CONTEXT ANALYSIS: CLOSE-TO-COMMUNITY PROVIDERS IN MOZAMBIQUE

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BACKGROUND

The REACHOUT ('Reaching out and linking in: health systems and close-to-community services') programme is a five-year, eight-partner consortium focusing on 'close-to-community' (CTC) health service providers — i.e. health workers operating at community level. The main attention of REACHOUT concerns formal community health workers, but their interaction with other, less formal CTC providers such as expert patient volunteers, informal private practitioners, lay counsellors and health promoters is also of utmost importance.

The Mozambique REACHOUT team comprises researchers from Universidade Eduardo Mondlane (UEM). The team focused its attention on the country's formal CTC providers, known as *Agentes Polivalentes Elementares* (APEs). The APE programme was originally conceived and introduced in 1978 as a strategic solution to improve access to health care services for the rural population. The programme faced challenges since implementation, such as the civil war, so the Ministry of Health decided to revitalize it in 2007, introducing a new training curriculum in 2010, with modified terms of reference and a policy for payment of a monthly subsidy.

There is a scarcity of published and unpublished literature regarding CTC providers in Mozambique, despite the APE programme having been established over three decades ago. The initial APE programme (developed in 1978) faced challenges which resulted in the interruption of programme implementation in the mid-1990s. Primary concerns were that the APEs felt abandoned, due to almost non-existent supervision and a progressive decrease in support from the National Health Service, although many continued to receive drug and supply kits. Different APE training curricula and methodologies, implemented mainly by non-governmental organizations (NGOs) supporting the Ministry of Health, resulted in 'vertical programmes' within which APEs were regarded as volunteers. These volunteers were supposed to receive support from their communities (i.e. helping with their subsistence farming, providing foodstuffs, giving presents as recognition for their work etc.), but this became scarce. NGOs implemented a system of subsidies and provided additional incentives for those under their supervision, which led to increased frustration among existing active APEs who were not supported by NGOs. Finally, communities viewed APEs as health service providers and demanded more curative services from them, which also led some APEs to become 'private health care providers' who charged fees for their services.

With these challenges in mind, in 2010 the government embarked on a revitalization of the programme. A range of stakeholders were involved in the process of fully

redesigning the programme, and the government leads the implementation and scale-up of the revitalized programme with its partners. As part of the REACHOUT work a range of stakeholders were identified, including governmental institutions at different levels, development cooperation agencies and local and international NGOs.

Despite revitalization of the APE programme, considerable challenges remain, including: sustainability of the programme; integration of former APEs; payment of subsidies; persisting weak monitoring and supervision of APEs; challenges related to ensuring a gender balance during selection of APE candidates (with the current majority being men, contrary to policy intentions); and challenges with regard to home visits by APEs due to poor road access, despite the distribution of bicycles. It is these barriers and facilitators that REACHOUT set out to explore.

This report combines findings from a desk review, a mapping of CTC providers and data collected during qualitative explorations carried out in two selected districts of Maputo Province as part of the context analysis.

METHODOLOGY

For the exploratory study, qualitative research methodologies were used — namely, in-depth interviews and focus group discussions. Individual interview and focus group discussion guides were developed to capture the experiences and perceptions of purposefully selected participants, including members of the Provincial Health Directorate, District Health Directorate and Community Health Committees, community leaders, APEs and mothers of children under five years of age (the most common clients of CTC providers). Provinces were selected to avoid duplication of interventions, following discussion among stakeholders. Data were recorded, transcribed and simultaneously translated into Portuguese, prior to the development of a thematic framework, through reading and re-reading several transcripts to develop themes and sub-themes, in accordance with the generic REACHOUT conceptual framework. Qualitative data analysis software (Nvivo10) was used to facilitate the coding of data for analysis.

FINDINGS

The qualitative study provided insights, views, perceptions and experiences from study participants. Facilitating factors of and barriers to CTC providers' performance that came up in previous reports (Succato et al., 1995; Bhutta et al., 2010; MISAU, 2012; Ministry of Health, 2010; UEM, 2013) include the payment of non-uniform subsidies and incentives; unmet career path expectations; poor transport options to reach remote areas; inconsistencies in training curricula; gaps in support for APEs from their communities (as compared to expectations); irregular supply chains; and significant weaknesses in supervision and feedback of data.

The main findings relating to broad contextual and health system-related facilitating factors or barriers are presented below.

- **APEs belong in their communities but also the health system:** Our findings reveal perceptions, across all types of participants and regardless of APE programme challenges, that APEs are appreciated and needed at community level, especially in the context of the lack of availability of other options to access health care services. In turn, APEs not only originate from and feel they have a privileged social position in their communities; they also feel a useful part of the health system.

  This explains in part why APEs usually felt that certain habits and customs existing in the community might not have been hazardous to children's health, because they shared the same social and cultural context, which can greatly facilitate their work. They were thus able to overcome communication challenges, identify problems in households that were widely known in the community and address relevant health promotion issues tailored to the community or household, such as regarding, for example, latrine use, facility delivery etc.

  At the same time, the potential links among communities, APEs and the health system were not all operational, due to constraints in terms of budget limitations, scarcity of professional human resources, difficult geographic access and ethnic diversity. These in turn also affected reporting and educational activities — the latter possibly limiting the effectiveness of health education, supervision and supply chain management.

- **The selection and recruitment of APEs** involves different stakeholders, such as formal public health sector staff, community leaders and community members. This represents one aspect of the overall positive and powerful nature of the community engagement system that extends beyond selection into monitoring, support and governance through empowered communities. The recruitment process as defined in the revitalized APE policy is being observed, and no relevant grievances or problems were identified from any respondent. The APEs felt motivated because they feel they have been selected by their communities and can help them as an integral part of the national health system.

- **Access** to CTC preventive, promotive and curative services continues to be a challenge for the community, APEs and health care workers due to geographical and distance issues. The geographical distances and lack of health facilities and transport contribute to the community regarding an APE as a health worker who is able to provide curative services. However, the APE programme formally has its main focus on health promotion and disease prevention (80% of APEs' time should

be spent on these activities), with a very limited role regarding curative services. Our research revealed significant tensions between community expectations of curative services (and APEs' willingness to perform them) and official policy dictating a focus on preventive services and health promotion.

- **The APEs' target population and services** mainly focus on children, but adults also benefit in the case of malaria, diarrhoea or first aid. Pregnant women are also beneficiaries of the identification of danger signs and referral to health facilities.

Much of the discussion emerging from the data centred on barriers to and facilitators of CTC providers' performance, and these often related to intervention design factors, as follows:

- **Continuous professional development** opportunities were regarded as essential for better performance by all, including health workers and APEs.

- **Allowances, subsidies and incidentals:** APEs expressed their discontentment regarding the substantially delayed arrival of promised and expected subsidies and other incentives, with reference made to colleagues who had stopped working as APEs as a result.

- **Non-financial incentives** (such as bicycles, uniforms etc.) are arranged by the formal health sector but also provided by the community (such as help with transportation, gifts etc. but also non-material incentives such as 'respect').

- **Supervisory system:** Despite the supervision policy and progress on funding, there are still critical challenges such as timely allocation of funding, the heavy workload of scarce health workers responsible for supervision (particularly in distal health facilities) and the lack of transportation.

- **Reporting system:** Although defined by the Ministry of Health with instruments made available, the reporting system in everyday practice seems more geared towards upward accountability (to seniors at increasingly high levels) than downward accountability (back to the APEs and communities). It lacks a proper feedback loop from central to more distal levels and to APEs. Even with a lack of feedback, APEs continue to send reports and complete periodic reporting forms because they regard it as important for performance assessment.

- **Supplies and logistics:** There are challenges in the timely provision of medicine and supply kits. Often some supplies in the kit are finished before APEs are allowed to request another kit.

IMPLICATIONS

The implications of these findings are:

- improvements can be made to avoid delays in the payment of subsidies and the provision of logistical support for drugs and other supplies;
- monitoring and evaluation mechanisms and supervision feedback loops should be strengthened, through context-tailored solutions; and
- supervision constraints need tailored solutions to ensure regular supportive supervision, as each district/community has its own specific characteristics and challenges.

Identifying quality improvement cycles is not an easy task, as different stakeholders suggest different interventions, based on their own perceptions of relevance and applicability at study sites. Thus, what is proposed below is based on the evidence from the context analysis and through consensus of the REACHOUT country team and stakeholders.

- Supervision does not happen regularly due to challenges previously described, but it is of the highest importance for the success of the APE programme. Creative solutions could be developed, based on the literature on supervision and experiences from other countries to develop sustainable and viable solutions for implementation within resource-constrained settings.

- The monitoring and evaluation system developed for APEs requires tailoring to the context. Better ways of providing feedback from central to distal levels (where data are generated and/or aggregated) are required. Once again, experiences reported in the literature and other countries could be of great help in developing creative, sustainable and timely monitoring and evaluation systems within resource-constrained settings, allowing appropriate and timely feedback between levels.

The APE programme in Mozambique has been given a second chance to remedy weaknesses experienced during implementation of the original programme. The revitalized programme has taken into account some of these issues. However, several of the challenges, which the Ministry of Health has sought to avoid, are being repeated in the revitalized programme, such as supply and logistics constraints, difficulties implementing supervision and challenges regarding monitoring and evaluation.

These challenges will require creative, context-tailored solutions which incorporate existing local and international successes to overcome them. Thus, for the quality improvement phase of the project, the Mozambique REACHOUT team will focus its

efforts on developing improvement cycles for supervision and monitoring and evaluation.

CONTENTS

AIDS	Acquired Immune Deficiency Syndrome
APE	*Agente Polivalente Elementar*
CAG	Country Advisory Group
CTC	Close-to-community
FGD	Focus group discussion
GDP	Gross Domestic Product
GHWA	Global Health Workforce Alliance
HIV	Human Immunodeficiency Virus
iCCM	Integrated community case management
IDI	In-depth interview
IESE	Instituto de Estudos Sociais e Económicos
IMF	International Monetary Fund
JICA	Japan International Cooperation Agency
KIT	Royal Tropical Institute, Amsterdam
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MoH	Ministry of Health
NGO	Non-governmental organization
NIS	National Institute of Statistics
PESS	*Plano Estratégico do Sector de Saúde*
PHC	Primary Health Care
REACH	Research for Equity and Community Health
TBA	Traditional Birth Attendant
UEM	Universidade Eduardo Mondlane
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
US$	United States Dollar
WHO	World Health Organization

BACKGROUND

REACHOUT ('Reaching out and linking in: health systems and close-to-community services') is a project that involves research institutions from the following eight countries: the United Kingdom, the Netherlands, Mozambique, Malawi, Kenya, Ethiopia, Bangladesh and Indonesia.

Within the REACHOUT project, the designation 'close-to-community' (CTC) is used as an umbrella term to describe health workers at community level. The main focus of REACHOUT are the formal community health workers, but their interaction with other less formal CTC providers such as expert patient volunteers, informal private practitioners, lay counsellors and health promoters is also of utmost importance for the project.

It is well known that the CTC providers' responsibilities vary within and between different contexts and may range from a single health area (e.g. maternal health) to multiple areas of curative and preventative interventions. The level at which they operate also varies, from full-time, salaried workers with many responsibilities (Malawi and Ethiopia) to part-time volunteers with limited tasks (Traditional Birth Attendants (TBAs) in Indonesia). CTC providers may operate in the public or private sector, respond to single or multiple diseases and have differences in their level of knowledge and training, their practice setting and their relationship with regulatory systems.

In Mozambique, CTC providers that are formally linked with the national health system are known as *Agentes Polivalentes Elementares* (APEs) and operate under the supervision of the public health sector. There is an established recognition that CTC providers play an important role within health systems to achieve the Millennium Development Goals (MDGs), and, although considerable progress has been made, there is still a need for the formal health system to better understand the context and conditions of CTC services, to strengthen and support these critical services to realize their potential.

The concept underpinning REACHOUT is that CTC services and providers can be strengthened to enhance health systems' performance in terms of equity, effectiveness and efficiency. In fact, according to the REACHOUT project, the extent to which CTC services are successful depends on three broad and interrelated areas or determinants: national, district and local policies related to CTC providers; the interactions of CTC providers with the rest of the health system; and the community

context. These relationships develop and are influenced by a broader national social and political context.

Thus, this report aims to present the context analysis that was carried out to respond to one of the main objectives of the REACHOUT project (Work Package 1), which is to identify how community context, health policy and interactions with the rest of the health system influence the equity, effectiveness and efficiency of CTC services. This objective is the foundation of REACHOUT. It involves a multi-method context analysis that takes into account a wide range of factors influencing CTC services and their likely interdependencies.

The Mozambique REACHOUT team comprises researchers from Universidade Eduardo Mondlane (UEM). The team focused its attention on the formal CTC providers in the country which are designated APEs. The APE programme was originally conceived as a strategic solution to improve the low access to health care services of the rural population and was first introduced in Mozambique in 1978. The programme faced challenges since its implementation, and with the emergence of HIV/AIDS new types of CTC providers appeared. The Ministry of Health (MoH) decided to revitalize the APE programme in 2007 and introduced a new training curriculum, modified terms of reference and implemented a policy for payment of a monthly subsidy. This revitalized programme (including the new curriculum) was developed and approved by the MoH in 2010.

This report will present the information gathered and processed from desk review (peer-reviewed published material as well as grey literature) and from data collected during the fieldwork.

CONTEXT ANALYSIS

The context analysis, which is the first phase of REACHOUT, was designed to inform the development of an analytical framework that was planned to support the design and analyse the improvement cycles of the second phase. The context analysis consisted of four components:

- an international literature review carried out by the Royal Tropical Institute (KIT) that was used to develop a draft conceptual framework that informed the specific country context analyses;
- a desk study of the Mozambique-specific documents on health system support and details of CTC providers' programmes obtained from in-country offices (and websites) from government, universities, United Nations organizations and international and national non-governmental organizations (NGOs) conducting or researching programmes that include CTC providers;

- a mapping of CTC providers to identify the type of CTC providers in the country and, specifically, the study sites, through consultation with stakeholders including the government and NGOs; and
- a qualitative exploratory study to fill gaps in knowledge about the factors influencing the specific aspects of what works well and why.

The objectives of the context analysis were:
- to identify evidence for interventions which have an impact on the contribution of CTC providers to the delivery of effective, efficient and equitable care;
- to map the types of CTC providers;
- to assess the structures and policies of the health system for strengths and weaknesses regarding the organization and management of CTC services and providers;
- to identify and assess contextual factors and conditions that form barriers to or facilitators of the performance of CTC providers and services; and
- to synthesize evidence on key barriers and facilitators to be built on in future CTC interventions and identify knowledge gaps to be filled regarding CTC services.

A draft conceptual framework (see Figure 1) was developed by KIT based on a systematic review of international literature relating to CTC providers. It was presented to and discussed and adopted by the consortium partners. The conceptual framework provided the basis under which findings of the context analysis were to be reported under the headings of broad contextual factors, health systems factors and intervention design factors. Reference is made to this draft conceptual framework throughout the report.

Figure 1: REACHOUT draft conceptual framework

Health System Factors

- HRH
  - Current policies
  - Professional associations
- Service delivery
  - Organizational model
  - Current state of development
- Financing model
- Information (including M&E systems)
- Governance arrangements
  - Accountability
  - Regulation
  - QA
- Supplies & Logistics

Intervention Design Factors

- Intervention Focus
  - Promotive, preventive or curative
  - Health priority
  - Characteristic of target population
- HR related
  - CTC provider profile
  - Remuneration
  - Supervisory systems
  - Embedment in the formal services
  - Managing multiple workloads
- Referral systems
- Community links: community embedment, support, security, management
- M&E feedback loops
- Quality Assurance: protocols, tools, training, continuous learning
- Communication other providers and services

CTC Provider Performance

CTC Provider Level Variety of elements which beget each other

- Improved self esteem
- Improved motivation
- Improved attitudes
- Improved competencies
  - Communication
  - Diagnosis
  - Treatment
  - Referral
  - Advocacy
- Improved adherence with standards and procedures
- Improved job satisfaction
- Improved capacity to facilitate community agency

Mediating Processes: which beget each other

- Improved access (refers to improved financial, physical, social access)
- Improved quality
- Improved responsiveness
- Improved productivity
- Improved community capacity to claim rights

User End Points

- Increased and equitable utilization of services
- Improved health seeking behavior
- Adoption of practices that promote health
- Community empowerment

Impact

- Equitable reduction in
  - Morbidity
  - Mortality
- Reduction in incidence
  - HIV
  - Unwanted pregnancy
  - Others
- Improved well being

BROAD CONTEXTUAL FACTORS   **BROAD CONTEXTUAL FACTORS**   **BROAD CONTEXTUAL FACTORS**

- **Community Context** Social networks, Gender norms, Cultural practices, Beliefs
- **Political Context** (Type of polity, Security, …..);
- **Other contextual factors** (Legal system, Environment, Economy)

The report is structured as follows:

- Chapter 2 presents the desk review: from the process used to gather literature (published and grey) to synthesis obtained from analysis of the data or information;
- Chapter 3 presents information related to stakeholders with an interest in or influence on CTC providers, mainly the APE programme;
- Chapters 4, 5 and 6 look at the qualitative study developed and implemented to obtain data related to the APE programme to complement existing data analysed for the desk review; and
- Chapter 7 provides a summary but also considers the implication of analysis for the draft REACHOUT framework and highlights the opportunities for quality improvement cycles.

The importance of Chapter 7 is related to quality improvement cycles within the REACHOUT project. The 'improvement cycle' is defined as a combination of interventions focused on one problem area — such as human resource management or monitoring and evaluation (M&E) — identified through the project framework.

INTRODUCTION

CTC providers emerged in the 1970s as an essential strategic component of primary health care (PHC), particularly inspired by the success of Chinese 'barefoot doctors' (Kan, 1990). The CTC health providers were regarded as the most viable option for health service provision to communities with limited or no access to formal health care (Roemer, 1986; Walt, 1988; Chaos & Kostermans, 2002). After the famous Alma-Ata Conference in 1978, many developing countries implemented a national programme focusing on CTC health providers (Lehman & Sanders, 2007). Although the functions or roles of CTC health providers were similar in different countries, the titles that were given to them varied, with more than three dozen different names identified by some researchers (Lehman & Sanders, 2007). A clear expansion in the number of CTC health providers occurred during the late 1970s and at the beginning of 1980s in many countries, as evidence of implementation increased (Walt, 1988).

Community Health Program merited particular attention in the context of the MDGs. Many experts in public health, health systems and from international organizations such as the World Health Organization (WHO) and the Global Health Workforce Alliance (GHWA) envisaged that CTC providers could accelerate progress towards achieving the MDGs (particularly MDGs 4, 5 and 6) and lead to a reduction of morbidity and mortality in many developing countries (Victora et al., 2010; Freeman et al., 2009; WHO, 2010).

In Mozambique, the Community Health Workers trained under the MoH were designated APEs, and the national programme was first implemented in 1978 (Succato et al., 1994; MoH, 2010a; 2010b; 2010c). The programme was under exclusive responsibility of the MoH, particularly regarding the training and re-deployment of APEs in their communities of origin. However, the community was highly involved in the selection of APEs. The selection process, training package and scope of tasks defined for APEs were somehow similar to national programmes from other developing countries, including from sub-Saharan countries (Lehman & Sanders, 2007). The MoH of Mozambique viewed the APE programme as a way of expanding coverage of its PHC services; in fact the name *Agentes Polivalentes Elementares* means 'providers of multiple basic services', highlighting the PHC role which APEs provide, particularly to underserved rural parts of the country (MoH, 1977).

The main aim of this desk review was to analyse relevant published and unpublished literature to provide a better understanding of the context, scope, objectives and impact of APEs in Mozambique. It also aimed to identify gaps in existing knowledge and evidence regarding APE-related issues in Mozambique, with a view to design quality improvement interventions within the REACHOUT project.

For the purposes of this revision, the literature search involved a selective, deliberate search of bibliographic material referring to APEs since the programme's inception in 1978. The following sources were searched:

- PUBMED was searched with the aim of obtaining published literature from indexed peer-reviewed journals regarding CTC health care providers by using the following set of keywords (in English): community health workers (and CHW); primary health care worker; community-based health worker; lay health worker; and Mozambique.
- Google Scholar was used to identify additional grey literature such as government reports or other documents produced under the governmental orientation, and any other documents or reports produced by NGOs or any other organization or individuals (such as students' dissertations or theses).

In addition, several stakeholders were contacted with the aim of obtaining literature that was not found by the means described above. These stakeholders included the Mozambican MoH, as well as NGOs involved with the APE programme. Literature requested included policy documents, national and donor reports and technical briefing papers.

All materials obtained were reviewed by the Mozambican REACHOUT team to assess their relevance to the context analysis referred to above (and in alignment with the REACHOUT project framework — see Annex).

CTC PROVIDER MAPPING

When first implemented in 1978, the APEs were the only CTC health care providers in Mozambique. There were other CTC providers, such as agriculture extension providers and adult literacy workers, but not health care providers. After 1992, the for-profit private health sector emerged (Ferrinho & Omar, 2006; MoH, 2012), and the activities of NGOs expanded to overcome gaps left by public services, as a result of the Structural Adjustment Programme promoted by the World Bank/International Monetary Fund (IMF) (Pfeiffer, 2003), often with detrimental effects on the local health system (Cliff, 1993; Pavignani & Colombo, 2001). The negative impact also affected the APE programme, by promoting varied types of CTC providers with diverse types of training and work focus (many with a vertical approach, mainly related to

HIV/AIDS programmes) (Simon et al., 2009; MoH, 2010a; Maes & Kalofonos, 2013). The reports available mention several different types of CTC health care providers, but the precise numbers and types were never well assessed (Simon et al., 2009; MoH, 2010a; Maes & Kalofonos, 2013). Some CTC health providers other than APEs include the following:

- TBAs, whose role has changed recently to one of offering counselling-type services, instead of active midwifery services;
- HIV/AIDS activists (trained to provide different type of services, from counselling and testing to home-based care, antiretroviral therapy adherence support etc.); and
- community volunteers to support directly observed tuberculosis treatment (DOTs), community activities to support treatment adherence for clients with leprosy etc.

Although the role of TBAs, as mandated by the MoH, is education and promotion of good pregnancy and family planning practices in the community, the proportion of births attended by TBAs has not changed much in many remote rural districts of Mozambique (MoH, 2013).

