative as an integral component of the local government structure to be managed as a local government entity. The local governments can allocate local grants to facilitate their function. The County Health Department has to plan for the recurrent operations of the structure.


Political & Admin
Technical
Healthcare Levels
President, Parliament, Minister of Health, Under Secretarv
Ministry of Health
Teaching Hospitals
Governor, State Assembly, SMOH, DG
State Ministry of Health
State Hospital
County Council, Paramount Chief, Commissioner, Executive D,
County Health Department
County Hospital
Payam council/ Executive chiefs, Payam Admin,
Payam Health Department
Primary Health Care Centre
Boma Health Teams
Individual, household & community
Home Health Promoters
Boma Chief/ Boma Admin, Boma Health Committees
Primary Health Care Unit

3.1.2 Description of the institutions, their composition and roles.

The organogram provides panoramic linkages between the Boma health initiative and the wider government, and health institutions. This section is dedicated to describe each institution, the stake holders, their roles and how these impact on the Boma Health Initiative. The roles of the higher levels of government are well known, shall only be mentioned for emphasis. More time shall be spent on the community structures at the Boma level.

3.1.2.1 National Level

i) Stake holders: Presidency, Parliament, Ministry of Health, Development partners

ii) Political Leadership: Driven by the vision to improve service delivery at the grassroots level, ('taking Towns to Villages') there is strong political commitment from the presidency and development partners to establish a community health system to reach communities with basic health services. The Minister of Health has commissioned trips to Ethiopia, Rwanda, Cuba, and Turkey to better understand the community health systems in those countries to inform the development of this implementation guideline.

This commitment is reflected in the National Health Policy 2015-2024 and the National Health Sector Strategic Plan 2015-2019, which seek to establish community health system as a formal structure of the national health system by creating the structure and positions for Community Health Workers to be on government salary pay roll.

iii) Governance: The oversight Health Committees have an important role in guiding health sector planning and budget and more importantly advocate for health and more health resources besides monitoring health services. The parliamentary committees and council of Ministers approves of the establishment of this structure to improve health service delivery.

iv) The Ministry of Health: The core functions of the ministry of health includes; Stewardship and governance, Policy formulation, standards, and guidelines, Human resources capacity building, Decentralisation and effective delegation, Regulation, legislation and strong partnership, Research, planning and quality assurance, Supervision, monitoring and evaluation, Health financing and management. The development of this implementation guideline was led by the Ministry of health technical teams with technical support form WHO, Integrated Health Service Delivery (JHpiego), Health Pooled Fund, the South Sudan Red Cross and the Swiss Red Cross & Canadian Red Cross and UNICEF.

i) **Development partners:** There is overwhelming partner support for the establishment of community structures. Most projects in communities first set community structures of their own, train them to deliver services and set supervision teams. Development of implementation guidelines will not only streamline the establishment of this critical structure but also reduce the initial investment costs to future projects. This is expected to improve coordination of partner activities at community level and sustainability of health sector investments.

3.1.2.2 State Level

i) Stake holders: The Governor, The State Assembly, the State Ministry of Health, other Ministries e.g. Directorates under the relevant line ministries; Education, Environment, Agriculture and Forestry, Water, Gender, Health Development Partners, the private sector, Civil Society.

ii) State Ministry of Health: Stewardship and governance, Implementation of health care services, Planning and management of state services, Joint assessments, research and planning, Supervision, monitoring and evaluation, Referral system & epidemiological surveillance, Efficient and cost effective use of resources are the functions of the State Ministry of Health. Some states have established regular management meetings to improve coordination, e.g. conducting state health & nutrition cluster meetings, provision of feedback to service providers and partners, coordination with state, partners and community leaders especially at county levels.

In line with the mandate of the states in the health sector and the ongoing practices of coordination of health services, the states are expected to plan and mobilise resources for the functionality of Boma health structure, monitor their performance and technically support the counties and Payams to manage the Boma health initiative.

3.1.2.3 County Level

i) Stake holders: The County Council, the County Commissioner, the Executive Director, the County Health Department, other departments in the Local Governments including Education, Environment, Agriculture and Forestry, Water, Gender; health development partners, and the private sector .

ii) County Health Department: is responsible for planning, policy and programs implementation, follow up activities, reports. It supports clinical health services and promotes involvement of communities in various health activities. The establishment of the BHI will enable the county in its role of promoting community participation in health activities, and intersectoral collaboration currently strained by lack of an elaborate structure. It is expected that county health departments will start planning for

community health services in equal measure with the clinical health services. The County Health departments shall be strengthened at the (county level) to this effect. Staffed with personnel with Public Health background and facilitated to supervise the Boma Health Initiative.

3.1.2.4 Payam Level

i) Stake holders: Payam council, Payam Administration, paramount chiefs, Payam Administrator, Payam health, other departments and development partners.

ii) The Payam Health Department: The Payam Health department was structured to strengthen community health services with strong provisions for health inspection, health promotion, maternal and child health focus. Few Payams have established this structure resulting into ineffective delivery of the community health services. Establishment of Payam health offices in every Payam is critical to the success of the Boma Health Initiative. Specifically the Payam Health Department provides the following support;

i) Technical guidance: to guide Boma Health Committees, train Boma Health Teams, and technically supervise Boma Health Teams and give reports to County Health Department.

ii) Guide implementation: Plans, organises, directs and supervises, monitors and takes responsibility for health service implementation in the Bomas of that Payam. It consolidates the reports of the Boma health Teams into Payam report and submits to the county Health Department,

iii) Supply chain and logistics: Liaises with the County health department and/or the PHCC to ensure adequate supply of commodities required for service provision at household level, including drugs, vaccines, reporting tools etc.
Ensure appropriate storage of commodities required for service delivery at the community and household level.

