VU Research Portal

Patients, providers, and systems

Angwenyi, V.

2020

document version
Publisher's PDF, also known as Version of record

Link to publication in VU Research Portal

citation for published version (APA)
Angwenyi, V. (2020). *Patients, providers, and systems: local models for chronic care and self-management support in southern Malawi*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:
vuresearchportal.ub@vu.nl

Download date: 13. Feb. 2025

CHAPTER 8

Moving to a strong(er) community health system in Malawi: analysing the role of community health volunteers in the new national community health strategy

Vibian Angwenyi, Carolien Aantjes, Ketwin Kondowe, Joseph Zulu Mutchiyeni, Murphy Kajumi, Bart Criel, Jeffrey V Lazarus, Tim Quinlan, Joske Bunders-Aelen

Published in

BMJ Global Health
2018;3:e000996

Special issue series: *The Alma Ata Declaration at 40: reflections on primary health care in a new era*

ABSTRACT

Since the Alma Ata Declaration in 1978, community health volunteers (CHVs) have been at the forefront, providing health services, especially to underserved communities, in low-income countries. However, consolidation of CHVs position within formal health systems has proved to be complex and continues to challenge countries, as they devise strategies to strengthen primary healthcare. Malawi's community health strategy, launched in 2017, is a novel attempt to harmonise the multiple health service structures at the community level and strengthen service delivery through a team-based approach. The core community health team (CHT) consists of health surveillance assistants (HSAs), clinicians, environmental health officers, and CHVs. This paper reviews Malawi's strategy, with particular focus on the interface between HSAs, volunteers in community-based programmes, and the community health team. Our analysis identified key challenges that may impede the strategy's implementation: 1) inadequate training, imbalance of skill-sets within CHTs, and unclear job descriptions for CHVs; 2) proposed community-level interventions require expansion of pre-existing roles for most CHT members; and 3) district authorities may face challenges meeting financial obligations, and filling community-level positions. For effective implementation, attention and further deliberation is needed on the appropriate forms of CHV support; CHT composition with possibilities of co-opting trained CHVs from existing volunteer-programmes into CHTs; review of CHT competencies and workload; strengthening coordination and communication across all community actors; and financing mechanisms. Policy support through the development of an addendum to the strategy, outlining opportunities for task-shifting between CHT members, CHVs' expected duties, and interactions with paid CHT personnel is recommended.

INTRODUCTION

Community health volunteers (CHVs) play a vital role in extending care and support to communities, particularly underserved populations, in settings with health workforce shortages and resource challenges [1]. In sub-Saharan Africa and most low-income settings, CHVs contribution to community health have resulted in several health indicator gains in child health, maternal and reproductive health, malaria, and HIV/AIDS [1-4]. Efforts to achieve universal health coverage [5], and the Sustainable Development Goals agenda, emphasize the need for countries to invest in their community health workforce to support the delivery of primary healthcare interventions [6-8]. This call to action has witnessed African governments make commitments to address the human resources for health challenges [8], supported by global initiatives such as the One Million Community Health Workforce campaign [9]. In the past, CHVs have been part of primary healthcare systems, embedded within communities yet outside of, but aligned to professional health service structures [10]. The current global agenda is to integrate CHV programmes into formal structures of national health services [10]. This complex yet critical task has been undertaken by a number of countries, including Malawi, which is the focus of our analysis.

Malawi recently launched a national community health strategy (2017–2022), which provides a national framework, founded on a team-based approach, for harmonising multiple health initiatives at the community level, and for strengthening delivery of primary health services [11]. Prior to this strategy, state-paid health surveillance assistants (the lowest professional health worker cadre) were responsible for delivering a range of community-level health interventions which were often components of different vertical programmes [12, 13]. Numerous volunteer-led community-based programmes were active in the same communities, and provided disease-focused interventions with external financing, guided by a national community home-based care policy [13, 14]. The new strategy has a broader goal and provides a roadmap for coordination of all of Malawi's community health services [11]. The strategy is a product of extensive consultations between the government, development partners (donors), and civil society organisations.

This paper reviews Malawi's community health strategy. It is guided by three questions: *1) what services are expected to be delivered at community level under this new strategy, and by whom; 2) how are community actors coordinated and guided in implementing this strategy; and 3) how are activities financed?* Our analysis was informed by an extensive desk review of government documents and other publications on community and primary healthcare in Malawi; drawing on authors expertise in community health and joint reflections on the strategy's content; and context-specific information obtained from a larger study [15], which focused on CHVs' roles in supporting chronic care services in Phalombe district, Malawi conducted between 2016 and 2017 – (see additional information in Supplementary File 1). Below, we briefly review the

historical and current context of community health before our analysis of Malawi's strategy.

COMMUNITY HEALTH VOLUNTEER INITIATIVES WITHIN NATIONAL HEALTH SYSTEMS

There is global consensus on the importance of community-based health workers, and on consolidating the contribution of community-led health initiatives [7, 10, 16]. Common generic terms for these workers are 'community health volunteers' or 'community health workers' which covers an array of individuals, selected through different mechanisms (e.g. nomination, election, and/or hired from communities), who receive basic healthcare training, and fulfil a variety of roles within communities [1, 7, 17]. Examples include India's Accredited Social Health Activist [18], Nepal's Female Community Health Volunteer scheme [19], Ethiopia's health extension workers [20], and other broad terms like lay volunteers [1]. However, there is general acknowledgement that the roles and categories of these health providers are often blurred due to variable terms of engagement such as; whether they are paid or unpaid, contracted as permanent or casual workers, have undergone accredited training, and what recruitment mechanisms are used, including whether or not they ought to be residents of communities they serve [2, 17, 21].

These are issues which, in the 1990s and early 2000s, led countries (e.g. Ethiopia, Kenya, Rwanda, South Africa, Zambia) to establish national community health policies and strategies [20, 22-26]. In some cases, additional guidelines were developed and scaled-up to facilitate collaboration and task-shifting processes between professional and non-professional health workforce [3, 23]. The challenges encountered in this historical process have been considered in a number of studies [2, 26-29]. For instance, CHVs in some countries are often overlooked in government policies even though 'on the ground', they are known to liaise and/or work with formally recognised community health worker cadres, such that recently there have been recommendations for more inclusive policies [2, 10, 21]. Furthermore, providing financial incentives for volunteers, remains contentious; the threat to the longstanding ethic of voluntarism set against concerns about the inequity, in impoverished communities, of not compensating CHVs [30-32]. While these challenges are not new nor unique to present day health systems, they require solutions that align to the commitments declared in Alma Ata in 1978 [33].

COMMUNITY HEALTHCARE IN MALAWI

Malawi, a southern-African country with 17 million people, has a three-tier healthcare system [13, 34]. That is, primary health (including community-level services), secondary and tertiary levels of care, linked through a referral system [34]. In 1998, health service management was decentralised to district council authorities, who oversee planning, coordination, and financing of health activities in their jurisdiction [13]. Nonetheless, in a country where over 80% live in rural areas, Malawi has depended on community-level health workers for many years. For instance, in the 1960–70s volunteers were hired to serve as smallpox vaccinators and cholera assistants [13, 35]. Absorption of such volunteers into the national health workforce came to fruition in 1998, when Malawi officially created the health surveillance assistant (HSA) cadre as a permanent post (see Table 1) [36, 37]. HSAs recruitment criteria includes secondary school completion, language competence, and upon selection, individuals must undergo at least 12 weeks pre-service training [37, 38]. At present, HSAs constitute more than one-third (over 9000 employees) of Malawi's health workforce, performing a broad range of tasks that include health promotion, immunisation and disease surveillance [34, 38]. Existing evidence documents how HSAs' roles evolved overtime, their performance towards achieving health goals, and job-related challenges [12, 35, 36, 39]. Recent evidence shows HSAs' gradual support to facility-based tasks for non-communicable diseases (NCDs) and mental health services [40, 41].