It is important to also mention that there are an unspecified number of informal CTC health providers in Mozambique, mainly providing traditional health care services, which have often been ignored in reports and literature related to CTC providers. The literature tends to be biased towards CTC providers that have some formal interaction with the national health system. However, the Community Involvement Strategy (MoH, 2004) neglects the care provided by traditional health practitioners, although their presence and the use of their services at community level are relatively common (Audet et al., 2012).

The Community Involvement Strategy mainly emphasizes the need to strengthen participatory community initiatives, largely related to health promotion and illness prevention. These aim to change the behaviour, attitudes and practices of individuals, families and communities to promote better health (MoH, 2004).

DESK REVIEW FINDINGS

Before presenting the information analysed related to CTC providers, a brief historical background will be presented, particularly on demographic, socio-economic, political and health system aspects. Issues more specifically related to CTC providers and APEs will then be discussed.

HISTORICAL BACKGROUND

Mozambique inherited significant socio-economic asymmetries from the period of colonial rule, between urban and rural areas and between the south and the north of the country. These asymmetries were not only related to socio-economic conditions but also included access to health care services and education, among other socioeconomic issues. In 1975 the country gained independence from Portugal and promptly adopted a health system that emphasized PHC which was guaranteed only by state-managed health care facilities and health workforce (Pfeiffer, 2003). It was within this system that the APE programme was established in 1978. The programme was viewed as a convenient and quick way to expand access to health care to remote rural areas that were severely underserved.

However, the 16 years of civil war, which lasted from roughly 1976 until 1992, damaged the health sector in the country, mainly due to the destruction of health infrastructure and the disorganization of the delivery of health care services (Garenne et al., 1997). The civil war also severely hampered the APE programme (Succato et al., 1994) and caused other considerable harm in the country, leading to a worsening of poverty, famine and other socio-economic problems (Cliff & Noormahomed, 1988; Garenne et al., 1997).

In the mid-1980s, Mozambique embarked on political and economic reforms with the support of the IMF, the World Bank and other international donors. These reforms led to liberalization of the economy and to a new multiparty Constitution of the Republic even before the peace agreement in October 1992 (MoH, 2012). However, the reconstruction of health infrastructure destroyed during the civil war only began after the peace agreement and was highly dependent on contributions from international partners. It occurred at a pace not always adequate to meet the country's pressing needs (Yates & Zorzi, 1999; Pavignani, 2001; Frenk, 2009). After 1992, significant development of the private socio-economic sector occurred, including the emergence and expansion of a for-profit private health sector (Ferrinho & Omar, 2006; MoH, 2012).

This new setting also led to an expansion of the activities of NGOs to overcome gaps left by public services, as a result of a Structural Adjustment Programme promoted by the World Bank/IMF (Pfeiffer, 2003), often with detrimental effects for the local health system (Cliff, 1993; Pavignani & Colombo, 2001). Some of the negative effects reported included: the existence of multiple NGOs with competing interests and duplicating support programmes; the establishment of parallel service delivery programmes; burdening health workers with duties other than those that were part of their routine; contributing to inflationary pressures on the per diem rates; and interfering with the planning processes for local services (Pfeiffer, 2003).

According to Pfeiffer (2003):

> "The per diem phenomenon had immediate detrimental effects on some routine community health programs. In the early post-independence period, mobile vaccination brigades initially relied on local communities to provide food and lodging to visiting vaccination teams. However, by the early 1990s, as salaries plummeted large per diems were routinely paid to mobile brigades. Unneeded district personnel often accompanied brigades in order to receive the per diem payments. Much of the funding for per diem was distributed per NGO by district."

The NGOs had a vertical approach to their programmes, which had a negative impact on their interaction with formal public health services, including a lack of harmonization of the types of CTC providers, with different NGOs providing different training for CTC providers, resulting in CTC providers with differing roles and responsibilities, and duplications of activities and conflicting interventions (Simon et al., 2009; MoH, 2010a; 2010c; Maes & Kalofonos, 2013).

To resolve some of the problems caused by the presence of NGOs, the Mozambican MoH signed codes of conduct with donor agencies and NGOs (MoH, 2000; 2005). These agreements are aligned with what is known as the Sector-Wide Approach (SWAp) process, which seeks better-coordinated external support to national health services (Pfeiffer, 2003). There were some positive outcomes, particularly after the Kaya Kwanga Commitment signed in May 2000, such as more resources directed towards building the capacity of the national health system (Pavignani & Colombo, 2001). Coordinated efforts of NGOs, partner countries and international funding agencies have also been put in place to revitalize and support implementation of the APE programme since 2010.

In this report, the revitalized APE programme will be analysed. The process of analysis will include desk review (published and grey literature) and data collection and analysis from fieldwork carried out specifically to support the study of the country context.

GEOGRAPHIC AND DEMOGRAPHIC CHARACTERISTICS

Mozambique is situated on the east coast of southern Africa (see map). It is divided into 11 provinces, each with its own capital, but Maputo City is the capital of the country. The 136 districts are sub-divided into localities and administrative posts. The provinces are grouped in three regions: Southern Region (Maputo City, Maputo Province, Gaza and Inhambane); Central Region (Sofala, Manica, Tete and Zambézia); and Northern Region (Nampula, Cabo Delgado e Niassa). The country's climate is tropical, with two main seasons: the dry and relatively cooler season, and the warm

and humid season. Mozambique has approximately 23.4m inhabitants and population growth decreased from 2.7% to 2.4% from 1997 to 2003 (NIS, 2003; MoH, 2012).

Just over half (55%) of adults are literate, and 62% of the population resides in rural areas. Access to drinkable water is relatively low in Mozambique (47%) when compared to other countries in the same region (68%). Similarly, life expectancy in Mozambique is estimated to be 49 years — lower than the average of 56 years in other sub-Saharan countries (MoH, 2012).

According to the MoH of Mozambique (2012), citing the United Nations, the rate of urbanization almost doubled from 21% in 1990 to 38% in 2010. The percentage of the population living below the poverty line is estimated to be 54.7% and has been constant since 2003. The proportion of women with no formal schooling has decreased from 43% in 1997 to 31% in 2011, while women with primary- and secondary-level schooling has increased from 4.4% to 18.5% in the same period (NIS, 2012).

According to the National Institute of Statistic (NIS) of Mozambique (2007), 45% of the population is younger than 15 years, and 20% are aged between 15 and 24 years. The population density is 20 inhabitants/km^2, and higher along the coast than in inland. Women comprise 53% of the population, of which 24.9% are of fertile reproductive age. Children under the age of 5 comprise 17% of the total population, and 4% of the population are under 12 months of age. The overall population below 18 years of age corresponds to about 50% of the total population of Mozambique (NIS, 2007; 2012).

SOCIO-ECONOMIC PROFILE

Mozambique shifted from being a socialist to a market-oriented economy with the introduction of a Structural Adjustment Programme in 1987, promoted by the World Bank/IMF. However, Mozambique continues to be regarded as one of the poorest countries in the world, with 60.7% of the population living in extreme poverty and Gross Domestic Product (GDP) per capita estimated to be US$906 in 2012 (UNDP, 2013). The main source of the country's economic growth is agriculture, which has been cyclically affected by natural disasters. Several studies regarding Mozambique's economic development carried out by researchers from the Instituto de Estudos Sociais e Económicos and others, with different analytical perspectives such as its structural dimensions, the exploration of natural resources and economic

dependence, among others, suggest that the country's economic growth is still only marginally able to reduce poverty and to have a positive impact on the health and educational sectors (Boom, 2011; Castelo-Branco, 2010a; 2010b; Castelo-Branco et al., 2010). Table 1 presents selected macroeconomic indicators.

Table 1: Selected macroeconomic indicators for Mozambique

Indicators	Value	Year	Source	Value	Year	Source
GDP (billions of US$)	4.333	1998	IMF, 2008	8.069	2007	IMF, 2008
GDP per capita (US$)	433	1998	IMF, 2008	843	2007	IMF, 2008
Annual GDP growth (%)	1.1	2000	WB, 2008	7.0	2007	WB, 2008
% of GDP spent on health	4.0	1998	WHO, 2008	4.7	2008	WHO, 2008
% of public budget spent on health	9.0	2000	UNDP, 2007	1.,0	2004	UNDP, 2007

Note: IMF = International Monetary Fund; WB = World Bank; WHO = World Health Organization; UNDP = United Nations Development Programme). This table is based on UNDP, 2007; UNDP, 2009; UNDP, 2013; World Bank, 2008a.

HEALTH SECTOR CHARACTERISTICS

After independence, in 1975 the country adopted a national health system covered only by the public sector, as all existing health facilities were nationalized and private practice abolished. The priority was to deliver PHC as extensively as possible, with expansion to rural areas in a context of limited coverage of health services, which were largely confined to urban areas. For a short time and based on evidence of progress, the approach was regarded as a model of best practice, attracting considerable international interest and support. However, soon the system collapsed, due mainly to a deepening of the civil war, worsening of the delivery of rural health services, disruption of the supply of drugs and devastation of the country's economy.

After the peace agreement in 1992, the MoH of Mozambique undertook a comprehensive policy review focused on post-war rehabilitation of health facilities and acceleration of the training and deployment of the health workforce, including the creation of new categories of mid-level cadres to address workforce shortages and to deliver PHC services. Private practice re-emerged (Sidat et al., 2010). The private sector was made up of for-profit and non-profit health care delivery services, and the community sector involved APEs and other health care services offered by multiple providers (public sector and private non-profit sector, mainly NGOs).

The administrative machinery of the MoH of Mozambique is organized into three levels: the central level corresponding to the MoH itself; the provincial level made up of 11 Provincial Health Directorates; and the district level represented by the District

Directorate of Health, Women and Social Affairs. Since 1992, progress has been made by the national health system, which accompanied overall socio-economic improvements in the country (MoH, 2012). Government spending on the health sector increased considerably during the period of rehabilitation of the health infrastructure and accelerated training of the health workforce (Noormahomed & Segall, 1993). Currently, the Mozambican health system is sub-divided into three sectors: the public sector, made up of four levels of health care service delivery with a main focus on PHC (see Figure 2). PHC centres refer to district- and regional-level hospitals, provincial hospitals and national referral centres in a hierarchical manner.

Figure 2: Distribution of Mozambican health care services (by four levels)
(Source: MoH, 2007a; 2007b)

Since independence, the services provided by the MoH have been regulated by the five-yearly plans and other government policies, strategies, rules and regulations. Box 1 highlights some of the outcomes defined in the Health Sector Strategic Plan (*Plano Estratégico do Sector de Saúde — PESS*).

Box 1: Outcomes of the PESS II (2007–2012)

The PESS II guides the health sector in terms of objectives and strategies. It aims to ensure that provincial and district levels articulate the means by which these objectives and strategies can be achieved. It also constitutes a tool for monitoring the achievements of targets and indicators. Expected outcomes for PESS II included:

• increased access to health services;
• consolidation of the PHC approach and integrated service delivery;

> • *strengthened referral system and continuity of care;*
> • *improved quality of services delivered at all levels;*
> • *improved functioning and performance of health care facilities at all levels of care;*
> • *guaranteed, adequate and early response to emergencies and epidemics;*
> • *a strengthened community participation approach;*
> • *promotion of a collaborative approach with other health care providers; and*
> • *improved inter-sectoral collaboration.*
>
> *(Source: MoH, 2012b)*

Although clear progress has been made by the national health system in recent years, there are still considerable constraints related to limited health service coverage of the country (estimated to be below 50%) and the high dependency on external funding from donor (partner) countries (estimated to be between 50% and 70%) (MoH, 2012b). Table 2 presents some selected health indicators.

Table 2: Selected health indicators

Indicators	Values
Infant mortality	*93 per 1000[1]*
Mortality of children under 5 years of age	*138 per 1000[1]*
Maternal mortality	*500 per 100,000[1]*
Chronic undernourishment	*44%[1]*
Vaccine coverage rates	*DPT3: 71%[2]*
	Measles: 64%[2]
HIV infection prevalence (15–49 years)	*11.5%[3]*
Main causes of morbidity and mortality: transmissible diseases such as malaria, HIV/AIDS, tuberculosis, diarrhoeal disease and acute respiratory infections, and non-transmissible diseases such as cardiovascular diseases, diabetes, injury and death related to trauma and violence	

Sources: INSIDA, 2009; World Bank, 2008a; 2008b

There is no doubt that the disease profile is changing in Mozambique, as in other sub-Saharan countries. While transmissible diseases such as malaria, tuberculosis, diarrhoeal disease and acute respiratory infections, malnutrition and maternal complications persist, a recent increase in HIV infections and an upsurge in cases of chronic vascular diseases, diabetes, chronic respiratory conditions, trauma and violence are contributing considerably to the burden of diseases and other harms afflicting the country's health system.

The Community Involvement Strategy emphasizes the need to strengthen participatory community initiatives, largely related to health promotion and illness prevention. These aim to change the behaviour, attitudes and practices of individuals, families and communities to promote better health (MoH, 2004), and the APE programme is well positioned to address these priorities.

APE PROGRAMME: FROM INCEPTION TO NOW

The APE programme was first implemented in 1978, soon after the celebrated Alma-Ata Conference (Succato et al., 1994; MoH, 2010a; 2010b). The programme was the exclusive responsibility of the Mozambican MoH, particularly regarding the training and re-deployment of APEs in their communities of origin. The MoH viewed the APE programme as a way to expand coverage of its PHC services, particularly to underserved rural parts of the country (MoH, 1977), and the newly revitalized programme carries forward the same community focus.

The initially conceived programme faced a number of challenges, and a critical review (often called the 'Swiss Report') outlined a number of insurmountable challenges that led to a complete rethink of the design of community health services in the country (Succato et al., 1994).

In addition to learning lessons from the review of the initial programme and inputting these into the design of the revitalized programme, a qualitative baseline study was conducted on community expectations with a wide range of representation from across the whole country. This raised — among other issues — the importance of the APEs as a 'bridge' between communities and health facilities and the widespread community expectation of curative services continuing (MoH, 2010a).

Table 3 summarizes similarities and differences between the initially conceived programme and the currently implemented revitalized programme. This summary is a result of desk review and personal experience of the authors of this report.

LESSONS LEARNED FROM THE APE PROGRAMME IMPLEMENTED FROM 1978

After independence there was an emphasis on PHC, and within this the APE programme was developed and then implemented in 1978. The aim of the programme was to rapidly expand health care to the rural areas which were underserved because the distribution of health care facilities inherited from the colonial period had favoured urban areas. Between 1978 and 1988, a total of 1500 APEs were trained and deployed to serve their communities of residence or origin (Bhutta et al., 2010). However, with the intensification of a civil war which lasted until 1992, the

programme faced great challenges, particularly in supervising existing APEs and also in training new ones.

After 1992, and with the increasing burden of the HIV/AIDS epidemic, different types of CTC providers emerged with diverse lengths of training and scopes of work, mostly with vertical approaches focused on particular health programmes or illnesses. This created chaos in the communities they served, such as duplication of services provided, discontentment with the different levels of subsidy and other incentives provided by NGOs, and the lack of accountability of NGOs to the MoH. This led to the MoH declaring the suspension of the APE programme in the early 1990s (it is unclear whether this happened in 1978 or later, as data are lacking regarding this issue) (Bhutta et al., 2010; MoH, 2010). However, although new APEs were not selected and trained under the MoH, it continued to provide medicines (Bhutta et al., 2010).

According to the report of an evaluation of the APE programme funded by the Swiss Cooperation and published in 1995, the main constraints were (Succato et al., 1995; Bhutta et al., 2010; MoH, 2010):

- there were considerable problems with the training of APEs, with different curricula and methodologies implemented mainly by NGOs supporting the MoH's 'vertical programmes';
- APEs felt abandoned because supervision was almost inexistent and because of a progressive decrease in support from the national health system, although many continued to receive medication kits specifically prepared by the MoH with medications and supplies for APEs;
- APEs were regarded as volunteers and supposed to receive support from their communities (i.e. helping with their subsistence farming, providing foodstuffs, giving presents as recognition of their work etc.), which started to become scarce;
- NGOs implemented a system of subsidies and provided other incentives for those health care workers under their supervision, which led to increased frustration among existing and active APEs in the early 1990s;
- APEs were seeking opportunities to become part of the national health system and were frustrated at not being able to do so; and
- communities viewed APEs as health service providers and demanded more curative services from them, which also led to some APEs becoming a type of 'private health care provider' and charging fees for their services.

In fact, the emergence of the HIV/AIDS epidemic and its intensification in Mozambique led to a progressive growth in the number and diversity of CTC providers, as indicated by Simon et al. (2009) and mentioned by the MoH (2010) in its document on the revitalized programme. Many of these CTC providers operated independently from existing MoH-led APEs (Maes & Kalofonos, 2013).

Table 3: Summary of similarities and differences between the APE programme conceived and implemented between 1978 and the late 1990s and the current revitalized APE programme implemented since 2010[1]

Characteristics	1978 to late 1990s	2010 onwards
Selection of APEs	- Active involvement of the community and based on criteria defined by the MoH	- Active involvement of the community and based on MoH-defined criteria
Training of APEs	- Defined by the MoH and implemented by selected experienced health workers; - APE training centres established in some provinces; - APE training curriculum developed as well as teaching/learning materials; - Length: 6 months	- Defined by the MoH and implemented by selected experienced health workers; - APE training provided in all districts; - APE training curriculum developed as well as teaching/learning materials; - Length: 4 months
Deployment of APEs	- To communities of origin	- To communities of origin
Scope of work of APEs	- Focus on PHC (health promotion, disease prevention and limited curative work)	- Focus on PHC (health promotion, disease prevention and limited curative work); proportion of curative tasks limited to 20%;
Supervision of APEs	- By health workers from health facilities of the catchment area and from the District Health Directorate; - Irregularly supervised	- By health workers from health facilities of the catchment area and from the District Health Directorate; - Efforts in place to regularly supervise
Remuneration of APEs	- Regarded as volunteers and relying on the goodwill of their community members	- Paid a basic subsidy defined by the government (currently dependent on donor funding)
Relationship with the community	- Community engagement in the selection process mainly	- Community engagement in the selection process and supervision of APEs
Relationship with health sector	- Regarded as providers of basic health services where health service coverage was scarce, but not always well supported and irregularly supervised	- Regarded as providers of basic health services where health services coverage was scarce, but efforts are being made to provide all necessary support and supervision
APE programme funding	- Relying on government funding at the start and later with the support of NGOs (mainly after 1992)	- Planned to be funded by the governmental budget, but currently dependent on donor funding (for training, subsidy payment, some of the supervisory activities;

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[1] This table was elaborated based on desk review (Bhutta et al., 2010; MoH of Mozambique, 2010b; 2012b; Succato et al., 1994) and personal experience of the authors of this report.

Overall, the process for selecting APEs remains unchanged in the revitalized programme when compared to the 1970s. There is substantial involvement of community members and leaders. The candidates are selected by communities based on the following criteria defined by the MoH (2010): being aged 18 or over; being a resident and active member of the community and well respected by fellow community members; and having at least minimal literacy (able to read and write in Portuguese) and numeracy (able to perform basic arithmetic calculations). Preference was given to women candidates (although in practice more men were selected for reasons yet to be better studied).

The decision to start an APE selection process is commonly agreed between the community leadership and the district health authorities. The APEs are theoretically placed to serve around 500 to 2000 inhabitants (depending on population density and geographical coverage) and should ideally be working in an area between 8 and 25km from the health facility of their reference — far enough to cater to underserved populations and close enough to allow appropriate supervision and support from the health system staff (MoH, 2010b). Because coverage of health services in Mozambique is quite low (around 40%), there is persistent pressure from the communities for the MoH to instruct and deploy APEs even in areas that are further from the established limits. After being trained, the APEs are deployed to their communities of origin or residence.

APE TRAINING

The development and delivery of the APE training curriculum is and always has been the responsibility of the MoH, implemented by experienced health workers linked with the formal health system. The initial programme had established APE training centres in some provinces, but in the new revitalized programme APEs can be trained in any district if experienced health workers are available and able to be trainers. In the current programme, almost all of the training happens away from the health facility, while before it used to be within the health facility. The main reason behind this shift of policy is that while in health facilities, APEs in training were being 'used for' and 'exposed to' health care skills and competencies which they often went on to apply in their communities without appropriate supervision and supplies. Examples include giving injections and treating wounds and other illnesses that are beyond their scope of work (Succato et al., 1994).

The training originally lasted six months but was shortened to four months with the revitalized programmed. The emphasis continues to be on health promotion and disease prevention, with curative training limited to testing and treating malaria in children and adults; diagnosing diarrhoea and dehydration, using oral rehydration

solutions; and diagnosing and treating acute respiratory infection in children. Additionally, APEs are trained to provide first aid and to detect danger signs in children, adults and pregnant women (MoH, 2010).

Training is officially supposed to take place in Portuguese, but in practice local trainers often explain concepts in the local language. Support materials (one reference manual per student) should be made available to trainees to accompany training (see Figure 3).

