

Health Surveillance Assistants' Practices of Postnatal Care in Lilongwe District, Malawi

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Abstract

Health surveillance assistants (HSAs) participate in the provision of postnatal care in Malawi, although their knowledge and skills in maternal and reproductive health are limited. This article presents the findings of a mixed-methods study that was conducted in three selected health centres to document the practices of HSAs in the provision of postnatal care to mothers and babies in Lilongwe district in Malawi. A random sample of 97 HSAs participated in the quantitative part of this study and 30 of these participated in the qualitative aspect of the study. Quantitative data were analysed using descriptive statistics while qualitative data were analysed using thematic analysis. This study found that many respondents (>60%) had limited capacity to provide adequate postnatal care and 85.3% of them never checked the vital signs of mothers and babies. They also lacked knowledge and skills in some aspects of postnatal care including danger signs. Almost all the respondents (96.8%) had never received any training in Basic Emergency Obstetric and Neonatal Care (BEmONC), or



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Emergency Obstetric and Neonatal Care (EmONC). Considering that HSAs have limited capacity to provide postnatal care to mothers and their babies, shifting tasks of nurses or midwives to HSAs should not be considered as an “outright solution” for increasing access to postnatal care in low-resource settings because it may compromise the quality of care.

Keywords: postnatal care; practices; health surveillance assistant; community health worker; neonate

Introduction

Health surveillance assistants (HSAs) are salaried community health workers (CHWs) responsible for preventive and some curative health services across the country in Malawi (Kok and Muula 2013). Their main duty is to deliver health promotion services, and they receive 10 to 12 weeks of training for this role (Callaghan-Koru et al. 2013). However, HSAs have been overloaded with additional tasks including the provision of reproductive health services (Kok and Muula 2013). They often receive in-service training for various vertical programme activities, including family planning (Callaghan-Koru et al. 2013). Globally, task shifting is used to address maternal healthcare shortages in low-income countries (Hosler, Abrams, and Godsay 2018). Similarly, Malawi, which has a shortage of health professionals (Smith et al. 2014), uses HSAs to improve access to primary care for rural communities (Callaghan-Koru et al. 2013).

The literature suggests that the provision of universal access to reproductive healthcare in low-resource settings is impeded by a shortage of health workers (Dawson et al. 2014). Nevertheless, it is documented that task shifting can be used to expand the reach of lifesaving services to women and newborns worldwide (Deller et al. 2015). Consequently, programmes have been rolled out to empower HSAs with skills and knowledge necessary for the provision of information, counselling and referral of mothers and neonates to an appropriate health facility in Malawi (Ministry of Health 2007). Despite these efforts, the maternal mortality ratio for Malawi remains high at 675 per 100,000 live births (NSO and ICF Macro 2011). Furthermore, evidence shows that over 60% of all maternal deaths occur in the postpartum period in Malawi (Chimtembo et al. 2013).

Thus, postnatal care is an important component of obstetric and neonatal care in preventing and managing complications that continue to endanger the survival of the mother and the newborn in the country (Chimtembo et al. 2013). This is corroborated by Matijasevich et al. (2009) who asserted that the postpartum period is an important time to provide interventions that are vital to the health of both the mother and her newborn, although it is the most neglected area in the healthcare delivery system. The government of Malawi estimated that almost 80% of maternal deaths can be prevented by actively engaging the community (Ministry of Health 2005). As such, postnatal care is provided by midwives in healthcare facilities and HSAs across the country. Kok et al.

(2016) asserted that HSAs remain an essential cadre in driving forward efforts to achieve universal health coverage and improve maternal and neonatal health. However, the practices of HSAs in the provision of postnatal care remain unknown. Therefore, this article documented the practices of HSAs in the provision of postnatal care to mothers and babies in Lilongwe district in Malawi.

Methods

Study Design

This was a mixed-methods study in which both quantitative and qualitative data were collected concurrently. The study design helped the researcher to fit together insights provided by the qualitative and quantitative research (Johnson and Onwuegbuzie 2004) to effectively assess the practices of HSAs in the provision of postnatal care to mothers and babies. The results from both the qualitative and quantitative research were triangulated to have a better understanding of HSAs' practices in the provision of postnatal care.

