

IMPACT PROGRAM

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The Expert Client Model

Peer-based Support to the Continuum
of HIV Care in Malawi



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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
ACRONYMS	iii
EXECUTIVE SUMMARY	I
1.0 BACKGROUND	2
2.0 METHODOLOGY	6
3.0 STUDY FINDINGS	8
3.1 Expert Client job role and “fit” within the health facility staffing structure	9
3.2 Acceptability of Expert Clients by health workers	10
3.3 Management and supervision of Expert Clients	12
3.4 Expert Client referral mechanisms and community linkages	14
3.5 Constraints and bottlenecks	15
4.0 KEY SUCCESSES OF THE EXPERT CLIENT MODEL	16
4.1 Improved HIV service delivery	16
4.2 Reduced service provider workload	16
4.3 Improved retention of patients in care	16
4.4 Increased demand for HIV services	17
5.0 RECOMMENDATIONS	18
5.1 Scale up the CRS/IMPACT Expert Client model	18
5.2 Shift the responsibility of supervision	18
5.3 Conduct regular site visits and reorientation	18
5.4 Adjust and standardize the Expert Client incentives/stipend	19
5.5 Provide uniforms or a standard means of identification	19
6.0 CONCLUSION	19
7.0 REFERENCES	20
APPENDIX I: Interview guides	22

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CRS	Catholic Relief Services
DHO	District Health Office
DHMT	District Health Management Team
HTC	HIV Testing and Counseling
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HCW	Health Care Worker
HTC	HIV Testing and Counseling
IEC	Information, Education and Communication
IMPACT	Integrated (HIV Effect) Mitigation and Positive Action for Community Transformation
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
TB	Tuberculosis
USAID	United States Agency for International Development



EXECUTIVE SUMMARY

The HIV epidemic has had a tremendous impact on human resources for health in many countries, and Malawi has not been spared. Task-shifting—the intentional delegation of routine functions from highly skilled to less-skilled workers—has been proposed as a feasible alternative for improving HIV service delivery in resource-constrained settings. Through the USAID-funded Integrated (HIV Effect) Mitigation and Positive Action for Community Transformation (IMPACT) program and with the support of a joint Ministry of Health ART/PMTCT Technical Working Group Task Force, Catholic Relief Services (CRS) developed and implemented a peer-based task-shifting approach known as the Expert Client model. HIV-positive Expert Clients were recruited and trained to provide counseling, psychosocial support and assistance in navigating and accessing HIV care for their HIV-positive peers, including pregnant women and their exposed or infected children.

The Expert Client program operated for three years (2011–2014) through 79 health facilities in 9 districts. Anecdotally, the program has been widely lauded by health care providers, district health managers and patients in HIV care for the extent to which Expert Clients “fit” in the existing HIV care and treatment system. Evidence about the Expert Clients’ contributions improving service delivery is needed to inform crucial human resource management and task-shifting decisions. Specifically, this report is intended to provide insights into the (a) acceptability of this volunteer cadre by salaried HIV service providers, (b) workload implications for HIV service providers when the Expert Client is introduced into the health facility staffing structure, and (c) factors that appear to facilitate and/or hinder Expert Client performance.

A formal study, contracted by CRS and conducted by the Center for Public Health Policy Research and Development (CPHPRD), employed qualitative methods, including in-depth interviews, document review and observations, to obtain data both retrospectively and prospectively. Researchers visited 20 health facilities and conducted 61 in-depth interviews. This report relies heavily on that study, supported by IMPACT program monitoring data, reports, success stories and both published and unpublished literature and videos.

The overall conclusion of the document is that the Expert Client model is well accepted by health care workers (HCWs); at most facilities, Expert Clients are viewed as an integral part of the multi-disciplinary team. While Expert Clients were specifically recruited to assist with providing health education and default tracing, their presence has reduced workload and stress for salaried HIV service providers through the performance of many additional tasks and by simply being “an extra pair of hands.” Though originally positioned to report to

the senior Health Surveillance Assistant (HSA), Expert Clients are actually best supported and supervised by the clinical service provider in charge of either HIV services specifically (in bigger facilities) or the facility at large (at smaller health centers).

Furthermore, there is evidence that the deployment of Expert Clients in health facilities has resulted in several benefits, including the following:

- Increased demand for HIV prevention, testing and treatment services
- Streamlined patient flow and service delivery
- Accelerated retrieval of “missed appointments” and improved retention of patients in care
- A strengthened functional referral system between facility and community
- Increased male involvement in prevention of mother-to-child transmission (PMTCT)

Expert Clients serve in areas where the majority of Malawians live and the shortage of skilled service providers is felt most acutely. There is a consensus from all stakeholders that Expert Clients, drawn from within the communities they serve, are available, highly motivated and well-placed—as trained peers—to support HIV service provision. The success of the Expert Client model was, however, moderated by some challenges, including lack of uniforms or common identity, unstandardized and unreliable incentive packages and transportation challenges.

1.0 BACKGROUND

Malawi is considered a high HIV burden country, with national prevalence estimated at 10.6% among adults aged 15–49 (MDHS, 2010). The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that in 2010 there were 920,000 adults and children living with HIV in Malawi; of these, 120,000 were children under 15 years. According to MDHS (2010), AIDS remains the leading cause of death among adults of productive age.

Intensive efforts over the past decade have increased awareness about HIV and appear to have had a positive effect in reducing the national HIV prevalence from 15% in 2003 to 10.6% in 2010. Malawi's national HIV treatment program has achieved international recognition for its rapid scale-up. By the end of 2012, the country had achieved more than 60% antiretroviral therapy (ART) coverage (Ministry of Health, 2012).

Despite these successes, Malawi continues to suffer from an acute shortage of HCWs at every level, which compromises the population's access to quality HIV services (DfID, 2010; GoM Health Sector Strategic Plan, 2011–2016). Health workforce shortfalls in Malawi, as in most of Africa, are caused by a combination of factors including migration to better paid posts in other countries, high attrition due to ill health and death (often HIV-related) and migration from the public sector to the private sector (Willis-Shattuck et al., 2008). These shortfalls have occurred just when health care providers are in extraordinarily high demand, as the response to HIV requires a larger, more skilled and better coordinated health workforce response than the country has ever known.

Additionally, stigma, discrimination, fear of disclosure and lack of adequate support from their communities still affect people living with HIV (PLHIV) and contribute to high loss to follow-up and default rates for HIV prevention, testing and treatment services. One study done in Malawi found that the main reasons for defaulting from care were stigma (43%), dissatisfaction with care (34%), poor understanding of disease or treatment (56%) and drug side effects (42%) (McGuire et al., 2010).