Figure 3: Training materials for APEs
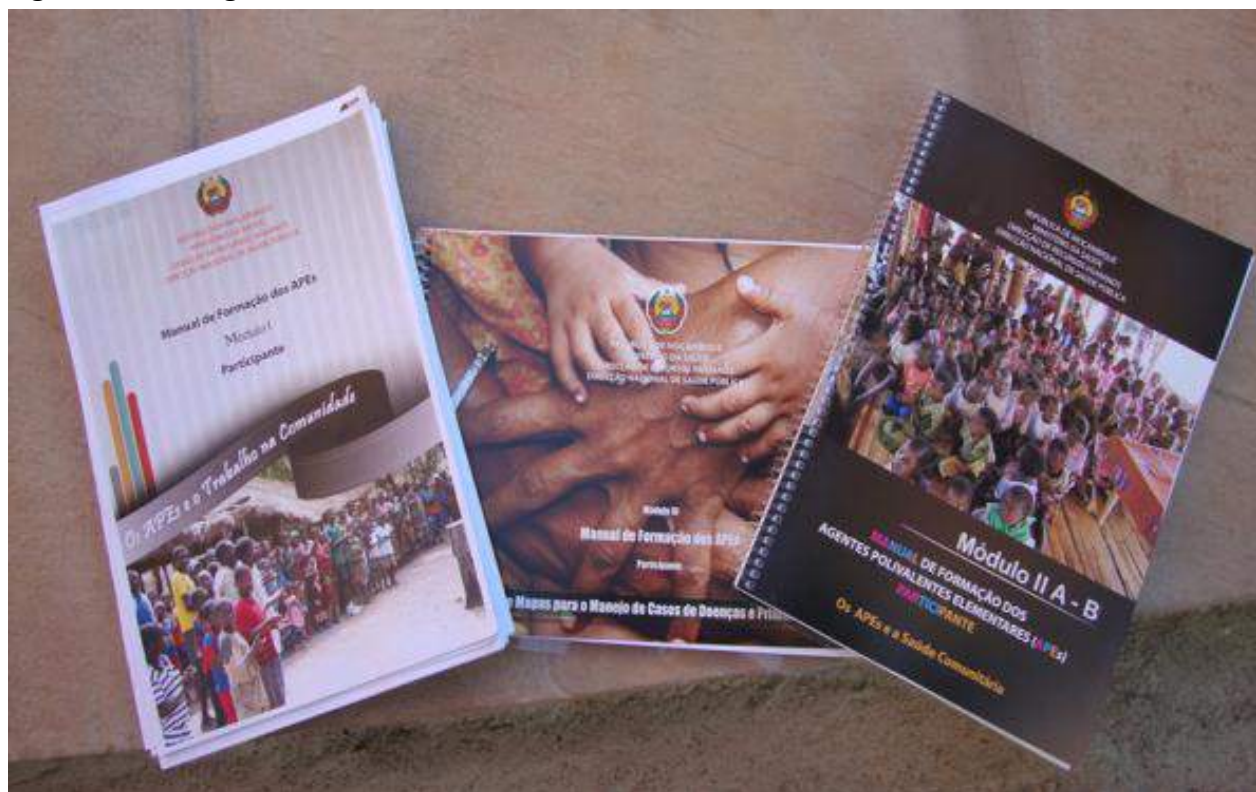
SCOPE OF WORK OF APES

The job description of APEs currently states that they should spend 80% of their time on health promotion and disease prevention activities and the remainder on curative activities (MoH, 2010). The initial APE programme had a similar emphasis, but circumstances led them to dedicate most of their time to curative work, as stated by Succato et al. (1994). There is considerable demand and pressure from community members for APEs to provide more curative services, mainly because clients have limited or no immediate access to health care services other than those offered by APEs or other CTC health providers (if existent in the community) (Succato et al., 1994).

SUPERVISION OF APES

It has been specified in the previous and current APE programme (MoH, 2010) that the supervision of APEs should be carried out by health workers from health facilities of the catchment area and by health workers from the District Health Directorate. However, the previous programme experienced difficulties in carrying out regular supervision, mainly due to constraints caused by the civil war as well as due to a lack of resources (human, transport and funds). The current programme established resource allocation, mainly in the form of funding provided initially by partner NGOs and health system funding agencies, to allow regular supervision. However, supervision constraints exist also for other health care workers and at different levels of the health system (MoH, 2013).

REMUNERATION OF APES

The previous programme regarded APEs as volunteers, and they had to rely on either the goodwill of their community members or charging fees for curative services (Succato et al., 1994). The current programme established an allowance or subsidy (equivalent currently to US$45 per month) to be paid by government bodies at district level (currently dependent on donor funding). To facilitate their private practice, they used health posts and made use of medication and other medical supplies that were provided to them each month to maintain their practice even though they were not supported technically or supervised appropriately (Succato et al., 1994). Because APEs were setting up private clinics in health posts, the MoH abolished health posts altogether in the revitalized programme.

The current programme requires APEs to be mobile and perform regular home visits to their fellow community members, instead of being stationary in health posts (MoH, 2010). Additionally, APEs are forbidden to charge fees for their services. This is emphasized to APEs during training, and also to community members at public gatherings. The rationale is that because they are paid a subsidy, APEs have no reason to charge a fee for the services they provide to community members.

POSSIBLE BARRIERS TO AND FACILITATORS OF THE REVITALIZED APE PROGRAMME

Using the REACHOUT conceptual framework outlined in Chapter 1, we reviewed the local literature to identify additional facilitators and barriers related to the broad contextual factors, the health system factors and the intervention design factors. Two reports in particular are of relevance here: MISAU (2012) and UEM (2013).

Broad contextual factors

The revitalized APE programme has been facilitated by the political imperative and push for improved health coverage, the current economic stability which resulted in donor commitment and the establishment of policies that have learned from past mistakes. Gender is regarded by some as a barrier to the programme. Currently (and historically) around 71% of APEs are male, although his varies by region and is falling over time. This gender imbalance presents a mismatch with client expectations and can also be a cultural barrier to visiting pregnant women and newborn babies. Some reports call for mechanisms for horizontal communication, taking as reference knowledge about APEs, community health and disease and cultural issues that may influence the implementation of the programme. There is also a need to promote greater awareness of the programme among community leaders and community members, clarify aspects of the new methodology which are not well accepted, and discuss the reasons why they are considered effective in terms of the programme's objectives.

Health system factors

Current policies and organizational delivery models of APE service delivery support a strong programme, complemented by training curricula that can be rolled out effectively with quality assurance and standardization. A number of barriers remain regarding financing and the sustainability of the programme, including integration of former APEs in this programme, and the payment of subsidies (MISAU, 2012; UEM, 2013). Supplies were described as regular in contexts where NGOs are issued kits but irregular in other contexts. Transport was a major challenge; while bicycles were issued, their supply and maintenance was described as irregular.

Intervention design factors

APEs in the revitalized programme have a clear focus on children's health, and the balance between curative services, on the one hand, and promotive and preventive services, on the other, is well described. A number of barriers were described in the report about the human resource management of this cadre. Of particular note in available reports were the weak monitoring, supervision and feedback systems for APEs. APE supervisors have a dual role as APE supervisor and health facility worker in the programme, and their supervision and monitoring of the APEs in communities is crucial to the programme's success. In particular, the allocation of resources for transportation/fuel to enable the movement of supervisors to the communities and the APEs to the health facilities was a recurring theme. While referral systems were laid out in policy, this may be different from practice, and the reports concluded that there was a need to increase measures that foster greater communication between communities, the health facilities and the district headquarters. Finally there was an expressed need to adapt the working methodology of the APEs to match their abilities,

the type of roads on which they have to travel and the communities that they serve to the wishes and interests of community members.

CONCLUDING REMARKS AND LIMITATIONS

Overall, it could be said that there is a scarcity of published and unpublished literature regarding CTC providers, although the APE programme was first established more than three decades ago. After the emergence of the HIV/AIDS epidemic in the country, diverse types of CTC providers emerged, but very little has been written and published about them, either in reports or peer-reviewed articles. However, we could not exclude reports of those working with different types of CTC providers eventually produced for diverse purposes and the knowledge of which is lacking among those who are presently working, whether at the MoH, NGOs or other organizations.

In fact, because there are poor record-keeping practices at the MoH, NGOs and other organizations, it becomes difficult to obtain everything written on the subject of interest of this report. This constitutes an important limitation to bear in mind. Before presenting analysed information related to CTC providers, a brief country context description will be presented, particularly on demographic, socio-economic, political and health system aspects. More issues specifically related to CTC providers and APEs will then be presented.

Studies indicate that implementation of the new methodology of the APE work ('going from house to house') could experience difficulties, and warn of the urgent need for further clarification. It is considered urgent to adapt this methodology to the capabilities/physical conditions of the APEs and to the type of roads in the communities. While bicycles are being distributed to the APEs, the poor state of roads makes home visits to elderly people and communities very difficult.

There are many stakeholders somehow interacting with CTC providers, but there is no systematized information regarding who are they and their exact role within the CTC system. Thus, with the existing challenges, the team made an effort to identify organizations that were known to interact with CTC health service provision in the country and in the selected REACHOUT province and districts in particular (Table 4).

Table 4: Stakeholder roles in the APE programme and their link to REACHOUT

Category	Stakeholder active in REACHOUT province	Role in APE programme	Link to REACHOUT
Government stakeholders	Ministry of Health	Implementation and oversight of the programme	CAG members
	Ministry of Public Service		
	Ministry of Finance		
International donor/cooperation agencies	WHO	Support the programme in different ways (funding, logistics and materials)	CAG members
	UNICEF		
	UNFPA		
	World Bank		
	USAID		
	Swiss Cooperation		
	Irish Aid		
	Canadian Cooperation Agency		
Local NGOs	Foundation for Community Development		CAG members
	Catholic Church Programme Religious organizations in Moamba	Support in logistics and allowances	
International NGOs	PATHFINDER		
	JHPIEGO		
	JICA		
	Save the Children		

Interaction with the REACHOUT team

The international agencies and NGOs are active in provinces that were purposefully selected after agreement with the MoH, to avoid duplication of interventions in the same provinces. Thus, for example, within the REACHOUT project that has defined Maputo Province as its study and intervention site, there are very few stakeholders, and those available have been invited to be part of the Country Advisory Group (CAG).

OUTCOMES

Our stakeholder mapping exercise revealed a well-coordinated centralized approach that controlled and coordinated stakeholder inputs for the APE programme in each province. This had the advantage of having clearly defined tasks, links to other programmes supported by the same donors and/or NGOs and a narrowing of the duplication of efforts and, instead, allowing completion of eventual gaps in the national health system by supporting vertical or integrated programmes.

In Mozambique, REACHOUT is working with the MoH, in particular the national revitalized APE programme, which creates similarities with the government programme. Most of the organizations selected as a CAG member are supporting this programme; however, some of these organizations are working particularly in HIV and integrated community case management (iCCM).

According to these institutions' interest in and alignment with the project, the Mozambique REACHOUT team remains a permanent contact by participating in awareness-raising and knowledge-sharing activities, workshops, training courses and biannual stakeholder meetings; influencing policy; issuing invitations to attend presentations of research findings; briefly sharing research/objective reports; and using consultative/collaborative research practices.

In the meetings held with different stakeholders, some outcomes were noted that may support our improvement cycle strategies. Some participants identified reduced and delayed subsidy payments, drug stock-outs, inadequate transport, the lack of financial and human resources, weak communication and the lack of refresher training as barriers to the effective implementation of the programme. Some factors identified as facilitators were: a well-structured national programme, the experience of the MoH in managing the programme, the involvement of older APEs with experience, and community engagement.

These actions ensure continued communication among these partners and their strong commitment to guarantee effective and efficient participation. We believe that these strategies can enhance and stimulate their participation in the project and create synergies for the benefit of all parties involved. These organizations will help REACHOUT to influence policymakers to create a better link between public health policies and community health interests.

OBJECTIVES

MAIN OBJECTIVE

The aim of the REACHOUT study is to maximize the equity, effectiveness and efficiency of CTC health care services in rural areas and urban slums. The qualitative study is part of a context analysis whose purpose is to develop an analytical framework that will be used to design improvement cycles and to explore barriers and facilitators, opportunities and constraints in existing CTC programmes in Mozambique.

SPECIFIC OBJECTIVES

The objectives defined for the context analysis were to:

- identify evidence of interventions that result in effective, efficient and equitable care by community health care providers;
- map the types of community health care providers;
- evaluate the structures and policies of the health system to identify the strengths and weaknesses in the organization of community health services and their management;
- identify and assess contextual factors and conditions that form barriers to and facilitators for the performance of community health care providers; and
- synthesize evidence about the main barriers and facilitators to be developed in future interventions and identify knowledge gaps to be filled in relation to community health services.

STUDY DESIGN

This exploratory qualitative study followed a participatory approach to the discussion of APE-related work in the study communities. Qualitative research was conducted through in-depth interviews (IDIs) and focus group discussions (FGDs) to explore and understand all aspects regarding the development of the improvement cycles. This approach allowed a full and detailed identification of issues relating to experience and context as well as regarding the APEs' activities and programme. IDI and FGD topic guides focused on context and community, programme management and the experiences and perceptions related to the APE programme. IDIs were conducted with APEs, supervisors and community leaders, and FGDs with APE clients (mothers of children under five years of age).

The fieldwork was conducted in two districts: Manhiça and Moamba. The selection criteria for these districts were based on their geographical situation, being hard to access and having the APE programme running (in line with the REACHOUT principles regarding the quality and equity of community health services).

Manhiça

The district of Manhiça is located approximately 80km from the northern part of Maputo Province and has a population of about 192,638 inhabitants; more than 50% are young and female. Its health network, despite being significantly evolved, is still insufficient to meet the national standards for health service provision; instead, there is one health facility for every 8730 inhabitants, one bed for every 665 people and one health care professional for every 1600 people (MAE, 2005a).

The epidemiological status of Manhiça district and community is dominated by malaria, diarrhoeal diseases, sexually transmitted infections and AIDS, which represent almost all notified cases every year. It is estimated that 58% of the population is illiterate, with differences between women and men in the administrative posts visited: in Calanga 70.2% of women and 46.4% men are illiterate; in Maluana 63.4% of women and 37.9% of men (MAE, 2005a).

Moamba

The district of Moamba is located in the northern part of Maputo Province and has a population of about 43,396 inhabitants, mostly young and female (53%). Its health network, despite some progress, is still insufficient to improve on the following average indices: one health facility for every 7800 inhabitants, one bed for every 419 people and one health care professional for every 1390 people (MAE, 2005b).

The epidemiological status of the district is dominated by malaria, pneumonia, HIV and sexually transmitted infections (MAE, 2005b). The similarities between Manhiça and Moamba, especially in the communities visited, include the difficult access to health services due to the poor coverage of the health network and deficient access to roads and transportation. Factors related to transportation, the poor coverage of the health service network, drought and illiteracy mean that these communities are vulnerable with regard to inequitable access to quality health services.

Administrative posts

Within the districts, administrative posts were chosen by convenience sampling, taking into account geographical location, the number of APEs, access to health facilities, the presence of older APEs and geographical accessibility. According to these criteria, two

administrative posts were selected in Manhiça (Maluana and Calanga) and one in Moamba (Sabié).

In both districts (Manhiça and Moamba) and their selected administrative posts, the APEs were selected based on representation in terms of age, sex and geographical location. Mothers (service clients), supervisors and community leaders were chosen, taking into account the community where the APEs worked. The managers included in the study were selected based on being the representative at district level overseeing the APEs. The term *gestores* ('managers' in Portuguese) includes APE supervisors at health facility and district levels, and we have analysed these together as one category of managers.

The REACHOUT project team held sensitization meetings with participants and personnel interested in the project, to explain the project and their participation. These were national, provincial and district-level directorates of the APEs, health facility supervisors of APEs and community members. Almost 15 days before the study was carried out, the team sent a formal letter to the province- and district-level directorates and requested permission for the study. During the study, the district coordinators of the APEs supported the team in locating the selected APEs, and support was also given by the community leaders.

The selection of health facilities and communities was done in collaboration with the District Health Directorates of Women and Social Affairs, taking into account the availability and provision of the APEs and the access roads to these communities.

All participants were informed about the study by the research team, and were asked whether they wanted to participate. People who agreed to participate were requested to give individual consent.

DATA COLLECTION INSTRUMENTS

Topic guides were developed for use in all IDIs and FGDs to ensure that all issues were effectively covered. The use of semi-structured topic guides allowed the respondents themselves to dictate the flow of discussions with guidance from the moderator, and a qualitative approach is more flexible than a quantitative approach.

Four data collection tools (one FGD and three IDI guidelines) were developed (see Annex 3):
- topic guide for IDIs with APEs;
- topic guide for IDIs with supervisors/managers;
- topic guide for IDIs with community leaders; and

- topic guide for FGDs with mothers.

The fieldwork took place during July and August 2013 in Maputo Province, in the districts of Manhiça and Moamba. The research team collected data under the supervision of the Principal Investigator.

During the fieldwork, the district supervisors supported the research team on the location of the communities and the first contacts with the APEs. The APEs supported the team in communicating and selecting participants for FGDs and IDIs with community leaders and mothers of children under five. Guided by these procedures, 18 communities were visited. Ten were from Manhiça — namely, Chichongue, Barrica, Doane, Lagoa Pati, Pateque, Pondzoene, Maluana, Chirindza, Mobane and Calanga; and eight were from Moamba: Mahungo, Goane 2, Mukhakazi, Sabié-Valha, Sabié-Missão, Baptine, Langa-Boi and Mavunguane.

Community leaders, clients and APEs were interviewed in their own communities, with the exception of some in Moamba who were interviewed in their district headquarters during a continuous training. Health managers were interviewed at their workplaces, district directorates and health facilities. The interviews were recorded by digital voice recorders and kept in secure files belonging to the Mozambique REACHOUT team.

Portuguese transcripts were made from digital recordings (that were in Portuguese or local language depending on the circumstances and the ability of respondents to ask Portuguese) and double-checked by another researcher. The qualitative data analysis was performed by reading and re-reading the transcripts and identifying emerging themes and sub-themes. A frame for coding (see Annex 5) was developed based on the draft REACHOUT framework, used to generate the topic guides, and themes arising from the data/transcripts. Transcripts were entered and coded with management software used for electronic qualitative data analysis (Nvivo 10). Then, queries were run according to the main codes and sub-codes, and more complex queries looking at sub-groups. Draft narratives were written, reviewed and discussed. Additional analysis was performed to identify the contextual factors that need to be taken into account for the development of the first cycle of improvement.

Care was taken in the following ways to ensure that the data collected were accurate:
- the researchers were familiar with the data collection tools and were given clear guidance by the Principal Investigator;
- only researchers with experience in data collection and committed to data quality were used for the study;

- the IDIs and FGDs were recorded, transcribed and verified independently by researchers and the Principal Investigator; and
- a group of local experts and partners of the Liverpool School of Tropical Medicine (LSTM) and KIT with extensive experience in social sciences, health and gender were involved in the analysis to ensure that the data were interpreted from a variety of professional backgrounds. Stakeholders brought different perspectives to the study and data.

Due the respondents' limitations in communicating in Portuguese, including most clients, community leaders and some APEs, we had to use local languages during almost all interviews and FGD discussions, as a way to guarantee the quality of data collection.

The fieldwork was carefully monitored and continuously supported by the Principal Investigator. Each researcher presented daily progress of the activities to the Principal Investigator, ensuring that all work was carried out as scheduled.

STUDY LIMITATIONS

As related to our approach, the recruitment of study participants is considered a limitation, as APEs were involved in selecting and recruiting participants for the community FGDs with mothers and the IDIs with community leaders; this may have led to bias in these respondents' answers. Another issue of bias in sampling may have been that APEs tended to select participants who were living in close proximity to where the discussion was to be held (the village with the health post to which the APE was attached) and, therefore, also lived closer to the health post and had easier access to the APEs and their services. Other APEs mentioned that they might have selected those they knew well or with whom they had a good relationship.

The decision to limit interviews with service users to women with children under five was made in view of the focus on children's health, and this presents a possible limitation given the findings that many APEs focus on curative services and often treat adults as well.

Many rural areas in Mozambique are hard to access by cars (including 4x4 vehicles), bicycles or even walking, and this meant that time management of data collection became a concern; this was another reason to select respondents not living too far from easily accessible locations.

Furthermore, as is the case of many developing countries, in Mozambique the level of education of community members, including our respondents, is relatively low, and this influenced the level of understanding during data collection as well as the need for

additional layers of translation, from local languages to Portuguese and from Portuguese to English, with a potential loss of fidelity in transcribing.

ETHICAL CLEARANCE

Ethical clearance was obtained from the ethics committee at KIT in the Netherlands and the Institutional Bioethics Committee of UEM. Administrative approval was obtained from the Maputo Province Health Directorate and the District Health Directorates of Manhiça and Moamba. The study implementation adhered to good research practices. For example, the purpose and objectives of this study were thoroughly explained to all potential participants, and only those who agreed were enrolled in the study. Potential participants were informed that participation was voluntary, that there were no harms or other negative consequences for those who declined to take part in the study, and that all information obtained during the study would be anonymized and stored with strict adherence to confidentiality norms.

A total number of 29 participants took part in IDIs. Of these, 18 were APEs (nine in each district), two were representatives of the district programme, three were health workers (also considered health managers at their level) who are supervisors of the APEs at health facility level, and six were community leaders. We carried out nine FGDs with mothers or caregivers of children under five years. For more detail, see Annex 7 related to the number and type of respondents.

CHARACTERISTICS OF RESPONDENTS

CHARACTERISTICS OF APES

In total 18, mostly young, APEs were interviewed, seven female and 11 male, aged between 18 and 45, who were trained in the new programme. Most of the APEs were single; others were not officially married but living with a partner in what in Mozambique is called 'consensual union' (common-law marriage). Most of the APEs had completed the first level of secondary education, while others had completed primary education in the first degree. The basis of their domestic income was agriculture and the subsidy they receive from the programme. More information about this group can be found in Annex 7.

CHARACTERISTICS OF MANAGERS

Five health managers were interviewed, four male and one female, aged 24 to 45. The four men had completed the secondary level of education (12th grade), whereas the women had only completed primary level. Regarding marital status, the four men lived in consensual union, and the woman was married. Two men and one woman were from Moamba (one man being the district supervisor, and the others health facility supervisors), and two men were from Manhiça (one district supervisor and one health facility supervisor).

CHARACTERISTICS OF COMMUNITY LEADERS

Six community leaders were interviewed, all aged over 45. Three community leaders had completed a primary level of education, two had never been to school, and one had completed secondary level. Regarding marital status, three lived in consensual union, and three were married. The leaders mostly belonged to families that have already led communities, highlighting the succession between these families. The domestic economy of the leaders is based on agriculture, while they receive some income from their work as community leaders.

CHARACTERISTICS OF THE CLIENTS OF APES (MOTHERS)

A total of 67 APE clients participated in the FGDs. Most of them had not attended school. Some left school before completing primary level. In this group of clients, aged 16 to 48, 41 women lived in consensual union, others were married, and others unmarried. Some clients were not the mothers, but grandmothers who presented themselves as caregivers of the children. The basis of their domestic economies is the family farm and work in the informal sector, and mining in South Africa. Some interviewees are involved in agriculture through their spouses.

BROAD CONTEXTUAL FACTORS

The context of the community was taken so much for granted by the participants that few commented on broad contextual factors and cultural attitudes. Community expectations and desires for a certain type of APE overlap with cultural understandings, and the narratives that arose on this issue are presented here, although they also relate closely to aspects of community engagement. Deliberate strategies to engage the communities in the programme (such as their formal role in recruitment) may be seen more as intervention design factors and are captured there. Additionally, issues of access to services due to geographical distance or due to barriers because of the attitudes of staff can be seen as broad contextual factors, although they are not explicitly stated in the framework. The theme of access was a recurring theme in almost all transcripts in the Mozambique context.

ACCESS TO COMMUNITY SERVICES AND HEALTH CARE

Access to health care services was addressed to explore the ease or difficulty with which the communities have access to the scope of these services. This can manifest itself in the form of equal access but also in terms of distances.

