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Models for community health programmes supported by different actors: mixed methods study, Guinea

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Introduction

Guinea's Ministry of Health has proposed a standardised national community health programme, including health promotion, case management, and referral; historically however the system has been implemented piecemeal by various actors. MSF has been present in Kouroussa, northern Guinea, since 2017. MSF activities there have been focussed on community healthcare, through training and support for community health workers, or "recos". Before exiting, MSF conducted a mixed-methods study to understand differences in the models and effects of MSF community health programmes, as compared to those implemented by other actors.

Methods

We implemented an explanatory, sequential, mixed-methods study in Kouroussa and in three other zones, Mandiana, Télimélé, and Boussou; sites were selected to represent a diversity of situations, and those outside Kouroussa are supported by non-MSF actors. During the quantitative phase, 137 recos and 13 supervisory community health agents were interviewed about their demographic and professional details, availability of tools, the package of activities, activity levels, and practical knowledge. A qualitative phase, including 24 focus group discussions and 65 individual interviews followed, aiming to better understand the community and local health professional perceptions of community health programmes in each of the four zones. Quantitative data were analysed using R (Vienna, Austria) to calculate descriptive measures; differences were compared between zones using chi-square and t-tests. Qualitative data audio recordings were translated and transcribed, read, and re-read to identify codes and themes.

Ethics

This study was approved by the MSF Ethics Review Board and by the Comité National de la Recherche, Guinea.

Results

Overall, recos in Mandiana and Télimélé were primarily involved in health promotion and referral, while recos in Kouroussa (supported by MSF), and some in Boussou, additionally conducted case management. In Kouroussa, recos conducted a median of 16.5 malaria consultations per month, compared to 8.0 in Boussou, 2.1 in Télimélé, and 0 in Mandiana ($p<0.0005$). The zones where recos conducted case management were those where medicines were more available, with 92% of recos in Kouroussa possessing anti-malarials at the time of visit, compared to 38% in Boussou, 3% in Télimélé, and 7% in Mandiana ($p<0.0005$). Qualitative data revealed that for recos to expand from health promotion into case management, medicines must be available, and in Kouroussa the community emphasized the importance of free care. Moreover, qualitative data showed the primary motivation for recos was their loyalty to their community, and that recos were better accepted and more effective when they came from the same community they served, or were a "child" of the village.

Conclusion

To consistently achieve stated national ambitions of having recos that conduct case management, including in Kouroussa after MSF exits, medicine availability must be assured through appropriate resourcing. Additionally, our data suggest that each community should continue to have the power to choose their own reco.

Conflicts of interest

None declared.

Saa Michel Komano is currently head of community activities for the community-based primary healthcare project for children under five in Kouroussa, Guinea and has been working on this project since 2017. Saa Michel Komano is a public health technician by profession with experience in different organisations. He worked with MSF as a malaria project mortality surveillance officer in Gueckedou, Guinea from 2012 to 2014, and an Ebola project nurse supervisor from 2014 to 2015. He then worked with the Alliance for Medical Action as an Ebola nurse trainer for the Ebola response preparation project in Burkina in 2016, then with the National Health Security Agency of Guinea as a support agent for community-based services at the prefectural Directorate of Kissidougou in 2016.