



**PUBLIC SERVICES  
INTERNATIONAL**

*The global union federation of workers in public services*

# **PROMOTING SOCIAL DIALOGUE**

**to Improve Working  
Conditions for Community  
Health Workers in Malawi**

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**A MANUAL FOR TRADE UNIONS**





# PROMOTING SOCIAL DIALOGUE TO IMPROVE WORKING CONDITIONS FOR COMMUNITY HEALTH WORKERS IN MALAWI

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A Manual for Trade Unions



## ACKNOWLEDGEMENTS

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## FOREWORD

In Malawi, Community Health Workers (CHWs) are engaged in health promotion, disease prevention, including basic treatment, and collecting community health information. However, the voices of CHWs pertaining to the problems and challenges they face in the course of their work are not often heard in discussions of policy and practice. For instance, one critical challenge confronted by CHWs is task-shifting, which is often implemented without policy support and takes place in an environment where there are competing demands, inadequate training and resources and poor supervision on CHWs amidst non-integrated programmes at community level.

This Manual provides insights on factors that interplay to shape the working conditions of CHWs who serve as the interface between health facilities and communities, particularly in the rural areas. In a context of acute human-resource shortages in Malawi, there is need for trade unions, civil society and policy makers to understand and address the challenges and problems confronted by CHWs through an enabling policy environment. One way of achieving this is through the promotion of social dialogue for CHWs.

This Manual can be a starting point for PSI affiliates in Malawi, namely: Civil Servants Trade Union (CSTU), National Organisation of Nurses and Midwives in Malawi (NONM) and Water Employees Trade Union of Malawi (WETUM) to make calls for creating and strengthening social dialogue structures towards promoting decent work for all workers in the public sector. For this to be possible, institutional capacity of PSI affiliates in Malawi should be strengthened in order to remain relevant as the voice of all workers in the public sector.

**GANIZANI  
THYANGATHYANGA**

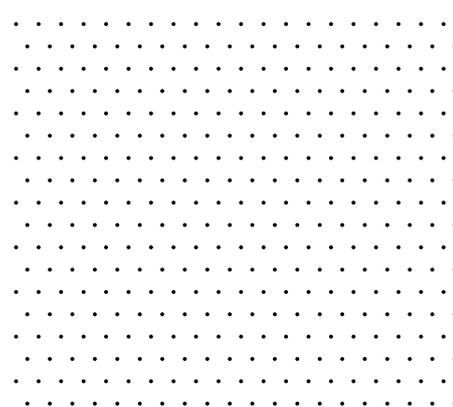
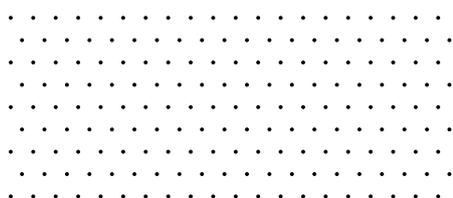
***Chairperson for PSI  
National Coordination  
Committee (Malawi)***

In this vein, the PSI affiliates in Malawi have a critical role to use social dialogue as a tool to promote the improvement of working conditions for CHWs. I believe that this Manual will assist the PSI affiliates in Malawi to understand the plight of CHWs, as well as the role of trade unions in promoting decent work for CHWs.



# CONTENTS

<b>ABBREVIATIONS</b>	<b>8</b>
<b>DEFINITION OF TERMS</b>	<b>9</b>
<b>INTRODUCTION</b>	<b>10</b>
<b>PURPOSE OF THE MANUAL</b>	
<b>CHAPTER 1: GENERAL OVERVIEW OF COMMUNITY HEALTH</b>	<b>12</b>
1.1. HEALTH SERVICES IN MALAWI	13
1.2. COMMUNITY HEALTH WORKERS	14
1.3. COLLECTIVE BARGAINING	18
1.4. RELEVANT POLICY INSTRUMENTS	19
<b>CHAPTER 2: WORKING CONDITIONS FOR COMMUNITY HEALTH WORKERS</b>	<b>20</b>
2.1. COVID-19 PANDEMIC	21
2.2. WORK OVERLOAD	23
2.3. SUPERVISION	25
2.4. ACCOMMODATION	25
2.5. SUPPLIES AND LOGISTICS	25
2.6. TRAINING	27
2.7. CONFLICT OF PRIORITISATION	27
2.8. CIVIL SOCIETY AND TRADE UNION RESPONSES	27
<b>CHAPTER 3: SOCIAL DIALOGUE AND ROLE OF TRADE UNIONS</b>	<b>29</b>
3.1. CONTEXT OF SOCIAL DIALOGUE FOR CHWS	30
3.2. PROCESS OF SOCIAL DIALOGUE FOR CHWS	33
3.3. ROLE OF TRADE UNIONS ON IMPROVING WORKING CONDITIONS FOR CHWS	34
<b>REFERENCES</b>	<b>36</b>