Malawi's extensive network of CHVs [13, 14, 42], emerged largely in response to the HIV/AIDS shifting epidemic, and directed by donor-driven project activities and global financing mechanisms for health (see Table 1). Community home-based care programmes run by CBO/FBOs offered health promotion, HIV testing advocacy, palliative care, and home nursing for HIV/AIDS patients through a volunteer workforce [14, 42-44]. In 2005, Malawi's government introduced a CHBC policy and guidelines, which set standards for CHBC programmes, and later revised in 2011 to incorporate care support for patients with other chronic conditions (such as cancer and cardiovascular diseases) and at-risk groups [43].

Table 1 — HSAs and CHVs before Malawi's community health strategy

	HEALTH SURVEILLANCE ASSISTANTS (HSAs)	COMMUNITY HEALTH VOLUNTEERS (CHVs)
Terminologies and brief description	• A health surveillance assistant is a state-paid, primary healthcare worker serving as a link between a health facility and the community	• CHVs are *"individuals who willingly offer their time, skills, and knowledge to work with communities to improve the health status of communities they reside in without expecting financial remuneration"* • Some examples include: volunteers in community/faith-based organisation (CBO/FBOs); community-based distribution agents; growth monitoring volunteers; peer educators; traditional birth attendants; sanitation promoters; representatives selected to community committees (such as village health committees)
Policy context (key timelines)	• **1960s:** Government hires and trains volunteers as small pox vaccinators • **1970s:** Government hires and trains volunteers as cholera assistants • **1998:** Government formally establishes HSAs cadre • **2014:** HSAs task-shifting policy and guidelines introduced	• **1980s to early 2000:** informal caregivers provide home-based care (pre-antiretroviral treatment era) • **2005:** Introduction of a national palliative care policy and community home-based care (CHBC) guidelines. Policy focused on HIV and other opportunistic infections • **2011:** Revision of CHBC policy to place emphasis on care and support for other chronic conditions and vulnerable groups
Formal requirements (or other selection mechanism)	• Have completed Malawi School Certificate of Education or Junior Certificate of Education • Can speak and write in English and Chichewa (national language) • Attend HSA pre-service training programme • Once hired, expected to reside in the same catchment area of communities they serve	• CBO/FBOs are composed of lay volunteers living in the same community with people (clients) they serve • A desire to volunteer and work for communities • Other entry requirements are optional (gender, age, education level)
Basic or professional training	• Undergo HSA pre-service certified training of 12 weeks (8 weeks class-based and 4 weeks practical) • May receive specialised training when new health interventions are added to service delivery packages	• CHBC providers (including volunteers in CBO/FBO) receive training for 10 days using the national CHBC guidelines • May receive training offered as part of project-driven activities

	HEALTH SURVEILLANCE ASSISTANTS (HSAs)	COMMUNITY HEALTH VOLUNTEERS (CHVs)
Main roles (scope of activities)	• **1998:** HSAs expected to conduct health promotion, immunisation, disease surveillance, patient referral to care, and community case management • **2005:** HSAs support HIV care as part of task-shifting initiatives • **2010 onwards:** pilot interventions on working with HSAs to support with mental health services and non-communicable diseases in some districts in Malawi • **Other:** responsible for supervision of other community-based groups	• They offer a range of health and non-health support • CBO/FBOs thematic areas include: 1) HIV/AIDS care; 2) home-based care; 3) safe motherhood; 4) hygiene and sanitation; 5) elderly and disabled persons care; 6) orphans and vulnerable children care; 7) support community-based child care centres; 8) human and child rights; 9) youth; 10) gender; 11) environment/ climate change and agriculture; 12) livelihood support through income-generating activities
Reporting lines (formal and informal)	• Report directly to senior health surveillance assistants. HSAs post is under the Department of Environmental Health (Ministry of Health) • Works with and reports to other health worker cadres such as clinical officers, nurses, depending on assigned tasks • Beyond health facility level, HSAs work together with other community volunteers and groups, and local authorities	• CBO/FBOs are registered groups with the Department of Social Welfare (Ministry of Gender, Children, Disability and Social Welfare) • Work closely and disseminate reports to various departments of health and social welfare office, and Ministry of Local Government and Rural development • HIV patient support groups are established and embedded within CBO/FBOs. Patient organisations like the Network of People Living with HIV/AIDS Malawi (NAPHAM) work with CBO/FBOs.
Contractual arrangements	• Permanent post, employed by the government (Ministry of Health) and receive a standardized monthly salary, with possibilities of job promotion	• Not official, engage in periodic project-led activities and could at times receive a monthly stipend (non-standardised)
Forms of support or incentives	• Receive a monthly salary, supported with other financial and non-financial incentives e.g. housing, uniforms, bicycles, and motorcycles	• Variable incentives (1990s-present day) ranging from provision of T-shirts, bicycles, stipends, home-based care kit supplies • **2005:** National funding through the National AIDS Council to support civil society organisations and CBO/FBO programmes in HIV/AIDS activities • **2015:** Direct funding to CBO/FBOs from the National AIDS Council stopped

MALAWI'S COMMUNITY HEALTH STRATEGY (2017−2022)

The strategy proposes formation of a community health team (CHT), consisting of frontline health staff (HSAs, senior HSAs, nurses, and environmental health officers) supported by CHVs, in linking community and primary healthcare interventions [11]. The strategy's core principles and objectives are highlighted in Table 2. Malawi's transition to the proposed service delivery structure is anticipated to be a dynamic process with possible overlaps in key areas of service delivery, coordination, and finance, which we highlight in the next section.

Table 2 — Malawi's strategy objectives and guiding principles

1. **Health service delivery:** Deliver integrated health services at point of care through a community health team 2. **Human resources:** Build a sufficient, equitably distributed, well-trained community health workforce 3. **Information, communication, and technology:** Promote a harmonised community health information system with a multi-directional flow of data and knowledge 4. **Supply chain and infrastructure:** Adequately provide supplies, transport, and infrastructural support to community health teams 5. **Community engagement:** Strengthen community engagement and ownership of community health 6. **Leadership and coordination:** Ensure sufficient policy support and funding for community health, and that community health activities are implemented and coordinated at all levels
Six cross-cutting guiding principles for implementing the strategy 1) Integration; 2) Community leadership; 3) Equity; 4) Gender equality; 5) Learning; 6) Transparency and accountability

POTENTIAL DYNAMICS, OVERLAPS, AND FRICTION IN IMPLEMENTING MALAWI'S STRATEGY

Service delivery and the community health workforce

The different care providers within CHTs, have different responsibilities and would require adjusting to 'newer' roles, to ensure the provision of a range of services at community level, defined in the strategy as essential health package (EHP) – as illustrated in Table 3. Focussing on HSAs and CHVs, HSAs previously carried out disease surveillance, health promotion, immunisation, reproductive, and child health activities. Under this strategy, HSAs are to provide psychosocial support, home follow-up visits, and advice to patients with non-communicable diseases. Furthermore, HSAs are to take up more supervisory tasks, by overseeing CHVs' activities, and other community-based groups. Notably, some interventions such as dispensing antiretroviral therapy, providing first-line treatment for epilepsy and depression, are reserved exclusively for clinicians based at primary healthcare level (i.e. community health nurses and community midwife assistants). A mismatched and mal-distributed health workforce at community level remains a concern. While

HSAs are expected to deliver the bulk of community-level EHP interventions, filling these posts to the recommended target of 1 HSA per 1000 people within a short time frame remains a challenge.

