

A conversation with Development Media International's Qualitative Research Team, October 17, 2014

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Note: These notes were compiled by GiveWell and give an overview of the major points made by the Qualitative Research Team, as translated by Matthew.

Summary

GiveWell spoke with Development Media International (DMI)'s Qualitative Research Team (QRT) as part of its site visit to DMI in Burkina Faso. Conversation topics included the role of community health workers and the availability of medicine in rural areas.

Choosing a community health worker (CHW)

In the late 1980s or early 1990s, the participants of a regional governmental conference in Burkina Faso decided that each rural community would be required to have at least two CHWs (one man and one woman). Sometimes, larger communities have more than two CHWs. The government let the communities make their own nominations (rather than appointing the CHWs) because it knew that people were more likely to follow the advice of someone they had elected.

CHW traits

Typically, communities elect someone who is deeply embedded in community to be a CHW, and the nomination is an expression of the community's trust in that person. Chiefs are never chosen as CHWs, although sometimes a CHW will come from a chief's family. Health agents give communities advice about choosing CHWs when they visit, including:

- Do not choose someone who already has a position of responsibility.
- Choose someone who can be frequently available.
- Choose someone who will have time to devote to the position.
- Do not choose someone who is too old, because the CHW needs to be able to ride his or her bike to the homes of sick children and go to the local

health clinic (Centre de Santé et de Promotion Sociale, or CSPS) to get supplies.

- If possible, choose someone who has some reading ability.

Accepting the position

CHW is not a particularly desirable position: there is no remuneration (other than sometimes selling antimalarials and oral rehydration solution (ORS) at small margins, as the program intends) and the work is difficult. However, the position comes with some prestige. Nominees usually accept the position simply because their community has asked them to and there is social pressure to accept. In other words, it is unlikely that someone would refuse the nomination.

The election of CHWs has historically caused some social friction. Before Burkina Faso's revolution during the 1980's there was a different type of health worker in most rural communities, called a PSP (Poste de Santé Primaire). When communities chose CHWs, they would sometimes exchange older PSPs for younger CHWs. This made the PSPs unhappy; they identified with their previous health role and did not want to leave.

The nomination process can also lead to social negotiations. For example, one community had an official midwife, but relieved her of her role with the election of a new CHW. Around the same time, an NGO started a program to distribute birth control pills in the community. The man nominated for the position of CHW decided to accept the position, but only on the condition that his aunt (who was the former midwife) would get to distribute the birth control pills for the NGO's program.

CHW training and supplies

CHWs are trained to recognize and treat simple cases of malaria and simple cases of diarrhea. For any health issues beyond early malaria and diarrhea, or health issues that the CHW does not recognize, the CHW will refer his or her patient to the CSPS.

The only medications a CHW has on-hand are:

- Oral Rehydration Solution (ORS) (treatment for diarrhea) - recently ORS began being distributed in packaging with Zinc; although the new packaging does not appear to have yet reached all CHWs, and the old packaging is still available in some places.
- Antimalarial pills

CHWs who are in a community that has a CSPS sometimes do not keep treatments in stock; rather, they simply send people to the CSPS for any necessary treatments.

There is a pilot program that is training CHWs to recognize and treat the first signs of respiratory infections. The QRT does not know which treatments CHWs are being trained to give to someone with early respiratory infections, although antibiotics might be expected. This is a very new program and it is only happening in one zone in Burkina Faso.

The QRT always checks a CHW's stock of treatments when the QRT conducts field visits to villages. The QRT does not record the quantity of each type of treatment; rather, the team will simply ask a CHW whether or not the treatment is in stock. This information is not compiled or tracked systematically, but it informs the QRT's intuitions about limiting factors to child health in Burkina Faso. The QRT does not believe that lack of access to health supplies is the biggest limiting factor to the adoption of the behaviors that DMI promotes. The QRT's opinions about the biggest limiting factors for each health behavior are recorded in the respective message briefs they have written. [*Editor's note:* Those message briefs are posted at: <http://www.givewell.org/international/top-charities/DMI#Sources>]

ACT supplies

Two years ago, a project called PECADO was funded to encourage Artemisinin-based Combination Therapy (ACT, an antimalarial) sales. PECADO allowed ACT to be sold to CHWs at the price of about 75 CFAs (~\$0.14) and then allowed CHWs to sell ACT to community members at the price of about 100 CFAs (~\$0.19). The CHWs were making some profit off of ACT, which incentivized them to keep up their stock. PECADO ended approximately a year ago, and now CHWs must both buy and sell the ACT at 100 CFAs, thereby making no profit.

With the end of PECADO, there are now cases of CHWs not having ACT. Some CHWs no longer sell ACT because they cannot profit from it. Others continue to stock ACT despite the lack of profit. Some CHWs still keep up a very large stock of ACT. For example, in Boromo, a CHW was so well-stocked that when the local CSPS ran out of ACT supplies, it would come to him to refill (normally CHWs restock at CSPSs, not the other way around).

The QRT believes that ACT is currently widely available—anyone can receive it if he or she would like. Because so many people catch malaria each year, the government has ensured that ACT is generally in stock.

