Reachout
Linking Communities & Health Systems

VOICES AND EXPERIENCES OF FRONT LINE HEALTH WORKERS IN MALAWI: STRATEGIES AND OPPORTUNITIES TO BETTER SUPPORT COMMUNITY BASED HEALTH SYSTEMS

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BACKGROUND

Malawian Health Surveillance Assistants (HSAs) play a key role in delivering health services at the front line in communities in a broader national context of acute shortages of human resources for health. This study aimed at understanding and analysing the perspectives and challenges faced by HSAs.

METHODS

Qualitative research using focus group discussions and semi-structured in-depth interviews was conducted in two districts in the central region of Malawi: Mchinji and Salima. Data analysis combined grounded theory, which means a reading of the transcripts and noting issues emerging from the text, and a framework approach, which used the objectives and the issues explored in the topic guides.

FINANCIAL INCENTIVES FOR HSAS

ALLOWANCES FOR HSAS: A COMPLEX PICTURE

Allowances were a key factor in motivating HSAs, considering the low salaries they received. An allowance culture was pervasive, contributing to laziness, conflicts and selective commitment to health programmes thereby undermining the sustainability of some health programmes.

SALARY AS AN INCENTIVE FOR HSAS

Most HSAs were very dissatisfied with the salaries they received. They argued that the salaries were not enough to cater for their daily needs.

NON-FINANCIAL INCENTIVES FOR HSAS

ACCOMMODATION

Accommodation was a widespread problem within the health sector, and HSAs' accommodation needs were not prioritised, a situation aggravated by lack of accommodation policy for HSAs. Services offered by some HSAs motivated some communities to build houses, particularly in areas where village clinics were operational.

UNIFORMS FOR HSAS

Most HSAs described shortage of uniforms as a demotivating factor, pointing out that most of the uniforms they had were either torn, old, or no longer fitting. Gumboots and raincoats were no longer provided. HSAs regarded the uniform as their identity which made them to be recognized.

SUPPLIES AND LOGISTICS

TRANSPORT: Shortage or unavailability of transport was a major barrier to referral. Communities complained about the exorbitant transport charges they incurred when they got referred. They explained that the high cost of transport led them to sell their food, which in the end affected their food security at household level. Most of the time it was difficult for health facilities to provide ambulances for a number of reasons, including shortage of fuel.

HUMAN RESOURCE MANAGEMENT

TRAINING AS AN INCENTIVE FOR HSAS:

Training was also a key factor in motivating HSAs. Training was linked to a number of issues including, among others: career progression, allowances, distribution of materials, mentoring, and capacity building. Training was a divisive issue in terms of division of labour among HSAs. Some HSAs left out of training insisted that those who went for training should be the ones to provide the services, as they had received allowances during the training. Since training is inextricably linked to allowances, the preceding view defeats the expectation that those trained should train others to provide the services.

SUPERVISION OF HSAS

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 such as supervisors from the district or national level could be seen to go and supervise community health workers. HSAs did not usually get feedback from their supervisors. Furthermore, feedback was usually given when something went wrong.

CAREER PERSPECTIVE

There were some systems for career development within the Ministry of Health. However not all HSAs were aware of such opportunities, insisting that the Ministry of Health did not support their career progression efforts.

WORKLOAD

Most HSAs complained that they had too much work, which included supervision of volunteers and carrying out duties that are incrementally added.

COMMUNITY LINKS AND SUPPORT

While HSAs working in hard-to-reach areas were trained to run village clinics, inadequate training for some HSAs meant that they had little knowledge on how to provide some services. This impacted negatively on their relationships with community members as people felt that HSAs were deliberately denying them the services.

RECOGNITION

HSAs regarded themselves as the 'eyes' of the Ministry and acted as a bridge between health systems and the communities. HSAs felt they were not being valued by the Ministry compared to their fellow community workers in the agriculture and education sectors.

DISCUSSION AND CONCLUSION

Challenges faced by HSAs emanate from initiatives that are applied at organisational, community, family and individual levels. These levels directly or indirectly and positively or negatively affect HSAs motivation. The study has also demonstrated the existence of an interplay between these levels and how each depend on the other for motivation to be enhanced and strengthened throughout the period one works as an HSA. HSAs, who are embedded at community level, play a vital role in linking health systems and marginalized communities. Their voices and experiences need to be considered and acted upon to build equitable and sustainable community based health systems. There is a need to address the multiple concerns of HSAs through coordination, transparent and accountable approaches to incentives and supportive supervision.

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