Table 3 — Essential health package interventions at community level*

PROGRAMME	INTERVENTION	PROVIDERS AND ROLES		
		CHN CMA	HSA EHO	CHVs in CHBC***
Community and environmental health	1. Vermine and vector control and promotion		X	
	2. Disease surveillance		X	X
	3. Community health promotion and engagement		X	X
	4. Village inspections (emergencies, health and safety)		X	
	5. Promotion of hygiene (hand washing with soap and food safety)		X	X
	6. Promotion of sanitation (latrine refuse, drop hole covers, solid waste disposal)		X	X
	7. Occupational health promotion (climate change and health)		X	X
	8. Household water quality testing and treatment		X	
	9. Home-based care for chronically ill patients		X	X
HIV/AIDS	1. HIV testing services		X	X
	2. Viral load (collection of samples only)		X	
	3. Prevention of mother-to-child transmission	X		
	4. Cotrimoxazole for children	X		
	5. Antiretroviral treatment (all ages)	X		
Non communicable diseases	1. Basic psychosocial support, advice, and follow-up		X	X
	2. Anti-epileptic medication	X		X
	3. Treatment of depression (first line)	X		
Tuberculosis	1. 1st line treatment for new tuberculosis (children)		X	
	2. 1st line treatment for retreatment tuberculosis (children)		X	
Malaria	1. 1st line uncomplicated malaria treatment (adults)	X		
	2. 1st line uncomplicated malaria treatment (children)		X	
	3. Malaria rapid diagnostic test		X	
Vaccine preventable diseases	1. Rotavirus vaccine; Measles Rubella vaccine, Pneumococcal vaccine, BCG (Bacillus Calmette–Guérin) vaccine; Polio vaccine; Pentavalent vaccine; Human papilloma virus vaccine		X	

8

PROGRAMME	INTERVENTION	PROVIDERS AND ROLES		
		CHN CMA	HSA EHO	CHVs in CHBC***
Reproductive, maternal, neonatal and child health	1. Insecticide treated nets distribution to pregnant women		X	X
	2. Modern family planning: injectable, contraceptives pill, male condoms		X	X
	3. Tetanus toxoid (pregnant women)	X	X	
	4. Deworming (pregnant women)	X		
	5. Daily iron and folic acid supplementation (pregnant women)	X		
	6. Syphilis detection, treatment (pregnant women)	X		
	7. Child protection		X	X
Integrated community case management	1. Growth monitoring		X	
	2. Pneumonia treatment (children)		X	
	3. Diarrhoeal diseases; oral rehydration salts, zinc		X	
	4. Malaria rapid diagnosis test (under-5)		X	
	5. Community management of nutrition in under-5 (i.e. plumpy nut, micronutrient powder and vitamin A)		X	
Nutrition	1. Vitamin A supplementation (pregnant women)		X	
	2. Management of severe malnutrition (children)		X	
	3. Deworming (children)		X	
	4. Vitamin A supplementation (6–59 months)		X	
Neglected tropical disease	1. Schistosomiasis mass drug distribution		X	
	2. Trachoma mass drug administration		X	

NOTES: **Clinical community health team:** CHN (community health nurse) and CMA (community midwife assistant) **Non-clinical community health team:** HSA (health surveillance assistant), SHSA (senior HSA), EHO (environmental health officer), supported with CHVs (community health volunteers). **CHVs in CHBC*****: Data from interviews, meetings, and observation of activities led by community health volunteers (CHVs) in CBO/FBOs, providing community home-based care (CHBC).

SOURCE: National community health strategy (2017–2022), Health sector strategic plan II (2017–2022), and data synthesised from a qualitative study on community home-based care programmes in Phalombe district

The lack of specificity on CHVs' envisaged roles or expected contribution as CHT members may potentially cause ambiguity. Authors' experience with CBO/FBOs in one district, suggested CHVs' roles prior to the strategy were continuously expanding, and their specialisation in certain domains served as a basis for allocating responsibilities to individuals (see Table 4, column 5). There is potential danger for CHVs, under the new configuration, to be drawn into service delivery tasks/responsibilities beyond their competence, such as, non-communicable diseases and mental health, which CHVs mentioned they required additional training and skills building. While the strategy recommends provision of refresher training and development of a national integrated training guideline for CHTs, these developments were yet to unfold at the time of our analysis, and the extent of CHVs' inclusion unspecified.

Multiple accountability and coordination structures

Malawi's strategy presents a new accountability and reporting structure for coordinating all community health actors (see Box 1). At the community level, the proposal is to engage various community-level groups such as the village health committees (VHCs); typically composed of volunteer representatives selected by communities, working together with health and local administrative structures [45]. VHCs functions include developing community health action plans, channelling information and promoting primary healthcare activities among community members [11, 45]. VHCs are tasked with selection of skilled CHVs for the CHTs. HSAs in turn are expected to support the establishment of VHCs, train VHCs on their expected roles, and provide supervision. HSAs are to organise monthly meetings with VHCs and CHVs, and quarterly meetings with VHCs and CHT members. This approach of forging closer linkages and setting up mechanisms for communication and reporting, is anticipated to strengthen synergies and efficiencies in community health service delivery under the Ministry of Health umbrella. CBO/FBO structures have traditionally worked with and reported to different sectoral authorities linked to health, social welfare, local government, education, and agriculture. Under the new strategy, formal accountability and reporting lines will now be concentrated under the Ministry of Health.

However, our experiences in Phalombe district revealed concerns over the extent HSAs and health facility staff are prepared to operate under this new accountability structure, while pre-existing challenges linked to CBO/FBOs activities remain largely unaddressed. Discussions with CBO/FBO volunteers revealed: 1) the absence/lack of regular feedback and supportive supervision from HSAs and health facility staff; 2) a lack of awareness by HSAs and other health facility staff of CBO/FBOs activities within their catchment area; and, 3) frictions and overlaps between activities implemented by CBO/FBOs and those of other community-based groups.

At the subnational/district level, the strategy proposes creation of a community health officer (CHO) post, to coordinate and oversee community health activities, at district level. Previously, these activities fell under the responsibilities of different district officers such as the health promotion officer, environmental health officer, palliative care coordinator, and the district AIDS coordinator. The latter was actively engaged in community-based HIV related activities, and development partners (including non-governmental organisations) expected to report and coordinate their activities through this office. While the new CHO post offers opportunities to consolidate all community health activities, 'newer' challenges may emerge, such as: 1) how to fully align CHO cadre within current district-level structures; and 2) the practical considerations of identifying and engaging all actors/officers as part of one large community health network.

Box 1 — Key actors and their position in Malawi's community health system*

Level A – Communities: They have primary ownership of community health system. Expected to use, provide, and monitor community health services. Community engagement, participation, and ownership are promoted as guiding principles. This level forms the basis for selecting community health volunteers. Community-based groups at this level play an important role in supporting community health.

Level B – Community health team: This consists of community health volunteers, health surveillance assistants, senior health surveillance assistants, community midwife assistants, community health nurse, and assistant environmental health officers. This level links activities in community and primary healthcare facilities.

Level C – Prioritised community structures: These include Village Health Committees (VHCs), Community Health Action Groups (CHAGs), Village Development Committees (VDCs), and Area Development Committees (ADCs). These structures fall under the Ministry of Local Government and Rural Development.

Level G – Health facility level: Health committees at this level include the Health Centre Advisory Committees (HCACs) situated at primary healthcare level, and the Hospital Advisory Committees (HAC) at secondary/referral health facilities within a district.

