

**Christian Health
Association of Malawi:**
General Report of the Health
Workforce Productivity
Assessment and Early Progress
on Implementation of
Improvement Interventions

July 2015

Elled Mwenyekonde and **Mwai Makoka**, Christian Health Association of Malawi; **Theresa Nyamupachitu** and **Doris Mwarey**, IMA World Health; **Wanda Jaskiewicz**, IntraHealth International



USAID
FROM THE AMERICAN PEOPLE



CapacityPlus
Serving health workers, saving lives.



The views expressed in this document do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

INTRODUCTION

Similar to many African countries, Malawi faces numerous human resources for health (HRH) challenges, including production, deployment, retention, performance, and motivation of health workers, that hinder achievement of national health goals. For several years, the Malawian government and local and international cooperating partners have made significant investments in strengthening the health workforce in Malawi. They have directed their efforts toward increasing the staffing levels in various facilities, increasing capacity for health training institutions to improve the quality and quantity of output, and providing tools and an enabling environment for improved work performance.

The Christian Health Association of Malawi (CHAM) is a major stakeholder that has contributed to these efforts. CHAM provides 37% of health services in Malawi through its network of 175 health facilities nationwide and has the second-highest number of health workers (over 9,000) employed in its institutions after the Ministry of Health.¹ CHAM saw a critical need to maximize service delivery efficiencies by improving the productivity of the existing health workforce.

Health workforce productivity measures the number of health services produced by health workers in a given period of time. Assessing health workforce productivity at the health facility level is a key step for developing and implementing effective improvement strategies. CHAM, in collaboration with the *CapacityPlus* project—which is funded by the US Agency for International Development (USAID) and the President’s Emergency Plan for AIDS Relief (PEPFAR)—conducted a productivity assessment through a field test of the Health Workforce Productivity Analysis and Improvement Toolkit, developed by *CapacityPlus*.

The purpose of this report is to present findings from the assessment as well as early progress from implementation of the improvement interventions through June 2015.

METHODS

CHAM facilitated the productivity assessment in Dedza District, Malawi, by applying the stages and steps of the *CapacityPlus* [Health Workforce Productivity Analysis and Improvement Toolkit](#). The toolkit describes a step-wise process that empowers managers and supervisors to calculate the productivity of facility-based health workers, understand the underlying causes of productivity problems, and identify potential interventions to address them, thereby improving health service delivery and achieving health goals.

The objectives of the assessment were to:

- Measure health workforce productivity at select health facilities
- Assess and analyze the productivity problems by identifying their root causes

¹ Christian Health Association of Malawi: 2015-2019 Strategic Plan.

- Identify and prioritize possible interventions to improve the productivity of the health workforce in the facilities through a participatory process with stakeholders
- Draft an action plan to implement interventions to improve health workforce productivity.

The participatory process included a multisectoral stakeholder meeting in Dedza to orient stakeholders to the productivity assessment and improvement process, discuss the issues affecting the health workforce, and share preliminary findings to stimulate interest and action. Critical to the effort was the one-and-a-half day training to build the capacity of nine representatives from CHAM and the Dedza District Health Office (DHO) to apply the productivity analysis and improvement approach, including calculating workforce productivity, collecting qualitative data, analyzing the findings, and reporting out for decision-making and developing action plans. The training also involved conducting a pretest in a health center not included in the sample to practice applying the qualitative data collection instruments and to adapt the tools as needed.

The first stage in the assessment process was to calculate the productivity of the health workforce at each of the selected health facilities by completing stage one of the Health Workforce Productivity Analysis and Improvement Toolkit. The toolkit uses a quantitative, formula-driven approach to calculate health workforce productivity, as a ratio of the aggregate service delivery outputs (e.g., institutional deliveries, immunizations) produced to the human resources inputs (e.g., salaries) used, as illustrated in the following definition:

$$\frac{\text{Service delivery outputs}}{\text{HRH inputs}} = \text{Health workforce productivity}$$

(as measured by health services produced over a given period of time)

(as measured by health worker salary costs over the same period of time)

The facility with the highest productivity score becomes the benchmark or reference facility to which the others are compared, as the toolkit measures *relative* productivity. Thus, comparing each facility's health workforce productivity score to the benchmark and multiplying by 100 results in a total health workforce productivity rate for each facility. While the benchmark facility results in a 100% productivity rate, this does *not* imply that it has perfect productivity, as even the most productive facility is also likely to have inefficiencies that can be improved upon. The high workforce productivity level of the benchmark facility only signifies that the facility is *more* productive than the others in the sample.