3.1.2.5 Boma Level: The Boma Health Initiative

This is a deliberate reform of the segment of the health system below the Payam to support community health programs.

Stake holders: Boma Administration, Boma Health Committees, Payam Health Office, Health Facilities, Health Partners, Boma Health Teams, Home Health Promoters,

Households, and individuals. The institutions outlined as stakeholders above constitute the components of the Boma Health Initiative at the functional level.

Component 1: Boma Administration

i) Composition: Boma chief and Boma Administrator.

ii) Roles: Boma Administration is responsible for implementation of all government and development programs at the Boma level; generates development needs that feeds into bottom- up planning process. It follows that the Boma administration is responsible for the functionality of the community health system, the Boma Health initiative, as a government structure to support health sector development program.

Component 2: Boma Health Committees

i) Description: The Boma Health Committee is a multi-stakeholder platform for the governance of the Boma Health Initiative. To achieve multi-sectoral collaboration and community participation in health in line with primary health care principles, representation on this committee will span beyond the composition of the Boma administrative unit. This expansion is supported by the lean structure of the Boma administration and the wide spectrum of stakeholders in health matters.

ii) Composition: Boma administrator, Boma Chief, Boma Health Teams, Payam Health Officer, Health Facility In-Charge, Head Teachers, representation of respectable personalities, women group members, youth group members, persons with disabilities and interest groups. The number should be between 9 and 11.

iii) Roles:

1. Governance:
    a) The Boma Health Committees recommend Boma Health Teams nominated by communities for recruitment through a competitive process into the public service.
    b) BHC provide guidance to Boma Health Teams on implementation of approved health service package activities in communities.
    c) Review program reports and resource use for accountability
    d) BHC appraise the BHT and recommend replacement of an absentee or non performing BHT member to the recruiting authority.
2. Resource Mobilisation and support

a) The committee mobilises local resources to facilitate functionality of the BHTs
b) Support the BHTs in the communities to avoid misunderstanding and to improve the relationship with the communities and Home Health Promoters.

3. Vital Statistics
   a) Oversee birth and death notification in the Boma by the BHT
   b) Recommend for issuance of Birth and Death Certificates by the authorised office.

iv) Selection: Boma Health Committees will be appointed by the Boma Chiefs at the recommendation of the Boma Administrator.

Component 3: Boma Health Teams

i) Description: The concept of Boma Health Teams evolved from the challenges faced with the health system design for delivery of health promotion services through PHCUs based at the Boma level. It was realised that preventive and promotional services tagged to health facilities could not reach communities effectively as PHCUs were not constructed in every Boma. Secondly, the capacity of the health workers to deliver both curative and preventive services was limited by time and numbers. Lastly, areas without health facilities missed curative as well as preventive services resulting into inequitable service provision.

In response to this encumbrance, the Ministry of Health adopted a new approach for the delivery of health promotional services to complement the facility- based curative approach. This entails the development of a health structure devolved to the Boma level for delivery of health promotion activities. The staff of the structure, Community Health Workers, shall be solely dedicated to provide health promotion, disease prevention and selected treatment services at the community level.

In an effort to retain the Community Health Workers within the health system, they will be salaried public servants, and a career development path will be developed to upgrade them to formal professionals through a modular training packages for further motivation

ii) Composition: The Boma Health Teams (BHT) will consist of three (3) Community Health Workers comprehensively trained to deliver the service package for the Boma Health Initiative. They will work in teams supported by the Home Health Promoters to deliver services at the household level.

iii) Roles:

1. **Carry out Health Education:**
   a) To plan and carry out health education on health promotional aspects of BPHNS at the village, household level.
   b) Carry out comprehensive health education related to maternal and child health activities, communicable and non-communicable diseases, epidemics, emergencies and disasters as guided by the BHT Health Education Guide.
   c) Participate in door to door mobilisation and behaviour change campaigns as may be required by the health authority for example during disease outbreaks.
   d) Work with, supervise and mentor all Home Health Promoters in the Boma to mobilise communities, cascade health education messages, and get local health information from the communities.
   e) Share information with the Boma Health Committee regularly and when requested.

2. **Provide selected treatment packages:**
   a) Integrated Community Case Management
   b) Preventive Chemotherapy for Neglected Tropical Diseases
   c) Case referral to health facilities for further management.
   d) Any such intervention approved by the Ministry of Health.

3. **Support Community Management Information System:**
   a) **Community based HMIS**; collect, and report regularly on services delivered using designated Health management information system and send to the Payam Health Office for collation.
   b) **Community based Surveillance (1):** Passive surveillance reports on any adverse health events in the community at any time to the Payam Health office and the health facility for further investigation.
   c) **Community based Surveillance (2):** Active surveillance reports daily during the control of outbreaks to the Payam office or the control centre.

