Chitsanzo Programme Proposal

Chitsanzo (Chichewa: ''Example, Model'')
Date: 12-07-2024
By: Mulanje Mission Hospital PHC department, email: director@mmh.mw

1. Introduction

Mulanje Mission Hospital consists of a large primary healthcare (PHC) department and a secondary level, not-for-profit hospital. A wide array of activities are employed with well documented results, leading to national recognition as an institution providing high quality programmes and care. PHC is provided in the areas of indoor residual spraying/malaria vector control, maternal, neonatal and child health, cervical cancer prevention, teenage pregnancy prevention, palliative care, HIV/TB prevention and treatment, rehabilitation, primary eye care, water and sanitation, youth friendly health services and livelihood interventions. See also table 1.

Primary Healthcare		Hospital	
Orphans/vulnerable children	600 in care	Deliveries/yr	2700
Catchment population	100.000	C/Sections/yr	510
Antenatal care visits/yr	12.600	Nursery admissions/yr	700
ART clinic	6.500 in care	Maternal mortality rate	43/100.000
Palliative care	200 in care	Neonatal mortality rate	11/1000
Outreach clinic sites	14	Outpatient visits/yr	30.000
Cervical cancer screening	250/month	Admissions/yr	8.000
Youth	21 youth groups	In-patient mortality	2,4%
Humanitarian aid team	WASH, prevention, emergency aid	High dependency unit, digital X-ray	
Malaria control	72 villages included	No of nurses/doctors	77/5
Sustainable Livelihoods	Works in 15 villages		

Table 1. Key statistics, Mulanje Mission Hospital

Key results are a reduction in childhood deaths due to malaria, low maternal mortality, excellent HIV control, and addition of new areas of work in recent years, such as rehabilitation, palliative care, expansion of NCD management. All PHC services are provided free of charge.

MMH works in line with government strategies and other organizations. The mission of the current National Community Health Strategy (MoH, 2017) is ''to ensure quality, integrated community health services that are affordable, culturally acceptable, scientifically appropriate, and accessible to every household through community participation – in order to promote health and contribute to the socio-economic status of all people in Malawi''. However, it has not been implemented at a significant scale.

There is an urgent need for PHC in Malawi to expand and professionalize. Malawi is barely moving towards Universal Health Coverage as health facilities are underfunded, there are acute shortages of drugs and supplies (due to lack of money, weak supply chain, irrational use and theft) and 10% of the population lives >8km from a health facility. Malawi faces crises of cancer and malnutrition (Rudd 2017), frequently undiagnosed (Prince 2018) and TB (NTCPM 2018). 11% of Malawians live with HIV, many with cancer, which increased from 2002 to 2010 in women from 29 to 69 per 100,000 and in men from 31 to 56 (Msyamboza 2012).

2. MMH's approach to PHC

MMH employs the largest and most diverse basket of primary healthcare services for any hospital in Malawi. These have been built up from the 1970s. Programmes currently cover the entire catchment area of 74 villages, but not everyone in the area is reached yet. Communities participate in prevention, finding, referring and caring for patients, for example in the areas of safe motherhood, palliative care and water supply.

Our strategy is local integration and long-term investment in PHC as individual projects and funders come and go. MMH's strategic plan for 2023 -28 (link) emphasizes the need to expand primary care and public health services to all in our catchment area and provides a route map to achieve this.

As visible in figure 1, NCDs are an increasingly heavy burden of disease in Malawi. MMH has responded to this by adding a new NCD clinic and eye clinic to the hospital, opening an epilepsy clinic, training staff in medicine, mental health and rehabilitation. Quality of care for NCDs has drastically improved (local data).
Palliative care is provided at African Palliative Care Association level two, including home based care, chemotherapy and childrens' care. Services are spread throughout the catchment area in 13 health posts, that provide a basic package plus NCD clinics and cervical cancer screening in selected posts.