Task-shifting has been proposed as a feasible alternative for improving HIV service delivery in resource-constrained settings (WHO, 2008). Much of the evidence relating to task-shifting through a peer-based model comes from Swaziland, Zambia, Botswana, Uganda and South Africa (Shroufi, 2013; Kim, 2012). Successes of these task-shifting programs included saving nurses several hours of time each month, increased access to HIV services and ART, improved patient flow, re-orientation of clinician focus from record-keeping tasks to patient care, decreased virologic failure rates and reduced loss to follow-up (Tenthani, 2012; Belmans, 2010; Yaya 2013; Kim, 2012; Torpey, 2008; Arem, 2011). Studies also reported that these models are leading to increasing acceptance of HIV at the community level, less expensive follow-up care of comparable quality and long-term monetary savings (Ledikwe, 2013; Kiweewa, 2013). Of note, clinic staff reported that the peer-based adherence support programs improved the overall care of the clinic patients. Patients who talked to someone living positively with HIV, such as an Expert

CRS/IMPACT program Expert Client model

CRS designed the Expert Client model as part of its IMPACT program, a four-year USAID-funded program focusing on providing services for orphans and vulnerable children (OVC) and PLHIV in nine districts. IMPACT was led by CRS and implemented in a consortium comprised of Africare, Chikwawa Diocese, Catholic Health Commissions of Dedza, Lilongwe and Zomba Dioceses, Emmanuel International, Project Concern International, Save the Children, World Vision, D-tree International, Opportunity Bank of Malawi (OBM) and the National Association for People Living with HIV/AIDS in Malawi (NAPHAM). Between 2012 and 2014, IMPACT partners identified, placed and supported 158 Expert Clients in 79 health facilities in 9 districts, as well as 453 Community Facilitators whose role was to receive tracer cards from the Expert Client, find the “missing” patient, and bring him or her back into the system. With extensive coverage in southern and central Malawi, IMPACT aimed to demonstrate that the CRS/IMPACT Expert Client model could be successfully implemented in Malawi at scale.



Client, before initiating ART had a better understanding of the importance of adherence and less fear of disclosure (Arem, 2011; Chang, 2008).

In Malawi, peer-based task-shifting models have been implemented on a pilot basis by several other non-government organizations, including Mothers 2 Mothers, Dignitas International, Bridge II, Medicines Sans Frontieres and the Baylor College of Medicine Tingathe program. In each of these programs, HIV-positive individuals are deployed to assist salaried HCWs in provision of services, thereby removing some of the barriers to universally accessible, high quality HIV services. They are known as Expert Clients, Community Referral Agents, Model Clients, Adherence Support Workers, Mentor Mothers and Community Facilitators.

This group of service providers can be found in a variety of roles and settings where they assist with individual and group treatment literacy sessions, HIV testing and counseling (HTC) and referral, individual adherence counseling and tracing ART patients who have missed appointments as well as those who are classified as defaulters. They provide the uniquely relevant approach that can only be offered by a peer from within the same community, willing to use his or her own experience of living with HIV as a tool to establish credibility and rapport. Perhaps most importantly, this cadre frees up skilled HCWs, enabling them to focus on the more complex, technically challenging patients in HIV service areas and patients in the general population.

There is still, however, a lack of empirical evidence about the impact of peer-based interventions in Malawi. Development of a solid evidence base has been compromised by a range of confounding factors, including rapidly changing service protocols, intermittent shortages of supplies and medications and variable quality of service by salaried service providers. Data quality is difficult to maintain because of reliance on paper-based record keeping and the absence of a national electronic registration system for HIV services. A project-based approach to this intervention and short project/donor cycles have also hampered the collection of longitudinal data.

In spite of these constraints, the evidence base is slowly emerging as long-term actors (such as Dignitas International, Medicines Sans Frontieres, Mothers-2-Mothers, Clinton Health Access Initiative (CHAI) and Baylor College/Tingathe) are accruing much-needed quantitative evidence. During IMPACT's four years of implementation, anecdotal evidence pointed to the success of the Expert Client model, especially around patient retention in care and reducing HCW workload.

The CRS/IMPACT Expert Client model was designed to improve ART adherence, strengthen referral linkages and increase enrollment in care and treatment. To inform design of the model, CRS was mandated by the national ART/PMTCT Working Group to conduct a situation analysis that would aid in understanding the work of peer-based HIV treatment support using volunteers, the referral mechanisms used by relevant organizations, and the various training programs and remuneration packages. When the findings were shared with the Ministry of Health (MoH), CRS was tasked with leading the development of the Expert Client training manual and designing a functional referral mechanism in collaboration with a task force of the ART/PMTCT Working Group.

The individuals selected to serve as Expert Clients were HIV-positive support group members who were open to disclosing their HIV status, had good records of ART adherence and had reasonable literacy (Chichewa) and numeracy skills. Selected individuals were trained by district ART/PMTCT and HTC coordinators, facilitated by IMPACT partners, according to the newly developed Expert Client training manual. Uniquely, the IMPACT model trained Community Facilitators, drawn from PLHIV support groups, to provide a functional link between facility and community and ensure availability of sufficient numbers of trained volunteers to provide rapid and effective tracing.

After the first three years of implementation, leveraging its experience and reach, CRS/IMPACT designed a qualitative study to document the management considerations and workload smoothing benefits of the facility-based Expert Client model. The study examined Expert Client placement from a systemic perspective to elicit a description of what makes the relationship between the Expert Client and health facility staff successful. It identified constraints and bottlenecks to the successful deployment of the Expert Client. The study explored the clarity and relevance of the Expert Client job role and the fit (or lack of fit) with the health facility staffing structure. This study also examined the acceptability of a volunteer cadre, as well as the perceived value of the peer approach.

The study, bolstered by analysis of program monitoring data and documented implementation experience, provides qualitative evidence and recommendations specifically related to the role of facility-based Expert Clients in reducing the workload burden and stress of salaried HIV service providers. The positioning of these findings, alongside the emerging evidence of reducing defaulter rates and improved retention in care, is intended to inform MoH in future decision making about human resources for health and HIV service management.

2.0 METHODOLOGY

The review employed qualitative methods, specifically in-depth interviews, focus group discussions, document reviews and observations. The study team interviewed HIV service providers and Expert Client supervisors to understand the functionality of the Expert Client's reporting relationship. Other key informants included health facility In-charges (Medical Assistants or Clinical Officers); District Health Management Team (DHMT) members; and District ART, PMTCT and HTC coordinators. The study team also observed Expert Clients at work to obtain a first-hand perspective on their role. In addition, the study team conducted a review of documents, including literature collected by CRS and the IMPACT Expert Client program training manual.