The study was conducted in Basic Emergency Obstetric and Neonatal Care (BEmONC) and Emergency Obstetric and Neonatal Care (EmONC) facilities located in semi-rural (Lumbadzi Health Centre) and urban areas (Bwaila Hospital and Kawale Health Centre) in Lilongwe district, Malawi. Bwaila Hospital is a secondary level hospital which serves 40,852 women of childbearing age with 8,881 expected deliveries per year (Ministry of Health 2015a). Kawale Health Centre serves 61,830 women of childbearing age with 13,441 expected deliveries per year while Lumbadzi Health Centre attends to 19,322 women of childbearing age with 4,200 expected deliveries per year (Ministry of Health 2015a). These facilities offer free maternal and neonatal health services, family planning, cervical cancer screening, under-five and nutrition clinics, and outpatient services, anti-retroviral therapy and tuberculosis treatment. These services are provided by nurses, midwives, medical doctors, clinical officers, and HSAs. The midwives had received some training in EmONC/BEmONC while HSAs received some training in community-based maternal and neonatal care. Besides HSAs, there are community health nurses who are expected to render community maternal and childcare services. However, the availability of community health nurses is generally limited or non-existent in the community.

Sample

The target population for the study was all HSAs ($N=163$) working in the catchment areas of the selected health facilities (Bwaila, $n=102$, Lumbadzi, $n=25$ and Kawale, $n=36$). The study used proportional stratified sampling to select 97 HSAs for the quantitative part. This ensured that each health facility was represented in the sample in the exact proportion to its total population. A list of HSAs from the District Environmental Health Office (DEHO) and a table of random numbers was used to select a proportional sample of 97 HSAs representing 60% of the target population of HSAs. It is documented that a sample of greater than 30% is adequate to yield meaningful

results in any social research (Bryman 2006; 2008). Sample sizes for each health facility were as follows: Bwaila (67), Lumbadzi (12) and Kawale (18), resulting in a total of 97 HSAs who were invited to participate in this study. Thirty (30) HSAs were purposively sampled among those who provided quantitative data (10 from each health facility) to participate in the qualitative aspect of this mixed-methods study in 2016. The sample size in the qualitative component was determined by data saturation. This occurred when no new data emerged from the focus group discussions.

Materials

A structured questionnaire and a focus group discussion (FGD) guide were used to collect data. These research instruments were adapted from the guidelines in the Malawian Ministry of Health's *Participant Manual in Integrated Maternal and Neonatal Care* (Ministry of Health 2015b) and the World Health Organization's postnatal guidelines (WHO 2013). The structured questionnaire consisted of two sections, namely demographic data—age, gender, education level, work experience, rank, and attendance of continuous professional development (CPD) programmes on BEMONC and/or EmONC (six items), and HSAs' knowledge and practice of postnatal care (7 items). The following items with binary responses (Yes/No) were included in the questionnaire to measure knowledge and practice of postnatal care: (1) Assessed physical well-being of the mother, (2) assessed emotional well-being of the mother, (3) assessed concerns regarding birth, (4) checked the general conditions of the mother and baby, (5) checked the vital signs, and (6) asked about danger signs. Item number 7 asked about topics that HSAs covered during health education and counselling. This item (7) had multiple responses (23) from which participants were to tick all options that applied to them. The questionnaires were in both Chichewa and English so that participants could choose the language with which they were comfortable. The focus group discussion guide for collecting qualitative data focused on HSAs' practices of postnatal care, the attitudes of HSAs and challenges faced when providing postnatal care. The developed tools were reviewed by experts in the Faculties of Nursing and Midwifery at the University of Malawi, Kamuzu College of Nursing and pretested on HSAs at Area 18 Health Centre.

Data Collection

The researchers personally invited a total of 97 HSAs to participate in the quantitative aspect of this study and they were informed that they might be selected to participate in the focus groups later. The 94 HSAs who accepted gave a written consent and three declined. The researchers handed out a total of 94 self-administered questionnaires to the HSAs (Bwaila=64, Lumbadzi=12, and Kawale=18) and collected 92 completed questionnaires, resulting in a response rate of 97.9%.