Regarding equity in access, all participants argued that there is no differentiation between members of the community and that there is no discrimination against people who are possibly infected with HIV or tuberculosis. As one of the community leaders stressed:

> "Here are all met by the nurse [APE], here in our community... there is no one who comes here and he is looking, he meets all without exception... even those people who are sick he meets." (Community Leader, Moamba)

Likewise, another APE stated that, as per the guidance of their training as an APE, all people would receive his services without any discrimination:

> "When I was training I swore I would treat all people in my community without choosing anyone else, also because if I do not treat people here in my community it is the same as abandoning my own family... then anyone who

comes here I have the duty of tartar until those people who come from other communities." (APE, 22 years old, female)

GEOGRAPHICAL ACCESS

One of the problems frequently described as having a very considerable influence with regard to access to health services were the distances within the community and the extent to which the homes of community members were dispersed.

The limited transport and difficulties in accessing households was felt by almost all participants to exert a great influence on the services, since the APEs cannot always be covering their areas and, therefore, there are some places where people still remain without the services provided by them. Several APEs and mothers of children under five years who participated in our study mentioned this as a major difficulty:

> *"Here we have the districts 1, 2 and 3, but I hardly ever went to the interior of the neighbourhood 3 because the distance is too far and the access conditions are more difficult, especially when riding a bicycle."* (APE, 42 years old, female)

> *"Here we have a problem of transport; to see a care provider here is difficult. When the APE can't cure our child, we become worried. And we don't have money to pay the care provider, and the health facilities are distant. This is the big problem that we have in the community."* (Mother, Moamba)

Figure 4: APE carrying heavy kit

The issue of distances can also be considered challenging because they involve APEs walking long distances with a heavy weight (the large kit box – see Figure 4) on their head, which eventually becomes, as some APEs reported, a demotivating factor.

> *"What hurts me most here is the distance. For example, when the kit arrives at the health unit in Chekwe, it is a kit that weighs about 20kg or 18kg, so I have to walk out of here to go to Chekwe and take the box and walk that whole distance of 20km with the box on my head to and fro. It is not easy, and it demotivates me to work very well and then even worse when I have to go from house to house on the same day or next day."* (APE, 23 years old, female)

Meanwhile another APE stated:

> *"...Working with the community has been going well, but the same problem I have is transportation — not transport for me, but to transport stuffs for work like fetching medicines — and there are times I cannot because the disease is attacking me."* (APE, 28 years old, male)

In general, the issue of distance was identified as the biggest problem faced by APEs as well as their supervisors and the communities regarding access to health services. APEs complain about how difficult it is for them to carry out household visits because of the distance to some communities, but also community members refer to the distances to the APE's health post and to the health facility. It was also mentioned by the APE supervisors and community leaders:

> *"There are people who live far away. ...I'm not lying: sometimes you give birth at home because you must have money for transportation. ...For example, I had to give birth at home. I wasn't fine, and I felt pains at midnight, and to go to the hospital they asked me for 500 metical to pay the transport. The distance to the hospital is far, and because I did not have money I gave birth at home. My husband had no money either."* (Community leader, 54 years old)

> *"The problem of movement within communities is very serious in this district. APEs are required to do many miles away each day to do their activities in health promotion, and this creates a strain for them. It is normal to go more than 500 metres and not find any family, so the next day he prefers to stay in the post and eventually sacrifices those people who cannot afford to go to where he is."* (Manager, Manhiça)

Therefore, it can be said that the issue of access to health services at the community level is often affected by geographical conditions and not by intrinsic motivations of APEs or communities, eventually creating inequalities in access itself.

There were two aspects of the conditions and qualifications required to become an APE. The first focused on the requirements of the MoH, which required that the candidate should have basic knowledge of arithmetic, reading and writing and have primary-level education. The second focused on community eligibility criteria. From the perspective of the community, attributes such as humility, respect for the community, responsibility, love for neighbours, dedication, and listening to the community emerged as central criteria for eligibility.

The notion of humility is understood to be the opposite of pride. Pride is considered an inhibitor of a healthy relationship between the APE and the community, as proud people are seen as worried about their own ego, benefit and personal whims, without taking into account the needs and circumstances of others. Therefore, pride is not compatible with living in the community:

> "I think an APE should be a humble person, should not be a proud person, because when he is proud he doesn't know how to respect the community and will not listen to the community because if I do not hear the community it means that I do not like working with them. When someone is humble and the flu goes up while it is night, I must go to see the sick people, that is why I have a flashlight so as not to say 'until tomorrow because I've left now'. My work must never end for the community. I've got to meet the people at the time they arrive and need my help. Someone who is proud can say 'I do not work at night.'" (APE, 43 years old, male)

> "We never want people who do not treat others in a good way. That boy that we chose to be our APE is very respectful and likes to help others;. He treats everyone as if he was someone from church, and he is humble; that is why we like him because he respects us." (Community leader, 52 years old, male, Moamba)

The notion of humility is also implicated in the notion of respect, as can be seen in the statement above. The notion of respect is seen as ensuring a cordial service by APEs to the community, without discrimination, and the community members respect the APEs' work:

> "You have to be a person of respect. You must first be a person who respects people's home and the people of this community, to be respectful when treating clients, because if you do not have respect, it will be difficult to work with the population. The community members are much harder than people who have studied; you can be beaten up by the population." (APE, 23 years old, female)

The above statement makes it clear that respect generates consensus within the community. In the absence of consensus, friction can be created between the APE and the community, and this can even lead to delegitimize the work of the APE within the community.

COMMUNITY EXPECTATIONS

When community members (mothers and community leaders) were asked about their expectations regarding the work of the APEs in Manhiça, they in general emphasized the need to have growth monitoring, maternity care, antenatal care services and increased knowledge of services so that APEs can extend their healing abilities.

In Manhiça district, expectant mothers especially thought that APEs should do growth monitoring because, according to them, it is difficult to take their children for this service regularly due to a lack of transportation and sometimes a lack of financial resources to pay for transportation, even for immunization. In this scenario the APEs should offer these services to minimize the cost for clients and reduce distances, as is suggested by the mothers:

> *"We also have growth monitoring problems; sometimes the health professionals say that they will come, but they don't appear, so if we had growth monitoring here there would not be a problem. And it is difficult to carry a child to health facilities, especially if the child already is more than a year old, so this is what makes hard work for us."* (Mother, Manhiça)

The problem of a lack of growth monitoring and some paediatric knowledge by the APEs and the need for such knowledge is also recognized by community leaders:

> *"There are displaced mothers going to Checua only because of the growth monitoring. But our APE says that she doesn't know and she doesn't have the equipment for that, so if they could increase her knowledge it would help."* (Community leader, 78 years old)

In Moamba this demand was not noted because the APEs already provide most of these services; however, the need to train more APEs in curative activities was a dominant discourse of mothers and community leaders. In fact, this issue emerged as central also in Manhiça. It was clear that communities have the perception that the APEs are a kind of medical doctor in the community and that their aid station would represent an extension of health facilities to communities, which means that the demand is to increase the capacities of their 'medical staff' and their aid stations:

> *"I think what they would need to learn more is about how to apply injections and to take blood tests to see what disease the person has. There is no medicine*

for paralysis, for hypertension, so why not teach them, that is what we think should increase." (Community leader, 54 years old)

"Also we would like to increase the capacity of the health post, having a great hospital, because people when they are pregnant and during the delivery time they just give birth at home because here they only treat malaria." (Mother, Moamba)

"Yes, we would like you to have drugs for asthma and growth monitoring. We would like to have drugs for all kinds of diseases we have — for example, rheumatism, pain in the legs. If you have pre-delivery pains here and do not have transportation to the hospital, how are you going to get to the hospital for childbirth?" (Mother, Manhiça).

In addition to the increased knowledge of the APEs and the capacity of health centres, the communities would like to have ambulances to evacuate seriously ill patients and pregnant mothers, and diversification and increased quantities and qualities of the drugs. This demonstrates that communities want more curative activities than the preventive and promotive activities currently carried out by the APEs, despite the recognition of the importance of these activities.

HEALTH SYSTEM FACTORS

In this section we cover the perceptions of the health system factors, including perceptions of the current policies, organizational model, monitoring and evaluation systems, governance arrangements and supplies and logistics.

PROGRAMME MANAGEMENT

Regarding communication, the APE participants mentioned that there are limited coordination and communication links, at least from the district level to the community level. Most communication is done via phone due to logistics constraints in terms of transport and travel for personnel to carry out supervisory visits, although at the community level communication mostly happens face to face. However, communication via phone has faced some difficulties due to the use of personal credit that is often inadequate or non-existent:

"I have no trouble communicating with my supervisor or even with my friends (APEs). I use the phone, but now I am without a phone because my phone went into the water. It was a big plus for me because sometimes I'm home at lunch, when I get home a message comes from someone who is ill, and I have to do my things and run fast to rescue the person. These days I've no phone [head shaking]*, even my supervisor does not know if it's me or not in need".* (APE, 28 years old, male)

"The only means of communication I use to be in contact with the APEs is my personal phone because we're not given any cellular phone or airtime, so I must use my own resources to do my job. I also normally talk to them when they bring the report once a month and during the supervision visits or when we recognize that there is a need." (Manager, Manhiça)

"We use phone for communication, but the problem is that you do not always have credit on your phone. I think they should give us credit because they themselves at the health facility when we connect use the phone service, but they want us to use our telephones, and our credit is already so complicated despite being advantageous, because I think the same way as they use the phone they should have done the same thing with us." (APE, 42 years old, female)

"With the community I use the phone. When I'm away I talk to the community through the telephone. I always have the number of the clerk of the district to call. If I do not have money at that time, I send a message to people — for example, if someone comes from a place that I plan to go to meet I ask you to let you know that on x I will be in the zone, tell the person to tell the clerk of the district or write a letter to the secretary and commit the person." (APE, 23 years old, female)

Regarding logistical coordination, many participants indicated problems regarding the issue of drugs, delayed monthly allowances and transportation. Overall, APEs complained about the distances they have to travel to collect drugs and supplies and to leave their reports and receive their monthly subsidies:

"There are those clients who get medication, and I have to stand in line at the district, and it is far. It could be better if the drugs could be delivered here, so I could give them to clients." (APE, 62 years old, male)

Another problem mentioned that deserves special attention is the management of medicines. As a supervisor of the health facility says:

"What people are not doing well and is difficult is to manage the drug kit. We have a certain record/template you have to fill in, and if the APE does not fill in this record, it is difficult to know and believe what comes in the report; it is difficult for us to know what procedure was given to the patient. Regarding the request for the kit, we need to see what the consumption was, which depends on these records. If they fulfil these, it will not be a difficulty faced by the APEs." (Manager, 23 years old)

With regard to sustainability in terms of partnerships with other organizations at the district level, only one faith-based organization directly supporting the APE programme in one district was found. This organization provides logistical support and an increase in the basic allowance to which the APEs are entitled:

> *"The Catholic Church is only in some areas of the district and not in all. ...They give a subsidy strengthening the APE; it seems that they are 400 or 600 metical. Before, when they signed a memorandum of understanding with the Ministry of Health, they had to support the allowance of the APE and build and equip some posts for APEs. When it was decided that there were already posts, they continued to give subsidies."* (Manager, Moamba)

ORGANIZATIONAL MODEL AND THE AVAILABILITY OF OTHER HEALTH PROFESSIONALS AND SERVICES

When asked about the existence of other community workers (volunteers) or health professionals who may be covering the places where the APE services do not reach, in general, in both districts participants were unanimous that no other community health services exist, with the exception of cases in which there are 'mobile brigades' from the reference unit of the APE or the district headquarters to control growth monitoring, vaccinations and vitamin supplementation in children under five years of age.

> *"No, there is nobody else. I have an APE that is close to me, but he also cannot go to places that I will not, but when there is a mobile brigade I explain to people in the community they should get there because this can benefit health services."* (APE, 21 years old, male)

> *"We have a vaccine for children only when there are no mobile health brigades arriving there. The ACS [Community Health Agents] that there are, are only participating in campaigns sometimes when there are vaccinations."* (APE, 22 years old, female)

REPORTING AND DATA MANAGEMENT

The reporting system was indicated as being organized as follows: the APEs report their work to the supervisor of the health facility, who in turn reports to the district supervisor, who reports to the district coordinator, who reports to the provincial coordinator, who reports to the MOH at national level. The feedback system does not work, and most APEs never receive feedback on the development of their activities. On the few occasions that feedback is given, it is in verbal form, with the aim of clarifying questions submitted by APEs for completing the log book and resolving issues.

Regarding the lack of feedback, one APE says:

> *"The [boss] comes back, reviews the book and begins to write, but I do not know what he is writing, and then he doesn't tell me anything."* (APE, 34 years old, male)

When the managers (supervisors) were asked about the feedback process and also their roles, one of them stated:

> *"They all collect data using the register book and put in the monthly report sheet and bring it to me. When I have the data from all APEs, I compile and send this information to the provincial level. If I say that I report to the APEs, I should be lying, but when I can I try to give some feedback about their performance."* (Manager, Moamba)

One APE described one of the few times that there was feedback:

> *"[The supervisor] observed the log book and asked me about other things that I had probably forgotten, and then I explained myself."* (APE, 23 years old, male)

Despite the weakness of the feedback system, most APEs consider it important to send the reports to the health facility and contact their supervisors to establish a time to learn and improve their knowledge. This is described by one APE as follows:

> *"The supervisors come to see how we work and open the record book. I like it because they are my teachers; I do not know when they explain something to me or make me remember what they taught me there in training."* (APE, 34 years old, female)

APEs in particular stated that they know and comply with this activity, especially sending monthly reports. They were aware that the payment of their monthly allowance and the raising of a new kit of medicines are dependent on sending data in report form at the end or beginning of each month to the facility supervisor:

> *"At the end of the month we produce a monthly report with the data that was filled throughout the month in the register and put in the monthly summary and send it to the health unit to record when I take medication or commit someone who goes there."* (APE, 42 years old, female)

In general, it seems that the APEs know little or almost nothing about the purpose of the data they send, and apparently the data are not used to inform on the health status of the community or to take any action on health; it remains unclear whether the data are entered into the health information system.

MONITORING AND EVALUATION, FEEDBACK AND QUALITY CONTROL

The monitoring and evaluation of programme development (through the control of activities of APEs) is done almost exclusively through monthly reports submitted by APEs to their supervisors. This process, while collecting data for monitoring purposes which is transferred in an upwards direction, is not discussed with or fed back to APEs, who as a result are unaware of their own performance and the state of the programme in general. Supervision has also been mentioned as a mechanism for monitoring and evaluation:

> "They tend to evaluate using the monthly summaries. Observe the number of cases treated, number of pregnant women, newborns, adults and children, transferred cases, people who had been treated for malaria, number of lectures and participants. They want to know how many people I have attended to, and if this is to reduce or increase." (APE, 23 years old, female)

> "I think that they evaluate me through supervision. When they come here they want to know what will work, see the log book, seeking to know if I have doubts. Soon when coming to supervision I have to express my doubts; the supervision facilitates me, and I know how my work is going." (APE, 28 years old, male)

INTERVENTION DESIGN FACTORS

INTERVENTION FOCUS – CLIENT GROUP

Regarding the characteristics of clients in the community, participants described them as being in general all members of the community. However, the largest number of clients are children, followed by women (mothers), elderly people and young people, although with some variation depending on each community. As one of the APEs said:

> "My clients who come here are all the people here in the community. They are people of all ages; others have accompanied their children, young children too. But the largest number of children is because many children have diarrhoea, malaria, fever and breathing problems." (APE, 22 years old, female)

> "People who seek APE treatment are all people; they can be adults, children, women, all sorts of people approaching to ask for my help, but most are mothers who bring their babies when they are sick and the elderly who suffer from rheumatism and almost always cannot stand to walk." (APE, 42 years old, female)

Another reference in relation to the characteristics of APE patients in the community is made by another APE, focusing more on children:

> *"Most of them are children and women. Men also go, but not very often. Most often they are women and children and the elderly because of rheumatism, but I cannot attend to them because I do not deal with drugs for rheumatism."* (APE, 45 years old, female)

It can be noted that, although according to their training and guidance by the MoH, formally the focus of the APEs is to take care of children under five years, even when it is the children who seek more health care from the APEs, they provide health services to all members of the community without distinction in age.

Also, all categories of participants highlighted two fundamental issues regarding what is going well and what is going badly in relation to the provision of services by APEs.

In relation to what is going well, participants mentioned that one of the positive things is that there is collaboration between the APE and the community and between the APE and health personnel, both in health facilities and at the district level. This collaboration is expressed by the support in cleaning that the community gives and by the technical and logistical support received from health professionals:

> *"What makes my work go well is that people in my community help me do cleaning at my post here. As always, they came here yesterday to clean that grass and left water for me to drink."* (APE, 22 years old, male)

> *"My job is going well. I have received support from my community leaders. They mobilize people for meetings here in the community, and it makes it easy to do lectures because when the leader is to convene the meeting, all will respect the meeting, so he helps me a lot."* (APE, 62 years old, male)

Regarding the aspects that hinder the provision of health services by the APE, community participants reported problems with stock-outs of drugs, geographical accessibility and a lack of illustrative material for lectures:

> *"In my work there are many difficulties that affect me. The medicine is not enough; often three weeks after picking up the medication I no longer have any. For example, drugs that are in high demand are antimalarials, paracetamol, amoxicillin, zinc and ORS [oral rehydration salts], but ferrous sulphate comes in bulk and does not have much demand."* (APE, 28 years old, male)

> *"When I give talks in the community it is a bit hard to explain everything without education materials. There are no pamphlets to show people how you*

catch diarrhoea, as well as how the treatment should be, even for malaria, which is very common here in the community. I have nothing to bring along, just talk with your mouth.” (APE, 23 years old, male)

Regarding the types of care provided by APEs, participants in general made reference to the treatment of diarrhoea, malaria, respiratory infections and constipation, while for other diseases clients are referred to health units:

“Many children who come here I have to treat for problems related to diarrhoea, malaria, fever and breathing problems. Sometimes people appear with rheumatism problems; especially older people always complain of rheumatism.” (APE, 22 years old, female)

“Here the common illnesses are malaria, diarrhoea and coughs, but many people have problems that come with simple headaches and then just take paracetamol and go back home.” (APE, 27 years old, male)

Health problems that the APEs do not address were reported by the participants to include HIV and AIDS, rheumatism, pregnancy, skin problems in adults and others, because these cases should officially be referred to health units rather than treated by APEs:

“…I went there yesterday because I did not feel good. My body was aching, and I felt headaches. When I arrived, he said that was not a problem he could solve because I had rheumatism, so he gave me paracetamol and told to go to the health facility.” (Community leader, 58 years old, male)

“There is much HIV and AIDS; many people who live here have HIV and AIDS. These people come from Maputo to come to work here, and many arrive while they are sick. When they come to me, I tell them to go to the hospital; some accept, but many say that they don’t come here for advice.” (APE, 23 years old, female)

Almost none of the APEs interviewed complained regarding their workload, although they recognize that they spend a lot of time on their APE work. When asked about the time they spend on APE activities, they mentioned an average of 8–9 hours per day, of which some are spent in the morning and others in the afternoon in curative and promotive health activities:

“I start working at 07:30, and sometimes I start at 08:00 and end at 12:00, and I come home for lunch and then I go to the meeting (lectures) that I usually have with people in my community at 13:00, and often I only finish my work at 18:00

or even 19:00 hours, depending on where I am working that day." (APE, 45 years old, female)

Some APEs mentioned that they do not have time to work as APEs because all the time they are called by the community and must always be ready to support them:

"For example, I have no set days to do my job as an APE because even on Saturdays and Sundays I work, depending on movements. Any time I go to work I can be called to help people in my area." (APE, 28 years old, male)

"I can say that I work from Monday to Friday, but every day someone comes needing services, then I have to treat the person. It is a long time I have to work, but I have no problem with that because I have sworn to serve my community, and that's what I'm here for." (APE, 42 years old, male)

There is a relative difference between Manhiça and Moamba in terms of planning. While in Manhiça the APEs do both activities during the same day (health promotion and curative activities), in Moamba they have specific days for each activity and also specific days that they stay at the post:

"I work on Tuesday, Wednesday and Thursday. I give lectures, and treatment I do every day because patients always appear." (APE, 22 years old, female)

COMMUNITY ENGAGEMENT IN RECRUITMENT AND SELECTION

Interviews with APEs, community leaders, health managers and clients of the APEs in the community revealed a strong community commitment to and involvement in the recruitment and selection process of the APEs, as well as the importance of the coordination of health professionals with communities during the process.

In the recruitment and selection process of the APEs, the two district health management teams organized a community consultation to make the programme known to the community leaders and to discuss the qualifications required for eligibility; in turn the community leaders passed the information on to the community members with a view to selecting the ideal people. One health manager summarized the process of consulting and dissemination:

"For recruitment first we did sensitization among the communities regarding the programme. The release consisted of meetings with community leaders, secretaries of districts, and heads of local government posts in the person of the Administrator. In this sensitization we explained about the programme in which some community members were to take part, and then later, the community leaders and community members in their communities should choose a competent and responsible person who has basic knowledge of writing and reading and who could be the ideal person to support the health of his

community. Then the leaders send names of the chosen candidates, and we submit to them a mini-test before we approve them." (Manager, Manhiça)

In some communities, particularly in Moamba, priests were involved in recruitment, as one APE told us:

"They said they wanted a person to be an APE. Then the priest came to tell me that they want someone to work as an APE there. Then later he took me aside and said that they had already found someone to become an APE, and I was presented as the one, so then the community members said I could be because I was acceptable." (APE, 26 years old, female)

Although priests participated in this process, they always seemed to have had the consent of the community members and also the community leaders. In some cases, the community leaders made the selection and the priests and the community were then informed about the choice and given the opportunity to approve or disapprove. This happened in some communities in Moamba:

"I was chosen because the secretary had first chosen another person to go to the training, and when he arrived there in the training he began dating and stopped studying and went home; then the priests came looking for somebody else. Then the priest asked the clerk who had judgement in the community who could go for the training to become an APE. Then the secretary said that person could be me." (APE, 27 years old, male)

Somehow, the involvement of many actors in this process ensured its acceptability. The presence of priests in Moamba was due to the fact that they had worked and continued to work with communities and gave support for health issues. Incidentally they were the same priests who built all the APE posts in Sabié-Moamba district.