# ABBREVIATIONS

<b>CBDAs</b>	<b>COMMUNITY BASED DISTRIBUTION AGENTS</b>
<b>CHAM</b>	<b>CHRISTIAN HEALTH ASSOCIATION OF MALAWI</b>
<b>CHWS</b>	<b>COMMUNITY HEALTH WORKERS</b>
<b>CMAS</b>	<b>COMMUNITY MIDWIFE ASSISTANTS</b>
<b>CSTU</b>	<b>CIVIL SERVANTS TRADE UNION</b>
<b>CSOs</b>	<b>CIVIL SOCIETY ORGANISATIONS</b>
<b>HSAs</b>	<b>HEALTH SURVEILLANCE ASSISTANTS</b>
<b>HSSP</b>	<b>HEALTH SECTOR STRATEGIC PLAN</b>
<b>ILO</b>	<b>INTERNATIONAL LABOUR ORGANISATION</b>
<b>IPCAs</b>	<b>INTER-PERSONAL COMMUNICATION AGENTS</b>
<b>LMIC</b>	<b>LOW AND MIDDLE INCOME COUNTRIES</b>
<b>MoH</b>	<b>MINISTRY OF HEALTH</b>
<b>NCHS</b>	<b>NATIONAL COMMUNITY HEALTH STRATEGY</b>
<b>PNFP</b>	<b>PRIVATE NOT FOR PROFIT</b>
<b>NGOS</b>	<b>NON-GOVERNMENTAL ORGANISATIONS</b>
<b>NONM</b>	<b>NATIONAL ORGANISATION OF NURSES AND MIDWIVES IN MALAWI</b>
<b>PSI</b>	<b>PUBLIC SERVICES INTERNATIONAL</b>
<b>WETUM</b>	<b>WATER EMPLOYEES TRADE UNION OF MALAWI</b>

# DEFINITION OF TERMS

## COMMUNITY HEALTH:

basic preventive, promotive, curative, and rehabilitative health services, delivered at the community level with participation and ownership of rural and urban communities.

## COMMUNITY HEALTH WORKERS:

cadres hired by the Ministry of Health (MOH) or nongovernmental organisations to deliver basic preventive, promotive, curative and rehabilitative health services at the community level.

## TASK SHIFTING:

A strategy where non-qualified health workers are given responsibilities normally performed by highly qualified and highly skilled professionals.

## SOCIAL DIALOGUE:

Negotiations and consultations, such as exchange of information between and among representatives of governments, employers and workers on issues of common interest relating to economic and social policy, a particular workplace, enterprise and sector.

## NONGOVERNMENTAL ORGANIZATION (NGO):

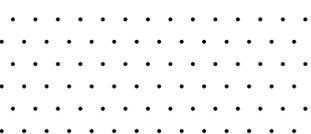
the most common name used internationally for an organisation formed to serve the communities or the public. The term is used interchangeably with civil society organisations (CSOs).

## TRADE UNION:

an organisation of workers who have come together to achieve many common goals, such as protecting the integrity of their trade, improving safety standards and attaining better wages and working conditions.

## SOCIAL PARTNERS:

Players involved in social dialogue e.g. government, employers and workers.



# INTRODUCTION

**Community health workers (CHWs) are increasingly recognised as an integral component of the health workforce that is required to achieve public health goals in low and middle-income countries (LMICs) such as Malawi. Due to the human resources for health crisis, LMICs have made increased investments in CHW programmes to extend the reach of inadequate health services to rural and remote populations.**

CHWs occupy a unique position in-between the community and state bureaucracy, which tends to be challenging for CHWs to balance as they are accountable to both. This intermediary position poses disadvantages for CHWs when the expectations of the community and the state bureaucracy differ, leading to high workload and demotivation among CHWs.

Nevertheless, given the acute shortage in the health workforce in Malawi, CHWs will remain an essential cadre in driving forward efforts to achieve universal health coverage. It is therefore important to better understand the working conditions of CHWs and explore practical ways on how to achieve decent work for CHWs.

## **Purpose of the Manual**

According to the International Labour Organisation (ILO), an effective social dialogue is a means to promote better wages and working conditions, as well as peace and social justice.



*A health surveillance assistant on duty in the community. Courtesy of UNICEF.*



*CHW on duty in a rural community. Courtesy of MHS.*

As an instrument of good governance, social dialogue fosters cooperation and economic performance, helping to create an enabling environment for the realisation of decent work at the national level. It is therefore critical for trade unions to promote a supportive, enabling and healthy work environment for healthcare workers through social dialogue. Increased cooperation between workers, employers and government in the health sector within the framework of social dialogue not only benefits the health care workers, but also the patients and the general public in terms of better quality of health services.

This Manual is intended to equip the affiliates of PSI in Malawi to articulate the struggles of CHWs in Malawi and understand the work, role and positioning of CHWs within the health systems in Malawi. This Manual is sub-divided into three chapters. The first chapter introduces community health in Malawi, while the second chapter highlights the working conditions for CHWs and the interventions by civil society organisations (CSOs) and trade unions to improve working conditions for CHWs. The last chapter presents a model on how social dialogue can be used to promote decent work for CHWs in Malawi. This chapter further discusses the role of trade unions in promoting better working conditions for CHWs.

# CHAPTER 1:

## GENERAL OVERVIEW OF COMMUNITY HEALTH

This chapter presents a general overview of health services in Malawi and locates the position and the critical importance of community health in the entire health system in Malawi.



## 1.1. Health services in Malawi

Health services in Malawi are provided by public (free of charge), private for-profit (PFP) and private not-for-profit (PNFP) sectors (Malawi Government, 2017a). The PNFP sector consists of faith-based institutions, NGOs, statutory corporations and companies. Linked to each other through a referral system, the health services are organised at four levels, as shown in Table 1 below:

**Table 1: Levels of health services in Malawi**

Level	Description
Community	Provided by CHWs, health posts, dispensaries, village clinics, and maternity clinics.
Primary	Provided by health centres and community hospitals.
Secondary	Consists of government owned hospitals and Christian Health Association of Malawi (CHAM) hospitals at district level.
Tertiary	Consists of five government owned central hospitals located in the four major cities.

### CRITICAL IMPORTANCE OF COMMUNITY HEALTH

The shortage of human resources for health remains a key challenge to the aspiration of achieving quality universal health coverage in Malawi. In response to this, there have been increasing investments in community health with the aim of bringing health services closer to communities and making services more accessible in resource-constrained settings.