Data on outputs consisted of the indicators for the health service areas listed in Table 1 with their service weights (i.e., the value assigned to account for the fact that not all services are of equal value in terms of effort, resources, and impact), which ranged from 0.5 to 3. The service statistics used were from the district's health management information system (HMIS) and were provided by the HMIS department at the Dedza DHO. The human resource inputs were represented by the compensation (basic salary from government and top-up allowances from

facilities) received by the available health workers that supported these health service areas at the facilities. These included the following categories of staff:

- Medical assistants
- Hospital attendants
- Nurse/midwife technicians
- Laboratory attendants
- Pharmacy technicians
- Dental attendants
- Patient attendants
- Pharmacy attendants

The time period for both the health services (outputs) data and the health worker salary costs (inputs) data was July 2013-June 2014.

Table 1: Output Indicators and Service Weight per Health Service Area

Service Delivery Area	Output Indicator (July 2013–June 2014)	Service Weight
Outpatient department (OPD)	# outpatient attendance	1
Inpatient care	# inpatient days	3
Antenatal care (ANC)	# ANC visits	1
Labor and delivery	# deliveries attended by skilled health personnel	3
Child vaccination	# fully immunized children under 1 year	0.5
HIV services	# people 15–49 years receiving voluntary and confidential testing and serostatus results	1

CHAM selected the district and facilities through purposive sampling. The facility selection criteria included comparability of health centers, representation of different demographics, and consideration of access and distance due to logistical constraints (in particular due to the mountainous terrain in the district). A total of nine health centers were included in the sample. (NB. The facility names have not been included due to the sensitivity of the information.)

Two CHAM teams, which were representative of the major stakeholders, carried out the qualitative data collection over a two-week period. The teams consisted of staff from the CHAM secretariat, Catholic Health Commission, Dedza DHO, Dedza health facilities, and CapacityPlus.

The study population included health facility in-charges, health workers at the selected facilities (described above), and members from the surrounding communities.

The data collection methodology included the following:

- Focus group discussions with health workers and in-charges, using a semistructured discussion guide, elicited their views on productivity at their health facilities and their reflections on possible reasons for any productivity problems.
- Focus group discussions with community members within the facilities' catchment areas used a semistructured discussion guide to understand community attitudes toward the health facilities. The discussions were conducted separately by gender to encourage contributions from all participants and to better understand the differing needs that women and men have when seeking health services. The questions focused on health-seeking behavior: reasons why people may not use the facility's services for treatment when ill, for preventive care (i.e., HIV counseling and testing and immunizations), or for pregnancy-related care (i.e., antenatal care and delivery). Suggestions for improving the quality of and demand for services were also solicited from participants.
- Health worker flow mapping helped to identify any needed organizational, structural, or managerial changes that may improve service efficiency and health worker productivity. For periods of one to two hours, observers plotted the movements of health workers—particularly medical assistants and nurses/midwives, as they are the main players in the delivery of health services—within their facilities as they provided services to assess whether they spent their time productively.

In a final stakeholder meeting using participatory engagement approaches, stakeholders reviewed the findings, identified and prioritized potential interventions, and drafted action plans to implement and monitor improvement interventions.

FINDINGS

Estimating Health Workforce Productivity

Service delivery data from July 2013 to June 2014 were used to estimate the total health workforce productivity in the health centers (Table 2). The output index refers to the aggregate of the weighted health service outputs (e.g., number of antenatal care visits) used to measure total provision of the selected health services from July 2013–June 2014. The total HRH costs represent the sum of salaries and allowances paid to the health center staff that contributed to the specified health services during the same period. As described earlier, the facility's health workforce productivity score is measured by dividing the total output index by the total HRH costs. As the facility with the highest productivity score, Health Center I became the benchmark or reference facility to which the others were compared. Its 100% productivity level does *not* imply that it has perfect productivity, as even the most productive facility in the sample is also likely to have improvements that can be made. For more detailed information regarding how the productivity was calculated, please refer to Stage 1 of the [Health Workforce Productivity Analysis and Improvement Toolkit](#).

CHAM's application of the productivity assessment approach revealed moderate to low levels of productivity in most of the assessed facilities (Figure 1). Two-thirds of the health centers (six out of nine) were less than half as productive as the benchmark facility (Health Center I). Health Center I spent the second-least on HRH costs and had the second-highest level of weighted service outputs, thus earning benchmark status (Table 2). Health Center H was the second-most productive health center with a health workforce productivity rate of 90%. Health Center H's significantly higher total output index greatly offset its high HRH costs, particularly in terms of the indicator of inpatient days. Health Center G measured about two-thirds (67%) of the benchmark facility as its lower-than-average output index was balanced by having the least HRH expenditure. The remaining health centers had relatively low health workforce productivity levels ranging from 29%–51%, due to either low output indices, high HRH costs, or a combination of both.

