AUGUST 2016

AFRICAN STRATEGIES FOR HEALTH

DEMAND-SIDE DETERMINANTS TO INTEGRATED COMMUNITY CASE MANAGEMENT CARE-SEEKING: LESSONS FROM SENEGAL

Photo by ISED

Background

Despite significant progress over the past two decades in reducing child mortality worldwide, a large proportion of children in sub-Saharan Africa continue to die of preventable and treatable causes before their fifth birthday. In 2015, malaria, diarrhea, and pneumonia alone accounted for an estimated 1.1 million child deaths—37% of all under-five deaths—in sub-Saharan Africa.[1]

Integrated community case management (iCCM) is an equity-based strategy aimed at improving access to services for children outside the reach of health care facilities, where most deaths occur. The strategy aims to train, equip, and supervise community health workers (CHWs) so they can treat children for malaria, pneumonia, and diarrhea using artemisinin-based combination therapy, oral rehydration salts, zinc pills, and antibiotics. Bringing these services into the community has the potential to lead to estimated 70%, 60%, and 70-90% reductions in under-five mortality due to pneumonia, malaria, and diarrhea, respectively.[2]

Although the strategy has been adopted by several low- and middle-income countries, iCCM services appear to be under-utilized in many areas. To enhance understanding of demand-side factors that influence the use or non-use of iCCM services and identify strategies to address them, USAID's Bureau for Africa commissioned the African Strategies for Health (ASH) project to conduct a study in Senegal and the Democratic Republic of Congo (DRC), where rates of child mortality are high and iCCM is heavily relied upon to improve child health outcomes. This technical brief presents a summary of key findings from Senegal.

Country Context

Senegal has achieved notable declines in child mortality in recent years, reducing under-five deaths per 1,000 live births from 115 to 59 between 2000 and 2015.[3] However, the burden of child death remains high, and every year an estimated 27,000 children die in their first five years of life, mostly from preventable and treatable causes.[4]

Senegal has a strong history of treating illness at the community level. The full package of iCCM services was introduced in 2003 and has since been expanded to cover all of Senegal's 14 regions and 72 of 75 health districts. iCCM services are provided by the USAID Community Health Program (CHP), in collaboration with the Ministry of Health (MOH), in 2,245 health huts.[5]

Health huts, where iCCM services are delivered, are run by volunteer CHWs who are trained to provide child health services to their communities. Health huts are linked to public sector health facilities through supervisory and supply systems. Senegal's community health strategy emphasizes community ownership, thus CHWs are selected by the communities they serve and volunteer village health committees (VHCs) oversee the functioning of health huts. Under a cost-recovery mechanism, user fee revenues are used to replenish medicine stocks and cover health hut operational costs. As part of their reporting duties, CHWs are responsible for estimating needs and submitting purchase requests to the district level to restock medicines and health commodities.

Objectives and Methodology

The objective of this study was to examine the demand-side determinants of use or non-use of iCCM services in Senegal and the DRC and to provide recommendations—based on identified best practices, innovations, and lessons learned—to inform the introduction and/or scale-up of other iCCM programs.

This study was conducted in Senegal in two districts with relatively high iCCM service utilization rates (Ranérou and Foundiougne) and two districts with relatively low rates (Keur Massar and Tivaouane). Two health huts were chosen in each district. The districts and intervention sites were selected based on the proportion of children under five living in the intervention site area; the incidence of expected cases of malaria, diarrhea, and pneumonia; the number of malaria, diarrhea, and pneumonia cases received by CHWs; and the average utilization rate of iCCM services for all three illnesses.

This study used qualitative methods, including document review, key informant interviews, and focus group discussions.

In total, 158 caretakers of children under five, 17 CHWs, five CHW supervisors, 34 VHC representatives, four district chief doctors, eight traditional healers, 50 community leaders, three iCCM focal points, and four officers working for technical and financial partners participated in this study. ASH collaborated closely with a team from the *Institut de la Santé et Developpement* (ISED) based in Dakar, Senegal, which led the in-country data collection and analysis.

Select Findings and Recommendations

Utilization, quality, access and availability, and demand were identified as key research themes for the analytical framework. Select key findings—including facilitators and barriers to iCCM utilization—are presented in the following subsections. Findings were analyzed to develop practical programmatic recommendations for increasing demand for and uptake of iCCM services in Senegal and other countries in the region. A more detailed analysis can be found in the longer country report which is available on the ASH website.

Utilization

This section outlines the basic determinants of use and non-use of iCCM services as reported across the four districts. It covers findings related to the decision-making process for seeking care outside of the household, including the timing of doing so, who is involved in making decisions, and why families may prefer to seek care for a sick child from providers other than their local CHW.