4. **Vital Statistics**
   a) Record Births in BHT register for updating the Boma Master register.
   b) Record Deaths in the BHT register for updating the Boma Master Register.

c) Registration of families and members under a Community Health Worker as a baseline for service delivery; kept in family folder
d) Any other record required for planning e.g. Number and location of schools, latrines, water points and other physical structures related to the determinants of health.

iv) Selection of a community health worker:

a) Nominated by the community and recommended by the Boma Health Committee for recruitment into the public service.

b) To be selected, a BHT must:

- Have completed primary education with numeric and literary skills for reporting, training and meetings.
- Be Permanent resident the Boma.
- Be accepted by the community and have commitment to serve the community.
- Speak the local language/dialect of the community
- Be interested to work as BHT for at least 5 years
- Be 21 – 45 years of age
- Priority to be given to women
- Willingness to possibly work in rural area.
- Does not hold any other full time employment.

v) Remuneration: Members of the Boma Health Team will enter the public service payroll at the grade of the current CHW (Grade 17). They are entitled to lunch allowance at local rate for field works that take more than 3-4 hours.

Component 4: Home Health Promoters

i) Description: Bomas in South Sudan, though the smallest administrative units, are generally too large for home to home service delivery from the Boma level. Current practices rely on teams of Home Health Promoters based at the village level that interface with the partner staff from the higher levels of the health system. The BHT per Boma will work in coordination with HHPs from within the local community to maximise mobilisation.

ii) Composition: Home Health Promoters shall be selected at the ratio of 1HHP per 30-40 households in densely populated areas (urban), or two HHPs (one woman and one

man per village) in sparsely populated areas (rural). They will work together with the Boma Health Teams on voluntary basis with a defined basic incentive mechanisms.

iii) Roles:

a) Collaborate with Boma Health Teams to carry out mobilization of communities for health programs; Health promotion, disease prevention, treatment and rehabilitation services.
b) Collaborate with BHT to disseminate key health messages
c) Collaborate with health facilities and BHT to follow up on health service undertakings including home- based treatment, follow ups, Defaulter tracing, Quarantines, Referrals, etc.
d) Offer selected community- based health interventions; commodities, tablets as prescribed by the BPHNS
e) Under the supervision of BHT, collect data for community based HMIS and community based surveillance and report to the BHTs.

iv) Selection:

a) Selected by the local community (Village) in a meeting of the Boma Health Committee based on the population density criteria described earlier.
b) To be elected, an HHPs must be:
    - Permanent resident of the cluster of 30 – 40 HHs or village.
    - Women highly encouraged (at least one must be a woman)
    - Accepted by the community
    - Must speak the local language/dialect of the community
    - Literate and have numeric skills for reporting, training and meetings (desirable)
    - Aged between 21 – 45 years
    - Have commitment to serve the community as HHP on voluntary basis
    - Socially acceptable and responsible persona.
    - Ready to work for a period of one year renewable until 60 years of age.

v) Incentives/motivation:

The incentives for HHPs will mainly be activity- linked payable at local rates, monetary /in-kind in terms of prescribed goods; and in addition will receive continuous capacity building, awards, recognition as opportunities allow. They will not be paid salary.
Unlike in many urban settings, Social responsibility, concern for the community too, is known to motivate some people. With two volunteers per village the work load is expected to be manageable.

Component 5: Households

i) Description: In extended family systems defining a household may not be straight forward. There is often a father or father figure, a mother or a mother figure, children and or dependants, eating together with a centre or centres of authority.

Recognising this structure defines the entry point into the family for health promotion and related health services.

The ultimate responsibility to address the health determinants, health risks and find alternatives to mitigate effects of health inequities lies in the hands of individual households with government setting enabling environment. Health education aims to create awareness to stimulate appropriate action to promote, maintain or restore health; making the household the most important institution for 'production of health'. This process is never cheap as it requires intensive, repetitive, consistent messaging from multiple channels, actors and levels of authority.

The Boma Health initiative, and the associated heavy investments in the Boma Health Teams and HHPs are aimed at achieving this critical interface with families for immense health benefits. The cost benefit of this investment outweighs the alternative investments in curative services if health promotion and disease prevention interventions are not undertaken in the first place.

ii) Health system expectation out of households is:

i) Improved health seeking behaviour
ii) Adoption of behaviours that promote, maintain or restore health.

3.2 Service Package; Content, Training Manuals and Reporting Tools

The Boma Health Initiative shall provide a service package drawn from the BPHNS that is aligned with the disease profile of the country. On the other hand the structure of the BHI aims at equitable access to preventive services by strengthening community structures that facilitate effective contact with communities at house hold level.

The BPHNS has five program areas that expands the details for service delivery, namely; Health Promotion, Maternal and Child Health, Communicable diseases, Non Communicable Diseases and Epidemics, Emergencies & Disasters. The BHI focuses on Health Education components of all the program areas and selected curative health services with high impact. This concept forms the basis of the health service package delivered by the BHTs and the HHPs.

The details of the specific programs to be delivered at the community level are detailed in the Service Package for BHI as attached in Annex 1. The development of the BHT Training Manuals and Hand books shall be aligned with the program details selected for the BHT. Community Based Health Management Information Systems shall be developed to measure system performance, access and quality of services provided.