Community participation in the recruitment and selection of the APEs is evident from all interviews, and all community leaders ensured that the APE was chosen by the community:

"...It was us the community who chose the APE. We saw that he was someone able to meet all the needs of the community, then he is a person who is able to walk from house to house and talk to people with respect and wonder if someone is sick. We saw his commitment in the church. He enjoys helping the community, and we decided that he would be the ideal person." (APE, 23 years old, female)

The majority of APEs selected are male. Respondents explained that this is because traditionally in rural areas, including Moamba and Manhiça, female education is not prioritized, and many females in this community did not have the basic educational

qualifications to meet the programme's eligibility standard. In addition, some male partners did not agree to their female partners' participation, arguing that she might engage in relationships with other men during the training and might not have time to take care of household issues:

> *"In the community, a majority of us women didn't get the opportunity to go to school; ours fathers didn't allow us to go to school. And in the APE activities you must know how to read and write in order to not give the wrong medicine to the community. …Some women know how to write and read; however, some husbands refuse to allow their wife to become an APE, arguing that she will have a relationship with other men during the training and that she will not have time to take care of the household and the children."* (Mother, 45 years old, Manhiça)

HABITS AND CUSTOMS REGARDED AS DETRIMENTAL TO HEALTH

Some APEs and community members referred to habits and customs that are detrimental to health. According to one APE, these customs are based on traditional norms — for example, in these communities people usually use the bushes to defecate, and it turns out difficult to change this:

> *"It's difficult to work with the community. When I am telling some member of the community that they have to build a latrine, they say that we were born using the bushes to defecate and we didn't get disease and now you are telling us to make a latrine?"* (APE 34 years old, male)

This argument was confirmed by community members:

> *"Here, the people don't use the latrine; people use the bushes to defecate. When the APE says to build a latrine, some say 'come and build it for me'; others say that they are too old to build it. When the APE hears that, he advises them to wash their hands."* (Mother, 39 years old)

These examples illustrate the challenge faced by APEs and the strategy adopted by them to overcome this situation. The data also show that they do not consider this a hindrance to their work because they share the same social and cultural context. Additionally, they are able to overcome communication challenges, identify problems in households that are widely known in the community and address relevant health promotion issues tailored to the community or household, as in the case of latrines.

INITIAL TRAINING AND CONTINUOUS PROFESSIONAL DEVELOPMENT

Regarding initial training the respondents stressed the importance of the training as an essential tool for the work that they undertook in the community. Most of the APEs highlighted that the contents of the training were adequate to solve most of the problems they faced within the communities:

"For me the training to become an APE was very useful, because now I can treat almost all the diseases that appear in my community without many difficulties." (APE, 32 years old, male)

"I think that what I know is because I was trained, and they trained me very well. Before the training I didn't know anything about health, but now I can even talk to my community about health issues and explain how somebody can get ill and how to prevent them from getting ill." (APE, 23 years old, female)

What APEs said about the importance of training was confirmed by the supervisors:

"The training was well designed and very well given, taking into account that an APE is someone very simple and will work with very simple people, his community, so the contents were well designed for their level." (Manager, 34 years old)

Despite all the good things about the training, some APEs thinks that in later training they should expand on the contents because they were not trained to deal with some diseases that they are required to treat by the communities, such as HIV, rheumatism, pregnancies etc.:

"I believe that the training was very good, but when you are working in the community, most of the time people appear with diseases that I can't treat because I was not trained, so they should train us to treat other diseases like HIV, a woman being ill while she is pregnant, some old people with rheumatism; that could be good."

In general, most of the APEs stress the importance of continued training as a way to enhance their skills and gain more knowledge about diseases that they cannot treat:

"I hope to have many continuous training courses, as I said I'm also an activist, so whenever there is anything, the community chooses me to go to the training. From the government, I just want them to give us more training; perhaps one day I can cure other diseases that now I do not know." (APE, 35 years old, male)

Another APE said:

"In training we share our experiences with others and learn from others. Each person will tell us how they work, and you will see that it is interesting work and then you learn from others." (APE, 32 years old, male)

In addition to increasing their capabilities, the APEs also talked about developing their career and know that this will only be possible through continuing education. This aspect was mentioned by a health care manager:

"…Some want to increase their knowledge even more in the future, because they want to move on to the national health system; they have this perspective." (Manager, 32 years old)

ALLOWANCES, SUBSIDIES AND INCIDENTALS

In both districts where the fieldwork took place, the delay in the allocation, distribution and receipt of subsidies was identified as a problem that can demotivate APEs. Most identified the delay and lower subsidies as an aspect that can decrease their job satisfaction. This creates imbalances in household finances and transportation difficulties for the APEs to go to the health facility and obtain medical kits. Some APEs found themselves obliged to use their own money to transport medical kits or buy phone credit:

"To carry the kit of medicines by public transport needs money. My shipping is also paid up. There are things that are not clear. Sometimes you want to call the health facility to see if the medicine kit is there, but at that time you do not have money for airtime because the subsidy never comes. Sometimes you sacrifice some money thinking that in the period X you'll have it, but when that period comes you find that you're still with no money." (APE, 34 years old, female)

"When I was chosen as an APE, they spoke about the monthly allowance, and I hoped that allowance was monthly, that at the end of each month I would get my allowance. We APEs complained about that because this is my 4th month and I have not received such a subsidy. This subsidy is just not enough for anything, but they promised us and should at least give us the little at the end of the month, and they give just nothing. …I have my wife and two sons, and my mother is elderly and can no longer go to the farm, and I have to support my family." (APE, 32 years old, male)

The issue of subsidy debt is also mentioned by the health managers as a difficulty which can lead to APEs providing a low quality of service or dropping out, but also decrease the quality of supervision that the supervisors perform:

"In this one year only 22 people worked, and three people already gave up. I'm sure that if the process continues so many will give up, only because of the subsidy. The first complaint is that it is little, and even then it does not appear monthly; the delay influences them a lot. …Every day that passes there is a message that comes to us asking about the subsidy. They always send messages asking about the allowance: when will it come out? We are now on 21 August, and this is the fifth month that we do not have a subsidy." (Manager, 28 years old)

The delay in the payment of subsidies has created difficulties in accountability between APEs and supervisors:

> *"On the other hand, we have had trouble — I and the APEs — regarding the allowances that take too long for them, and before being APEs there are old people who had their profitable activities who are older than me and who I regard as my parents. I foster them to continue a little longer to enter the subsidy, but it does not enter at the scheduled date because according to the information given to me I must go to them and say that the subsidies for August fall in mid-September, so I tell them. But then no subsidy came out this period, and when the amount is out, it is for two months, while you have six months of debt. It would be great if we could overcome this difficulty, not only for them but also for me as a supervisor."* (Manager, 34 years old)

Clearly the low subsidy and delay in subsidy payment has conditioned the motivation of the APEs in their activities, and limited the ability of supervisors to provide for APEs, as supervisors did not feel comfortable demanding more work knowing that APEs are receiving delayed subsidies and are demotivated.

Overall it was evident that communities do not make any type of payment for the services rendered by the APEs nor for the medications they receive, with the exception of one community which stated that they paid 5 metical (MZN5) for the drugs received. This non-payment for services was explained by the fact that communities have gathered and communicated to each other that they do not need to pay for the services. The government argued that the services provided by the APEs should not be paid for; this meant that the community knew that services should be provided for free.

Although communities have knowledge of this, some communities report helping their APE with transportation to the health facility to request medication, because they are aware of the delays in the receipt of subsidies by the APE:

> *"...We saw that as there is a delay in their salary of three months, this subsidy comes when they no longer have anything. Sometimes the population takes something away to fetch the medicine; the transport needs money. She is also a peasant. It is the people who saw the suffering. She didn't say anything or complain. We have seen that there has to be something, when it is called to the district direction. Ever seen it before three months? It is much time."* (Community leader, 54 years old)

The delay of the subsidy and the need to fetch medicines for the population mean that some, but not all, communities take initiatives to give some money to some APEs.

NON-FINANCIAL INCENTIVES AND DISINCENTIVES

To better understand the issues related to non-financial incentives, APEs were interviewed regarding their motivation and satisfaction with the work they do in communities. Based on their answers we derived three categories that affected their satisfaction and motivation: non-financial material and non-material incentives, the latter subdivided into non-material internal and external incentives.

NON-MATERIAL INCENTIVES

Non-material (internal and external) incentives are those related to the APEs' personal motivation and satisfaction. Several non-material internal incentives were mentioned by APEs. Most felt that they were chosen by the community and should comply with and want to help their communities. Other reasons that were given include respect and social status that they have in the community and the opportunity to acquire new knowledge.

One APE mentioned wanting to be able to work close to home. Although there are some differences related to emotional issues, most APEs emphasized the importance of working in the community as a motivating factor. Sometimes a sense of a divine calling was expressed, as follows:

> *"Working for health is equal to a pastor who works for God. Working for the people and for God is a complete work. ...It is not because of the money that people go to work in health."* (APE, 32 years old, male)

> *"I see the love the community has for me, and they look like family, and I can help. All this leads me to be happy because I'm working in my community. ...I have no hope of any benefit. I cannot demand anything of the population as a native here because I also see their difficulties."* (APE, 26 years old, male)

Non-material external incentives reported by APEs included more oversight, respect from the community, respect for their work, the support of the community in cleaning and fetching water, capacity-building, and training to acquire skills to be able to treat more diseases. These greatly increased the satisfaction and motivation of APEs for the work they do:

> *"It would be good to give us more training courses and increase the medicines, giving us new skills to treat other diseases, because there are things that are missing here in the community. For example, co-trimoxazole they no longer give us, but we were given it before."* (APE, 23 years old, female)

NON-FINANCIAL MATERIAL INCENTIVES

Regarding non-financial material incentives, almost all APEs made reference to the need of transport in general, and to bicycles and motorbikes as an incentive that could generate satisfaction and motivation for their work.

Some APEs reported that incentives in information, education and communication materials would improve motivation and satisfaction. Two APEs referred to the increase in drugs as a motivating factor:

> *"The support I would like to be given is related to transportation, because the bicycles that they gave us you can only use one day; the second day it is already broken. They are not strong, then you are forced to walk on foot. Sometimes in a day you can only come to two houses because the houses are too far apart."* (APE, 34 years old, male)

SUPERVISORY SYSTEMS

In both districts (Manhiça and Moamba) the supervisory system appears organized in three distinct steps. First, there is the supervisor of the health facility of reference to communities where the APEs are based. The supervisor is responsible for supervision on a monthly basis, observation of procedures for completing the record books, and supporting the APEs in the difficulties they encounter during their work in the community. Supervisors also support the APE in writing the monthly reports, which serve as one of the tools to assess and control their work. The support provided by supervisors to the APEs makes the APEs feel that supervision serves a purpose of ongoing education:

> *"When I receive supervision visits, I ask about things that I cannot do, and they show me how to do them. So we learn things we don't know how to do during the supervision, and we like that."* (APE, 26 years old, male)

The communities are also involved in supervision activities, represented by community leaders from whom the health facility supervisors and the district supervisors want to know how the APE is working. A supervisor said:

> *"We coordinate with the head of the neighbourhoods. For example, the Head controls the activities, so I have to be informed about how they are working. He gives me the information. I have not received a review of my round there. The only thing they focused on was that the secretary asks the APE to be there even on weekends because when the weekend comes around the APE goes back home. More time is also not easy because he needs to rest, and all weekend there is no rest. We have not yet reached a consensus on this; this is the only complaint we had there in the communities."* (Manager, 28 years old)

From the health facility to the district there is a district supervisor who receives and evaluates monthly reports made by the APEs and also makes quarterly supervisory

visits to communities. The district coordinator also makes a general report on the activities of the APEs, based on monthly reports of the APEs, and submits it to the provincial level, which then in turn generates data for the national MoH.

Although the supervision system is organized according to a timetable, it does not always occur on the scheduled dates. The lack of transportation, long distances and difficult access to communities have been identified as factors that negatively affect regular supervision. In some cases, supervisors spend more than two months without carrying out supervisory activities (while supervision should be conducted monthly). Supervisors have identified delays in the allocation of fuel and logistics, pending maintenance of their motorbikes and their work overload as affecting their ability to perform supervisory activities effectively:

> "Working as an APE supervisor has not been easy, because I'm single, and when I go out for supervisory activities, other activities are stopped, but I cannot let the activities of the APEs suffer because of the others. I always have to run behind time. Sometimes I cannot do oversight on the scheduled dates, and I have to go after hours. We also have difficulties with transportation in that a motorcycle sometimes does not have fuel. I waited one month following the request without receiving the fuel. Also there is the issue of faults: most of the time or almost always I have to do maintenance of the motorcycle, because waiting for the district means stopping, and how many activities will that affect? Rather than waiting for the district, I'm going after it myself." (Manager, 26 years old)

These difficulties contribute to the irregular supervision of the work of the APEs that was observed during the fieldwork when it became evident that after roughly two years since the beginning of the programme some communities and APEs had only had two supervisory visits. These conditions may negatively affect the performance of the programme in achieving its objectives. This situation can make APEs demotivated, reduce the communication between APEs and health facility coordinators and reduce the effectiveness and efficiency of the programme interventions.

REFERRAL SYSTEMS

In relation to the referral system, APE participants are more or less clear about the type of disease or health concerns which are beyond their level of competence and that by their nature require referral and transfer to the health unit of reference. For example, they reported that when an APE has a case that they cannot medicate it is when the disease is severe:

> "When I see that this is a serious malaria problem I send the patient to the hospital using a transfer guide. I write something like 'this patient is sick, is feeling it more' and then sign it and then say I will come to your house to see if

it was the hospital or not and to see what the health worker wrote." (APE, 23 years old, female)

"We have problems here. Sometimes the person is too sick for a long time and then it becomes very serious. They can have a simple diarrhoea, but because over time it became very serious, they get here just to say that the person shows no sign of danger, and it is not my level, so I have to give first aid... and then fill the transfer guide for the health unit." (APE, 28 years old, male)

According to the national revitalization programme, this referral system is very well established; however, its operation could be further improved by ensuring that APEs receive feedback about their clients following referral, since in many cases the APEs have no knowledge of what happens with clients referred to the health facility because in practice there is no clearly established feedback mechanism for referrals.

It should be noted that some health facilities, in collaboration with the APEs, have adopted feedback measures which serve to give some feedback on the diagnostic use and treatment of clients referred by the APEs, although this is not completely effective. However, this system is not widely used, and only certain health facilities have adopted this practice of writing referral notes on the back of the referral form:

"The boss [supervisor of the health unit] receives the sick person when I send him there after doing analyses, and he gives the treatment. Afterwards they write the transfer guide about what the patient had and which medicine they gave, for me to know and learn so that when I am receiving the same kind of sick persons I already know what can be done, but people do not always come here after returning from the hospital, so I have to go to their homes anyway." (APE, 22 years old, female)

All study participants said that the referral system works fine in the sense that when a patient is transferred to the reference health facility s/he receives 'special' treatment, since clients referred by APEs are not expected to stand in a queue with other clients who have not been referred. However, this system does not always work:

"We cannot lie to them. When we go to the hospital to transfer with the guide that our 'nurse' gives us, they meet us without delay, and no need to stand in the long queue. I even went last month, and it did not take me long." (Mother, Manhiça)

"We had problems. I have seen cases of my colleagues who have used the APE guide for transfer to the facility. ...When the patient arrived there with the guide and presented it, the nurses said 'you're sick, and these people who are here are not sick? Join the queue.' Maybe this person is the last to arrive

because it is far. I have watched it many times. So when I take a transfer guide, it does not help you at all." (APE, 27 years old, male)

QUALITY OF HEALTH CARE PROVIDED BY APES: FROM THE PERSPECTIVES OF THE COMMUNITY, SUPERVISORS AND APES

In both districts the community respondents visited were unanimous in stating that the quality of service is good and is helping communities to reduce disease and the distance between communities and health facilities, serving as a link between them. Their perception of the quality of services is that there is good prescription, improvement in health status after medication, accompaniment of the patient during treatment and house-to-house visits:

> *"What makes us say their services are of a good quality is that you never see someone going to an APE and not being attended to. If you go while you are ill you will get medication and come back better. The APE is very committed with our health problems, and what I most like from him is that he accepts the criticism; when you tell him that this is not right, he asks you in which way he should proceed."* (Community leader, Moamba)

> *"The ability to recognize the need to make timely referrals, the zeal with which he treats his patients, makes communities consider the APE as sacrificing himself for the good of all from the community."* (Community leader, 78 years old)

The APEs' persistence in promoting community health through basic knowledge and rules of personal and collective hygiene are also part of the community perceptions regarding the APE programme:

> *"...Another thing that makes me consider it a good programme is because the APEs teach us many things in our homes. They teach us how to take care of our homes, water and food in order to not catch diseases."* (Mother, Moamba)

These perceptions about the APEs' work generate confidence and satisfaction in the community members regarding the services provided, which offers community members a basis for comparing the APEs' work and the services provided at health-facility level. They prefer the APEs and consider that the staff at health facilities tend to cater poorly to the patients:

> *"I don't have any complaint with the APE but only with the health facility. When I delivered at home some health professionals said 'your midwife is here', pointing at my aunt — to mean that I just delivered at home because I trusted her more than the health facility, while the*

problem was money for transportation. And because of that I was only seen very late as a punishment, but when you go to the APE this never happens." (Mother, Manhiça)

The perceptions about the good work done by the APEs in larger cases are based on the time the community members spend in the health facility and during the APE visit.

The main complaints regarding the APEs' work (in terms of quality) relate to the low number of APEs in each community and stock-outs of medicines, but in general it is considered that the quality of the APEs' work is contributing to the reduction of disease and improving the quality of health of the communities. These perceptions arise from continuous communication between the APEs and the communities, thereby serving as one of the factors for their legitimacy and social acceptance.

The quality of care provided by APEs is described by most supervisors, who argued that, despite some constraints related to transportation and some technical and logistical difficulties, APEs in general provide a good service.

Some also stressed that this is reflected both by reducing the demand for services at the level of health facilities as well as the observations made by clients in relation to their work. It must, however, be noted that so far there is no instrument to assess the quality of the technical performance of APEs.

> *"I think that there are critical things, because visits are made and when the residents bring some clients the attention they always have to give that patient medication and monitor the patient's condition, so I can say that they do a job with an acceptable quality despite the transport problems they face."* (Manager, 28 years old, male)

> *"Well, the quality of service is good. You may miss one or another aspect because the procedures and health programmes are not static; they are dynamic. Now, one hour to another or from one day to another, or one year to the next, something can change. The strategy is already not the same, or treatment is of that type and they are not in time to keep up with changing the term 'healing', but his work is quality."* (Manager, 32 years old, male)

APEs referred to community feedback when asked about the quality of care which they think they provide. They feel that because they have not received complaints from the community and have requests to provide more services, the quality of the care they provide is good. In addition, everyone they have treated has improved:

> *"I think it's good because there are people who appear here as they are serious, and I give medicine and they improve. Others I give a transfer guide, and there*

are others that I provide first aid to and then send to the hospital, but they do not go. And when I visit, they say they were not there because they have already improved. When I answer someone and then the person improves, to me that means quality work." (APE, 23 years old, female)

"Well, I have not seen or heard anything strange. I think it is a good job because people do not complain. I have never done one person and not looked good, and people always got it with a good heart. I do not get angry with people." (APE, 45 years old, female)

"The quality is much better here in our community, because if I were not doing this job it would be like the old days; people formerly were hard-headed and would not listen, but with the work I do I can see change in the community even in respect of hygiene." (APE, 21 years old, male)

Therefore, in general, if we consider quality to be the relief of health problems and the absence of complaints from community members — excluding thus the technical aspects of the services provided — it can be said that the APEs produce work of considerable quality.

In this chapter we will discuss the results of the literature review, the stakeholder mapping and our qualitative research findings. We will do this using the themes suggested by the draft framework introduced earlier (see Annex 2) and attempt to provide answers to the specific objective of identifying and assessing contextual factors and conditions that form barriers to and facilitators of the performance of community health care providers.

Our findings reveal that all participants feel that APEs are needed at community level in a context of an absence of other options to access health care services. All respondents share this view, regardless of the challenges existing in the implementation of the APE programme.

We identified a range of barriers to and facilitators of the revitalized programme and discuss these under the three themes. These both endorse those areas identified in our desk review and highlight new areas that need consideration. Areas that came up in previous reports (Succato et al., 1995; Bhutta et al., 2010; MISAU, 2012; MoH, 2010; UEM, 2013) include the payment of non-uniform subsidies and incentives, unmet career path expectations, the poor transport to remote areas, inconsistencies in training curricula, gaps in support for APEs expected and received from their communities, irregularities of supplies and significant weaknesses in supervision and feedback of data.

New areas that emerged include the positive and powerful nature of the community engagement system that extends beyond selection into monitoring, support and governance through empowered communities. We reveal significant tensions between community expectations of curative services (and APEs' willingness to perform them) and official policy dictating a focus on preventive services and health promotion.

BROAD CONTEXTUAL FACTORS

The revitalized APE programme in Mozambique is strongly influenced by historical factors. It is currently supported by government policy and backed by co-funding from development partners. The health sector strategic plan affirms the PHC approach, including an important role for community participation.

These features shape community expectations of APEs as well as the strong level of community ownership and engagement that we found in our interviews. This participation served to legitimize and create spaces for communities to support, monitor and sometimes claim some additional issues they think the APE should take on. Generally these related to maternal and children's health services that are not

necessarily part of APEs' mandate but which clients found difficult to access in formal health facilities, for reasons of distance and cost.

In fact, 'access' constituted a recurring theme in the IDIs and FGDs across all study participants, even when APEs were seen as offering their services without discrimination to those in need. The wide dispersal of homes and considerable distances APEs would need to cover between communities in difficult terrain, paired with limited transport options, implied that more distant populations still remained without services, thus creating inequalities. At the same time, some APEs felt demotivated, while these logistic constraints also hampered reporting and supervision.

The perspectives of government, policy and communities on the selection criteria varied widely, from expectations of literacy (hampered by low literacy levels in at least one study district) and numeracy to personal attributes such as integrity and humility. Through the direct role given to communities in recruiting APEs, the official policy is able to endorse these attributes as unofficial selection criteria that have overall benefits to the community.

At the same time, our data reveal persisting challenges in the selection of candidates for the APE programme, mainly regarding the imbalance between males and females, with the current majority being male (contrary to what the programme policy documents suggests). Female community members often seem to face gender-based difficulties in accessing APE positions, related to their limited educational background and male partners' disapproval.