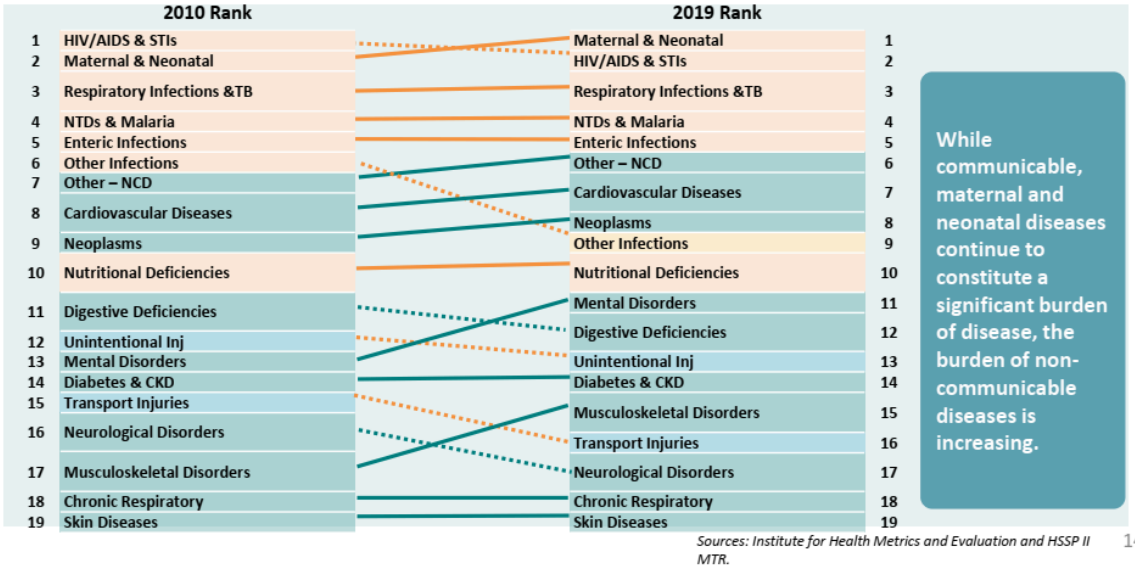


Figure 1: Ranking of DALY's lost in Malawi, by disease category, 2010 versus 2019 (MoH, HSSPIII, 2023).

In line with guidance from the World Health Organization, we believe investment in Primary Health Care is the best way forward in order to reach universal health coverage in Malawi and will provide most results per kwacha spent on healthcare.

3. Cooperation between MMH and Buurtzorg

Buurtzorg (BZ) is an organization for community-based care in the Netherlands, founded upon the principle of decentralized teams organized around the community they serve. Through the Maja Foundation, a palliative care programme has been run with good results from 2022 onwards. During interactions early 2024, BZ and MMH PHC recognized several areas of mutual interest and potential learning. This project proposal provides the framework for collaboration in the coming five years between MMH and BZ, noting that changes may be needed as the work develops.

4. Gaps in PHC delivery in Malawi: problem analysis

4a. Countrywide challenges

Existing primary healthcare programmes in Malawi are mostly externally funded, vertically implemented programmes with little local ownership and financial control at the facilities that are implementing them. Examples are the HIV-response, vaccination coverage and reduction of malaria deaths through nets and treatment. These programmes are limited by nature in that funding can only be accessed for very specific budget lines and the implementing facility has no control over the use of resources.
This vertical approach has led to significant disparities in funding for health; for example, there is a strong HIV-response but virtually no designated funding for NCDs in Malawi. In order to respond to new challenges such as NCDs and climate change, a strong horizontally organized national PHC network is urgently needed. Existing successful work can of course be integrated into this. Currently, it is a matter of luck for a patient whether he/she lives in an area with a hospital providing PHC or not.