Health workforce productivity can be improved either by increasing service delivery outputs for a given number of HRH inputs, or by reducing the inputs or HRH costs for a given level of service outputs. As shown in Table 2, with the exception of Health Center H, most facilities with higher staff expenditures did not produce sufficient service delivery outputs to offset the HRH input costs, leading to low rates of health workforce productivity. For example, while Health Center D produced almost the same output index as the most productive facility (Health Center I), it did so with a much higher staff allotment, of which about half were higher-earning technical staff.

Table 3: Data Values Used to Calculate Health Workforce Productivity, by Health Center

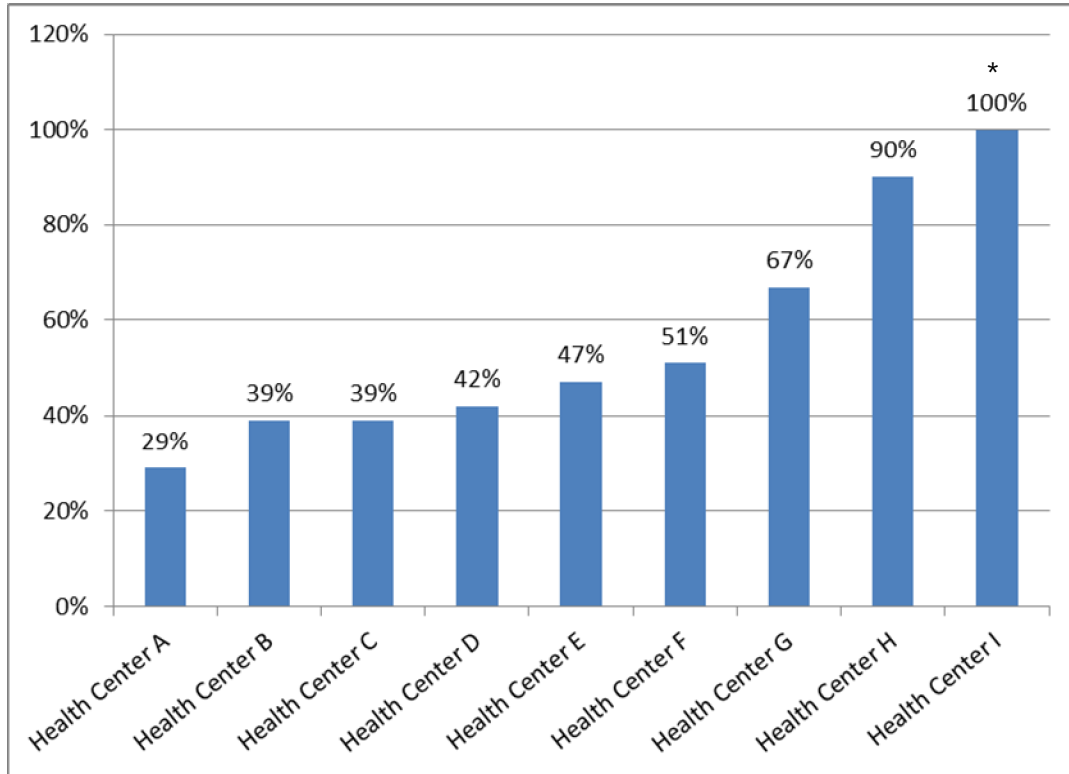
July 2013–June 2014	Health Center A	Health Center B	Health Center C	Health Center D	Health Center E	Health Center F	Health Center G	Health Center H	Health Center I
Service Outputs									
Total ANC visits	955	907	1,442	2,682	1,067	1,050	788	2,106	2,899
No. of deliveries attended by skilled health personnel	429	686	564	605	677	485	369	751	636
No. of 15–49 year olds receiving testing and serostatus results	1,684	2,177	1,073	2,076	1,446	1,452	776	3,571	1,943
No. of OPD attendance	4,936	10,179	5,534	8,396	10,071	16,033	11,346	30,758	14,510
No. of fully immunized children < 1 year of age	576	2,104	573	396	419	1,003	912	1,071	558
Total inpatient days	540	1,970	1,087	3,955	1,223	2,198	740	12,704	1,991
Total Output Index (Mean: 26,722) (=weighted sum of service outputs)	10,770	22,283	13,289	27,032	18,494	27,086	16,693	77,336	27,512
HRH Data									
No. of health workers/No. of high earning staff ^{1,2}	18/1	19/9	14/3	24/11	13/4	17/7	9/2	28/10	7/3
No. of total months of salary & allowances paid ²	179	182	102	215	148	161	108	274	73
Total HRH Costs (Kwacha)	8,717,128	13,511,297	7,950,574	14,937,215	9,164,576	12,388,761	5,830,152	20,099,463	6,446,593
Health Workforce Productivity Score (=Total output index/Total HRH costs)	0.00124	0.00165	0.00167	0.00181	0.00202	0.00219	0.00286	0.00385	0.00427*
Total Health Workforce Productivity Rate (=Productivity score/Benchmark facility score)	29%	39%	39%	42%	47%	51%	67%	90%	100%*