3.3 Tools and Supplies

The success of the BHI requires that the Boma Health Committees, Boma Health Teams and Home Health Promoters are equipped with tools for performance of their tasks. These tools among others are summarised in the table below;

Tool/supplies	Example	Purpose
Stationery	Data Collection tools	ICCM, Mass Drug Distribution, Health Education record,
	Registers	Family Records, Birth and Death Registers,
	Reporting Forms	Summary reports for transmission to the Payam Health Office.
	Counter books	Keeping minutes of meetings
Protective gear	Aprons, Gum boots, Raincoats, Torch, Identity cards, Umbrella, gloves.	For Identification, protection from weather changes and infection control
Equipment	BHT Tool Box, Thermometers, MUAC tape	For keeping registers, data collection tools and reporting forms, Medicines for ICCM and NTDs; assessment of children for fever and nutrition status.
Guidelines	Health Education and Promotion guidelines; ICCM guidelines; and HMIS, Surveillance and Birth and Death Registration Guidelines	To maintain quality of interventions, reference, facilitate training, mentorship, supervision and reporting.
	IEC materials	To aid communication, eases understanding and memory
Medicines & Health Supplies	Medicines for ICCM and NTD	For management of Malaria, Diarrhoea, and RTI.

Communication	Mobile phones	Coordination, transmission of data and information.
Furniture	Chair with a writing pad	To facilitate writing in the field including communities meeting held under trees.
Buildings	Store	Safe custody of vital statistical archives and storage of medicines a head of mass distribution.
Transport	Motorcycles and Bicycles	To facilitate the BHT and the HHPs respectively
Utilities	? Telephone bills	Communication

3.4 Skills and Training

Most Payam Health Officers, Boma Health Teams and HHPs will be new to the health system, with diverse backgrounds, different levels of education. For assurance of quality and ease of implementation, substantial resources will be invested to train the human resources.

The BHT and HHPs will perform tasks across all program areas of the BPHNS;

i) Carry out Health Education
ii) Provide selected curative packages
iii) Support Community Management Information System:
iv) Vital Statistics

The training curriculum of the BHT and the HHP shall be based on health education and selected treatment services and other non- technical skills sets. The training curriculum shall aim to provide the knowledge, skills and attitudes consistent with the tasks of the BHT and HHPs as outlined under their roles; and the service package for BHI.

BHT and HHPs need a training that increases their knowledge in the technical areas to competently provide health education and treatment. Additional non-technical skills are also required to manage public affairs successfully. The training will cover;

a) Technical Knowledge

Basic understanding of the BPHNS and its program areas is needed;

i) Health Promotion
ii) Maternal and Child Health
iii) Communicable diseases

iv) Non communicable diseases
v) Epidemics, Emergencies & Disasters

Understanding some basic principles in the following areas is vital;

i) Principles of Health Education
ii) Selected curative services
iii) HMIS and Vital statistics

b) Non-technical skills

i) Action skills
ii) Problem solving skills
iii) Communication skills
iv) Interpersonal skills
v) Personal Administration

4. Implementation Strategy for the Boma Health Initiative

The justification, objectives, guidance for implementation have been extensively described with adopted options considered optimal by actors in the foregoing section. Systematic steps are described in this section for harmonious and effective implementation of the Boma Health Initiative. The implementation strategies will include the following;

1. Advocacy and dissemination of the BHI Concept for implementation
2. Establishment of structures of the community health system
3. Institution of measures for increased access and quality control in Service delivery
4. Strengthening leadership, governance and management
5. Monitoring and Evaluation of the BHI

4.1 BHI Concept advocacy and dissemination

The Boma Health Initiative will be widely disseminated and advocated for. Clear understanding of the concept, resource requirement, methods of work and expected results are critical to a multi-stakeholder commitment for a successful implementation. The BHI will be adopted by the Council of Ministers and launched by the Minister of

Health or a higher authority of his choice. The Parliament, and Council of Ministers are key stakeholders who should have clear understanding of the basics of this strategy. The highest level of representation of Donors, the United Nations agencies, Representatives of Multilateral and Bilateral Organisations, International and National NGOs, Civil Society and Media will be deliberately targeted and mobilised for their buy in.

Key activities will include:

i) Engagement of relevant ministries on the concept for their buy in; Ministries of Public Service, Finance, Social Services, Parliamentary affairs, Education, Agriculture.
ii) Engagement of Donor

Dissemination to States, Counties, Payams, and Bomas targeting the governance bodies health managers and health workers, NGOs Civil Society, Media, and special interest groups will be undertaken to enable the subnational levels constitute the governance structures, select, and recruit the BHTs in readiness for implementation of the community health program. Inventory of the Administrative units, the existence and functionality of health committees, and staffing will be documented.

The expected output:

i) Readiness of states to implement the Initiative is assessed.
ii) Partner support for the Boma Health Initiative mapped.
iii) Government support reiterated

4.2 Strengthening leadership, governance and management (Needs 2)

The Boma Health Initiative will directly involve over 7,500 staff at the Boma level. Clear leadership, strong governance and dynamic management is needed at all levels of the health system. The implementation process will be closely monitored to enable innovation and adaptation to changes. A coordination structure for multiple partnerships at National, State, County, Payam and Boma levels will be established or strengthened. Implementation of the Boma Health Initiative will rely on local government structures and tap to the extent possible the existing Professional and non-

health professional human capacities that already exist. It is hoped that implementation of the BHI will have health system wide positive impact.