As community members themselves, the APEs have a good understanding of cultural norms and practices as well as of individual households. Although the APEs gave several examples of habits and customs existing in the community that may be hazardous to the health of the population, it became clear from the data that they do not consider them a hindrance to their work, because they share the same social and cultural context, which can greatly facilitate their work. They are able to overcome communication challenges, identify problems in households that are widely known in the community and address relevant promotion issues tailored to the community or household (for example, latrine use, facility delivery etc.). However, their very intimacy also raises concerns for community members about how they will be treated and judged and whether their confidentiality will be maintained — issues that are reflected in their discussions of the attributes of APEs in our IDIs and FGDs.

Thus, the fact that the APEs meet their socio-cultural universe and have to deal with it also contributes to their feeling engaged in their activities and tasks. However, this universe is not static; therefore, the needs of the population are changing, and the

demands made by the APEs clearly demonstrate how social contexts are dynamic and flexible.

This is reinforced by the inference that "the success of a project, system or healing mechanisms depend to a large extent on the existence of networks of social relations that sustain it as a discourse endowed with authority, shape and operating apparatuses" (Matsinhe, 2007), to which we would add the level of commitment of the actors of the programme. We see this as applicable to the APE programme, which has great potential to improve and expand the health care network to serve communities — and especially children — while maintaining a constant social dialogue among all actors involved.

HEALTH SYSTEMS FACTORS

By design, communities are linked to the health system — in terms of services via the availability of health facilities and the APE programme, and in terms of governance in the form of one jointly managed committee for each health facility, which comprises representatives from various community health committees. This system approach is also visible in APEs' sense of being part of the health system that was derived from our data. They felt that they were not working in isolation but as part of a team, and this in turn was related to the perceptions of APEs and their supervisors about performance, quality and motivation.

At the same time, the potential links among communities, APEs and the health system are not all operational, due to constraints in terms of budget limitations, the scarcity of professional human resources, difficult geographical access and ethnic diversity. These factors in turn also affected reporting and educational activities, with the latter possibly limiting the effectiveness of health education, supervision and supply chain management (leading to frequent stock-outs of the drugs most in demand).

The reporting system in everyday practice seems more geared towards upward accountability (to senior managers at higher levels) than downward accountability (back to the APEs and communities).

While not explicit in the data, there seems to be an expectation among some APEs to have an enhanced role, and some indicated their willingness or even eagerness to become permanent members of the national health system. The prospect of one day becoming part of this system seemed to motivate them.

INTERVENTION DESIGN FACTORS

A number of important intervention design factors were identified that directly or indirectly constitute facilitating factors of or barriers to the performance of APEs.

Human resources

Regarding human resources issues generally, we found a good relationship and coordination between APEs and health workers, a strong engagement of communities in the recruitment and selection of APEs, as well as (indirect) supervision of the APEs, who mostly originate from and are deployed in their own communities. However, gender-related issues related to the current APE workforce and recruitment issues (e.g. men not being in favour of their partners going away for training) paired with expectations about services also to benefit women and children lead to contradictions and may affect APEs' performance. In particular, if young female APEs need to work with older men and women in the community, they would need a wider range of skills to perform the role effectively.

APEs' motivation

Our data reveal a strong level of commitment and motivation from APEs; it approached a 'religious calling' and was not linked to expectations of financial remuneration. There are no studies (indexed or not) that evaluate the reasons for APEs' motivation. However, preliminary data from the qualitative study (MoH, 2012a) carried out under the baseline of the APE revitalization programme indicate that APEs constitute a 'bridge' between communities and health facilities; therefore, APEs feel they have a privileged social position in their communities, and this of itself constitutes an important motivational factor in the performance of their duties.

Most APEs are strongly committed, their motivation being non-financial but mostly related to a sense of belonging, both in terms of responding to and being respected by their community and belonging to and being supported by the health system. Other non-material incentives highlighted were community support (e.g. cleaning, fetching water), receiving training, means of transport (e.g. bicycles) and information, education and communication materials for health education.

Still, when the promised monthly subsidies, even if modest, do not arrive months in a row (mostly due to government–donor issues), many APEs feel demotivated. Other incentives such as the distribution of bicycles are weakened due to the poor road conditions which hinder home visits by APEs to the communities.

Preventive/promotive vs. curative services: focus contradictions

Health system constraints and especially the access issue mentioned under broad contextual factors resulted in communities indirectly challenging the formal policy's balance between curative (20%) and preventive/promotive (80%) services. This formal balance was echoed by supervisors and reports (MoH, 2012a), as the total numbers of beneficiaries receiving treatment may be small compared to the numbers reached through group meetings for health promotion.

In practice, our findings revealed that APEs felt that more attention and time was needed (and often used) for curative work, and it was this which they found rewarding. These feelings were linked to community expectations of curative services and their role as community members themselves, desiring to fill a gap in services created primarily by long distances (and the associated cost) to reach health facilities. Some APEs felt significant tensions in addressing these dual (formal and informal) expectations, and possibly in dealing with the pressure to report activities in line with official policy, thereby obscuring the reality and creating tensions for APEs and supervisors alike.

Health posts

A related but different issue are the APE health posts, built by communities in many places under the old programme but discouraged by the current policy as a symbol of the 'curative' role while APEs should be mobile and make frequent home visits.

Training

Training takes place in all districts and is designed as hands-on, although some APEs feel it is still too theoretical. Others say it should have more emphasis on the type of (often curative) services demanded by their communities. Continuous education is seen as needed by APEs as well as communities, but a refresher training programme is non-existent, although envisioned in the new policy that will expand APEs' portfolio.

Workload

Not many APEs commented on or complained about their workload, even though most devote most of their time to APE work. As more APEs are recruited, the workload can be shared among more of them. The recent decision to expand the range of services offered may constitute a challenge and require not only additional training but also careful monitoring of ensuing performance. (It must, however, be noted that so far there is no instrument to assess the quality of APEs' technical performance.)

Supervision

Our desk review found that APEs in the previous programme felt abandoned due to the lack of supervision, and this appears to be a recurring constraint in the revitalized programme. While some APEs indicate that they want more supervision, constraints in supervision frequency arise at both facility and district levels, relating to budget and access issues but also supervisors' heavy workload and limited means of transport. Tailored solutions would be required, as each district/community has its specific characteristics, and challenges are not always similar in all parts of the country. Furthermore, when supervision does take place, feedback and thus learning opportunities are often too limited.

Referral

All study participants said that the referral system works fine in the sense that when a client is transferred to the health facility of reference, they receive 'special' treatment, as clients referred by APEs are not expected to queue with other clients who have not been referred. However, this system does not always work in practice.

The referral system is weak, mainly due to operational challenges, as already mentioned, and most often has no feedback mechanism to APEs. Monitoring and evaluation feedback loops are weak overall, and data collected by APEs are not used to improve the quality of services.

Monitoring and evaluation

There is also room for improvement in monitoring and evaluation mechanisms and feedback loops. Generally, it seems that APEs know little about the purpose of the data they submit, and apparently these data are not used to inform on the health status of the community or to take action on health issues; it remains unclear whether the data are entered into the health information system. However, any improvements might require context-tailored solutions which are perhaps not uniformly applicable across the country.

Quality

Despite the above challenges, community perceptions of the quality of APE services are positive. All respondent types felt positive about the availability of malaria rapid diagnostic tests used and related treatment by APEs, and there was a general sense of pride in the programme's ability to provide services such as this at community level.

APEs are professionals, who will instruct the community and demonstrate favourable practices and behaviours for the health of the population — not only from a biomedical perspective but also taking into account that the practices existing in the community have deep socio-cultural meanings (Nunes et al., 2002).

Sustainability

Since the APE programme was revitalized in 2010, sustainability has been one of the considerable challenges. This includes addressing the integration of former APEs into the new programme, the integration of the programme into the national health system and the payment of subsidies.

This chapter highlights implications of the findings and discussion presented earlier, with some general recommendations and, more specifically, implications for the draft framework and the upcoming quality improvement cycles.

In general terms, we can conclude that the work undertaken by APEs in the communities is contributing to reducing some of the diseases such as malaria, diarrhoea and respiratory infections, and especially in children of less than five years of age.

The APEs strengthen the national health system by bringing basic health services to communities that have limited access to health facilities due to the large distances between health facilities and communities and the shortage of professional health workers.

Even so, the programme faces several challenges that can partly be addressed, thus improving programme development and access to quality health services for more communities. Initial recommendations include:

- undertake regular monitoring of the APEs' activities through supportive supervision, since most APEs have no higher education degree that may enable them to assimilate some activities with relative ease;
- train supervisors on supervision and monitoring and evaluation, particularly the supervisors of health facilities;
- provide continuous training to APEs, especially regarding the most frequent diseases in their communities;
- provide individual feedback on APEs' performance;
- provide information, education and communication materials to support the activities of health promotion and disease prevention;
- create a more functional mechanism for distribution and drug stock control; and
- create mechanisms to deliver the monthly allowance effectively.

IMPLICATIONS FOR THE FRAMEWORK

The broad contextual and health system factors as presented and discussed above largely confirm the validity of the factors contained in the model. However, more explicit attention may be needed in the framework on the issue of access to services due to geographical distances, paired with limited transport options. This was a recurring theme in our study, and we observed that this may lead to inequalities, as populations in need remain without services.

The intervention design factors contained in the framework are also validated as relevant by our study. The issues around physical infrastructure (related to the debate on the APE health posts) and around sustainability may require more attention than the framework currently encourages.

PROPOSED QUALITY IMPROVEMENT CYCLES

To recommend the way forward for quality improvement cycles is not an easy task, as different stakeholders would suggest or put forward different plans and proposals based on their own perceptions of relevance and applicability at study sites (at least as a trial or experiment). Thus, what is proposed here is based on the consensus the country team reached, and for the next phase of the project, it intends to focus its efforts regarding improvement cycles on the following two areas:

- **Supervision** does not happen in a regular and planned manner for a number of reasons (some of them mentioned above), but is of highest importance for achieving the success of the APE programme. Creative solutions could be developed based on the literature on supervision and experiences from other countries — for example, as demonstrated by authors such as Daniels et al. (2010) in an exploratory qualitative study about supervision of community peer counsellors for infant feeding in South Africa. There is a need for solutions that are sustainable and viable for implementation in resource-constrained setting such as the study sites (which reflect the majority of districts in the country).

- The **monitoring and evaluation** system developed for APEs requires tailoring to the context and setting for its application. Additionally, better ways of providing feedback from proximal to distal levels (where data is generated and/or aggregated) is required. Once again, experiences reported in the literature and other countries (UEM, 2013; MoH, 2012a; Geaoge et al., 2009; Nankunba et al., 2006) could be of great help to develop creative, sustainable solutions for a monitoring and evaluation system tailored for resource-constrained settings and allowing appropriate and timely feedback between different levels.

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Annex 1: Definition of CTC provider

Annex 2: Draft framewor*k (included below)*

Annex 3: Data collection tools final versions

Annex 4: Root cause analysis and problem statements

Annex 5: Final coding framework (from Nvivo)

Annex 6: Copy of ethical approval letter

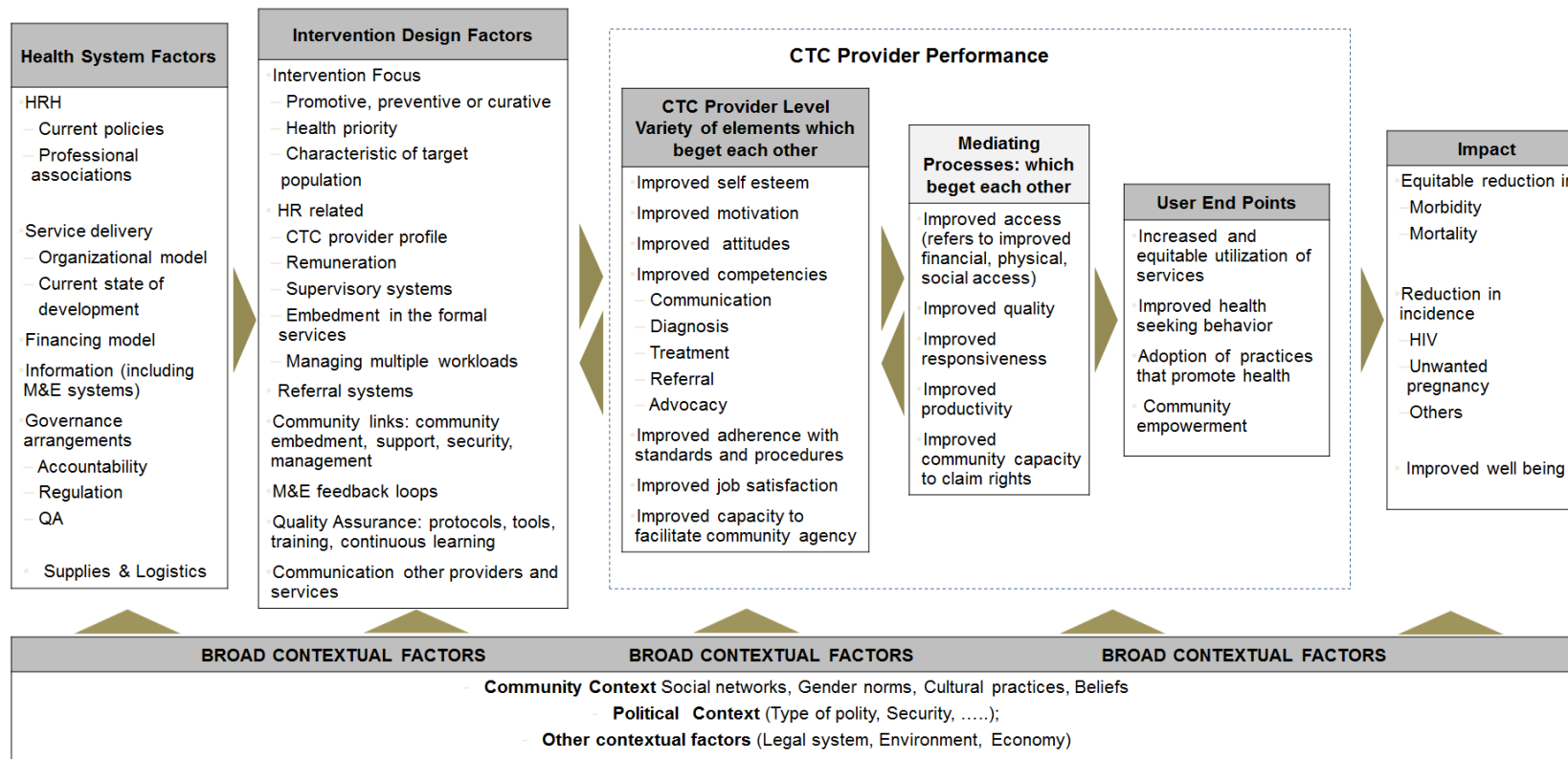Annex 7: Participant characteristic tables

Annex 1: CTC Provider Definition used by REACHOUT

A CTC provider is a health worker who carries out promotional, preventive and/or curative health services and who is the first point of contact at community level. A CTC provider can be based in the community or in a basic primary facility. CTC providers have at least a minimum level of training in the context of the intervention that they carry out and not more than two or three years of para-professional training.
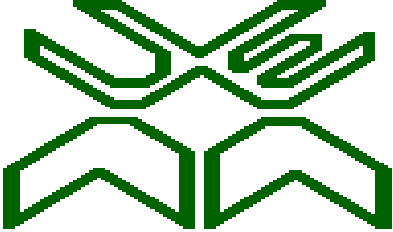
Annex 2: DRAFT FRAMEWORK

Major themes from the framework (see diagram below) on factors influencing CTC provider performance:

- Broad contextual factors
  - Community factors
  - Policy factors
- Health system factors
- Intervention design factors
  - Human Resource Management
  - Quality Assurance
  - Monitoring & Evaluation

GUIÃO DE ENTREVISTA DO APE		
	Título da Pesquisa: *Desempenho e Sustentabilidade dos APEs para Melhorar os Serviços de Saúde em Moçambique.*	
Nome da Unidade Sanitária de Referência:_____ **Comunidade onde Realiza o trabalho:**_____		
Código:_____	Data da entrevista: _____/____ / 2013	
Entrevistador:		
Anotador:		
Entrevista Gravada: ☐Sim ☐ Não		

Nos países subdesenvolvidos, dos quais Moçambique é parte integrante, a equidade e a igualdade no acesso aos serviços e cuidados de Saúde tem constituido um problema. Tendo em conta estes problemas, vários programas e politicas têm sido desenvolvidas tendentes a aproximar os cuidados de saúde as populações, sobretudo as mais vulneraveis e residentes nas zonas peri-urbanas e rurais. Ciente desta problemática o Projecto Reachout Moçambique está a desenvolver uma avaliação formativa que visa analisar o desempenho e Sustentabilidade dos APEs na melhoria de serviços de saúde em Moçambique. Esta avaliação procura medir a eficácia e a eficiência dos serviços comunitários de saúde prestados pelos APEs e igualmente a maneira pela qual se pode alcançar serviços mais equitativas. Com base neste estudo vão-se criar plataformas e mecanismos de intervenção para a melhoria do programa nacional dos APEs em diferentes niveis identificados. Nesta sequência vamos procurar saber os motivos que o levaram a ser APEs, sobre o trabalho que faz nas comunidades, supervisão do trabalho, dificuldades e aspectos que facilitam a realizaçã do seu trabalho.

DADOS SÓCIO-DEMOGRÁFICOS E SÓCIO-ECONÓMICOS

Idade:_____ anos	**Sexo:** Feminino☐ Masculino☐

Estado civil: Solteiro(a) ☐ Casado(a)/União de facto☐ Separado (a) ou Divorciado(a) ☐Viúvo(a) ☐

Onde nasceu:_____	**Qual é o seu grau de Escolaridade:**_____ **A quanto tempo trabalha como APE**_____

FORMAÇÃO, MOTIVAÇÃO E RETENÇÃO DOS APEs

I. Recrutamento dos APEs
1. Como é que foi recrutado para ser APE? Explorar: comunidade, profissionais de saúde, ministério da saúde, ONG / OCB. Porquê é que acha que a comunidade lhe escolheu?
2. Recebeu alguma formação? O que é que gostou e o que é que não gostou?
3. A formação foi importante para o seu trabalho como APE? Porquê?
4. Alguma sugestão para proximas formações? O que poderia ser melhorado?
5. O que lhe fez decidir aderir ao programa? O que lhe atraiu?
6. Que critérios foram utilizados na selecção para o seu trabalho (APES) / papel?
7. Olhando para trás, o que você acha sobre cada um desses critérios?

8. Se você tivesse que fazer os critérios para novos APEs que mudanças você faria, se houver, nos critérios ou processo de recrutamento. Que tipo de pessoa deve ser selecionada como APE? Porquê?

II. Incentivos/renumeração/motivação

1. Que coisas fazem com que os trabalhadores de saúde se sentem bem ou não tão bem com o seu trabalho; Explorar: contribuição que eles fazem através de seu trabalho; O apoio ou incentivos que recebem, por exemplo, a nível social, apoio à subsistência, os benefícios económicos, outras recompensas? Preocupações? Explorar: sentimentos sobre o voluntarismo e renumeração regular.
2. Que beneficios esperas ter do seu trabalho como APE?
3. O que esperas dos pacientes da comunidade? E o que esperas do governo?
4. Gostarias de continuar a trabalhar como APE? Porquê? Por quanto tempo?
5. Gostaria que os seus filhos ou filhas fizessem este trabalho? Porquê?
6. Que aspectos influenciam a sua satisfação e no trabalho e como? Está satisfeito com o seu trabalho? Sim ou não, porquê?
7. O que lhe motiva ou desmotiva? Explorar: equipamentos e suprimentos, a carga de trabalho, ambiente de trabalho, comunicação e transporte, segurança e assédio sexual, perspectiva de carreira, supervisão pacientes, colegas e outros profissionais de saúde.
8. Como é que o APE é visto na comunidade? Porquê?
9. A comunidade reconhece/respeita o trabalho de APE? Como?

TAREFAS DO APE NA COMUNIDADE

IV. Tarefas
1. Que aspectos influenciam a forma como os trabalhadores de saúde se sentem sobre as tarefas que realiza como APE? Explorar: expectativas da comunidade, pacientes, outros trabalhadores e supervisores;
2. Como é que eles (trabalhadores da Saúde, pacientes e comunidades) se sentem sobre o alcance dessas expectativas, preocupações, o que acontece se algo der errado, se um paciente reclama? Se apropriado, explorar, sobre a legislação de tarefas relacionadas clinicamente;
3. Quanto tempo gasta nas tarefas como APE por dia ou semana? Quanto tempo dedica as actividades curativas? E as actividades de promoção de saúde e prevenção de doenças? Pode dar exemplos?
4. Como organiza as actividades de promoção de saúde e prevenção de doenças?
5. Como organiza as actividades de cura/curativas?

V. Pacientes da comunidade
1. Quem são os seus pacientes?
2. Por favor, pode desenhar um mapa da comunidade/enfermaria e indicar de onde vêm os pacientes? Explorar sobre quem vive em cada uma das áreas indicadas e as áreas onde não tem pacientes?
3. Explorar o porquê. Se outros Trabalhadores Comunitários de Saúde cobrem outras áreas, perguntar se alguma outra área é deixada de fora e porquê. Explorar quem na comunidade lhe apoia, como, e porquê?

FACILITADORES, BARREIRAS E LIÇÕES APRENDIDAS

VI. Facilidades e barreiras
1. O que você acha que está a correr bem no seu trabalho? Dê exemplos?
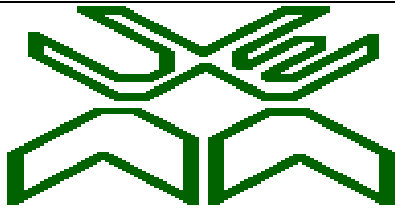2. O que facilita para que seu trabalho corra bem? Dê exemplo

VII. Lições aprendidas, restrições de oportunidades
1. Pensando sobre o seu trabalho e o que pode ser feito para melhorá-lo, o que você sugere? Como isso poderia ser feito?

de como isso funciona?

3. O que você acha que não corre sempre bem? Pode dar algum exemplo?

4. O que influencia para que essetrabalho não corra bem? Pode dar algum exemplo? Quando são dados exemplos tenta explorar as razões que podem influenciar o trabalho se elas não forem ditas espontaneamente.