¹ Staff earning ≥ 80,000 Kwacha. Includes nursing sisters, nurse/midwife technicians, senior medical assistants, laboratory technicians, and pharmacy technicians.

² Not all staff were employed at the health center during the full 12-month period.

*Benchmark facility to which other health centers' productivity scores are compared to obtain total health workforce productivity rate

Figure 1: Health Workforce Productivity (%), by Health Center¹

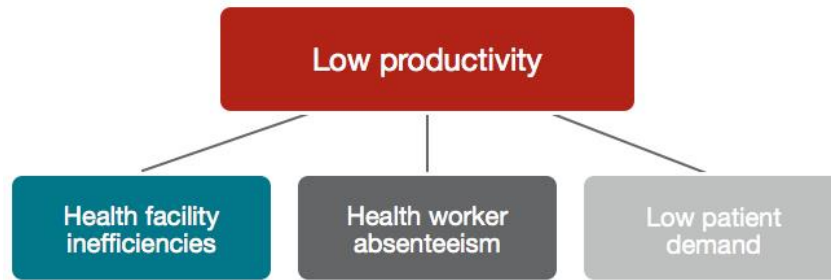


¹Health center names were removed due to the sensitivity of the information. * The facility with the highest productivity among the sample is labeled the benchmark or reference facility to which others are compared, and thus its productivity is set to 100%.

Identifying Causes of Productivity Challenges through Qualitative Assessment

To inform the selection of health workforce productivity improvements, the team further examined the quantitative productivity results through a qualitative assessment using focus group discussions and health worker flow mapping. As described in the toolkit and presented in Figure 2, the causes of low productivity can be classified under three interconnected types of health worker productivity problems: health facility inefficiencies, health worker absenteeism, and low patient demand.

Figure 2: Types of Health Workforce Productivity Problems



The overall summary of the findings that negatively affected health workforce productivity is presented below by productivity problem type. The underlying causes described in this section were generally applicable to all or almost all of the health centers in the sample. Thus, resulting priority improvement interventions could be applied to all the facilities. If prioritized, any respective interventions would only be applied to facilities that experienced that particular problem.

Health Facility Inefficiencies

The focus group discussions with health workers and managers revealed a number of findings related to inefficiently organized services. The findings below are from the perspective of the facility staff:

- “ Poor staff housing conditions, including shortages and poor infrastructure (e.g., electricity and piped water)
- “ Poor remuneration, including low salaries and a lack of allowances and benefits
- “ Heavy workload due to shortage of professional staff
- “ Lack of infection-prevention equipment (e.g., sterilization equipment, aprons, gumboots, and masks)
- “ Lack of continuing education and professional development programs for support staff
- “ Poor working environment, including inadequate infection-prevention equipment and poor human resources administration.

The health worker flow mapping resulted in the following observations across the facilities:

- “ Unproductive use of time by most support staff when there are no patients (e.g., chatting)
- “ Poor infection-prevention procedures and unavailable/inadequate equipment
- “ Illegal enhancements of support staff scope of practice to perform professional staff duties
- “ Short consultation times (3–5 minutes), especially during high patient turnout times; communities complained of inadequate time for explanation and examination

- “ Increased workload and unstable availability of medicines and supplies at facilities located near Mozambique border lines, due to cross-border demand for health care services.

