**SUPPLEMENTARY FILE 1: A REVIEW OF MALAWI’S NATIONAL COMMUNITY HEALTH STRATEGY[[1]](#footnote-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]](#footnote-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 qualitative study is summarised in the table below.

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| **National Community Health****Strategy*** **6 strategic objectives (SO)**
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| **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 samecommunity with patients. CBO/FBOs are registeredcommunity 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) aredefined 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, andemphasis 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). |
| **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 rangeof active volunteers was between 20 and 120, among the CBO/FBOs included in our qualitative studyAs 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 financialmanagement. 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 serving393,587 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 areresponsible 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 healthFurthermore, 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, performancemanagement and supportive supervision.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 |

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|  |  |  | 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 activitiesIn 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. | 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 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. | The strategy’s aspiration is to ensure complete alignment ofservice package delivered by CHTs, which include preventive, promotive, community case management, disease surveillance, referral and rehabilitative care.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.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. |
| **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 | CBO/FBOs which participated in a donor-led project wereallocated project funds using the following model: 1) 50% spent on strengthening health services; 2) 25% on CBO/volunteer development; 3) 25% on volunteerempowermentVolunteers 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 | Support to CHVs is not clearly stipulated in thestrategy, 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 | CHW salaries, essential health package commodities andsupplies, 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 thecommunity-based health workers. Communities are expected |

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| housing, transport support,uniforms, identity cards etc. | of HIV counselling and testing done. This target driven modelaimed at increasing service coverage and motivating volunteers. The withdrawal of monetary and organisational support contributed to volunteer attrition.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. | 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. | to contribute through work as volunteers, and supportinfrastructure 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. |
| **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 drugmanagement to cover all community health.**Target 2022:** 95% of HSAshave a high quality, durable bicycles; 900 health posts are | CBOs/FBOs reported experiencing financial and resourcegaps 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 ableto continue implementing their activities. This was attributed to the presence of active and resourceful leaders. | The focus of the strategy is on provision ofconsumables (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 deliverystructures, 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 healthmanagement 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. |

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| operational and supportingintegrated community health service delivery in hard toreach areas |  |  |  |
| **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 throughcommunity 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 districtfell 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.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 toimplement 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. | Some foreseeable challenges highlighted in thestrategy include district health officers (and authorities) lack sufficient oversight over implementing partners’ activities in theirjurisdiction, which results in poor coordination of programmes. The lack of clear guidelines on devolution means that oversight roles of governance structures across the systemremains 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.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. | The CHO post is an opportunity to consolidate all communityhealth 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 largecommunity 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 ofcommunity actors/committee members to be familiar with their expected responsibilities.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. |

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| **G. DATA REPORTING AND****MONITORING****SO3 key interventions:**1) harmonising datamanagement 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 togenerate 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 careguidelines, 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 andimprove community health services. | At national level, a number of initiatives are yet to be rolledout 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. |

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-](https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf) [content/uploads/National\_Community\_Health\_Strategy\_2017-2022-FINAL.pdf](https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf). Lilongwe: Ministry of Health 2017. [↑](#footnote-ref-1)
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.* [↑](#footnote-ref-2)