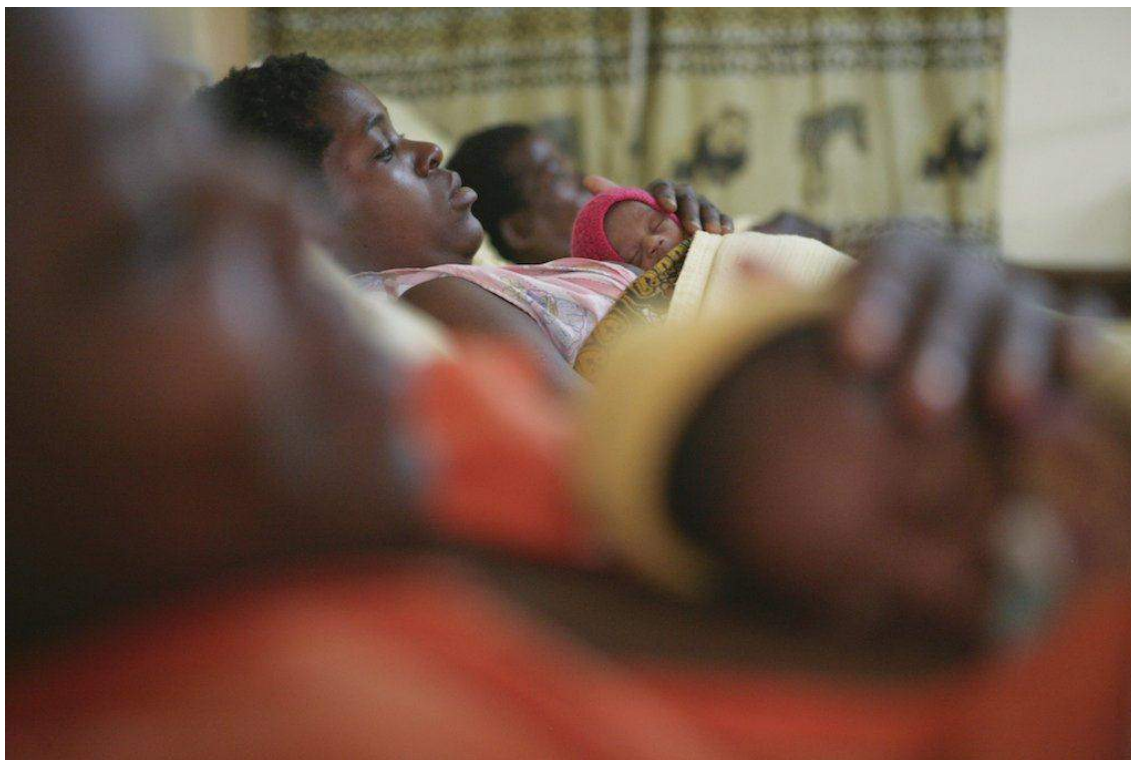




CONTEXT ANALYSIS: CLOSE-TO-COMMUNITY PROVIDERS IN MALAWI



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March 2014



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ACKNOWLEDGEMENTS

We would like to thank the European Union for its financing and support. This document reflects only the authors' views, and the European Union is not liable for any use that may be made of the information contained herein.

We appreciate the support from the Country Advisory Group (CAG) for the project. Furthermore, we thank health workers, NGO officials, traditional leaders and community members from the study areas in Mchinji and Salima districts.

EXECUTIVE SUMMARY

This study was part of the broader REACHOUT project and aimed at describing and analysing factors that affect the performance of close-to-community (CTC) providers. The REACHOUT project consists of three phases: a context analysis; followed by a first quality improvement intervention cycle aimed at improving the performance of CTC providers; and a second intervention cycle with further interventions to improve performance. In Malawi the focus of the project is on improving services provided by Health Surveillance Assistants (HSAs), a cadre of community health workers employed and salaried by the Ministry of Health. This document reports on the results of the context analysis. The study had the following objectives:

- to map the types of CTC providers;
- to assess structures and policies of the health system to understand the strengths and weaknesses regarding the organization of CTC services and management of CTC providers;
- to identify and assess contextual factors and conditions that form barriers to or facilitators of the performance of CTC providers and services; and
- to synthesize evidence on key barriers and facilitators to be built on in future CTC interventions and identify knowledge gaps to be filled regarding CTC services.

The context analysis study was implemented in two phases. The first phase was a desk review which mostly used grey and some published literature on CTC providers in Malawi. The second phase was a qualitative study conducted in two districts in the central region of Malawi — namely, Mchinji and Salima. Focus group discussions and semi-structured in-depth interviews were used to collect data. Respondents for the study included: mothers with children under five years of age, clinicians, nurses, environmental health officers, traditional leaders, volunteers, Traditional Birth Attendants (TBAs), HSAs, officials working for non-governmental organizations in the districts and District Council officials. Data were analysed using a combination of a framework approach and grounded theory in the sense that we used a conceptual framework to organize our data yet allowed for an incremental addition of themes in the course of data collection and analysis. The conceptual framework consisted of three major themes: broad contextual factors, health systems factors and intervention design factors that could affect the performance of CTC providers of health services.

A stakeholder analysis was also conducted using a stakeholder matrix, which guided the analysis to identify the most influential stakeholders which also had an interest in the objectives of the REACHOUT project.

Both the desk review and the qualitative research that followed were guided by the conceptual framework. Findings from the desk review were similar to what was noted from the qualitative study. Thus, broad contextual factors such as the unfavourable economic conditions were reflected across the study phases through an outcry related to poor remuneration and unfavourable working conditions (at the level of CTC interventions). The major health system factors emerging were inadequate supplies and logistics: CTC providers reported a shortage of supplies such as uniforms and bicycles, as well as basic materials such as pens and reporting forms.

Among the intervention design factors, the providers reported challenges related to supervision. Supervision was mostly not done due to inadequate financial and human resources. Where supervision was conducted, it was often uncoordinated, top-down and unsupportive. Most HSAs reported receiving feedback only when something went wrong with their work. Another prominent intervention design factor was the issue of remuneration, particularly allowances. Allowances were a key incentive to CTC providers in their work; at the same time they were a demotivating factor with the potential to harm the health system in at least three ways. First, CTC providers who felt sidelined by those in charge of allowances opted not to dedicate themselves to the tasks at hand. Second, the CTC providers were more dedicated to activities that promised more allowances, such that organizations that paid no allowances or offered lower allowance rates were shunned. Third, a craving for allowances had reduced training sessions into allowance-generating activities.

These findings on remuneration were applicable to both HSAs, who are the main CTC providers, and other CTC providers generally referred to as volunteers. High attrition was reported among volunteers, which has implications for loss of institutional memory and the need for ongoing training and support of new volunteers.

Although the concern about allowances is certainly a predominant one, it is not an easy target for quality improvement cycles; the issue concerned several stakeholders which had disparate policies related to allowances. Therefore, based on the study findings, we decided to focus on an improvement cycle that would allow for at least two things. First, the intervention has to be feasible; the issue of allowances is too complex and involves too many stakeholders which are not yet ready to be brought onto one line to allow for a plausible intervention. Second, it has to be an intervention where progress could be demonstrated within the three year time-frame of the REACHOUT project.

Following the sharing of the study results with different stakeholders at national and district level, stakeholders prioritized strengthening the supervision system as the focus for the first intervention cycle. Based on this, we decided to focus on supervision, which was one of the major challenges affecting the performance of CTC providers. The different aspects related to supervision, such as training supervisors and developing systems for supportive and cost-effective supervision through group supervision meetings, can be addressed to deliver tangible results within the specified REACHOUT project time period. The improvement cycle would mainly focus on HSAs, as they are the main link between the health systems and the community volunteers. HSAs also carry the responsibility of supervising other CTC providers including the volunteers. There is a need, therefore, to safeguard and support HSAs as salaried civil servants and part of the health system. The sustainable services they offer are valued and appreciated by most community members, including those who are hard to reach.

The focus on supervision has two elements. First, we will focus on the supervision of HSAs, and, as some of their responsibilities require them to engage and mobilize communities, we expect that they will be more vigilant in supporting other CTC providers, including the volunteers that work within their catchment areas. Here, the approach is to support the coordination of supervision and training of supervisors and advocate for District Health Management Teams to prioritize the supervision of HSAs in a context where curative services are generally more preferred (since HSAs mainly report through the preventive health services department). Training of supervisors would focus on the HSAs' supervisors as well as the HSAs themselves, since HSAs do supervise volunteers.

Second, the health focus will be on an ongoing programme implemented by HSAs, on child health with a focus on integrated community case management (ICCM) of common childhood illnesses including malaria, pneumonia, diarrhoea and pre-referral treatment of newborn sepsis. This will provide an opportunity to design a supervision intervention based on an established programme which has supervision challenges because it has both curative and health promotional components. HSAs generally fall under the preventive health services department and are supervised through it. However, ICCM requires that they should be supervised by staff with clinical skills. This has, therefore, caused some challenges in the HSAs' supervision system and requires better coordination and planning to ensure that HSAs are effectively supervised on their different roles. Thus, we will seek to address the supervision-related challenges identified in the study by focusing on the programme's supervision structure. Therefore, while aimed at addressing the challenges identified, the intervention will also seek to draw lessons on what works well within the programme. Such a two-pronged approach will allow for new lessons on integrating effective supervision in largely donor-funded programmes such as the ICCM and the challenges related to routine work carried out by the HSAs.

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ABBREVIATIONS AND ACRONYMS

ARVs	Antiretrovirals
CHAM	Christian Health Association of Malawi
CHBC	Community home-based care
CTC	Close-to community
DHO	District Health Officer
FGD	Focus group discussion
HSA	Health Service Assistant
ICCM	Integrated community case management
IDI	In-depth interview
MSF	Médecins Sans Frontières
MSH	Management Sciences for Health
NAPHAM	National Association for People Living with HIV and AIDS
NGO	Non-governmental organization
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PSA	Patient Support Attendant
TB	Tuberculosis
TBA	Traditional Birth Assistant
VHC	Village Health Committee

CHAPTER 1 – INTRODUCTION

BACKGROUND

There is a growing recognition of close-to-community (CTC) providers of health services as an integral component of the health workforce needed to achieve the Millennium Development Goals [1]. There are many types of CTC providers, such as community health workers, midwives, Traditional Birth Attendants (TBAs), informal private practitioners and lay counsellors, delivering a wide range of services in different contexts. Their roles include education, counselling, screening and point-of-care diagnostics, treatment, follow-up and data collection.

CTC providers may operate in the public or private sectors, including Christian Health Association of Malawi (CHAM)¹ facilities, respond to single or multiple diseases and have differences in their level of knowledge and training, their practice setting and their relationship with regulatory systems [2]. We use ‘CTC providers’ as an umbrella term to describe health workers at community level, and define CTC providers as follows:

A CTC provider is a health worker who carries out promotional, preventive and/or curative health services and who is the first point of contact at community level. A CTC provider can be based in the community or in a basic primary facility. A CTC provider has at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training.

Thus, CTC providers are embedded within communities and can offer opportunities to strengthen health services in equitably, effectively and efficiently, though these objectives are often unmet. Vertical, disease-specific programmes that use CTC providers for service delivery tend to give limited consideration to the multiple workloads and competing priorities they face. Services struggle to plan and manage their human resources, resulting in high staff attrition and poor effectiveness, and the quality and supervision of services varies widely. CTC services often lack monitoring and evaluation systems, and referral mechanisms to formal health facilities are poorly tracked or recorded. The contribution of CTC services is often not valued, nor is their potential maximized. There is a need for the formal health system to better understand the context and conditions of CTC services to strengthen and support these critical services to realize their potential.

¹ Christian Health Association of Malawi (CHAM) is a non-profit organization and provides 37% of the health services in Malawi.

In Malawi, the engagement of CTC providers takes place in a context of acute human resources shortages, identified as a key barrier to achieving the Millennium Development Goals, particularly in the health sector [3]. One prominent cadre of CTC providers in Malawi is that of the Health Surveillance Assistants (HSAs). The Malawi Ministry of Health defines HSAs as primary health care workers serving as a link between a health facility and the community [4, 5].

The history of HSAs can be traced back to the 1950s, when they were known as ‘Public Vaccinators’ and later ‘Smallpox Vaccinators’ after they were engaged in the smallpox eradication campaigns spearheaded by the World Health Organization in the late 1960s and early 1970s [6, 5]. Following a 1973 cholera outbreak in Nsanje district, the shortage of health workers necessitated the recruitment of additional staff, including the hitherto smallpox vaccinators. Known as ‘Cholera Assistants’, the new staff were supposed to be primary school graduates and worked on a temporary basis with contracts terminated at the end of each outbreak. Based on the Public Health Departments’ recommendations, the Ministry of Health maintained the Cholera Assistant post and extended their recruitment to all districts. Subsequently, the more encompassing name of ‘Health Surveillance Assistant’ was adopted [7, 6]. Therefore, HSAs are a well-grounded CTC provider cadre in Malawi.

HSAs have performed a number of duties over the years. Presently, their tasks cover community health, family health, environmental health, prevention and control of communicable diseases, and management and administration [8, 5, 7]. Driven by the task-shifting philosophy,² duties and responsibilities for HSAs have expanded such that some HSAs are not able to list all the activities they are required to perform [6]. Besides a heavy workload, HSAs also face challenges related to poor remuneration, inadequate equipment and a lack of a clear career path [6, 8].

While HSAs are a key CTC cadre in Malawi, there are other CTC providers playing important roles in Malawi. Such providers include TBA,³ expert patients, community-based distribution agents and community care providers [8, 9, 10, 11, 12]. Unlike the preceding CTC providers, HSAs are an outstanding cadre because they are clearly linked to the health system, have national coverage — thereby making their services relatively equitable and accessible — and

² The World Health Organization (2006: 7–8) describes task shifting as “moving appropriate tasks to less specialized workers [which] represents a radical departure from traditional delivery models that depend on specialist workers, and it could make a major contribution to expanding access to [health care] services, especially among poor and marginalized populations.” [9 pp. 7-8].

³ Although the role of TBAs is contested (for example, see 10), they are nevertheless important CTC providers with influence in the provision of maternal and child health services at community level in Malawi.

are on the government payroll, enabling their services to be sustainable [6]. However, there is significant room for improvement in the way CTC providers, including HSAs, deliver services to ensure equity, effectiveness and efficiency.

The premise that underpinned our thinking was that CTC services and providers can be strengthened to enhance health systems' performance in terms of equity, effectiveness and efficiency. The extent to which CTC services are successful depends on three broad and interrelated areas or determinants: broad contextual factors, health systems factors and intervention design factors (see Annex 1).

STUDY AIM AND OBJECTIVES

This study aimed at describing and analysing factors that affect the performance of CTC providers in Malawi and had the following objectives:

- to map the types of CTC providers;
- to assess structures and policies of the health system for strengths and weaknesses regarding the organization of CTC services and management of CTC providers;
- to identify and assess contextual factors and conditions that form barriers to or facilitators of the performance of CTC providers and services; and
- to synthesize evidence on key barriers and facilitators to be built on in future CTC interventions and identify knowledge gaps to be filled regarding CTC services

CONTEXT ANALYSIS

The context analysis involved a number of activities — namely, a desk review, stakeholder mapping and qualitative research in two districts.

REPORT SECTIONS

In the following sections we present findings from the desk review, the stakeholder analysis and qualitative research. These sections are followed by a discussion of the findings and implications for the conceptual framework and quality improvement cycles.

CHAPTER 2 – DESK REVIEW

INTRODUCTION

This desk review covers: a mapping of CTC providers in Malawi and an overview of the evidence of their effectiveness; health system, community and policy barriers to and facilitators of the performance of CTC providers in Malawi; and key barriers and facilitators to be built on in future CTC interventions. For purposes of this review and in accordance with the definition of CTC providers adopted by the REACHOUT project, HSAs were regarded as the main CTC providers, while the other health service providers at community level were categorized as other CTC providers. Other CTC providers covered in the review included: Village Health Committees (VHCs), community care providers, support groups, patient support attendants, 3M mothers,⁴ community-based distribution agents and TBAs.

METHODOLOGY

Documents for review were sourced by:

- obtaining relevant policy documents from the Ministry of Health (one of the Country Advisory Group members for the project assisted with some of these documents);
- visiting institutions involved in conducting community health research;
- visiting relevant libraries and archives;
- visiting NGOs involved in the provision of community health services;
- conducting online searches; and
- consulting relevant literature published by REACH Trust researchers.

The institutions visited included:

- The Centre for Social Research;
- Kamuzu College of Nursing and College of Medicine of the University of Malawi; and
- The Chancellor College Library of the University of Malawi and Malawi National Archives in Zomba.

NGOs contacted included:

- Médecines Sans Frontières (MSF);
- World Vision, Mai Khanda Project under the Health Foundation;
- the National Association of People Living with HIV/AIDS (NAPHAM); and
- the Malawi Network of People Living with HIV/AIDS (MANET+).

⁴ Mother to mother to child.

Documents obtained from these institutions were reviewed, and those that were found relevant were included in the review. The main inclusion criterion for the documents was that the studies and documents needed to have community health workers as their focus. It did not matter what the role of the health workers was. The time period for the studies and policy documents was left open-ended.

FINDINGS

CTC PROVIDER MAPPING

HEALTH SURVEILLANCE ASSISTANTS

As noted in the introduction to this report, HSAs are the main CTC providers in Malawi. Having explained the HSAs' background in the introduction, this section will focus on their training and further details on their roles.

Training periods for HSAs have changed over time. They starting at six weeks in 1992, increased to eight weeks in 1995 and 10 weeks in 2003 and stood at 12 weeks in 2013 [4, 7]. Three centres have been used to train HSAs — namely, Mzimba in the north, Mponela in the centre and Mwanza in the south. The revision of the HSA:population ratio from 1:2000 to 1:1000 has meant the recruitment of more HSAs who require training [6, 4, 7]. The overwhelming number of HSAs in need of training was also due to the recruitment of 6000 HSAs in 2006 with support from the Global Fund to Fight HIV, Tuberculosis and Malaria [6]. The high number of HSAs led to the decentralization of their training to district level, and the new recruits were supposed to learn on the job from experienced HSAs while waiting for their turn to be trained, since the training was done in phases [6].

HSAs have performed a number of duties over the years. Presently, their tasks cover community health, family health, environmental health, prevention and control of communicable diseases, and management and administration. Driven by the task-shifting philosophy, duties and responsibilities for HSAs have expanded such that some HSAs are not able to list all the activities they are required to perform [6]. Government agencies and non-governmental organizations (NGOs) tend to use HSAs as favoured conduits to provide any new CTC health programmes. Besides the assigned responsibilities, some projects have used HSAs to distribute contraceptives and other family planning methods [6, 11], record vital events in relation to child mortality [10] and support informal health care providers offering tuberculosis (TB) and HIV services by linking them to the formal health system.

Furthermore, selected HSAs are involved in the provision of services at village clinics. The clinics were pioneered by UNICEF, under the child survival call to action campaign, which mobilized countries to end preventable child deaths. Under the initiative, HSAs were allowed to operate from their homes or in some instances communities led by their chiefs would identify a shelter where HSAs would provide health care services. This then was called the ‘village clinic’. Basically, the clinic ensures that treatment is only a few minutes’ walk away, thereby bringing health care closer to the people. Services provided at the clinic include treatment of pneumonia, uncomplicated malaria and diarrhoea.

VILLAGE HEALTH COMMITTEES

The Public Health Department introduced VHCs to motivate and encourage communities to participate and become involved in public health activities, including prevention and control of cholera [7]. Functions of the VHCs include: helping to raise the standard of sanitation in the community; reporting health-related problems to health workers; mobilizing communities for health promotion activities; assisting health workers in community work; and bridging the gap between communities and health workers. VHCs, whose members are unpaid volunteers selected by community members, are expected to participate during problem identification, planning, decision-making, implementation, monitoring, evaluation, re-planning and supervision. HSAs form VHCs in consultation with village chiefs and provide them with training and supervision (7).

COMMUNITY CARE PROVIDERS

The Malawi Community Home-Based Care (CHBC) Policy defines a community care provider as “a community member identified by the community and trained in CHBC to render direct patient care to chronically/terminally ill persons and other vulnerable people in their homes” [4]. The provider works in the context of CHBC identified by the Malawi Ministry of Health as a key strategy in responding to patients suffering from HIV, cancer and TB. Other people requiring CHBC are those with stroke, liver cirrhosis, asthma, epilepsy, complicated diabetes, as well as elderly people and people with disabilities [4].

According to the Malawi National CHBC Policy, a community care provider is expected to carry out the following roles: identifying and recruiting patients requiring CHBC; providing basic nursing care; ensuring a safe and healthy home environment for the patient while seeking assistance in terms of resources from the community as required; managing simple ailments such as cough, fever, diarrhoea, vomiting, skin problems and other common problems; providing psychosocial support and nutrition counselling to patients/clients and families; referring patients/clients to health and other support services; keeping patients’ records on care given and providing monthly reports to their immediate supervisor; monitoring side-

effects and adherence/compliance for patients on long-term drugs including antiretrovirals (ARVs), Cotrimoxazole prophylaxis and TB drugs; conducting follow-up visits to expert clients; providing information, education and communication to patients and family members on the prevention of HIV, TB and malaria and the importance of HIV testing and counselling; advocating for the use of insecticide-treated nets by people living with HIV (PLHIV) and chronically ill patients; monitoring patients'/clients' response to treatment and CHBC; and facilitating mobilization of community transport for referral of patients from community to health facilities. Community care providers are unpaid volunteers.

SUPPORT GROUPS

The National CHBC Policy sets out the following roles for support groups: providing treatment literacy to patients/clients; providing basic nursing care, nutrition, peer and psychosocial counselling and support to patients/clients and families; mobilizing communities to access HIV services; conducting advocacy to communities and service providers; following up expert clients and ART defaulters; providing information, education and communication on HIV testing and counselling; and referring patients/clients to health and other support services.

One organization that epitomizes the role of support groups in Malawi is NAPHAM. A small group of PLHIV established the association in 1993 to fight stigma and discrimination and promote and advocate for an environment where PLHIV would live to their full potential and realize their goals. NAPHAM is a membership organization working in all 28 districts of Malawi, and all PLHIV interested in the association's activities can become members. It works through support groups formed at community level.⁵ Support group members work as unpaid volunteers.

PATIENT SUPPORT ATTENDANTS

Patient Support Attendants (PSAs) work as expert clients⁶ in Thyolo district to take on some of the adherence counselling workload of HSAs. The cadre was constituted following discussions between MSF, NAPHAM and the District Health Office. Qualifications for PSAs include: possessing a Junior Certificate of Education, having disclosed HIV status, being knowledgeable about HIV and having worked as a home-based care volunteer [12].

The PSAs' job description constitutes the following main tasks: individual and group education prior to initiation of antiretroviral therapy; conducting health promotion sessions for clients of

⁵ See: <https://www.justassociates.org/en/ally/national-association-people-living-hiv-and-aids-malawi-napham>.

⁶ The Ministry of Health defines an expert client as a person with more knowledge and experience in the specific condition who has been on treatment or with the condition for not less than two years and is better and willing to help fellow patients/clients on issues concerning the condition.

all services; identifying and promptly referring patients at risk and requiring medical attention; supporting patient-tracing activities; providing treatment literacy sessions; keeping records; and cleaning facilities [12].

THE 3M PROGRAMME

Mai ndi Mai ndi Mwana (Mother to Mother to Child) focuses on the prevention of mother-to-child transmission (PMTCT) of HIV. It is a peer support initiative modelled on the mother to mother (M2M) programme⁷ and is carried out by MSF and Thyolo District Health Office [13]. The objectives of the 3M programme include: reducing the number of babies infected with HIV and following up mothers and babies to ensure they receive appropriate medical care and support until the end of their PMTCT enrolment; providing peer education and psychosocial support to HIV-positive pregnant women and new mothers; helping women access existing PMTCT services; empowering HIV-positive pregnant women and new mothers to take responsibility for their own and their babies' health and well-being; encouraging and supporting disclosure of HIV status and fighting HIV-related stigma; and improving male involvement [13, p. 11].

To qualify as a 3M mother, besides considering her attitude and motivation, the applicant needs to fulfil the following criteria: be HIV-positive; have recently completed pregnancy in the PMTCT programme; live in the catchment of the health facility she has to apply for; have disclosed HIV status; and have basic numeric and literacy skills. The recruits undergo two weeks of basic training. Working as full-time employees with a MK12,000 monthly salary, the 3M mothers are mainly based at health facilities, where they conduct group and individual PMTCT and reproductive health-related health education sessions, provide individual psychosocial support, organize and facilitate PMTCT support groups and follow-up on the care and treatment provided by the nurse [13].

COMMUNITY-BASED DISTRIBUTION AGENTS

The Community-Based Distribution Agents (CBDAs) distribute oral contraceptives and both male and female condoms in selected Malawian districts⁸ under a project called 'Community-Based Family Planning and HIV and AIDS Services'. Targeting hard-to-reach and underserved areas, the project is implemented by Management Sciences for Health (MSH) and the Ministry

⁷ The M2M programme is aimed at "increasing uptake of and adherence to PMTCT interventions and promoting maternal and infant health. The model involves recruiting, training, employing, and supporting mothers living with HIV as Mentor Mothers to support, educate, and inspire HIV-positive pregnant women and new mothers to access and adhere to PMTCT interventions and prevent HIV transmission to their babies". See: http://www.aidstar-one.com/promising_practices_database/g3ps/mothers2mothers_pmtct_program.

⁸ The districts are Karonga, Kasungu, Nkhosakota, Salima, Mangochi, Balaka, Phalombe and Chikwawa.

of Health with Futures Group International (FGI) and Population Services International (PSI) as collaborators [11].

According to an evaluation report for the project [11], most CBDAs (85%) were recruited through voting by community members, while around 6% were selected by the village headmen. The rest of CBDAs were recruited through interviews; by replacing deceased members; through clubs, friends and HSAs or VHCs; and through NGOs such as MSH and Save the Children. CBDAs should be able to read and write, and should be trustworthy so as to keep sensitive information related to HIV status confidential.

CBDAs have been in existence in Malawi since the 1980s [11]. However, the training curriculum developed at that time was inadequate to deal with new challenges of HIV and family planning. To train the CBDAs under the new curriculum, the Reproductive Health Unit and the MSH trained two individuals per district, who in turn trained the CBDAs in their respective districts. The two-week training covered the following major topics: population and reproduction; the history of family planning in Malawi; adolescent reproductive health; the human reproductive system and conception; modern family planning methods; natural family planning methods; prevention of HIV transmission; and referrals and record keeping [11]. It should be noted that besides members of the communities, HSAs were also trained under the project in the administering of contraceptives, particularly depot-medroxyprogesterone acetate (DMPA).

TRADITIONAL BIRTH ATTENDANTS

Prior to the Ministry of Health's order that stopped TBAs from delivering babies [10], it was responsible for the training and control of TBAs in Malawi [14]. Smit (1994) traces the training of TBAs to 1976 when the Ministry of Health opened a register listing all trained TBAs at the time. In 1978, selected TBAs were trained at Kamuzu Central Hospital in Lilongwe, expanding the training programme to Mzimba, Dowa and Mwanza districts in 1980. By 1982 the programme had expanded to the entire country such that 841 TBAs had been trained by February 1987. However, this account does not imply that the history of TBAs in Malawi can be traced to these training programmes. In Malawi, TBAs predate the arrival of modern medicine, which initially targeted government officials, settlers, missionaries and their bearers [15, 16]. Elsewhere in the world TBAs predate modern medicine and have been a key human resource during childbearing [17].

As alluded to earlier, TBAs were banned from performing their midwifery role of assisting with childbirth. Instead, they were expected to refer pregnant women to health facilities [10]. However, studies have revealed that, despite the ban, TBAs were still assisting with child deliveries. For instance, an evaluation study by Munthali and Mvula (2009) in Kasungu and

Mangochi districts [18] showed that TBAs were still the preferred first point of call in women's health-seeking behaviour in relation to maternal health. In that study, TBAs were mostly called on because they were considered more adept at handling delicate issues apparently beyond the expertise of professional health workers. For instance, TBAs handled pregnancy-related matters supposedly emanating from witchcraft, including late deliveries, difficult labour and miscarriages. In a broad sense, TBAs were preferred to professional midwives, among other reasons because, first, women felt freer with the TBA. Second, TBAs took good care of women who miscarried, and, third, the TBA provided medicine that ensured smooth delivery [18].⁹

BARRIERS AND FACILITATORS TO THE PERFORMANCE OF CTC PROVIDERS IN MALAWI

HEALTH SYSTEM FACTORS INTERACTING WITH THE PERFORMANCE OF CTC PROVIDERS

Several health system factors are reported in the literature including inadequate human, financial and material resources, heavy workload, lack of and inadequate training, inadequate tools such as drugs and registers, and a lack of feedback after referrals [19, 6, 14, 18, 11,].