Facilitators	Barriers
■ Understanding of causes, symptoms, and danger signs of illness leading to recognition of need for professional treatment ■ Early care-seeking outside of the home (prior to the emergence of danger signs requiring a higher level of care) ■ Early communication to caregivers on the causes and signs of illness	■ Delayed care-seeking outside of the home (only after appearance of warning signs) ■ Use of traditional healers or self-treatment as first point of care
Recommendations	
■ **Improve community understanding of disease and options for care:** Health workers and community mobilizers and leaders should enhance sensitization of caregivers on best practices in prevention as well as identification of symptoms and warning signs of key childhood illnesses that necessitate care.	

Quality

Perceptions of the quality of services are known to impact use or non-use. Monitoring and supervision were found to be important factors in ensuring quality of service provision.

Facilitators	Barriers
■ Satisfaction with and trust in quality of services offered at health hut (in insular communities without alternative providers aside from traditional healers)	■ Perceived lack of competency and satisfaction with CHWs and the services they provide (as compared to other nearby health care providers) ■ Irregular monitoring of CHWs and supervisory visits from head health post nurse or CHP agent ■ Poor condition of the health hut
Recommendations	
■ **Implement more accurate monitoring of quality of care:** Head health center nurses should be more involved in the training, monitoring, and assisting of CHWs, through regular formative supervision which may enhance the perceived competence of CHWs. The central government should also explore the feasibility of implementing and institutionalizing alternative supervisory methods—such as peer mentoring or the use of communication technology—to complement the current approach and reduce the burden on head nurses. Tools, such as checklists and job aids, should be provided to CHWs to monitor quality of care as well as appropriateness and timeliness of case referral.	

Photo by Morgana Wingard/USAID

Access and Availability

Financial accessibility, geographic accessibility, and communities' perceptions of CHWs and the services they offer were found to influence caretakers' decisions to seek and utilize services from CHWs as the first point of care. Supply-side issues, such as medicine supply and health worker motivation and supervision, were also noted as factors affecting the utilization of iCCM services.

Facilitators	Barriers
■ Integration of CHWs in community networks and activities ■ Distance of health hut to other facilities ■ Proximity of iCCM services to the community ■ Availability of CHWs at health huts ■ Flexible payment options and subsidization of certain medicines	■ Proximity of health huts to alternative providers ■ Lack of trust and perceived legitimacy of CHWs ■ Supply-side issues (lack of drugs, equipment, diagnostic capability) ■ Irregular presence and perceived lack of motivation of CHWs ■ High cost of treatment

Recommendations

- **Ensure appropriate placement and establish credibility of CHWs:** The MOH and local partners should better rationalize the distribution of CHWs that offer iCCM services and consider redefining the national strategy for their placement. Health huts should not be built in close proximity to alternative (public or private) providers to reduce overlap and comparison of services. To establish their credibility, CHWs should be integrated into communities' social activities and communities involved in health hut operations.
- **Reduce perceived supply-side issues:** Management of medicines and materials should be strengthened and systematized to guarantee a consistent stock, particularly through building the capacity of VHCs. The MOH should strengthen the integration of CHWs into the national health system to enhance their credibility and improve access to medicines through the national supply chain. CHWs and head nurses must work together to better monitor service utilization and inform requests for stock replenishment. Further, establishing mechanisms to motivate CHWs could encourage them to maintain regular working hours.
- **Improve financial accessibility of iCCM services:** The MOH should increase its investment in the iCCM program and consider systematically eliminating unaffordable user fees for iCCM services by extending the national Universal Health Coverage initiative to the health hut level. The state should also enhance its promotion of local cooperatives to contribute to the costs of health hut operations, CHW motivation, and medicine and materials stocks. Successful community financing mechanisms used across high utilization districts of this study, such as a pooled resources fund, could be replicated and/or adapted in other sites.

Demand

Communities' knowledge of iCCM services impacts demand. Findings in this section relate to health promotion activities that communities find most useful as well as caretakers' understanding of CHWs and their roles in their communities.

Facilitators	Barriers
■ Involvement of community actors (e.g., community mobilizers, village chiefs, public figures, and religious leaders) in establishing the legitimacy and promoting the use of iCCM services	■ Limited understanding of the curative role of CHWs (as opposed to prevention and health promotion) ■ Limited understanding of iCCM as a package of care

Recommendations

- **Enhance information, education, and communication (IEC) activities to increase demand for iCCM services:** Caregivers and other household decision-makers should be educated on the availability of iCCM services offered by CHWs. Community mobilizers should tailor IEC activities to target specific groups and their differing roles in iCCM service utilization, paying particular attention to local context and messaging.
- **Involve community stakeholders:** A range of community stakeholders, including well-respected community leaders and public figures, must be actively involved in promoting the legitimacy of and trust in the iCCM program. Especially in communities where higher level facilities are hard to reach, enhancing community ownership of health hut activities may facilitate demand for iCCM services.