The main activities will include;

i) Providing continuous leadership through development of appropriate guidelines, policies, legislation and regulatory frameworks.
ii) Establishing coordination mechanisms for strategic partnerships intersectoral collaboration, and regular management reviews of implementation processes.
iii) Mainstreaming BHI activities and aligning health operations of local governments with BHI.
iv) Regulate community health services and partnership in line with the provisions of the BHI.
v) Capacity building in leadership and governance.

Expected output;

i) Supportive Policy, Legislative and Regulatory frameworks for the BHI are in place.
ii) Partnership-coordination structure established.
iii) Strategic Partnerships and intersectoral coordination structures are established
iv) BHI operations are provided for in Planning and budgeting guidelines by MoH.

4.3 Establishment of institutional structures for the community health system

The Boma Health Initiative requires institutional structures at every level of government. The institutional capacities for governance and management are at different levels of functionality. The gaps identified during assessment and advocacy shall be filled to provide the prerequisite strength for implementing the BHI. This will include assessment of national and Sub national needs and capacities for Trainer of Trainers, managers and supervisors of the initiative and the required infrastructure, tools and equipment.

Main activities will include;

i) Activation/institution of governance bodies at Boma, Payam, County and State and National levels.
ii) Selection and Recruitment of Community Health Workers to form the BHT.
iii) Filling gaps in Human Resource for Health (Professional and non-professional) requirements at Payam, County Departments, and gaps in State and National Ministries of Health to support implementation of the initiative.

iv) Preparations for cascaded Training of staff and retooling of the health institutions for performance.
v) Mobilisation of resources for acquiring infrastructure, tools and equipment for the BHI

Expected output

i) Boma Health Committees are formed. Payam, County, State and National Health Committees are sensitised.
ii) Three CHWs are appointed to constitute the BHT in every Bama
iii) Staffing capacities in Ministries and Department for BHI implementation is improved.
iv) Technical capacities for CHW, Health Managers and TOT are built to manage the BHI.
v) Infrastructure, Materials, Tools and Equipment are mobilised to start implementation.

4.4 Institution of measures for increased access and quality control in service delivery

Most members of the Boma Health Teams (CHWs) will be members of the community with basic literacy and numeric skills, and varied backgrounds. Selection per Boma assures extensive access to services, however, additional measure will be needed for assurance of quality of services provided. Adherence to CHW selection criteria, the quality of training (material, methods, workload, timing etc.), availability of health commodities and tools, support supervision, innovation, motivation and community engagement will determine quality and success to a large extent.

Main activities will include;

i) Developing, printing (and testing) of Training Manuals and Hands Books for the BHTs to standardise training and service delivery.
ii) Training BHTs, progressively, in modules for all program areas starting with, Child Health, Maternal health, and Communicable Diseases etc. in stepwise manner.
iii) Consider establishing schools for the CHWs in the future.
iv) Train Home Health Promoters in community mobilisation techniques to collaborate with the BHT.
v) Collaborating with partner organisations and countries in the development of a long term (formal) training program for Community Health Workers.

vi) Participatory program planning, implementation, support supervision, monitoring and evaluation of the BHTs health activities.
vii) Establish BHT for all Bomas and mobile communities through innovation and selection of mobile CHW within that community.
viii) Carry out evidence based approaches for community engagement through door to door mobilisation, community dialogue, and community action for health.

Expected outputs

i) Training Manuals and Hand Books (guidelines) for BHTs are produced.
ii) BHTs are trained in the service packages of the BHI in modular fashion.
iii) In the long run, CHW Training Schools are established.
iv) Activities of BHTs and Home Health Promoters are professionally managed; Planned, implanted under supervision, and monitored.
v) BHT are functional using community engagement techniques in all Bomas in collaboration with Home Health Promoters guided by the Ottawa Charter.

4.5 Monitoring and Evaluation of the BHI

The Boma Health Initiative was conceived to increase access to health services. An M&E systems will be established to measure increase in access to health services, quality of intervention, levels of awareness in communities, and performance of the community health system. Such information will be used for making strategic and management decisions. Routine data collection and surveys will be used to synthesise information.

The main activities will include;

i) Developing the M&E framework for the implementation of BHI.
ii) Developing key indicators for monitoring implementation
iii) Building capacities for data collection, reporting, collation, analysis, feedback and use of information.
iv) Developing operational research to guide implementation
v) Regular reviews at all levels to make use of the lessons learnt.

Expected outputs

i) Key indicators by level of the health system and the methods of collection are identified.

ii) Operational research concepts and methodologies developed.
iii) A dissemination or review plan is developed.

5. Financing the Boma Health Initiative

5.1Possible sources

The sources for financing the BHI shall come from three main sources;

1. The Government of the Republic of South Sudan shall finance;
    a. Salaries of the Community Health Workers (staff).
    b. Recurrent budget of the Payam Health office, BHT and HHP.
    c. Acquire tools, equipment
    d. Medical and health commodities
2. Health Development partners/ assistance
    a. Recurrent budget of the Payam Health office, BHT and HHP.
    b. Contracting staff to fill vacancies at the County and Payam
    c. Acquire tools, equipment
    d. Medical and Health Commodities
3. The Local governments. These funds may come from locally generated funds, conditional grants for capacity building in local governments, or discretionary funds available to the counties from any source. They could be used for;
    a. Recurrent budget of the Payam Health office, BHT and HHP.
    b. Contracting staff to fill vacancies at the County and Payam
    c. Acquire tools, equipment