The researchers also conducted three FGDs, one per facility. Ten HSAs from each facility were selected to participate in an FGD that was held in a quiet room, free from disturbances, at each facility. The FGDs were conducted in both English and Chichewa.

Data from the FGDs were audio-recorded after getting consent from participants to ensure accurate data and facilitate analysis. In addition, field notes were taken to enrich the audio-recorded discussions.

Data Analysis

The quantitative data were analysed using the Statistical Package for Social Scientists (SPSS 22.0) to generate descriptive statistics including frequencies, percentages and graphs. The qualitative data from the FGDs were transcribed verbatim and analysed using thematic analysis. This involved categorising issues according to the recurrent themes that emerged across the data. The emerging themes were used to address the research questions of the study that sought qualitative data.

Ethics Approval

Ethical approval (P.03/16/1914) was obtained from the College of Medicine Research and Ethics Committee (COMREC).

Results

Demographics

The findings of this study revealed that more than two thirds of the respondents (67.4%) had obtained the Malawi School Certificate of Education (Table 1). Furthermore, nearly all the respondents (96.8%) had never received any training in BEmONC and/or EmONC.

Table 1: Demographic characteristics of respondents

Characteristics	%
Age	
≤30 years	70
≥31 years	30
Education level	
Junior Certificate	28.4
Malawi School Certificate of Education	67.4
Tertiary education	4.2
Gender	
Male	42.6
Female	57.4
Work experience	
< 5 years	92.6
>5 years	7.4
Rank	
Entry position	86.3
Senior rank of HSAs	13.7

Attended CPD on BEmONC and/or EmONC

Yes	3.2
No	96.8

CPD=Continuous Professional Development, BEmONC=Basic Emergency Obstetric and Neonatal Care, EmONC=Emergency Obstetric and Neonatal Care

Respondents Practices in the Provision of Postnatal Care

This study found that many respondents (>60%) had limited capacity to provide adequate postnatal care (Table 2). For instance, 85.3% of the respondents reported that they never checked the vital signs of mothers and babies.

Table 2: Respondents' practices in the provision of postnatal care

Practices	No %	Yes %
Assessed physical well-being of the mother	62.1	37.9
Assessed emotional well-being of the mother	80	20
Assessed concerns regarding birth	70.5	29.5
Checked the general conditions of the mother and baby	66.3	33.7
Checked the vital signs	85.3	14.7
Asked about danger signs	60	40

Consistent with these quantitative findings (Table 2) was a theme: lack of knowledge and skills, which emerged from the FGDs data. A participant in one FGD reported the following:

Our knowledge is limited, so we just do what we can manage as long as they are things that are helpful for the survival of the mother and baby. (Bwaila FGD)

This was corroborated by another participant who indicated that:

We do not have knowledge. We need postnatal training so that when we see some signs we should be able to know them. Sometimes we just think it is how that particular child is. (Kawale FGD)

Despite the lack of knowledge and skills, some HSAs reported that they engaged in the provision of health education and some direct postnatal care. This is in agreement with quantitative data which revealed that 14.7% to 40% of the respondents provided the appropriate direct postnatal care to mothers (Table 2). Data from the FGDs showed that participants gave health education to mothers on various issues including encouraging them to do the following: go for the first postnatal check-up at one week post-delivery; observe any danger signs and report at hospital any observed danger signs; keep the baby's umbilical cord dry and avoid contaminating it; breastfeed their babies

exclusively for six months with an emphasis on best breastfeeding positions; bring their babies for immunisation at six weeks; and initiate family planning methods for good child spacing. These findings are summarised in the statements of two participants who reported the following:

We encourage the women to come for the first check-up which is one week after normal delivery ... If there is any problem, they can be referred to the hospital. ... Our other role is to encourage women to breastfeed their children without giving them extra food until the child is 6 months old. We also tell them to rush to hospital if they start bleeding heavily even after delivery and ... if they observe that the child has jaundiced eyes. (Bwaila FGD)

I also encourage and remind them about immunisation so that a child receives the necessary immunisation. ... We also tell the mother to bring their children for under-five clinic after 6 weeks ... We also encourage mothers to visit [a] Family Planning Unit to access family planning methods. (Bwaila FGD)

Although some participants provided some health education, it was limited in terms of coverage (Figure 1) in relation to the broad topics that emerged during the FGDs. Most respondents taught about exclusive breastfeeding and its benefits (82.1%) as well as positioning and attachment (56.8%). However, the coverage of teaching on best feeding practices for HIV-positive mothers (61.1%) and possible breast problems likely to be experienced by mothers (60%) was largely inadequate (see Figure 1).