Among material resources, transport challenges were widely reported, with HSAs reporting that they did not have bicycles. Where the bicycles were available, HSAs were supposed to cover the maintenance costs [14, 18, 19].

Supervision systems were unclear and not very functional. Inadequate fuel and transport challenges affected supervision. Clinical services were preferred to preventative health, and supervision mostly targeted health workers in projects run by NGOs [11, 18, 19]. An evaluation in Thyolo also found that good human resources management had significant influence on motivation and performance [12].

COMMUNITY FACTORS INTERACTING WITH THE PERFORMANCE OF CTC PROVIDERS

Studies reported several challenges faced by CTC providers in their work at community level. The challenges included conflicts with other providers, being despised by some community members and a poor response from community members [18]. Furthermore, community members, including traditional leaders, expected hand-outs and allowances whenever they

⁹ A widespread belief among some communities in Malawi holds that infidelity by the husband during a woman's pregnancy will lead to difficult labour. Such difficult labour, it is believed, is also encountered when the husband is not responsible for the wife's pregnancy (if the wife 'cheated' on the husband). If the husband sleeps with another woman during his wife's pregnancy, the TBA, among other sources, can provide medication to reverse the misfortune. In the event that the husband is not responsible for the wife's pregnancy, labour is made easy when the wife confesses to the TBA about the man responsible for her pregnancy. Therefore, delivering at a health facility under such circumstances is out of the question.

were called on to participate in activities carried out by the CTC providers [6, 14]. There were also socio-cultural challenges that interfered with the work done by CTC providers. Such challenges were more pronounced in programmes focusing on reproductive health issues. For instance, a woman revealing that she was pregnant — for purposes of follow-up by CTC providers — was considered a taboo in some communities. However, some pregnant women were motivated to disclose their pregnancies through benefits such as iron tablets and mosquito nets [18]. In such cases, health programmes, such as those focusing on malaria control, were seen to be contributing to the uptake of services offered by other health programmes, thereby enhancing the integration of services within the health sector.

Despite the highlighted challenges faced by CTC providers at community level, it was noted that there was general goodwill by most community members towards the services provided by the CTC providers. Studies reported that these providers were highly regarded by most community members and that the recognition motivated the CTC providers [18, 6].

Studies further reported that the engagement of community health workers contributed to an increase in the uptake of health services. For instance, Bello (2013) [20] found that informal health providers in integrated TB and HIV services at community level were associated with a substantial increase in access to services and initiation of HIV treatment. In another study, Hermann et al. (2012) [12] found that intensive community support was crucial to the early success of MSF programmes in Thyolo district. Hermann and colleagues reported that better HIV outcomes were noticed in areas with community involvement. Among others, the involvement of informal health providers from the communities contributed to retention and adherence, with more people (96%) still alive and on HIV treatment than in places without community care, which reported 76% of people alive and on HIV treatment.

POLICY FACTORS INTERACTING WITH THE PERFORMANCE OF CTC PROVIDERS

In a context of acute shortages of human resources for health, the Malawi Health Sector Strategic Plan (covering the period 2011–2016) considers HSAs as key to the delivery of the Essential Health Package (EHP) under the Sector Wide Approach (SWAp) arrangement [3]. Other health-related policies such as the CHBC Policy emphasize the need to engage community health workers and volunteers in the delivery of health services.

Although the policy was clear on the roles of HSAs [5, 8], these roles and responsibilities were unstable and were constantly changing. As noted earlier, this is shaped by the situation whereby most NGOs and government health-related programmes use HSAs as conduits to reaching the communities. Callaghan-Koru et al. (2012) present an example of disagreement at national level in Malawi about CTC services: in 2009 the Medical Council considered the

community case management programme to be illegal because it had objections to HSAs performing clinical services [21].

KEY BARRIERS AND FACILITATORS TO BE BUILT ON IN FUTURE CTC INTERVENTIONS

In this section, we summarize the key barriers and facilitators identified in the desk review:

A lack of coordination in the use of HSAs: HSAs as the enemy of their own success — they were being used by different programmes with a clear lack of coordination.

Sustainability: Other CTC providers than HSAs not being incorporated into the Ministry of Health establishment — programme design needs to consider sustainability issues, explicitly stating what will happen when the programme/project phases out and putting in place a monitoring and evaluation system to ensure that sustainability issues are monitored.

Inadequate resources: To ensure the smooth running of activities, resources must be set aside for supplies and materials that are considered basic (e.g. registers, forms, pens) should be readily available. It may be ambitious to consider integrating other community health workers such as volunteers into the health system when HSAs already integrated are facing challenges to access basic materials for their work.

CHAPTER 3 –STAKEHOLDERS’ MAPPING

METHODS

A stakeholder matrix was used to identify the most influential stakeholders which also had an interest in factors that affect the performance of CTC providers. Following instructions from a facilitator, two members from the Malawi team listed the stakeholders and isolated those with the most influence and interest. The selection was made on the basis of experiences from REACH Trust, where such stakeholders had been seen to be influential and to have interest. The other basis was the literature, particularly programme-specific reports within the health sector, which highlighted the stakeholders involved with CTC providers’ work in the specific programmes such as those focusing on HIV/AIDS, TB and maternal and child health.

OUTCOMES

Stakeholders related to the REACHOUT project

In Malawi, the following institutions were some of the stakeholders in relation to the REACHOUT project:

- Ministry of Health Planning Department
- Ministry of Health Primary Health Care under the Preventive Health Department
- Ministry of Health Reproductive Health Unit
- Ministry of Health HIV Unit
- National AIDS Commission
- Traditional leaders
- Department of Community Health, College of Medicine (University of Malawi)
- World Health Organization
- UNICEF
- UNAIDS
- Malawi Health Equity Network (MHEN)
- NAPHAM
- Centre for Social Research (University of Malawi)
- UK Department for International Development (DFID)
- Malaria Consortium
- Network for Equity in Health in Eastern and Southern Africa (EQUINET)
- Wellcome Trust
- MANET+
- MSF

- World Vision International (Malawi)
- media
- clients.

Institutions with both high alignment and high interest in the REACHOUT project

The following institutions could be said to have both high alignment and high interest in relation to the REACHOUT project:

- Ministry of Health Primary Health Care under the Preventive Health Department
- Ministry of Health Reproductive Health Unit
- MHEN
- NAPHAM
- Department of Community Health, College of Medicine (University of Malawi)
- Centre for Social Research (University of Malawi)
- MSF.

INSTITUTIONS WITH THE MOST INFLUENCE

Our designation of influence was based on evidence from other projects in Malawi where it showed that, generally, at least three institutions were the most influential in terms of health policy and practice. The institutions included the Ministry of Health, donors (e.g. DFID) and United Nations agencies (e.g. UNICEF). However, different actors were influential at different levels. For instance, regardless of the influence wielded by donors and government agencies, traditional leaders could thwart the implementation of a project at local level. Also, health workers could 'sabotage' the implementation of a project if not properly or adequately consulted. Although different actors had influence at different levels of the health system, we mainly focused on those with influence at the highest level for the sake of this stakeholder mapping exercise.

ADVOCACY STRATEGIES

The Deputy Director for Preventive Health responsible for primary health care is a member of the Country Advisory Group. This should support the buy-in from the Ministry of Health at the highest level possible. An officer from the Reproductive Health Unit of the Ministry of Health is also a member of the Country Advisory Group and also supporting its buy-in. At our Country Advisory Group meeting in January 2014, we asked these Ministry of Health officials if REACH Trust should be a member of a Technical Working Group on primary health care and human resources which oversees aspects of community health workers in Malawi, to provide our input through findings from the REACHOUT project. Our request was accepted, and we were invited to a meeting immediately thereafter. The Trust is also a member of the Technical Working Group on integrated management of childhood illnesses. The Trust also plans to have face-to-

face meetings with key institutions with most influence identified through the stakeholder mapping. Policy briefs will be produced and shared with policymakers and other key stakeholders advocating for strong community-based health systems.

CONCLUSION ON STAKEHOLDERS' MAPPING

The process of engaging the stakeholders is ongoing. We will ensure that the stakeholders are invited to the meetings and that we share the study findings with them. We will also keep in close contact with them during the quality improvement cycles, to bring their perspectives into the design and analysis phase and to ensure our approach is timely and reflective of their needs and priorities.

CHAPTER 4 – QUALITATIVE RESEARCH METHODOLOGY

STUDY DESIGN

The study used a qualitative research strategy which emphasizes depth over breadth of investigation. In that regard, this study sought to have a detailed exploration of factors that affect the performance of CTC providers and used focus group discussions (FGDs) and in-depth interviews (IDIs) as the study methods.

DESCRIPTION OF RESEARCH SITES/DISTRICTS

Mchinji and Salima districts were selected in consultation with the Country Advisory Group for the project. Mchinji is situated to the west of Malawi, along the border with Zambia, while Salima is a lakeshore district to the east of Lilongwe. Both districts have a visible NGO presence and a lot of health and other programmes using CTC providers. For instance, both districts had NGOs working on HIV/AIDS and maternal and child health programmes. The districts were categorized as rural, although their respective headquarters contain urban attributes. It was, therefore, possible to interrogate issues related to access to health services and the role of CTC providers because some areas within the districts were clearly hard to reach, while others had ease of access.

SAMPLING AND PARTICIPANT SELECTION

We conducted FGDs and IDIs in Mchinji and Salima districts, focusing on different categories of respondents, thus taking the diverse nature of the respondents into account. Overall, a total of 132 interviews (both IDIs and FGDs) were conducted and are presented in Table 1 below.

Table 1: Number of interviews and study participants in Mchinji and Salima districts

Respondents	Mchinji	Salima	Total
IDs with HSAs	10	3	13
Senior HSAs	2	3	5
FGDs with HSAs	2	3	5
FGDs with clients	9	4	13
IDs with TBAs	7	3	10
District-level managers	9	10	19
FGDs with TBAs	1		1
IDs with volunteers	2	4	6
FGDs with volunteers	11	10	21
KIIs with traditional leaders	4	3	7
KIIs with health centre in-charges	2	3	5
IDs with health professionals	1	5	6
IDs with patients	7	1	8
IDs with NGO directors	4	8	12
Total	71	60	131

RECRUITMENT OF PARTICIPANTS

In Malawi, in-charges of health facilities within the selected districts were informed by the District Health Officers (DHOs) or their representatives. Since the study mostly dealt with the delivery and utilization of services at community level, we worked with the District Environmental Health Officers who supervise HSAs. We purposefully identified NGOs that worked with volunteers in the delivery of health services. We interviewed such volunteers as well as the NGO officials with whom they worked. Through a stakeholder meeting in Mchinji, we had an appraisal of CTC providers in the selected district by engaging health managers, district assembly officials and NGOs. This also gave us an idea of what we would find in Salima before we went there for fieldwork. Such an appraisal helped us to come up with a sampling frame which, in line with qualitative methodology, was not rigid but accommodated other CTC providers whose categories cropped up in the course of the study. In each community, a courtesy call was made to the traditional leader, who is the gatekeeper for the community.

A purposive sampling approach was used. CTC providers were asked by officials at health facilities and NGOs if they wanted to take part in an FGD or IDI. FGDs with volunteers were

conducted in collaboration with health and NGO officials. TBAs were recruited in collaboration with HSAs and traditional leaders. Some researchers also participated and observed discussions during the quarterly meetings by Mai Khanda and its volunteers known as key informants in Mchinji.

Health managers and policymakers were identified by purposefully contacting relevant government departments. A snowball sampling then followed whereby the officials initially contacted referred us to others they considered suitable for our study. Informed consent was obtained from all participants. However, involving health workers and traditional leaders in the recruitment of participants had the potential to coerce the participants. We addressed the issue during the training of research assistants, who were briefed on the rights of respondents, including the right to decline an interview and withdraw from participation.

RATIONALE FOR THE SELECTION OF CTC PROVIDERS

In Malawi, HSAs, in collaboration with VHCs, have provided preventive health services for at least three decades. In their work, the HSAs worked with VHCs and other volunteers. These cadres usually worked in preventive health including health education on sanitation, delivery of immunization, HIV/AIDS and maternal and child health. The government and NGOs retrained these cadres from time to time to deliver health and other services. In other cases, NGOs recruited new people as CTC providers. Therefore, to meet our study objectives, we initially focused on HSAs, VHCs and other volunteers, and TBAs. This was because these CTC providers provided the majority of HIV/AIDS and maternal and child health services which were part of our study focus. We anticipated encountering other types of CTC providers during our fieldwork, and we included them accordingly, in line with the qualitative methodology whereby the recruitment of respondents can be open and ongoing depending on the initial data coming out of the fieldwork. The gender of CTC providers and their level of experience informed the selection to ensure that a variety of respondents were included.

RATIONALE FOR THE SELECTION OF HEALTH PROFESSIONALS

Health professionals were selected for IDIs and FGDs on the basis of their knowledge of the CTC programmes that were conducted in their area — for example, supervisors of CTC providers, outreach workers in touch with CTC providers and in-charges of facilities who worked with CTC providers.

The selection criteria for health managers and policymakers were:

- knowledge of the CTC programmes;

- responsibility for policy development — for example, Director of human resources for health, planning, monitoring and evaluation and relevant health issue at national and district levels; and
- having played a role in the management of CTC provider programmes — for example, relevant Project Officers for NGOs, District Managers responsible for the CTC programmes (Environmental Health Officers in the case of Malawi).

RATIONALE FOR THE SELECTION OF CLIENTS

Clients were selected based on:

- their knowledge of the CTC programme — for example, clients of CTC providers;
- clients who were not using CTC providers and had a similar profile as the clients; and
- variations in gender, social, economic, cultural and geographical background.

In Malawi, clients included men and women who utilized, among others, HIV/AIDS and maternal health and child health services such as those provided at the village clinics.

DATA COLLECTION INSTRUMENTS AND TRAINING

Research assistants participated in the review and translation of study tools as part of their training. Topic guides were formulated for different respondent categories including managers, CTC providers and clients (see Annex 2). Training was conducted for one week. Besides the translation of the tools in general, there was back translation for key concepts. Thus, the members of the study team had a similar understanding of what the concepts meant. Other topics covered during the training included interview techniques for FGDs and IDIs, and research ethics where issues related to the rights of respondents — including the importance of informed consent — were covered.

DATA ANALYSIS

A combination of grounded theory, which means a reading of the transcripts and noting issues emerging from the text, and a framework approach [22], which used the objectives and the issues explored in the topic guides, formed a lead for the development of a coding framework. The coded transcripts were entered into an electronic qualitative data management and analysis software (Nvivo). Data were further analysed, ‘charted’ into themes and sub-themes and summarized in narratives for each theme and sub-theme. The narrative led to further questions and associations between the themes to obtain answers to the original objectives and the themes that emerged from the data.

An analysis workshop also took place to identify contextual factors that needed to be taken into account for the development of the first improvement cycle. The workshop aimed to deliver:

- a joint understanding of the data collection process and agreement on the next steps on completing the context analysis including a discussion;
- a draft of the coding framework to be applied generically and adapted to the Mchinji/Salima context;
- a very preliminary discussion of the findings from debriefing the research team and an early reading of the transcripts against the key themes in the coding framework; and
- discussion on the stakeholder workshop and next steps and capacity-building in using Nvivo (through a co-learning process).

The team held a brief overview of the process of analysis and coding. Transcripts were assigned to pairs, ensuring that all key participant groups were covered (HSAs, clients, volunteers/TBAs). Transcripts were individually read, and then individuals started coding. Each pair was given the challenge to identify potential themes which were not on the initial coding framework, to support the process of data immersion and inductive analysis. Plenary feedback and discussion followed during the workshop.

This process was repeated, although this time new codes/themes were written on yellow sticky paper (one code per piece). Initial impressions of the data against the themes in the initial coding framework were written up, and any new codes or issues were identified (which were then written up on individual yellow stickies). This led to further refinement and discussion and extraction of additional information. We then projected the initial coding framework on to the wall, and each team put its new codes/themes onto it, discussing whether they could be collapsed under an existing theme or if they constituted a sub-theme or a new theme. This was an interesting discussion and illustrated how the themes were interconnected in many ways and the value of a holistic health systems approach. Finally, the initial coding framework was compared with new codes emerging from the data, and an adapted coding framework (with codes specific to the Malawian context highlighted in red) was refined.

QUALITY ASSURANCE/TRUSTWORTHINESS

To ensure that the data collected were of an acceptable quality, the following measures were taken:

- Oversight for fieldtesting and finalizing the data collection instruments and training data collectors rested with the experienced Principal Investigator in Malawi, who worked closely with expert colleagues from the Royal Tropical Institute (KIT) in the Netherlands and the Liverpool School of Tropical Medicine (LSTM) in the UK.
- Only research assistants with previous experience in collecting qualitative data and the right local language skills were recruited, and these were thoroughly trained in

collecting the various types of data, the importance of respectful attitudes etc. They were supervised during fieldwork, when quality assurance procedures were also applied (checking recordings, keeping field notes etc.), and debriefing sessions were conducted.

- The qualitative data collection instruments were initially drafted in English and translated into Chichewa, the local language.
- To ensure quality, during the researchers' training, key terms were translated into Chichewa and translated back by others to confirm that terms were understood in the same way.
- During the training, researchers were made aware of the importance of discussing interviews and FGDs and reviewing topic guides during data collection so as to identify issues for further probing or new issues emerging that needed to be incorporated into the guide.
- Interviews and FGDs were digitally recorded, transcribed (and, where applicable, at the same time translated into English) and independently checked by someone not involved in transcribing.
- Data validity was judged via triangulation (comparing and contrasting results from FGDs and IDIs and answers from different groups of respondents) and the mixed-methods approach (comparing and contrasting results from desk review and primary data), as well as during a preliminary data validation workshop with the participation of key stakeholders. While in the field, the research team worked together in collecting data and held daily debriefing meetings to share data collected during the day and initial impressions and to triangulate diverse or contradictory findings. They downloaded the recordings of the interviews into Dropbox ready for transcription.
- To ensure that data were interpreted from a multi-disciplinary perspective, a group of local experts with various professional backgrounds were included in data analysis, as well as a scientist from LSTM and one from KIT with a background in social science, health and gender, in addition to the stakeholders, which contributed differing perspectives.

STUDY LIMITATIONS

The study design had the following limitations:

- The collection and presentation of qualitative data was deemed appropriate for the objectives of this study (generating a context analysis to design intervention cycles that in turn will be evaluated). However, qualitative data cannot and should not be quantified to define characteristics of people, services or other elements of the study.

- Some of the CTC providers and health workers were not willing to participate for a variety of reasons.
- Data quality depended on the ability of the interviewers and FGD facilitators (who were thoroughly trained), as well as the willingness and ability of respondents to collaborate (for whom a favourable environment was created and sensitivity used during the interview or FGD).
- Due to language-related challenges, despite preparing materials and training data collectors, the contents of some data could be lost during translation and transcription. We tried to address this by using trained data collectors and social scientists with rich experience in data collection in the community, and ensuring that transcripts were double-checked and compared with the audio records.

ETHICAL CLEARANCE

The generic protocol was approved by the KIT Ethical Review Committee. The specific research protocol for Malawi, which was derived from the generic protocol, was submitted to and approved by the Malawi Health Sciences Research Committee (see Annex 4).

CHAPTER 5 – QUALITATIVE RESEARCH FINDINGS

In both study districts, both male and female HSAs and other CTC providers were recruited. Other respondents were clients, including caregivers with children under five years of age, officials working for NGOs, traditional leaders and other health care workers (besides HSAs). Among HSAs, most respondents were male, while most caregivers were female. Health workers were drawn from each of the district hospitals, at least two health centres from each district and from selected communities in the districts.

The following findings are organized in line with the conceptual framework, focusing on broad contextual, health system and intervention design factors that affect the performance of CTC providers. For each category of factors, the focus is first on HSAs and then on other CTC providers (categorized under an umbrella term of volunteers).

FACILITATORS AND BARRIERS

BROAD CONTEXTUAL FACTORS FOR HSAS

SOCIO-ECONOMIC FACTORS AFFECTING THE PERFORMANCE OF HSAS

Some HSAs were involved in entrepreneurship including farming, apart from the health services they provided. Such activities improved their socio-economic status. Since these HSAs earned more and had become economically more dependent on their businesses than their official jobs, some of them had developed bad attitudes and behaviours that greatly affected service delivery. They were rarely available and, when available, mistreated clients. Such attitudes and behaviours led to resentment from some communities. Below is an illustration of such an observation:

“Here we have health care providers alright, but the problem is that they are always at beer parlours. When you go to their homes for help in the morning at their homes when someone is ill, you are told to come later in the day. And when you go back you find they have already started drinking. If they want to help you, they go and provide what you need, but if not, you are sent back and you are left to find your own way.”
(FGD, Female client, Mchinji)

Some HSAs, particularly in hard-to-reach areas, had become economically well off to the extent that they opted to resign rather than be transferred to another area. Clients reported that one HSA could even provide services, such as family planning, while at his garden. In addition to affecting the quality and effectiveness of services they provided, such an

attitude might also indicate where the HSAs' interests lay. When the community, led by the traditional leaders, petitioned health officials to redeploy the HSA, they were informed that if the HSA were redeployed to another area, it would be difficult to replace him, since most HSAs were unwilling to work in hard-to-reach areas.

GOVERNANCE INSTITUTIONS AFFECTING PUBLIC HEALTH

Chiefs played a critical role in the work undertaken by CTC providers. They mobilized communities to either access services or support CTC providers. Chiefs were found to be a critical governance institution and greatly affected public health. They influenced HSAs' and broader CTCs performance' as summarized below:

"...on the housing issue, the chiefs do provide temporary accommodation to the HSAs when they come, but the houses are very small and sometimes not conducive to the standard requirements of the health personnel, so it must be the government's responsibility to build good houses suitable for them right in the communities they are posted in, just as they do with the Forestry and the Police and other government institutions." (FGD, Female client, Mchinji)

GEOGRAPHICAL FACTORS AFFECTING SERVICE DELIVERY AND ACCESS

Ragged terrain and poor road infrastructure, particularly during rainy season, had a negative impact on service delivery and access. Few HSAs were willing to work in hard-to-reach areas. Additionally, most hard-to-reach areas either had a health facility but with very few health care workers or, in some instances, the facility would be completely closed due to the absence of health workers. As a result, people travelled long distances to access health care services:

"...problem here is the hospital is very far, so most of us are not tested as we don't have access to hospital health care. The only time we are forced to go to the hospital is when we are attending antenatal clinics and postnatal clinics. Some few people got tested last year in 2012, when the mobile clinic visited this area; otherwise it's not regular." (FGD, Female client, Mchinji)

"The cost from here to Kaigwazanga health centre is K750, to Mchinji Hospital is K3000. But if you are travelling by public transport it is K2000 round trip per head. It may happen that you get to Kaigwazanga health centre at that cost, and get sent back without getting any treatment, and that is a complete loss on our part. Sometimes you travel with a colleague on the same bicycle, personal ride, and along the way the bike breaks down. You don't get help from the hospital. Your ride is broken, and you have to find money to fix it still, so you get more problems, unlike the help you intended to get in the first place." (FGD, Female client, Mchinji)

REFERRAL SYSTEM

HSAs, particularly those running village clinics, referred clients to other health facilities. Communities also visited them in their homes when they needed medical services. Referral by HSAs was either to the health centre or the district hospital, depending on the severity of the case at hand, as explained by one client in an FGD:

“We go to them, since they are closer. Like the HSA, we visit his house to be helped because its near and he sometimes has the drugs, which he takes from the hospital, but he refers us to the hospital when the situation is not improving to go to Kazyozyo Health centre, or Kaigwazanga health centre, or Mchinji District Hospital if the case has become very serious.” (FGD Female client, Mchinji)

A lack or shortage of human resources for health was also highlighted as a contributing factor to poor access to health care:

“We need the government to provide us with medical personnel here at Kazyozyo health centre. The current one only comes here on part time basis, and this is affecting us, as a lot of us are suffering as a result of lack of proper medical care. If there would be health personnel, a lot of lives will not be lost. We have a very big problem on our hands. This case where we are sent back from Kaigwazanga whilst we have very sick children is always very painful for us. We end up going back home and stay without help; this wouldn’t happen if we had medical personnel here. Please help us; the situation is very bad.” (FGD, Female client, Mchinji)

However, we learned that efforts were being made to deploy more health care workers in hard-to-reach areas:

“In hard-to-reach areas, what we can help you with is to deploy extra workers to help in health service provision, since there are very few personnel in the areas; because in the meantime, we are only having 121 village clinics that are running in the hard-to-reach areas. There is a need to deploy more people, and capacity-building to help the people in delivery of health services.” (KII, Male District Manager, Mchinji)

Referral letters were also used at different levels of the health delivery system:

Facilitator: “What procedure does he use to refer you the hospital?”

Respondent: “He writes a reference to the concerned hospital.”

Facilitator: “What other illnesses are you given a reference for?”

Respondent: “Any serious case, also when a woman is in the eighth month she is sent to the hospital to await delivery.”