Health Worker Absenteeism

During the community focus group discussions, community members raised a number of issues that pertained to health worker absenteeism. These included:

- “ Perception that health workers appear less willing to attend to patients near the end of the workday, at night, and on weekends. Community members described having to deliver their babies by themselves when the skilled health worker did not come, being issued fines for arriving late, having the security guard send back patients, or being forcibly admitted as inpatients as punishment for coming off hours.
- “ Health workers arriving late in the morning or returning late from lunch, resulting in long waiting times and delays in attending to patients.
- “ Delays in arriving to attend to patients who come in the middle of the night seeking treatment.

Low Patient Demand

Community members described a number of quality and access issues, which they believed affected patient demand at the health facilities. These included the following perceptions related to *quality* of health services:

- “ Inadequate numbers and types of professional staff, leading to long wait times and delegation of duties to untrained support staff, such that support staff may conduct services and procedures for which they are unqualified (e.g., reports of patient attendants conducting deliveries and providing injections)
- “ Bad attitudes and disrespectful treatment from the staff, such as shouting at patients in labor and during deliveries
- “ Perceived favoritism of patients from distant villages, as well as patients from Mozambique, who pay more
- “ Unnecessary or delayed referrals, contributing to deaths before patients can reach the district hospital
- “ Health workers do not always do physical examinations on the patients. Community members feel that their explanations of their health issues are not well heeded. This leaves the patients going home dissatisfied.
- “ Patients fear a lack of confidentiality at HIV testing and counseling/antiretroviral therapy clinics because the patients know the health workers personally. Consequently, patients often go to more distant health facilities where they may not be known or recognized.
- “ Inadequate and old infrastructures, such as small labor wards, inpatient wards, and waiting areas, and a lack of guardian shelters
- “ Patients complain that family planning services are unavailable in Catholic health centers.

- “ Unequal coverage and lack of ambulances for referrals—CHAM facilities that do not have ambulances are unable to receive assistance from government facilities, so patients prefer going to the public health facility to benefit from public ambulances in case of referral.
- “ Lack of specific drugs (e.g., iron tablets, cotrimoxazole) at select health centers and shortage of equipment and supplies (e.g., bed linens and blood pressure machines)
- “ Community members feel that Health Advisory Committees (HACs) are ineffective in resolving issues they bring to their attention.

With regard to *financial access* to health care, many of the community discussions mentioned the difficulty to pay for health services or purchase medicines, including:

- “ High cost of treatment and ambulances
- “ Patients are asked to leave collateral (e.g., bicycles or a family member or guardian) until payment can be made or they receive fewer drugs when they cannot pay in full.
- “ Lack of transparency and standardization of prices for services. Some patients feel they pay a lot more for treatment than others do.
- “ Many community members will access a public health facility because services and treatment are free. However, they acknowledged that the quality of services is often better in CHAM facilities and that the public health centers are often out of stock of medicines.

In terms of *geographic access* to health care services, some of the communities had difficulties in accessing the facilities. Comments included:

- “ Limited access to health centers due to distance, washed away bridges, and poor roads
- “ Community members seek services from traditional birth attendants and illegal health practitioners as they are located closer to some communities, are more easily accessible, and are less expensive.

INTERVENTIONS TO ADDRESS CAUSES OF PRODUCTIVITY PROBLEMS

During the stakeholder meeting to present and discuss the findings of the productivity assessment in Dedza District, stakeholders reviewed the underlying causes of poor productivity and identified possible interventions to address them. The stakeholders focused on suggesting improvements that consisted of relatively low-cost/high-effect interventions that health workers and facility- or district-level managers could readily implement on their own. Approaches developed at the facility or community level, with contributions from the local community, are often the most effective and sustainable.

The interventions were categorized as immediate, short-term, or medium- to long-term solutions to differentiate between the interventions that may be quicker to implement versus those that may take more time to plan, execute, and see effect. The timing was influenced by CHAM’s

eagerness to rapidly address the productivity issues and improve health services as well as to maximize the remaining months of technical support from CapacityPlus.

After the initial identification of possible improvement interventions, stakeholders prioritized the many possibilities. Using the criteria below, stakeholders voted on which interventions would likely be the most time- and cost-effective to improve health workforce productivity:

- “ Timeframe for implementation
- “ Timeframe to achieve results
- “ Resource needs
- “ Level of decision-making and action
- “ Acceptability of intervention.

The complete list of interventions identified and prioritized can be found in Appendix A. The interventions highlighted in color received the most votes and were prioritized and included in the action planning exercise. Table 3 presents the prioritized interventions by the related productivity assessment findings they address.