Multi-staging purposive sampling was used to select 20 health facilities for the study from among the 79 health facility names provided by CRS. The sampling unit was service delivery point. Multi-stage sampling was used with proportionate stratified sampling, using IMPACT partner organizations as the strata. Seven of the nine implementing partners were represented. Lilongwe Catholic Health Commission was excluded because their operations had been reduced for internal reasons, and Zomba Catholic Health Commission was inadvertently excluded during sampling. Within each stratum, systematic random sampling was used, applying a sampling fraction of 0.25. Random numbers generated by Microsoft Excel were used in each stratum. Further, a purposive sampling strategy was employed to identify replacement of health facilities after two sites were declared unfit¹. Of the 20 facilities selected (Table 1), 16 were government-run, while four were under Churches Health Association of Malawi management. Individuals were selected purposefully based on their designation.

A team of nine research assistants and four supervisors were recruited based on merit. They were prepared for qualitative data collection through a five-day training. The training focused on project background and rationale, study objectives, interviewing and probing techniques to maintain quality data and research ethics. As part of the training, data collection tools were finalized and validated through pilot testing at Bwaila and Likuni

¹ Two facilities were dropped from the sample because at one, the Expert Client had only been there for a few months, and at the other, there was no Expert Client in place at all since one had moved to a new community and the other was ill.

TABLE 1: 20 HEALTH FACILITIES WERE SELECTED FOR INCLUSION IN THE STUDY

IMPACT Partner	District	Health Facility
Africare	Mulanje	Milonde Health Center (HC)
		Mpala HC
		Mulanje District Hospital
		Naphimba HC
Chikwawa Diocese	Chikwawa	Makhuwira HC
		Ngabu Rural Hospital
Dedza Catholic Health Commission	Ntcheu	Mikoke HC
		Nsiyaludzu HC
		Ntcheu District Hospital
Emmanuel International	Machinga	Mposa HC
		Ntholowa HC
	Zomba	Domasi Rural Hospital
		Machinjiri HC
Project Concern International	Balaka	Balaka District Hospital
	Machinga	Gawanani HC
Save the Children	Zomba	Mayaka HC
		Sadzi HC
World Vision International	Thyolo	Makungwa HC
		Namileme HC
		Thyolo District Hospital

Hospitals and Chitedze Health Centre in Lilongwe District. All issues noted in the piloting were resolved in plenary sessions before use of the interview guide in the field.

Data collection took place March 10–14, 2014. CRS and IMPACT implementing partners pre-arranged meetings with respondents and guided the three study teams to the selected health facilities. To ensure a successful visit, team leaders confirmed availability of respondents at each health facility by phone or text messaging.

In the field, the team held debriefing meetings every evening to check data quality and review problematic areas. Problems that arose with interview guides and study logistics were resolved before the next day's data collection. For interviewers who had difficulty administering certain questions, supervisors conducted continuous skill building on a one-on-one basis, especially to ensure consistency and appropriate probing. Consent was secured, and most interviews were audio-recorded except in a few

circumstances where the location was not conducive to recording (e.g., noisy places). The team conducted the interviews in pairs and ensured completion of thorough note-taking during each interview. Interviews lasted between 20 and 90 minutes.

Some interviews were transcribed concurrently with data collection, while the remaining interviews were audio-taped. These were later transcribed verbatim and translated simultaneously from Chichewa into English by the interviewers using a standardized transcription protocol. Detailed notes were expanded and typed immediately after the interview to capture as much of the content as possible. Five transcriptionists were engaged, and three supervisors checked the accuracy of the transcripts, data cleaning and analysis.

Using NVIVO 10.0, one analyst structurally coded data that was directly linked to the key questions. A codebook was developed to reflect all thematic areas covered in the interview guides; team members reviewed it to ensure accuracy. Coding reports were produced for each of the codes, followed by data summaries that describe all themes within each code. An independent researcher provided data checks by listening to selected recordings and matching them with transcripts. Data were analyzed using the “Framework” approach described by Pope et al., 2000. Through the familiarization process, recurrent themes were identified and coded. The team developed thematic frameworks and established concept association between context, networks links and evidence. The analysis involved interpretation of emergent issues to extract meaning out of them and aimed to address the research question.

3.0 STUDY FINDINGS

The research team interviewed a total of 118 respondents either individually or in groups with the aim of collecting as many respondents’ views as possible. Table 2 shows a breakdown of respondents by category.

TABLE 2: STUDY SAMPLE POPULATION, KEY INFORMANTS

Category	Total Number	Men	Women
Health Care Workers	43	25	18
Expert Clients	35	13	22
Supervisors	18	12	6
Key Informants	22	11	11
Total	118	61	57

Table 2 also shows that, of 118 respondents, 52% (n=61) were men and 48% (n=57) were women. Expert Clients were the only predominantly female sub-group, with 63% (n=22) female and 37% (n=13) male. This may be because, in general, more women than men are engaged in voluntary work, since men are likely to prioritize income-generating activities. It’s also important to note that women are more heavily represented at PLHIV support groups, where they comprise 70% of the membership. Not only are women more likely than men to know their HIV status, it is widely acknowledged in

Malawi that women are more likely than men to disclose their HIV status (Angotti et al., 2009).

3.1 Expert Client job role and “fit” within the health facility staffing structure

It was clear to the study team that Expert Clients have been thoughtfully deployed to assist salaried staff with a range of HIV care and support services. Their multifaceted role includes providing daily health education talks about HIV and on-the-spot counseling and psychological support for patients who come for review and drug refills. They trace ART patients who miss appointments and actively pursue all contacts of index patients (e.g., their spouses and children) to encourage HIV testing (Table 3). Patient tracing records indicate whether the individual has died or left the area, allowing the facility to close defaulter files as appropriate.

HCWs also appreciate the assistance Expert Clients provide in improving patient flow. Expert Clients check patients’ weights; pull master cards (patient’s records of HIV care and treatment) for expected patients and file them after each visit; pack medications in preparation for distribution; and distribute nets, soap and buckets to antenatal mothers. Expert Clients also guide patients to various departments within health facilities and identify very sick patients from the outpatient department to ensure they are fast-tracked for service. Each of these tasks serves to reduce staff workload and address congestion and distress among patients.

Conversely, Expert Clients in some facilities are assigned menial tasks such as sweeping, mopping, dusting and running errands. While they don’t mind to help out occasionally, this type of misuse has become a pattern in some poorly run facilities. Although disheartened and disappointed, Expert Clients are generally reluctant to advocate for themselves and have relied on

“In the past when we were working alone, ART patients were fighting in a queue, but now because we are many, and with Expert Clients helping with patient flow, they are able to properly queue for services. There is order now.”

—Kennedy Thala,

Senior HSA, Makhwira Health Center, Chikwawa district

TABLE 3: EXPERT CLIENTS TRACK HIV PATIENTS INDIVIDUALLY AND INTERVENE QUICKLY TO ENSURE THEY ARE RETAINED IN CARE.