4b. Local challenges in Mulanje

In the MMH catchment area, inadequate skilled staff time is the main barrier to providing PHC to all. There is not enough time to man outreach clinics and reach all potential clients, compounded by incomplete knowledge on community nursing amongst newly recruited staff.
The remote area at Mlatha is not sufficiently served and patients have to travel for hours to reach a health facility.
Not all cases in the catchment area are identified: 10.5% of clients with hypertension and 3,7% with diabetes are currently in care (Gowshall, 2018 and local data). Palliative and rehabilitative care is currently only provided at the hospital, for some patients over 30km away and therefore inaccessible – and care for NCDs is only done at the hospital and in four outreach sites.
Where available, care is insufficiently integrated and inefficient. Although involved in caring tasks, families of palliative care patients are not adequately supported by a healthcare worker close to their home. Home based care is not sufficiently done because of shortage of trained volunteers and basic resources eg gloves, detergents, drugs etc.This leads to many patients lacking optimal care, such as end of life and advanced care plan formulation.
The management of NCDs is suboptimal. Many clients, despite being on treatment, remain sub optimally controlled despite progress in recent years and fail to comply with weight loss and exercise plans.
Essential supplies such as food support for palliative care patients, soap, and diapers are not adequately funded through the government refunding mechanism, leaving patients in unsanitary conditions and malnourished.
Community structures that MMH works with, such as safe motherhood groups are not all actively engaged and reporting back to the hospital, thus missing an important opportunity to boost outreach and self-help.
Reproductive health, though indicators at the hospital are relatively good, suffers from a very low uptake of long-term family planning methods and HPV vaccination against cervical cancer hardly done at all, whilst VIA screening rates are at 30% of the needed numbers. Despite progress, high-risk groups continue to contract HIV at unacceptable rates.
Communities remain at risk of contracting malaria and diarrhoeal disease due to inadequate coverage of latrines and boreholes despite progress in recent years: each household should have a separate latrine and the WHO advises one borehole for 250 people.
There is an epidemic of road traffic accidents due to an influx of motorcycles, social media use whilst driving and drunk driving. Mental health services are currently absent whilst Mulanje district reports high suicide rates.
Many hours each day a community health works is spent reporting data in manual register books. This is inefficient, inflexible and data is not operationally used in most cases. The benefits of digital technology have not at all penetrated to PHC work in Mulanje.
The Malawi government, despite publishing the NCHS, does not invest significant funds in integrated PHC and the newly presented Health Sector Strategic Plan, III (2023), once again concentrates on secondary and tertiary care.
Tellingly, the NCHS expired in 2022 but a new strategy has not been published since.

Table 2 provides a list of challenges to effective PHC for all in Malawi.

Geographical	PHC is currently unevenly distributed across the country, with marked differences in provision between catchment areas of different hospitals.
Lack of multi-sectoral approaches	Ineffective and weak integration with other sectors such as education and agriculture
Economic barriers	Large differences in availability of locally affordable and free PHC at the point of care, funding needs not fulfilled
Decision making	Decision makers at the decentralized (district) and centralized (national) levels focus heavily on secondary (curative care) instead of preventive and primary care
Evidence	Malawi lacks evidence of cost-efficient health facilities including reliable solar power, adequate infrastructure, control of drug pilferage and efficient decentralized management
Discourse	Little debate at national level on the economic benefits of PHC

Donor ecosystem and aid dependency	Fractured funding: 166 donors and 264 implementors in Malawi's healthsystem in 2021 (HSSP III) Inefficient strategies by many donors and recipients to use funds for structural improvement.
Culture and beliefs	Late attention to formal health services Some religious practices
Climate change	More extreme weather, forced displacement, poor harvests and increase in communicable disease such as cholera
Inefficiency	Data is collected, but rarely used for operations and by the staff collecting them. Very low level of digitalization.