Table 3: Interventions Prioritized by Stakeholders, by Productivity Assessment Finding

Productivity Finding to Address	Intervention
High cost of treatment and ambulance	Establish village health schemes within catchment area
	Standardize and make transparent the costs of drugs
	Buy drugs in bulk for savings*
Bad attitude of staff	Conduct training on customer care
	Increase number of staff to reduce the workload
Poor infrastructure	Renovate staff houses, wards, guardian shelters, etc.
Lack of physical examination	Conduct supportive supervision
Unavailability of family planning	Train health workers on natural family planning if not providing modern methods

*For now, this may not be possible, but it has been included in CHAM’s Strategic Plan (2015-2019).

ACTION PLAN DEVELOPMENT

The stakeholders planned how they would implement the prioritized interventions to address the underlying causes of low health workforce productivity. The resulting action plans defined the problem to be addressed, the intervention activities and steps, the responsible person or institution, and the estimated timeframe. The action plan for improvement interventions applicable to all or most health centers can be found in Appendix B.

EARLY PROGRESS ON INTERVENTION IMPLEMENTATION

CHAM paid immediate attention to the interventions that had the highest votes from stakeholders. Using the findings from the productivity assessment, CHAM was able to leverage donor support it receives through other projects to act on a number of the prioritized interventions. Examples of progress highlights for each intervention include:

- **Village health schemes to address cost issues:** CHAM developed plans and secured funding to pilot a community health insurance scheme at two facilities included in the productivity assessment. The purpose of this work, supported by DanChurchAid, is to reduce the financial barrier for poor people living in rural areas to access health care, a key issue highlighted in the study. The project dates are April-October 2015.
- **Cost standardization and transparency:** Health service price lists have been posted at most of the facilities to address the issue of lack of the transparency in pricing. A few facility in-charges felt this would cause problems as some charge a penalty fee for coming off hours, especially for non-emergency cases. Other facilities charge differing amounts for the same drug as an affirmative action strategy, whereby richer patients subsidize the poor. Hence in those cases, posting the prices was deemed to not be ideal.
- **Customer care training to improve staff attitude:** CHAM conducted a customer care orientation workshop for health facility in-charges to address the issue of bad staff attitude. The session also covered institutionalization of quality assurance at the facility and community expectations regarding quality of health care. The purpose of the session was for the health facility staff to appreciate the value of integrating good customer care values in the delivery of health care services. The training included three main components: a) customer care; b) understanding who the customers are; and c) effective communication—a key driver to good customer care and dealing with “difficult” clients. The in-charges rolled out the orientation to staff at their respective facilities.
- **Staff allocation to reduce workload and improve staff morale:** CHAM secretariat staff held several meetings with ministry counterparts to discuss equitable allocation of resources between CHAM and government facilities. The government is responsible for paying salaries for all health workers working in both government and CHAM facilities, yet salaries had only been increased for health workers in government facilities. This was rectified in February 2015 after CHAM appeals and consultations with the ministry. In terms of obtaining additional staff to reduce workload in some facilities, CHAM still

cannot recruit staff due to a prevailing government stop order that was initiated a year ago. CHAM provided the necessary information requested by the government at the time and is waiting for the stop order to be lifted.

- **Improving ambulance services:** At the district level, resources such as ambulances were agreed to be shared between government and CHAM facilities. However, despite the positive response from the DHO in Dedza, there is a high likelihood that this may not work, as the budgets for the districts were reduced by half due to financial challenges. This means fuel for ambulances may not be adequate to serve both government and CHAM facilities.
- **Renovation to address poor infrastructure:** CHAM secured funding for plans to expand health center infrastructure including construction of staff houses and maternity wards and installation of piped water, sewer, and solar systems. This work is being conducted under the KfW-funded project to improve maternal, neonatal, and child health services and will benefit four of the health facilities included in the productivity assessment. Construction works commenced in February 2015. In addition to improving staff housing and health center infrastructure, the project will train health workers on Basic Emergency Obstetric Care (BEmOC) and procure appropriate equipment and supplies for BEmOC service delivery.
- **Supportive supervision to address clinical protocol deficiencies (i.e., lack of physical examinations):** In-charges from various facilities were oriented on good customer care and then briefed their facility staff about the importance of good history taking, physical examination, and the provision of patient-friendly services. In addition to the customer care and quality sessions, the facilities will receive supportive supervision to monitor and further support their efforts to improve quality of care.
- **Training on natural family planning to address unavailability of modern methods:** This activity has not yet been implemented. CHAM is looking for funding opportunities to carry out this activity.
- **Increasing knowledge of rights of patients and health workers:** The facilities received posters listing patients' rights and health workers' rights (in both the local language and in English). The posters were displayed on the walls of the facilities and will help the community members to demand services while respecting the rights of health workers.
- **Rapid attention to facility-specific issues:** In the majority of facilities, the in-charges acted immediately to correct the individual issues affecting productivity and service quality. These included speaking to individual staff to correct noted misbehavior; addressing issues related to adherence to clinical protocols, infection prevention standards, and facility policies and practices; adjusting staff rosters to reduce work overload and ensure day and night coverage; and adjusting policies to be more client-friendly.