Level D – District level: Consists of a district health management team, led by a district health officer, district medical officer, district nursing officer, district environmental health officer, district health promotion officer, and a district chief promotion officer. The Community Health Officer (CHO), a new cadre, works with and reports to members of the health management team. This level (D) involves close working relations with officers from other government departments and partners listed in level H (such as public sector donors, private sector investors, implementing partners and civil society). Zonal officers (Level E) and national level officials (Level F), support district health offices with strategic direction, policy oversight, monitoring and provide technical support.

*NOTE: The proposed community health system is shown as a figure, available in Page 22, at https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf

Financing community health activities in a decentralised district health system

Malawi's community health strategy estimated cost in 5 years (2017–2022) is USD $407 million (approximately USD $3.9 per Malawian annually) [11]. A recent report showed Malawi's health financing is heavily donor-dependent, and cumulatively over 60% of health funds allocated to HIV/AIDS, malaria and reproductive health programmes [46]. Through the inter-governmental fiscal transfer framework, revenue is transferred from national to district authorities [46]. The strategy stipulates that the central government shall support procurement of essential health package interventions. District authorities are responsible for additional staff salaries (HSAs), provision of supplies, and infrastructural support towards construction of health posts and HSAs housing [11]. The strategy proposes provision of incentives (monetary and non-monetary) to community-based structures to promote performance and motivate CHTs. We noted this support mainly focused on health workers within CHTs, and to a limited extent, village health committees through training and provision of bicycles. The strategy does not speak of incentives, of any form, for CHVs outside prioritised structures (see Box 1).

From our analysis, three main financial challenges for implementing the strategy emerged. One, annual district implementation plans are often inadequately resourced, which may also affect funding allocation towards community health strategy activities. Furthermore, local authorities have limited and differing capacities to generate additional revenue to supplement budget deficits. The suggestion to lobby support from development partners may prove difficult, since project funds are generally tied to specific activities, with little flexibility for diversion to fill funding gaps in other programme areas.

Two, the 'silence' in the strategy on CHVs' compensation poses another challenge in a context where external-funding support has become increasingly irregular. Previously, the majority of CBO/FBOs received direct funding from national level, to support HIV/AIDS community-based activities; however, this ceased in 2015. CBO/FBO volunteers indicated project-based stipends, when available, were considered as the main income source, especially in contexts of extreme poverty and high unemployment levels. CBO/FBO volunteers reported occasions whereby, due to the voluntary nature of their work, external agents engaged them in unpaid work.

The dependence on CHVs to deliver essential health package interventions in the face of these constraints is worth reviewing, and for preventing volunteer attrition in the absence of a defined compensation mechanism. We noted some CBO/FBOs dealt with funding challenges in different ways: 1) through CHV monthly contributions, although irregular; 2) income generating activities such as small-scale cash farming; 3) member contribution to village savings and loans schemes; 4) CBO/FBO visitors contribution ('drop-box' kitty); and 5) grant proposal writing. While these initiatives show resilience on the part of CBO/FBOs, there is need for district-level structures to continue supporting CBO/FBOs and enable them to contribute to the strategy's implementation.

POSSIBLE OPPORTUNITIES AND RECOMMENDATIONS FOR FURTHER STRENGTHENING MALAWI'S COMMUNITY HEALTH STRATEGY

While our analysis highlighted possible dynamics, overlaps and frictions arising from Malawi's transition to a new service delivery structure, we also identified opportunities and current strengths to be further explored as Malawi's strategy implementation scales-up. Here we reflect on experiences and lessons presented in the literature on community health.

First, the delivery of community-level EHP interventions through multi-disciplinary CHTs requires a thoughtful, as well as pragmatic streamlining of roles and matching of skill-sets at team level. There is a risk that competency gaps may result in

underserved areas within the EHPs and/or lower standards of care. As reported in earlier Malawian studies [12, 35, 36], there are genuine concerns over HSAs' roles, which expanded over time against unmatched training support, and the expectation that they can deliver both community and facility-based activities as part of their job description. Experience from South Africa's ward-based outreach team model suggests that while primary healthcare staff are expected to assume more community-based responsibilities, including leadership and clinical supervision to non-health professional team members, in reality, they tend to prioritise facility-based care given workload demands [47]. The expansion of CHBC programmes in Malawi to include patients with other chronic conditions (besides HIV) [14], has to a large extent been unsupported by capacity building in these areas. In a changing epidemiological context, there is need for a well-trained health workforce sufficiently skilled to respond to the shifting healthcare demands within communities [7]. While EHPs are structured around disease-specific programmes [11], training should preferably cut across all listed domains to minimise the risk of neglecting areas which have traditionally received the least form of support, such as community mental health. In the long-term, the proposed development of a national integrated training manual for CHTs is critical.

Second, CHTs workload requires attention, particularly in the face of financial and operational difficulties to fill all team positions in the short-term. Health managers/supervisors could consider mapping trained CHVs from existing networks of volunteer-led programmes (e.g. CBO/FBOs) and assigning them to CHTs. CHVs could continue supporting health promotion and home-tracing activities since they are embedded in communities, while available HSAs could support outreach activities, and other specialised tasks under community-level EHP interventions. However, experiences elsewhere caution against reliance of volunteers as substitutes/replacement for professional health workforce, while facing critical health workforce shortages [2, 10, 17, 28]. This could potentially exacerbate problems such as strained relationships between paid and unpaid personnel, undermining the value of volunteer work, or raise expectations as volunteers hope for consideration into paid positions, which may prove difficult [2, 30]. For Malawi, an addendum to the strategy, outlining possibilities of task-shifting between CHT members, expected duties of CHVs and interactions with paid CHT personnel, is necessary. Clear reporting lines and supportive supervision are essential to make these arrangements work.

Third, the ongoing flux in financial and material support for volunteer-based programmes and the risk this poses for implementing Malawi's strategy needs further deliberation. Much has been written about 'voluntarism' in healthcare delivery in low-income settings, how this can or should be supported, and by whom [1, 2, 28, 30-32]. Malawi is not an exception, and the existence of a large network of volunteers who provide essential support to a range of community-based interventions [11, 14, 43], warrants discussions of how to absorb them under the new strategy. Over the years,

CHBC programmes, and within them CHVs, have had to be resilient to interruptions in donor-funded and national HIV programme support, and to the absence of clear compensation mechanisms. District authorities and project partners need to deliberate on appropriate forms of support, that respect and enhance the critical role of community-based structures, and civil society in healthcare delivery. Options applied elsewhere in the region include development of a standardised costing structure for volunteer-led work which takes into consideration workload, nature of tasks, and opportunity costs, as illustrated by a Ugandan study [31]; or provision of non-financial incentives such as bicycles in remote settings, stationery support, and other forms of recognition such as certificates [27, 32, 48].

Fourth, the management of multiple actors in the community health strategy requires strong leadership from district health systems. In the early implementation phase, mobilisation and sensitisation of all actors and structures within the community health system is paramount. Strategies to strengthen coordination include building upon existing forums, reinforcing the role of technical working groups, and identifying avenues for communication and dissemination at community and district levels. For example, in the study district, monthly forums to discuss CBO/FBO issues were organised with representatives from social welfare and district AIDS coordinator's office. The experience of community health policy implementation in Kenya illustrates how community health structures were reformed on a large-scale [24, 27]. The process was spurred by decentralisation of governance functions to sub-national level, and realignment of coordination structures to fit with stipulations of a revised national constitution.

At national level, updated guidelines and harmonisation of policies allied to the community health strategy, and their subsequent dissemination is necessary. While Malawi's strategy is directed towards unifying multiple actors and sectors working on health, Rwanda's 'One Health' approach [49], exemplifies an attempt of forging close collaboration across sectors/disciplines, guided by a single strategy and pooled funding, to integrate approaches to manage various determinants of animal, human and environmental health. Financing Malawi's strategy therefore requires joint efforts between district authorities, development partners, private sector, and central government to pool funds and ensure sufficient allocation for community health activities. In particular, it is crucial to ensure that EHP interventions are constantly available, in order for communities to receive appropriate care when needed.