Table 2: Barriers to effective PHC delivery in Malawi

5. Chitsanzo Programme: fundamental approach

5a. Theory of Change

MMH and BZ believe that high quality, integrated primary healthcare services by well qualified nurses, driven by and monitored through efficient data collection offer the most value per kwacha. Chitsanzo will show that, in Malawi, cost-effective healthcare is best achieved through a locally rooted organization investing in primary healthcare. Chitsanzo will produce a working model, document challenges and successes, rigorously collect and analyze data, and advocate for its use within Malawi and beyond, so that policies and decision-makers increasingly turn to a PHC approach.

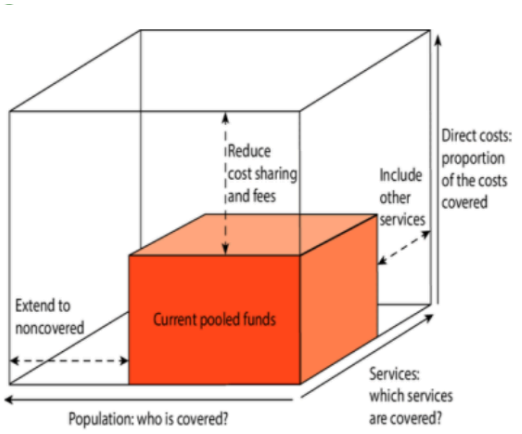
5b. Chitsanzo's impact

In Chitsanzo, MMH and BZ will achieve better health in Mulanje through increased access to efficient primary healthcare and reduced costs, establishing a model for replication to achieve universal health coverage. Ultimately, it will demonstrate, through rigorous evaluation, how a model which increases expenditure on preventative health measures is good value for money, as less expenditure is required on curative, secondary healthcare.

Without this programme, the communities of Mulanje will not have access to good PHC, which will lead to loss of life and quality of life, especially to preventable diseases and for those struggling with palliative conditions and disability: a violation of human rights.

Our impact will be measured both in numeric indicators and qualitatively through exit-interviews, assessment of self-help, economic improvement etc.

Critically, Chitsanzo will not work for, but <u>through</u> communities: the Village Health, Village Safe Motherhood and Village Development Committees in the individual 74 villages that will guide the programme to the persons in need of PHC and will involve their family members. A new group we will equip, Home Based Care Volunteers, will efficiently increase reach to those with disability and palliative conditions.



Increasingly universal health coverage through Chitsanzo can be visualized in the UHC cost cube (figure 3, from Malawi MoH HSSP III, 2023). Chitsanzo will increase access to UHC by (1) extending chronic care to those currently uncovered, by adding a health post and increased case finding, and (2) by limiting fees through subsidized drug procurement, an injection of staff into the PHC department and marshalling of communities to help themselves (3) addition of mental health – so in all three directions.

6. Achievements in Chitsanzo:

Chitsanzo will achieve:

1. Improved health and reduced incidence of disease in the MMH catchment area through improved provision of PHC.
Chitsanzo will employ 2 extra community health nurses at MMH, bringing the total to 10 and train all nurses in home based care supervision, NCDs, HPV vaccination and cervical cancer screening, and community diagnosis. The nurses will do active case finding, screening, train and supervise 74 homebased care volunteers, and run daily outreach clinics including at a newly constructed healthpost in the most remote corner of the catchment area. Frequency clinics in outreach areas will increase from 8/month to 12/month for NCDs, 0 to 2/month for palliative care and 0 to 2/month for rehabilitation, on top of the hospital clinic. There will be no stockouts and therefore inhumane conditions for patients in end-of-life care, which will improve in quality and quantity. Proven community interaction through village committees will be strengthened by equipping 85 CBDA's, 750 VHC members, and the HMC and training communities on long-term family planning, HIV testing.
MMH leading role in malaria control will be expanded through indoor residual spraying to five more villages in year 1, expanding exceptionally low under-five mortality. The WHO targets for sanitation and clean will be brought closer.
A road safety campaign, a first for the district, will work on reducing the burden of accidents and our first mental health provider will see patients and provide community mental health.

