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Malawi
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Health centre committees ensuring services respond to the needs of people living with HIV in Malawi

Malawi's health profile

Population	15 906 000
Percent population urban	16
Gross national income/capita PPP US\$	730
Percent population living on <US\$1/day 2010	72
Adult literacy rate 2010	75
Life expectancy at birth	59
Under 5 year mortality rate	71
Maternal mortality /100 000 live births	510
Adult HIV prevalence	7.1
Percent unmet need for contraception 2010	26
Antenatal care coverage, one visit + 2010	95
Antenatal care coverage, four visits	46
Measles immunisation in 1 yr olds	90
Nurses and midwives / 10 000 people 2012	3.4
Per capita expenditure on health PPP\$ 2008	49

2012 data unless otherwise specified.
Source: WHO Global Health Observatory 2015



Malawi map © Gavi 2015
<http://www.gavi.org/country/malawi/>

Malawi is a low income country in southern Africa, with a high rate of poverty. Like many others in the region, the country is experiencing combined burdens of communicable disease, chronic conditions and maternal, neonatal and child mortality. In 2006, according to Ministry of Health data, HIV/AIDS was the leading cause of death, accounting for a third of all deaths, followed by respiratory infections and malaria. The Ministry of Health has overall responsibility for health services in Malawi, and provides 60 percent of services, together with the Christian Health Association of Malawi (CHAM) providing 37 percent, and private institutions providing 3 per cent. The public healthcare system is thus the main source of care for people, and within this the 414 government-run primary care health centres are the frontline services most commonly used by people, together with 138 health centres run by CHAM. Cases may be referred by these health centres to district hospitals and from there to central hospitals. Malawi supports primary health care (PHC) and community participation as key policy principles. Health

centres provide outreach to communities and a number of community-based cadres support primary health care in the community. They include health surveillance assistants (HSAs), community-based distributing agents, village health committee members, and other volunteers mainly from non-governmental organizations (NGOs). While one HSA should serve about 1000 people, they are often more thinly spread. Each health centre should have a health centre advisory committee.

Health centre advisory committees in Malawi

Malawi's 1994 Constitution obliges the state to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care, within the resources available, and guarantees equality in access to these health services. Community participation is a central pillar for implementing PHC in Malawi's 2011-2016 Health Sector Strategic Plan, which commits to ensuring that local communities



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An outreach clinic in Mzimba District, Malawi
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have a voice and an opportunity to participate in issues that affect their health. The Ministry of Local Government and Rural Development has provided guidelines for the mechanisms to achieve this, including village development committees and area development committees that are responsible for identifying a wide range of development issues within villages and across a number of villages respectively.

A further mechanism for participation, recognised in the health sector strategy and in the 2014 Malawi Guidelines for Community Participation in PHC, is the health centre advisory committee (HCAC). While the HCACs are not prescribed in law, they get their mandate from national strategy and guidelines. The committees are set up to monitor the performance of health centres and to ensure that communities get the quantity and quality of services set in policy. They work with the village health committees to promote PHC activities and with community health workers to promote health and prevent disease, such as through promoting hygiene, and access to safe water and sanitation. While every health centre should have a HCAC, it is not clear whether this is the case in practice. This needs a special audit.

The HCAC membership is about 10 people, elected from surrounding villages. Specific capacities are considered when electing the members, including literacy and leadership skills. Communities may elect retired civil servants, for example, or those living close to the health centre so they could quickly respond to challenges. The HCACs also include representatives of women, of people with disability, and church and political party members. The personnel-in-charge at the health centre is the secretary of the committee.

The functioning of these mechanisms depends also on how well people know their roles. Health centre committee members, community health workers and health workers interviewed from three districts from each of the three regions in Malawi were not aware of the specific laws and guidelines governing the operations of the HCAC. They were, however, aware health centres should have committees. They had common views on the role of HCAC to be a bridge between the communities and the health centres, and to support communication between communities and health workers, including on grievances about services. They also understood their role as one of mobilizing communities to participate in health activities, giving an example such as molding bricks and collecting sand to build waiting shelters for women about to deliver. Members of HCACs monitor the delivery of medicines at health facilities. They should sign the delivery forms as witnesses to confirm the correct quantities of medicines supplied. As this may not always happen, the HCAC member may need to come and verify this later. While the HCAC members broadly understand their roles, it was evident that those interviewed needed clearer guidelines on these roles to give more certainty to their work.

Ensuring health services respond to the needs of people living with HIV

Although HCACs do not specifically target services for HIV and AIDS, they have played a role in supporting services to be responsive to the needs of people living with HIV. In Luzi health centre in the northern district of Mzimba, for example, five committee members were trained in prevention of vertical transmission (parent to child) of HIV in early 2014, together with community volunteers and chiefs, with input from the district health office. The committee members worked with volunteers, visiting villages with messages about prevention of vertical transmission and the services available for it. These promotion activities included local dances such as *malipenga* and *mbotoska*, that attracted crowds of people, followed by health message on HIV and AIDS, on services for prevention of vertical transmission and on health services generally. The activities were reported to have raised awareness in the community on these services, with some men now accompanying their wives for antenatal care and HIV testing.