	Total	Male	Female
# of HIV patients identified by Expert Clients as “missed appointments”	6,571	4,586 (70%)	1,985 (30%)
# of “missed appointments” patients located	4,768 (73%)	3,333 (70%)	1,435 (30%)
# of “missed appointments” patients returned to care*	3,380 (52%)	2,348 (69%)	1,032 (31%)

*Patients located but not returned to care include those who have died, have left the catchment area, cannot be swayed from a decision to stop treatment, or who return to care only after the closing date of the reporting period.

supportive supervision visits from IMPACT partners to remind salaried staff of the Expert Client mandate and agreed job role.

While some Expert Clients reported being confined to their job descriptions, the study team noted that where trust has emerged, HCWs assign Expert Clients responsibilities over and above their mandate, heightening job satisfaction among Expert Clients. Expert Clients step up to fill these roles out of curiosity and in acknowledgement of the workload burden borne by staff. Some extend their services beyond HIV care to the general population. One health facility reported sending the Expert Client to the DHO (a bicycle trip of more than 80 kilometers round trip) to collect drugs for the facility. This allowed HCWs to remain at their duty stations, seeing patients, while the Expert Client assisted them in overcoming chronic transportation problems.

“To us as health workers, we feel less stressed. ...The Expert Client is vital in our system. I believe we cannot do without him.”

—**Hezekial Mwale**, Senior Clinician, Likangale Health Center, Zomba district

Interviews with health care providers unveiled concerns and misconceptions about the Expert Client’s role (see Section 3.2: Acceptability of Expert Clients by health workers). It is important to be alert to concerns, misunderstandings and potential gaps in service provision, especially in such a rapidly evolving environment. As HIV care continues to respond to new technologies, changing policies and increasing patient burden, a regular revisit of the Expert Client’s role would ensure that both the supervisory staff and the Expert Clients agree to the job description, that the rationale for its scope and limitations is well understood and that Expert Client placements adhere to the Expert Client’s job description.

3.2 Acceptability of Expert Clients by health workers

Health service providers and managers communicated profound satisfaction with the extent to which Expert Clients are providing services to patients. Most HCWs interviewed expressed heartfelt appreciation for the commendable work done by Expert Clients and recognized that their presence has helped tremendously to improve the delivery of HIV services. In particular, they reported that the health education talks and psychosocial counseling Expert Clients provide resonate deeply with patients because Expert Clients pull from personal experiences. This openness and honesty motivates many patients to get tested, and it reduces the worries they have about being HIV positive.

Barring a few exceptional cases, Expert Clients also reported that they are generally well accepted and have good working relationships with HCWs. Expert Clients felt this was a great achievement because, under normal circumstances, it is difficult to build such strong bonds between professional and non-professional cadres. Both Expert Clients and HCWs reported having a “good work relationship” that was built on team spirit, trust, mutual respect and clear understanding of each other’s roles. At Mulanje

A PEER-BASED ADHERENCE SUPPORT MODEL FOR MALAWI



Through intentional task-shifting, Expert Clients reduce the workload of salaried service providers

MEGAN COLLINS FOR CRS

Hospital, Expert Clients have been provided with dustcoats², which made them easily identifiable and contributed to their sense of belonging.

There was concern at program inception that the Expert Client cadre would not be easily accepted by HCWs because they were lacking formal credentials. Indeed, the study found that vestiges of unease still remain. Some HCWs expressed concern that training was inadequate to ensure Expert Clients could maintain confidentiality in this sensitive service setting. Others suggested that Expert Clients should be trained in conducting HIV rapid testing; the majority, however, opposed this suggestion. There were recommendations from HCWs that Expert Client training should include more information about infection control, CD4 count and Viral Load testing, the link between HIV and TB and how to use some hospital equipment (e.g., wheel chairs).

While the vast majority of HCWs believed that Expert Clients were competent and had been correctly placed in their job role, there were some HCWs who were concerned that this “uneducated” cadre might not have sufficient comprehension of the health information that underpins the provision of quality counseling and health education talks for patients. They suggested that the entry requirement for Expert Clients be upgraded to Malawi School Certificate of Education (MSCE), which is equivalent to high school graduation in the United States. However, this suggestion was contradicted by the majority, who reiterated the Expert Clients’ core mandate. They were able to articulate clearly that the fundamental strength of the model is that the Expert Clients are recruited from the facility’s catchment area, bringing local language fluency and in-depth familiarity with

“At first, before we had those [Expert Clients] in the system, it was chaotic but with the coming of these Expert Clients, the workload has significantly reduced because we now have an extra hand.”

—Gerald Munthali,
In-charge, Milonde Health Center, Mulanje district

² Africare provided all Expert Clients in their operational area with blue dustcoats, branded with USAID and IMPACT logos. This was welcomed by patients, staff and Expert Clients alike. This motivated the purchase and distribution of aprons, made of IMPACT-branded zitenge cloth, by the IMPACT program in 2014.

Expert Clients attend staff meetings to share information and resolve concerns.

MEGAN COLLINS FOR CRS



customs and local context. Expert Clients thus have a distinct advantage in their ability to develop relationships and credibility with patients. With regard to academic requirements, the study revealed the consensus view that the ability to read and write in the local language along with arithmetic skills sufficient for basic record-keeping are the most relevant academic prerequisite for this role. However, Expert Clients require continuous hands-on training to meet the changing environment of HIV service delivery.

3.3 Management and supervision of Expert Clients

A number of factors were identified as likely to facilitate Expert Clients' ability to execute their work effectively. It was reported that in facilities where supervisors are proactive and engaged, they provide on-the-job training and input to Expert Clients' performance and are available to answer questions. They observe Expert Clients as they conduct health talks and are available to answer technical questions that might arise. They provide feedback to Expert Clients, who find this motivating. Supportive supervision, coaching and mentoring of Expert Clients from DHMT members, NAPHAM District Coordinators, HCWs, CRS and implementing partners also facilitated good performance of Expert Clients.

However, Expert Clients have not flourished in all facilities. Rarely, but importantly, some facilities failed to embrace Expert Clients as part of their multi-disciplinary teams. Neither the Expert Client role nor their referral mechanism was well understood. They received little supervision and often felt unwelcome. It is also concerning that Expert Clients are frequently requested to perform housekeeping tasks such as damp dusting, mopping and sweeping.

The topic of remuneration arose several times not only from Expert Clients themselves but also from facility staff. The IMPACT Expert Client model was designed such that Expert Clients, as volunteers, would not be paid any salary for their services. Instead, Expert Clients receive a monthly stipend ranging from MK6,000 (US\$15) to MK15,500 (US\$36) per month (determined by the

A PEER-BASED ADHERENCE SUPPORT MODEL FOR MALAWI



Expert Clients ensure patients' weights are checked regularly, since weight loss is an early indicator of treatment failure.