2. Tem se reunido com outros APEs? Falam sobre o trabalho de APE? O que discunte?

3. Se quiser iniciar um programa como o seu em outro distrito o que deve ser feito para fazer o programa funcionar? O que deve ser evitado?

QUESTÕES POR EXPLORAR SE NÃO EXPLORADAS

8.1. Supervisão

8.1.1. Voces tem recebidos supervisão?

8.1.2. Como é que a supervisão acontece?Explorar: O que você gosta sobre a supervisão e o que não gosta sobre a supervisão?

8.1.3. Quantas vezes eles sãosupervisionados? Quando foi a última vez? O que aconteceu?

8.1.4. A supervisão ajuda para melhorar o trabalho?

8.2. Controlo no trabalho

8.2.1. Como é que é feito o controlo do trabalho? Acha que essa forma de controlo influencia o seu desempenho?

8.2.2. Explorar: Influência dos tomadores de decisão, sentimento de impotência, processo de resolução deproblemas, por exemplo, o que acontece quando há problemas de fornecimento corrente ou outrosproblemas. Explorar o processo passo a passo

8.3. Bem-estar geral e interface de casa-trabalho

8.3.1. O que você sente que está a influenciar o seu bem-estar?

8.3.2. Acha que o trabalho como APE influencia o seu bem-estar? Como? Por favor pode explicar? É facil conbinar/consiliar o seu trabalho como APE com a sua vida doméstica?Explorar: proximidade com a família, a importância relativa do trabalho e da vida doméstica, a carga detrabalho, (várias tarefas fora do trabalho do APE em sua casa e na comunidade) formas e a importância do relaxamento e recreação

8.1. Qualidade dos cuidados

8.1.1. O que você acha sobre a qualidade dos cuidados, em geral, dos serviços de saúde prestados?

8.1.2. O que voce acha sobre o seu próprio trabalho?

8.1.3. Como voce vê ou define qualidade de trabalho? Quando é que o serviço/cuidado é bom ou não bom.

8.1.4. Como é que a qualidade do seu trabalho é avaliada? Por quem? Como? Como você se sente sobre isso?

8.1.5. Você recebe comentários sobre o seu trabalho? Explorar as diretrizes, protocolos, monitoria da qualidade.

8.1.6. O que você acha que as pessoas na comunidade pensam sobre a qualidade dos serviços de saúde? Sobre o seu trabalho?

8.1.7. Como você sabe o que a comunidade ou os pacientes pensam sobre os serviços que presta? O que eles gostam mais? O que eles gostam menos?

Acha que pode melhorar a qualidade do seu trabalho? Como?

COMUNICAÇÃO E REFERÊNCIAS	73| P a g e

8.1. Comunicação e interacção com colegas

8.1.1. Comunica-se com seus colegas? Como, quando, quantas vezes? É útel para o seu trabalho?

8.1.2. Como é que é a comunicação e interacção com os colegas (todos os quadros, incluindo supervisores,responsáveis de departamentos e outros) influenciam a satisfação e motivação no trabalho?

8.1.3. Explorar: canais de comunicação, reuniões, contactos informais, quantas vezes, sobre o que é a comunicação. Sentimentos sobre a comunicação.

8.4. Referência/transferência

8.4.1. O que você faz quando um paciente tem um problema que você não pode resolver?

8.4.2. A quem você refere o paciente?

8.4.3. Como é que o processo de referência funciona?Explorar: diferentes processos de referência para diferente condição, pedir exemplos.

8.4.4. O que se corre bem e não tão bem sobre a referência? Porquê? Exemplos?

8.5. M&A

8.5.1. Que registos de si ou outros sobre o seu trabalho você guarda? Como essa informação é recolhida? Que canais de comunicação são utilizados? O que acontece com esta informação?

8.5.2. Você recebe feedback sobre os resultados do seu trabalho? Se sim, como isso é comunicado e por quem? Você sabe, se algo precisa de ser melhorado? Se sim, como e por quem? Exemplos?

8.6. Uso de telemóvel para a saúde

8.6.1. Você usa tecnologia móvel (celulares, PDAs) no seu trabalho? Para que propósito a usa?

8.6.2. Explorar para uso diferente: para recolher e enviar informações, para coordenar coisas, para procurar conselho dos outros, para entrar em contacto com os pacientes. Para cada uso, descobrir o quê, com quem e com que frequência.

8.6.3. Quem comprou o aparelho? Quem paga os custos de utilização, o carregamento, etc?

8.6.4. Como você se sente sobre o uso desses dispositivos: vantagens, desvantagens?

GUIÃO PARA DGF DOS UTENTES DO APE	
	Título da Pesquisa: *Desempenho e Sustentabilidade dos APEspara Melhorar os Serviços de Saúde em Moçambique.*

Nome da Unidade Sanitária que é Referênciado:_____

Comunidade onde Reside:_____

Código:_____	Data da entrevista: _____/_____ / 2013

Entrevistador:

Anotador:

Entrevista Gravada: □ Sim   □ Não

Nos países subdesenvolvidos, dos quais Moçambique é parte integrante, a equidade e a igualdade no acesso aos serviços e cuidados de Saúde tem constituido um problema. Tendo em conta estes problemas, vários programas e politicas têm sido desenvolvidas tendentes a aproximar os cuidados de saúde as populações, sobretudo as mais vulneraveis e residentes nas zonas peri-urbanas e rurais. Ciente desta problemática o Projecto Reachout Moçambique está a desenvolver uma avaliação formativa que visa analisar o desempenho e Sustentabilidade dos APEs na melhoria de serviços de saúde em Moçambique. Esta avaliação procura medir a eficácia e a eficiência dos serviços comunitários de saúde prestados pelos APEs e igualmente a maneira pela qual se pode alcançar serviços mais equitativas. Com base neste estudo vão-se criar plataformas e mecanismos de intervenção para a melhoria do programa nacional dos APEs em diferentes niveis identificados. Nesta sequência vamos requer que reflita e responda sobre o trabalho dos APEs nas comunidades. Vamos procurar saber como é que eles ajudam as comunidades, como fazem a referência para as unidades Sanitárias, o que deveriam fazer e o que não fazem e o que estão a fazer mal e que pode ser melhorado.

DADOS SÓCIO-DEMOGRÁFICOS E SÓCIO-ECONÓMICOS

Idade:_____ anos	**Sexo:** Feminino□ Masculino□

Estado civil: Solteiro(a) □Casado(a)/União de facto□ Separado (a) ou Divorciado(a) □Viúvo(a) □

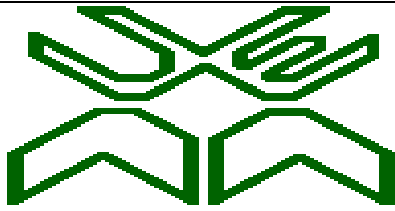|	
Onde nasceu:_____ Que comunidade pertence:_____ Como se chama o program de envolvimento comunitário da sua comunidade:_____ Lingua que fala:	**Qual é o seu grau de escolaridade:_____**

PERCEPÇÕES SOBRE OS SERVIÇOS DOS APEs E SUA QUALIDADE

1.Questões gerais

1. A que tipo de problemas de saúde/doenças recorre a APEs?
2. O que é que ele faz para cada tipo de problema ou doença?
3. Tem procurado o APE? Quando e porquê?
4. Qundo é que o APE visita a sua casa? O que faz?
5. O que é que acha que ele devaria fazer mais que não faz? E Porquê?

5.1. Percepção dos serviços do APE

5.1.1.   Que percepções tem sobre os cuidados e tratamento que recebe dos APEs?.Explorar: disponibilidade acesso (facilitadores e barreiras).

Explorar: utilidade do diagnóstico, promoção, funções clínicas e preventivas, se relevante.

Sente-se satisfeito com o tratamento e orientação para prevenção e auto-cuidado dado pelo APEs? O que acha sobre o que ele ensina?

6.   Percepções sobre qualidade de serviço

1. Como você se sente sobre as habilidades e os conhecimentos do APE?
2. Que limitações acha que tem o APE?
3. Como você se sente sobre a sua atitude para com os pacientes. Peça exemplos.
4. O que você aprecia em seus serviços? Dê exemplos
5. **O que você gostaria de ver melhorado?**

PACIENTES NA COMUNIDADE

II. Pacientes da comunidade

1. Quem são as pessoas da comunidade que procuram cuidados do APEs?
2. Há qualquer grupo na sua comunidade ou comunidades vizinhas que é deixado de fora do acesso aos serviços? Se sim, quem são essas pessoas? Porquê esse é o caso?
3. Há questões em torno da estigmatização dos pacientes e APEs em determinados programas (Planeamento Familiar, HIV/SIDA, TB?).
4. Qual é o envolvimento da comunidade com o programa dos APEs?
5. O que você acha que é a importância do programa dos APEs?
6. Qual é a sua potencial contribuição? Você vê alguma desvantagem desse programa?
7. O que você acha que vai muito bem no programa dos APEs? Dê exemplos?
8. Que coisas acha que ajudam para o programa correr bem. Explorar sobre um caminho (fluxo de eventos, razões pelas quais algo corre bem)?
9. O que você acha que nem sempre corre bem? Pode dar um exemplo?
10. Que coisas estão influenciando que este não vai bem? Pode dar um exemplo?

Quando são dados exemplos tenta explorar as razões que podem influenciar o trabalho se elas não forem ditas espontaneamente.

REFERÊNCIAS E COMUNICAÇÃO

Referência/transferência

1. Quando um APE não consegue resolver um problema da saúde o que é que ele faz?
2. Quando recebem uma nota de referência como são recebidos? O que correu bem e o que não correu bem? Pode dar exemplos?
3. O que corre bem e não tão bem na referência? Porquê? Exemplos?

Uso de telemóvel para a saúde

1. Poderia me dizer se os APEs usam alguma tecnologia móvel (celulares) no seu trabalho? Outros trabalhadores de saúde usam? Para que propósito a usam?
2. Como vocês se sentem sobre o uso desses dispositivos: vantagens, desvantagens?

CUSTOS DE SERVIÇOS PARA AS COMUNIDADES

Custos

1. Pagam alguma coisa pelo serviço do APEs (dinheiro, produtos)? Se paga o que é paga? Que tipo de serviços pagam?

	Título da Pesquisa: *Desempenho e Sustentabilidade dos APEspara Melhorar os Serviços de Saúde em Moçambique.*	

Nome da Unidade Sanitária que é Referênciado:_____

Comunidade onde Reside:_____

Código:_____	Data da entrevista: _____/_____ / 2013

Entrevistador:
Anotador:
Entrevista Gravada: ☐ Sim   ☐ Não

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DADOS SÓCIO-DEMOGRÁFICOS E SÓCIO-ECONÓMICOS

Idade:_____ anos	**Sexo:** Feminino☐ Masculino☐

Estado civil: Solteiro(a) ☐Casado(a)/União de facto☐ Separado (a) ou Divorciado(a) ☐Viúvo(a) ☐

Onde nasceu:_____ Que comunidade pertence:_____ Como se chama o program de envolvimento comunitário da sua comunidade:_____ Lingua que fala:	**Qual é o seu grau de escolaridade:**_____

PERCEPÇÕES SOBRE OS SERVIÇOS DOS APEs E SUA QUALIDADE

1.Questões gerais

7. Conhece o APE? O que faz na comunidade?
8. Quem escolheu o APE? Ha pessoas na comunidade que não gostam do APEs escolhido?Porquê?
9. O que é que o APEs faz na comunidade? Como?
10. Como é que ele ajuda as comunidades?
11. A que tipo de problemas de saúde/doenças as pessoas da comunidade recorrem a APEs?
12. O que é que ele faz para cada tipo de problema ou doença?
13. As pessoas na comunidade tem procurado o APE? Quando e porquê?
14. Qundo é que o APE visita a sua casa? O que faz?
15. O que é que acha que ele devaria fazer mais que não faz? E Porquê?

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15.1. Percepção dos serviços do APE

15.1.1. Acha que o trabalho do APE contribui para a melhoria de qualidade da saúde da comunidade? Como?

15.1.2. Voce como lider comunitário gosta do trabalho do APE? Porquê?

15.1.3. Que percepções tem sobre os cuidados e tratamento que a comunidade recebe dos APEs?.Explorar: disponibilidadee acesso (facilitadores e barreiras).

Explorar: utilidade do diagnóstico, promoção, funções clínicas e preventivas, se relevante?

15.1.4. Como lider, acha que a sua comunidade sente-se satisfeito com o tratamento e orientação para prevenção e auto-cuidado dado pelo APEs? O que acha sobre o que ele ensina?

</td><td>

16. Percepções sobre qualidade de serviço

6. Como você se sente sobre as habilidades e os conhecimentos do APE?

7. Que limitações acha que tem o APE?

8. Como você se sente sobre a sua atitude para com as comunidades. Peça exemplos.

9. O que você aprecia em seus serviços? Dê exemplos

10. O que você gostaria de ver melhorado?

11. Como é que avalia o trabalho do APE na comunidade?

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PACIENTES NA COMUNIDADE

II. Pacientes da comunidade

11. Quem são as pessoas da comunidade que procuram cuidados do APEs?
12. Há qualquer grupo na sua comunidade ou comunidades vizinhas que é deixado de fora do acesso aos serviços? Se sim, quem são essas pessoas? Porquê esse é o caso?
13. Há questões em torno da estigmatização dos pacientes e APEs em determinados programas (Planeamento Familiar, HIV/SIDA, TB?).
14. Qual é o envolvimento da comunidade com o programa dos APEs?
15. O que você acha que é a importância do programa dos APEs?
16. Qual é a sua potencial contribuição? Você vê alguma desvantagem desse programa?
17. O que você acha que vai muito bem no programa dos APEs? Dê exemplos?
18. Que coisas acha que ajudam para o programa correr bem. Explorar sobre um caminho (fluxo de eventos, razões pelas quais algo corre bem)?
19. O que você acha que nem sempre corre bem? Pode dar um exemplo?
20. Que coisas estão influenciando que este não vai bem? Pode dar um exemplo?

Quando são dados exemplos tenta explorar as razões que podem influenciar o trabalho se elas não forem ditas espontaneamente.

REFERÊNCIAS E COMUNICAÇÃO

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Referência/transferência

4. Quando um APE não consegue resolver um problema da saúde o que é que ele faz?

5. Quando as pessoas da comunidade recebem uma nota de referência como são recebidos no hospital? O que correu bem e o que não correu bem? Pode dar exemplos?

6. O que corre bem e não tão bem na referência? Porquê? Exemplos?

</td><td>

Uso de telemóvel para a saúde

3. Poderia me dizer se os APEs usam alguma tecnologia móvel (celulares) no seu trabalho? Outros trabalhadores de saúde usam? Para que propósito a usam?

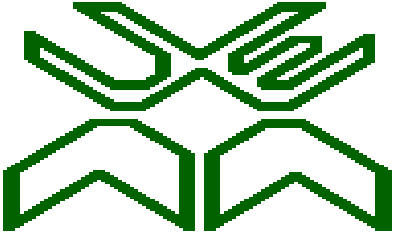4. Como vocês se sentem sobre o uso desses dispositivos: vantagens, desvantagens?

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MOTIVAÇÃO E RETENÇÃO
1. O que é que a comunidade faz para ajudar o APEs a trabalhar bem? Como?
2. Acha que o APE sente que a comunidade o ajuda no seu trabalho?
3. O que acha que a comunidade deveria fazer para que o APE se sinta muito feliz em trabalhar?
4. Como lider comunitário o que faz para motivar o APE no seu trabalho? Para além do que faz, acha que poderia-se fazer mais alguma para ajudar o APE no seu trabalho?
5. Acha que o APE se sente safisfeito com o seu trabalho?

CUSTOS DE SERVIÇOS PARA AS COMUNIDADES

Custos
1. As comunidades pagam alguma coisa pelo serviço do APEs (dinheiro, produtos)? Se paga o que é paga? Que tipo de serviços pagam?

GUIÃO DE ENTREVISTA PARA GESTORES DE SAÚDE E FAZEDORES DE POLITICAS		
	Título da Pesquisa: *Desempenho e Sustentabilidade dos APEs para Melhorar os Serviços de Saúde em Moçambique.*	

Instituição que o entrevistado Representa:

Código:_____	Data da entrevista: _____/____ / 2013

Entrevistador:

Anotador:

Entrevista Gravada: ☐Sim   ☐Não

Nos países subdesenvolvidos, dos quais Moçambique é parte integrante, a equidade e a igualdade no acesso aos serviços e cuidados de Saúde tem constituido um problema. Tendo em conta estes problemas, vários programas e politicas têm sido desenvolvidas tendentes a aproximar os cuidados de saúde as populações, sobretudo as mais vulneraveis e residentes nas zonas peri-urbanas e rurais. Ciente desta problemática o Projecto Reachout Moçambique está a desenvolver uma avaliação formativa que visa analisar o desempenho e Sustentabilidade dos APEs na melhoria de serviços de saúde em Moçambique. Esta avaliação procura medir a eficácia e a eficiência dos serviços comunitários de saúde prestados pelos APEs e igualmente a maneira pela qual se pode alcançar serviços mais equitativas. Com base neste estudo vão-se criar plataformas e mecanismos de intervenção para a melhoria do programa nacional dos APEs em diferentes niveis identificados. Nesta sequência vamos procurar saber Neste estudo vamos lhe pedir que reflecta sobre o programa dos APES em Moçambique. Vamos procurar saber das barreiras e aspectos facilitadores da implementação do programa. Procuramos compreender questões ligadas as ploticas, recursos humanos, motivações e retenção dos APEs, bem como o que se espera com este programa.

DADOS SÓCIO-DEMOGRÁFICOS E SÓCIO-ECONÓMICOS

Idade:_____ anos	**Sexo:** Feminino☐ Masculino☐

Estado civil: Solteiro(a) ☐Casado(a)/União de facto ☐Separado (a) ou Divorciado(a) ☐Viúvo(a) ☐

Qual é o seu local de nascimento?	**Qual é o seu grau de escolaridade?**

Na Prov. de Maputo:
    Cidade de Maputo ☐
    Cidade da Matola ☐
Niassa, Cabo Delgado ou Nampula ☐
Manica, Sofala, Zambezia ou Tete ☐
Inhambane ou Gaza ☐
Outro Pais _____
	Ens. Primário ☐Ens. Básico ☐Ens. Médio☐
	Licenciado☐
	Outro☐ (especificar):_____

Para que Organização trabalha? Em que departamento trabalha?	Quais saõ as suas funções?

NOTAS INTRODUTÓRIAS

Introdução
1. Você pode me dizer um pouco sobre o seu trabalho, as tarefas que você faz em um dia normal?
2. Qual tem sido o seu envolvimento com o programa dos APEs? Como você sabe sobre o programa?
3. Você está em contacto directo com os APEs? Em caso de contacto direto qual é o seu papel? Explorar sobre tarefas, a frequência dos contactos? Para quê?

4. Que meios usam para entrar em contacto com os APEs?

FACILITADORES, BARREIRAS E LIÇÕES APRENDIDAS

II. Facilidades e barreiras
1. O que você acha que é a importância do programa dos APEs? Você vê alguma desvantagem desse programa? Que impacto espera do programa?
2. O que você acha que vai muito bem no programa dos APEs? Dê exemplos? Que coisas acha que ajudam para o programa correr bem. Explorar sobre um caminho (fluxo de eventos, razões pelas quais algo corre bem)?
3. O que você acha que nem sempre corre bem? Pode dar um exemplo? Que coisas estão influenciando que este não vai bem? Pode dar um exemplo?
4. Quando são dados exemplos tenta explorar as razões que podem influenciar o trabalho se elas não forem ditas espontaneamente.

III. Lições aprendidas, restrições de oportunidades
1. Pensando sobre o programa dos APEs e o que pode ser feito para melhorá-lo, o que você sugere? Como isso poderia ser feito?
2. Se quisermos iniciar um programa como este em outras áreas o que deve ser feito para fazer o programa funcionar melhor? O que deve ser evitado?
3. O que mudaria no actual programa?

QUESTÕES POR EXPLORAR SE NÃO EXPLORADAS

4.1. Políticas
4.1.1. Quais as orientações para os APEs que você tem conhecimento? Quais são os aspectos mais importantesdessas orientações na sua opinião?
4.1.2. Quais são os pontos fortes que podem ser ainda melhorados?
4.1.3. Quais são os pontos fracos que podem ser melhorados?

4.2. Planificação de RH
4.2.1. Você está familiarizado com a planificação dos APEs? Se sim, como está organizada? Explorar: proporção da população servida; critérios/processo de selecção de áreas onde eles trabalham? Processo para a identificação de tarefas e legislação de tarefas, avaliação da carga de trabalho, integração no sistema de saúde.
4.2.2. O que você acha sobre cada uma dessas medidas? Se você tivesse que decidir o que deveria acontecer em um novo programa, o que você incluiria e o que você faria de diferente?

4.3. Gestão de RH
4.3.1. Como os APEs são recrutados e quais são os critérios de selecção?
4.3.2. Quais são os seus incentivos, renumeração, perspectivas de carreira, formação, formação contínua e supervisão?
4.3.3. O que você acha sobre cada uma dessas medidas?

4.4. Motivação
4.4.1. Que coisas influenciam a satisfação e motivação no trabalho dos APEs e como? O que os motiva ou osdesmotiva?Explorar: equipamentos e suprimentos, carga de trabalho, ambiente de trabalho, comunicação, equipamentos e transporte,

Se você tivesse que decidir o que deve acontecer em um novo programa, o que você incluiria e o que você faria de diferente?Explorar: sentimentos sobre voluntarismo e renumeração regular.	segurança e assédio sexual, perspectiva de carreira, supervisão, comunidade, pacientes, colegas e outros profissionais de saúde.

4.5. Estruturas, incluindo a legislação

4.5.1.	Que coisas influenciam a forma como os APEs se sentem sobre as tarefas que realizam?Explorar: expectativas da comunidade, pacientes, outros trabalhadores de saúde e supervisores, como eles se sentem sobre o alcance dessas expectativas, preocupações, o que acontece se algo der errado, se um paciente reclamar? Se for o caso, explorar sobre legislação de tarefas clinicamente relacionadas.

4.6. Pacientes da comunidade

4.6.1.	Quem são os pacientes dos APEs? É qualquer grupo de fora?

4.6.2.	Há questões em torno da estigmatização dos pacientes e APEs em determinados programas (Planeamento Familiar, HIV/SIDA, TB?). Todos os grupos relevantes são incluídos?