At Luzi health centre, several NGOs supported the health promotion activities and have supported efforts of the HCAC to ensure effective delivery of health services. The National Association of People Living with HIV/AIDS (NAPHAM) provided food to people living with HIV who belonged to support groups. They also provided money (about US\$17 per month) to support the outreach by local support groups. NAPHAM provided goats and pigs to people living with HIV in the community, who passed the offspring of these animals to other support group members. Population Services International (PSI) trained youths on HIV and the youths passed on the training to others.

At Makungwa health centre in Thyolo district, south of Malawi, some members of the HCAC were selected by the health centre to help with health education on HIV and expert clients were trained to help with health education at the facility, particularly on adherence to anti-retroviral therapy. However in this case, the support did not come from the local NAPHAM but from an international organisation, and when this organisation phased out their support for the area the expert patient activities were negatively affected, so that only two expert patients remained active. While some other international agencies took over the activities on prevention of vertical transmission, they too left the area. This experience highlighted the challenges in sustaining programmes that are stimulated by external funding.

At Msakambewa health centre in the central district of Dowa, activities were carried out to work with support groups in the community to screen children for malnutrition and to mobilise communities on health. These activities were



Malipenga dances in community health promotion activities in Mzimba © L Nyirenda 2014



Support group and nurse at Luzi health centre
© M Nyirenda 2009

implemented by the community volunteers and support groups that were active around the health centres, and that involve people living with HIV.

At Luzi health centre, a nurse openly living with HIV was a leader of one such support group for people living with HIV, and directly communicated the concerns of people living with HIV to the health centre authorities, including on issues of how people access their anti-retroviral medicines, and how their privacy is maintained when they visit health services.

The NGOs and support groups in these areas often worked independently of the HCACs. However a number of ways were raised through which HCAC members could better support the activities of the NGOs' and support groups and ensure that health services respond to the needs of people living with HIV. HCACs could

- mobilise communities on HIV prevention and treatment and promote HIV testing and counselling;
- support client adherence to anti-retroviral therapy;
- engage health centre staff to address concerns of people living with HIV. The concerns raised included negative staff attitudes and timely opening of the clinic to ensure people collect ARVs in time;
- advocate for more rapid decentralisation of services so that ARVs are provided at health centres, to alleviate the challenges people face in accessing ARVs and to promote adherence to treatment.

Lessons to share

The HCACs are a still partly untapped resource in Malawi. There are examples of HCAC activities that have supported the functioning of health centres, but these are still patchy in scope. For these practices to spread more widely there needs to be greater clarity and guidance on the roles of HCACs, and a more active process to support their training and activities. With AIDS a leading cause of mortality in Malawi, HCACs can play an important role in HIV prevention and in uptake of services, as found in Luzi health centre.

The activities currently being implemented by HCACs are growing from the bottom up. This shows the interest in participation. The activities are, however, often ad hoc, led or funded by NGOs, without sustainable frameworks or integration within health centre and district plans. Those involved can become demotivated when funders phase out their activities, especially when activities are linked to project allowances rather than to the core functions of the HCAC. As one member noted: "Wali kunanga ni ma NGO pa nkhani ya ma alawansi." ("It is the NGOs that messed up things with the introduction of allowances.")

The lessons from the experience of HCACs in Malawi suggest the need to

- Design and strengthen mechanisms and processes to ensure sustainability of the roles played by the HCACs; embedding the activities in the daily activities of the health centres, reflected in their budgets, and not reliant on external funding.
- Link NGOs and volunteers that help to mobilise and stimulate activities to HCACs and health centres, to build synergy and co-ordination of activities and identify strategies for sustainability of support for these activities;
- Develop linkages and working relationships between HCACs and support groups for people living with HIV. Where this happened the activities complement and strengthen each other

- Include advocacy for services related to HIV in the roles played by HCACs and train the HCCs, health workers at the health centres, and district health officials on such roles.



Communities marching for health, Lilongwe © MHEN 2008

References

1. Ministry of Health (2011). Malawi Health Sector Strategic Plan 2011 – 2016: Moving towards equity and quality. Ministry of Health, Lilongwe
2. Ministry of Health (2014 in press). The Malawi Guidelines for Community Participation in Primary Health Care. Lilongwe: Ministry of Health, Lilongwe
3. Richardson, F., M. Chirwa, M. Fahnestock, M. Bishop, P. Emmart and B. McHenry (2009) Community Based Distribution of Injectable Contraceptives in Malawi, Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.

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