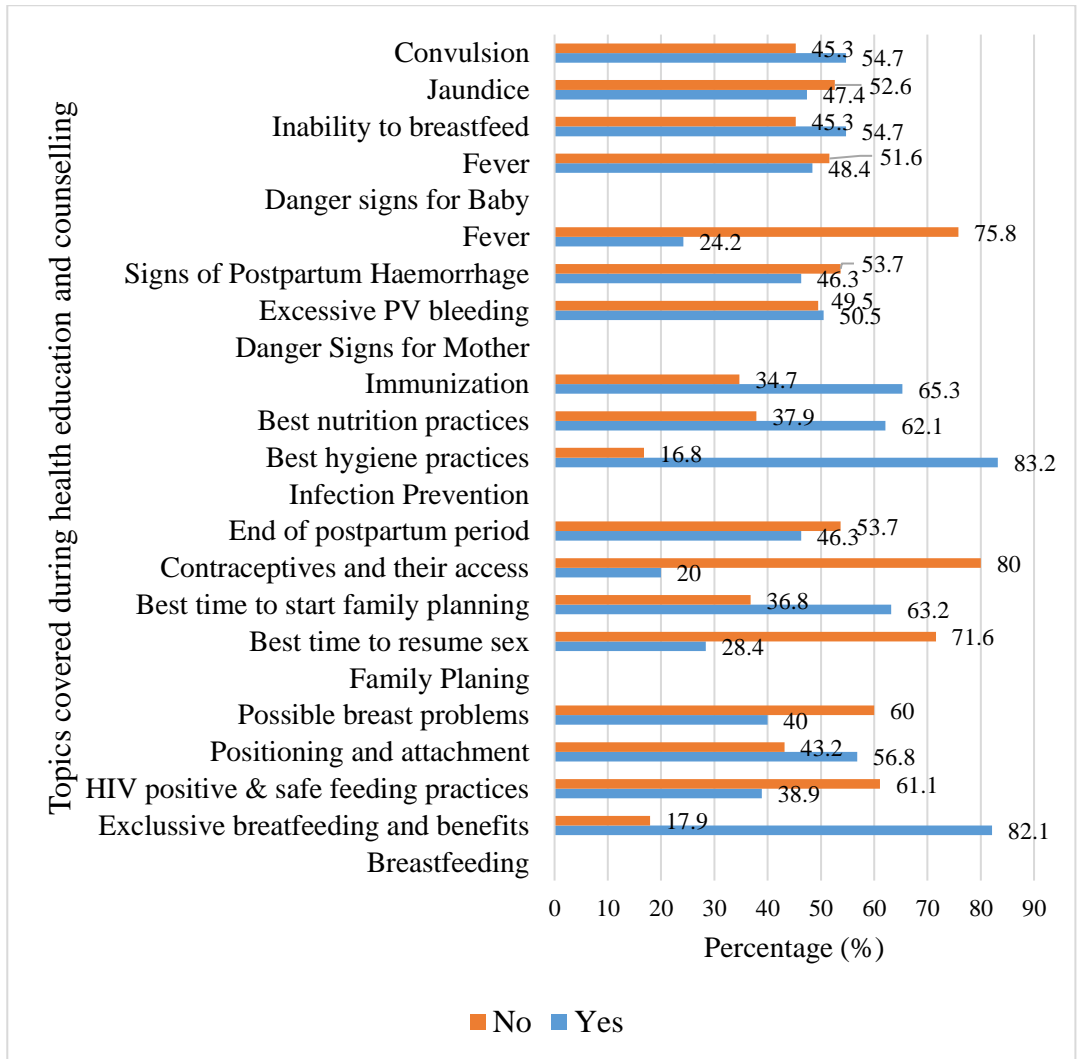


Figure 1: Health education and counselling during postnatal care

Data from the FGDs also yielded a theme: direct care provision. This is consistent with quantitative findings which showed that some HSAs provided direct care (Table 2). Some participants in the FGDs reported that they provided some form of postnatal care to women and their neonates, including nutritional assessment of the lactating women, and door to door follow-up visits with mothers until their children are 5 years old. They also indicated that they conducted quick assessments of babies and referred them to hospital if they identified any problems during the door to door visits. Furthermore, they indicated that they provided vitamin A supplements to postnatal women who did not receive it on discharge from hospital. This was represented in the following quote:

We find these women in their homes; we follow them up from the time they start antenatal, to the time they give birth up to the time the baby is five years. We also check

MUAC when mothers are lactating. We do a door to door follow up, even when they have moved houses, we follow them through the help of chiefs and volunteers. We also supply them with Vitamin A, if they have not received at the hospital. We check that the baby is breastfeeding well. We do some quick check up on the baby so that if there is need, they should take it to the hospital. (Kawale FGD)

Discussion

This study has shown that HSAs have limited capacity to provide postnatal care. This can be attributed to shortfalls in the initial training HSAs receive, which does not emphasise safe motherhood. It is evident that HSAs' training is inadequate and they need to learn more to function competently in their expanded roles due to task shifting (Kok and Muula 2013). In this study, almost all of the HSAs (96.8%) had never received any CPD training on maternal and neonatal health, yet they were expected to provide postnatal care. This is corroborated by Kok and Muula (2013) who asserted that HSAs performed some tasks that were shifted to them without formalised training. This may explain why many HSAs (>60%) in this study could hardly assess the physical well-being of the mother, the emotional well-being of mothers, concerns regarding birth, the general conditions of the mother and baby, vital signs and danger signs.

The literature suggests that community health workers such as HSAs can effectively provide care only when they are adequately trained (Haver et al. 2015). It is important that community health workers receive regular training to maintain a good level of knowledge and skills (Namazzi et al. 2017) in the provision of postnatal care. Conversely, local evidence showed that there are variations in the amount and type of training received by HSAs in some districts in Malawi, which resulted in disparities in the skill sets among HSAs and activities they implemented (Martiniuk et al. 2014).

In this study, some HSAs reported that they lacked knowledge and skills in some aspects of postnatal care, including danger signs. These findings are consistent with those of Namazzi et al. (2017) who found that the knowledge level of community health workers on danger signs and essential home-based newborn care was very low in Uganda. Despite having inadequate knowledge and skills of postnatal care, some HSAs reported that they engaged in the provision of health education to mothers in this study. However, some topics were not comprehensively covered during the health education sessions, as some crucial issues were left out. There is evidence which shows that community health workers provided inadequate information about planning for the delivery of the baby, breastfeeding, postnatal care and the danger signs in pregnancy during health education sessions in South Africa (Wilford et al. 2018).

Nonetheless, health education is important because it enables clients to make informed decisions about maternal and neonatal health (Watson 2014). As such, it is essential for HSAs to offer correct and comprehensive information that may effectively address maternal and neonatal health needs of the individual clients. This may be achieved through regular supportive supervision of community health workers who provide

postnatal care (Namazzi et al. 2017). Unfortunately, HSAs do not receive adequate supervision in Malawi (Smith et al. 2014), partly due to a gross shortage of health professionals. Furthermore, community midwives/nurses are not available in many communities and their tasks related to postnatal care were shifted to HSAs. In this study, HSAs indicated that they conducted nutritional assessment, partial assessment of the baby, and provided vitamin A supplements to postnatal women during door to door visits. This may have contributed to an increased workload for these community health workers (Haver et al. 2015) and consequently impeded their ability to provide quality postnatal care.

Study Limitations

This study used a relatively small sample and results should be cautiously applied to other settings.

Conclusion

This study suggests that HSAs have limited capacity to provide postnatal care to mothers and their babies. They lack adequate training in postnatal care. Most of them could not assess the physical well-being of the mother, the emotional well-being of mothers, concerns regarding birth, the general conditions of the mother and baby, vital signs and danger signs. Thus, shifting the tasks of nurses or midwives to HSAs should not be considered as an “outright solution” for increasing access to postnatal care in the local setting because it may compromise the quality of care.

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