According to the Malawi Government (2017b, p. 10), community health refers to “a basic package of preventive, promotive, curative, rehabilitative, and surveillance health services delivered in rural and urban communities with the participation of people who live there”. Community health is essential in improving health of 84% of the population that lives in rural areas. Community health, therefore, connects millions of people to the health system. Community-level interventions in health are critical in fighting the top four leading causes of illness in Malawi, namely: HIV/AIDS, lower respiratory infections, malaria, and diarrheal diseases.



*HSA on duty in a rural community.  
Courtesy of Village Reach.*

## 1.2. Community Health Workers

A community health worker (CHW) is defined as “any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention, and having no formal professional or para-professional certificate or degree in tertiary education” (Lewin et al., 2010, p. 7). In addition, it is argued that CHWs “should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system... and have shorter training than professional workers” (Lehmann & Sanders, 2007, p. 1).

In the Malawi context, CHWs are cadres hired by Malawi Government or NGOs to deliver basic preventive, promotive, curative and rehabilitative health services at the community level. The Malawi Secondary Certificate Examinations (MSCE) is the minimum educational requirement to obtain employment as a CHW and a 12-week training programme offered by the Ministry of Health (MoH).

### THE ROLE OF CHWS

CHWs are first-level health service providers and serve as a key link between a health facility and the community. They are supposed to be assisted by village health committees (which normally consist of 10 volunteers at village level). CHWs are deployed in a community setting and each CHW has an assigned catchment area.

The CHWs’ tasks continue to evolve largely due to task-shifting. A (full-time) job of CHWs consists of:

1. conducting community assessments on health;
2. promotion of hygiene and sanitation by village and business inspections and feedback to the community;
3. formation, training and supervision of Village Health Committees (VHCs);
4. health education on different topics;
5. promotion and delivery of the Accelerated Child Survival and Development of children under five;
6. provision of immunisations, vitamin A and de-worming drugs;
7. growth monitoring of children under five and giving tetanus vaccinations to women of child-bearing age;
8. disease surveillance and responding to disease outbreaks;
9. monitoring of safe water supply;
10. chlorination of water;
11. conducting village clinics on specified days for treatment of minor ailments (and referring severe cases to the nearest health facility);
12. promotion of vector and vermin control at the household level and provision of reproductive health services; and
13. recording all types of data in various registers (Village Health Registers, Health Management Information System registers and registers of specific programmes).



CHWs can be assigned to perform any other duties by their supervisor. There are also programmes designed by NGOs to complement government efforts in community health. Such programmes, which are often implemented by CHWs, cut across the promotion of hygiene and sanitation; health education and awareness; disease surveillance and reproductive health, among others.

### BOX 1: TASK SHIFTING:

This is “a strategy where non-qualified (often non-medically qualified) health workers are given responsibilities normally performed by highly qualified and highly skilled professionals”

Source: (Muula, 2016).



## CATEGORIES OF CHWs

In Malawi, there are various cadres of CHWs. There are reports that 60% of CHWs are women. Some of the categories of CHWs are as follows:

### 1. HEALTH SURVEILLANCE ASSISTANTS

The health surveillance assistants (HSAs) were initially deployed in the 1950s as “public vaccinators”, and later as “smallpox vaccinators” in the 1960s. In the 1970s, there was a group that was mobilised as “cholera assistants”. HSAs have officially been part of the health system in Malawi since 1995.

There are currently around 12,000 HSAs across the country representing 30% of the health workforce. They are recruited by the government. Each HSA is expected to serve a population of approximately 1,000 people. However, the actual size of their catchment population is often larger than this (Malawi Government, 2017b). This is especially challenging during the rainy seasons. HSAs are attached to a health facility, an average of 7.2km away from their catchment areas. They organise themselves in groups, often rotating their services in the community and at health facilities.

HSAs are supervised by senior HSAs or Assistant Environmental Health Officers who are also considered as CHWs in some official literature (Malawi Government, 2017b). HSAs are attached to a health centre, but are supposed to spend most of their time in the community. HSAs are civil servants on pension occupying Grade M. They earn around MK 130,000 monthly, which is equivalent to the salary of first-level clerical staff. They are entitled to scholarships and promotions within the Department of Environmental Health (United States Agency for International Development, 2015). However, some of them do not upgrade to become staff in the departments of Environmental Health or Preventive Health because there are limited positions available. Hence, they eventually become clinical officers and abandon HSA positions altogether (United States Agency for International Development, 2015).

## 2. COMMUNITY MIDWIFE ASSISTANTS

Community midwife assistants (CMAs) are young women specifically recruited, trained for 18 months at a nursing college and then deployed to rural communities where their core functions include health care to women in pregnancy and throughout labour and birth as well as to mothers and babies in the postnatal period. CMAs also provide reproductive health services, parenting advice and promotion of girl child education in the community among others.

The recruitment and training of CMAs was started in 2011 by the MoH to provide an adequate skilled attendant at birth in order to reduce escalating deaths from delivery complications, particularly in the rural areas. They are supervised by Nurse Midwifery Technicians. At the onset of the programme, the MoH's target was to train at least 1,000 CMAs. Currently, there are approximately 700 young women who have enrolled in the programme for CMA training since inception, out of which 500 remain unemployed. The CMAs are civil servants on pension occupying Grade L.

On 12 February 2021, unemployed CMAs held demonstrations in Lilongwe against the MoH's delays to offer employment to over 500 CMAs who remained jobless. They presented a petition to the civic offices in Lilongwe.