“When you get ill and get to the hospital and the doctor has examined you, and finds out that you need the attention of the main hospital, they write you a reference letter to the hospital.”(FGD, Female client, Mchinji)

“We write a referral form [from the district hospital] which is attached to the booklet [health passport], and it includes the first treatment we gave to the patient. Those on drip, we go with them to the hospital.” (IDI, Female health professional, Salima)

“There are really procedures that we follow when we refer the children to the health centre. Firstly, we explain to the parent that the problem that the child has we cannot manage to deal with it and it needs a doctor to look at him or her at the hospital. So after the explanation some complain about transportation; during this time we write a referral because we have the referrals that we have to use when a problem like this occurs...” (FGD, Female HSA, Mchinji)

In some instances though, HSAs were said to be using verbal advice, or on critical cases they were using their mobile phones to call for an ambulance:

“He doesn’t give us a referral letter; he just tells us with word of mouth, but he says ‘when you reach there and they ask you the type of drugs you have given the child, tell them it’s Panadol because by the time you reach the hospital the child’s fever will not be the same; it will change, so tell them that I gave him Panadol as I was coming here.’” (FGD, Female client, Salima)

“...In the case of an emergency, the HSAs use phones to call for an ambulance to ferry the patients to the main hospital.” (FGD, Female client, Mchinji)

REFERRAL-RELATED CHALLENGES

The shortage or lack of availability of transport means was a major barrier to referral. Communities complained about exorbitant transport charges they incurred when they were referred. The clients explained that the high cost of transport led them to sell their food, which in the end affected their food security at household level. One respondent in an FGD had this to say:

“On referral, we spent up to K1000 one way to get to Mchinji District Hospital, and if you hire a bicycle, you pay K1500. When you are referred to the main hospital it means you will be admitted, and it means you will need to have a guardian and will need food to sustain you for the entire stay in the hospital. This costs us a lot of money. So for us to reach that much money, we sell the produce we have acquired and meant for consumption to come up with transport.” (FGD, Female client, Mchinji)

Due to transport challenges, some clients failed to get to the health facilities despite the referral letters they obtained. One respondent in an FGD lamented:

“When you are critically ill and have no money, then the hospital personnel tell you there is no ambulance available and you must find your own means of travel to the District Hospital, what can you do in that situation? We become helpless. Those are some of the factors which don’t go well with referral.” (FGD, Female client, Mchinji)

Most of the time it was very difficult for health facilities to provide ambulances for a number of reasons, including shortage of fuel:

“This problem of transport in referral is a major concern, if you don’t have money to hire a taxi; you just spend a long time in the hospital waiting. Sometimes you are told that the ambulance can’t come since it doesn’t have fuel and you will have to wait until that is sorted.” (FGD, Female client, Mchinji)

“On the ambulance, recently there is a problem when it comes to call for one. We are told that there are a lot of cases which are in need of an ambulance service in other hospitals too, and when you go to Kaigwazanga health centre, you find a lot of cases which were referred to the main hospital and have not yet gone. If you have an emergency you just opt to hire your own car to take you to Mchinji District Hospital.” (FGD, Female client, Mchinji)

“Of course we may do that, but you find the person saying ‘I don’t have means of transport’ — that’s the challenge we face, but those who have means of transport we refer them and they get treated. Sometimes if we have fuel those who do the microscopy carry the sputum to another facility to test them, but it is not always easy because sometimes we do not have fuel. It is easy when the motorcycle is active because one of them just spends the whole day there and does the testing.” (IDI, Male SHSA, Mchinji)

“When a patient calls for an ambulance, the whole day may last till the following day without the ambulance coming to pick the patient up, and they say the ambulance has travelled to some area. So a patient can be told to go to the district but has no transport. Patients even die here because of lack of transport to the district hospital.” (IDI, Female HSA, Mchinji)

However, some communities also lamented that the attitudes and general behaviour of HSAs acted as a barrier to some of their referral services:

“If the child gets sick and we need help to get to the hospital, we need the HSA to give us a reference letter, so the problem is that he is rarely around or if he is around he is mostly at the beer parlour. When you don’t get help like that and the child gets very sick, and you are walking a long distance to get to the hospital, sometimes the child dies along the way, and it gets very sad knowing this could have been prevented if he gave referral in time, and then you just return back home.” (FGD, Female client, Mchinji)

CHAM facilities were not spared transportation problems when it came to referral. One health centre in-charge at one of the CHAM facilities explained as follows:

“OK, we have an ambulance at this facility; however, it is in the hands of our sister-in-charge at Khombedza, and it is unreliable in most urgent cases. It is meant to be an ambulance for this hospital, Khombedza and Thavite; however, it is now more like a personal vehicle for the sister-in-charge. At the moment we rely on a government ambulance; however, it has its own challenges as well.” (IDI, Male Health centre in-charge, Salima)

FOLLOW-UP OF REFERRAL CASES

The problem of transportation did not only affect referral of critical cases; it also affected attempts by HSAs to make follow-up visits to their clients when adherence to subsequent access to care would be confirmed. During an FGD with HSAs, one HSA explained as follows:

“In terms of follow-up, there is also a transportation problem. The catchment of Chitala health centre is very big if you can look to the number of the babies who are born here. It is higher than the number of Dry Blood Samples that we collect. The reason is a lack of follow-up due to transportation. Had it been the DHO has provided us with a motorbike, we could not be facing the problems in the follow-up of these children, TB patients and people on ARVs in hard-to-reach areas too.” (FGD, Male HSA, Salima)

Follow-up was also problematic due to a lack of communication between the HSA making the referral and the receiving institution:

“When a person being referred gets treatment and is discharged, they don’t write on the discharge sheet the medication they gave them for our records, so it becomes very difficult to do the follow-ups. We would like it if they do this; otherwise as at the moment there is a breakdown in communication.” (IDI, Male HSA, Mchinji)

However, some HSAs observed that some doctors in some facilities were actually sending feedback to them when referred cases had been attended to:

“So after the explanation some complain about transportation; during this time we write a referral because we have the referrals that we have to use when a problem like this occurs. So when there is a problem of transportation, the community helps until there is a way for the child to be taken to the hospital. When they bring the child here and the doctor helps him or her, they also write a feedback which the parents have to give us. In this they explain to us the problem and the prescriptions that have been given to the child.” (MLW-MC-MK-IDI-HSA-05)

“As for the HSAs, things are just okay because they have their own references. Like when the Red Cross was phasing out, they left us many referral forms which we are still using up to date. We have a specific referral form which they use to refer; if maybe a child has pneumonia or malaria or anyone with a danger sign, they fill out that form which they bring here at the health centre, and when they hand it to the medical assistant after giving the treatment to the particular child, they also write the type of treatment which he has given to the child on the form. Then he cuts off one part of the referral form and gives it to the woman who in turn gives it back to the HSA who referred her as a feedback for him to know that the child he had referred has been assisted.” (IDI, Male SHSA, Mchinji)

Overall, although referral that used forms or letters was said to be aiding follow-up for child cases, the study learned that referral of TB suspects was very poor. Challenges such as distribution of equipment were cited as a major barrier to referral of TB cases:

“What goes well is with the referral forms, because at any time we receive feedback, but referring using word of mouth the provider just assists the person without even giving the feedback. Concerning TB I would say things are not working well, because when they send them here they find that the battery for the microscope is down, and probably we did not manage to borrow the battery from others, so the person keeps on coming. When he comes today you probably tell him ‘you should come on Monday to hear the results’. The person comes on Monday, but he finds that we have not tested the sputum; then you give him another date, but if five days are gone without testing the sputum it means we have to destroy the sputum and give them other sputum containers, and this becomes a burden to him. Sometimes you even feel pity on the person because he looks very sick, and you wish you had assisted him. So there are such types of things.” (IDI, Male SHSA, Mchinji)

SHORTAGE OF STATIONERY

Supervision was hampered by a shortage of stationery such as printing paper, as well as printers:

“Stationery serves as one of the problems during supervision, since stationery is supposed to be taken — for instance, reporting forms. As such, if you do not carry the reporting forms, it might happen that you don’t find the forms as well at the health centre. That is, there are no papers, no printer issues which serve as a problem.” (KII, Female District Manager, Mchinji)

However, stationery was readily available when the HSAs were implementing projects for an NGO. This was observed in both study districts as summarized by one health centre in-charge below:

“Yes. These days they are very serious, and even the books (where we keep records) are given to us by them. They give record books for different reports, and they come to get their reports because their books are in Triplicate form and they just get a copy. This has empowered us, and our job is better now compared to the past because we now have what we didn’t have then.” (IDI, Male Health centre in-charge, Salima)

HEALTH SYSTEM FACTORS FOR VOLUNTEERS

MAPPING VOLUNTEERS

In both study districts, volunteers were variously named depending on the programme or NGO with which they work. In most cases, different NGOs used the same volunteers to whom they gave different names. Such names included community-based distribution agents (CBDAs), community facilitators, key informants, promoted volunteers, care groups, home-based care groups, support groups, taskforce and growth monitoring volunteers. TBAs were the other volunteers. As observed by one volunteer in an FGD, NGOs usually worked with volunteers who were already popular and well known in the community:

“On top of that you are well known to everyone, and if a certain organization wants to do something, our names are always mentioned as people who do charitable work. So it is like we market ourselves to the people.” (FGD, Male Volunteer, Mchinji)

EQUIPMENT AS MOTIVATION FOR VOLUNTEERS

Some volunteers working with NGOs received some materials related to their work, which included cell phones, airtime, t-shirts, caps, wrappers (*zitenje*) and bags. For instance, some TBAs working with one NGO in Mchinji received cell phones and airtime, as explained by one NGO coordinator:

“...they needed cell phones to communicate with the hospital when we can’t get to the hospital quickly and we need someone to advise us when there is a need, so we need cell phones and airtime...” (KII, Female NGO coordinator, Mchinji)

NGOs provided most resources channelled towards volunteers' work and took a leading role in issues such as training for volunteers, as captured in an FGD with HSAs:

"The other thing is we take a lot of activities from the government to the community, like for the village health committee and growth monitoring volunteers, so these committees are the ones that help us. However, they need trainings and refresher courses. But to do that we have to give them something, but we fail even to give them a bottle of Fanta. We need some support so that we should be sailing in the same boat with them. Otherwise they will be far behind in terms of knowledge, as you know that things are changing each and every day these days. In short these days they don't even come for the meeting because they are demotivated because we don't have support to make them happy." (FGD, Male HSA, Salima)

Volunteers were, therefore, visible and more active when an NGO or a government programme was funding an activity. In most cases, volunteers stopped performing their duties once an NGO that funded such activities pulled out. The volunteers moved on to the next NGO or government department with a new programme. One senior HSA had this to say:

"I would say most of the services I have mentioned are currently not working well because of starting with the HBC; after they were trained and start implementing their activities there are no refresher trainings which they receive. As a result most groups died a natural death. If maybe there were twenty people you find that only five people are working and the rest dropped out because there is nothing to motivate them." (IDI, Male SHSA, Mchinji)

INTERVENTION DESIGN FACTORS FOR HSAS

FINANCIAL INCENTIVES FOR HSAS

ALLOWANCES FOR HSAS: A COMPLEX PICTURE HIGHLIGHTING INSTITUTIONAL DIFFERENCES

The study found that allowances were a key factor in motivating HSAs. However, allowances had brought about many consequences, some of which were negatively affecting the services provided by the HSAs. An allowance culture was so pervasive, contributing to laziness, conflicts among health workers and selective commitment to health programmes which were providing better allowances. Some HSAs summarized the notion of laziness, explaining that the vice had affected health workers from all cadres:

"In addition, the coming of these organizations has brought laziness among the volunteers. Because in the past we used to reinforce the volunteers to work, and they

were doing that knowing that if there will be any incentive, then it will be on Childs Healthy Day's or so which was once. But these days different organizations are coming with trainings where they come with money. However, if one day an organization will come to work with them for free, it will be hard. For instance, as you have come to conduct this survey, that is why I asked you at first before we started this that is there something that we will get after this, because we are used that whenever we are gathered like this we expect to get some money." (FGD, female HSA, Salima)

"This is the same as the volunteers. If you can go today as your first time not all volunteers will come because they will first consider what you have brought that will make them happy. So the coming of the organizations with the incentives has really promoted laziness, even to us as health personnel. We cannot do our work effectively if we know there is no payment or money afterwards; instead we will be more willing to go for the organization that will at least give us something. Otherwise you are just lucky that you have managed having the whole of this team." (FGD, Male HSA, Salima)

"Sometimes we boycott. ...Sometimes meetings fail to take place. ...We have also even boycotted the workshop held by the Ministry. I remember this other time we had a workshop of nutrition held by Mary Shaba we really boycotted." (FGD, Male HSA, Salima)

The HSAs noted that health workers, including HSAs, worked hard and were more willing and feeling indebted to work for organizations that paid better allowances:

"Again what motivates you sometimes are the accommodation allowances which they give because some keep the money to use at home so they feel they were assisted through the programme, and next time they call them they don't want to be seen like a failure, so you try your best to implement their activity." (IDI, Male SHSA, Mchinji)

The idea of working harder for and being indebted to well-paying NGOs was corroborated by some NGO officials. For instance, one official explained that HSAs sometimes abandoned projects that paid less:

"They say 'you people, why do you just call us and just give us refreshments?' You take an HSA into the community, it is part of his job, but when we are parting ways with the HSA he complains 'how can you just leave', but you have been there to support that person doing his job. So it is a challenge. And when they are discussing

they say 'We should abandon this project because it does not have money.' In such a way we are not progressing." (KII, Female NGO coordinator, Salima)

The issue of allowances is complex. There are no standard rates for allowances. Bigger international NGOs paid more allowances than small local NGOs:

"The issue of the community demanding allowances is due to the number of developmental partners that go to the communities. We go there without allowances, while other development partners go there with K2000, and other partners go there with K1000. So it is like the communities are confused, so when we go there they are like 'so this NGO is offering nothing; we better go with this partner', so in such a way we are facing a lot of challenges." (KII, Female NGO coordinator, Salima)

The allowance syndrome was not only prevalent among the health workers such as HSAs and volunteers. The study also found that communities expected allowances to participate in activities, as expressed by one official from a local NGO:

"Again in the villages, people always think of money; they always rely on donors, so even if we are going for meetings they expect to receive money. So we had to explain that this is their own project, it's their own, it's not ours, it is for their own benefit that they have to understand that we have to work hand in hand together; otherwise they are always looking for money, money, money. So that is another challenge. When we call a meeting, they always expect us to give them money." (KII, Female NGO coordinator, Salima)

However, one NGO had a different perspective on allowances. An official explained that they did not pay allowances; instead they offered meals and reimbursements to participants in their activities:

"And World Relief does not give hand-outs like cash when we organize trainings or allowances to the people, no. What we do is just to give them meals so that they should know the value of the training. If we give them cash like allowances they will just look at the value of the allowance but not the training, so we just organize meals for them, they eat and reimburse their transport and off they go. So they are used that this organization is there to assist us with the knowledge so that we can serve ourselves." (KII, Male NGO coordinator, Salima)

Some HSAs and community members believed that the DHOs or NGO officials misappropriated allowances meant for them:

"...they have already planned that twenty HSAs will attend the workshop. And every one of them will have to receive MK36,000, hence if some will be receiving MK1500

then there will be a balance because it won't reach MK36,000. It will be around MK7500. This means they will take the remaining money for themselves.” (FGD, Female HSA, Salima)

“I think they get information from the District Commissioner or somewhere else on how the organizations pay the health workers when they come at district level. I think from district they first meet the DHO where they find out, then that is when an NGO come with their figures. We are saying this because we have seen it happening here when this other NGO came and promised to be giving us MK8000. After the meeting the people above they told them that we give our HSAs MK1500.” (FGD, Male HSA, Salima)

However, one of the district managers confirmed that HSAs received MK1500 as their field allowance:

“For the HSAs, it depends on the donor. Like I will give you this donor of ours, our main partners, their honorarium is K1500.” (KII, Male District Manager, Salima)

On the other hand, a key informant working with one of the NGOs in Salima gave a comparison of allowances as motivation by different implementing agencies:

“HSAs participate in trainings and monthly meetings where they are able to receive allowances. I think that's what motivates them. ...They hold monthly meetings at health centres; it's a lunch allowance. ...For us they get K1000, and for another NGO they get K1500. In the past the DHO used to give us a lunch allowance of K250 when we went to the outreach clinics.” (KII, Female District Manager, Salima)

The perception that NGO officials swindled allowances meant for community participants was corroborated by some NGO respondents. One official explained:

“There were some community members who influenced others that if NGO X comes back with K600, don't accept, let them go back; it is possible that they are stealing money meant for us. So when I discussed with the Village Headman that the training will not benefit us but your own community so the focus must not be on the money but the focus must be on what you are going to acquire from it so through peaceful dialogue we reached a consensus that let us do the training.” (KII, Male District Manager, Salima)

The study found that as vengeance for perceived swindled allowances, sometimes some HSAs wrote inaccurate reports. Therefore, if not well handled, grievances related to allowances can negatively impact on monitoring and evaluation and reporting systems. The

desire to exercise such vengeance is explained in the following conversation in an FGD with HSAs in Salima:

Respondent: "Yes, so since he or she has fooled us we just get our revenge on the report."

Facilitator: "You may fool him?"

Respondent: "Yes, we either don't write a report for him or we write wrong things."

Facilitator: "Ooh! He should receive a wrong report as a result of fooling you?"

Respondent: "Ooh! Yes. He may discover that it is wrong on his own."

HSAs explained that non-payment of allowances could even affect the sustainability of health programmes. Some HSAs said that they were not willing to participate in new programmes that had initially not involved them. The study found that involvement usually meant benefiting from allowances:

"This is very frustrating because they do this because they know that they will get allowances there. And the HSA knows that people are given the lunch allowances there. So in that situation, these groups work alone, and when the programme has phased out, there is always no one to encourage them because this HSA was not involved at the beginning. So there is a need to involve him at the very beginning after selecting the group. It doesn't matter if he is not part of the facilitators; he can be part of the team, and things go well that way."(IDI, Male SHSA, Mchinji)

In relation to allowances, CTC providers at one CHAM facility reported that they were treated differently from their counterparts working at public health centres. Such CTC providers alleged that they were mostly not considered for allowances:

"Just to add on the issue of allowances, we HSAs who are in CHAM facilities most of the times we are not considered by the government in terms of allowances. Those who are in government facilities get allowances for outreach clinics, while here we work for nothing if we go for outreach clinics and in terms of transport. In government facilities they are considered with a motorcycle, but in CHAM not." (FGD, Male HSA, Salima)

Some HSAs noted that not all of them could benefit from allowances. However, the HSAs demanded hardship allowances comparable to what is given to teachers in hard-to-reach areas. Nevertheless, the study found that HSAs were receiving an amount of MK10,000 in addition to their salaries. The HSAs explained that the additional money was that which was

initially only paid to other health workers such as nurses, clinicians and medical doctors. The demand for hardship allowances is highlighted below:

“So you feel bad if you see your friends being invited to some training where they receive maybe lunch allowance, yet you are there without being invited to any training because we are many HSAs. But programmes are very few, which probably involves very few people. So most HSAs are not motivated because of that. If maybe they were doing the same way they do with teachers like giving every HSA a hardship allowance of maybe five thousand kwacha it means everyone will be motivated even if they are not involved in any of the workshops. These are the major challenges which affect their performance most of the times. The rest are minor.”(IDI, Male SHSA, Mchinji)

“The other challenges are incentives. Other civil servants in the same hard-to-reach areas, like teachers, receive hardship allowances, while we don’t, us being civil servants like them serving the same communities. It could be that we do work even harder and much longer than the others while providing services, but we don’t have such privileges as them.”(IDI, Male HSA, Mchinji)

One health centre in-charge emphasized the significance of allowances and explained that not all HSAs can benefit at once. He put it this way:

“The allowances motivate them a lot because, though the main aim is to improve their skills, they are also given some money, which is a good thing, but they [HSAs] need the trainings to be conducted frequently so that all of them should be benefiting because they don’t go at the same time — they go in groups; a group at a time.” (IDI, Male Health Centre In-charge, Salima)

Despite acting as a disincentive when not provided, allowances also mediated the relationship between HSAs and volunteers in a number of ways. The allowances enhanced trust or distrust between HSAs and volunteers and were a source of conflict between these cadres and a source of guilt to HSAs when not provided to volunteers:

“In addition, for our job to be successful we need to work hand in hand with volunteers, and yet they do not give them allowances when they take them to outreach to help us, and this makes them lose trust in us.” (FGD, Female HSA, Mchinji)

“The other thing is about the issue of refresher courses for our volunteers. A long time has passed without a training, so they might have forgotten some of the things we trained them. But these volunteers also get motivated through these trainings, so

to work with them is becoming unbearable. These people are working without money.” (IDI, Male SHSA, Salima)

SALARY AS AN INCENTIVE FOR HSAS

In general, most HSAs were very dissatisfied with the salaries they received. They argued that the salaries were not enough to cater for their daily needs including accommodation and school fees for their wards:

“Poor remuneration because you have to pay your children’s school fee, take care of your house, and then the money becomes insufficient with how expensive goods are. Our children are like they belong to the poor person who is not a government worker, and their education is similar to those children from the village. They raise the salaries with the mouth, but tax is high.” (IDI, Female HSA, Mchinji)

However, some HSAs felt their salaries were better off, as mentioned by one HSA in an FGD:

“Speaking on the positive side, it has been raised. Like to some of us, the elders, who started long ago, we were then receiving MK3000.” (FGD, Female HSA, Salima)

However, other HSAs in the same FGD argued that prices of commodities had also gone up:

“Yes we are receiving around MK50,000, but look at how the prices of items in the stores and groceries have been raised.” (FGD Male HSA, Salima)

Some HSAs argued that although the salary was inadequate, it nevertheless alleviated their problems and was most of the times paid on time:

“The money we get helps alleviate our problems, though it’s not enough and there isn’t really job satisfaction.” (IDI, Female HSA, Mchinji)

“...we are most of the times paid on time, though we don’t get paid on time sometimes.” (IDI, Female HSA, Mchinji)

HSAs also pointed out that they received salary top-ups that other cadres had received for some time before HSAs were also considered:

“...when they promoted us to grade M, because at first we were at subordinate class. From 2011 if not 2010 that is when they promoted us to grade M. So because we are at grade M that is when we started receiving the allowances.” (FGD, Female HSA, Salima)

Health workers working for private not-for-profit health facilities were also satisfied with salaries. One nurse had this to say:

“Salary is good, and we get an annual increment every January.” (IDI, Female health professional, Salima)

There was a lack of salary differentiation based on promotion, length of service or academic qualification. Most HSAs reported that this was a significant demotivating factor:

“No, even if am a hard worker there is no chance of being promoted, unless I upgrade my education. If you are an HSA, you will be at the same position. Maybe you can only be chosen to be the leader of all the HSAs, which we call senior HSA. And even when you’re a senior HSA you receive a salary which is the same as any HSA. For example, our senior HSA started working as an HSA in 1993, while I started working as HSA in 2007, but we receive the same salary. This demotivates us and make us not work extra hard.” (IDI, Male HSA, Salima)

“Just to add on that I would say as HSAs we were employed at different times, and our ministry does not consider who came first because you find that our salaries are the same and that demotivates those who came first. As a result they begin applying for jobs elsewhere. Another thing is that someone with JC and MSCE receive the same salary, and that too demotivates them, and there is no respect at all. There is a need to give salaries according to the qualifications of the person. What they do in other departments, if someone starts today they put him on, say, grade M and another at some other grade. Such types of things motivate them.” (IDI, Male SHSA, Mchinji)

“As for me, I’m called a senior has, but I get the same salary as the people I supervise. We have the same grade, and sometimes if you advise them, they look at me and say ‘there is no difference; we are of the same grade’. So this demotivates us as senior HSAs. It is also not good for the person who started work twenty years ago and a three years person to get the same salary.” (IDI, Male SHSA, Salima)

However, according to the respondents, it was senior HSAs who mostly attended workshops where allowances were given. As noted earlier, it was mostly HSAs from the district headquarters who benefited from such allowances.

HSAs widely compared themselves with other civil servants such as teachers in relation to remuneration and other work-related benefits. Some HSAs alleged that some teachers had convinced authorities to reduce the HSAs’ salaries that had been revised upwards by the Ministry of Health:

“...What I know is that there was an error in calculations in the ministry of how much to give according to the qualifications. Like those with certificates from recognized institutions their salaries were lower than an HSA who just went for 10 weeks’ training, so they went to plead with the ministry on the matter, which was at a later

stage fixed. The revision was looking at those factors.” (KII, Male District Manager, Mchinji)

TRAINING AS AN INCENTIVE FOR HSAS

The study found that training was also a key factor in motivating CTC providers. Training as an incentive was linked to a number of issues including, among others, career progression, allowances, distribution of materials, mentoring and capacity-building.

On training as an incentive linked to career progression, one District Manager had this to say:

“The department or the ministry has introduced a programme of sending some HSAs who have at least MSCE to various colleges like Malawi College of Health sciences to pursue different medical qualifications, so this motivates them to work hard.” (KII, Male District Manager, Mchinji)

Other District Managers said the following on the link between training and allowances as well as the distribution of materials as incentives:

“Motivation is important, especially of HSAs who are like health workers. They are like health workers as a result of workshops which came and corrupted us, thus their motivation comes mostly as a result of inviting them once in a while to attend different trainings, whether for malaria by telling them issues to do with malaria, thus giving them money or mosquito nets as incentives.” (KII, Female District Manager, Mchinji)

“HSAs participate in trainings and monthly meetings where they are able to receive allowances; I think that’s what motivates them.” (KII, Male District Manager, Salima)

“They say they have too much work, and they have transportation problems so they can’t monitor in the areas that are far; and because there are no longer refresher courses which used to motivate them.” (KII, Female District Manager, Mchinji)

On training as an incentive linked to mentoring and knowledge gaining, a government District Manager and NGO official, respectively, said the following:

“...We have our assistant environmental health officers...they supervise HSAs; they can do some on-the-job training, and mentoring is actually done.” (KII, Male District Manager, Salima)

“The other thing is because we mentor them, they also acquire new skills accordingly, so they feel like they are doing the right things. Also they learn other things because

if you meet other HSAs, they can explain to you about pneumonia almost like a clinician or a nurse, so to them it's another incentive because the knowledge they have on pneumonia it's almost like anybody else in the clinic or in the nursing.” (KII, Male NGO Coordinator, Mchinji)

Training was also an incentive linked to capacity-building. Such training was at times for special programmes such as TB management and community case management (CCM) supported by NGOs, as explained by one District Manager and an HSA below:

“Yes at the moment, we had a chance with SSDI, communication; we have trained about thirty HSAs...and we wanted to train at least about ninety, so the programme just stopped abruptly; otherwise it is a very good programme for HSAs in order for them to have knowledge and skills on TB management in the community.” (KII, Male District Manager, Salima)

“Some time back an organization working on CCM came and trained some HSAs in drug management, but it did not target all the HSAs.” (IDI, Male HSA, Mchinji)

At other times, such trainings were offered as refresher trainings:

“Another thing is the refresher training which makes us remember what we were taught during training.” (FGD, Male HSA, Mchinji)

Some of the training provided to HSAs was considered inadequate, as a result of training sessions that were too brief to cover all the required course material:

“...everybody was trained as HSAs, but for us who are six years in our job as HSAs, we were trained just two and half months, but the modules were too many, so the teaching was very intensive to meet the duration which the government has for the HSAs training. So in the case of TB, that is according to myself, we don't have more knowledge of TB as the result of training which we received because if we can take TB per se it needs a lot of time to be taught things concerning TB. At the training they just jump us up and down like we are in a frying pan, so to tell you the truth, we don't have enough skills.” (FGD, Male HSA, Salima)

“The other thing is about trainings, things that you are supposed to learn for two or three weeks, they teach us for three days only, so it becomes very difficult to apply them when we are in the community. We feel like we don't know where to start.” (FGD, Male HSA, Salima)

Inadequate training meant that the HSAs had little knowledge on how to provide some services. The demonstration of inadequate knowledge by HSAs negatively affected their relationships with community members; people in the community felt that HSAs were deliberately denying them the services. One HSA in an FGD summarized the sentiments as follows:

“Let me add something on those who live in their catchment areas. Because they are not fully trained, sometimes their people tend not to rely on them because you cannot offer all services as they expect. For instance, when a child is sick they run to you expecting medicine, and if you don’t help then it becomes a problem. In addition, when a woman wants family planning methods and you don’t have one, they tend not to rely on you. As a result we just choose not to live there. We travel if we want to walk there on motorcycle. But if they can train us in all things then we can be reliable and the work can be easier.” (FGD, Female HSA, Salima)

There were no clear guidelines for selecting training participants. Some HSAs were seen to attend trainings more frequently than others:

“I have never attended, but some are taken from time and again or monthly. ...Some are taken to the workshops, while others not since we came, and it hurts and we are forced to work to a certain limit because they favour others than us.” (IDI, Female HSA, Mchinji)

“As HSAs in the hard-to-reach areas, we are not considered for trainings; whenever there are trainings, they only take the HSAs at the District; in that case they are better oriented than us who are in the fields. Instead of rotating or considering us in some of the trainings to refresh us and orient us on to new things, they treat us like discarded HSAs.” (IDI, Male HSA, Mchinji)

Training was a divisive issue in terms of the division of labour among HSAs. As previously mentioned above under the section on allowances, some HSAs left out of training insisted that those who went for training should be the ones to provide the services, arguing that those who received allowances during the training should be the ones to provide the services. Since training is inextricably linked to allowances, this view defeats the expectation that those trained should train others to provide the services. One HSA in an FGD summarized the view as follows:

“...when you know something like family planning methods without trainings, HSAs tend not to work because they did not go to the trainings and did not get the allowances their friends got at the trainings. So one may not be willing to work because they did not get that money.” (FGD, Female HSA, Salima)

The study further found that inadequate resources hampered training, thereby affecting the motivation of HSAs:

“...However, we also fail to conduct refresher training workshops because of the same financial problems.” (KII, Male District Manager, Salima)

QUALITY ASSURANCE

Most HSAs argued that their formal training and the training for special programmes was too brief to ensure sufficient quality:

“The other time we went for a CCM refresher course, but while there we were surprised to hear that we have to do another training for two days dealing with children under two months, but our friends in Dowa did the same training for two weeks. I can't even apply properly what we trained on because the time was too short. We are piled up with too many things without enough training.” (FGD, Male HSA, Salima)

“There is a lot of workload, but with little briefing we cannot give the right information to the community. For example, we were picked for early infant diagnosis, but we just did that for two days, yet the course content is very big and if you can ask everybody here how many samples have you collected, you will find that it is zero. The reason behind that is lack of proper training. Talk about TB: the HSA has to work hard on his own to search for the information for TB. If the mother is suffering from TB, the child also should be given some drugs to prevent it from contacting the disease, but here and there we try to work hard to help the community, and also the supervision encourages us somewhere.” (FGD, Male HSA, Salima)