It should be noted that other recent developments could potentially have a negative effect on the progress made thus far. First, some health workers recently migrated from CHAM facilities to

government facilities due to salary increases that had only been given to staff in government facilities from October 2014-January 2015. Second, the government is strongly committed to introducing user fees in the government facilities as part of its Public Health Sector Reform. This initiative may lead to an increase in patient load at CHAM facilities when implemented. Many patients and community members noted that while they perceived CHAM to offer better quality health services, they sought care at government facilities due to free services offered. However, if public sector facilities will also charge user fees, cost differentials may become a less important factor in the choice of health care provision.

WAY FORWARD

CHAM, in collaboration with the Dedza Catholic Health Commission, will continue to monitor the implementation of the interventions through phone calls and site visits when feasible. CHAM will also continue to engage with the ministry at different levels to strengthen their partnership and collaborations and continue discussions for progress on the noted policy issues.

Once health workforce productivity interventions have been implemented, monitoring their progress as well as their effects on total health worker productivity will be important. Additionally, during implementation and monitoring, quality should be taken into account to ensure that interventions to improve productivity do not come at the expense of quality or compromise outcomes of care. Ideally progress toward improvements in health worker productivity levels should be assessed after approximately six months to one year to allow sufficient time for the interventions to take effect. Currently, CHAM does not have funding to support this but will seek funding from partners.

With its newly acquired capacity in health workforce productivity, CHAM may consider assisting dioceses and churches in other districts to conduct their own productivity assessments to highlight productivity improvement actions specific to their respective facilities. CHAM may also consider using the tools and process for the productivity assessment in the existing mechanism for supportive supervision and monitoring of the health workforce. As part of the Africa Christian Health Association Platform (ACHAP), CHAM has the opportunity to share its lessons with other Christian health associations in the region.

APPENDIX A. INTERVENTIONS IDENTIFIED AND PRIORITIZED BY STAKEHOLDERS

Productivity Finding to Address	Interventions* <small>*Interventions highlighted in color received the most votes</small>	No. Votes
Timeframe: Immediate (within 1 month)		
High cost of treatment and ambulance and lack of transparency in pricing	Standardize cost at diocese level so each facility has same cost	7
	Buy drugs in bulk for savings	3
	Display price list in health centers	1
	Sensitize/communicate with community members so they understand price list and why facility is increasing prices	0
	Establish village health schemes within catchment area for income-generating activity	4
	Government to subsidize drugs for CHAM facilities	1
	Negotiate with district health officer to transport patients if government ambulance is being used	1
	Establish health service agreement for under-five and pregnant women services	2
Patients must leave collateral until payment made	Empower health advisory committees to follow up on debts in the community, recover the money from the patients (instead of asking them to leave bicycles), and remind people in the village who have a debt that they pay it	1
Bad staff attitude	Conduct training on customer care	9
	Sensitize community that there is only one nurse and one medical assistant or just one nurse and they have to provide outpatient, antenatal care, maternity, and other services	1
	Use suggestion boxes and display where patients can write their concerns	0
	Empower health advisory committee to collect feedback (positive and negative) from communities and share with health centers	0
	Conduct performance appraisals of health workers	1
	Encourage teamwork, better coordination among staff to help each other when busy for better patient service coverage	1
	Publicize poster of the rights of patients and rights of health workers	2
	Establish disciplinary committees for health workers who misbehave	0
Unequal coverage of government ambulance	Hold round-table discussion between District Health Management Team and CHAM facilities (if government ambulance is coming, should see if other facilities need the ambulance). Provide motorcycle ambulances	2
Timeframe: Short-term (2-3 months)		
Lack of physical examination	Conduct staff meeting to address challenges	2
	Use patient surveys/suggestion boxes to understand where they may be lacking	0
	Conduct more frequent support supervision by health secretary/coordinators	6
	Add refresher courses	2
Support staff are idle	Provide intensive supervision from ward in-charges and hospital in-charges	0
Services provided by	Increase staff/put adequate staff on duty roster	3

