Close-to-community health care providers in Malawi

“Communities appreciate and value Health Surveillance Assistants.”

INTRODUCTION

In Malawi, close-to-community (CTC) health care providers are a vital part of community health services. One prominent group of CTC providers are Health Surveillance Assistants (HSAs). Supported by the Ministry of Health, these HSAs are primary health care workers serving as a link between a health facility and the community. HSAs can be traced back to the 1950s when they were known as ‘Public Vaccinators’, and later ‘Smallpox Vaccinators’ when they engaged in campaigns spearheaded by the World Health Organization. In 1973, they were known as ‘Cholera Assistants’, and the Ministry of Health later extended their recruitment to all districts in Malawi, officially naming them Health Surveillance Assistants.

HSAs have performed a number of duties over the years, and presently their tasks cover community health, family health, environmental health, prevention and control of communicable diseases and management and administration. HSAs are salaried civil servants, have national coverage and are an important part of the health system. However, HSAs’ duties and responsibilities have expanded such that some HSAs are not able to list all the activities they are supposed to perform. They also face challenges relating to: poor remuneration; inadequate equipment and supplies; inadequate supervision; and a lack of a clear career path. Other CTC providers in Malawi also play important roles and they include Traditional Birth Attendants, expert patients, community-based distribution agents and community care providers.

This research brief presents information from the first phase of REACHOUT (see page 2), which identifies factors that influence the performance of HSAs and other CTC providers in Malawi. The results will inform the implementation of two improvement cycles to test interventions aimed at improving CTC provider performance.

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Reachout
Linking Communities & Health Systems

KEY MESSAGES

- Communities, including those who are hard to reach, appreciate and value HSAs.
- Remuneration and allowances are key incentives to CTC providers, but often CTC providers report not receiving adequate or promised amounts. This affects their motivation to work, and they are often dedicated to the activities or training that provides the most allowances.
- HSAs are supervised through the preventive health services department, but supervision systems are generally weak. Some programmes, such as the Integrated Management of Childhood Illnesses includes curative work, which should involve clinical supervision.
- HSAs often have a heavy workload, receive inadequate training, and lack proper tools such as drugs, registers, uniforms, reporting forms and pens.

ABOUT COMMUNITY HEALTH WORKERS

In the 1970s, countries invested in Community Health Workers (CHWs) who received basic training and were often volunteers. Programmes involving CHWs went into decline due in part to political instability, economic policies and difficulties in financing. However, there is renewed interest in strengthening community-level services, using a variety of close-to-community (CTC) providers.

ABOUT REACHOUT

REACHOUT (Reaching out and linking in: health systems and close-to-community services) is a five-year multi-country project consortium. It aims to maximize the equity, effectiveness and efficiency of CTC services in rural areas and urban slums in six countries - Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique - with support from its European partners in the Netherlands and UK.

A CTC provider is a health worker who carries out health promotion, prevention and curative services and who is the first point of contact for the community. A CTC provider can be based in the community or in a primary facility with a minimum level of para-professional training (two to three years). The performance of CTC providers can be influenced by broad factors such as community and political contexts, health system factors (such as financial model, logistics and supplies) and factors related to the design of interventions, such as incentives and supervision. The main focus of REACHOUT concerns formal community health workers, but their interaction with other less formal CTC providers such as expert patient volunteers, informal private practitioners, lay counselors and health promoters is also important.

REACHOUT consists of three phases: conducting a context analysis through desk review and qualitative studies to identify factors that influence the performance of CTC providers and CTC services; implementing two improvement cycles to test interventions for improving CTC performance and their contribution to CTC services; and further interventions to improve performance.

- Map the different types of CTC providers
- Assess the structures and policies of the health system to understand the strengths and weaknesses of the organisation of CTC services and management of CTC providers
- Identify and assess contextual factors and conditions that form barriers to or facilitators of the performance of CTC providers and services
- Synthesize evidence on key barriers and facilitators in order to influence future CTC interventions.

SYNTHESIS OF LEARNING

METHODS

The context analysis used a desk review and a qualitative study. The desk review examined mostly grey and some published literature on CTC providers in Malawi. The qualitative study included focus groups discussions and semi-structured in-depth interviews. Respondents included mothers with children below five years of age, clinicians, nurses, environmental health officers, traditional leaders, volunteers, Traditional Birth Attendants, Health Surveillance Assistants, officials working for non-governmental organizations in the districts and District Council

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officials. Data were analyzed using a combination of a framework approach (a conceptual framework to organize data based on apriori identified themes and study objectives) and grounded theory (that allowed for incremental addition of themes generated from the data). The conceptual framework had three major themes: broad contextual factors, health systems factors and intervention design factors. All of these can affect the performance of CTC providers of health services.