*Graduation of CMAs in August 2015 at St Luke's College of Nursing (Zomba).  
Courtesy of NyasaTimes.*

### 3. INTER-PERSONAL COMMUNICATION AGENTS

Inter-personal communication agents (IPCAs) are non-permanent HSAs that are hired by NGOs. On average, IPCAs under Population Services International are paid based on performance. They are contracted to do 10 group sessions (MK750 for each session) and 75 one-on-one or door-to-door sessions (MK 150 for each session). For every 50 referrals on average, they earn MK 25,000 and an additional MK 6,000 every month for transportation and communication expenses. The maximum successful referral amount for referrals above 50 in number is MK 26,000 (United States Agency for International Development, 2015).

### 4. VOLUNTEER CHWS

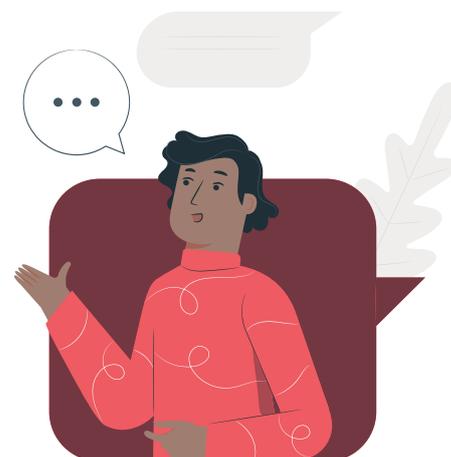
There are also CHWs who work as volunteers. Among these are Community Based Distribution Agents (CBDAs), whose major role is to provide information, education, counselling and family planning services within the communities where they reside (United States Agency for International Development, 2015). The CBDAs have existed in Malawi since the 1980s. However, the training curriculum developed at that time was inadequate to deal with new challenges of HIV and family planning. The CBDA programme was reintroduced in 1992 at CHAM facilities in Mzimba and Thyolo districts. The MoH, with support from partners, continued to provide oversight of the CBDA program.

Two individuals per district were trained by the MoH and Management Sciences for Health, which, in turn trained the CBDAs in their respective districts for two weeks. To qualify as a CBDA, one has to be able to read and write, and be trustworthy to keep sensitive information related to HIV status as confidential.

Presently, there is no record of how many CBDAs are active in Malawi or the type of training that active CBDAs have completed. Trainings and materials are received by CBDAs on an ad-hoc basis (United States Agency for International Development, 2015).

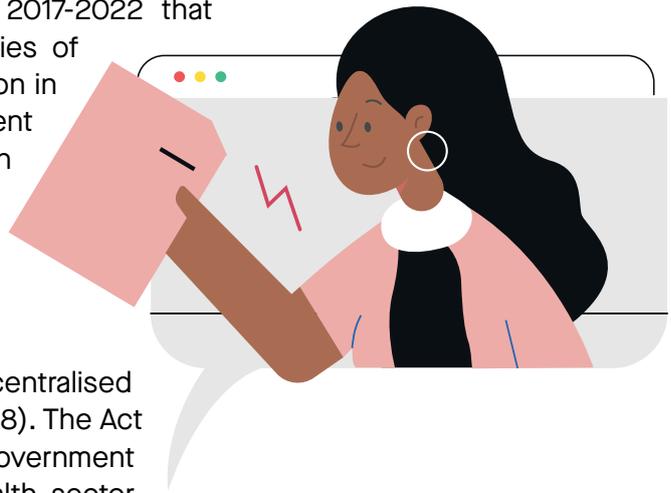
## 1.3. Collective bargaining

Other health care workers such as medical doctors, laboratory technicians, clinical officers and nurses have their own professional bodies that represent them when it comes to collective bargaining. Currently, there is no professional body for CHWs. Hence, unlike other cadres of health-care workers, the CHWs lack a unified voice to advance their collective interests. However, Civil Servants Trade Union (CSTU) and National Organisation of Nurses and midwives in Malawi (NONM) have attempted to organise HSAs and CMAs. Currently, only 60 HSAs and 11 CMAs are members of CSTU and NONM respectively.



## 1.4. Relevant policy instruments

The functions of CHWs are guided by the Malawi Government's National Community Health Strategy (NCHS): 2017-2022 that outlines the aspirations, processes and activities of how the community health system should function in Malawi. The NCHS is essentially a policy instrument that sets out the Health Sector Strategic Plan (HSSP II) of the Malawi Government, which underscores the critical importance of primary health care and community participation in the entire health system.



The Malawi health sector operates under a decentralised system guided by the Local Government Act (1998). The Act delegates authority and funding from central government ministries to district assemblies that guide health sector planning, budgeting, procurement and service delivery at district and community levels. The local government is mandated to oversee the day-to-day implementation of community health activities as stipulated in the NCHS (2017-2022). The local government structures have strong linkages to health-specific structures such as VHCs, which are coordinated by CHWs, District Health Officers (DHOs) as well as other local government structures such as Village Development Committees and District Councils.

The NCHS (2017-2022) recommends the ratios of CHWs to members of the population as follows:

- i. **1 HSA per 1,000 people**
- ii. **1 senior HSA per 10 HSAs**
- iii. **1 CMA per community health delivery structure**

The implementation of the NCHS (2017-2022) requires coordinated efforts from all actors working in the community health system including central and local government, NGOs, CHWs, and communities. The implementation plan for the NCHS (2017-2022) is aligned to strengthen health services decentralisation, promoting the ownership of planning and implementation at district and community levels.

# CHAPTER 2:

## WORKING CONDITIONS FOR COMMUNITY HEALTH

The tasks performed by CHWs involve a high level of social interaction such that they work with the local communities regularly. The nature of their job is flexible, and that allows them some high degree of independence. Hence, they can set most of their daily tasks and goals without talking to a supervisor first for instructions. They are entrusted to make critical decisions on a weekly basis that impact the local communities as well as the reputation of the MoH and the NGOs that hire them.



