An equity analysis of the experiences and expectations of the revitalised community health worker programme in Mozambique

BACKGROUND

In Mozambique, community health workers, known as Agentes Polivalentes Elementares (APEs), were introduced in response to communities' limited access to health care in remote, rural areas. After a number of setbacks, the APE programme was revitalised in 2010 to increase both the coverage and quality of essential health services. APE policy prioritises health promotion and disease prevention, stipulating that 80 per cent of APEs' time should be spent on this area, with just 20 per cent on curative care, such as diagnosing and treating malaria and diarrhoea.

Community health programmes have the potential to improve equity in health care: delivering services that are accessible, acceptable and of the same quality for everyone. In Mozambique, the impact of the APE programme on equity is unclear. Many factors influence equity, including those on the demand-side (for example, costs, age, gender and culture which affect health-seeking behaviour and access) and supply-side (health system policies and practice such as the location of APEs or their training). The impact of these factors is felt most by poor and vulnerable groups. APEs, who are embedded within their communities, serve as a bridge between the rural community and the health system, and must satisfy the needs and requirements of both. To explore the expectations and experiences of the APE programme from the perspective of equity, REACHOUT carried out a qualitative study in two rural districts in Maputo province. In all, 29 in-depth interviews were held with APEs, their supervisors at the district and health facility level and community leaders, as well as nine focus group discussions with mothers of children under age five who had used APE services. Interviews were translated, verified and analysed using a framework approach.

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KEY FINDINGS

"Sometimes is difficult to me when a community come to me to have a health service and I tell them that this disease I cannot treat. I would like to have more training to avoid this and help much more my community."

APE, male, 36 years old

Overall, APE health services were seen as improving equity compared to those provided by the health facility, in terms of access, acceptability and quality. Three themes arose from the analysis: they illustrate the interaction and tensions between community perspectives (demand-side) and health system policy and practice (supply-side).

- Quality, access and coverage: APEs were valued in both districts: the community, most supervisors and the APEs themselves all rated the quality of their services as good. Complaints related to stock-outs of medicine and the lack of APEs. Participants felt that APEs did not discriminate between members of the community: a key indicator of equity. Most community members found APEs more approachable than health facility staff. Distance and lack of transport affected access to services, making it difficult for members of the community to reach health facilities and for APEs to visit remote homes, especially when carrying heavy supplies.
- Availability of responsive and appropriate services: Given the limited coverage of health services and remoteness of health facilities, communities felt that APEs' tasks should be broadened to include a wider range of curative services, such as immunisation and antenatal care. Community members, APEs and some managers saw additional training for APEs as the answer. APEs, who were seen as "community doctors", were caught between supply and demand: struggling to fulfil APE policy prioritising health promotion and prevention as well as the community's demands for increased curative services.
- Accountability and ownership of APEs: APEs and their supervisors expected the role to act as a bridge between communities and the health system. APEs felt loyal and responsible to the community as well as accountable to their supervisors. Some APEs found creative ways of meeting the requirements of both, for example spending time on individual curative care while disseminating health promotion messages to large groups to meet the 20:80 per cent target.

LIMITATIONS

Women who were interviewed in-depth after they received MR services were not enlisted from the community, and were questioned in clinics rather than at home. Because of the selection strategy, women who had received MR services from informal providers only were not included in the study, and their experiences were not recorded. A further limitation concerns perspective. Issues of trust and relationship between CTC providers and the community were viewed from the providers' point of view only rather than from the clients' perspective. Additional research should endeavour to capture clients' voice.

CONCLUSIONS

Communities felt that APE services improved equity in health care compared to the services provided by the health facility. They appreciated the APEs, rated the quality of care as good, and considered that their services were accessible and acceptable. In low-income settings where the health system is weak, APEs face significant challenges in meeting all the needs of adults and children in rural communities where people may have limited or no access to health care. APEs must strike a delicate balance between satisfying the community's demands for curative services and complying with official policy focused on health promotion and prevention of diseases, and be accountable to both. APE policy appears at odds with rural communities' perceived health needs, who lack the resources to travel to a distant health facility, and therefore view the APE as a "community doctor" who they can turn to for treatment. APEs succeed at times in reconciling the conflicting needs and demands of both. If the range of services offered by APEs was extended to encompass more curative care, without sufficient training or supportive supervision, the quality of care could suffer.

The closeness of APEs to the community also presents opportunities. APEs are in a unique position to understand the community's cultural attitudes towards health, and can boost demand for health services, helping to reduce delays in people seeking health care. This REACHOUT study emphasises the need to look at the factors affecting the demand and supply of health care in the community. In order to improve the effectiveness and equity of the CHW programme in Mozambique, it is vital to foster communication between stakeholders, including the community and APEs.

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Give C.S., Sidat M., Ormel H., Ndima S., McCollum R. and Taegtmeyer M. (2015) **Exploring competing experiences and expectations of the revitalized community health worker programme in Mozambique: an equity analysis,** Human Resources for Health 2015, 13:54

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