ORS supplies

ORS used to be sold primarily in stores called boutiques. Boutiques bought the ORS from commercial suppliers (not from the CSPSs). However, five years ago boutiques were banned from selling ORS. Originally, this made ORS more difficult to obtain (it was generally sold further away from people). However, since then, the primary providers of ORS have been CSPS pharmacies, other local pharmacies, and CHWs. This shift, particularly to CHWs as vendors, changed the availability of ORS, bringing it much closer to community members and making it more accessible.

A new program that is integrating ORS and Zinc has pushed to make CHWs be the primary sellers of ORS+Zinc. This program only started in February 2014. Currently, the availability of ORS+Zinc varies from zone to zone. In some zones, CHWs have been trained to use ORS+Zinc, but they do not yet have it in supply. In other zones, the QRT has seen CHWs that have the ORS+Zinc, even though the local CSPS does

not. In one zone, this happened because the source that provided ORS+zinc had two different supplies chains—one for the CSPS and one for the CHWs. The stock for the CSPS supply chain ran out, while the stock for the CHWs did not.

CHWs make a small profit from selling ORS+Zinc, thanks to the government's new distribution plan, which includes subsidies for the product. Because the distribution of ORS+Zinc is a national program that has received large investments, the QRT believes that there is a high likelihood that ORS+Zinc will soon be as widely available as ACT.

Details on some treatment-seeking behavior

When a person visits the CHW, this generally means one of two things:

1. The person does not believe in herbal remedies, or
2. The person has tried herbal remedies, which did not work.

Essentially, once a person has decided to go to the CHW for a solution to his or her child's health problems, that person is not likely to return to trying herbal remedies to deal with the issue. Thus, if the CHW does not have the correct treatment, the QRT expects the person will immediately make the journey to bring his or her child to the CSPS, even if the journey is very far. This is because:

- By going to the CHW, the person has actively recognized that his or her child's health problem can only be solved by modern medicine. If the CHW does not have the medicine that will solve the problem, then the CSPS is the next solution, and taking care of their child will be a high priority.
- The CHW will generally check in on the person until he or she takes their child to the CSPS for proper treatment.

If a mother has tried herbal remedies before coming to the CHW, her child's disease may have already advanced to the acute stage. Once this has happened, the QRT believes a mother will do everything that is possible to get her child the necessary treatment. For example, if the closest CSPS is 25km away but a washed-out road makes it inaccessible, a mother will travel 60km to get to the second-nearest CSPS rather than give up on her child getting better. DMI's QRT has seen a woman who almost drowned crossing a high river to get her child to a CSPS when a bridge was washed out; she was swept away by the current but saved by people on the bank of the river.

CHW activities

The CHW's role is primarily to provide information and assist prevention programs. For example, even though CHWs may not be trained in treating respiratory infections, they are still helpful because they encourage mothers to put Shea butter in their children's nostrils (which captures the dust that would otherwise go into the child's lungs).

Depending on a CHW's dedication, a CHW may be actively involved in all of the health initiatives in his or her community. CHWs can become very passionate advocates for the community's health programs. CHWs are not experts, because they are not formally trained (they are volunteers), but when a professional nurse visits the community, he or she will speak with the CHWs, giving them new health advice.

How community members interact with CHWs

People will typically go to their CHWs before going to the CSPS, because CHWs are much more easily accessible than the CSPS. This trend does not mean that CHWs are better health providers than CSPSs.

It is rare for a community to have no CHW or for a CHW to be inactive. Even if the CHW is not hardworking, people almost always know who he or she is and will introduce the research team to him or her when the team asks. One exception is in Gaoua (which is not one of the RCT zones, although there is a pilot health program occurring there), where the QRT met people who did not know who the local CHW was.

Generally, there are many different types of CHWs. A CHW's effectiveness depends on his or her level of education, commitment, goodwill, and integrity. It can also depend on the health projects that may or may not already exist in the community. Sometimes CHWs are very active and involved in communities. Other times the communities so strongly dislike the CHW that people will always go to the CSPS even though it is 20km away.

The majority of visitors to CHWs are mothers. This is true whether or not the CHW is a woman.

DMI's messages

It is helpful for CHWs to hear DMI's messages, but DMI's messages are not targeted at CHWs (the messages are targeted at the general population). Often, DMI's radio spots will include a CHW character because CHWs are the first step in the modern health system, and DMI is trying to encourage rural communities to use that system.

The core goal of the radio spots is to get people to identify the early signs of malaria, diarrhea, and pneumonia, and pursue early treatment. Thanks to the spots, the QRT has already seen evolution in people's behaviors. For example, the pneumonia spots try to demonstrate rapid breathing and recommend that people go directly to the CSPS (because CHWs do not have pneumonia treatment yet). According to the QRT's research, before DMI's program, people used to consult diviners more often when considering using modern medicine. Since the spots have started running, the QRT has observed an increase in modern treatment-seeking behaviors. DMI's next strategy is to even further emphasize the need for early treatment. The spots need to help people understand the distinction between treatment and early treatment.

All GiveWell conversations are available at <http://www.givewell.org/conversations>