Under normal circumstances, CHWs work a standard 40-hour work week. The MoH and NGOs in the health sector organise workshops and trainings to upgrade the skills and knowledge of the CHWs. When they attend meetings, trainings and workshops outside their residential area convened by the MoH and NGOs, they are given adequate allowances to cater for their expenses during the activity. Furthermore, all CHWs under the payroll of Malawi Government are currently on pension scheme earning a monthly income above the statutory minimum wage. It is further acknowledged by the MoH and other stakeholders that services delivered by CHWs are highly cost effective and that CHWs can be deployed far faster and at lower cost than other medically trained cadres.

However, as the assignments of CHWs pile up and their role in community health grows, more and more people tend to increasingly depend on their productivity and efficiency. Against this backdrop, the CHWs face myriad problems and challenges related to poor remuneration, inadequate supplies and materials, and poor supervision, among other issues that which are discussed in this section.

## **2.1. COVID-19 pandemic**

The tasks of CHWs have recently expanded amidst the COVID-19 pandemic. In many instances, CHWs are tasked to identify early signs/symptoms of COVID-19 in communities, support isolation and refer the COVID-19 cases to health facilities. CHWs are also well positioned to provide timely, accurate information about COVID-19 transmission and preventive measures that people can take to protect themselves and their families, and tools for obtaining access to care and support.

However, studies by Christopher, Isaac, Rupali, and Thangakunam (2020) and Gao, Sanna, Tsai, and Wen (2020) confirm that frontline health care workers such as CHWs are significantly more susceptible to COVID-19 than the general public.

## INFECTIONS AND DEATHS

According to the International Labour Office (2020), infections and deaths recorded for the COVID-19 pandemic globally have also occurred among front line health care workers. Due to the increased risk of exposure to coronavirus, frontline health care workers such as CHWs fear that they may contract coronavirus in the course of duty and subsequently infect their family members at home.

In response to this, the WHO issued standard precautions for the protection of health care workers treating COVID-19 patients, which include the use of personal protective equipment (PPE) such as surgical facemasks, disposable gloves, plastic aprons, and face shield/goggles, and hand washing. However, it has become evident that PPE and safety protocols are not always available for all front line health care workers dealing with COVID-19 patients in developing countries such as Malawi (Delgado et al., 2020).

## VIOLENCE

Some connections can be drawn between occupational violence and pandemics such as COVID-19. During pandemics, some patients refuse to cooperate with health care workers such as CHWs and become reluctant to comply with health protocols. This sometimes leads to patients resorting to violent attacks and aggressive behaviours against health care workers such as CHWs. According to the ILO (2020), people working in occupations with a high risk of infection such as CHWs may face stigmatisation, leading to exclusion from society and increased exposure to violence and harassment.

For instance, in some rural areas like Balaka and Kasungu, there have been media reports of violence by communities against health care workers over some deaths medically declared as caused by COVID-19. The communities suspected foul play by health care workers. The media has also reported incidents of passengers refusing to use public transport with health care workers on suspicion that any health care worker is a super spreader of COVID-19. Such acts of stigma and violence against health care workers have caused sense of anxiety and trauma among health care workers including CHWs.



*CHW on duty in a rural community amidst COVID-19 pandemic. Courtesy of UNICEF.*

## 2.2. Work overload

CHWs, much like the rest of health care workers in Malawi, experience increased workloads, longer hours of work, limiting of “off-duty” time and multi-tasking.

### TASK-SHIFTING

Job descriptions of HSAs tend to change many times with the advent of new programmes. Additional tasks are assigned informally to HSAs by both the MoH and local NGOs that coordinate the specific programmes (Kok & Muula, 2013; Smith et al., 2014).

#### **BOX 2: TASKS NOT EXPLICITLY ON JOB DESCRIPTION FOR HSA'S IN ZOMBA**

- 1. Nutrition supplementation programmes for malnourished children at facilities;**
- 2. TB testing, drug dispensing, patient review;**
- 3. Dispensing and administering injectible contraceptives within family planning activities;**
- 4. Antiretroviral therapy for HIV dispensing and monitoring, defaulter tracing and antiretroviral therapy activities such as encouraging blood tests and engagement with health centres;**
- 5. performing dry blood spot testing for infant withing the prevention of mother to child transmission of HIV (PMTCT) programmes**
- 6. Cholera management at health centres;**
- 7. Drug Store management**
- 8. Outpatient register at the facility**

*Source: Smith et al. (2014).*

Some of the additional tasks given to CHWs are conventionally performed by more qualified health care workers. The integrated management of childhood illnesses (IMCI), community case management (CCM) programme known as “village clinic” is an example of a task recently added to the current HSA job description that took time to be incorporated in the pre-service training curriculum provided by the MoH (Smith et al., 2014). The programme requires HSAs to assess children aged two months to five years in communities for common illnesses.

## **TASKS NOT EXPLICITLY ON JOB DESCRIPTION FOR HSAs IN MWANZA**

- 1. Filling in of the Out Patient Department (OPD) HMIS register at the OPD clinic**
- 2. Malaria and Tuberculosis Microscopy**
- 3. Working in Voluntary Counseling and testing (VCT) on HIV and PMTCT4.**
- 4. Home-Based Care**
- 5. Cleaning in hospital wards and other rooms / surroundings**
- 6. Administering anti-rabies vaccine**
- 7. Treating cholera cases**
- 8. Caring for patients in the wards**
- 9. Diagnosing patients, administering patients.**

*Source: Kok and Muula (2013).*

Task-shifting contributes to work overload that may eventually lead to frustrations and demotivation among CHWs.