Moving forward, further evidence is needed which explores how the proposed accountability structure is functioning at multiple levels; document actual experiences within CHTs on work performance, job descriptions and support structure; and EHP interventions delivery and cost-benefit analysis of implementing this strategy at scale. This evidence is necessary as Malawi and other countries in the region, pursue

the synergies between public, private, and civil-society investments in community health.

CONCLUSION

Malawi's national community health strategy demonstrates the country's strong commitment to the promotion of primary healthcare, based on a functional community health system, and as close to the community as possible. Our analysis shows the complexities of reconfiguring existing structures to a system that is capable of maximising health coverage, with the combined inputs of actors and resources, while providing the necessary oversight and stewardship. There is need for close collaboration between state-paid workers and community volunteers, and synergies across multiple actors and sectors engaged in community health, to realise full implementation potential.

REFERENCES

1. World health Organisation. *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.* 2007. Available from: http://www.who.int/hrh/documents/community_health_workers.pdf.
2. Leon N, Sanders D, Van Damme W, Besada D, Daviaud E, Oliphant NP, Berzal R, Mason J, and Doherty T. *The role of 'hidden'community volunteers in community-based health service delivery platforms: examples from sub-Saharan Africa.* Global health action, 2015. 8(1): p. 27214.
3. Lunsford SS, Fatta K, Stover KE, and Shrestha R. *Supporting close-to-community providers through a community health system approach: case examples from Ethiopia and Tanzania.* Human Resources for Health, 2015. 13.
4. Schneider H, Hlophe H, and van Rensburg D. *Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects.* Health Policy & Planning, 2008. 23(3): p. 179-87.
5. World Health Organization. *Health in 2015: from MDGs, millennium development goals to SDGs, sustainable development goals.* 2015. Available from: http://www.who.int/gho/publications/mdgs-sdgs/en/.
6. World health Organisation. *Human Resources for Health: foundation for Universal Health Coverage and the post-2015 development agenda.* 2013. Available from: http://www.who.int/workforcealliance/knowledge/resources/report3rd_GF_HRH.pdf.
7. World Health Organisation. *Global strategy on human resources for health: workforce 2030.* 2016. Available from: http://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf?ua=1.
8. World Health Organisation. *Fifth Forum of the African Platform on Human Resources for Health 2017.* Available from: http://www.who.int/hrh/news/2017/african_hrh_communique.PDF?ua=1.
9. Singh P and Sachs JD. *1 million community health workers in sub-Saharan Africa by 2015.* The Lancet, 2013. 382(9889): p. 363-365.
10. Schneider H and Lehmann U. *From Community Health Workers to Community Health Systems: Time to Widen the Horizon?* Health Systems & Reform, 2016. 2(2): p. 112-118.
11. *Government of Malawi. National Community Health Strategy 2017–2022: Integrating health services and engaging communities for the next generation.* 2017. Available from: https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf.
12. Smith S, Deveridge A, Berman J, Negin J, Mwambene N, Chingaipe E, Ritchie LMP, and Martiniuk A. *Task-shifting and prioritization: a situational analysis examining the role and experiences of community health workers in Malawi.* Human resources for health, 2014. 12(1): p. 24.
13. Devlin K, Pandit-Rajani T, and Egan. KF. *Malawi's Community-based Health System Model: Structure, Strategies, and Learning. 2017.* Available from: https://www.advancingpartners.org/resources/technical-briefs/malawi-community-based-health-system-model.

14. Masanjala W and Kajumi M. *Multi country research on community caregivers: the backbone of accessible care and support - Malawi report*. 2013. Available from: https://www.cordaid.org/media/medialibrary/2013/09/Malawi_CAN_Report_26_July2013_2.pdf
15. Angwenyi V, Aantjes C, Kajumi M, De Man J, Criel B, and Bunders-Aelen J. *Patients experiences of self-management and strategies for dealing with chronic conditions in rural Malawi*. PloS one, 2018. 13(7): p. e0199977.
16. Bhutta ZA, Lassi ZS, Pariyo G, and Huicho L. *Global experience of community health workers for delivery of health related millennium development goals: a systematic review, country case studies, and recommendations for integration into national health systems*. Global health workforce Alliance, 2010. 1(249): p. 61.
17. Tulenko K, Mgedal S, Afzal MM, Frymus D, Oshin A, Pate M, Quain E, Pinel A, Wynd S, and Zodpey S. *Community health workers for universal health-care coverage: from fragmentation to synergy*. Bulletin of the World Health Organization, 2013. 91: p. 847-852.
18. Saprii L, Richards E, Kokho P, and Theobald S. *Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles*. Human resources for health, 2015. 13(1): p. 95.
19. Glenton C, Scheel IB, Pradhan S, Lewin S, Hodgins S, and Shrestha V. *The female community health volunteer programme in Nepal: decision makers' perceptions of volunteerism, payment and other incentives*. Social Science & Medicine, 2010. 70(12): p. 1920-7.
20. Teklehaimanot HD and Teklehaimanot A. *Human resource development for a community-based health extension program: a case study from Ethiopia*. Human resources for health, 2013. 11(1): p. 39.
21. Baatiema L, Sumah AM, Tang PN, and Ganle JK. *Community health workers in Ghana: the need for greater policy attention*. BMJ global health, 2016. 1(4): p. e000141.
22. Schneider H and Nxumalo N. *Leadership and governance of community health worker programmes at scale: a cross case analysis of provincial implementation in South Africa*. International journal for equity in health, 2017. 16(1): p. 72.
23. Keller B, McCarthy E, Vosburg KB, Musonda M, Mwila J, van den Broek JW, and Walsh FJ. *Task-shifting impact of introducing a pilot community health worker cadre into Zambia's public sector health workforce*. PloS one, 2017. 12(8): p. e0181740.
24. *Government of Kenya. Strategy for Community Health 2014–2019 Transforming health - Accelerating the attainment of health goals. 2014. Available from: h*ttps://www.medbox.org/kenya-strategy-for-community-health-2014-2019/download.pdf.
25. Republic of Rwanda. *National Community Health Policy of Rwanda* 2008 Available from: https://www.advancingpartners.org/sites/default/files/projects/policies/chp_rwanda_2008.pdf.
26. Aantjes C, Quinlan T, and Bunders J. *Integration of community home based care programmes within national primary health care revitalisation strategies in Ethiopia, Malawi, South-Africa and Zambia: a comparative assessment*. Globalization and health, 2014. 10(1).
27. McCollum R, Otiso L, Mireku M, Theobald S, de Koning K, Hussein S, and Taegtmeyer M. *Exploring perceptions of community health policy in Kenya and identifying implications for policy change. Health policy and planning,* 2015. 31(1): p. 10-20.
28. Wringe A, Cataldo F, Stevenson N, and Fakoya A. *Delivering comprehensive home-based care programmes for HIV: a review of lessons learned and challenges ahead in the era of antiretroviral therapy*. Health policy and planning, 2010: p. czq005.