Discussion

Demand-side elements often receive less attention than supply-side elements in program design and implementation. However, in order to provide more equitable coverage of iCCM and other proven child survival interventions, careful attention must be paid to the demand-side barriers and facilitators affecting caregivers when seeking health care for their children. Many caregivers who participated in this study indicated that, despite the establishment of CHWs and iCCM services in their communities, a range of factors influence their decision whether, when, and where to seek care for their sick children. Findings revealed that barriers to or enablers of appropriate care-seeking are often complex and affected by a range of issues related to knowledge of causes, symptoms, and danger signs of illness as well as options for care; geographic and financial accessibility of iCCM services and proximity of health huts to other facilities and providers; perceived supply-side issues; and perception of CHWs, the quality of services they provide, and their role and relationship with the community. It is evident that caregiver behavior is not driven by one factor in isolation; rather, the relationship between the identified determinants can be multifaceted.

Of particular note, findings suggest that caregivers' and key household decision-makers' knowledge and awareness of disease danger signs is a fundamental determinant of seeking health care both outside the home and from a CHW in a timely manner. In communities with limited options for services, health huts typically represent the first point of care. However, when alternative providers are situated nearby, caregivers compare providers' competency as well as the quality, availability, and cost of services. In the presence of more educated providers, the credibility of and trust in CHWs may be questioned. Frequent medicine stock-outs, recurring unavailability of CHWs at the health hut, and perceived poor motivation of CHWs weakens the reputation of health huts and encourages caregivers to follow alternative—perhaps inappropriate—pathways of care. As paying for health services can be a burden on low-resource families and deter them from using health huts, flexible financing mechanisms have proven to be important factors in driving uptake of iCCM services. Findings also reveal the critical value of involving a range of actors in community sensitization and mobilization in generating demand for iCCM services.

Conclusion

The aim of this study was to identify demand-side drivers of the use or non-use of iCCM services across four districts and eight community sites in Senegal. The findings and recommendations may be relevant for countries that are considering introducing, modifying, or scaling up an iCCM program at the community level. As governments and implementing partners do so, efforts to address demand-side drivers of care-seeking must be incorporated into the national iCCM strategy alongside an appropriate supply of child health services in order to promote equitable access to health care for children. ■

This summary brief was prepared by Stephanie Rotolo with contributions from JoAnn Paradis and Alison Corbacio (all ASH). It is based on a longer report prepared by ASH partners ISED and MSH. ASH is thankful to the ISED research team, USAID/Senegal, USAID-CHP, USAID/AFR and all individuals who provided their insights on the use of iCCM services in Senegal.

ABOUT ASH

African Strategies for Health (ASH) is a five-year project funded by the U.S. Agency for International Development's (USAID) Bureau for Africa and implemented by Management Sciences for Health. ASH works to improve the health status of populations across Africa through identifying and advocating for best practices, enhancing technical capacity, and engaging African regional institutions to address health issues in a sustainable manner. ASH provides information on trends and developments on the continent to USAID and other development partners to enhance decision-making regarding investments in health.

ENDNOTES

1. UNICEF Data: Monitoring the Situation of Women and Children. Child Mortality Estimates 2015. Available at: http://www.data.unicef.org/child-survival/under-five.html.
2. WHO & UNICEF. WHO/UNICEF Joint Statement on Integrated Community Case Management: an equity-focused strategy to improve access to essential treatment services for children. June 2012.
3. Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], et ICF International. 2015. Sénégal : Enquête Démographique et de Santé Continue (EDS-Continue 2014). Rockville, Maryland, USA : ANSD et ICF International.
4. UNICEF. Levels and Trends in Child Mortality Report 2015. Available at: http://data.unicef.org/child-mortality/under-five.htmlhttp://www.data.unicef.org/child-survival/child-survival-and-the-sdgs.html
5. Programmatic data provided by ChildFund Senegal, which leads the implementation of USAID-CHP.

Additional information can be obtained from:
African Strategies for Health 4301 N Fairfax Drive, Arlington, VA 22203 • +1.703.524.6575 • AS4H-Info@as4h.org
www.africanstrategies4health.org

This publication was made possible by the generous support of the United States Agency for International Development (USAID) under contract number AID-OAA-C-11-00161. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.