4.6.3.	Os grupos marginalizados e pobres são coberto pelos serviços dos APEs? Só pelos APEs? Qualquer grupo com acesso muito limitado?

4.7. Referência/transferência

4.7.1.	Como é que o sistema referência do programa dos APEs está organizado?Explorar: diferentes processos de referência para diferente condição, pedir exemplos.

4.7.2.	O que se corre bem e não tão bem sobre a referência? Porquê? Exemplos?

4.8. Controlo no trabalho

4.8.1.	Como os APEs são permitidos e limitados em seu controlo no trabalho?Explorar: Influência dos tomadores de decisão, sentimento de impotência, processo de resolução deproblemas, por exemplo, o que acontece quando há problemas de fornecimento corrente ou outrosproblemas. Explorar o processo passo a passo.

4.9. Qualidade dos cuidados

4.9.1.	O que você acha sobre a qualidade dos serviços de saúde prestados em geral?

4.9.2.	 Como é que a qualidade dos serviços dos APEs é organizada e avaliada? Como você se sente sobre isso? Explorara: Como as competências são mantidas, por exemplo, formação, formação contínua, supervisão?

4.9.3.	 Como é que a qualidade logística (equipamentos e medicamentos) é assegurada? Para cada um, quem é responsável? Quais são as actividades?

4.9.4.	Os APEs recebem feedback sobre o seu desempenho? Explorar: directrizes, protocolos de controlo dequalidade e feedback.

4.9.5.	O que você acha que as pessoas na comunidade pensam sobre a qualidade dos serviços de saúde prestados pelos APEs?

4.9.6.	Como você sabe o que a comunidade ou os pacientes pensam sobre os serviços prestados? O que eles gostam mais? Do que eles se queixam?

4.9.7.	Há alguma ONG envolvida em qualquer das

**4.10.	Comunicação e interacção com colegas**

4.10.1.	Como é que é a comunicação e interacção dos APEs e seus colegas (todos os quadros, incluindo supervisores, responsáveis de departamentos e outros) está organizada?Explorar: canais de comunicação, reuniões, contactos informais, quantas vezes, sobre o que é a comunicação. Sentimentos sobre a comunicação.

|	
actividades para garantir a qualidade do atendimento?Explora/perguntar de seguimento, conforme apropriado: Nome da ONG, as actividades realizadas; lideranças envolvidas: veja a folha de registo.	
4.11. M&A 4.11.1. Como a informação sobre o desempenho é recolhida? Que canais de comunicação são utilizados? O queacontece com esta informação? 4.11.2. Você dá feedback sobre os resultados do trabalho? Se sim, como isso écomunicado e por quem?	**4.12. Uso de telemóvel para a saúde** 4.12.1. Os APEs usam alguma tecnologia móvel (celulares, PDAs) no seu trabalho? Outros trabalhadores de saúde usam? Para que propósito a usa?Explorar para uso diferente: para recolher e enviar informações, para coordenar coisas, para procurar conselho dos outros, para entrar em contacto com os pacientes. Para cada uso, descobrir o quê, com quem e com que frequência. Quem comprou o aparelho? 4.12.2. Quem paga os custos de utilização, o carregamento, etc? 4.12.3. Como você se sente sobre o uso desses dispositivos: vantagens, desvantagens?

Annex 4: Root cause analysis and problem statements

Supervision root cause analysis
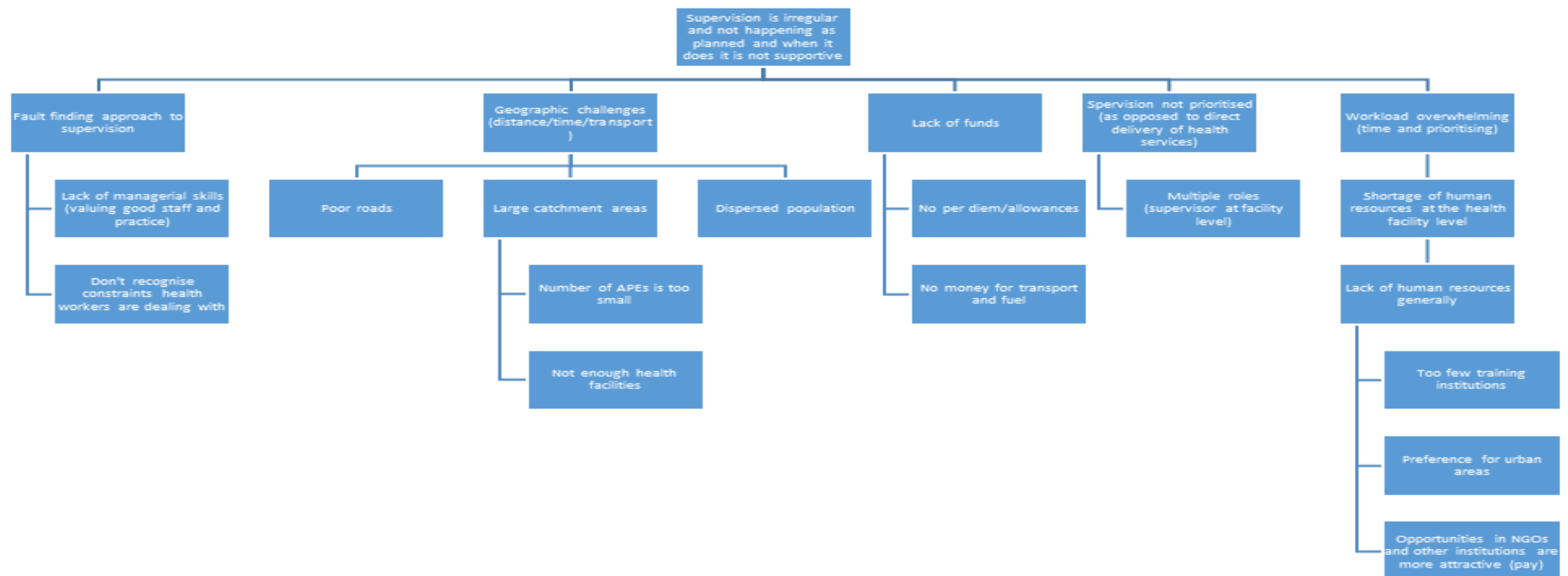
Workload root cause analysis
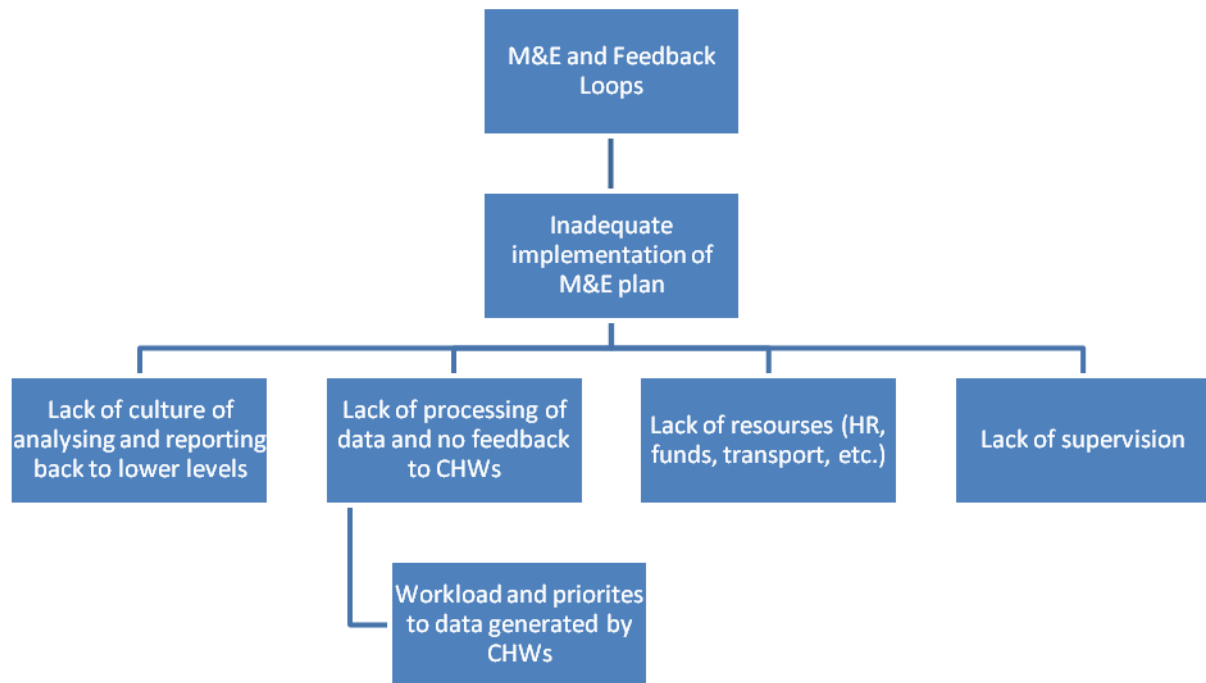
Training root cause analysis
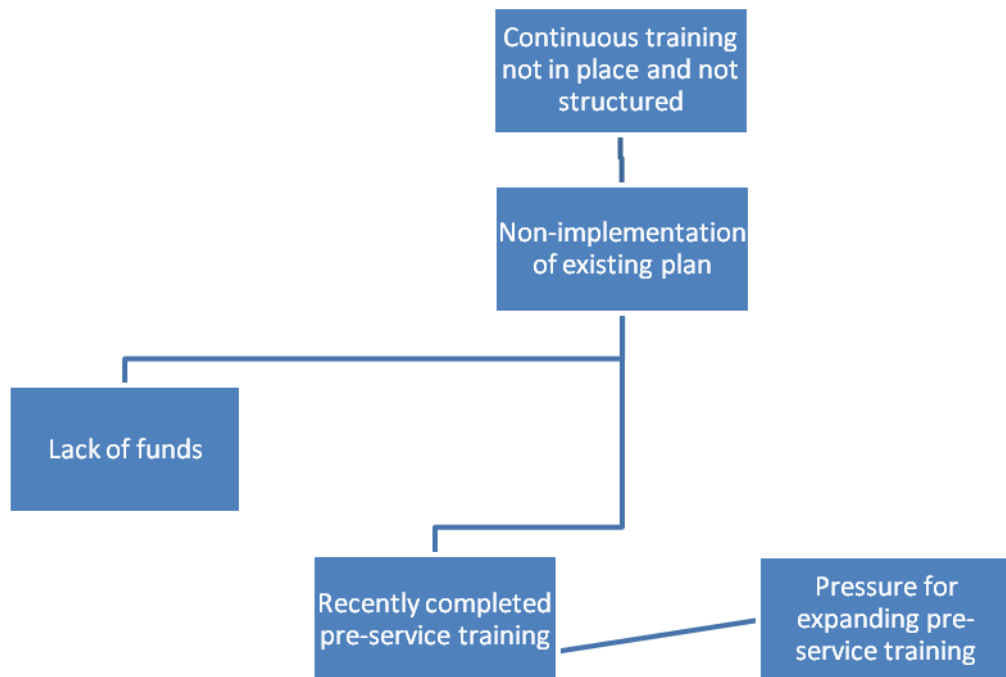
Annex 5: Coding framework

1. Close to community provider description
   a. Types
   b. Characteristics
   c. Duration of practice as a CTC provider

2. Community links
   a. Community context (e.g. Cultural and religious, migration, security, stigma and discrimination)
   b. Community engagement
   c. Recruitment and selection
   d. Community support to implementation, incentives, communication and transport
   e. Community governance (supervision, monitoring, accountability)
   f. Community capacity to claim rights
   g. Community expectations (e.g. Of CTC provider roles and tasks, client groups, curative versus promotive etc.)
   h. Community and client perceptions of providers and health services (e.g. Quality of care, valuing of CTC provider (e.g. recognition, trust, importance of CTC provider), CTC providers acting as role models)
   i. Community attitude to health
      i. Understanding and knowledge
      ii. Health seeking behaviour - service utilisation
      iii. Adoption of practices that promote health

3. HR management and planning
   a. Selection and recruitment
      i. Qualifications and attributes considered at selection
      ii. Gender dynamics
   b. Initial training – length and focus, MoH or NGO specific, content, appropriateness etc.
   c. CTC provider role
      i. Focus of the work (health intervention focus, e.g. HIV, maternal health)
      ii. Official tasks (curative, promotive) and tension of policy versus practice
      iii. Location of tasks (facility or community)
      iv. Understanding of role (e.g. provider, client, others)
   d. CTC provider workload (includes multiple tasks; CTC-client ratio etc.)
   e. Continuous professional development (refresher training; on-the-job training)
   f. Career prospects and advancement or attrition
   g. Financial incentives and disincentives
      i. Allowances, subsidies and incidentals
      ii. Salaries
      iii. Selling drugs, supplies or services
   h. Non-financial incentives and disincentives
      i. Material (e.g. uniform, transport such as bikes, accommodation)
      ii. Non material external (e.g. training, supervision, community recognition)
      iii. Non material internal (e.g. personal motivation and satisfaction, nature of the job itself, status in the community, comparison with others)
   i. Supervisory systems
      i. Approach and relationship (fault-finding, checklist, problem solving, mentoring etc.)
      ii. Implementation (who, hierarchy of reporting, feedback mechanism, frequency)
   j. Peer group formation and peer support

4. Programme Implementation

a. Access
   i. Transport and distance
   ii. Equity of access (gender, age and vulnerable groups)
b. CTC service delivery
   i. CTC client characteristics (adults, children, pregnant women etc. whole households)
   ii. CTC package of care (health education lectures, accuracy of diagnosis, appropriateness of treatment, kit contents)
c. Availability of staff and services (e.g. Doctors, nurses, CTC providers, volunteers, informal CTC providers, and coverage of services such as family planning, SRH, HIV, TB)
d. Quality of care
   i. Confidentiality
   ii. Adherence to protocols
   iii. Supervisor perceptions
   iv. Client-centred approach and attitudes (see also under community)
   v. Self-reflection (includes awareness of limitations)
e. Reporting, data systems, registers
f. Referral

5. Programme management

a. Protocols and tools, manual
b. Coordination and communication
   i. With clients
   ii. With volunteers
   iii. With other health providers and CTC providers
   iv. With and between NGOs
   v. With informal providers
   vi. Technical methods (e.g. mHealth, credit for airtime)
c. Supplies and logistics (e.g. Drugs, test kits and consumables supply , infrastructure, storage safety and availability of required once off materials - IEC materials, bicycle, manual)
d. Sustainability
   i. Financing (e.g. user fees and funding mechanisms)
   ii. Role of other organisations, including donors, UN agencies, NGOs, faith based organisations (e.g. dependence, departing NGOs, role and future commitment in co-financing)
   iii. Distortion caused by vertical programming and variation in incentives
   iv. National support

6. Programme Quality

a. M&E feedback loops (data analysis and use)
b. Quality assurance systems
c. District and national level governance
d. Policy change at national level (e.g. impact on programme of re-structuring, re-orientation of tasks)
e. Recommendations and suggestions

Annex 6: Copy of ethical approval letter

Anexo 1: Resultado final da revisão dos protocolos sujeitos a revisões profundas ou não aprovados.

Após a revisão do protocolo tendo em conta as recomendações do Conselho Científico		
O Investigador cumpriu com as recomendações da revisão anterior?	Sim ☐ ✔	Comentários:
	Não ☐	
O protocolo está apto para ser aprovado ?	Sim ☐ ✔	Se não Porquê? Explique brevemente as razões
	Não ☐	

Resultado final			
Escolha uma das seguintes alternativas	1. O Protocolo aprovado, recomenda-se a carta de aprovação		✔
	2. O Protocolo ainda requer pequenas alterações conforme os comentários anteriores		☐
	3. O Protocolo ainda requer alterações profundas		☐

Coordenadora do Conselho
Nome: **Natércia Fernandes**   Assinatura _Natércia Fernandes_   Data: 3 , 6 , 13
Secretariado:
Nome: **Cátia Taibo** _____   Assinatura _____   Data: / /

UNIVERSIDADE EDUARDO MONDLANE
FACULDADE DE MEDICINA
CONSELHO CIENTÍFICO

Exmo. Senhor
Prof. Doutor Moshin Sidat

Maputo, aos 3/6/2013

Assunto: Parecer sobre o protocolo " *Desempenho e Sustentabilidade dos APEs para melhorar os Serviços de Saúde em Moçambique*"

O Conselho Científico da Faculdade de Medicina analisou as correções efectuadas no protocolo acima mencionado e sobre o mesmo chegou a seguinte conclusão:

- O Conselho Científico da Faculdade de Medicina não vê nenhum inconveniente que impeça a realização do estudo pelo que, dá a sua devida aprovação,
- O Conselho Científico da Faculdade de Medicina recomenda que os investigadores o mantenham informado do decurso do estudo.

Sem mais de momento as nossas cordiais saudações.

Natércia Fernandes
Natércia Fernandes (MD, MSC, PhD)
Coordenadora do Conselho Científico

Comité Institucional de Bioética em Saúde
da Faculdade de Medicina/Hospital Central
de Maputo (CIBS FM&HCM)

H&M

O Dr. Jahit Sacarlal, Presidente do Comité Institucional de Bioética em Saúde da Faculdade de Medicina/Hospital Central de Maputo (CIBS FM&HCM)

CERTIFICA

Que este Comité avaliou a proposta do (s) Investigador (es) Principal (is):
Nome (s): Moshin Sidat
Protocolo de investigação datado de Maio de 2013
Consentimento informado – versão2_Maio de 2013
Guiões de entrevistas – versão 2_Maio de 2013

Do estudo:
TÍTULO: "ReachOut – Desempenho e sustentabilidade dos APEs para melhorar os Serviços de Saúde em Moçambique"

E faz constar que:
1º Após revisão das respostas dos investigadores das recomendações da reunião do dia 02 de Maio de 2013, acta 04/2013 o CIBS FM&HCM, emite este informe notando que não há nenhuma inconveniência de ordem ética que impeça o início do estudo
2º Que a reunião se realizou de acordo com o Regulamento do Comité Institucional da FM&HCM – emenda 1 de 19 de Fevereiro de 2013.
3º Que o protocolo está registado com o número CIBS FM&HCM/07/2013
4ª Que a composição actual do CIBS FM&HCM está disponível na secretária do Comité
5ª Que não existiu nenhum conflito de interesse registado pelos membros do CIBS FM&HCM.
6ª O CIBS FM&HCM faz notar que a aprovação ética não substitui a aprovação científica nem a autorização administrativa.
7ª Recomenda aos investigadores que mantenham o CIBS informado do decurso do estudo.

E emite
RESULTADO: APROVADO

Assinado em Maputo aos 16 de Maio de 2013

CIBS
FM & HCM

Faculdade de Medicina, Av. Salvador Allende nº702, telefone: 21428076   Página 1 de 1

Annex 7: Participants characteristic tables

Nr	APEs	Age	District	Education	Place of Birth	Marital state	Administrative Post	Sex
1	APE_Barrica	18-24 anos	Manhica	Secundario Geral	Maputo	Solteiro	Maluana	Male
2	APE_Chichongue	18-24 anos	Manhica	Secundario Geral	Gaza	Solteiro	Calanga	Famale
3	APE_Chirindza	18-24 anos	Manhica	Secundario Geral	Maputo	Solteiro	Maluana	Famale
4	APE_Doane	>45 anos	Manhica	Primario Grau 2	Maputo	Uniao marital	Maluana	Male
5	APE_Lagoa Pati	25-35 anos	Moamba	Primario Grau 2	Maputo	Casado	Calanga	Male
6	APE_Mobane	25-35 anos	Manhica	Secundario Geral	Maputo	Solteiro	Maluana	Male
7	APE_Munhangue	36-45 anos	Manhica	Primario Grau 1	Maputo	Solteiro	Calanga	Famale
8	APE_Pateque	25-35 anos	Manhica	Secundario Geral	Maputo	Solteiro	Maluana	Male
9	APE_Pondzoene	36-45 anos	Manhica	Primario Grau 1	Maputo	Uniao marital	Calanga	Famale
10	APE_Baptine	18-24 anos	Moamba	Secundario Geral	Maputo	Solteiro	Sabie	Famale
11	APE_Goane 2	18-24 anos	Moamba	Primario Grau 1	Maputo	Uniao marital	Sabie	Male
12	APE_Langa-Boi	18-24 anos	Moamba	Primario Grau 1	Maputo	Solteiro	Sabie	Famale
13	APE_Mahungo	36-45 anos	Moamba	Primario Grau 1	Inhambane	Casado	Sabie	Male
14	APE_Mavunguane	36-45 anos	Moamba	Primario Grau 1	Maputo	Solteiro	Sabie	Famale
15	APE_Missão	18-24 anos	Moamba	Secundario Geral	Maputo	Solteiro	Sabie	Male
16	APE_Mukhakhazi	18-24 anos	Moamba	Primario Grau 2	Maputo	Uniao marital	Sabie	Male
17	APE_Valha	18-24 anos	Moamba	Secundario Geral	Maputo	Solteiro	Sabie	Male
18	APE2_Missao	36-45 anos	Moamba	Primario Grau 1	Maputo	Divorciado	Sabie	Famale

Nr	Community Leaders	Age	District	Education	Place of Birth	Marital state	Administrative Post	Sex
1	Barrica	>45 anos	Manhica	Primario Grau 1	Maputo	Casado	Maluana	Male
2	Calanga	>45 anos	Manhica	Primario Grau 1	Maputo	Uniao marital	Calanga	Male
3	Chichongue	>45 anos	Manhica	Primario Grau 1	Maputo	Uniao marital	Calanga	Male
4	Doane	>45 anos	Manhica	Secundario Geral	Maputo	Casado	Maluana	Famale
5	Mahungo	>45 anos	Moamba	Nenhuma	Maputo	Uniao marital	Sabie	Male
6	Valha	>45 anos	Moamba	Nenhuma	Maputo	Casado	Sabie	Male

Nr	Managers and supervisors	Age	District	Education	Place of Birth	Marital state	Administrative Post	Sex
1	Maluana	25-35 anos	Moamba	Secundario Geral	Maputo	Uniao marital	Maluana	Masculino
2	Corrumane	>45 anos	Moamba	Primario Grau 2	Maputo	Casado	Sabie	Feminino
3	Sabie	18-24 anos	Moamba	Secundario Geral	Inhambane	Uniao marital	Sabie	Masculino
4	Manhica	25-35 anos	Manhica	Secundario Geral	Sofala	Uniao marital	Not Applicable	Masculino
5	Moamba	25-35 anos	Moamba	Secundario Geral	Zambezia	Uniao marital	Not Applicable	Masculino