### **SHORTAGE OF CHWS**

The MoH experiences an acute shortage of CHWs in Malawi. For instance, Malawi needs an additional 7,000 HSAs to meet the policy recommendation of one HSA per 1000 people (Malawi Government, 2017b). This further increases the workload on the current HSAs and contributes to occupational stress as they struggle to cope with the increasing job demands amidst shortage of HSAs.

### **INADEQUATE REMUNERATION**

In light of task-shifting, in some instances the HSAs are expected to take on tasks for which they are not qualified. While their roles keep on expanding, their remuneration remains static (Chikaphupha, Kok, Nyirenda, Namakhoma, & Theobald, 2016). For instance, amidst the COVID-19 pandemic, CHWs are expected to undertake additional tasks on prevention and handling of COVID-19 cases at community level.

## 2.3. Supervision

Supervision of CHWs is reported to be poor amidst task-shifting. For instance, studies by Kok and Muula (2013) and Smith et al. (2014), conducted in Mwanza and Zomba districts respectively, revealed that there was limited supervision of HSAs. The two studies highlighted that there were no regular visits, no supervision checklist with transparent criteria known by HSAs and no feedback mechanism.

The Assistant Environmental Health Officers and Environmental Health Officers who supervise the HSA supervisors sometimes do not receive the necessary training for tasks shifted to HSAs, thus restricting their capacity to effectively supervise HSAs and HSA supervisors. Sometimes, feedback from supervisors is perceived by HSAs as punitive rather than facilitative and feedback is usually only given when something has gone wrong (Chikaphupha et al., 2016).

## 2.4. Accommodation

According to the MoH, HSAs are expected to reside in their catchment areas. While the MoH has constructed houses for clinicians, nurses, and medical assistants in rural and hard-to-reach areas, the same is not the case for HSAs (Chikaphupha et al., 2016). Many HSAs are reluctant to be based in rural areas without proper accommodation, opting instead to reside within the closest trading centres. The lack of electricity, running water, and poor housing facilities are some of the key factors that drive HSAs out of the communities they are supposed to reside in.

## 2.5. Supplies and logistics

CHWs face challenges pertaining to supplies and logistics (Chikaphupha et al., 2016).

## TRANSPORT

Unavailability of transport and poor road networks are barriers to referrals, leading to both community dissatisfaction and demotivation of HSAs. Transport challenges also affect the ability of HSAs to make follow-up visits to their clients.

## STATIONERY AND OTHER SUPPLIES

The HSAs' work is hampered by shortages of stationery and other supplies.

## UNIFORMS

Some HSAs lack uniforms, footwear and raincoats, while for others, the uniforms are either torn, old, or no longer fitting.



*An HSA receiving a donation of a bicycle from UNICEF in Phalombe. Courtesy of Malawi24.*

## 2.6. Training

There are numerous challenges that are raised pertaining to the training of CHWs, which may contribute to demotivation and job dissatisfaction that eventually affect the quality of service provided by the CHWs.

### LACK OF TRAINING

Some HSAs do not receive the required 12-week training by the MoH on the understanding that they will be trained on the job, which is sometimes difficult due to the heavy workload of other HSAs and a lack of time on the part of the supervisors (Kok & Muula, 2013). This results in poor performance as well as resentment between the trained HSAs and non-trained HSAs.

### DELAYS IN DEPLOYMENT AFTER TRAINING

For the CMAs in the first cohort of 2011, it took five years for the government to offer them positions after duly qualifying as CMAs. Due to this delay, some CMAs started to upskill themselves and eventually switched careers.

### SALARY DELAYS AFTER TRAINING

There are reports that, for some CMAs, once employed by the government, did not receive their first salaries for a number of months.

## 2.7. Conflict of prioritisation

CHWs are involved in multiple programmes offered by both government and NGOs. This entails competing demands on them to prioritise their activities (Smith et al., 2014). There is lack of integration of NGO programmes such that, in some instances, some NGOs bypass the district supervisor of HSAs and directly engage HSAs for their programmes. This lack of integration of NGO programmes poses implications on task-shifting for CHWs as discussed earlier.

## 2.8. Civil society and trade union responses

There are interventions by civil society organisations (CSOs) and trade unions towards addressing the problems and challenges confronted by CHWs in Malawi.

## CAMPAIGN FOR BETTER WORKING CONDITIONS

Since 2017, CSOs and trade unions in Malawi have been actively participating in a national campaign for the improvement of working conditions for CHWs under the coordination of AMREF-Africa. Trade unions are represented in this campaign by the National Organisation of Nurses and midwives of Malawi (NONM).

A CHW model legislation by AMREF-Africa was endorsed by CSOs and NONM, which have collectively lobbied for the incorporation of some elements from the CHW model legislation into the review of the Public Health Act of 1948 (AMREF, 2020). Some of the proposals into the review of the Act include: formalising the CHWs into the health system and regulatory mechanism(s) for the recognition and working conditions for CHWs among others. Some of the planned activities under the campaign that were disrupted by the emergence of COVID-19 include:

- 1. Meetings with the Special Law Commission, legislators and MoH officials on the review process of the Public Health Act;**
- 2. Community sensitisation activities and engagement with district health officials and CHWs in the pilot districts of Ntchisi, Mangochi and Karonga on how to address the critical challenges confronted by CHWs.**

## ORGANISING CHWS

Around 2014, after the graduation of the 1st cohort of CMAs were Around 2014, after the graduation of the first cohort of CMAs who were then not employed immediately, NONM intervened to organise the CMAs to effectively represent their grievances. Some of them are currently among the membership of NONM.