5.2 Estimated cost of establishing the Boma Health Initiative

1. Structure for the Boma Health Initiative

Assumptions	2008	2017
Boma	2136	2500
Payam	509	545

Counties	79	85
States	10	12

2. Cost of Salaries

Structure	Staff	Min. Qualification	No. of Staff	Unit Cost	Freq of payment	No. of Units	Sub total
State Ministry of Health	Director PHC	Masters	1	2000	12	12	288,000
County Health Office	Public Health Officer	Degree	1	1200	12	85	1,224,000
Payam Health Office	Health Promotion/ Education Officer	Diploma	1	800	12	545	5,232,000
Boma Health Office	Community Health Workers	School Certificate	3	500	12	2500	45,000,000
Total							51,744,000

3. Costs of Advocacy Sensitization and Training

Activity	**Structure**	**No. of participants**	**No. of Admn. Units**	**Unit Cost**	**Freq of payment**	**Sub total**
Advocacy	National Launch	60	1	500	1	30,000
	State Ministry of Health	40	12	250	1	120,000
Sensitization	County Health Office	40	81	250	1	810,000
	Payam Health Office	40	545	250	1	5,450,000
Training	Boma Health Office	40	2500	250	14	350,000,000
Total						356,380,000

4. Cost of material resources

Item	**Description of units**	**No. of Units**	**Unit cost (SSP)**	**Sub total**	**Total**

Stationery	*Data Collection tools*	7,500	100	750,000	
	Registers	7,500	100	750,000	
	Reporting Forms	7,500	100	750,000	
	Counter books	7,500	100	750,000	**3,000,000**
Protective gear	*Aprons*	7,500	50	375,000	
	Gum boots	7,500	50	375,000	
	Rain Coats	7,500	50	375,000	
	Tourch	7,500	50	375,000	
	Identity cards	7,500	50	375,000	
	Umbrella	7,500	50	375,000	
	Gloves	7,500	50	375,000	**2,625,000**
				-	
Equipment	*BHT Tool Box,*	7,500	500	3,750,000	
	Thermometers	7,500	20	150,000	
	MUAC tapes	7,500	20	150,000	**4,050,000**
				-	
Guidelines	*Health Education and Promotion guidelines;*	7,500	500	3,750,000	
	ICCM guidelines	7,500	500	3,750,000	
	HMIS and Surveillance Guidelines	7,500	500	3,750,000	
	Birth and Death Registration Guidelines	7,500	500	3,750,000	
	IEC materials	7,500	500	3,750,000	**18,750,000**

Medicines & Health Supplies	*Medicines for ICCM and NTD*	7,500		-	
Communication	*Mobile phones*	7,500	300	2,250,000	**2,250,000**
Furniture	*Chair with a writing pad*	7,500	150	1,125,000	**1,125,000**
Buildings	*Store*	2,500	15000	37,500,000	**37,500,000**
Transport	*Motorcycles*	500	20000	10,000,000	
	Bicycles	7,500	1500	11,250,000	**21,250,000**
Utilities	*? Telephone bills*	7,500	100	750,000	**750,000**
Grand Total					**91,300,000**

5.Operational costs for service delivery through Outreach

Item	Description of unit	No. of Units	Unit cost (SSP)	Freq	Sub total	Total
Allowances for Payam Health Officer	Lunch allowance	500	20	156	1,560,000	
	Transport	500	30	156	2,340,000	**3,900,000**
				156		
Allowances for BHT	Lunch allowance	7500	20	156	23,400,000	**23,400,000**
	Transport	0		156	-	
				156		

					-	
Allowances for HHP	Lunch allowance	5000	20	156	15,600,000	**15,600,000**
Total						**42,900,000**

Operational costs

Assumptions:

1. 3 outreach programs per week
2. work with HHP per outreach
3. Local rate apply
4. Payam Health offices functional

6. Summary of cost estimates for BHI implementation:

Cost Area	Cost Estimate
Cost of Salaries	51,744,000
Cost of Advocacy, Sensitisation & Training	356,380,000
Cost of Material Resources	91,300,000
Operational Costs for service delivery	42,900,000
Total	**542,324,000**

Annex 1: Health Service Package for the Boma Health Initiative

This annex outlines the Health education, and health/treatment intervention objectives for the BHI. It further guides the development of the training syllabus for the Community Health Workers and Home Health Promoters.

The Health Service Package for the Bama Health Initiative has two main aspects; the aspect that defines what the communities deserve based on the disease pattern (what a community health program **should** deliver), and the second aspect that defines what

the Community Health Workers **can** deliver based on their numbers, level of education, the area of a Boma.

Aspect 1: What Communities deserve is detailed in the table below. It is comprehensively aligned with the community components of the Basic Package of Health and Nutrition Services. It sets the benchmarks for all community health programs designs, integrated or vertical alike.