Some HSAs were not trained immediately after recruitment, particularly those recruited with support from the Global Fund in 2006. In some cases, other HSAs were not trained at all for special programmes such as to provide TB services. One senior HSA and one TBA, respectively, explained this as follows:

“When the Ministry of Health employs the HSAs, they don't send them to the training right away. No, they first undergo on-the-job training, and they are those old employees who train these new recruits on such types of things.” (IDI, Male SHSA, Mchinji)

Health managers and supervisors explained that they ensured quality assurance through supervision:

“...we supervise them to ensure that quality is not compromised.” (KII, Male District Manager, Salima)

ACCOMMODATION

Accommodation challenges were negatively affecting HSAs' services to clients. Some clients explained this as follows:

"There is also a problem of housing for the CTC providers. Imagine that the one who was supposed to be here in this area stays very far, at 2B, reason being they want to have better accommodation. Here there are no houses good enough for renting, and those places have good houses as they are for the estates." (FGD, Female client, Mchinji)

"We always emphasize the need for housing for the health personnel here at the hospital, and most of the health personnel live in rented houses. The HSA who lives at Chimsasa belongs here and operates here. We urge the government to look into this matter and provide good houses for the HSAs here at the health centre." (FGD, Female client, Mchinji)

There was no accommodation policy for HSAs, as noted by one District Manager:

"Accommodation challenges are not only for HSAs but teachers as well. We do not have a policy to build houses for HSAs. I believe HSAs have to be accorded the same too [as is the case with teachers]." (KII, Male District Manager, Mchinji)

Accommodation was a widespread problem within the health sector, and HSAs were not prioritized. One District Manager put it this way:

"As the District Health Office, basically there is nothing we did for them to get better housing, and even here at the district level, there aren't enough houses to accommodate the staff, so it could be a problem to build the houses in the community." (KII, Male District Manager, Mchinji)

There were several suggestions about how to address accommodation challenges faced by HSAs. The first suggestion was the involvement of communities:

"...When I first came, I had been living in a very small house for two months — in a house without windows and a leaking roof. The community promised to repair it but had not done it when the rains began in November. I hired a carpenter to repair my house, and he charged me K3500. I used a door from one of the rooms in the house and put it on the main door, and I boarded up the windows, as the louvres had fallen off — all this using my own savings. And the chiefs and the community never took part. If the bosses would be coming into the field to check on how their employees are faring, they would notice these things, and if they could see the distances we

cover each day on the broken bicycles, they would be able to assist us with better things.” (IDI, Male HSA, Mchinji)

“An issue of accommodation is dealt with by lobbying with the communities. Some have been given accommodations in teachers’ houses which have a better accommodation.” (KII, Male District Manager, Mchinji)

“...So that is one other challenge we have, but we are happy some communities have now started moulding bricks trying to construct houses for HSAs...” (KII, Male District Manager, Salima)

Services offered by some HSAs motivated some communities to build houses for them, particularly in areas where village clinics were operational:

“I think it is the HSAs’ services [that motivate communities]. They value the presence of the HSA in their communities, and a very good example is those HSAs that are running a village clinic, because the communities indeed value that first treatment given to under-five children by the HSA within the community.” (KII, Male District Manager, Salima)

However, the capacities of communities were limited. Some accommodation challenges required the intervention of other actors who could provide resources beyond the capacities of communities, as summarized by one senior HSA:

“...when they employ the HSA they require him to reside in his own community, but there is a challenge on housing. There are other chiefs who dedicate themselves by moulding bricks and building the house for the HSA, but the challenge comes in when it comes to buying the iron sheets and other materials because it requires the community to contribute the money. Otherwise they manage to mould the bricks and do the building. So instead of the HSAs staying in his own community, of course he can go and stay now after roofing the house with glass because it is not rainy season, but once the rain comes he finds himself a house at the trading centre so that he should not have problems with moving his house property.” (IDI, Male SHSA, Mchinji)

The other suggestion on how to address accommodation challenges faced by HSAs was to involve higher authorities in the health system:

“...If we can come up with some assistance, say from the council, in terms of iron sheets and maybe bags of cement, and things like those, this challenge can be addressed. Otherwise it is a big challenge indeed.” (KII, Male District Manager, Salima)

Accommodation challenges were more pronounced in hard-to-reach areas:

“Some of the challenges which they face are about housing, for most of the HSAs in the hard-to-reach areas have no proper housing, and yet they are civil servants, so there is no proper housing. That’s one of the main challenges.” (KII, Male District Manager, Mchinji)

HSAs were shunning areas without proper accommodation, with most of them opting to reside in the closest towns. The lack of energy, running water and poor housing facilities were the key factors that drove them out of the communities in which were supposed to reside. A District Manager and an HSA, respectively, summarized the challenge as follows:

“Accommodation it is another serious challenge — how could I forget this one? In fact, if you ask me a few more questions on the village clinic, I will share with you one other challenge and a concern. Actually, I think I have one letter here which says that ‘your HSA is not actually staying in our village.’ Yes, the HSA is at the trading centre, always like that, so these challenges are very, very difficult because the HSAs now are demanding that they be accommodated in good houses and also in locations where they will access energy whether solar or electricity. Of course sometimes it is not necessarily electricity, but maybe they may find themselves in a village where they are not comfortable to find themselves a house that may not meet their minimum standards...” (KII, Male District Manager, Mchinji)

“The first challenge is housing. HSAs are supposed to be living in their catchment area. There is a big challenge with housing.” (IDI, Female HSA, Mchinji)

Related to accommodation, there was also inadequate office space for HSAs to use:

“Another concern is lack of offices; we are given only one room which is used as an office and also a room for vaccination, which is not good.” (FGD, Female HSA Mchinji)

Accommodation challenges had a negative impact on the quality of services offered by HSAs, who suggested that communities should build houses for them:

“But there is a need for the community to build a better house for me, since the current one is too small for me — not fit for someone with a family — and as a result the services I offer are getting more and more substandard.” (IDI, Male HSA, Mchinji)

TRANSPORTATION

Almost all HSAs reported that they faced challenges related to transportation. They included a shortage of bicycles, broken bicycles and a lack of spare parts. According to some HSAs,

the HSAs were supposed to be given bicycles every two years, and they were supposed to take care of the maintenance of the bicycles. One senior HSA explained as follows:

“The first challenge is transportation. Every HSA is supposed to be given a bicycle every two years, but you find that ten years elapses without receiving another one, and when he receives that bicycle he is supposed to buy the materials by himself if it breaks down. So if there are some who have the bicycles now it means they just did some replacements of the old parts of the bicycle.” (IDI, Female SHSA, Mchinji)

The requirement that HSAs should take care of the maintenance of the bicycles was hugely unpopular among the HSAs, who observed that their meagre earnings could not cater for maintenance-related costs such as spare parts:

“...We are given bicycles, but we are supposed to repair it using our own money, and sometimes it takes years before we are given new bikes. They tell us government operations depend on the passing of the budget...” (IDI, Female HSA, Mchinji)

“I want to speak on the issue of transport; it could have been good if they could have been giving us spare parts, or if they could have been adding some money which we should use to buy the bicycles spare parts.” (FGD, Male HSA, Mchinji)

“...I have a broken bicycle which is making mobility difficult...” (IDI, Male HSA, Mchinji)

However, one District Manager clarified that HSAs were indeed responsible for the maintenance of bicycles:

“The HSAs are held responsible for the maintenance of the bicycles. Previously when an HSA is getting the bike, he was required to sign an agreement that after a period of so long the bicycle will be yours. If you are to remember previously there was what we call TOT. In the TOT agreement, if you have used your car, they were giving you money. So that way the bicycles were taken good care knowing tomorrow the bike will be his/hers.” (KII, Male District Manager, Mchinji)

Some HSAs felt that other HSAs were favoured in the distribution of bicycles:

“...Favouritism: others have received bicycles several times, and it hurts us. ...The District Health Officer said the bicycles are for the HSAs. ...Like the past months they gave an HSA a bicycle, and after six months they gave the same person another bicycle...” (IDI, Female HSA, Mchinji)

Other HSAs were sometimes forced to borrow bicycles from community members — a situation that affected their standing within the community. HSAs used their own resources to borrow such bicycles; this ate into their already meagre remuneration:

“How can a person regard you, when as a government employee you borrow a bicycle to make rounds within the community? They now charge me for borrowing their bicycles: K1500 per trip...” (IDI, Male HSA, Mchinji)

HSAs working in CHAM facilities also reported transport-related challenges. They emphasized that the challenges negatively affected their provision of services to hard-to-reach areas, such as transportation of sputum specimens and follow-up of TB patients and people on ARV treatment:

“In terms of follow-up, there is also transportation problem. ...There is lack of follow-up due to transport problems. Had it been the DHO has provided us with a motorbike, we could not be facing the problems in the follow-up of these children, TB patients and people on ARVs in hard-to-reach areas.” (FGD, Male HSA, Salima)

“...So the DHO should prioritize the rural areas first in distributing the bicycles because in cases of TB we don't have a microscope here. We send the sputum to Salima or Khombedza by ambulance, which comes once a week. If we had proper transport we could have been using it to transfer the sputum before it gets destroyed. If we tell the clients to drop off the sputum themselves at Khombedza they say they are very old and cannot manage to travel there because the HSA can cycle all the way to drop the sputum off, as it belongs to your mother or sister, but since we have chosen this job, this is why we are saying that the government should think deep to open a microscopy centre here or provide us with better transportation like a motorbike so that we should reduce the spread of TB in our catchment areas.” (FGD, Male HSA, Salima)

NATURE OF THE HSA JOB

Despite the many challenges they faced, most HSAs described their work as fulfilling in the sense that they helped the communities that they served:

“I love my job, and that motivates me. ...We are happy, and we like our job because we were chosen and we got employed to help the Malawian nation.” (IDI, Female HSA, Mchinji)

“I was touched when I saw sick children and also pregnant mothers and seeing that they need counselling and health care provision, and maybe you see a person relieving himself in the bush and you wonder why they are doing that, do they have a

latrine at home or it is just a tendency? So as a result of cases like these, I wanted to do something and make a difference in their lives.” (IDI, Male HSA, Mchinji)

“The work of an HSA has been my desired job ever since. I was interested to help the children who are being born, the expectant mothers, all the women and the under-fives to have a healthy life. We have to give the services to these people because they are the leaders of tomorrow. If these people cannot have better services, then this country will not be good in future. The second thing is to help the Malawi nation in the fight against HIV through knowledge sharing and spreading the messages to reduce HIV and AIDS. ...I love this job; I did not join it for money.” (IDI, Male SHSA, Salima)

“...the other thing that motivates us is that we are human beings, so we have to give the services to the community.” (FGD, Male HSA, Salima)

UNIFORMS FOR HSAS

Most HSAs widely described a shortage of uniforms as a demotivating factor, pointing out that most of the uniforms they had were either torn, old or no longer fitting. HSAs regarded the uniform as their identity, which enabled them to be recognized both at community level and at the clinics:

“...we have a problem with uniforms: the uniforms we wear are our identity. People in the village or at the clinic identify us easily because of the uniform, but some of us have not been given uniforms...” (IDI, Female, HSA Mchinji)

Not only were uniforms inadequate or unavailable, but also accompanying regalia were hard to come by for most HSAs. The HSAs noted they no longer received such equipment from the Ministry of Health:

“Protective wear like the gumboots, raincoat — at first they used to provide us, but these days we don’t receive such protective wear anymore.” (FGD, Male HAS, Salima)

The gumboots and raincoats were mostly required during the rainy season. Not only did the HSAs serve the hard-to-reach areas, but the topography of the areas they served was rugged and extremely difficult to access during rainy season:

“As an HSA, I don’t have a uniform, gumboots and raincoat to be used during the rainy season. We asked our authorities to consider helping us with these materials, but until today, we were not given any. ...My work is affected so much during the rainy season, I don’t usually work during the rainy season.” (IDI, Male HSA, Salima)

“...but for us to get to the health facility and even get around when doing follow-ups in the community during a rainy season is a challenge. We don’t have the right protective clothes like gumboots, raincoats; you cannot use an umbrella in the process, as some times we experience stormy rains which an umbrella can’t accommodate. ...We raised these issues several times, but there seems to be no solution. And this is demoralizing us; we ask ourselves that, why, after having us sent to hard-to-reach areas, they have no regard for our welfare, and why are we treated as animals without feelings? And even our safety is compromised, so these are the challenges we face here...” (IDI, Male HSA, Mchinji)

Some HSAs were frustrated and expressed their dissatisfaction with the way authorities at district level were handling their grievances regarding the supply of equipment. These HSAs stated that there was a need for authorities to consider providing such items in particular to those HSAs who were running village clinics and were hard working. Their view was that this would motivate HSAs:

“... I think they are not happy with people who are hardworking, but they are happy with people who don’t care about their work, like the way the one who was here was doing: he could leave his area for up to two months and be at MchinjiBoma, to visit his wife. There were no outreach programmes, and he never used to visit the people in the communities, but now all these things are happening, and people are no longer dying. ...I am now frustrated, and this I am revealing to you, that I am planning to leave here as soon as I harvest the produce. ...I don’t care if they will terminate my services, but I am fed up. ... I should not be going for the same issue all the time, and yet I have responsibilities here like the village clinic.” (IDI, Male HSA, Mchinji)

Some HSAs felt that their colleagues, particularly those based at the district hospital, were being favoured in the distribution of uniforms:

“...only one person got the uniform, while the rest of us put on civilian clothes, and it hurts because we are entitled to a uniform, but they never bought one for us. We work with complaints that they favour one person.” (IDI, Female HSA, Mchinji)

“...We are sometimes told that the district hospital has received uniforms for us to share, but by the time we get there the HSAs at the district just share them amongst themselves. Some get up to three uniforms; we in the field get none. Sometimes they are given cloth and some money to sew uniforms, but we are not. When we get there we are given oversize uniforms and are only allowed to get a single uniform. In my case since I started working I have been given a uniform once, and I have been wearing it every day and now I don’t have a uniform.” (IDI, Female HSA, Mchinji)

However, some HSAs based at the district hospital felt that other health workers such as nurses were the ones favoured in the distribution of uniforms:

“...they say they will give us uniforms, but it’s all lies because our colleagues like nurses, cleaners, are already given them. Sometimes the DHO says we are not important to receive the uniform. As of now our colleagues have received the uniforms three times now from the time we came here, but we still have the first uniform they gave us...” (FGD, Female HSA, Salima)

Some HSAs noted that resources were limited to cater for all their needs such that the District Health Officer could not afford to provide all the necessary equipment such as bicycles and raincoats:

“...even the DHO on his own, I don’t think, can manage to be issuing these through the budget they have. So we shouldn’t blame him so much because with what happened recently, especially with the fall of the Kwacha, I don’t think he could manage...” (FGD, Male HSA, Salima)

ROLE OF NGOS IN MOTIVATING HSAS

The HSAs further observed the need for NGOs to play a role in providing basic equipment such as bicycles and raincoats. Many NGOs were working to support the health system, but few were taking deliberate steps to address such basic necessities, as noted by some HSAs:

“However, in other hospitals, things like bicycles, raincoats etc. sometimes they are issued by other non-governmental organizations...” (FGD, Female HSA, Salima)

“I think both the government and the NGOs should prioritize the distribution of the bicycles and other supplies...” (FGD, Male HSA, Salima)

Some District Managers concurred with HSAs that the government alone could not afford to provide all the equipment such as bicycles. They noted that some NGOs were involved in alleviating transport challenges. One manager explained as follows:

“On the issue of transportation, there are other organizations like UNICEF which procure bicycles for these HSAs, since it is impossible for the government to procure these bicycles all at once for everyone. So if it has selected a number of people some two years might pass to procure for others, while at the same time others are still waiting. That is, when other organizations come in to help us source some means of transportation.” (KII, Female District Manager, Mchinji)

COMPARISON WITH NON-HEALTH WORKERS

HSAs compared themselves with other civil servants working at community level such as teachers and agricultural extension workers. Areas of comparison included accommodation. Such comparisons are summarized below:

“Yes, when you’re in the community that is what you hear according to their point of view. When you’re with the teachers, they will say the HSAs are honoured more than they are, and the other way round when you are with the HSAs. But the issue at hand is that of the teachers having houses, while the HSAs do not have houses given by the government. But what they forget is that the teachers are well educated since they went to school to become a teacher, while the HSAs are only oriented. They are not professional in the way the teachers are. There are issues like Local Development Fund which comes with criteria, and if those criteria are not known to them, they will think that they are favouring the teachers, since it mainly targets the education sector.” (KII, Male District Manager, Mchinji)

“...almost every HSA has the problem of housing. We are supposed to live in the community we are working in. Honestly, the houses we live in are not that good to live in. I remember telling someone that if the government can build houses for HSAs just as they do with the agriculture extension workers, then I think we can be motivated.” (IDI, Male SHSA, Salima)

“It is because the HSA for this catchment area stays at Chitala. He used to stay here in a teacher’s house, but when a teacher was allocated for this primary school, the HSA was supposed to move out and find another accommodation, and due to this he went back to Chitala and only comes here on specified days. As such the medicine is kept at this house for easy reach.” (FGD, Female client, Salima)

“We are denied incentives that we are entitled to that our fellow civil servants are accessing. We also work even at odd hours and even on weekends because of the demands of our work, as compared to our friends, who have much time on their hands. We feel that these challenges need to be addressed; failing which there is a risk that the quality of provision of health services in the communities will be compromised. We are showing commitment on our part, but the government doesn’t seem to appreciate the services we do offer.” (IDI, Male HSA, Mchinji)

Some HSAs felt that communities appreciated more the work of other community-based civil servants such as those working in the education and agricultural sectors. For instance, they complained that their meetings were not well attended:

“OK, then limited space for our offices and being underrated should be the last one. They insult us that we are not educated, and even when we call for meetings in villages, men will not attend — only females who also happen to have under-five children. But when the education sector calls for a programme, all village members will attend.” (FGD, Male HSA, Mchinji)

Different civil servants were valued depending on the services they offered. For instance, agricultural extension workers were valued more because they were in charge of the distribution of coupons in the Farm Input Subsidy Programme (FISP). One HSA explained as follows:

“In our communities where we are working I can say the major problem is that chiefs are very resistant to mobilize community members when we want to meet with people. Sometimes if we are lucky they can mobilize women only. This affects our work because we come back without doing what we intended to do, and you have to understand me: this does not happen in all villages. I can say that this happens maybe because people are now used to receive handouts. Like an agriculture extension worker is highly favoured as compared to us because they know that at some point they will receive coupons.” (IDI, Male SHSA, Salima)

COMPARISON WITH FELLOW HSAS

Some HSAs based in rural areas felt that HSAs based at the district hospital benefited more from training workshops, which also offered allowances:

“We HSAs in the hard-to-reach areas are also not considered for trainings; whenever there are trainings, they only take the HSAs at the District; in that case they are better oriented than we who are in the fields. Instead of rotating or considering us in some of the trainings to refresh us and orient us on to new things, they treat us like discarded HSAs.” (IDI, Male HSA, Mchinji)

“...But you can see that they give better bicycles to people living around the district whose catchment areas are very small...” (IDI, Male HSA, Mchinji)

“...for example, the HSA who is at Salimaboma is given a bicycle, while the one in hard-to-reach areas is not, and yet the HSA at Salima most of the time is given fuel coupons for the motorcycle when travelling long distances. So the DHO should prioritize the rural areas first in distributing the bicycles.” (FGD, Male HSA, Salima)

COMPARISON WITH OTHER HEALTH WORKERS

HSAs compared themselves with other health workers such as nurses in terms of how their work is recognized, equipment such as uniforms, transport and general welfare:

“Another problem is about respect. We are not respected as health workers comparing to our friends who also do the same work like nurses. They think because our work is based in the villages, then we are not important. For instance, this other time we heard on the radio people complaining when our salaries were raised. This does not encourage us, and communication between us and them does not work well because they underrate us. This is a big problem to us.” (FGD, Male HSA, Mchinji)

HSAS’ PERCEPTIONS REGARDING THEIR WORKING CONDITIONS

Some HSAs felt that they were vulnerable compared to other civil servants. They pointed out that one aspect that pushes them to continue working regardless of the challenges they face was the general situation of high unemployment in the country. One HSA explained as follows:

“...with the scarcity of jobs you can’t just leave a job while you haven’t found another one. Seeing others, how they are suffering with no jobs, I ask myself then what will I be doing. Though we are working with difficulties, still we just work under pressure.” (IDI, Male HSA, Mchinji)

“I think it is better to work as an HSA than just staying doing nothing, but I cannot say am motivated by anything. I just take my job as a charity work. Maybe I am supposed to help people; otherwise looking at the living cost is too high.” (IDI, Male SHSA, Salima)

However, such HSAs were hopeful that their situation would change, citing the improvement in welfare over the years as chronicled by senior colleagues:

“We have hope that maybe someday there will be changes, because as we started our job we started with very low remuneration, and little by little there were changes, and we have hope that one day we shall be happy, so we just work with all our heart. And if we are with our old colleagues, they encourage us that when they had started working they were receiving two hundred something kwacha, and comparing to what they are receiving now we get encouraged. When you ask them for how long they have been working, they say for fifteen years and when you compare yourself of not even reaching ten years but only six years, so there is hope that maybe if we reach twelve or fifteen years there will be a change for us.” (IDI, Male HSA, Mchinji)

One HSA who started off as a ward attendant was very excited with her job. Despite the challenges faced, the HSA considered the new position as a promotion:

"I became an HSA in 2007, but I had been a ward attendant from 2003, and for me to go from being a ward attendant to a HSA is a big promotion, and whenever I am working I get committed. We face many challenges, working on a low salary being in a field, but we don't regard that as a setback for our work." (IDI, Male HSA, Mchinji)

SUPERVISION OF HSAS

FEEDBACK MECHANISMS

HSAs did not usually receive feedback from their supervisors, with most of the feedback provided through meetings which were also dependent on the availability of resources. Furthermore, feedback was usually given when something went wrong in the work done by HSAs. Long distances also hampered supervisors' efforts to give feedback to the HSAs. On the use of meetings as avenues to give feedback, one District Manager observed as follows:

"When we have funds available, we have quarterly meetings where we invite the Traditional authorities (TAs) and their Group Village Headmen for the whole district, two HSAs from every health facility and discuss what has happened in the communities in the last quarter, and then people discuss the successes, the challenges and the way forward. The current one we had happened last month, and it was conducted here at the hospital." (KII, Female District Manager, Mchinji)

A health centre in-charge had the following to say on the use of meetings as avenues for feedback:

"OK, there is supervision from government and other organizations. For instance, Ministry of Health send supervisors to attend some of the outreach activities like health tasks led by HSAs. From there they give feedback to them." (IDI, Male Health Centre In-charge, Salima)

However, besides giving feedback through meetings, supervisors sometimes gave feedback through routine visits and in writing:

"Yes, we get feedback through routine visits and sometimes written feedback." (IDI, Female health professional, Salima)

However, long distances were a key barrier to giving feedback in person through routine visits, as bemoaned by one District Manager:

"Yes, feedback is supposed to be given, but maybe this is another challenge. ...Yes, we don't give them feedback. Imagine you are here; you cannot go back to Thavite."

...The report has come here, but you can't go back to Thavite. Because we have had the report, we just respond." (KII, Male District Manager, Salima)

Feedback was usually given when something went wrong in the activities carried out by HSAs. One HSA in an FGD summarized the widespread view as follows:

"In most cases we do not receive any feedback, but if something didn't go well, we hear the feedback. That may be we are not doing well on vaccination, such is the kind of feedback. But most of the times they are just silent. And we assume all is well. ...Although the feedback is partial; if you have done well, they should tell you that you have done well, and if you did not do well, they should also tell you that you did not do well. That is good and motivating, and not that they should just be telling you on areas which you have not done well — that is not good." (FGD, Male HSA, Mchinji)

However, some managers pointed out that they did give feedback whether or not something had gone wrong with the work done by HSAs:

"Yes, they receive some feedback on where they are doing fine, and if there are any challenges in their reports, they also get feedback..." (KII, Male District Manager, Mchinji)

HIERARCHY OF REPORTING/SUPERVISION

There were clear supervisory structures in place, and it was easy to follow the line of authority in the way health services were being provided in the districts. This was both at district and health facility as well as community levels. Sometimes supervision could also skip some stages — for example, supervisors from the district or national level could be seen to go and supervise community health workers:

"We have got this organogram which we have here. So in terms of supervision, it depends on the levels. We follow the ranks in terms of supervision. For example, in the environmental department we have HSAs, HSA supervisors, Assistant Environmental Health Officers (AEHO), Environmental Health Officer (EHO), the District Environmental Health Officers (DEHO). However, it also happens that the DEHO can jump from the top to supervise the bottom HSAs. That happens because we are in the same department. That also depends on what kind of activities or the situation. Therefore, there are rare situations you can find such scenarios." (KII, Male District Manager, Mchinji)

"We are saying the senior HSAs are always there. The HSAs produce the monthly work plan. The senior HSAs also produce their monthly work plan on how they will supervise the HSAs. Of course Mchinji has been divided into clusters, so supervision is also done in those clusters. Senior HSAs supervise HSAs; EHOs supervise Senior HSAs."

In the monthly plan are details on how the supervision will be like. There are specific circumstances that will call for the supervision to be done together.” (KII, Male District Manager, Mchinji)

“...the senior medical assistant. That is the one responsible for filing the report, although at health centres they have what they call the focal person — for example, the focal person of malaria. This focal person, after writing the report, he or she is supposed to give it to the in-charge, who then hands in the final report to me. ...From me, it goes to my focal person of malaria who is the DMO. ...The DMO then sends the report to the DHO or sometimes I write to the DMO and a copy to the DHO to which after an instruction from the DMO I send it to the DHO. The DHO then sends the report to the central zone; that’s how the process of reporting is carried out.” (KII, Female District Manager, Mchinji)

“The HSAs report through their health centres, where the Senior HSAs compile one report for the health facility, and send it to the District Health Office; and from the District Health Office they compile one report and send it to the central level. For instance, in the village clinic when an HSA has seen a lot of patients, by the end of the month, he has to compile a report, and that report is sent to the senior HSA, where he compiles reports for all the village clinics for that health centre. When the health centre sends those reports, one report is also compiled and sent to either Integrated Management of Childhood Illnesses unit, which is the overseer of those village clinics nationwide.” (KII, Male District Manager, Mchinji)

PROGRAMME-SPECIFIC REPORTING/SUPERVISION

Some HSAs pointed out that they felt in control of their work, explaining that they came up with their work plans, which they shared with their supervisors:

“You outline your own work plan...” (IDI, Female HSA, Mchinji)

Nonetheless, supervision of specific programmes was being conducted by specific institutions that were implementing the projects. Likewise, reports were being compiled separately, each related to a specific disease of focus, and were submitted to specific line managers or organizations:

“TB reporting is like the district: every quarter you consolidate the district activities concerning TB. So mainly we target TB case finding, how many cases have been found in that quarter, again we report on TB treatment outcomes. ...We also report on TB/HIV, like how many people were put on ART, how many people were tested for TB, for HIV. So we report on a quarterly basis, and at the same time the report goes

to Zone level; from the Zones, they go to national level.” (KII, Male District Manager, Salima)

“...We are also supervised quarterly by the Save the Children Fund and Mai Mwana organizations, which assess our work and advise us on room for improvement.” (IDI, Male HSA, Mchinji)

“To the side of CCM, they do supervise us, and we also have mentorship. They come to see all the procedures we follow when treating the child at village clinics, and they also take us to Khombedza Health Centre to do mentorship. ...Sometimes they come all the way from the headquarters to supervise us in our catchment areas, and the other year we were mentored by the people from abroad in our catchment areas.” (FGD, Male HSA, Salima)

“Each task force volunteer has to write a report about his work every day — for example, about the number of pregnant women in a particular community, when did the pregnant woman start antenatal care, and some information about how many women delivered in a particular month. Before the meeting, the volunteers submit the reports to me, and I compile a report which I give to the Mai Khanda on the day of our meeting.”(IDI, Male HSA, Salima)

WHO CARRIES OUT SUPERVISION?