29. Zulu JM, Kinsman J, Michelo C, and Hurtig A-K. *Integrating national community-based health worker programmes into health systems: a systematic review identifying lessons learned from low-and middle-income countries.* BMC public health, 2014. 14(1): p. 987.
30. Cataldo F, Kielmann K, Kielmann T, Mburu G, and Musheke M. *'Deep down in their heart, they wish they could be given some incentives': a qualitative study on the changing roles and relations of care among home-based caregivers in Zambia.* BMC health services research, 2015. 15(1): p. 36.
31. Kasteng F, Settumba S, Källander K, Vassall A, and Group iS. *Valuing the work of unpaid community health workers and exploring the incentives to volunteering in rural Africa.* Health policy and planning, 2015. 31(2): p. 205-216.
32. Topp SM, Price JE, Nanyangwe-Moyo T, Mulenga DM, Dennis ML, and Ngunga MM. *Motivations for entering and remaining in volunteer service: findings from a mixed-method survey among HIV caregivers in Zambia.* Human resources for health, 2015. 13(1): p. 72.
33. World health Organisation. *Declaration of Alma-Ata International Conference on Primary Health Care.* 1978. Available from: http://www.who.int/publications/almaata_declaration_en.pdf?ua=1.
34. Government of Malawi. *Health Sector Strategic Plan II 2017 - 2022: Towards universal health coverage.* 2017. http://www.health.gov.mw/index.php/policies-strategies?download=47:hssp-ii-final.
35. Chikaphupha KR, Kok MC, Nyirenda L, Namakhoma I, and Theobald S. *Motivation of health surveillance assistants in Malawi: A qualitative study.* Malawi medical journal, 2016. 28(2): p. 37-42.
36. Kok MC, Namakhoma I, Nyirenda L, Chikaphupha K, Broerse JE, Dieleman M, Taegtmeyer M, and Theobald S. *Health surveillance assistants as intermediates between the community and health sector in Malawi: exploring how relationships influence performance.* BMC Health Serv Res, 2016. 16: p. 164.
37. Government of Malawi. *Guidelines for the Management of Taskshifting to Health Surveillance Assistants in Malawi.* 2014, Ministry of Health: Lilongwe – Malawi.
38. Government of Malawi. *Health Surveillance Assistant Training manual facilitator's guide.* 2009 Available from: https://www.advancingpartners.org/sites/default/files/malawi_health_surveillance_assistant_training_manual_facilitators_guide.pdf.
39. African Strategies for Health. *Community health worker incentives: lessons learned and best practices from Malawi,.* 2015. Available from: http://www.africanstrategies4health.org/uploads/1/3/5/3/13538666/chw_incentives.lessons_and_best_practices_for_malawi.final_report.pdf.
40. Kachimanga C, Cundale K, Wroe E, Nazimera L, Jumbe A, Dunbar E, and Kalanga N. *Novel approaches to screening for noncommunicable diseases: Lessons from Neno, Malawi.* Malawi Medical Journal, 2017. 29(2): p. 78-83.
41. Kauye F, Chiwandira C, Wright J, Common S, Phiri M, Mafuta C, Senganimalunje L, and Udedi M. *Increasing the capacity of health surveillance assistants in community mental health care in a developing country, Malawi.* Malawi Medical Journal, 2011. 23(3): p. 85-88.
42. Bowie C, Gondwe N, and Bowie C. *Changing clinical needs of people living with AIDS and receiving home based care in Malawi – the Bangwe Home Based Care Project 2003–2008 – a descriptive study.* BMC Public Health, 2010. 10(1): p. 370.
43. Government of Malawi. *National Community Home Based Care Policy and Guidelines 2011 Ministry of Health,: Lilongwe.*

44. Pindani M, Maluwa A, Nkondo M, Nyasulu BM, and Chilemba W. *Perception of people living with HIV and AIDS regarding home based care in Malawi.* Journal of AIDS and Clinical Research, 2013. 4(3).
45. Government of Malawi. *National training manual for Village Health Committees.* 2017 Available from: https://www.strath.ac.uk/media/other/malawi/chikwawa/VHC_TRAINING_MANUAL_Sep_202017.pdf.
46. Ministry of Health. *Malawi National Heath Accounts Report for Fiscal Years 2012/13, 2013/14 and 2014/15. 2016 Ministry of Health: Lilongwe – Malawi*
47. Marcus TS, Hugo J, and Jinabhai CC. *Which primary care model? A qualitative analysis of ward-based outreach teams in South* Africa. African journal of primary health care & family medicine, 2017. 9(1): p. 1-8.
48. Kuule Y, Dobson AE, Woldeyohannes D, Zolfo M, Najjemba R, Edwin BMR, Haven N, Verdonck K, Owiti P, and Wilkinson E. *Community Health Volunteers in Primary Healthcare in Rural Uganda: Factors Influencing Performance.* Frontiers in public health, 2017. 5: p. 62.
49. Nyatanyi T, Wilkes M, McDermott H, Nzietchueng S, Gafarasi I, Mudakikwa A, Kinani JF, Rukelibuga J, Omolo J, and Mupfasoni D. *Implementing One Health as an integrated approach to health in Rwanda.* BMJ global health, 2017. 2(1): p. e000121.

SUPPLEMENTARY FILE

File S1 — A Review of Malawi's National Community Health Strategy[1]

This supplementary file highlights Malawi's community health strategy objectives, proposed key interventions, and targets to be met during the implementation period (2017–2022). In reviewing this strategy, the paper draws on data collected as part of a larger study exploring community home-based care (CHBC) programmes role in supporting chronic care in Phalombe district, Malawi[2]. We synthesised data from: six key informant interviews with district health managers involved with CHBC programme implementation; 20 structured-observation reports of meetings and activities involving community health volunteers (CHVs) in CHBC programmes within the district; and four focus-group discussions with community/faith based organisation (CBO/FBO) volunteers (n=24 respondents). Three community-based organisations and two faith-based organisations were part of a pilot project (2010–2013) on capacity-building volunteers in chronic care, implemented by health partners working in Phalombe district.

The second component was a desk review of the national community health strategy, and other policies, reports, and relevant national publications on community and primary health in Malawi. These included the National Health Strategic Plans (2011–2016; 2017–2022); training manuals for health surveillance assistants (HSAs) and village health committees; guidelines for the management of task-shifting to HSAs; national health accounts report; national palliative policy and community home-based care guidelines.

Information extracted from these documents and synthesis of findings from the larger study is summarised in the table below.

[1] Government of Malawi: National Community Health Strategy 2017–2022: Integrating health services and engaging communities for the next generation In., https://www.healthynewbornnetwork.org/hnn- content/uploads/National_Community_Health_Strategy_2017–2022-FINAL.pdf. Lilongwe: Ministry of Health 2017.
[2] Angwenyi V, Aantjes C, Kajumi M, De Man J, Criel B, Bunders-Aelen J. Patients experiences of self-management and strategies for dealing with chronic conditions in rural Malawi. PloS one. 2018 Jul 2;13(7):e0199977.

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy – *challenges for implementation***	**Recommendations and opportunities to explore – *as stated in the strategy and research synthesis***
A. HUMAN RESOURCES *1) Description of the cadres* The term Community Health Workers (CHW) in the strategy refers to paid health worker cadre working in communities who include Health Surveillance Assistants (HSAs), senior HSAs (SHSAs), Community Midwife Assistants (CMA), Community Health Nurse (CHN), Assistant Environmental Health Officer (AEHO). CBO/FBO are composed of lay volunteers living in the same community with patients.	CBO/FBOs are registered community groups with the Ministry of Gender, Children, Disability and Social Welfare. They offer a range of health and non-health support. The focus is promoting health and social development. Care and support aim s at improving lives, self-reliance and mitigating economic vulnerability.	Community health volunteers (CHVs) are defined in the strategy as, "individuals who willingly offer their time, skills, and knowledge to work with communities to improve the health status of communities they reside in without expecting financial remuneration". While the strategy acknowledges the existence of an active network of CHVs, examples given of CHVs are not exhaustive, and CHVs potential roles not clearly spelt out. In the entire strategy, a lot of attention is targeted to the HSAs and other paid community health worker cadres.	The loose description of community health volunteers, and emphasis on those in prioritised community structures e.g. village health committees, risks the loss of recognition, and valuable contribution from volunteers in other programmes (e.g. volunteers in CBO/FBOs).