Table a: Comprehensive package of Community Health Services

Program area 1: Health Promotion	
a) Community Health Program	
Elements	**Health Education focus areas for behaviour change**
Nutrition	Breast feeding practices, maternal and Child nutrition, nutrition for vulnerable groups, food production, balanced diet, food handling and bad nutrition practices, nutrition linked diseases.
Water & Sanitation:	Culture and sanitation, water chain and water safety, water contamination and diseases, CTLS and PHAST, personal hygiene, domestic hygiene and environmental hygiene.
Individual Lifestyle risk factor:	Smoking, Alcohol, Narcotics, Eating habits, Exercise, Sex, sleeping habits, HIV/AIDS etc.
Health seeking behaviour	Risk and cost communication for improved health seeking behaviour
Work Environment	Occupational health risks; Hazards, Injuries and violence.
Housing/Home environment	Home improvement, accidents, use of space and storage, cooking, animal houses, pit latrines etc.
Road safety	Road use, common accidents, effects, First Aid
b) School Health Program	
School health	Adolescent Health, Behaviour Change Campaigns, Health Parades, Personal Hygiene, First Aid, Deworming, Vaccination, Substance Abuse, School WASH, Lightening,
c) Cross-cutting strategies for health promotion	
Strategies	Use of IEC Material, Interpersonal Communication, Sensitisation Campaigns, Coordination with groups in communities, Elders, Religious and Opinion leaders, Appropriate Channels, Peer groups, Demonstrations, Intersectoral Collaboration

Program Area 2: Maternal Child Health	
a) Child Health	
Elements	**Intervention focus area**
Expanded Program for immunisation (EPI)	Create awareness on vaccine preventable diseases, effectiveness of vaccination, possible side effects and the vaccination program for the community. Community mobilisation for routine and mass vaccination, vaccine preventable disease surveillance, surveillance for adverse effects following vaccination, and immunisation defaulter tracing.
Care of the new born	Training caregivers to keep the new born warm and extra care for LBW babies. Training in kangaroo mother care method (KMC) is essential for counselling mothers Prevention and identification of infection and Common new born danger signs for referral.
Integrated Community Case Management	Recognising diarrhoea, ARI and fever for community level case management, and danger signs for initiation of referral. Case detection and provision of community based treatment, and referral.
	Good breastfeeding practices; prompt initiation of breastfeeding, exclusive breastfeeding up to 6 months, appropriate introduction of complementary feeding 24 months and beyond.(up to new birth) **Identification of Malnutrition;** for appropriate management options **IYCF** (infant and young child feeding) practices as outlined below: • Community based growth monitoring • Demonstrations in diet rich in protein and calories by selection and enrichment of local weaning diet. • Screening and supplementary feeding for moderate malnutrition and for children in families of at risk child.
Program area 2: Maternal and Child Health	
b) Maternal health	
Elements	Intervention focus area
Safe Motherhood	**Health Education**: Focused Ante Natal Clinic, Safe delivery, Recognition of danger signs in pregnancy and labour, Nutrition counselling, Birth preparedness and family

	planning. **Mobilisation**: Identification of pregnant mothers, Referral for facility based deliveries and other services, Screening for malnutrition and referral.
Men's Reproductive Health	Counselling and awareness for gender equitable sexual and reproductive roles, male reproductive organ disorders, the signs and management options. Counselling, referral and Distribution of condoms.
Sexually Transmitted Infections	Encouragement of prompt health care-seeking behaviour in case of experiencing symptoms and signs of STI and referral for VCT Promotion of safer sexual behaviour including condom use. Distribution of condoms and Prevention and care of congenital syphilis and neonatal conjunctivitis
Adolescent Sexual and reproductive Health	**Awareness creation on ARH services**: demand generation for ARH and counselling of youth and their sexual partners for FP/RH services Youth focused services: Counselling and testing, syndromic management of STIs and counselling on sexuality and safe sexual practices
Maternal Death Surveillance and Response	**Awareness and Risk communication:** related to maternal deaths and the need to report maternal deaths to raise community awareness and guide response. Case identification verbal autopsy and reporting
Gynaecological conditions	**Awareness creation**: Obstetric and gynaecological complications and referral
Sexual and Gender based violence	**Awareness creation:** Definition, advocacy, prevention and management of GBV and referral

Program area 3: Communicable Diseases	
a) Common endemic diseases	
i) Malaria	**Environmental measures**: Awareness creation, Environmental sanitation, Use of LLITNs, Counselling/

	monitoring adherence to treatment **ICCM**: Case identification, Treatment, and Referral
ii) Tuberculosis	**Environmental control measures:** Creation awareness on; Housing design, avoidance of overcrowding, observing coughing etiquette, Counselling/ monitoring adherence to treatment **DOTS**: Identification of presumptive TB cases, Monitoring/ supervision of community based treatment DOTs, Refer for Preventative therapy for children contact of TB patients, Defaulter tracing.
iii) HIV/AIDS	**Communication for Safe sexual behaviour and compliance to treatment;** BCC for abstinence, faithfulness, condom use, adherence to treatment plan **Interpersonal intervention**: Condom distribution, HIV counselling and testing/referral for testing, Referral for HIV/AIDS treatment and care including PMTCT, Home based care and adherence counselling for PLWHA already on treatment, Counselling for de-stigmatisation.
iv) ARI	Environmental sanitation, avoidance of, indoor smoking, improved ventilation, warm clothing etc. **ICCM**: Prompt Community case management including referral
b) Diseases of High Epidemic Potential	
Cholera, Meningitis, Hepatitis B, Measles, Ebola etc.	**Creation of awareness**: • In the community on participatory health and sanitation (PHAST) actions for epidemics prevention. • Door to door Community mobilisation for vaccination, and any other appropriate community response to epidemics. • Emergency preparedness by identifying early warning signs for outbreaks, developing responses and reporting • Passive and active Integrated Community Based Surveillance and Response
c) Neglected Tropical Diseases	