Officials of different designations conducted supervision. One group of supervisors was that of mentors, as explained below:

“Supervision takes place, although there are different supervisions. Like I have said, there is an HSA at every clinic; among these there is also a senior HSA at that particular health centre. Thus, the senior HSA is supposed to go and supervise the village HSAs. At the same time, we have the mentor; the mentor is either a nurse or a medical assistant at that health facility. Mentor is supposed to supervise at every quarter everyone at that village level, to verify if they are following. Then the trainers and us the coordinators are also supposed to quarterly move in different health facilities and call each one from the village clinic for reporting their sick chart and register. Then we start asking them questions to serve as reminders of what they were taught. It’s a process which can take approximately the whole day by asking them about areas where they find problems. Then the items are shared amongst themselves as a way of monitoring each other and pointing out each other’s mistakes. At the end of the day discussion takes place on both the strengths and weaknesses which have been established.” (KII, Female District Manager, Mchinji)

At community level, supervision of HSAs was conducted by cluster supervisors. In every catchment area, HSAs were divided into groups of at least three each and were under the supervision of one block supervisor:

“These work plans are the ones that help us to follow the guidelines, and the other thing is each activity has its leader who is responsible for everything — like are the forms available, when is the report needed, is there enough supplies so each and every activity has a focal person — and HSAs are divided into three people supervised by the block supervisor.” (FGD, Male HSA, Salima)

INVOLVEMENT OF COMMUNITY MEMBERS IN SOME AREAS IN SUPERVISION

Community members, in some areas, were also involved in the supervision of services, particularly to ensure that health workers were not abusing resources, as explained by a District Manager below:

“The supervision covers everything, by even looking at the safe keeping of the drug box, by verifying whether the keys are not with one individual. If all the keys are with the HSAs, you consult the villagers and try to settle the issues so that the keys should be with two individuals. In which case, we discuss in case of the future, by making sure that the HSA should not be blamed for shortages.” (KII, Female District Manager, Mchinji)

FREQUENCY OF SUPERVISION OR REPORTING

In most cases, supervision was conducted on a quarterly basis. In some instances, it could be on a monthly basis:

“There is eventually a quarterly follow-up on HSAs, especially those handling drugs for ‘the hard to reach’. We had approximately 144 if not 145 village clinics.” (KII, Female District Manager, Mchinji)

“It is done every month for the DHO. Wwe are supposed to submit these on the 5th of every month. For organizations we also send them monthly reports, and others like NAC they come to collect the data. They just come to look at our registers.” (IDI, Male Health Centre In-charge, Salima)

“When the supervisors come, they monitor our work through the monthly sheets we send, although they don’t come regularly. They recommend us through the reports we submit...” (IDI, Male HSA, Mchinji)

SUPERVISION OR REPORTING IN THE CONTEXT OF DECENTRALIZATION

Supervision or reporting was also linked to the decentralization process. However, decentralization was perceived to be causing some problems in the hierarchy of supervision

between the district level and the national level, as described by a senior district council official below:

“I can say the decentralization we are talking about is there on paper, but not fully implemented because this time around what has been devolved is financial resources. In other words, the funding for government departments comes through the Council. When the funding comes we meet and discuss or they discuss it through their departments and inform us that we have discussed and agreed to use so much money. We discuss and agree, and if there is need for reports on other activities, they write the reports and bring them. The problem is that the staff for these departments is under the supervision of their line ministries. The ministries are the ones which employed and posted them. So sometimes we have problems with reporting. They [staff members] prefer reporting to their ministries (who are their bosses) to convince them that they are working, and most of the times they don’t copy the reports to us or they just send a brief report to us and send the detailed ones to their bosses, but on funds we work together and discuss except for the hospital which has a bigger funding, and we tell them to discuss it between themselves, but sometimes we discuss how to use the funds by looking at the problems we have.” (KII, Male District Manager, Mchinji)

SUPERVISION-RELATED CHALLENGES

INADEQUATE SUPERVISION

Some HSAs were of the view that supervision was inadequate. They complained that officials from the District Health Office were not supervising them and, instead, left them to be supervised by chiefs. These HSAs alleged that it was very difficult for chiefs to provide meaningful supervision for their work, as chiefs were not able to provide some of the solutions that HSAs would require:

“We need the visitation of the supervisors from the district office to come and monitor the way we do our work. They don’t need to only visit the health facility; they need also to visit the village clinics, meet the HSAs and note the problems faced every day and provide solutions. Some of the problems we have cannot be addressed by the chiefs; they need to come and sort out issues like accommodation, and the importance of having the HSAs living in the same community they are posted to.” (IDI, Male HSA, Mchinji)

“...the second thing that demotivates me is inadequate supervision; our boss sometimes does not come here to supervise us.” (IDI, Male SHSA, Salima)

HEAVY WORKLOAD

HSAs were regarded as supervisors to the volunteers. However, HSAs were unable to provide supervision to the volunteers due to their heavy workload. As a District Manager observed, HSAs complained that they had too much work:

“They [HSAs] say they cannot supervise because they have too much work...” (KII, Female District Manager, Mchinji)

TRANSPORTATION

Transportation problems hampered the supervision of health care services. A lack of available vehicles or motorbikes was mentioned as a major factor in officers’ failure to conduct supervision. In instances where these were available, a lack or shortage of fuel meant that no supervisory visits would be made to health centres:

“The issue of supervision, however, serves as a problem. For instance, there was no supervision in the last quarter. The last time we conducted supervision was in February, as a result of transportation. Even for us at district level, it’s a problem to move into various health centres if there is a shortage of fuel.” (KII, Female District Manager, Mchinji)

“...they have transportation problems, so they can’t monitor in the areas that are far...” (KII, Female District Manager, Mchinji)

“...we need to conduct monthly and quarterly supervision health centres, but it is not done nowadays because of transport problems. Any coordinator is a rider, but we have one motorcycle which is working.” (KII, Female District Manager, Salima)

SHORTAGE OF (TRAINED) SUPERVISORS

The study learned that the number of supervisors was often inadequate and that, for the few that were there, workload in other aspects of their job compromised their attention to their supervisory work:

“The other problem comes in as a lack of staff, since it could happen that as the supervision involves the mentor, he or she might not be cooperative enough, as most of his or her attention is not enough and is focused on the queue waiting for him or her to serve. That is, it tends to be a brief supervision with the mentor whose concentration is on the workload.” (KII, Female District Manager, Mchinji)

Not only was there a shortage of supervisors, but also some of them were not trained to carry out the supervision:

"It is a bit difficult as of now due to the transfer of our senior, and we are only the HSAs. They appointed our friend, Frank, to assist in some areas linking with the district on important matters, but we don't have a trained senior HSA. Sometimes the job is not properly done due to the lack of a supervisor, and you can go to work any time you want or even be absent. We all started the job together without being trained, and it is difficult to train ourselves." (IDI, Male HSA, Mchinji)

INTERVENTION DESIGN FACTORS FOR OTHER CTC PROVIDERS: VOLUNTEERS

INCENTIVES FOR VOLUNTEERS

FINANCIAL INCENTIVES: SALARY

Ideally volunteers were expected to work for free. This information was relayed to them during the recruitment process, as explained by one volunteer below:

"...We explain to the people we serve that this is charity work and we are not paid. So if you are venturing into this so that you get something, then it's not the kind of job for you, but if you are doing it with a heart to help, then you will manage this." (FGD, Female Volunteer, Mchinji)

However, some volunteers were put on monthly salaries. They were selected from among their colleagues. For instance, in Mchinji, Mai Mwana, a local NGO, had recruited some enumerators from volunteer groups, while in Salima, World Relief, another NGO, had a cadre known as promoted volunteers:

"...we have promoters who are based in the villages and are called promoted volunteers. ...They get salaries every month." (KII, Male NGO Coordinator, Salima)

FINANCIAL INCENTIVES: ALLOWANCES

Volunteers generally received allowances when they were involved in special activities such as immunization campaigns, child health days and workshops. However, other volunteers working with some NGOs received monthly allowances. For instance, some TBAs working with one NGO in Mchinji received allowances:

"...They also explained that they need incentives, since they used to be paid for the services they were rendering to the women. So we agreed to be giving them an allowance, as they are assisting the government in bringing the women to the hospitals for delivery, and that worked out just fine." (KII, Female NGO Coordinator, Mchinji)

Most volunteers explained that the allowances they received were not adequate; they could not even cover their transport costs:

“K300 is the allowance meant for our transport refunds. Let’s say some people are coming from a far area like Kapezi; how do they travel? That means they hired a bicycle taxi; so the money is not even enough to cater for their transportation.” (FGD, Female Volunteer, Mchinji)

NON-FINANCIAL INCENTIVES: NEW KNOWLEDGE AND SKILLS

Most volunteers stated that they obtain new knowledge and skills through their work, which keeps them motivated:

“We have been doing voluntary work for the same reasons as what the lady said: we do learn a lot of things through this work...” (FGD, Male Volunteer, Mchinji)

“...we have learned good speaking skills...” (FGD, Female Volunteer, Mchinji)

NON-FINANCIAL INCENTIVES: NATURE OF VOLUNTARY WORK

Most volunteers also explained that the idea of serving their communities motivated them:

“[...] we were encouraged most because we were told to serve our very own community, so it was worthy volunteering ourselves to help our own community. It would have been a great challenge if we were to be assigned to sensitize other communities. But it was our people benefiting.” (FGD, Male Volunteer, Mchinji)

“We love this job because we have been exposed to the public; people know us because of the work we do.” (FGD, Female Volunteer, Mchinji)

“I have been helping with the under-five clinic. I have been a growth monitoring volunteer since 1994, when we were providing this service under a tree before this structure was built. ...What has inspired me is that I have learned a lot of things from this work which has been influential to me and my family, because I have been implementing in my home and among my relations what I teach other people. ...I am regarded as someone educated, while I am not.” (FGD, Female Volunteer, Mchinji)

NON-FINANCIAL INCENTIVES: TRAINING

Training had an effect similar to that on HSAs. Thus, allowances associated with training were an important incentive for volunteers:

“[...] there are no incentives, but what we encourage is that when there is some training these people should be taken aboard and given something in the form of allowances from workshops or training at least to encourage that. The government and also our colleagues from non-governmental organizations should try to recognize the volunteers in their workshops and training so that they get something. I think that’s the only incentive that is mostly common and applicable. Apart from

that, unless there is a special exercise in that area where their services are needed and would get something, but we don't have any special provision for that.” (KII, Male District Manager, Mchinji)

Inadequate resources hampered the training for volunteers:

“Yes, we brief them that, for example, we are going to have this campaign at such and such a month, so we sit down together, we give them their roles, what they are supposed to do...but training is very important. If we could train them, we could have more capacity-building; they would be much better...but, again, this area also needs resources, so mainly we just brief them.” (KII, Male District Manager, Salima)

“But they are also supposed to be called for refresher courses, but because of lack of funds these are not done, so this has resulted in a lot of the CBDAs dropping out for lack of motivation.” (KII, Female District Manager, Mchinji)

Similar sentiments regarding the limited availability of opportunities for training were echoed by some TBAs, who mentioned that they had not been trained since they underwent training during the reign of Kamuzu (the first president of Malawi):

“...it is not recent that I started doing this work; it is a long time ago. We could receive the trainings. We stayed for four months in town doing the training and we received a certificate, but that was during the era of Kamuzu.” (IDI, Female TBA, Salima)

NON-FINANCIAL INCENTIVES: TRANSPORT

Most HSAs and clients observed that volunteers also deserved some incentives to encourage them. One such incentive was the provision of bicycles:

“Even the volunteers of hard-to-reach areas are supposed to be given bicycles by the DHO because they assist us much and they can be using these bicycles in advocacy.” (FGD, Male HSA, Salima)

“Transportation is the problem. We borrow bicycles and pay K500 per day, but if the bicycle stays overnight you pay an additional K500.” (FGD, Male Volunteer, Mchinji)

“Transportation is also a challenge for the volunteers; they were just chosen to service the communities without any means of transport. They travel long distances to give drugs. For example, they may come from here at Gada to give the drugs at Kawerewera, and Kawerewera is very far. You find that they will finish giving the drugs very late, around 6pm, and they have to travel back home very late, so for them this is a very big challenge.” (FGD, Female client, Mchinji)

NON-FINANCIAL INCENTIVES: CAREER PROSPECTS

Some volunteers were motivated by the possibility that the work they did could be used as a springboard for better career prospects:

“We have hope that if we work so hard on our area maybe the government will assist us [through] career perspectives, providing trainings to those who have worked for a long period of time. We have hope and anticipate.” (IDI, Male Volunteer, Mchinji)

THE COST OF VOLUNTEERING

The study also learned that volunteerism was too costly if viewed from the perspective of how much the volunteers were losing as they took on such responsibilities. It was lamented that it was unfair for organizations and government departments to simply come with incentives that did not consider the plight of volunteers. Thus there was a need to conduct thorough assessments of volunteers’ social-economic status and needs to determine what incentive would be sensible and acceptable by volunteers, as observed by an official from the NGO sector:

“I think we should also do some deliberate efforts, looking at how they are living in their houses, at household level because people choose a person as a volunteer and say this one or her. We are giving some incentives just to make him enjoy the work, but we don’t know how much suffering she has by leaving her home. And you know, helping others to improve their lives — for instance, if somebody leaves today, I mean this morning, saying I’m visiting two villages and I’m going to train them abcd... We don’t know how much work or activities he has missed at home: he hasn’t gone to the garden, he hasn’t been able to take care of a sick child at home and so forth. So that is an area that we also think that for the future programming, these people, we should not just look at them as volunteers, but we should also actually know and try to make deeper understanding and even a deeper assessment on how their lives are at home because most of them you will find that if we graduate or exit an area you find that maybe they haven’t improved, but they have managed to improve people’s lives, but they haven’t improved their lives at home.” (KII, Male NGO Coordinator)

Volunteers themselves echoed this reasoning and went further to mention that, considering the suffering they faced, they could easily drop out of initiatives, as the work they did within their communities had brought about very little change in their lives:

“...but the thing is we can also easily drop out because there is very minimum change in our lives. People scramble for money in this life for survival, so this voluntary work has very few benefits...” (FGD, Male volunteer, Mchinji)

CHAPTER 6 – DISCUSSION

The study found that HSAs were main CTC providers. Other CTC providers can be categorized as volunteers formally recognized by the Ministry of Health, such as VHCs and growth monitoring volunteers, and volunteers recruited by NGOs from time to time.

The latter group were given different names and were sometimes recruited because of the special characteristics they had. For instance, as we noted in the desk review, the 3M mothers were recruited because they had some personal experience of HIV/AIDS, and TBAs possessed special traditional knowledge in relation to maternal health. Volunteers were named differently by various NGOs and government departments, but most of the volunteers were the same people who worked for these organizations. The performance of CTC providers was affected by several factors including broad contextual factors, health system factors and intervention design factors, as highlighted in the conceptual framework.

Communities valued HSAs highly, particularly in rural, hard-to-reach areas. The HSAs were seen as the eyes of the community or the bridge between them and the health system. Generally, these communities valued HSAs more if the HSAs ran village clinics. More and more CTC providers were providing curative services. Thus, there was a shift from their traditional preventive services — a trend also observed elsewhere. However, this issue raised questions of acceptance in terms of rivalry between cadres: some health workers in curative departments argued the legality of the services provided by the HSAs as well as their competencies, considering that the HSAs belonged to the preventive health department [6, 21]. The HSAs were not legally covered in case of any medical error that affected either themselves or the clients they served [6]. However, in the case of medical error that affected the client, the HSAs were legally covered under the responsible person task shifting the work to the HSA.

Besides offering requisite training, the Ministry of Health and some NGOs have come up with guidelines and protocols that HSAs follow to conduct specific curative services. Nonetheless, these efforts or approaches have implications for training, as well as implications for curricula as a whole.

Programme-specific policies, despite being necessary, brought challenges for supervision and coordination. Different government programmes and organizations were using HSAs differently, which saw some programmes being better supervised than others. This has also been observed elsewhere, where fragmented health programmes have led to difficulties in ensuring coordinated supervision [23, 6]. A well-coordinated and standardized way of

conducting supervision would ensure high-quality service delivery. Better coordination would also contribute to addressing disparate allowance structures prevailing in the public sector and among NGOs. We noted that the issue of allowances had the potential to harm the health sector. Besides demotivating those who felt sidelined from the allowances, the notion of allowances had reduced training, a crucial element in human resource development, to a mere income-generating activity. Other studies in Malawi found that the allowance syndrome was pervasive and had worked itself into the entire public sector with potentially devastating consequences [24]. With this in mind, efforts by stakeholders in Salima district to harmonize the allowance regime were a welcome development. However, in a context of poor remuneration and generally poor working conditions, health workers considered such allowances a way to make additional income [6].

Generally, the community seemed to value other civil servants such as agriculture officers and teachers more highly than HSAs. This finding demonstrated a perception of how communities prioritized their needs. Communities preferred services that were seen to bring tangible answers to their problems, such as a bag of subsidized fertilizer to help them produce food. Such prioritization is not limited to study districts. It might explain why HSAs offering curative services through village clinics are valued more than other HSAs; there is high demand for curative services by communities, which could also explain the recent shift whereby more curative services are being provided by community health workers. However, an explanation premised on communities' desire for urgent needs may not help to explain why teachers are valued more than HSAs; education is a long-term investment. Therefore, we may have to look elsewhere for an explanation: perhaps teachers enjoy a higher status in the communities because they are better paid than HSAs, which gives them greater financial power, hence higher status.

Within the health sector, preventive health care was said to be generally under-prioritized [8]. As such, HSAs lacked some basic equipment such as stationery and gumboots. However, a programme such as immunization, which falls under preventive health, is highly prioritized by the Ministry of Health and is regarded as a flagship programme by the Malawi government [3]. Such prioritization can be traced to the preference for selective primary health care over primary health care in general, following the fall-out among prominent stakeholders after the Alma-Ata conference [25, 26]. The former approach preferred selected interventions, which were deemed cost-effective, arguing that primary health care as originally conceptualized was too ambitious. Whether primary health care or selective primary health care was implemented ultimately depended on who was controlling the resources. Since those advocating for primary health care lacked strong financial power, their approach was not favoured, regardless of the scientific merit behind their claims [26].

Such competing priorities at global level trickle down to countries through donors and UN agencies such as the World Health Organization and UNICEF and are reflected through the verticalization of health programmes on the ground [26]. Therefore, the preference for so-called cost-effective programmes has led to some programmes within the preventive health sector being prioritized. More significantly, there is a rise in packaged clinical interventions — hitherto regarded as curative — which are combined with preventive remedies. In Malawi, integrated community case management (ICCM), a descendant of the selective primary health care approach, is one such example.

The verticalization of programmes that resulted from competing priorities at global level has led to many challenges related to the work of CTC providers. As noted previously, prominent among the challenges is the lack of coordination on many issues, including remuneration of CTC providers and supervision. For instance, while the government had allowance guidelines for HSAs and other health workers, the involvement of numerous NGOs in the work of CTC providers led to a disjointed approach to the provision of allowances to health workers including HSAs and volunteers. As noted earlier, the lack of a general allowance policy for CTC providers prompted the providers to prefer some programmes to others.

Inadequate supervision largely emanated from inadequate financial and human resources. Thus, well-funded programmes within preventive or curative health departments were better supervised; resources were made available for logistics and training supervisors. Furthermore, most of the supervision did not employ a two-way and supportive approach considered important in human resource management, which might have emanated from a lack of supervision skills among supervisors. Instead, supervisors mostly gave feedback when they perceived that the HSAs and other CTC providers had done something wrong. For instance, some supervisors contacted HSAs when the latter delayed in sending reports. While there are recognized senior HSAs who acts as a supervisor, the lack of recognition in terms of salary means that the senior HSAs might not receive the required respect from their juniors. In a context of a pervasive allowance culture, supervisors made frequent visits to some areas as long as they were assured of allowances. Consequently, in many places, supervision was not driven by the expressed needs of the CTC providers but, rather, the opportunity for supervisors to make additional income through allowances.

Quality assurance was ideally done by ensuring that health workers adhered to protocols and procedures, and through training. For instance, HSAs who provided services through community case management of childhood illnesses in village clinics were provided with algorithms on the treatment of uncomplicated malaria, diarrhoea and pneumonia. Similar protocols were given to HSAs involved in HIV testing and counselling. These HSAs underwent training prior to engaging in the provision of the services. However, as noted

previously, the refresher training offered to HSAs was very much linked to the allowances received during such trainings. Therefore, in some instances decisions on who should attend trainings might be affected more by who should benefit from the allowances, rather than the need, thereby having a negative impact on the quality of services provided.

As we noted in the findings from the desk review, HSAs have been gradually and at times reluctantly incorporated into the health sector despite being at the centre of health service provision at community level, including hard-to-reach areas. Thus, until recently (2011), HSAs were not formalized within the health sector. Despite the critical role they played, HSAs were not among the initial recipients of top-up salaries funded through the Emergency Human Resource Plan (EHRP), though they were included at a later stage. In a context of acute shortages of human resources for health in Malawi the Ministry of Health should ensure that the HSA cadre is safeguarded through proper motivation and an enabling legal and policy environment, because their being part of the formal health workforce and their being paid employees makes their work sustainable, unlike the work done by volunteers [6].

Although volunteers complemented the HSAs' work, this study noted that the work done by the former was not sustainable. It was difficult to retain volunteers, so NGOs and government departments conducted repeated training sessions for the volunteers — a scenario that drained resources. There was no database that captured profiles of volunteers, including who the volunteers were, the type of training they had undergone, their areas of expertise and length of service. Such data would be necessary to identify which volunteers to integrate into the formal health system. Integrating volunteers into the formal system would enhance the sustainability of their work. As noted earlier, most volunteers were the same people with different job titles given to them by NGOs and government departments. Such an understanding would make the profiling of volunteers easier.

CHAPTER 7 – IMPLICATIONS

FOR THE DRAFT FRAMEWORK

CTC providers' motivation is a key factor in improving their performance. One crucial and prevalent motivating factor was the allowance received after attending meetings or training sessions. Faced with poor remuneration and working conditions, CTC providers considered allowances an important way of supplementing their incomes.

Among health systems factors with an influence on the CTC providers' performance, supplies and logistics were prominent. The CTC providers lamented the shortage and lack of availability of materials such as bicycles, uniforms and raincoats. Basic supplies such as pens and reporting forms were also in short supply. Therefore, the CTC providers were more concerned with their personal welfare and the equipment to be used in their work — issues that would address their immediate personal and work-related needs.

CTC providers referred to broad contextual factors only in relation to the impact of such factors on their welfare. As such, they noted the poor economic conditions, particularly the high cost of living, which, they argued, justified the necessity for a higher salary. Therefore, the CTC providers were less concerned about abstract policies, although they alluded to their insecurity with regards to an unfavourable legal framework in case of occupational injuries to them as well as their clients.

FOR THE QUALITY IMPROVEMENT CYCLES

Although the concern about allowances was certainly a predominant one, it was not an easy target for an improvement circle; the issue concerned several stakeholders who had disparate policies related to allowances. Of the many factors found to be affecting CTC providers' performance, we had to identify an issue in which we could intervene realistically. We also considered an intervention where progress could be demonstrated within the time-frame of the REACHOUT project. Based on such considerations, we decided to focus on supervision.

Based on the findings of the study, supervision was one of the challenges with the greatest impact on the performance of CTC providers. As noted previously, supervision was uncoordinated, was mostly one-way and unsupportive. It was also negatively affected by inadequate human and financial resources (see Annex 3).

The focus on supervision has two elements. First, we focus on supervision of CTC providers in general, with a particular focus on HSAs. Here, the approach is to address the coordination of supervision, training of supervisors and prioritization of supervision of HSAs

in a context where curative services are generally preferred. In relation to coordination, we will focus on ensuring that less well-funded programmes piggyback on well-funded ones so that supervisors can include the less well-funded programmes in trips to conduct supervision. Training of supervisors would focus on the HSAs' supervisors as well as the HSAs themselves, since HSAs do supervise volunteers. As regards prioritization of supervision of HSAs, the focus will be on advocacy among the District Health Management Team on the use of available resources.

Second, we will focus on an ongoing programme implemented by HSAs — namely, ICCM. Although the programme was not analysed thoroughly in this study, our focus on the programme will provide an opportunity to design a supervision intervention based on an established programme. Thus, we will seek to address the supervision-related challenges identified in the study by focusing on the programme's supervision structure. Therefore, while aimed at addressing the identified challenges, the intervention will also seek to draw lessons on what works well within the programme. As such, the intervention will be preceded by a brief exercise aimed at gaining a deeper understanding of how supervision is organized within the programme. Such a two-pronged approach will allow for a deeper understanding of supervision-related challenges in largely donor-funded programmes such as ICCM and the challenges related to routine work carried out by the HSAs. Annex 3 presents a root cause analysis of our intervention focus, detailing what we found to be the causes of the supervision challenges identified in the study.

REFERENCES

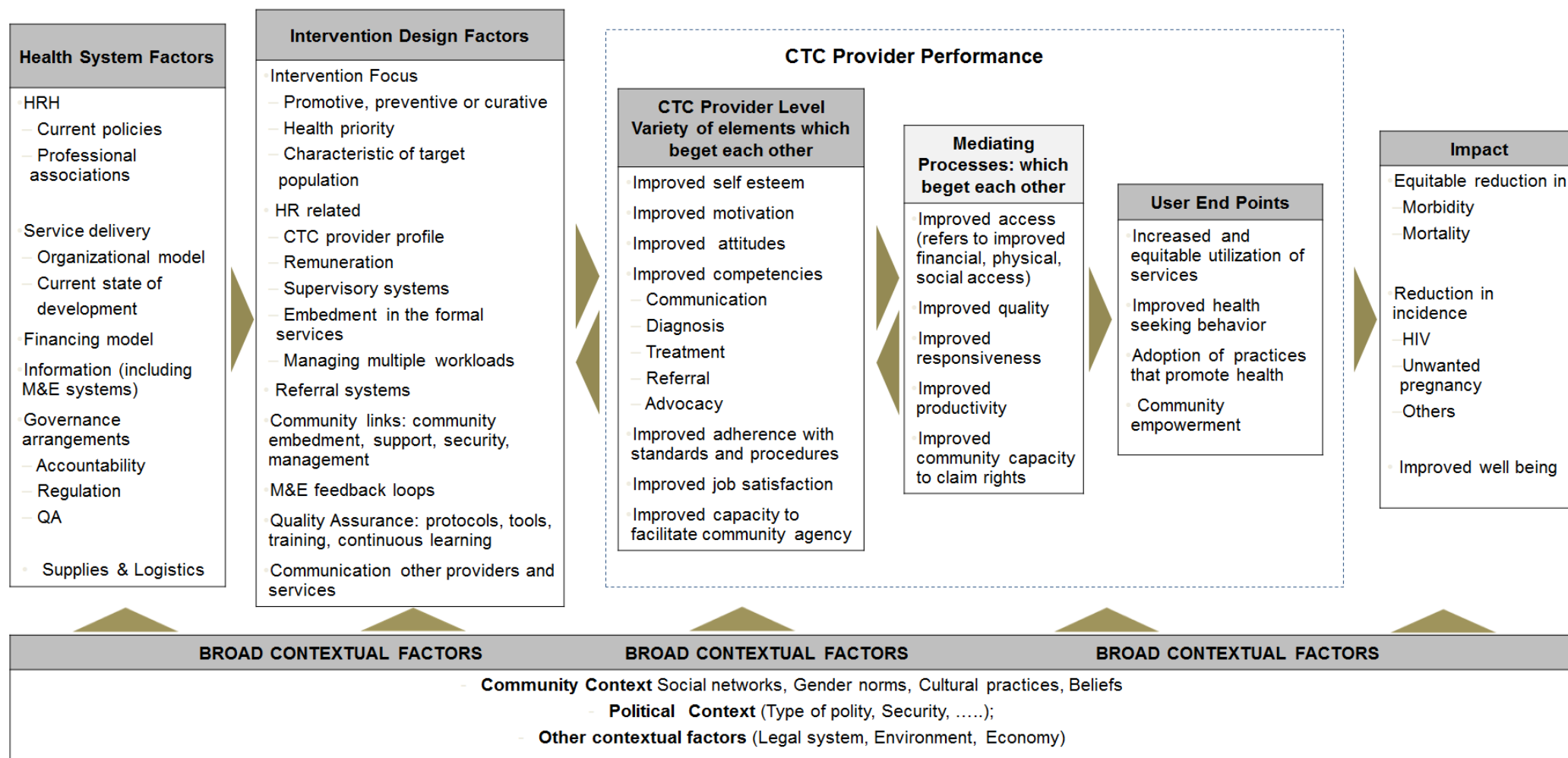
1. Global Health Workforce Alliance: Integrating Community Health Workers in National Health Workforce Plans. Geneva: WHO; 2010.
2. Bloom G, Standing H: Pluralism and marketisation in the health sector: meeting health needs in contexts of social change in low and middle-income countries. Brighton: Institute of Development Studies; 2001.
3. Ministry of Health (MoH) (2011). Malawi Health Sector Strategic Plan 2011-2016: Moving towards equity and quality. Lilongwe: Ministry of Health.
4. Ministry of Health (2009b). Health Surveillance Assistant Facilitator's Guide. Lilongwe: Ministry of Health
5. Ministry of Health (2009a). Health Surveillance Assistant Course Curriculum. Lilongwe: Ministry of Health
6. Nyirenda, L. and R. Flikke (2013) Frontline vaccinators and Immunisation Coverage in Malawi. *Forum for Development Studies* Vol. 40, No. 1, 27–46, <http://dx.doi.org/10.1080/08039410.2012.725676>
7. Ministry of Health (n.d) Health Surveillance Assistants Training Manual. Lilongwe: Ministry of Health
8. Kadzandira, J.M. and W.R Chilowa (2001) The Role of Health Surveillance Assistants (HSAs) in the Delivery of Health Services and Immunization in Malawi, Lilongwe: Ministry of Health and Population, and UNICEF
9. WHO, 2006, Taking Stock: Health Worker Shortages and the Response to AIDS, Geneva. http://www.who.int/hiv/toronto2006/TTR2_eng.pdf, accessed 28 June 2012.
10. Irin News. Malawi: Role of traditional birth attendants to change. See: <http://www.irinnews.org/printreport.aspx?reportid=74871>. Accessed 24.04.13
11. Munthali, A. and Mulwafu W. (2011). Evaluating the sustainability of the community based distribution agents (CBDAs) approach. Evaluation Report; Zomba: Centre for Social Research, University of Malawi
12. Hermann K, Zamadenga B. Ndeni A and L. Steven (2012). Improved Health Posts and Patient Support Attendants: Description and evaluation of the community HIV/AIDS programme of MSF in Thyolo; Thyolo: MSF
13. Hermann, K. and A. Mateyu (2011). Mai ndiMayindiMwana (3M). Programme Evaluation Report; Thyolo: MSF
14. Smit, J.J. Traditional Birth Attendants in Malawi. *Curationis*; 1994, 17(2):25-28
15. Vaughan, M. (1991). *Curing Their Ills: Colonial Power and African Illness*, Stanford: Stanford University Press.