In 2018, HSAs in Lilongwe intended to stage a strike against poor working conditions. CSTU intervened in the matter. The planned strike was called off and 60 HSAs from Lilongwe were recruited as members of CSTU.

# CHAPTER 3:

## SOCIAL DIALOGUE AND ROLE OF TRADE UNIONS



### 3.1. Context of social dialogue for CHWs

Social dialogue for CHWs may include all types of negotiation and consultation, such as exchange of information between and among representatives of governments, employers and CHWs on issues of common interest relating to economic and social policy, and the health sector in particular. A common understanding has to be reached on the purpose of social dialogue.

The social partners should have clear ideas on the elements of social dialogue for CHWs to be included. The social partners in the health sector are public authorities as regulators or as employers, non-governmental employers' and workers' organisations.

#### TYPES OF SOCIAL DIALOGUE

The types of social dialogue may be distinguished according to geographical coverage at national and local levels or according to coverage of workplaces at cross-sectoral, sectoral and enterprise levels.

#### BOX 4: TYPES OF SOCIAL DIALOGUE

##### 1. Bi-partite Social Dialogue

this refers to social dialogue in which the employers and workers and their organisations participate without the presence of government as a regulator. This type of social dialogue takes place mainly at the enterprise level. The government may participate in such dialogue as the public employer.

##### 2. Tri-partite Social Dialogue

This refers to social dialogue in which the government participates as a regulator together with the employers' and workers' organisations. This type of social dialogue can take place at national and local levels.

*Source: International Labour Office (2002)*

## AGENDA OF SOCIAL DIALOGUE

For CHWs, social dialogue may require concrete economic, social and labour issues to be on the agenda. In principle, all matters concerning the CHWs in particular and the health sector in general should be included in the social dialogue. These issues should be identified, and each social partner should have the right to examine such issues. These issues are often related to institutional reforms, financing of health services, the quality of health services, working conditions, skills and lifelong learning, recruitment and retention of personnel, career development, pay systems and gender issues.

All social partners should set the agenda collectively and agree on a number of questions, such as the issues to be covered. Women, who make up the majority of the health care workforce, continue to face discrimination, including inequitable pay. Social dialogue for CHWs can therefore contribute positively to addressing gender disparities in the health sector.

### BOX 5: DIFFERENT ELEMENTS OF SOCIAL DIALOGUE

#### 1. NEGOTIATION

**This is an integral and one of the most widespread forms of social dialogue. Parties can engage in collective bargaining at enterprise, sectoral, national, and international levels.**

#### 2. CONSULTATION

**This requires an engagement by the parties through an exchange of views which in turn can lead to more in-depth dialogue. The parties participating in tripartite or bipartite bodies can engage in negotiations and the conclusion of formal agreements.**

#### 3. INFORMATION SHARING

**this is one of the most basic and indispensable elements for effective social dialogue. It implies no real discussion or action on the issues but it is nevertheless an essential part of those processes by which dialogue and decisions take place.**

*Source: International Labour Office (2002)*

## REPRESENTATION OF THE SOCIAL PARTNERS

A prerequisite for effective social dialogue is strong, independent and responsible social partners who recognise the legitimate roles and interests of each other, commit themselves to constructive engagement in agreed processes of dialogue and deliver their side of negotiated outcomes.

### **BOX 6: RELEVANT ILO CONVENTIONS FOR SOCIAL DIALOGUE IN HEALTH SECTOR**

**Convention No.87: Freedom of Association and Protection of the Right to Organise, 1948.**

**Convention No.98: Right to Organise and to Bargain Collectively, 1949.**

**Convention No.135: Protection and Facilities to be Afforded to Workers' Representatives in the Undertaking, 1971.**

**Convention No.144: Tripartite Consultation, 1976.**

**Convention No.151: Protection of the Right to Organise and Procedures for Determining Conditions of Employment in the Public Service, 1978.**

*Source: International Labour Office (2002)*

Freedom of association and the effective recognition of the right to collective bargaining are included in the fundamental principles and rights at work as stipulated in the ILO Declaration on Fundamental Principles and Rights at Work of 1998. Member States of the ILO are bound to respect, promote and realise these fundamental principles

While examining the representation of government structures in social dialogue for CHWs, a detailed analysis of the decentralised responsibilities of government is required. It is important to distinguish whether a particular structure to negotiate with represents the government as the financing and regulating authority, or as public employer.

The agenda of the social dialogue is also relevant, since different government levels may be responsible e.g. for primary, secondary and tertiary health care. Often it is unlikely that these various responsibilities are represented by one structure (such as, in the

past, the Ministry of Health). Therefore, it must be asked carefully which structure can represent which responsibility. This analysis may use of a matrix which lists in the “head column” the various governmental structures responsible and in the “head row” the various responsibilities that would be taken up in the social dialogue.

A corresponding method such as that in the case of the government structures could be applied for identifying private employers and their representatives.

## 3.2. Process of social dialogue for CHWs

### PLANNING FOR SOCIAL DIALOGUE

Planning for a social dialogue for CHWs must be based on the continuous analysis of the current situation in the health sector. Planning must anticipate the process of reaching a common understanding, of recognising the social partners and of identifying indicators for effectiveness of social dialogue. This planning process has to be designed in advance and depends on the issues and the elements of social dialogue chosen for a given situation.

### INITIATING SOCIAL DIALOGUE

The process for social dialogue needs to be initiated by CHWs themselves or trade unions organising CHWs. The initiative for social dialogue depends on the issues chosen and requires addressing issues such as: who will take the initiative to enter into social dialogue; should social dialogue start as an informal or formal process; What should the agenda for this initial stage of social dialogue be.