OVERTOUN MAZUNDA FOR CRS

IMPACT implementing partner with whom they work), along with transport between their homes and the facilities. Most Expert Client respondents claim this is insufficient considering the rising cost of living in Malawi.

However, many Expert Clients reported that their motivation is based on good will and the need “to help and save lives” of people in their communities. They said that they derive satisfaction from being associated with the health profession, from their good working relationships with HCWs and from the easy access to treatment and care they receive when they fall sick. The study established that most of the Expert Clients are satisfied with their work and find it manageable because they work three days a week, generally until early afternoon.

While burnout, ill health, stigma, lack of supervisory support and dissatisfaction with compensation have been cited in the literature as constraints to maintaining a successful peer-based support model (Cataldo, 2013; Torpey, 2008; Yaya, 2013), the resounding finding of this study was that in fact, many reported that working as an Expert Client had transformed their lives. Expert Clients appreciate the knowledge and skills acquired during the training and continuous interaction with patients. The monetary incentives help them support their families and send their children to school. They feel valued knowing they are held in high esteem by their communities, and they are especially motivated by the thanks they get from individual patients.

Another challenge found by this study is that reporting relationships are not always straightforward. IMPACT's Expert Client model was designed to test the workability of having Expert Clients report to senior Health Surveillance Assistants. While HCWs and Expert Clients themselves knew this to be the arrangement, the study team noted that in reality, the Medical Assistant or the ART In-charge was more often responsible for supervision of Expert Clients on a daily basis. This was because HSAs spend much of their time

“I am encouraged to continue with this job because most people admire me for having survived that long after being tested positive. They see me active in farming and business while living positively. So I am proud to be a role model of people living with HIV and support my family.”

—Veressi Tonde,

Expert Client, Nsiyaludzu Health Center, Dedza district

Expert Clients provide daily treatment information sessions to those initiating ART. OVERTOUN MAZUNDA FOR CRS



in the field, while Expert Clients are primarily based at the facility. The In-charge of an ART clinic (or a Medical Assistant who typically is the In-charge of the entire facility) is available full-time at the facility and naturally provides oversight for Expert Client activities.

3.4 Expert Client referral mechanisms and community linkages

The study also established that Expert Clients successfully refer patients to community-based organizations for further support. Through the efforts of the Expert Client, every health facility has a list of all referral options posted in the senior HSA’s office, which eases referrals to both government and civil society services operating locally, including social welfare and safety net programs. Especially influential are referrals to PLHIV support groups, where patients find camaraderie, a safe place to discuss concerns, and peers with whom to face challenges of stigma and self-stigma and disclosure, and inspiration for living positively. Referrals are formalized by written letters from the Expert Client to a support group’s chairperson, who keeps track of all patients who have been received.

“ These people [Expert Clients] know many things. Many people do not know about HIV issues, and when someone with a similar background talks to them, they are encouraged.”

—Rose Njerere,
HSA, Domasi Rural Hospital,
Zomba district

Expert Clients are required to have a list of all support groups in their catchment area. This is normally collected from NAPHAM district-level offices. Some reported facing challenges when collecting their lists, perhaps because of staff changes at NAPHAM. HCWs and Expert Clients reported that some referred patients do not report to the support group, nor do they return to the health facility.³ These patients become especially difficult to track, as there is no feedback mechanism between a health facility and the community. Expert Clients appear to be the only link, and this link depends on each

³ The IMPACT program monitoring system tracked “referrals made” to many service points but was not set up to track “referrals completed.”



The Expert Client's non-judgmental approach and familiarity with the patient's community creates an environment conducive to counseling.

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patient's voluntary identification and honest disclosure of his or her name and contact details.

3.5 Constraints and bottlenecks

The literature describes common bottlenecks, barriers and constraints in peer-based programs, many of which are shared here. In addition to those discussed below, it is important to note that few programs in the past have reported receiving funding for programs from the MoH, bringing sustainability into question (Belmans, 2010; Kim, 2012; Morris, 2009).

Inadequate, non-standard, unreliable distribution of incentives: The majority of Expert Clients complained that the stipend they received was not enough considering the cost of living, the time spent away from home and the missed opportunities for piece work and/or productive labor in their own gardens, especially during planting and harvest seasons. In addition, some Expert Clients do not receive their stipends on a regular basis; this was demotivating. Unfortunately, they rarely received communication about why stipends were delayed.

The IMPACT model deliberately resisted prescribing a standardized incentive package across the consortium partnership. The monthly stipend ranged from MK6,000 to MK15,500 (US \$15.00 - \$41.00) per month according to each partner's pre-existing volunteer remuneration package, to maintain harmony between various volunteer cadres working in the same catchment area. For future Expert Client programming, implementers should consider whether incentives are in line with market demands. It is generally agreed that partners are funded differently and that maintaining integrity at the district or catchment level is important, but incentives should be reviewed periodically to ensure they are responsive to changes in the market.

Lack of uniforms or identification: Lack of uniforms or identification was a common complaint from both Expert Clients and HCWs, who advocated strongly that each type of worker or volunteer should be easily identifiable by the public. Some Expert Clients complained of lack of

protective wear such as rain coats and gum boots to use during rainy season.

Inadequate transport: Many Expert Clients reported that they did not have adequate means to commute within the communities and between the community and the health facility. Some Expert Clients reported that IMPACT bicycles provided two years ago are now in a non-functional state or need frequent attention. They break down easily, and Expert Clients find it difficult to repair them due to lack of funds. Indeed, maintenance of these bicycles is something that needs attention by partners. Mobility is key for Expert Clients. This issue needs serious consideration when planning future programming.

4.0 KEY SUCCESSSES OF EXPERT CLIENT MODEL

4.1 Improved HIV service delivery

HCWs at all levels reported an increase in uptake of services, especially in HIV testing and ART enrollments, which they attributed to the work of the Expert Clients. They also reported a reduction in the number of ART defaulters in those facilities with Expert Clients (see Section 4.3). Several health centers reported receiving awards and recommendations from the MoH for delivering excellent ART and PMTCT services since the introduction of Expert Clients.

4.2 Reduced service provider workload

The study found that by taking a share of the workload, Expert Clients have helped to free up HIV service providers to do work that they could not have otherwise done. A majority of HCWs also reported that operating hours in ART and PMTCT clinics have reduced since Expert Clients were introduced. Most of them said they are now finishing seeing patients by 12 pm, which gives them time to do other duties. In the past, their clinics could run late—up to 5 or 6pm.

It is widely acknowledged that HSAs have multiple roles and struggle to concentrate on ART services. Expert Client deployment has reduced the workload of both ART service providers and HSAs. Several HCWs recommended that the Expert Client model be expanded to all ART service delivery points.