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy – *challenges for implementation***	**Recommendations and opportunities to explore – *as stated in the strategy and research synthesis***
B. HUMAN RESOURCES *2) Setting up the community health teams (CHTs); deployment, supervision and training* **SO1 and SO2 key interventions:** 1) recruiting additional community level personnel; 2) promoting equitable geographical distribution of the community health workforce; 3) provide high-quality, integrated pre- service and in-service training to all CHT members. **Target 2022:** Malawi reaches 74% of its policy recommendation for the ratio of trained HSAs to members of the population, and that 75% of HSAs and SHSAs are residing in their catchment areas.	CBO/FBOs recruit volunteers from the community. The range of active volunteers was between 20 and 120, among the CBO/FBOs included in our qualitative study As part of their organisational structure, CBO/FBOs have specific volunteers/coordinators elected to lead certain activities e.g. home-based care, patient support-groups (usually this is a co-opted member of one of the HIV support groups). CBO/FBO volunteers also serve in other community leadership postilions. Volunteers in CBO/FBOs received various training as part of project driven activities. For instance, the majority of volunteers received initial home-based care training (10 days). Some volunteers and coordinators were trained on advanced home-based care, leadership, and financial management. Some volunteers were trained on HIV testing, and were later co-opted as HIV testing assistants in nearby health facilities.	In 2017, the district had 224 HSAs serving 393,587 residents, which is below the recommended target of 1 HSA to serve 1000 people. According to the national CHBC guidelines, CBO/FBO volunteers are required to coordinate their activities with HSAs. The link between HSAs and CBO/FBOs was reported as weak or non-existent. Most of the CBO/FBO volunteers reported the need for training in the management of other chronic conditions e.g. hypertension, epilepsy, cancer, and diabetes.	The strategy recommends that district authorities are responsible for, and take ownership of health personnel recruitment and deployment strategies to reflect district needs and context. The strategy proposes training of CHTs on integrated service delivery. This will be through development and rolling out of an integrated government-led training programme for all CHT members. However, it is important to find mechanisms to include capacity building for CHVs in volunteer-led programmes supporting community health Furthermore, the strategy recommends CHTs should benefit from peer-learning, working collaboratively to deliver services rather than operate in silos, strengthen referral mechanism and reinforce regular clinical monitoring, performance management and supportive supervision.

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	*Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi*	What are the current gaps in the strategy – *challenges for implementation*	Recommendations and opportunities to explore – *as stated in the strategy and research synthesis*
			Workload management: a possible alternative is to co-opt trained CHVs from the existing network of volunteer programmes into CHTs. In redistributing tasks, CHVs could continue supporting with health promotion and home-tracing activities, since they are embedded in communities, while available HSAs support with outreach activities, and other specialised tasks highlighted in the list of community-level essential health package interventions.
C. HEALTH SERVICES **SO1 key Interventions:** 1) Scaling up integrated delivery of the essential health package interventions at community level; 2) roll out of CHTs with clear job descriptions, for all community health worker cadre **Target 2022:** 75% of HSAs deliver the majority of the community com ponents of the essential health package interventions.	CBO/FBOs thematic areas include: 1) HIV/AIDS care; 2) home-based care; 3) safe motherhood; 4) hygiene and sanitation; 5) elderly and disabled persons care; 6) orphans and vulnerable children care; 7) support community-based childcare centres; 8) human and child rights; 9) youth; 10) gender; 11) environment/climate change and agriculture; 12) livelihood support through income-generating activities	Shortage of specified CHWs (HSAs and others) to deliver essential health package interventions at community level – hence will still have to rely heavily on the work of CHVs to meet specified targets.	The strategy's aspiration is to ensure complete alignment of service package delivered by CHTs, which include preventive, promotive, community case management, disease surveillance, referral and rehabilitative care.

National Community Health Strategy **– 6 strategic objectives (SO)** **– 6 guiding principles (GP)**	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy –** ***challenges for implementation***	**Recommendations and opportunities to explore –** ***as stated in the strategy and research synthesis***
	In some of the CBOs/FBOs, they had realigned their mission statement and objectives to address the HIV 90-90-90 targets through community awareness to increase HIV testing and early initiation to treatment. The majority of CBO/FBOs provide home-based care to patients living with chronic conditions. This includes support with domestic chores, counselling, spiritual guidance, basic nursing, identify and refer patients requiring medical attention to health facilities. In a previous pilot project on capacity building CBO/FBOs, volunteers used to provide essential drugs from their home- based care kits, and with the presence of a drug revolving fund, they used to procure and provide anti-epileptic drugs. However, this stopped once the project ended. Patients were able to meet their medical needs (due to consistent supply of some drugs). The CBO/FBOs were supplied with blood- pressure monitoring machines for community screening.	The lack of clear job descriptions for CHVs within CHTs (in form of expected duties), risks CHVs being pulled into service delivery tasks they are not well prepared for. Furthermore, delegation of tasks requires a systematic approach, and the need to strive for diversity and inclusion of trained CHVs to constitute CHTs. Development of an addendum to the strategy in which the possibility of task-shifting between CHT members is further explored, and stipulated in the form of expected duties of CHVs, and their interaction with other community-based health workers is critical.	However, current organisation of essential health package interventions is centred around vertical programmes. Community-based interventions for non-communicable diseases are minimal (e.g. provision of psychosocial care). Therefore, inclusion of more services such as community screening (e.g. for hypertension), health education and promotion of diet and lifestyle modification behaviour, could be beneficial.

8

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy – *challenges for implementation***	**Recommendations and opportunities to explore – *as stated in the strategy and research synthesis***
D. FINANCING *1) Incentive model* **SO2: Key interventions;** 1) provide incentives to all community-based health workers in CHTs to improve performance, retention and time spent. The package of non-monetary incentive includes HSAs housing, transport support, uniforms, identity cards etc.	CBO/FBOs which participated in a donor-led project were allocated project funds using the following model: 1) 50% spent on strengthening health services; 2) 25% on CBO/ volunteer development; 3) 25% on volunteer empowerment Volunteers incentives were tagged with achievement of certain indicators and submission of forms e.g. number of visits to chronic clients; number of patients joining support groups; number of HIV clients adhering to treatment; number of patients with tuberculosis adhering to treatment; number of HIV counselling and testing done. This target driven model aimed at increasing service coverage and motivating volunteers. The withdrawal of monetary and organisational support contributed to volunteer attrition.	Support to CHVs is not clearly stipulated in the strategy, except for incentives to prioritised structures like village health committees through training and provision of bicycles. The risks of excluding certain groups/ individuals from receiving any forms of incentives, could lead to tensions in work relations between paid and unpaid health providers, generate inequities, and lead to demotivation. Scalability is a threat for volunteer-led programmes or initiatives that are donor-dependent or externally funded, hence uptake and continuity of such initiatives by Ministry of Health (MoH) could be a challenge.	CHW salaries, essential health package commodities and supplies, and infrastructure account for the majority of costs. That is, 30%, 20%, and 20%, respectively. Financing the strategy will require support from government, donors, partners, and the private sector. Under Malawi's devolution policy, district authorities will be the primary source for CHT salary and supervision. They will also provide significant support towards transport and infrastructure including health posts and housing for the community-based health workers. Communities are expected to contribute through work as volunteers, and support infrastructure in construction of health post and housing (for HSAs etc). Due to changes in national level financing, district authorities could find alternatives within local budgets to fund and sustain CBO/FBO activities at district level.