16. King, M. and E. King (1992). *The Story of Medicine and Disease in Malawi*; Blantyre: Arco Books
17. Bergström, S. and E. Goodburn. *The Role of Traditional Birth Attendants in the Reduction of Maternal Mortality*. Found at <http://www.isieurope.org/safem/collect/safem/pdf/s2933e/s2933e.pdf>. Accessed 24.04.13
18. Munthali A. and P. Mvula (2009). *Evaluation of the MNCH Rapid scale up in Malawi*. Working Document. Formative Research on HSAs Recording of Vital Events in Kasungu and Mangochi; Zomba: Centre for Social Research, University of Malawi
19. Standing H, Mushtaque A, Chowdhury R: Producing Effective Knowledge Agents in a Pluralistic Environment: What Future for Community Health Workers? *Social Science and Medicine* 2008, **66**(10):2096-2107.
20. Bello, G. (2013) Is it possible to improve the analytical approach to the evaluation of cluster-randomised trials where the complexity of the intervention demands a small number of clusters: The case of the Triage plus Integrated TB-HIV Community Intervention Project in Lilongwe Rural, Malawi. Lilongwe: Research for Equity and Community Health Trust/Liverpool School of Tropical Medicine
21. Callaghan-Koru, J.A., et al., Health workers' and managers' perceptions of the integrated community case management program for childhood illness in Malawi: the importance of expanding access to child health services. *Am J Trop Med Hyg*, 2012. **87**(5 suppl): p. 61-8.
22. USAID: The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up Quality Services. *USAID Health Care Improvement Project* 2008.
23. Lehmann U, Sanders D: Community Health Workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. In. Edited by Evidence and Information for Policy. Geneva: Department of Human Resources for Health, WHO; 2007.
24. Norad Evaluation Department (2012). *Hunting for Per Diem: The Uses and Abuses of Travel Compensation in Three Developing Countries; Report 2/2012 Study*. Internet access. <http://www.oecd.org/derec/norway/Hunting%20for%20Per%20Diem.pdf>. Accessed: 30.01.14
25. Fee, E., Cueto M. and T.M. Brown (2008). WHO at 60: Snapshots From Its First Six Decades *Am J Public Health*; 98(4): 630–633. doi: 10.2105/AJPH.2007.132449
26. Birn, A., Pillay, Y. and T.H. Holtz (2009). *Text of International Health*. Oxford:Oxford

ANNEXES

- Draft framework (*Annex 1*)
- Data collection tools and consent forms (*Annex 2*)
- Root cause analysis and problem statements (*Annex 3*)
- Copy of ethical approval letter (*Annex 4*)
- Final coding framework (from Nvivo) (*Annex 5*)

ANNEX 1: REACHOUT conceptual framework



ANNEX 2: Data Collection tools and consent forms

Topic guide for clients (SSIs and FGDs)

Information sheet FGD clients

Gender F/M	age	Role in community	Education None/primary/ secondary/tertiary	Name CTC programme familiar with Name/none

Take consent

Fill in information and recording sheet

Explain process

If FGD ensure that ground rules are discussed

Perceptions of provider services

1. Can you tell us the different CTC providers of health services that are in your community? **Kodi ndi magulu ati ogwira/othandizira ntchito za umoyo omwe alipo ku dera lino?**
2. What type of services do these groups provide? **Ndi ntchito ziti zomwe magulu amenewa amagwira?**
3. Why do you use these services? **Chifukwa chiyani mumagwiritsa ntchito chithandizo cha za umoyo chomwe chimaperekedwa ndi magulu amenewa? *******
4. Why do people use these services? **Chifukwa chiyani anthu amagwiritsa ntchito chithandizo cha za umoyo chomwe chimaperekedwa ndi magulu amenewa?**
5. How do you feel about the services provided by HSAs, TBAs, volunteers etc? **Maganizo anu ndi otani pa momwe anthu monga, ma HSA, azamba ndi mavolontiya akugwirira ntchito zawo?**
6. How do you feel about the services you have ever used? **Maganizo anu ndi otani pachithandizo chomwe munalandirapo? (e.g. HIV, TB, Malaria)**
 - Probe for availability, distance, usefulness, limitations. **(Kupezeka kwa chithandizo, mtunda omwe ulipo, kufunikira, zofooka/zolepheretsa zomwe zilipo)**
 - Probe for usefulness of diagnostic, promotional and preventive roles if relevant. **(kufunikira kwa kuyeza kapena kufufuza matenda m'thupi, Kufalitsa uthenga, komanso njira zopewera)**

Clients community

7. Who are the clients of the HSAs, TBAs, volunteers? **(Ndi ndani omwe amalandira chithandizo kuchokera kwa anthu a za umoyo akumidzi?)**
8. Do you go to the service providers or do they come to you? **Kodi inu mumapita kwa a HSA, azamba, volontiya kapena iwowo amabwera kwa inu?**
9. Which services (HIV, TB etc) require the provider coming to the client or client going to the provider? **Ndi zithandizo ziti zomwe zimafunika ma HSAs, azamba, mavolontiya kukuyenderani nanga ndi ziti zimafunika inuyo kuwayendera ma HSA, azamba, ma volontiya ndi a zaumoyo ena?**
10. What are the constraints and facilitators to the arrangement above? **Ndi mavuto anji amene inuyo mumakumana nawo poyenderedwa kapena powayendera a za umoyowa?**
11. Can you tell us how services (HIV, TB, Malaria) are distributed in your area? **Kodi ntchito za zokhudza HIV, Malungo and TB ndi zofalikira bwanji? Fotokozani?**
12. Is any group in your community or in neighbouring communities left out of access to services? If so who are these people **(Alipo magulu ena a anthu omwe safikiridwa mu**

dera lanu kapena madera oyandikirana nawo? Ngati alipo magulu a anthu amenewa ndi ati?)

13. Why is this the case? **Chifukwa chiyani izi zili chomwechi?**
14. Are there cases in your community where HSAs, TBAs, volunteers's service is stigmatized based on the health status of the provider **Kodi zimachitika kuti ntchito za zamba, ma HSA, komanso mavolontiya zimasalidwa potengera kuti akuoneka ngati ndi odwalika kapena odwala kumene?**
15. Are there cases in your community where a client is being stigmatised due to conditions such as TB, HIV or having too many children? **Kodi zimachitika kuti ofuna chithandizo cha za umoyo monga odwala amasalidwa chifukwa choti ali ndi TB, HIV, kapena kukhala ndi ana ambiri/ochepa/opanda mwana?**
16. Do community members trust HSAs, TBAs, volunteers to keep issues confidential?**kodi anthu a m'dera lino ali ndi chikhulupiliro mwa ma HSA, volontiya, azamba kuti atha kuwasungira chinsinsi?**
17. What is the involvement of communities with the work of HSAs, TBAs, volunteers etc? **Kodi anthu a m'dera lino amatenga nawo mbali yanji pa ntchito zimene ma HSA, azamba, ma volontiya amagwira mu dela lino?**
18. What do you think is the importance of HSAs, TBAs, volunteers etc? **(Kodi kufunika kwa ma HSA, azamba, mavolontiya etc ndi kotani?**
19. What is their contribution towards health service delivery? **(Amathandiza motani?)**
20. Do you see any challenges of the work of HSAs, TBAs, volunteers etc? **(Kodi ma HSA, azamba, ma volontiya amakumana ndi mavuto otani pa ntchito yawo?)**
 - What do you think causes these challenges; what solutions can you suggest? **(Kodi mavuto amenewa amabwera bwanji? Kodi mavuto amenewa angathetsedwe bwanji?**
 - **(Note to interviewer: Ranking and scoring)**
- Probe – challenges around HRM, M&E, QA; In provision of HIV, TB Malaria etc **mavuto okhudzana ndi kuchuluka/kuchepa kwa anthu ogwira ntchito za umoyo, kuyang'anira kayendetsedwe ndi kuunikira m'mene ntchito za umoyo zikuyendera, ndondomeko zoonetsetsa kuti zinthu (ntchito za umoyo za HSAs, TBAs etc) zikhale zapamwamba**
21. What do you think goes really well when HSAs, TBAs, volunteers are executing their duties? Give examples? **(Kodi mukuganiza kuti ndi zinthu ziti zomwe zimayenda bwino kwambiri mu ntchito za ma HSA, azamba, ma volontiya etc? Taperekani zitsanzo?**
22. What things help to make this go well. Give examples? **(Ndi chiyani chimapangitsa kuti ntchito zawo ziziyenda bwino?) Taperekani zitsanzo?**
23. What makes their work **NOT** to go well? Can you give an example? **(Ndi chiyani chimapangitsa kuti ntchito zawo zisamayende bwino? Taperekani zitsanzo?**

Note to the interviewer: When examples are given try to probe for reasons that may influence what does and does not go well if they do not come spontaneous.

Costs

24. How much does it cost you to access services provided by HSAs, TBAs, Volunteers etc? (Probe: travel, referral, drugs, time, charges). **Mumaononga zinthu zochuluka bwanji pofuna chithandizo kuchokera kwaHSA, azamba, ma volontiya? (monga: mayendedwe, kutumizidwa kuchipatala, mankhwala, nthawi, zolipira)**

Perceptions of service quality

25. How do you feel about the skills and knowledge of the CTC provider? **Munganenepo chiyani pa za luso lomwe anthu ogwira ntchito za umoyo ku midzi ali nalo?**
26. To what extent do you trust services, or the individual providers of the services? **Chikhulupiliro chanu ndi chotani pa ntchito zomwe ma HSAs, azamba, volontiya amagwira**
- **Chikhulupiliro chanu ndi chotani pa ma HSAs, azamba, volontiya**
27. What are they good at, and what is outside their competencies. **Kodi zomwe amachita bwino kwambiri ndi ziti nanga zomwe zimaoneka kuti samakwanitsa ndi ziti?**
28. How do you feel about their attitude towards clients. Ask for examples. **Kodi khalidwe la ma HSAs, azamba, volontiya ndi lotani akamathandiza anthu ofuna chithandizo. Amalandira bwanji anthu ofuna chithandizo? Zitsanzo?**
29. What do you appreciate in their services? Give examples **Ndi zinthu ziti zomwe mumayamikira pa kagwiridwe kawo ka ntchito? Perekani zitsanzo?**
30. What would you like to see improved? **Ndi zinthu ziti zomwe mungafune kuti zisinthe pa kagwiridwe kawo ka ntchito?**

Referral

31. How do providers e.g. HSAs refer you to other facilities? ask for examples. **(Kodi anthu opereka chithandizo monga ma HSA amagwiritsa ntchito njira zANJI akamatumiza munthu ku chipatala china?Perekani zitsanzo**
32. What goes well and not so well in referral? Give examples? **(Ndi zinthu ziti zomwe zikuyenda bwino kapena sizikuyenda bwino pa ntchito yotumiza anthu ku zipatala zina) Taperekani zitsanzo?**

Mobile health

33. Is any mobile technology used by the HSAs, TBAs, volunteers? By other health providers?**(Kodi anthu ogwira ntchito ku midzi amagwiritsa ntchito njira zamakono monga ma foni pa ntchito yawo?)(Nanga ena ogwira ntchito za umoyo?)**

34. What do they use the mobile technologies for? **(Kodi njira zimenezi amazigwiritsa ntchito yanji?)**

35. How do you feel about the use of these devices: advantages, disadvantages? **(Kodi zidazi zili ndi ubwino kapena kuyipa kotani?).**

Consent form, SSI and FGD clients

MY name is I work with The REACH Trust. Reach Trust is a health research institution based in Lilongwe. In collaboration with Liverpool School of Tropical Medicine in England we are conducting a health-related study. The study has been approved by the National Health Sciences Research Committee.

Purpose and questions asked

This study wants to learn from the work that is carried out by community volunteers and community health workers such as HSAs and traditional birth attendants (TBAs) to help clients and communities to improve their health. We are especially interested in the work of the HSAs, volunteers and TBAs, and the way the government and other organisations are supporting or hindering their work. The views, opinions and experiences of you and others are important to find out how programmes can be best organised and improved in the future.

You are asked to take part in an individual interview that will take approximately 1 hour (or FGD that will take not more than 2 hours,). The interview or focus group discussion will take place in a private place.

You will be asked to talk about the work of HSAs, TBAs, volunteers and others; services they provide in relation to HIV, TB, and malaria, among others? What you like and dislike in their work, who is using their services, are some groups left out? What do you think works well and what kind of things you think can be improved?

Discomfort, risks and benefits

This study may not help you directly but the results will help to improve the provision of health services. If you feel that responding to some questions may bring discomfort to you, we suggest that you should not answer such questions.

Withdrawal

You do not have to take part if you do not wish to. If you do choose to take part you are free to refuse to respond to any questions that you do not want to answer. At any time while we are discussing, you can ask me to stop. If you decide not to take part or withdraw you can do so. Your participation in this study will not affect your access to health or other services in any negative way.

Confidentiality

If you do choose to take part, we will bring together what everybody is telling us. The consent form will be kept locked up and separate from the interviews and discussions. No one will be able to identify what exactly we discussed. To make sure that the information is correctly used the conversation will be recorded on a tape recorder in addition to taking notes. Your name will not be mentioned in relation to anything that will be said, written down and taped. No one will access the information apart from the researchers, and the information will be kept for 3 years and then get destroyed.

[If Focus Group Discussion]: In the group discussion you are asked to speak about what people in your group think or do. Other participants in the group will hear what you say and they may not keep this confidential. Therefore we ask you not to share personal information.

Procedures

The interview or FGD will be conducted in a private place where nobody can hear what is said.

Consent

Have you got any questions that you would like to ask?

Are there any things you would like to be explained further? If you do not want to take part in this interview you can refuse to do so, you can refuse to answer any questions and to stop the interview at any time. You will not be penalised in any way if you refuse to participate.

DECLARATION: TO BE SIGNED BY THE RESPONDENT GIVING CONSENT

Ideclare that I have understood the purpose of the study which was explained to me and I agree to participate voluntarily.

Signed

Date

WITNESS SIGNATURE

Signed

Date

respondent

For any questions and concerns, contact:

National Health Sciences Research Committee on Tel: 01 726 422/418

Reach Trust Tel: 01753260/261

Email: info@reachtrust.org

Kalata yotengera chilolezo

SSI and FGD clients

Dzina langa ndine..... Ndimagwira ntchito ku bungwe la REACH Trust ku Lilongwe, lomwe limapanga kafukufuku wa zaumoyo. Pakadali pano tikupanga kafukufuku mogwirizana ndi sukulu ya ukachenjede ya Liverpool ku mangalande. Kafukufuku ameneyu wavomerezedwa ndi a unduna wa zaumoyo mdziko muno.

Kafukufuku ameneyu akufuna kudziwa momwe ntchito zofuna kupititsa pa tsogolo umoyo wa anthu m'madera a kumidzi zikuyendera. Tikuyang'ana kwambiri pa ntchito zomwe ma alangizi a za umoyo (HSAs), ma volantiya, komanso azamba (TBAs) zikuyendera komanso kuyang'ana momwe boma ngakhale mabungwe omwe siaboma akuthandizira kapena kulepheretsa kagwiridwe ka ntchito zawo. Maganizo anu komanso a anthu ena onse ndi ofunikira kwambiri kuti tipeze njira za momwe ntchito zimenezi zingamayendetsedwere komanso momwe zingapititsidwire pa tsogolo.

Mukupemphedwa kutenga nawo mbali pa kucheza komwe kutenga mphindi pafupifupi ola limodzi kapena kupitilira apo ngati ali mafunso apagulu. Kuchezaku kuchitikira pa malo oti munthu wina sangatimvere.

Mufunsidwa maganizo anu pa ntchito yomwe ma HSA, volantiya, azamba, ndi ena, amagwira mmidzi. Mwachitsanzo; kodi magulu kapena mapologalamu amenewa amagwira ntchito zanje, kodi inuyo mumakonda kapena simukondapo zinthu ziti pa ntchito ya anthu amenewa, ndi ndani akugwiritsa ntchito ma pulogalamu amenewa, kodi magulu ena a anthu samafikiridwa ndi anthuwa?, ndi zinthu ziti zomwe mukuganiza kuti zimayenda bwino ndipo ndi ziti zomwe zikuyenera kuti zipititsidwe pa tsogolo.

Kafukufukuyu mwina sakhala ndi phindu lowonekeratu, koma kuti zotsatira zake zidzathandiza kaperekedwe ka chithandizo cha zaumoyo mutsogolo muno. Ngati pangapezeke mafunso ena omwe simungamasuke kuyankha, mutha kusayankha.

Simukukakamizidwa kutenga nawo mbali pa kafukufukuyu ngati inu simukufuna ayi. Ngati mukufuna kutenga nawo mbali muli omasuka kutero, ndipo dziwani kuti muli ndi ufulu okana kuyankhapo pa funso lina liri lonse lomwe simukufuna kuyankha. Muthanso kundifunsa kuti ndisiye kukufunsani mafunso nthawi ina ili yonse. Ngati simukufuna kutenga nawo mbali pa kafukufukuyu mulinso ndi ufulu kutero. Dziwani kuti simudzalandira chilango china chili chonse monga kukanizidwa kulandila chithandizo cha zaumoyo kaamba ka chisankho chokana kutenga nawo mbali pa Kafukufuku ameneyu.

Ngati musankha kutenga nawo mbali, tikufuna tikudziwitseni kuti tidzaika pamodzi zonse zomwe anthu akutiiza. Kalata imeneyi tidzasunga pa malo a chinsinsi kuti ena asayione. Palibe amene adzathe kudziwa zomwe takambirana. Pofuna kuonesetsa kuti zomwe tikambirane zikagwiritsidwe bwino ntchito, tijambula zokambirana zathu pamwamba poti tidzilembanso. Dzina lanu silidzatchulidwa pa china chili chonse chomwe chikambidwe pano, ndipo silikhala nawo gawo la zomwe tijambule kapena kulemba. Zimene mutiwuze pano zisasungidwa kwa zaka zitatu kenako tidzaziononga.

(Ngati kuli kukambilana kwa pagulu) Pano monga pa gulu tikupempheni kuti musakambepo china chili chonse chokhudza inu ngati munthu chifukwa anthu ena atha osasunga chinsinsi chanu. Tikukupemphani kuti mulankhule mokhudzana ndi zokhazo zomwe aliyense akufotokoza pa zokambirana zathuzi basi. Kuchezaku tichezera pa malo a chinsinsi pomwe wina aliyense sangatimvere.

Kodi muli ndi mafunso ena ali onse?

Pali zinthu zina zomwe mukufuna kuti tilongosolere bwino?

Ngati simukufuna kutenga nawo mbali pa kucheza kumeneku mutha kutero. Muthanso kukana kuyankha funso lina liri lonse, komanso mutha kuimitsa Kuchezaku nthawi ina ili yonse. Simukalandira chilango china chili chonse ku bungwe lanu chifukwa cha kukana kwanu

Inendikutsimikiza kuti ndamvetsetsa cholinga cha kafukufukuyu ndipo andifotokoza bwino lomwe. Ndavomera kutenga nawo mbali mosakakamizidwa.

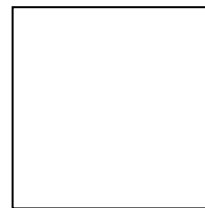
Sayini

Tsiku

Sayini ya mboni

Sayini

Tsiku



Chidindo cha chala

Ngati ndi funso kapena dandaulo zokhudzana ndi kafukufukuyu imbani foni pa nambala izi:

Bungwe loyang'ana za kafukufuku ku unduna wa zaumoyo, nambala: 01 726 422/418

Reach Trust, Nambala: 01756263/261

Email: 01 726 422/418

Topic guide for policy makers and health managers

<i>Information Sheet Policy makers, Health managers</i>	
Gender	Female, male
What is your age? (Muli ndi zaka zingati?)	
What is your marital status	
What is your religious affiliations?	
How many years education did you receive (Sukulu munafika nayo pati?)	None, Primary 1-3; primary 4-6; Jun secondaryyrs; senior secondary ...yrs Tertiaryyrs
What is your professional education (Maphunziro antchito yanu munafika nawo pati?)	
What is the health focus of your work? (Kodi mumagwira ntchito yotani makamaka pa nkhani ya za umoyo?) More than 1 focus area is possible.	Mother and neonatal health Child health, TB, HIV, Malaria Other.....
Duration of service	

Take consent

Fill in information and recording sheet

Explain process

Intro

1. Can you tell me a bit about your work, the tasks you do on an average day? **(Mungandifotokozere kuti ntchito yanuyi mumatani; tsiku lanu la ntchito limayenda bwanji?)**
2. What has been your involvement with CTC provider programmes? **(Mumagwira bwanji ntchito ndi magulu ena a anthu ogwira ntchito za umoyo monga ma HSA, azamba, volontiya?)**
3. How often are you in contact with them? For what purposes? **(Mumalumikizana nawo kangati tiyerekeze pa mwezi kapena pa chaka ndipo kulumikizana kumakhala pankhani yanji?)**

Facilitators and barriers

4. What CTC providers are working in this area? **Kodi ndi magulu ati omwe akugwira ntchito za umoyo m'dera lino**
5. What do you think is the importance of HSAs, TBAs, volunteers etc? **(Kodi kufunikira kwa ma HSA, azamba ndi mavolontiya ndi kotani?)**
6. What is their contribution towards health service delivery? **(Amathandiza motani?)**
7. What challenges do they face in providing health services? **(Kodi ndi mavuto anji omwe amakumana nawo pa ntchito yawo?)**
 - Probe – challenges around HRM, M&E, QA; In provision of HIV, TB Malaria etc **mavuto okhudzana ndi kuchuluka/kuchepa kwa anthu ogwira ntchito za umoyo, kuyang'anira kayendetsedwe ndi kuunikira m'mene ntchito za umoyo zikuyendera, ndondomeko zoonetsetsa kuti zinthu (ntchito za umoyo za HSAs, TBAs etc) zikhale zapamwamba**
8. What things go well in the provision of health services by HSAs, TBAs, volunteers etc? Give examples? **(Kodi mukuganiza kuti ndi zinthu ziti zomwe zimayenda bwino pamene inu ndi magulu ena monga HSA, TBA, volontiya mukugwira ntchito yanu? (Taperekani zitsanzo?)**
9. What helps to make the provision of services by HSAs, TBAs, volunteers go well? **(Ndi chiyani chimapangitsa kuti ntchitozo ziziyenda bwino?)**
10. What do you think does not always go well? Can you give an example? **(Ndi zinthu ziti zomwe siziyenda bwino nthawi zonse mumapologalamu amenewa?) (Taperekani zitsanzo)**

11. What things are influencing that this does not go well? Can you give an example? **(Ndi chiyani chimapangitsa kuti zinthuzo zisamayende bwino?) (Taperekani zitsanzo)**

Lessons learned, opportunities constraints

12. Thinking about the work that HSAs, TBAs, volunteers and other groups do, what can be done to improve their work? **(Mukuganiza kuti pachitike chiyani kuti ntchito za ma HSA, Azamba ndi ma volontiya komanso magulu ena ziziyenda bwino koposa momwe zikuchitira panopo?)** How could this be done? **(Zimenezi zitha kuchitika bwanji?)**
13. If we want to start such a programme in other areas what should be done to make the programme work? **(Ena atafuna kuyambitsa ntchito ngati zimenezi mumadera ena, mungawalangize kuti achite chiyani pofuna kuti ntchitozo ziziyenda bwino?)**
14. What should be avoided? **(Nanga ndi zinthu ziti zomwe mungawalangize kuti asamapange pofuna kuti ntchito zawo ziziyenda bwino?)**

Influence of CTC providers programmes on others

15. How would you describe the effectiveness of services provided by HSAs, TBAs, volunteers? **Mungafotokoze bwanji momwe ma HSA, azamba, volontiya akugwirira ntchito zawo mwa ukadaulo?**
16. How would you describe the quality of care provided by HSAs, TBAs, volunteers? **Mungafotokoze bwanji za chisamaliro chomwe ma HSA, azamba, volontiya amapereka? Perekani zitsanzo?**

The following are specific issues to be explored if not already addressed:

Policies

17. What guidelines for HSAs, TBAs, volunteers are you aware of? **(Ndi ndondomeko zANJI zomwe ma HSA, azamba, volontiya amatsatira pogwira ntchito zawo?)**
18. How do you ensure that these guidelines are followed? **Mumaonetsetsa bwanji kuti ndondomeko zimenezi zikutsatidwa?**
19. What are the most important aspects of these guidelines in your opinion? **(Ndi mfundo ziti zomwe zili zofunikira kwambiri mundondomeko zimenezi?)**
20. What could be improved in the guidelines? **(Ndi mfundo ziti zomwe zikufunika kukonza mundondomeko zimenezi?)**
21. How are CTC providers involved in the formulation of policies and guidelines related to their work? **kodi ma HSA, azamba, ma volontiya amatenga nawo gawo lanji popanga Malamulo okhudza ntchito zawo?**

HR planning & Management

22. What do you think about the tasks of HSAs, TBAs, volunteers in terms of; workload, skills, experience, knowledge, competency? **(Mukuganiza bwanji za ntchito zosiyana siyana zomwe ma HSA, azamba, volontiya amagwira potengera monga; kuchukula kwa ntchito, luso, kuthekera...)**
23. Regarding their tasks, what should be kept/could be changed? **(pa ntchito zomwe ma HSA, azamba, mavolontiya amagwira, ndi ntchito ziti zofunika kuti zikhale momwe ziliri panopo, kapena zoyenera kuti zisinthidwe?)**
24. How are HSAs, TBAs, volunteers recruited and the criteria for selection **(Note for interviewer: for HSAs; we are looking at recruitment for employment, and into specific programmes ?(Kodi ma HSA, azamba, mavolontiya amalembedwa bwanji ntchito, ndipo ndi ndondomeko yotani yomwe imatsatidwa?)**
25. What do you think about their:
- a. Incentives -**zowalimbikitsa**
 - b. Remuneration - **malipiro**
 - c. Career perspectives – **mipata yokwezedwa pantchito**
 - d. Training – **maphunziro apadera owonjezera pa luso lawo**
 - e. Continuing education **kupitiliza maphunziro**
 - f. Supervision? **kuyang'aniridwa kwawo pantchito**
26. How do you feel about voluntarism? **Maganizo anu ndi otani okhudzana ndi kugwira ntchito mongodzipereka?**

Motivation

27. What things influence job satisfaction and motivation of HSAs, TBAs, Volunteers etc and how? **(Ndi zinthu ziti zomwe zimapangitsa ma HSA, azamba, ma volontiya kuti adzikhutira ndi ntchito yawo komanso kulimbikisidwa?; zimenezi zimachitika motani)**
28. What demotivates them? **(Ndi zinthu ziti zomwe zimawabwezeretsa m'mbuyo?)** Probe for:
- a. Equipment **zida zogwiritsa ntchito**
 - b. Transportation (**, mayendedwe,**),
 - c. Safety (**chitetezo pa ntchito,**)
 - d. Career perspective (**Tsogolo la ntchito monga kukwezedwa kapena kupitiliza maphunziro,**)
 - e. Supervision (**Ndondomeko yomwe imatsatidwa poyang'anira munthu pa ntchito,**)
 - f. Community (**Mudzi kapena dera lawo,**)
 - g. Clients (**Anthu omwe amawatumikira kapena kuwathandiza,**)
 - h. Colleagues (**anzawo,**)

- i. Other health workers (**ena ogwira ntchito za umoyo**).