4.3 Improved retention of patients in care

ART clerks, providers and health facility In-charges reported a decrease in default rates, attributed to the Expert Client's efforts. IMPACT program monitoring data shows that Expert Clients identified a total of 6,571 patients who missed appointments, and returned 3,380 (52%⁴) of them to care.

4 IMPACT quarterly report to USAID, April 2014.

“When you look at the data of HIV and ART services for the district you can clearly see the difference in performance between health facilities which are within IMPACT targeted areas and which are outside the targeted area.”

—Beatrice Chigamba,
DHO representative, Chikwawa District



Expert Client explains early infant diagnosis to a mother as they walk through a busy hospital complex.

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Unfortunately, there was no way to demonstrate a gain here because there are no data on “number of patients who missed appointments” prior to the Expert Client intervention. However, since the Expert Clients trace every patient who misses an appointment, they retrieve patients into care before they are officially classified as “defaulters.” Thus, the number of defaulters has reduced. A baseline study (unpublished) done by CRS in 2011 revealed that when HSAs are tasked with tracing defaulters, only 8.7% are returned to care.

Similarly, a review of Expert Client monthly reports at Namileme Health Post shows that the number of defaulters has steadily decreased since the introduction of the Expert Client model. The study team noted that the number of defaulters has reduced from 25 to 0 since deployment of Expert Clients at this health facility.

4.4 Increased demand for HIV services

One important finding is that the introduction of Expert Clients into clinical settings has increased the demand for HIV testing and treatment. With regard to PMTCT, the study established that Expert Clients are in the forefront of promoting HIV testing among men through the distribution of “love letters” at antenatal clinics (ANC). Through this initiative (piloted by IMPACT), pregnant women receive letters during ANC visits to pass along to their spouses and partners, encouraging them to join their wives for ANC, PMTCT and HIV services. This initiative was often managed by Expert Clients, since regular staff did not have time to implement it singlehandedly. A key informant in Mulanje identified that ANC had been a “missed opportunity” to bring men to HIV testing, but noted that after Expert Clients became involved, the number of men

“...(before Expert Clients) we had a large volume of defaulters. If people are defaulting from treatment, they would develop resistance. This would be the biggest problem to the nation. Expert Clients are helping us to bring back into care — using their tracer cards, going into the villages, tracing patients, bringing them back into care.”

—Harrison Tembo,
PMTCT/ART Coordinator,
Zomba District Health Office

escorting their wives and undergoing testing has gradually increased. Further, Expert Clients champion the record keeping, proactively tracking men who accompany their wives to ANC and following up on the results of couples' testing. HCWs reported that more HIV-exposed babies are being tested due to proper counseling and follow-ups by Expert Clients.

Expert Clients also help to identify very sick patients at the outpatient department (OPD) and refer them to a clinician so that they can be prioritized for treatment. One In-charge in Mulanje district explained, “[Expert Clients] help to identify sick patients at the OPD and refer them to a clinician so that patients can receive treatment in good time. They also help to escort patients referred to other departments within the health facility. This has helped to make sure that patients are able to access the required care and treatment in good time.”

Although Expert Clients are based in the facility, they are often approached in the community by individuals who have questions related to drugs or their HIV status but do not want to make the journey to the health facility. This breaks down barriers to testing and treatment. Almost all HCWs interviewed spontaneously reported that Expert Clients have been referring people from the communities to health facilities for HTC, ART or PMTCT services. A number of Expert Clients also reported that they had been able to convince patients from the community to access HIV services.

5.0 RECOMMENDATIONS

5.1 Scale up the CRS/IMPACT Expert Client model

Wide-scale adoption will offset health service providers' workloads, improve uptake of services and improve facility-community linkages. Understandably, HCWs expressed grave concerns about the prospect of the Expert Client program phasing out in July 2014 as the IMPACT program closes, fearing an increase in the number of ART defaulters, reduced ART adherence with the resultant viral resistance, increased HIV-related deaths and an increase in their workload. Securing permanent funding for this cadre will require high level advocacy with donors and with the MoH.

5.2 Shift the responsibility of supervision

Shifting the responsibility of supervision from senior HSAs to HCWs serving as In-charges will ensure proper on-the-job supervision and mentoring. HSAs are, by the nature of their jobs, working outside the facility and are not available for supervision. In addition, their roles are, to some extent, in competition with Expert Clients which can cause tension between the two cadres.

5.3 Conduct regular site visits and reorientation

Regular quarterly supervisory visits and reorientations of the Expert Client

mandate and performance are needed to identify conflicts, bottlenecks or concerns and deal with them promptly. In particular, there is a need to pay attention to job role “creep”, where Expert Clients might face an ever-expanding set of duties including menial tasks unrelated to patient care, bearing in mind that this is a volunteer cadre. The practice of conducting these visits jointly with DHMT representatives and NAPHAM district coordinators should be encouraged. This will strengthen their work relationships, ease supervision of Expert Clients and avoid delegating duties that are outside the Expert Client scope of practice.

5.4 Adjust and standardize the Expert Client incentives/stipend

Stipends should be regularly revised to keep pace with the cost of living. Stipends should be provided on a regular, reliable basis, and explanations should be provided for exceptional circumstances of delayed payment. The program should consider providing standardized incentives to ensure Expert Clients are getting equal treatment and motivation across districts, since they are all performing similar roles. Finally, the Expert Client stipend should be sufficient to support the cost of bicycle maintenance.

5.5 Provide uniforms or a standard means of identification

It was observed that some Expert Clients are wearing different zitenje cloths (wrappers), while others wear ordinary t-shirts bearing different health messages, which do not look professional. More importantly, they are visible to the public as they handle sensitive documents and medications, and conduct confidential counseling sessions with patients. The appearance of “informal” lay personnel performing these duties could be confusing, even distressing, to the public. Providing uniforms is not only an important incentive to Expert Clients but a public relations imperative.

6.0 CONCLUSION

The overall conclusion of the review is that the Expert Client model is well accepted within the health facility architecture. With appropriate supervisory support, Expert Clients are able to absorb a range of tasks as they emerge, thereby easing workload and stress for salaried HIV service providers. Of equal importance, as true peers of those they serve, Expert Clients bring a unique and vital skillset to the multi-disciplinary care team that improves the quality, efficiency and coverage of services. This low-cost model increases uptake of HIV testing and treatment services and helps retain patients in the continuum of HIV care, making it highly relevant to a resource-constrained setting like Malawi. It is especially relevant in remote areas, where the majority of Malawi’s population lives and where HCWs are in short supply.

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APPENDIX I: Interview guides

INTERVIEW GUIDE FOR GROUP DISCUSSION WITH HEALTH WORKERS

Introduction

(Start recording) My name is _____. Thank you for your willingness to be part of this discussion. I am looking forward to hearing your thoughts on the questions I will ask you. Please know there are no right or wrong answers and we welcome every opinion about the topics we will discuss. So feel free to share your thoughts, opinions and views openly. If during our discussion there are issues or concerns that you would like to talk about, feel free to bring them up even if I did not ask about them. I want to confirm to you that what we discuss here will be kept confidential and we will not share your personal information and responses with anyone outside the interview. Now I will begin asking you some questions.