### SOCIAL DIALOGUE

Social dialogue is a process to be carried out in good faith. In the health sector, the implementation of a social dialogue plan is often difficult and depends on factors that may be beyond the complete control of the social partners. Therefore, to sustain support for these efforts, continuous attempts must be made to adjust or reinstate social dialogue.



## MONITORING AND EVALUATION

During the implementation process, implementation needs to be monitored in the light of the initial plan agreed upon by the social partners. Indicators must be set for this purpose. Substantial deviations from the plan need to be examined and evaluated in the light of the goals to be achieved. If the results are not satisfactory, corrective action must be taken by the social partners. Social partners must be trained in methodologies for the monitoring and evaluation of the process of social dialogue. All social partners should participate in such a process.

## MOBILIZING THE RESOURCES

The process of social dialogue is complex and can be lengthy. It therefore requires financial and human resources. To work effectively, the social partners engaged in social dialogue for CHWs should be provided with the resources required in terms of funds, time, facilities and training. All partners have a proportionate responsibility to invest in the social dialogue. Analysis is required on issues such as: what financial and human resources are needed for the process of social dialogue; who should contribute to mobilising these resources; and how can resource mobilisation be maintained throughout the process of social dialogue.

### 3.3. Role of trade unions on improving working conditions for CHWs

Safeguarding and protecting the fundamental rights at work is critical in improving the working conditions for CHWs. The following are some of the recommendations for trade unions to consider in the context of social dialogue.



#### INTENSIFICATION OF COLLABORATIONS WITH CSOs AT NATIONAL LEVEL

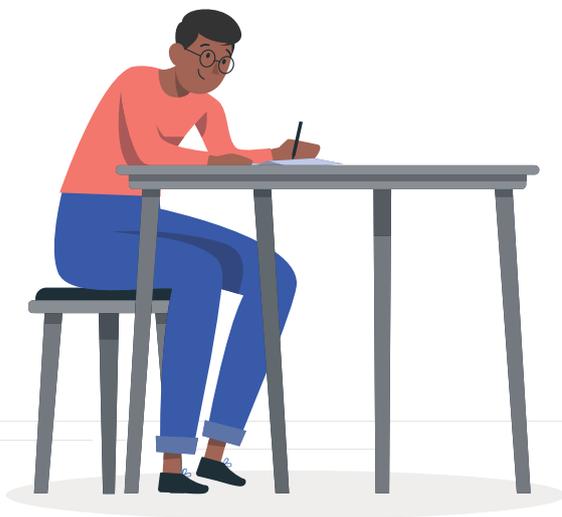
1. Engage in national campaigns that emphasise the centrality of fundamental rights at work in all national health policy interventions;
2. Intensify the CHW campaign by AMREF on improving the working conditions for CHWs;

## UTILISING SOCIAL DIALOGUE PLATFORMS AT NATIONAL LEVEL

3. Demand a mandatory social dialogue process to champion measures that secure jobs and advance the following for CHWs:
  - i. Social security entitlements (pension payments, parental/career/sick leave), adequate training and supervision for all CHWs;
  - ii. An increase in the remuneration for CHWs consistent with the ever increasing roles and tasks of CHWs;
  - iii. Provision of adequate PPE amidst COVID-19 pandemic and necessary supplies and logistical support for all CHWs;
  - iv. A manageable workload and work-schedule with weekly maximum number of hours as stipulated in the labour laws; and
  - v. Formal, quality training for CHWs to equip them to do their jobs to the best of their ability.

## CHWs' REPRESENTATION

4. Demand the inclusion of CHWs in platforms and discussions that relate to national policy responses on health.
5. Intensify efforts to organise CHWs to become members of trade unions such as CSTU/NONM for effective representation in social dialogue.
6. Formalise all categories of CHWs into the health system and push for regulation of working conditions for all CHWs.



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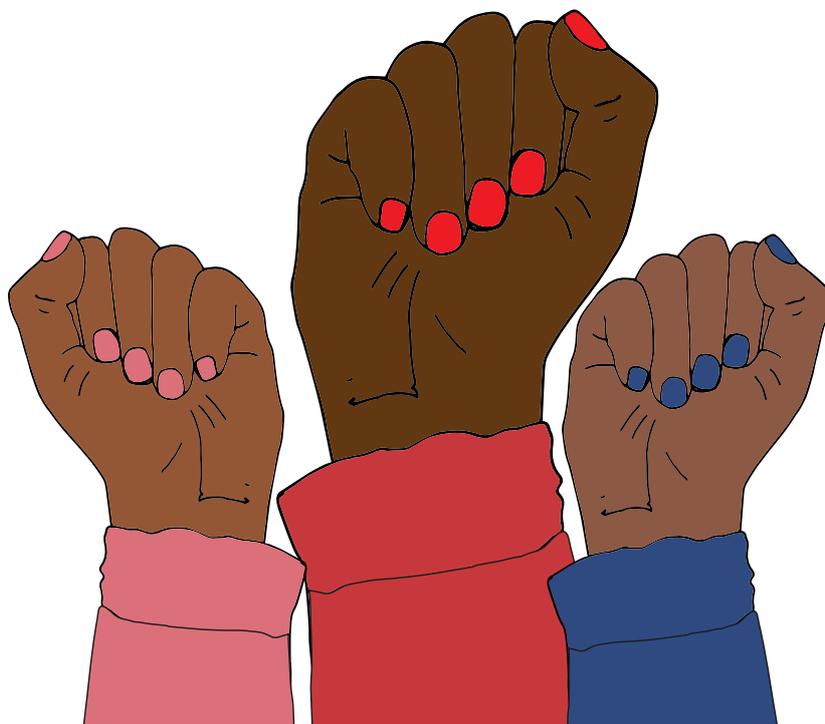
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