Structures including legislation

29. Does the work of HSAs, TBAs and volunteers etc, have legal backing to carry out their tasks? Explain. **Kodi ntchito yomwe ma HSA, azamba ndi ma volantiya ndiyovomerezeka ndi Malamulo a dziko lino? Fotokozani.**

Referral

30. How is referral of HSAs, TBAs, Volunteers programmes organized? (**Kodi ndondomeko ya katumizidwe ka anthu othandizidwa oti mavuto awo inu simungawathe-imayendetsedwa bwanji?**)
Probe for: different referral processes for different conditions (TB, HIV, Malaria) ask for examples. (**Njira zomwe zimatsatidwa potumiza mavuto osiyanasiyana kapena anthu omwe mukuwatumizawo. Perekani zitsanzo**)
31. What goes well and not so well in referral? Examples? (**Ndizinthu ziti zomwe zikuyenda bwino kapena kusayenda bwino pa ntchito yotumiza anthu omwe ali ndi mavuto omwe simumawakwanitsa. Taperekani zitsanzo?**)

Control at work

32. How are HSAs, TBAs, Volunteers enabled and limited in their control at work? (**Kodi mukuwona ngati ali ndi ulamuliro pa pantchito yawo?**) Probe:
- a. Influencing decision making? **kodi maganizo awo amamveka pakagwiridwe ka ntchito zawo?**
 - b. feeling powerless **kuchepekedwa mphamvu?**
 - c. Feeling less valued **kusawelengeredwa**
 - d. problem solving process e.g. what happens when there is a shortage of equipment and supplies? **momwe amathetsera mavuto okhudzana ndi ntchito yawo munga mayendedwe, kusowa kwa mankhwala, Kupelewera kwa Zipangizo etc)**

Quality of care

33. How is the quality of services that HSAs, TBAs, Volunteers provide organized and evaluated? – **kodi ntchito za ma HSAs, TBAs etc zimayendetsedwa ndi kuunikiridwa bwanji kuti zikhale zapamwamba**
34. What affects the quality of services which they provide? Probe for:
- a. Incentives -**zowalimbikitsa**
 - b. Remuneration - **malipiro**

- c. Career perspectives – **mipata yokwezedwa pantchito**
 - d. Training – **maphunziro apadera owonjezera pa luso lawo**
 - e. Continuing education **kupitiliza maphunziro**
 - f. Supervision? **kuyang'aniridwa kwawo pantchito**
 - g. Equipments **(zida zogwilira ntchito)**
35. How is the quality of logistics (equipment and drugs) ensured? **Pali ndondomeko zotani zoonetsetsa kuti zida zogwilira ntchito ndi mankhwala ndi zapamwamba?**
36. For each, who is responsible? How do they carry out their work? **Ali ndi udindo owonetsetsa kuti zida ndi mankhwala ndizapamwamba ndani? Amatani poonetsetsa kuti zimenezi ndizapamwamba?**
37. Do the HSAs, TBAs, volunteers etc receive feedback from their supervisors, colleagues, clients and community about their performance? **Kodi amafotokozeredwa za magwiridwe awo a ntchito; monga okuyang'anira, anzawo ogwira nawo ntchito komanso anthu amene amawatumikira?**
- Probe for:
- a. Reporting hierarchy (reports to who?) – **Malipoti amachokera ndi kupita kwa ndani**
 - b. Reporting schedule (frequency – after how long?) – **Malipotiwo amatumizidwa kangati, tiyerekeze pa mulungu, kapena pa mwezi.**
 - c. Complaints - **Madandaulo**
 - d. satisfaction - **Kukhutira**
38. What do you think people in the community think about the quality of health services (TB, HIV, Malaria) that you provide **(Mukuganiza kuti anthu a m'dera lino amaziyyika pamulingo otani ntchito zanu zomwe mumagwira)?**

Communication and interaction with colleagues

39. How is the inter and intra cadre communication and interaction amongst CTC providers?(i.e. Between HSAs, volunteers, TBAs or among HSAs, volunteers and TBAs.) **(Kodi kulumikizana ndi kugwilira ntchito limodzi pakati pawo ndi magulu ena kumayenda bwanji?)**
- Probe for:
- a. communication channels, **(Ndi njira ziti zomwe zimatsatidwa polumikizana),**
 - b. meetings, **(Misonkhano?),**
 - c. informal contacts, **(M'njira zongocheza)**
 - d. how often, **(Kulumikizanakumachitika kangati kapena Mowirikiza bwanji?)**
40. What is the communication about.**(Mumalumikizana pa zinthu ziti?).**

41. How do you interact and communicate with these CTC providers? (**Kodi kulumikizana ndi kugwilira ntchito limodzi pakati pa inu ndi ma HSA, azamba, ma volontiya kumayenda bwanji?**)

M&E

42. How is monitoring and Evaluation carried out? (**Kodi ntchito yoyang'anira ndi kuunikira ntchito zaumoyo imayenda bwanji?**)
43. How is the information about their performance collected? (**Kodi malipoti okhudza ntchito yawo amatoleredwa bwanji?**)
44. What communication channels are used? (**Ndi njira ziti zomwe zimagwiritsidwa ntchito potolera malipoti amenewa?**)
45. What happens with this information? (**Kodi malipoti amenewa amagwira ntchito yanji?**)
46. Do you/supervisors give feedback about the results of their work based on information about their performance? (**Kodi amauzidwa chili chonse chokhudzana ndi mmene akugwirira ntchito zawo?**)
47. If so, how is this communicated to them and by whom? (**Ngati ndi choncho, kodi amauzidwa bwanji komanso ndi ndani?**)

Mobile health

48. Do HSAs, TBAs, volunteers etc, use any mobile technology? (**Kodi amagwiritsa ntchito njira zamakono monga ma foni pa ntchito pogwira ntchito za umoyo?**)
49. What do they use the mobile technologies for? (**Kodi njira zimenezi amazigwiritsa ntchito yanji?**)

Probe:

- to collect and send information; (**Kutolera ndi kutumizira uthenga;**)
- to coordinate things; (**kulunzanitsa anthu monga pokonza misonkhano;**)
- to seek advice from others, (**Kupezera uphungu kuchokera kwa ena,**)
- to contact clients. (**Kulumikizana ndi omwe amawatumikira-ma client**)
- For each find out what with who how often.
- Who bought the device? (**Anagula chida/zida zamakono zimenezi monga foni ndi ndani?**)
- Who pays for the costs of use, charging etc.? (**Amalipira ma bilu ndi zina zoyendetsera zidazi ndi ndani?**)

53. How do you feel about the use of these devices: advantages, disadvantages? (**Kodi zidazi zili ndi ubwino kapena kuyipa kotani?**).

Topic guide SSI key informants

(Community leaders, NGO/CBO working with CTC providers)

<i>Information sheet key informants</i>	
Tasks by HSAs, TBAs, health volunteer familiar with Ntchito yomwe ma HSA, azamba, mavolontiya a za umoyo zomwe mukuzidziwa bwino	
District/Chieftdom of CTC providers work: Boma/mfumu yomwe pulogalamuyi ikuchitika	
Village: Mudzi:	
Function/ role: Mumagwira ngati ndani	
Duration of conducting this role/function Mwagwira nthawi yaitali bwanji muli pa udindo umenewu	
Organisation (if relevant) Bungwe lanji	
Role of organisation Bungwe limeneli limatenga gawo lanji	

Take consent

Fill in recorder and information sheet

Intro

1. Can you tell me about your work, particularly on health, the tasks you do? **(Mungandifotokozere kuti ntchito yanuyi mumatani; tsiku lanu la ntchito limayenda bwanji?)**
2. What has been your involvement in relation to the work done by HSAs, TBAs, volunteers and other CTC providers? **(Mwakhala mukukhudzidwa bwanji ndi ntchito zomwe ma HSA, azamba, mavalontiya ndi magulu ena a za umoyo amagwira?)**

Facilitators and barriers

3. What do you think is the importance of the work done by HSAs, TBAs, volunteers and other CTC providers? **(Kodi mukuwona ngati ntchito zomwe ma HSA, azamba, mavalontiya ndi zofunikira bwanji?)**
4. Do you see any challenges faced by HSAs, TBAs, volunteers and other CTC providers? **(Kodi ndi mavuto otani amene ma HSA, azamba, mavalontiya amakumana nawo?)**
5. What goes well and what does not go well in the work done by HSAs, TBAs, volunteers and other CTC providers? Why? **(Ndi zinthu ziti zomwe zimayenda bwino, nanga ndi ziti zomwe siziyenda bwino pa ntchito yomwe ma HSA, azamba, mavalontiya amagwira)**

Lessons learned, opportunities constraints

6. Thinking about the work that HSAs, TBAs, volunteers and other groups do, what can be done to improve their work? **(Mukuganiza kuti pachitike chiyani kuti ntchito za ma HSA, Azamba ndi ma volontiya komanso magulu ena ziziyenda bwino koposa momwe zikuchitira panopo?)** How could this be done? **(Zimenezi zitha kuchitika bwanji?)**
7. If we want to start such a programme in other areas what should be done to make the programme work? **(Ena atafuna kuyambitsa ntchito ngati zimenezi mumadera ena, mungawalangize kuti achite chiyani pofuna kuti ntchitozo ziziyenda bwino?)**
8. What should be avoided? **(Nanga ndi zinthu ziti zomwe mungawalangize kuti asamapange pofuna kuti ntchito zawo ziziyenda bwino?)**

Influence of CTC providers' programmes on others

9. How would you describe the effectiveness of services provided by HSAs, TBAs, volunteers? **Mungafotokoze bwanji momwe ma HSA, azamba, volontiya akugwirira ntchito zawo mwa ukadaulo?**
10. How would you describe the quality of care provided by HSAs, TBAs, volunteers? **Mungafotokoze bwanji za chisamaliro chomwe ma HSA, azamba, volontiya amapereka? Perekani zitsanzo?**

The following are specific issues to be explored if not already addressed:

Policies

11. What guidelines for HSAs, TBAs, volunteers are you aware of? **(Ndi ndondomeko zANJI zomwe ma HSA, azamba, volontiya amatsatira pogwira ntchito zawo?)**

12. How do you ensure that these guidelines are followed? **Mumaonetsetsa bwanji kuti ndondomeko zimenezi zikutsatidwa?**
13. What are the most important aspects of these guidelines in your opinion? **(Ndi mfundo ziti zomwe zili zofunikira kwambiri mundondomeko zimenezi?)**
14. What could be improved in the guidelines? **(Ndi mfundo ziti zomwe zikufunika kukonza mundondomeko zimenezi?)**
15. How are CTC providers involved in the formulation of policies and guidelines related to their work? **kodi ma HSA, azamba, ma volontiya amatenga nawo gawo lanji popanga Malamulo okhudza ntchito zawo?**

HR planning & Management

16. What do you think about the tasks of HSAs, TBAs, volunteers in terms of; workload, skills, experience, knowledge, competency,?(**Mukuganiza bwanji za ntchito zosiyana siyana zomwe ma HSA, azamba, volontiya amagwira potengera monga; kuchukula kwa ntchito, luso, kuthekera...**)
17. Regarding their tasks, what should be kept/could be changed? **(pa ntchito zomwe ma HSA, azamba, mavolontiya amagwira, ndi ntchito ziti zofunika kuti zikhale momwe ziliri panopo, kapena zoyenera kuti zisinthidwe?)**
18. How are HSAs, TBAs, volunteers recruited and the criteria for selection *(Note for interviewer: for HSAs; we are looking at recruitment for employment, and into specific programmes)*(**Kodi ma HSA, azamba, mavolontiya amalembedwa bwanji ntchito, ndipo ndi ndondomeko yotani yomwe imatsatidwa?**)
19. What do you think about their:
 - a. Incentives -**zowalimbikitsa**
 - b. Remuneration - **malipiro**
 - c. Career perspectives – **mipata yokwezedwa pantchito**
 - d. Training – **maphunziro apadera owonjezera pa luso lawo**
 - e. Continuing education **kupitiliza maphunziro**
 - f. Supervision? **kuyang'aniridwa kwawo pantchito**
20. How do you feel about voluntarism? **Maganizo anu ndi otani okhudzana ndi kugwira ntchito mongodzipereka?**

Motivation

21. What things influence job satisfaction and motivation of HSAs, TBAs, Volunteers etc and how? **(Ndi zinthu ziti zomwe zimapangitsa ma HSA, azamba, ma volontiya kuti adzikhutira ndi ntchito yawo komanso kulimbikisidwa?; zimenezi zimachitika motani)**
22. What demotivates them? **(Ndi zinthu ziti zomwe zimawabwezeretsa m'mbuyo?)** Probe for:
 - a. Equipment **zida zogwiritsa ntchito**

- b. Transportation (**mayendedwe**),
- c. Safety (**chitetezo pa ntchito**),
- d. Career perspective (**Tsogolo la ntchito munga kukwezedwa kapena kupitiliza maphunziro**),
- e. Supervision (**Ndondomeko yomwe imatsatidwa poyang'anira munthu pa ntchito**),
- f. Community (**Mudzi kapena dera lawo**),
- g. Clients (**Anthu omwe amawatumikira kapena kuwathandiza**),
- h. Colleagues (**anzawo**),
- i. Other health workers (**ena ogwira ntchito za umoyo**).

Structures including legislation

23. Does the work of HSAs, TBAs and volunteers etc, have legal backing to carry out their tasks? Explain. **Kodi ntchito yomwe ma HSA, azamba ndi ma volantiya ndiyovomerezeka ndi Malamulo a dziko lino? Fotokozani.**

Referral

24. How is referral of HSAs, TBAs, Volunteers programmes organized? (**Kodi ndondomeko ya katumizidwe ka anthu othandizidwa oti mavuto awo inu simungawathe-imayendetsedwa bwanji?**)

Probe for: different referral processes for different conditions (TB, HIV, Malaria) ask for examples. (**Njira zomwe zimatsatidwa potumiza mavuto osiyanasiyana kapena anthu omwe mukuwatumizawo. Perekani zitsanzo**)

25. What goes well and not so well in referral? Examples? (**Ndizinthu ziti zomwe zikuyenda bwino kapena kusayenda bwino pa ntchito yotumiza anthu omwe ali ndi mavuto omwe simumawakwanitsa. Taperekani zitsanzo?**)

Control at work

26. How are HSAs, TBAs, Volunteers enabled and limited in their control at work? (**Kodi mukuwona ngati ali ndi ulamuliro pa pantchito yawo?**) Probe:

- a. Influencing decision making? **kodi maganizo awo amamveka pakagwiridwe ka ntchito zawo?**
- b. feeling powerless **kuchepekedwa mphamvu?**
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Quality of care

27. How is the quality of services that HSAs, TBAs, Volunteers provide organized and evaluated? – **kodi ntchito za ma HSAs, TBAs etc zimayendetsedwa ndi kuunikiridwa bwanji kuti zikhale zapamwamba**

28. What affects the quality of services which they provide? Probe for:

- a. Incentives -**zowalimbikitsa**
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29. How is the quality of logistics (equipment and drugs) ensured? **Pali ndondomeko zotani zoonetsetsa kuti zida zogwirira ntchito ndi mankhwala ndi zapamwamba?**

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31. Do the HSAs, TBAs, volunteers etc receive feedback from their supervisors, colleagues, clients and community about their performance? **Kodi amafotokozeredwa za magwiridwe awo a ntchito; monga okuyang'anira, anzawo ogwira nawo ntchito komanso anthu amene amawatumikira?**

Probe for:

- a. Reporting hierarchy (reports to who?) – **Malipoti amachokera ndi kupita kwa ndani**
- b. Reporting schedule (frequency – after how long?) – **Malipotiwo amatumizidwa kangati, tiyerekeze pa mulungu, kapena pa mwezi.**
- c. Complaints - **Madandaulo**
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32. What do you think people in the community think about the quality of health services (TB, HIV, Malaria) that you provide (**Mukuganiza kuti anthu a m'dera lino amaziyika pamulingo otani ntchito zanu zomwe mumagwira**)?

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Probe for:

- a. communication channels, (**Ndi njira ziti zomwe zimatsatidwa polumikizana**),
- b. meetings, (**Misonkhano?**),
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- d. how often, (**Kulumikizanakumachitika kangati kapena Mowirikiza bwanji?**)

34. What is the communication about. **(Mumalumikizana pa zinthu ziti?)**.
35. How do you interact and communicate with these CTC providers? **(Kodi kulumikizana ndi kugwilira ntchito limodzi pakati pa inu ndi ma HSA, azamba, ma volantiya kumayenda bwanji?)**

M&E

36. How is monitoring and Evaluation carried out? **(Kodi ntchito yoyang'anira ndi kuunikira ntchito zaumoyo imayenda bwanji?)**
37. How is the information about their performance collected? **(Kodi malipoti okhudza ntchito yawo amatoleredwa bwanji?)**
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40. Do you/supervisors give feedback about the results of their work based on information about their performance? **(Kodi amauzidwa chili chonse chokhudzana ndi mmene akugwirira ntchito zawo?)**
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Mobile health

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Probe:

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- to coordinate things; **(kulunzanitsa anthu monga pokonza misonkhano);**
- to seek advice from others, **(Kupezera uphungu kuchokera kwa ena),**
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- For each find out what with who how often.
- Who bought the device? **(Anagula chida/zida zamakono zimenezi monga foni ndi ndani?)**
- Who pays for the costs of use, charging etc.? **(Amalipira ma bilu ndi zina zoyendetsera zidazi ndi ndani?)**

53. How do you feel about the use of these devices: advantages, disadvantages?**(Kodi zidazi zili ndi ubwino kapena kuyipa kotani?)**.

Consent form for SSI key informants, policy makers and health managers

MY name is I work with The REACH Trust. Reach Trust is a health research institution based in Lilongwe. In collaboration with Liverpool School of Tropical Medicine in England we are conducting a health-related study. The study has been approved by the National Health Sciences Research Committee.

Purpose and questions asked

This study wants to learn from the work that is carried out by community volunteers and community health workers such as HSAs and traditional birth attendants (TBAs) to help clients and communities to improve their health. We are especially interested in the work of the HSAs, volunteers and TBAs, and the way the government and other organisations are supporting or hindering their work. The views, opinions and experiences of you and others are important to find out how programmes can be best organised and improved in the future.

You are asked to take part in an individual interview that will take approximately 1 hour.

You will be asked to talk about what you think about the work that is being done by HSAs, volunteers, TBAs and others close to community providers.

Discomfort, risks and benefits

This study may not help you directly but the results will help to improve the provision of health services.

Withdrawal

You do not have to take part if you do not wish to. If you do choose to take part you are free to refuse to respond to any questions that you do not want to answer. At any time while we are discussing, you can ask me to stop. If you decide not to take part or withdraw you can do so. You will not be penalised in any way by your organisation.

Confidentiality

If you do choose to take part, we will bring together what everybody is telling us. The consent form will be kept locked up and separate from the interviews and discussions. No one will be able to identify what exactly we discussed. To make sure that the information is correctly used the conversation will be recorded on a tape recorder in addition to taking notes. Your name will not be mentioned in relation to anything that will be said, written down and taped. No one will access the information apart from the researchers, and the information will be kept for 3 years and then get destroyed.

Procedures

The interview will be conducted in a private place where nobody can hear what is said.

Consent

Have you got any questions that you would like to ask?

Are there any things you would like to be explained further? If you do not want to take part in this interview you can refuse to do so, you can refuse to answer any questions and to stop the interview at any time. You will not be penalised in any way if you refuse to participate.

DECLARATION: TO BE SIGNED BY THE RESPONDENT GIVING CONSENT

Ideclare that I have understood the purpose of the study which was explained to me and I agree to participate voluntarily.

<hr/>		
Signed	Date	<div style="border: 1px solid black; width: 200px; height: 100px; margin: 0 auto;"></div>
WITNESS SIGNATURE		
<hr/>		
Signed	Date	
		Thumbprint respondent

For any questions and concerns, contact:

National Health Sciences Research Committee on Tel: 01 726 422/418

Reach Trust on Tel: 01756263/261

Email: info@reachtrust.org

Kalata yotengera chilolezo

SSI key informants

Dzina langa ndine..... Ndimagwira ntchito ku bungwe la REACH Trust ku Lilongwe, lomwe limapanga kafukufuku wa zaumoyo. Pakadali pano tikupanga kafukufuku mogwirizana ndi sukulu ya ukachenjede ya Liverpool ku mangalande. Kafukufuku ameneyu wavomerezedwa ndi a unduna wa zaumoyo mdziko muno.

Kafukufuku ameneyu akufuna kudziwa momwe ntchito zofuna kupititsa pa tsogolo umoyo wa anthu m'madera a kumidzi zikuyendera. Tikuyang'ana kwambiri pa ntchito zomwe ma alangizi a za umoyo (HSAs), ma volantiya, komanso azamba (TBAs) zikuyendera komanso kuyang'ana momwe boma ngakhale mabungwe omwe siaboma akuthandizira kapena kulepheretsa kagwiridwe ka ntchito zawo. Maganizo anu komanso a anthu ena onse ndi ofunikira kwambiri kuti tipeze njira za momwe ntchito zimenezi zingamayendetsedwere komanso momwe zingapititsidwire pa tsogolo.

Mukupemphedwa kutenga nawo mbali pa kucheza komwe kutenga mphindi pafupifupi ola limodzi. Kuchezaku kuchitikira pa malo omwe ena sangathe kumva zomwe tikukambirana.

Mufunsidwa kuti mutiuze maganizo anu pa momwe ntchito ya ma HSA, volantiya, azamba ndi ena, yopereka chithandizo ku midzi, ikuyendera.

Kafukufukuyu mwina sakhala ndi phindu lowonekeratu, koma kuti zotsatira zake zidzathandiza kusintha ma pulogalamu ngati yomwe mukugwira inuyi mu tsogolo muno.

Simukukakamizidwa kutenga nawo mbali pa kafukufukuyu ngati inu simukufuna ayi. Ngati mukufuna kutenga nawo mbali muli omasuka kutero, ndipo dziwani kuti muli ndi ufulu okana kuyankhapo pa funso lina liri lonse lomwe simukufuna kuyankha. Muthanso kundifunsa kuti ndisiye kukufunsani mafunso nthawi ina ili yonse. Dziwani kuti simudzalandira chilango china chili chonse kuchokera ku bungwe lanu kaamba ka chisankho chokana kutenga nawo mbali pa Kafukufuku ameneyu.

Ngati musankha kutenga nawo mbali, tikufuna tikudziwitseni kuti tidzaika pamodzi zonse zomwe anthu akutiiza. Kalata imeneyi tidzasunga pa malo a chinsinsi kuti ena asayione. Palibe amene adzathe kudziwa zomwe takambirana. Pofuna kuonesetsa kuti zomwe tikambirane zikagwiritsidwe bwino ntchito, tijambula zokambirana zathu pamwamba poti tidzilembanso. Dzina lanu silidzatchulidwa pa china chili chonse chomwe chikambidwe pano, ndipo silikhala nawo gawo la zomwe tijambule kapena kulemba. Zimene mutiwuze pano zisasungidwa kwa zaka zitatu kenako tidzaziononga.

Kodi muli ndi mafunso ena ali onse?

Pali zinthu zina zomwe mukufuna kuti tilongosolere bwino?

Ngati simukufuna kutenga nawo mbali pa kucheza kumeneku mutha kutero. Muthanso kukana kuyankha funso lina liri lonse, komanso mutha kuimitsa Kuchezaku nthawi ina ili yonse. Simukalandira chilango china chili chonse ku bungwe lanu chifukwa cha kukana kwanu

Inendikutsimikiza kuti ndamvetsetsa cholinga cha kafukufukuyu ndipo andifotokozera bwino lomwe.Ndavomera kutenga nawo mbali mosakakamizidwa.

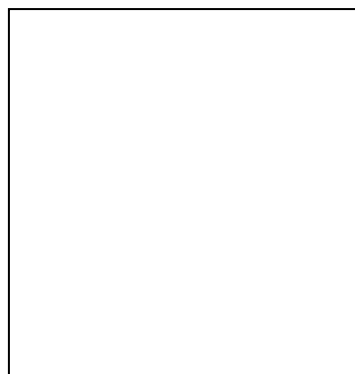
Sayini

Tsiku

Sayini ya mboni

Sayini

Tsiku



Chidindo cha chala

Bungwe loyang'ana za kafukufuku ku unduna wa zaumoyo, nambala: 01 726 422/418

Reach Trust, Nambala: 01756263/261

Email: info@reachtrust.org

Information sheet for other CTC providers

Gender	Female, male
What is your age? (Muli ndi zaka zingati?)	<input type="text"/>
What is your marital status	<input type="text"/>
What is your religious affiliations?	<input type="text"/>
What is your ethnic group?	<input type="text"/>
How many years education did you receive (Sukulu munafika nayo pati?)	None, Primary 1-3; primary 4-6; Jun secondaryyrs; senior secondary ...yrs Tertiaryyrs
What is your professional education (Maphunziro antchito yanu munafika nawo pati?)	<input type="text"/>
If not HSA, what is your occupation?	<input type="text"/>
What is the health focus of your work? (Kodi mumagwira ntchito yotani?) More than 1 focus area is possible.	Mother and neonatal health Child health, TB, HIV, Malaria Other.....
Duration of service*****	<input type="text"/>
Main Tasks (Ntchito za zikuluzikulu zomwe mumagwira)	<input type="text"/>
How much time do you spend on this work? (Kodi ntchito imeneyi imakutengerani nthawi yaitali bwanji tiyerekeze pasabata kapena pa mwezi)	...days ...hours
How long was your initial training for this work? (Kodi maphunziro oyamba okhudzana ndi ntchitoyi adatenga nthawi yaitali bwanji?)training daysdays on the job training
Did you get any other training (Mudalandirapo maphunziro ena pambali pa omwe mwatchulawa?)	For what: How long:

Information sheet FGD providers

Function	CTC provider Yes/no	Organisation	Gender M/F	age	Professional education

Topic guide SSI other CTC providers (SSI1b) and FGD CTC and other CTC providers (FGD1)

Take consent

Fill in information and recording sheet

Explain process

If FGD ensure that ground rules are discussed

Intro

1. Can you tell me a bit about your work, the tasks you do on an average day?

(Mungandifotokozere kuti ntchito yanuyi mumatani; tsiku lanu la ntchito limayenda bwanji?)