Theme I: Competency and perception of Expert Clients (ECs)

1. How many staff are there at this facility?
2. What is your catchment population? [Instructions to interviewer: Verify with hospital data.]
3. How many clients do you usually see in a week at this facility? [Instructions to interviewer: Ask for HIV services registers, e.g., PMTCT, HTC, ART. Verify clients numbers, and attempt to break them by gender]
4. Are you familiar with the job description of the EC? What are the services that EC are involved in at this facility?
5. Reflecting on EC's job description, what are the specific roles which you feel EC should not perform if the program is to continue?
6. Who supervises ECs? What support do you provide to the supervisor, e.g., nurses, HSA supervisor, ART coordinator?
7. What best practices have you observed in the management structure and supervision of ECs?
8. What are the opening hours for ART services?
9. How often do you provide ART services per week?
10. Can you explain ART services that are offered by ECs at this clinic? Drug adherence? Counseling? Education? HIV testing?
11. How comfortable are you to delegate tasks to ECs?
 - If you have delegated before what were the tasks?
 - Were they done satisfactorily? [This is to provide scale for measuring satisfaction.]
 - If not, what action did you take?
12. What are your views on the ability of the EC to provide information and education at this facility? [Instructions to interviewer: Probe on content, accuracy.]
13. Apart from information and education, what is your view on the level of competency of ECs to provide other services at this health facility?
14. In your opinion, what needs to be done to help EC effectively serve patients? [Instructions

to interviewer: Probe training, supervision, structure.]

15. Do you have any promising success stories that you may share with us on the work of ECs? Significant change in the way PLHIV are managed at this clinic

Theme 2: Referral systems

16. Can you explain how patient referrals for HIV services at this health facility are done from the community to the health facility?
17. Where do you or ECs refer them?
18. For what reasons are they referred?
19. If referrals are happening at this health facility to community-based structures, in your experience, what challenges do you face in referring clients for care and support? If not, why is that?
20. How best do you think we can improve referral mechanisms?

Theme 3: Relationship with EC

21. How can you describe your relationship with ECs?
22. In your experience, have you encountered any problems related to ECs at the facility?
- If yes, what were the problems?
 - How were these problems sorted out?
 - If no, in your opinion what facilitates good working relationships?
23. Would you accept this cadre (ECs) to be part of your multidisciplinary care team at the facility on a permanent basis if resources allow?

Theme 4: Workload reduction

24. When reflecting on HIV and other service provision at this health facility before and after introduction of ECs placement, do you feel there is any change in your workload? If yes, explain what has changed. If not, why is that so?
25. Do you think it is necessary to scale up EC services to other health facilities? Can you please explain your answer?
26. What recommendations are you suggesting for future EC programming?
27. Is there something I might have forgotten to ask you think it is important to share to regarding this EC program?

Thank you very much for taking part in this discussion.

INTERVIEW GUIDE FOR GROUP DISCUSSION WITH HEALTH CARE WORKERS

Introduction

(Start recording) My name is _____. Thank you for your willingness to be part of this discussion. I am looking forward to hearing your thoughts on the questions I will ask you. Please know there are no right or wrong answers, and we welcome every opinion about the

topics we will discuss. So feel free to share your thoughts opinions and views openly. If during our discussion there are issues or concerns that you would like to talk about, feel free to bring them up even if I did not ask about them. I want to confirm to you that what we discuss here will be kept confidential and we will not share your personal information and responses with anyone outside the interview. Now I will begin asking you some questions.

Theme I: Competency and perception of Expert Clients (ECs)

1. How many staff are there at this facility?
2. What is your catchment population? [Instructions to interviewer: Verify with hospital data.]
3. How many clients do you usually see in a week at this facility? [Instructions to interviewer: Ask for HIV services registers, e.g., PMTCT, HTC, ART. Verify clients numbers and attempt to break them by gender.]
4. Are you familiar with the job description of the EC? What are the services that EC are involved in at this facility?
5. Reflecting on EC's job description, what are the specific roles which you feel EC should not perform if the program is to continue?
6. Who supervises ECs? What support do you provide to the supervisor, e.g., nurses, HSA supervisor, ART coordinator?
7. What best practices have you observed in the management structure and supervision of ECs?
8. What are the opening hours for ART services?
9. How often do you provide ART services per week?
10. Can you explain ART services that are offered by expert clients at this clinic? Drug adherence? Counselling? Education? HIV testing?
11. What are your views on the schedule that is allocated for ECs to perform their duties at this facility? Adequate? Timely?
11. How do ECs work with the ART providers at ART clinic?
12. Apart from ART services, what are the other health services ECs offer at this facility?
13. What specific tasks do you do together with ECs?
13. How comfortable are you to delegate tasks to ECs?
 - If you have delegated before what were the tasks?
 - Were they done satisfactorily?—(To provide scale for measuring satisfaction)
 - If not, what action did you take?
14. What are your views on the ability of the EC to provide information and education at this facility? Probe on content, accuracy
15. Apart from information and education what is your views on the level of competency of ECs to provide other services at this health facility?
16. In your opinion, what needs to be done to help EC effectively serve patients? Probe Training? Supervision? Structure?
17. Do you have any promising success stories that you may share with us on the work of expert clients? Significant change in the way PLHIV are managed at this clinic

Theme 2: Referral systems

18. Can you explain how patient referrals for HIV services at this health facility are done from the community to the health facility?
19. Where do you or ECs refer them?
20. For what reasons are they referred for?
21. If referrals are happening at this health facility to community based structures, in your experience, what challenges do you face in referring clients for care and support? If not, why is that?
22. How best do you think we can improve referral mechanisms?

Theme 3: Relationship with EC

23. How can you describe your relationship with ECs?
24. In your experience, have you encountered any problems related to expert clients at the facility?
 - If yes, what were the problems?
 - How were these problems sorted out?
 - If no, in your opinion what facilitates good working relationships?
25. Would you accept this cadre (ECs) to be part of your multidisciplinary care team at the facility on permanent basis if resources allow?

Theme 4: Workload reduction

26. When reflecting on HIV and other service provision at this health facility before and after introduction of ECs placement, do you feel there is any change in your workload? If yes, explain what has changed? If not, why is that so?
27. Do you think it is necessary to scale up EC services to other health facilities? Can you please explain your answer?
28. What recommendations are you suggesting for future EC programming?
29. Is there something I might have forgotten to ask you think it is important to share to regarding this EC program?

Thank you very much for taking part in this discussion.