Productivity Finding to Address	Interventions* *Interventions highlighted in color received the most votes	No. Votes
unskilled staff (patient attendants deliver/inject)	Provide intensive supervision from ward in-charges and hospital in-charges	0
	Address improper delegation of staff (so only skilled staff are providing clinical services)	0
Timeframe: Medium- to long-term (≥4 months)		
Bad staff attitude	Increase number of staff to reduce the workload	3
Unavailability of ambulance	Mobilize resources (i.e., facility to write proposals to source an ambulance)	2
Poor infrastructure	Rehabilitate staff houses, wards, guardian shelters, etc.	8
	Develop maintenance plan at each facility and engage area development coordinators to support facilities through constituency development fund and local development fund	0
	Lobby for funds from donors to help with building	1
Unavailability of family planning	Train health workers on natural family planning	3
	Sensitize communities on where they can get modern family planning methods	0

APPENDIX B. GENERAL IMPROVEMENT INTERVENTION ACTION PLAN

Productivity Finding to Address	Intervention	Activities/Steps	Responsible Person/ Organization	Timeline (Nov. 2014-June 2015)								
				Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
High cost of treatment and ambulance	Establish village health schemes (VHS) within catchment area	Conduct feedback meeting for community members and village health committee in catchment area	Health facility in-charge	X								
		Present priority activities and interventions	Health facility in-charge	X								
		Constitute a team to champion the VHS	Chairman of Village Health Committee (VHC)		X							
		Brainstorm income-generating activities to implement VHS	VHC		X							
		Implement and monitor activities	VHC, health facility in-charge		X	X	X	X	X	X	X	X
	Standardize costs of drugs	Conduct community sensitization on costs for health care services and drugs	Health facility in-charge	X								
		Display prices for health care services and drugs	Health facility in-charge		X							
	Buy drugs in bulk	Revamp CHAM revolving drug fund a) Strengthen central drug warehouse	CHAM secretariat	X	X	X	X	X	X	X	X	
		b) Open regional offices so facilities can buy drugs within region	CHAM secretariat									X
	Bad attitude of staff	Conduct training on customer care	Identify training resources and trainers	Diocese and Synod		X	X	X				
Conduct training of trainers			Health coordinators		X	X	X					
Conduct training			Facility in-charge		X	X	X	X	X	X	X	X
Conduct monitoring			Health coordinators and District Health Management Team									

Productivity Finding to Address	Intervention	Activities/Steps	Responsible Person/ Organization	Timeline (Nov. 2014-June 2015)								
				Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
	Increase number of staff to reduce the workload	CHAM to negotiate with government on allocation of graduated students (clinical officers/medical assistants/nurse midwives in health facilities)	CHAM secretariat		X							
		Facility managers to advertise vacancies	Health facility in-charge		X	X	X					
Poor infrastructure	Renovate staff houses, wards, guardian shelters, etc.	Develop maintenance plan	Health facility in-charge		X	X						
		Mobilize resources	Health facility in-charge				X	X	X	X	X	X
		Begin renovation process	Health facility in-charge								X	X
		Monitor	Health facility in-charge, health coordinator, District Health Management Team		X	X	X	X	X	X	X	X
Lack of physical examination	Conduct supportive supervision	Develop and adopt a comprehensive CHAM list of health centers	CHAM secretariat			X						
		Proprietors to develop supervision schedule	Health secretary, health coordinators			X						
		Conduct supportive supervision visits	Health secretary, health coordinators with DHO			X	X	X	X	X	X	X
Unavailability of family planning (FP)	Train health workers on natural FP if not offering modern methods	Conduct orientation of selected staff	Nurse in-charge, CHAM, or government		X							
		Conduct training on natural FP	Nurse in-charge, CHAM, or government					X				
		Sensitize the community on natural FP as well as on where to access modern FP methods	Nurse in-charge						X			



USAID
FROM THE AMERICAN PEOPLE



CapacityPlus
Serving health workers, saving lives.



CapacityPlus is the USAID-funded global project uniquely focused on the health workforce needed to achieve the Millennium Development Goals. Placing health workers at the center of every effort, CapacityPlus helps countries achieve significant progress in addressing the health worker crisis while also having global impact through alliances with multilateral organizations.

The CapacityPlus Partnership



CapacityPlus
IntraHealth International

1776 I Street, NW, Suite 650
Washington, DC 20006
T (202) 407-9473
F (202) 223-2295

6340 Quadrangle Drive, Suite 200
Chapel Hill, NC 27517
T (919) 313-9100
F (919) 313-9108

www.capacityplus.org
info@capacityplus.org