2. Improved efficiency of healthcare provision by effectively using data in MMH, Malawi, and beyond
Together with and supporting the above, with BZ we will explore and build a hospital-wide database for recording, reporting and decision making. This will go hand in hand with the continued roll-out of the the MASH hospital information system package and Quickbooks accounts software. A customised PHC package or module in MASH will be explored and developed, potentially with BZ. Staff digital literacy training will be done on the job in the new computer lab at the hospital. Lessons learnt can be shared and used elsewhere, for example in hospital networks MMH is part of.

3. Primary Health Care in Malawi improves through effective advocacy of MMH best practices to decision makers.
Chitsanzo will continuously generate evidence on the value for money of PHC and community participation. Evidence generated of such as videos, posters, reports and footage of open days will be shared with BZ and policymakers, and ultimately measured through increased government and donor attention and financial support for PHC. During existing meetings, senior management will draw on data from Chitsanzo to advocate for realistic government funding and advocate with major bilateral donors. This will ultimately contribute to eliminate the random and sparse distribution of PHC in Malawi (table 2). This will provide input for debate at the national level and further.

A key product of Chitsanzo will be less dependency and more self-help within communities as these are equipped with knowledge and skills and MMH's strict allowance policies are applied. It will engage communities and question counterproductive practices, such as late health seeking behaviour. Chitsanzo will work with the agriculture and education sector, for example in value addition trainings and coverage of HPV vaccination.

7. Activities

Chitsanzo will employ a wide range of activities that engage local communities to recognize health problems in themselves and others, seek support where needed, organize themselves and support the hospital in providing care.

The full list of activities is available in the logframe. Summarizing, Chitsanzo will:

1. Improve health, reduce disease: What?	***How?***
Reach all 100,000 inhabitants of the catchment area with palliative, rehabilitative and NCD care	Case finding, integrated care clinics, training and mentoring of 74 homebased care volunteers, addition of a healthpost, strengthening 74 village health and safemotherhood committees and marshalling of xx community-based drug agents ***Tracking*:*** number and percentage of eligible population reached with NCD care, palliative care, and rehabilitative care in the planned outreach and static clinics.

	Monitoring health outcomes: well controlled diabetes and hypertension, controlled pain in palliative patient and increased quality of life for rehabilitative care patients.
Reduce HIV, cancer, malaria, diarrhoea, road traffic accidents and mental health problems	Invest in HIV testing, HPV vaccination, cervical cancer screen&treat, safe water and sanitation, road safety and a mental health service
Improve livelihoods: better lives, less disease	Teach farmers how to add value to their products (candles, honey, condiments, peanut butter etc)
2. Improve efficiency in PHC: What?	***How?***
Efficient data collection and use	Build a data and monitoring system, learning from BZ Improve the data dashboard for decision makers
Effective software at MMH	Integrate clinical and accounting software (MASH and Quickbooks)
Build capacity of staff in computer use	*Train staff in digital skills*
	Tracking: Assessing the advancement in implementing a hospital wide data base system. number of staff trained in the use of the database system and in overall digital skills.
3. Advocate for PHC in Malawi: What?	***How?***
Learning visits	BZ-MMH and vice versa
Documentation of best practices	Posters, videos, data sharing
Awareness with decision makers	Conference at MMH ***Tracking:*** number of advocacy activities and meetings with decision-makers, impact of advocacy efforts through increased government support through SLA.

8. Inputs

MMH will provide management support, buildings, vehicles, staff, etcetera to be able to increase the reach of the PHC programme. BZ will provide funding of €100,000,- per year towards Chitsanzo, see Project Agreement. This will primarily be spent on direct patient care and includes one new health post in a remote area. Funding may come from various actors within the Buurtzorg Network (amongst others Maja Foundation, Zonnekoningin and Jos de Blok).

9. Reporting

Quarterly financial and narrative reports will be shared with BZ by MMH. Materials for dissemination and for use by BZ will be designed in consultation. Visiting staff vice versa will provide a written report as well.

Annexes:

Budget summary and detail
Project Monitoring Framework
Workplan