**INTERVIEW GUIDE FOR GROUP DISCUSSION
WITH DHMT AND ART/PMTCT COORDINATOR**

Introduction

(Start recording) My name is_____. Thank you for your willingness to be part of this discussion. I am looking forward to hearing your thoughts on the questions I will ask you. Please know there are no right or wrong answers, and we welcome every opinion about the topics we will discuss. So feel free to share your thoughts opinions and views openly. If during our discussion there are issues or concerns that you would like to talk about, feel free to bring them up even if I did not ask about them. I want to confirm to you that what we discuss here will be kept confidential and we will not share your personal information and responses with anyone outside the interview. Now I will begin asking you some questions.

Theme 1: Competency and perception of Expert Clients (ECs)

1. Have you been going for supervisory visits to health centers?
2. During your supervisory visits, have you had any chance to interact with ECs? [Instructions to interviewer: Probe if ever they had a meeting at the facility and ECs participated in these meetings.]
3. What are other avenues you have provided support to ECs? [Instructions to interviewer: Probe for trainings, mentoring on the job.]
4. What support do you provide to the supervisor in charge of ECs at the facility?
5. What best practices have you observed in the management structure and supervision of ECs?
6. Are you familiar with the job description of the EC?
7. Reflecting on EC's job description, are there specific roles which you feel EC should not perform if the program is to continue?
8. Do you receive reports from partners on progress of their work in the district including that of ECs?
9. What are your views on the schedule that is allocated for ECs to perform their duties at this facility? Is it adequate? Timely?
10. How do ECs work with the ART providers at ART clinic?
11. Have you ever listened to an EC providing a group counseling session or health education session?
12. If yes, what are your views on the ability of the EC to provide information and education in facilities? [Instructions to interviewer: Probe on content, accuracy.]
13. Apart from information and education, what are your views on the level of competency of ECs to provide other services in health facilities?
14. In your opinion, what needs to be done to help EC effectively serve patients? [Instructions to interviewer: Probe Training, supervision, structure.]
15. Do you have any promising success stories that you may share with us on the work of ECs? Significant change in the way PLHIV are managed at this clinic?

Theme 2: Relationship with EC

16. How can you describe your relationship with ECs?
17. In your experience, have you encountered any problems related to ECs in facilities?
 - If yes, what were the problems?
 - How were these problems sorted out?
 - If no, in your opinion what facilitates good working relationships?
18. Would you accept this cadre (ECs) to be part of your multidisciplinary care team at the facility on a permanent basis if resources allow?

Theme 3: Workload reduction

19. When reflecting on HIV and other service provision health facilities before and after introduction of ECs placement, do you feel there is any change in facility workload? If yes, explain what has changed. If not, why is that so?
20. Do you think it is necessary to scale up EC services to other health facilities? Can you please explain your answer?

21. What recommendations are you suggesting for future EC programming?
22. Is there something I might have forgotten to ask you think it is important to share to regarding this EC program?

Thank you very much for taking part in this discussion.

INTERVIEW GUIDE FOR ECS SUPERVISOR AS A KEY INFORMANT

Introduction

(Start recording) My name is _____. Thank you for your willingness to be part of this discussion. I am looking forward to hearing your thoughts on the questions I will ask you. Please know there are no right or wrong answers, and we welcome every opinion about the topics we will discuss. So feel free to share your thoughts opinions and views openly. If during our discussion there are issues or concerns that you would like to talk about, feel free to bring them up even if I did not ask about them. I want to confirm to you that what we discuss here will be kept confidential and we will not share your personal information and responses with anyone outside the interview. Now I will begin asking you some questions.

Theme 1: Roles and responsibilities

1. For how long have you been working here?
2. What are your specific roles at this facility?

Theme 2: Health facility structure, supervision, EC hierarchy and reporting

3. How many EC are you supervising at this health facility?
4. How often do you supervise ECs?
5. What kind of supervision is provided to the EC? [Instructions to interviewer: Probe with the following questions: Do you have the checklist? May I see it?]
6. How much time is dedicated to supervise ECs? Please specify days per week.
7. How is feedback given to the ECs?
8. What problems do you encounter as you supervise the ECs?
9. How do you sort them out?
10. How often are ECs invited to attend facility meetings?
11. Are you comfortable with the management structure for the functionality of the EC model? If yes, explain. If not, why?
12. What best practices are there in the management of ECs' work?
13. If the IMPACT partner organization supervises the work of ECs, do they give the ECs and facility representative or contact person any feedback? [Instructions to interviewer: Probe.]
14. Is there documentation of ECs' work at the facility? [Instructions to interviewer: Verify documentation.]
15. How beneficial have those documents been to the facility?
16. How often do ECs produce progress reports?
17. Who are the users of the progress reports?
18. Apart from yourself, who else works with you in supervising the ECs at this facility? [Instruc-

tions to interviewer: Probe relationship with the other staff] How much support have you received from the other staff? Are there any constraints?

Theme 3: Competency and perception of ECs

19. What is your opinion about the services offered by ECs at this health facility? [Instructions to interviewer: Probe.]
20. Do you find ECs helpful? If so, how is that? If not, why?
21. Are you satisfied with the services they offer? Please explain.
22. From your observation, are ECs provided with adequate IEC materials to effectively deliver services to clients?
23. In your opinion, what needs to be done to help ECs more effectively serve patients? [Instructions to interviewer: Probe training, supervision, structure. (Option boxes)]
24. When reflecting on HIV and other service provision at this health facility before and after introduction of ECs placement, do you feel there is any change in your workload? If yes, explain what has changed. If not, why is that so?
25. What are your views on the ability of the EC to provide information and education at this facility?
26. Since an EC started working at your facility, what do you think is the most significant change in the way PLHIV are managed at this clinic? Why is this significant to you?

Theme 4: Relationship and Receptivity with health facility staff

27. How can you describe your relationship with them?
28. In your experience, have you encountered any problems related to expert clients with other facility staff? Probes
 - If yes, what were the problems?
 - How were these problems sorted out?
 - If no, in your opinion what facilitates good working relationships?
29. Do you think ECs explain things in a way that clients with HIV easily understand?
30. What specific tasks do you do together with ECs?
31. Do you think ECs explain to the clients HIV what check-ups/tests or treatment will be done?
32. Can you tell me more about your experience working with ECs?
33. How comfortable are you to delegate tasks to ECs? Probe
34. Are there instances where you have assigned work to ECs? Probes
 - If yes, what were the tasks?
 - Were they done satisfactorily?—(To provide scale for measuring satisfaction)
 - If not, what action did you take?
35. How is this delegation of tasks working for you?
36. If ECs are helpful, would you accept this cadre to be part of your multidisciplinary care team at the facility on a permanent basis if resources allow?
37. Do you have promising success stories that you may share with us on the work of ECs?
38. What can be done to improve the services of ECs?



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