2. What has been your involvement with other health provider programmes? **(Mumagwira bwanji ntchito ndi magulu ena a anthu ogwira ntchito za umoyo monga ma HSA, azamba, volontiya?)**

3. Are you in direct contact with other health providers? **(Kodi anthuwa mumalumikizana nawo?)** 4. How often are you in contact with them? For what purposes? **(Mumalumikizana nawo kangati tiyerekeze pa mwezi kapena pa chaka ndipo kulumikizana kumakhala pankhani yanji?)**

Facilitators and barriers

- What other CTC providers are working in this area? **Kodi ndi magulu ena ati omwe akugwira ntchito za umoyo m'dera lino**
- What do you think is the importance of HSAs, TBAs, volunteers etc? **(Kodi kufunikira kwa ma HSA, azamba ndi mavolontiya ndi kotani?)**
- What is their contribution towards health service delivery? **(Amathandiza motani?)**

What challenges do you face in providing health services? **(Kodi ndi mavuto anji omwe mumakumana nawo pa ntchito yanu?)** **(Note to interviewer: Ranking and scoring)**

- Probe – challenges around HRM, M&E, QA; In provision of HIV, TB Malaria etc **mavuto okhudzana ndi kuchuluka/kuchepa kwa anthu ogwira ntchito za umoyo, kuyang'anira kayendetsedwe ndi kuunikira m'mene ntchito za umoyo zikuyendera, ndondomeko zoonetsetsa kuti zinthu (ntchito za umoyo za HSAs, TBAs etc) zikhale zapamwamba**
- What things go well in the provision of health services by HSAs, TBAs, volunteers etc? Give examples? **(Kodi mukuganiza kuti ndi zinthu ziti zomwe zimayenda bwino pamene inu ndi magulu ena monga HSA, TBA, volontiya mukugwira ntchito yanu? (Taperekani zitsanzo?)**
- What helps to make the provision of services by HSAs, TBAs, volunteers go well? **(Ndi chiyani chimapangitsa kuti ntchitozo ziziyenda bwino?)**

- What do you think does not always go well? Can you give an example? **(Ndi zinthu ziti zomwe siziyenda bwino nthawi zonse mumapologalamu amenewa?) (Taperekani zitsanzo)**
- What things are influencing that this does not go well? Can you give an example? **(Ndi chiyani chimapangitsa kuti zinthuzo zisamayende bwino?) (Taperekani zitsanzo)**

Lessons learned, opportunities constraints

- Thinking about the work that HSAs, TBAs, volunteers and other groups do, what can be done to improve their work? **(Mukuganiza kuti pachitike chiyani kuti ntchito za ma HSA, Azamba ndi ma volontiya komanso magulu ena ziziyenda bwino koposa momwe zikuchitira panopo?) How could this be done? (Zimenezi zitha kuchitika bwanji?)**
- If we want to start such a programme in other areas what should be done to make the programme work? **(Ena atafuna kuyambitsa ntchito ngati zimenezi mumadera ena, mungawalangize kuti achite chiyani pofuna kuti ntchitozo ziziyenda bwino?)**
- What should be avoided? **(Nanga ndi zinthu ziti zomwe mungawalangize kuti asamapange pofuna kuti ntchito zawo ziziyenda bwino?)**

Influence of CTC providers programmes on others

- What is the influence of the work of HSAs, TBAs, volunteers on your work? **(Kodi ntchito za anthu a za umoyo zimakhudza bwanji ntchito yanu?) Probe for increased/decreased workload. How? (Kuchuluka kapena kuchepa kwa ntchito)**
- How would you describe the effectiveness of services provided by HSAs, TBAs, volunteers? **Mungafotokoze bwanji momwe ma HSA, azamba, volontiya akugwirira ntchito zawo mwa ukadaulo?**
- How would you describe the quality of care provided by HSAs, TBAs, volunteers? **Mungafotokoze bwanji za chisamaliro chomwe ma HSA, azamba, volontiya amapereka? Perekani zitsanzo?**

The following are specific issues to be explored if not already addressed:

Policies

- What guidelines for HSAs, TBAs, volunteers are you aware of? **(Ndi ndondomeko zANJI zomwe ma HSA, azamba, volontiya amatsatira pogwira ntchito zawo?)**
- How do you use these guidelines? **Mumagwiritsa ntchito bwanji ndondomeko zimenezi?**
- What are the most important aspects of these guidelines in your opinion? **(Ndi mfundo ziti zomwe zili zofunikira kwambiri mundondomeko zimenezi?)**

- What could be improved in the guidelines? **(Ndi mfundo ziti zomwe zikufunika kukonza mundondomeko zimenezi?)**

HR planning & Management

- What do you think about the tasks of HSAs, TBAs, volunteers in terms of; workload, skills, experience, knowledge, competency,?(**Mukuganiza bwanji za ntchito zosiyana siyana zomwe ma HSA, azamba, volontiya amagwira potengera monga; kuchukula kwa ntchito, luso, kuthekera...**)
- Regarding their tasks, what should be kept/could be changed? **(pa ntchito zomwe ma HSA, azamba, mavolontiya amagwira, ndi ntchito ziti zofunika kuti zikhale momwe ziliri panopo, kapena zoyenera kuti zisinthidwe?)**
- How are HSAs, TBAs, volunteers recruited and the criteria for selection **(Note for interviewer: for HSAs; we are looking at recruitment for employment, and into specific programmes? (Kodi ma HSA, azamba, mavolontiya amalembedwa bwanji ntchito, ndipo ndi ndondomeko yotani yomwe imatsatidwa?)**
- What do you think about their:
 - Incentives –**zowalimbikitsa**
 - Remuneration – **malipiro**
 - Career perspectives – **mipata yokwezedwa pantchito**
 - Training – **maphunziro apadera owonjezera pa luso lawo**
 - Continuing education **kupitiliza maphunziro**
 - Supervision? **kuyang'aniridwa kwawo pantchito**
- How do you feel about voluntarism? **Maganizo anu ndi otani okhudzana ndi kugwira ntchito mongodzipereka?**

Motivation

- What things influence job satisfaction and motivation of HSAs, TBAs, Volunteers etc and how? **(Ndi zinthu ziti zomwe zimapangitsa ma HSA, azamba, ma volontiya kuti adzikhutira ndi ntchito yawo komanso kulimbikisidwa?; zimenezi zimachitika motani)**
- What demotivates them? **(Ndi zinthu ziti zomwe zimawabwezeretsa m'mbuyo?)**
Probe for:
 - Equipment **zida zogwiritsa ntchito**
 - Transportation (**, mayendedwe,**),
 - Safety (**chitetezo pa ntchito**),
 - Career perspective (**Tsogolo la ntchito monga kukwezedwa kapena kupitiliza maphunziro**),
 - Supervision (**Ndondomeko yomwe imatsatidwa poyang'anira munthu pa ntchito**),
 - Community (**Mudzi kapena dera lawo**),
 - Clients (**Anthu omwe amawatumikira kapena kuwathandiza**),

- Colleagues (**anzawo**),
- Other health workers (**ena ogwira ntchito za umoyo**).

Structures including legislation

- What things influence how you feel about the tasks you carry out? (**Kodi ogwira ntchitowa amamva bwanji pa ntchito yomwe amagwira ndipo ndi zinthu ziti zomwe zimawapangitsa kuti adzimva chonchi?**) Probe for:
 - Expectations of community (**Chiyembekezo cha mudzi kapena dera lawo**),
 - How they feel about meeting these expectations (**Momwe amawonera chiyembekezo chimenechi**),
 - Clients (**Amene amawatumikira**)
 - Other providers and supervisors; (**Enanso ogwira ntchito kumudzi limodzi ndi owayang'anira**)
 - Worries (**Nkhawa**)
 - Concerns (**Madandaulo**)
- What happens if something goes wrong as you carry out your duties? Give examples? Probe If a client complains. (**zomwe zimachitika ngati zinthu sizinayende bwino? Pelekani zitsanzo? (Probe: otumikiridwirawo akadandaula)**)
- Do you have legal backing to carry out your tasks? Explain. **Kodi ntchito yomwe mukugwirayi ndiyovomerezeka ndi Malamulo? Fotokozani.*******

Clients community

- Who are the clients of the HSAs, TBAs, Volunteers etc? (**Ndi ndani yemwe amalandira chithandizo kuchokera kwa inu ndi anthu ena aza umoyo akumidzi**)
- Is any group left out? Why? (**Alipo magulu ena a anthu omwe safikiridwa? Chifukwa chani?**)
 - Religion (**chipembedzo**)
 - Cultural beliefs (**zikhulupiliro**)
 - Natural barriers e.g. Rivers rough topographical terrain (**monga mitsinje, mapiri**)
 - Distance (**mtunda**)
 - Money (**ndalama**)
 - Poor groups of people (**umphawi**)
- a. Are there cases in your community where a client is being stigmatised due to conditions such as TB, HIV or having too many children? **Kodi zimachitika kuti ofuna chithandizo cha za umoyo monga odwala amasalidwa chifukwa choti ali ndi TB, HIV, kapena kukhala ndi ana ambiri/ochepa/opanda mwana?**
- b. Are there cases in your community where a provider is being stigmatised due to conditions such as TB, HIV or having too many children? **Kodi zimachitika kuti ofuna chithandizo cha za umoyo monga odwala amasalidwa chifukwa choti ali ndi TB, HIV, kapena kukhala ndi ana ambiri/ochepa/opanda mwana?**

c. Are there cases in your community where a service is stigmatised due to a provider having conditions such as TB, HIV? **Kodi zimachitika kuti ofuna chithandizo cha za umoyo monga odwala amasalidwa chifukwa choti ali ndi TB, HIV,**

Referral

- How is referral of HSAs, TBAs, Volunteers programmes organized? (**Kodi ndondomeko ya katumizidwe ka anthu othandizidwa oti mavuto awo inu simungawathe- imayendetsedwa bwanji?**)

Probe for: different referral processes for different conditions (TB, HIV, Malaria) ask for examples. (**Njira zomwe zimatsatidwa potumiza mavuto osiyanasiyana kapena anthu omwe mukuwatumizawo. Perekani zitsanzo**)

- What goes well and not so well in referral? Examples? (**Ndizinthu ziti zomwe zikuyenda bwino kapena kusayenda bwino pa ntchito yotumiza anthu omwe ali ndi mavuto omwe simumawakwanitsa. Taperekani zitsanzo?**)

Control at work

- How are HSAs, TBAs, Volunteers enabled and limited in their control at work? (**Kodi mukuwona ngati muli ndi ulamuliro pa pantchito yanu?**) Probe:
 - a. Influencing decision making? **kodi maganizo anu amamveka pakagwiridwe ka ntchito zanu?** feeling powerless **mumaona ngati mumachepekedwa mphamvu?**
 - a. Feeling less valued - **kusawelengeredwa**
 - b. problem solving process e.g. what happens when there is a shortage of equipment and supplies? **momwe mumathetsera mavuto okhudzana ndi ntchito yanu monga mayendedwe, kusowa kwa mankhwala, Kupelewerwa kwa Zipangizo etc)**

Quality of care

- How is the quality of services you (HSAs, TBAs, Volunteers) provide organized and evaluated? – **kodi ntchito za ma HSAs, TBAs etc zimayendetsedwa ndi kuunikiridwa bwanji kuti zikhale zapamwamba**
- What affects the quality of services which you provide? Probe for:
 - a. Incentives -**zowalimbikitsa**
 - b. Remuneration - **malipiro**
 - c. Career perspectives – **mipata yokwezedwa pantchito**
 - d. Training – **maphunziro apadera owonjezera pa luso lawo**
 - e. Continuing education **kupitiliza maphunziro**
 - f. Supervision? **kuyang'aniridwa kwawo pantchito**
 - g. Equipments (**zida zogwilira ntchito**)
- How is the quality of logistics (equipment and drugs) ensured? **Pali ndondomeko zotani zoonetsetsa kuti zida zogwilira ntchito ndi mankhwala ndi zapamwamba?**

- For each, who is responsible? How do they carry out their works? **Ali ndi udindo owonetsetsa kuti zida ndi mankhwala ndizapamwamba ndani? Amatani poonetsetsa kuti zimenezi ndizapamwamba?**
- Do you (HSAs, TBAs, volunteers etc) receive feedback from your supervisors, colleagues, clients and community about your performance? **Kodi mumafotokozeredwa za magwiridwe anu a ntchito; monga ndi okuyang'anirani, anzanu ogwira nawo ntchito komanso anthu amene mumawatumikira?**

Probe for:

- Reporting hierarchy (reports to who?) – **Malipoti amachokera ndi kupita kwa ndani**
- Reporting schedule (frequency – after how long?) – **Malipotiwo amatumizidwa kangati, tiyerekeze pa mulungu, kapena pa mwezi.**
- Complaints – **Madandaulo**
- satisfaction - **Kukhutira**
- What do you think people in the community think about the quality of health services (TB, HIV, Malaria) that you provide **(Mukuganiza kuti anthu a m'dera lino amaziya pamulingo otani ntchito zanu zomwe mumagwira)?**

Communication and interaction with colleagues

- How is the inter and intra cadre communication and interaction amongst you and your colleagues?(i.e. Between HSAs, volunteers, TBAs or among HSAs, volunteers and TBAs.) **(Kodi kulumikizana ndi kugwilira ntchito limodzi pakati panu ndi magulu ena kumayenda bwanji?)**

Probe for:

- communication channels, **(Ndi njira ziti zomwe zimatsatidwa polumikizana),**
- meetings, **(Misonkhano?),**
- informal contacts, **(M'njira zongocheza)**
- how often, **(Kulumikizana kumachitika kangati kapena Mowirikiza bwanji?)**
- What is the communication about.**(Mumalumikizana pa zinthu ziti?).**

M&E

- How is monitoring and Evaluation carried out? **(Kodi ntchito yoyang'anira ndi kuunikira ntchito zaumoyo imayenda bwanji?)**
- How is the information about your performance collected? **(Kodi malipoti okhudza ntchito yanu amatoleredwa bwanji?)**
- What communication channels are used? **(Ndi njira ziti zomwe zimagwiritsidwa ntchito potolera malipoti amenewa?)**
- What happens with this information? **(Kodi malipoti amenewa amagwira ntchito yanji?)**

- Do you get feedback about the results of your work based on information about your performance? **(Kodi mumauzidwa chili chonse chokhudzana ndi mmene mukugwirira ntchito?)**
- If so, how is this communicated to you and by whom? **(Ngati ndi choncho, kodi mumauzidwa bwanji komanso ndi ndani?)**

Mobile health

51. Do you use any mobile technology? Do other health providers use mobile technology? **(Kodi mumagwiritsa ntchito njira zamakono monga ma foni pa ntchito yanu?)(Nanga ena ogwira ntchito za umoyo?)**

52. What do you use the mobile technologies for? **(Kodi njira zimenezi mumazigwiritsa ntchito yanji?)**

- to collect and send information; **(Kutolera ndi kutumizira uthenga);**
- to coordinate things; **(kulunzanitsa anthu monga pokonza misonkhano);**
- to seek advice from others, **(Kupezera uphungu kuchokera kwa ena),**
- to contact clients. **(Kulumikizana ndi omwe amawatumikira-ma client)**
- For each find out what with who how often.
- Who bought the device? **(Anagula chida/zida zamakono zimenezi monga foni ndi ndani?)** - Who pays for the costs of use, charging etc.? **(Amalipira ma bilu ndi zina zoyendetsera zidazi ndi ndani?)**

53. How do you feel about the use of these devices: advantages, disadvantages?**(Kodi zidazi zili ndi ubwino kapena kuyipa kotani?).**

Consent form SSI and FGD CTC providers

MY name is I work with The REACH Trust. Reach Trust is a health research institution based in Lilongwe. In collaboration with Liverpool School of Tropical Medicine in England we are conducting a health-related study. The study has been approved by the National Health Sciences Research Committee

Purpose and questions asked

This study wants to learn from the work that is carried out by community volunteers and community health workers such as HSAs to help clients and communities to improve their health. We are especially interested in the work of the HSAs, volunteers and TBAs and the way the government and other organisations are supporting or hindering their work. The views, opinions and experiences of you and others are important to find out how programmes can be best organised and improved in the future.

You are asked to take part in an interview that will take at least 1 hour and no more than 2 hours. The interview will take place at a private place.

You will be asked to talk about your work as an HSA, volunteer, TBA, [and other provider as appropriate]. Examples of questions are how and why did you decide to take part in the programme, how long you are doing this work, what you are doing, your training, your technical work, your workload, what are the things you are worried about, what you think works well and what kind of things you think can be improved.

Discomfort, risks and benefits

This study may not help you directly but the results will help to improve programmes like the one you work in the future.

Withdrawal

You do not have to take part if you do not wish to. If you do choose to take part you are free to refuse to respond to any questions that you do not want to answer. At any time while we are discussing, you can ask me to stop. If you decide not to take part or withdraw you can do so. You will not be penalised in any way by your organisation.

Confidentiality

If you do choose to take part, we will bring together what everybody is telling us. The consent form will be kept locked up and separate from the interviews and discussions. No one will be able to identify what exactly we discussed. To make sure that the information is correctly used the conversation will be recorded on a tape recorder in addition to taking

[If Focus Group Discussion]: In the group discussion you are asked to speak about what people in your group think or do. Other participants in the group will hear what you say and they may not keep this confidential. Therefore we ask you not to share personal information.

The interview or FGD will be conducted in a private place where nobody can hear what is said.

Have you got any questions that you would like to ask?
Are there any things you would like to be explained further? If you do not want to take part in this interview you can refuse to do so, you can refuse to answer any questions and to stop the interview at any time. You will not be penalised in any way if you refuse to participate.

Ideclare that I have understood the purpose of the study which was explained to me and I agree to participate voluntarily.

For any questions and concerns, contact:

National Health Sciences Research Committee on Tel: 01 726 422/418

Reach Trust on Tel: 01756263/261

Email: info@reachtrust.org

Kalata yotengera chilolezo

SSI and FGD CTC providers

Dzina langa ndine..... Ndimagwira ntchito ku bungwe la REACH Trust ku Lilongwe, lomwe limapanga kafukufuku wa zaumoyo. Pakadali pano tikupanga kafukufuku mogwirizana ndi sukulu ya ukachenjeda ya Liverpool ku mangalande. Kafukufuku ameneyu wavomerezedwa ndi a unduna wa zaumoyo mdziko muno.

Kafukufuku ameneyu akufuna kudziwa momwe ntchito zofuna kupititsa pa tsogolo umoyo wa anthu m'madera a kumidzi zikuyendera. Tikuyang'ana kwambiri pa ntchito zomwe ma alangizi a za umoyo (HSAs), ma volantiya, komanso azamba (TBAs) zikuyendera komanso kuyang'ana momwe boma ngakhale mabungwe omwe siaboma akuthandizira kapena kulepheretsa kagwiridwe ka ntchito zawo. Maganizo anu komanso a anthu ena onse ndi ofunikira kwambiri kuti tipeze njira za momwe ntchito zimenezi zingamayendetsedwere komanso momwe zingapititsidwire pa tsogolo.

Mukupemphedwa kutenga nawo mbali pa kucheza komwe kutenga mphindi pafupifupi ola limodzi kapena kupitilira apo koma osapilira ma ola awiri. Kuchezaku kuchitikira pa malo a Chinsinsi.

Mufunsidwa kuti mutiuze zambiri za ntchito yanu ngati ogwira ntchito ku mudzi (ngati volantiya, mlangizi, mzamba, etc). Mwa ena mwamafunso omwe tikufunsi ndi monga; chifukwa chiyani munasankha kugwira nawo ntchito mu pulogalamu imeneyi, munayamba bwanji, mwagwira ntchitoyi kwa nthawi yaitali bwanji, mukupanga chiyani panopo, maphunziro anu, kachulukidwe ka ntchito yanu, ndipo ndi zinthu ziti zomwe mumadandaula nazo, komanso mukuganiza kuti ndi ziti zomwe zikuyenda bwino, ndipo ndi zinthu ziti zomwe mungakonde kuti zipititsidwe pa tsogolo.

Kafukufukuyu mwina sakhala ndi phindu lowonekeratu, koma kuti zotsatira zake zidzathandiza kusintha ma pulogalamu ngati yomwe mukugwira inuyi mu tsogolo muno.

Simukukakamizidwa kutenga nawo mbali pa kafukufukuyu ngati inu simuli omasuka kutero. Ngati mukufuna kutenga nawo mbali muli omasuka kutero, ndipo dziwani kuti muli ndi ufulu okana kuyankhapo pa funso lina liri lonse lomwe simukufuna kuyankha. Muthanso kundifunsa kuti ndisiye kukufunsani mafunso nthawi ina ili yonse. Dziwani kuti simudzalandira chilango china chili chonse kuchokera ku bungwe lanu kaamba ka chisankho chokana kutenga nawo mbali pa Kafukufuku ameneyu.

Ngati musankha kutenga nawo mbali, tikufuna tikudziwitseni kuti tidzaika pamodzi zonse zomwe anthu akutiiza. Kalata imeneyi tidzasunga pa malo a chinsinsi kuti ena asayione. Palibe amene adzathe kudziwa zomwe takambirana. Pofuna kuonesetsa kuti zomwe tikambirane zikagwiritsidwe bwino ntchito, tijambula zokambirana zathu pamwamba poti tidzilembanso. Dzina lanu silidzatchulidwa pa china chili chonse chomwe chikambidwe pano, ndipo silikhala nawo gawo la zomwe tijambule kapena kulemba. Zimene mutiwuze pano zisasungidwa kwa zaka zitatu kenako tidzazionga.

(Ngati kuli kukambilana kwa pagulu) Pano monga pa gulu tikupempheni kuti musakambepo china chili chonse chokhudza inu ngati munthu chifukwa anthu ena atha osasunga chinsinsi chanu. Tikukupemphani kuti mulankhule mokhudzana ndi zokhazo zomwe aliyense akufotokozera pa zokambirana zathuzi basi. Kuchezaku tichezera pa malo a chinsinsi pomwe wina aliyense sangatimvere.

Kodi muli ndi mafunso ena ali onse?

Pali zinthu zina zomwe mukufuna kuti tilongosolere bwino?

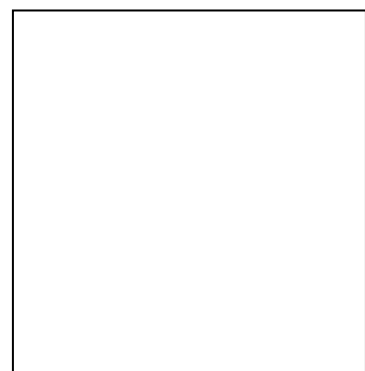
Ngati simukufuna kutenga nawo mbali pa kucheza kumeneku mutha kutero. Muthanso kukana kuyankha funso lina liri lonse, komanso mutha kuimitsa Kuchezaku nthawi ina ili yonse. Simukalandira chilango china chili chonse ku bungwe lanu chifukwa cha kukana kwanu

Inendikutsimikiza kuti ndamvetsetsa cholinga cha kafukufukuyu ndipo andifotokozera bwino lomwe. Ndavomera kutenga nawo mbali mosakakamizidwa.

Sayini

Tsiku

Sayini ya mboni



Sayini

Tsiku

Chidindo cha chala

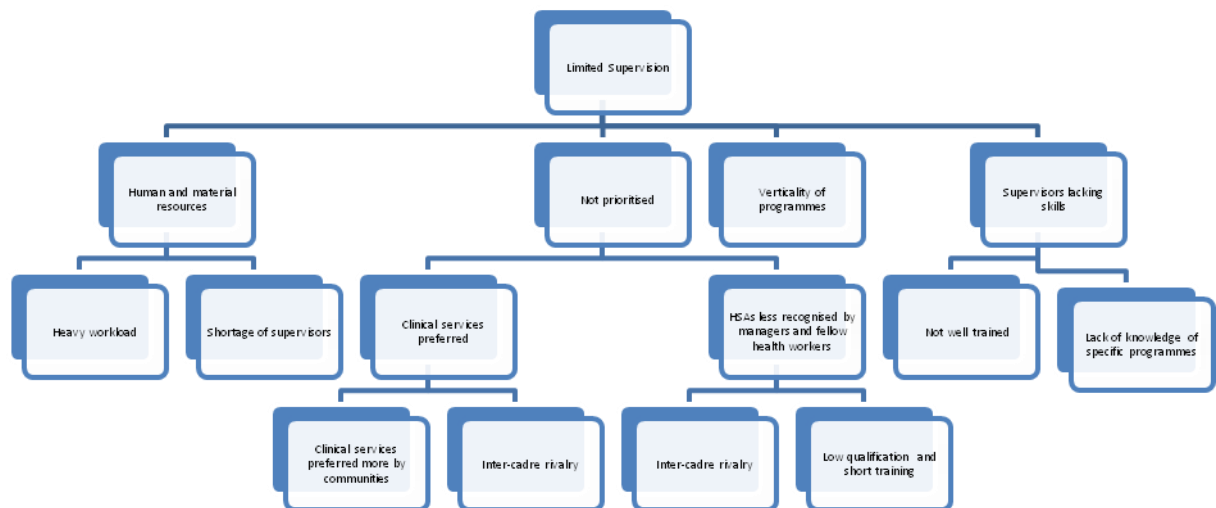
Ngati ndi funso kapena dandaulo zokhudzana ndi kafukufukuyu imbani foni pa nambala izi:

Bungwe loyang'ana za kafukufuku ku unduna wa zaumoyo, nambala: 01 726 422/418

Reach Trust, Nambala: 01756263/261

Email: info@reachtrust.org

ANNEX 3: Root cause analysis and problem statements



ANNEX 4: Ethical approval letter

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail doccentre@malawi.net

All Communications should be addressed to:
The Secretary for Health



In reply please quote No. MED/4/36c

MINISTRY OF HEALTH

P.O. BOX 30377

LILONGWE 3

MALAWI

6th June 2013

Ireen Namakhoma
REACH Trust

Dear Sir/Madam,

Re: Protocol # 1168: Context analysis for the performance and sustainability of close-to community providers to improve CTC health services

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : NHSRC # 1168
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 06/06/2013
- **EXPIRATION DATE** : This approval expires 05/06/14
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** : All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 724418, 0888344443 or by e-mail on moh@gmail.com
- **Other**:
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

A handwritten signature in black ink, appearing to be 'M. D.', written over a dotted line.

.....
FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH

Executive Committee: Dr.C.Mwansambo (Chairman), Prof. E.Molynuex(Vice Chairperson)

Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)

ANNEX 5: Final coding framework (from Nvivo)

Access
Client's costs
Equity in access
Geographical setting
Hard to reach
Transport constraints
Client characteristics
Communication
Between CTC providers
MHealth
Community context
Community capacity to claim rights
Cultural~ religious beliefs
Expectations
Health seeking behaviour
Migration
Security
Understanding~ knowledge
Community support
Implementation of CTC provider's tasks
Incentives
Referral
Selection and recruitment
Coordination and relationships
Client – provider relationships
With other health providers
With volunteers
With~ between NGOs
CTC provider characteristics (age, gender, marital status)
CTC provider's attitude
CTC provider's self-esteem~ role models
Financing
CHAM
Service level agreements
User fees
Governance
Community accountability
Community representation
District governance
National governance
Human Resource Management and Planning
(Dis)incentives
Financial incentives

Allowances
Salary
Non-financial incentives
Accommodation
Community recognition
Comparison with others
Nature of the job itself
Training
Transport
Uniforms
Career perspective (advancement)
Human resource availability
Availability of health professionals (doctors, nurses)
Availability of volunteers
CTC – client ratio (availability CTC provider)
Supervision
Feedback mechanisms
Frequency of supervision
Hierarchy of reporting
Supervisor (who)
Workload
Legal backing (for CTC provider)
Monitoring and evaluation
Policy factors
Quality Assurance
Continuous education
Protocols and guidelines
Training
Quality of care
Client perceptions on quality of care
Confidentiality
Recommendations and suggestions
Referral system
Selection criteria & recruitment process
Education requirements
Group formation
Service delivery
Role NGO
Standard training
Stigma and discrimination
Supplies and logistics
Drug supply
Infrastructure
Safety
Sustainability

Individual training related to commitment tasks
Leaving NGOs (out-phasing of programs)
Tasks of CTC provider
Community tasks
Facility based tasks
Focus of work (health issue addressed)
TBA related issues
Evolving policies
Ban
Implications for health seeking behaviour
Implications for relationships with other providers
Quality of care by TBA
Type of CTC provider (name)
Valuing of the CTC provider
Importance of CTC provider
Recognition
Trust