i) STH ii) Onchocerciasis iii) Lymphatic Filariasis, iv) Trachoma v) Guinea worm vi) Loa-Loa vii) Kalazar viii) Sleeping Sickness.	**Mass Awareness Creation:** On the causes, dangers and impact and means of prevention of the diseases NTDs. **Environmental Control Measure: S**afe water & sanitation and vector control **Preventive chemotherapy**: through mass drug administration (MDA) and supporting other national control programmes (Mass de-worming and micronutrient supplementation on National Immunization days)
d) Diseases targeted for Eradication	
i) Polio ii) Guinea Worm	**Mass Awareness Creation:** on the causes, dangers and impact and means of prevention of the diseases targeted for eradication including; • Safe water and sanitation Need for reporting cases for further investigation. • Case identification through heightened AFP and Guinea worm surveillance and Referral procedures. • Vaccination campaigns
Program area 4: Non Communicable diseases	
a) Systemic diseases and orders	
i) Diabetes ii) High Blood Pressure iii) Cancers	**Mass awareness creation** • Common signs and symptoms for seeking care and referral. • Good nutrition practices • Physical activity/exercises. • Risks of NCDs Alcohol, tobacco and substance use and abuse Socio economic risks, Counselling for appropriate care, referral for rehabilitation, and adherence to treatment.
b) Eye care and Visual Health Services	
Control of Preventable blindness	Awareness creation • Hygiene and sanitation • Nutritional deficiencies and blindness • Types and causes of eye diseases • Mass drug administration for treatment and prevention of blindness • Referral to health facility for eye care

c) Mental Health	
	Mass awareness creation Prevention of mental illnesses (including stress) and promotion of mental health, Identification of mental health issues, initiation of referral for psychosocial support to health facilities.
d) Therapeutic Nutrition	
Control of Malnutrition	**Mass awareness creation on** Malnutrition, Deficiencies and causes of malnutrition, Mass de-worming, micronutrient supplementation, National Immunization days. Screening and identification of malnutrition, Home based nutritional rehabilitation and follow up for mild malnutrition, Mass de-worming and micronutrient supplementation on National Immunization days Referral of malnourished cases
e) Physical disability	
Accidents & violence	**Mass awareness creation** Identification common hazards in the community and injury prevention, violence and occupational health Sensitization on disabilities to reduce stigmatisation, and promote social inclusion including education opportunities Referral for rehabilitation and other appropriate services.
Oral Health	**Mass awareness creation** Oral Hygiene Referral for oral health care
Program area 5: Epidemics, Emergencies & Disasters Preparedness and Response	
Community based Information and Surveillance System	
	Health Education for behaviour change
Community based IDSR	Awareness on identification of epidemics, emergencies and disasters, Report adverse health events in their communities including Maternal Mortality, Referrals, Payam Health Department/ Health facilities

Community HMIS	Report to Payam Health departments activity reports, resource use and accountability (Technical reports)
Community Mobilisation	Door to door community mobilisation.
Vital Statistics	Community awareness on vital statistics Report to Boma administration Vital Statistics; Births and Deaths, and other basic data required.

Aspect 2: The initial service package Community Health Workers can deliver at the beginning of the Boma Health Initiative is defined by the most common causes of illnesses and deaths. The initial package will include; Communicable diseases, Integrated Maternal Neonatal and Child Health services as outlined in the table (b) below.

Table b: Initial Package for the Boma Health Teams

Communicable Diseases	
Diseases	**Interventions by CHWs**
Malaria	• Health Education: For awareness, Prevention and Treatment • Commodity Distribution: ITN and appropriate use • Treatment: Use of ACT in case management • Mobilisation: environmental measures
HIV	• Health Education: on awareness, Prevention, treatment • Commodity Distribution: Condoms • Mobilisation: Mobilisation for VCT, Treatment and PMTCT
Tuberculosis	• Health Education: For awareness, Prevention and Treatment • Referrals: Presumptive cases or Sputum to diagnostic centres • Treatment: DOTS, follow ups and defaulter tracing
Diseases of epidemic Potential	• Health Education, Prevention, treatment where possible • Community based surveillance
Child Health	
Priority areas	**Interventions by the CHWs**
Immunisation	• Health Education: Awareness for immunisation uptake • Mobilisation: mobilisation of communities for outreach services • Vaccination: carry out vaccination
Nutrition	• Health Education: Breast feeding, and nutrition • Growth monitoring: Screening for nutritional status and

	advice • Referral: Further management
Malaria, Diarrhoea and Pneumonia	• Health Education: Wash • Treatment: Diagnose and treat • Referral: Further management in health facilities
Maternal Health	
Priority area	**Interventions by the CHW**
Safe motherhood	• Health Education on; ANC, safe deliveries, Post Natal Care, Care of the New, Family Planning • Referrals: Referrals for assisted deliveries.
	• Maternal Death Surveillance and Response
First Aid	
Priority area	Prevention and management of Injuries; Accidents and Violence.
Community Information System	
Priority Area	**Interventions by Community Health Workers**
Community HMIS	• Reporting: Regular activity reporting
Vital Statistics	• Family Records: Births and Deaths registration.