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy –** ***challenges for implementation***	**Recommendations and opportunities to explore –** ***as stated in the strategy and research synthesis***
	The National AIDS Commission (NAC) provided direct funding to CBO/FBOs through the district AIDS coordinators office to implement community-based HIV activities. In 2015, NAC direct funding to CBOs changed, with new requirements for CBO/FBOs to submit grant proposals to intermediary organisations. Hence, this has affected activities of CBO/FBOs, some of which became dormant, due to funding challenges. CBO/FBO initiatives to finance activities include: 1) through CHV monthly contributions, although irregular; 2) income generating activities such as small-scale cash farming; 3) member contribution to village savings and loans schemes; 4) CBO/FBO visitors contribution ('drop-box' kitty); and 5) grant proposal writing. Some CBO/FBOs seek support from private donors and charitable foundations to finance activities.		

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy – *challenges for implementation***	**Recommendations and opportunities to explore – *as stated in the strategy and research synthesis***
E. FINANCING *2) Supply and infrastructure support* **SO4 key interventions:** 1) construction of health posts and housing units for HSAs; 2) bicycles and motorcycles to CHWs; 3) scale-up of electronic supply and drug management to cover all community health. **Target 2022:** 95% of HSAs have a high quality, durable bicycles; 900 health posts are operational and supporting integrated community health service delivery in hard to reach areas	CBOs/FBOs reported experiencing financial and resource gaps to implement their activities, once project funds were withdrawn e.g. refills for home-based care kits, transport/bicycle ambulance for critical patients were no longer functioning, and blood pressure monitoring machines were not functional. Funding withdrawal also impacted on the quality of support to beneficiary households, and patients complained they no longer receive 'tangible' support from CBO/FBOs (client dissatisfaction). CBO/FBOs that still received sponsorship from multiple partners and through self-generated income, they were able to continue implementing their activities. This was attributed to the presence of active and resourceful leaders.	The focus of the strategy is on provision of consumables (hardware), but there's need to focus on the "software" and provision of non-monetary incentives in form of training or other forms of capacity-building for all CHT members (including CHVs).	Generally, health posts have been dormant service delivery structures, and mostly utilised by HSAs to run maternal and child health clinics. In Phalombe district, some implementing partners use these sites for organising health outreach clinics for general population and across all ages. District health management teams could set up monthly mobile clinics in health posts, where a team of health professionals offer services, and particularly targeting communities living in hard to reach areas.

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy –** ***challenges for implementation***	**Recommendations and opportunities to explore –** ***as stated in the strategy and research synthesis***
F. COORDINATION, PARTNERSHIP AND COMMUNITY ENGAGEMENT **SO6 key interventions:** 1) Scaling up the coordinating function of the Community Health Strategy section at national level; 2) recruiting a Community Health Officer (CHO) for each district; 3) strengthening community-level coordination through community health advisory groups and CHTs; 4) hosting regular coordination meetings between stakeholders at all levels **Target 2022:** community health actors will have completed 80% of all agreed-upon coordination activities and milestones. 70% of Village Health Committees (VHCs) are meeting regularly on a monthly basis to support community health activities and that 70% of CHAGs and health centre advisory committees (HCACs) are active.	Previously, community health related activities in the district fell under the responsibilities of different district officers e.g. district health promotion officer, district environmental health officer, palliative care coordinator, and the district AIDS coordinator. The latter were actively engaged in community-based HIV related activities, with CHBC programmes and implementing partners expected to report and coordinate their activities through this office. The CBOs/FBOs reported they linked up with community leaders e.g. local chiefs, area development committees, and village development committees. For instance, CBO/FBOs liaised with local chiefs in coordinating community HIV activities such as HIV/AIDS awareness campaigns, mobilisation for counselling and testing.	Some foreseeable challenges highlighted in the strategy include district health officers (and authorities) lack sufficient oversight over implementing partners' activities in their jurisdiction, which results in poor coordination of programmes. The lack of clear guidelines on devolution means that oversight roles of governance structures across the system remains weak. The absence of a community health focused technical working group at district level, and a weak capacity to coordinate further exacerbates coordination problems. With the proposed community health system structure, there are multiple actors and reporting structurers (at community and district level), which could create duplication, if remain unchecked.	The CHO post is an opportunity to consolidate all community health activities. However, further thought is needed on: 1) how to fully align the CHO cadre within current district-level structures; and 2) the practical considerations of identifying and engaging all actors/officers as part of one large community health network. An important exercise in the early implementation phase, is for districts to map and register partners to identify opportunities for support. In the early implementation phase, emphasis should be placed on broadcasting the strategy, and training of community actors/committee members to be familiar with their expected responsibilities.

8

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy –** ***challenges for implementation***	**Recommendations and opportunities to explore –** ***as stated in the strategy and research synthesis***
	A concern raised by CBO/FBO volunteers was the overlapping activities with other community-based groups/committees. For instance the area and village development committees were at times approached to implement health related tasks – similar functions as those of CBO/FBOs, which led to tensions in work relations. CBO/FBOs work closely with patient support groups and other patient organisations (such as National Association of People Living with HIV - NAPHAM). In Phalombe district, a unique forum existed where all CBO/FBOs in the district met monthly with representative from social welfare and district AIDS coordinators office, to disseminate reports and discuss CBO/FBO issues.	CHV selection and representation to the prioritised community structures is assumed to be through elected positions. An alternative approach is considering co-opting trained volunteers from CBO/FBOs who have valuable experiences, to the various committee structures at community level. However, selection processes and representation would still rely on, and influenced by locally set norms and standards.	There is need for streamling policies and guidelines linked to the community health strategy. For instance, the national palliative care policy and community home-based care guidelines, which have been a major source of reference in the provision of home-based care in Malawi.

National Community Health Strategy – 6 strategic objectives (SO) – 6 guiding principles (GP)	***Synthesis of data from research on community home-based care programmes role in chronic care in Phalombe district, Malawi***	**What are the current gaps in the strategy –** ***challenges for implementation***	**Recommendations and opportunities to explore –** ***as stated in the strategy and research synthesis***
G. DATA REPORTING AND MONITORING **SO3 key interventions:** 1) harmonising data management practices; 2) exploring integrated mHealth solutions for CHTs; 3) provide sufficient training for HSAs, supervisors and CHVs on data and information communication technology; 4) launching two- way feedback and data review systems between communities and the community health workforce. **Target 2022:** 75% of HSAs are reporting using the standardized village health register, and that 50% of CHTs are using mHealth for integrated service delivery, data collection, and supervision.	All registered CBO/FBOs programmes are expected to generate monthly reports and submit to the district ministry of health, social welfare office, and the district AIDS coordinator (different report indicators and using a paper based system). CBO/FBO volunteers were concerned with the lack of, or infrequent supervision visits from health personnel in nearby health facilities, to provide guidance for their activities.	In the national community home-based care guidelines, HSAs are supposed to link with CBO/FBOs to receive reports and support their work. Most of the CBOs reported this was not happening. The recognition in the strategy of the lack of integrated data collection tools and systems, and inaccessibility of data at community level – leads to duplication and workload burden. E.g. at present HSAs are assigned over 50 forms and processes, of which 40 are expected to be completed at least monthly. A foreseeable challenge mentioned in the strategy is HSAs and village health committees feel they do not receive feedback, hence lack ownership or value the need for elaborate data collection. At community level, leaders are unable to use data to plan, implement and improve community health services.	At national level, a number of initiatives are yet to be rolled out including: 1) development of integrated village health registers; 2) development and training of community health information systems; 3) ministry of health and partners working on revision of health indicators, and their inclusion in electronic information systems. District level health information/data officers will require support to strengthen CHTs capacity. To curb duplication with reporting (due to multiple reporting structures), the district health information office could serve as a central reporting unit, instead of each department collecting reports specific for their programmes.