MAIN FINDINGS

The services that HSAs offer are valued and appreciated by most community members, including those who are hard to reach.

Broad contextual factors that affected the performance of CTC providers included:

- **Unfavourable economic conditions in general**
- **Poor working conditions for CTC providers**
- **Difficult 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.**

Health systems factors that affected performance included:

- **Inadequate human, financial and material resources**
- **Heavy workload**
- **Lack of and inadequate training**
- **Inadequate tools such as drugs and registers**
- **A lack of feedback after referrals**
- **Inadequate supervision**

The main intervention design factors that affected performance included:

- **Inadequate supplies such as a shortage of uniforms and bicycles, pens and reporting forms**
- **Poor logistics**
- **Inadequate supervision (uncoordinated, top-down and unsupported)**
- **Poor remuneration for CTC service providers**

The study found that the key barriers and facilitators to the performance of CTCs were as follows:

1. A lack of coordination in the use of HSAs

HSAs are, in a way, the enemy of their own success; they are being used by different programmes with a clear lack of coordination.

2. Sustainability

Other CTC providers are not being incorporated into the Ministry of Health. Therefore programme design must consider sustainability issues, explicitly stating what will happen when a programme or project phases out. A monitoring and evaluation system could ensure that sustainability issues are addressed.

3. Inadequate resources

HSAs often lack the proper tools and equipment to carry out their work. 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). It may be ambitious to consider integrating other community health workers such as volunteers into the health system when HSAs who are already integrated are facing challenges to access basic materials for their work.

ANALYSIS OF THE FINDINGS

Findings from the study showed that two of the main issues for HSAs were remuneration and supervision.

REMUNERATION

The research found that the issue of remuneration, particularly allowances, for CTC providers including the main providers HSAs, was considerable. 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 service. This showed in three main ways:

1. CTC providers who felt sidelined by those in charge of allowances opted not to dedicate themselves to their work fully.
2. CTC providers were more dedicated to activities that promised more allowances. Organizations that paid no or low allowances were shunned.
3. CTC providers' desire for allowances had reduced training sessions into allowance-generating activities.

Although remuneration is critical, the issue is not an easy target for quality improvement cycles, because several stakeholders involved in remuneration have different policies for allowances. The issue of allowances is too complex and involves too many different stakeholders who are not yet ready to be drawn into one plausible intervention. When the study results were shared with different stakeholders at national and district levels, stakeholders prioritized strengthening the supervision cycle as the focus for the first intervention. The different aspects relating to supervision such as training supervisors and developing systems for supportive and cost-effective supervision, can be addressed to deliver tangible results within a specific time period.

SUPERVISION

HSAs are generally supervised through the Preventive Health Services Department. However, HSAs stationed in hard-to reach areas often work on the integrated community case management (iCCM) of common childhood illnesses including malaria, pneumonia, diarrhea and pre-referral of newborn sepsis. The iCCM requires that HSAs should be supervised by staff members with clinical skills, as the work involves curative services. This has caused some challenges in the HSA's supervision system and requires better coordination and planning to ensure that the HSAs are effectively supervised on their different roles.

RECOMMENDATIONS FOR IMPROVING INTERVENTIONS

The REACHOUT quality improvement intervention will focus on areas in which it is feasible to intervene. It will focus mainly on HSAs as they are the main link between the health systems and community volunteers. HSAs are also responsible for supervising other CTC providers in the community, including volunteers.

The two intervention areas are:

1. The supervision of HSAs

The approach will be to support the coordination of supervision with a focus on group supervision, and the training of supervisors. It will also advocate for District Health Management Teams to prioritize the supervision of HSAs in a context where curative services are generally more preferred. Training of supervisors will focus on HSA's supervisors as well as the HSAs themselves, because HSAs also supervise volunteers. As part of the intervention, an HSA performance appraisal system will be introduced.

2. Maternal, neonatal and child health programming

The health focus will be on an ongoing programme implemented by the HSAs, related to the integrated community case management (iCCM) of common childhood illnesses including malaria, pneumonia, diarrhea and pre-referral treatment of newborn sepsis; child immunization and home visits to pregnant women. This means a supervision intervention can be based on an established programme, where there are supervision challenges relating to both curative and health promotion components.

The interventions will address the challenges identified through the study and draw on lessons from what works well in the programme already. This approach will allow new lessons about integrating effective supervision and performance appraisal of CTC providers in a largely donor-funded programme such as the iCCM, and the challenges that the HSAs face when carrying out their routine work.

Brian Goddard (REACH Trust)

FULL PAPER

Nyirenda L., Namakhoma I., Chikaphupha K., Kok M. and Theobald S. (2014) Context analysis: Close-to-community providers in Malawi, REACHOUT Consortium http://reachoutconsortium.org/media/1819/

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