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Public Health Congress 2018: Frontline health workers profiling of Maternal and New-born Care (MNCH) burden in local communities in Nigeria: A case study of Bauchi and Cross River State - Ibrahim Suleiman - Population Council

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Statement of the Problem: Women and children are faced with a huge disease burden in local communities where Frontline Health Workers (FLHWs) deliver maternal, newborn and child health services. Methodology & Theoretical Orientation: To find out about the disease burden with a view to designing appropriate interventions towards empowering FLHWs to respond to the situation. A house hold survey was conducted among 1,548 respondents in selected LGAs of Bauchi and Cross River States (CRS), as part of a need assessment that took place in host communities. The data was analyzed using SPSS software. Findings: Reported illnesses among women were diseases (Bauchi: 20.9%; CRS: 8.4%), eclampsia (Bauchi: 5.2%; CRS: 0.2%), 41.4% were treated in PHCs and 33.3% in chemists with recovery rates (Bauchi, 54.2%; CRS 51.2%) and reported client satisfaction (Bauchi: 91.5%; CRS: 69.4%). Newborn and under-fives mainly suffered from watery stool (Bauchi: 36.5%; CRS: 10.9%), treated at PHC (Bauchi: 22.4%; CRS: 18.5%) and responded to treatment (Bauchi: 29.8%; Cross River: 33.2%) and to household satisfaction (Bauchi 55.6%, CRS: 39.3%). For under-fives??? illnesses report included fever (Bauchi: 55.6%; CRS: 49.8%), cough with catarrh (Bauchi: 24.8%; CRS: 37.0%) and watery stool (Bauchi: 17.8%; CRS: 10.8%) with treatment occurring in PHCs (Bauchi: 29.5%) and patent medicine vendors (CRS: 28.3%). Successfully treated under-fives (CRS: 56.2%; Bauchi: 40.6%) to household satisfaction (Bauchi: 66.2%; CRS: 62.4%). Deaths occurred among women 64% (Bauchi: 53.1%: CRS: 46.9%), due to wish of god (Bauchi: 38.2%), diseases (CRS: 46.7%), inadequate FLHW care in (Bauchi 41.2%) and spiritual attacks (CRS 73.3%). Newborns and under-fives died 79% (Bauchi 67.1% CRS 32.9%) from unknown causes (Bauchi: 41.5%; CRS: 30.8%) and wish of God (Bauchi, 88.7%; CRS 38.5%). Conclusion & Significance: Knowledge of household disease burden and perception of the causes of death will help in designing effective interventions for FLHWs to mitigate maternal and child health related diseases.

Study strengths and limitations

To our knowledge, this is the first qualitative study exploring the scope of practice of 10 different CHW cadres providing MNH services in five LMICs across two continents. Furthermore, it uses a working definition to purposively select CHWs and competency-based categories to objectively compare CHWs across continents. However, despite reviewing the policy documents of study countries and holding discussions with in-country partners while developing the study proposal, it was difficult to map out all the key groups of CHWs providing MNH services in these countries. Due to time and budget constraints, the primary research team had limited in-country discussions with the staff of governmental and non-governmental organisations without engaging community-level stakeholders. Consequently, the team left out some community support groups who would have qualified as lay health workers (working with paraprofessional CHWs) based on the working definition of CHWs.

We conducted a qualitative study using a multiple-case study design to explore the training duration, characteristics and scope of practice of CHWs providing MNH services in sub-Saharan Africa and South Asia. Five study countries were selected using multistage sampling. The countries in each subcontinent constituted the first-stage sampling units. Subsequently, relevant WHO documents. were reviewed to identify countries known to have health workforce shortages, high maternal mortality ratios and high neonatal mortality rates. These countries made up the second-stage sampling units and included 42 countries in sub-Saharan Africa and five in South Asia. The third stage entailed a comparison of these 47 countries with the 11 countries where the Centre for Maternal and Newborn Health at the Liverpool School of Tropical Medicine (authors' institution) was implementing the 'Making it Happen' programme to reduce maternal and newborn mortality and morbidity. All 11 programme countries were experiencing challenges with health workforce crisis and maternal and neonatal mortality and were included in the third stage sampling unit. Using a limited literature review, countries with a high density of CHWs providing MNH services were identified including Bangladesh and India (South Asia) and Kenya, Malawi and Nigeria (sub-Saharan Africa). Within each of these study countries, the location of the Making it Happen programme offices informed the selection of the study districts, states or counties as these offices provided logistic support for the study. A document review was done using the most recent versions of government policy documents which described CHW characteristics and their scope of practice in MNH care. The main cadres of CHWs providing MNH services in these countries include community healthcare

providers (CHCPs), community skilled birth attendants (CSBAs), family welfare assistants (FWAs) and health assistants (HAs) in Bangladesh; accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs) in India; community health volunteers (CHVs) in Kenya; health surveillance assistants (HSAs) in Malawi; and community health extension workers (CHEWs) and junior community health extension workers (JCHEWs) in Nigeria.

To understand and check if these were the main CHW cadres in each country, we purposively selected a sample of community and formal health system level stakeholders as study participants and invited them to participate in the study through email, phone calls and, where possible, face-to-face interview. Written consent was obtained from all study participants in English or in the relevant local language.

Results

Irrespective of training duration (8 days to 3 years), all CHWs identify pregnant women, provide health education and screen for health conditions that require a referral to a higher level of care. Therapeutic care, antenatal care and skilled birth attendance, and provision of long-acting reversible contraceptives are within the exclusive remit of CHWs with training greater than 3 months. In contrast, community mobilisation and patient tracking are often done by CHWs with training shorter than 3 months. Challenges CHWs face include pressure to provide MNH services beyond their scope of practice during emergencies, and a tendency in some settings to focus CHWs on facility-based roles at the expense of their traditional community-based roles.

Conclusion

CHWs are geographically and socially well positioned to provide MNH services to communities especially if they live in and/or are from the community. Globally, policy-makers continue to 'reposition' the role of CHWs including regarding the provision of MNH services. There is a need to categorise CHWs based on the level of education and duration of pre-service training as this largely informs their roles with regard to provision (or not) of aspects of MNH services. Policy-makers must, however, recognise the tensions between CHW policy and practice in which CHWs may have an expanded, limited or skewed role in MNH care due to local realities which shape their practice. Subsequently, they will be better positioned in revising existing CHW scope of practice to respond to local health needs and priorities.

Biography

Ibrahim Suleiman has his expertise in health system strengthening, human resource for health and research. He is also a Reproductive Health Specialist working towards strengthening the health sector in collaboration with the Nigerian Government.

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