



USAID
FROM THE AMERICAN PEOPLE

AFRICAN STRATEGIES FOR HEALTH



DEMAND-SIDE DETERMINANTS TO INTEGRATED COMMUNITY CASE MANAGEMENT CARE-SEEKING

Lessons from Senegal

August 2016

This publication was produced for review by the United States Agency for International Development. It was prepared by the African Strategies for Health (ASH) Project.

African Strategies for Health (ASH) is a five-year project funded by the United States Agency for International Development (USAID) and implemented by Management Sciences for Health (MSH). 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.

August 2016

This document was submitted by the African Strategies for Health project to the United States Agency for International Development under USAID Contract No. AID-OAA-C-11-00161.

Additional information can be obtained from:

African Strategies for Health
4301 N. Fairfax Drive, Suite 400, Arlington, VA 22203
Telephone: +1-703-524-6575
AS4H-info@as4h.org
www.africanstrategies4health.org

Cover photo by Institut de Santé et Développement, 2016.

DISCLAIMER

This technical report was made possible by the generous support of the American people through the US Agency for International Development (USAID). Its contents are the sole responsibility of ASH and do not necessarily reflect the views of USAID or the United States Government.

DEMAND-SIDE DETERMINANTS TO INTEGRATED COMMUNITY CASE MANAGEMENT CARE- SEEKING

LESSONS FROM SENEGAL

ACKNOWLEDGEMENTS

This study was conducted by Management Sciences for Health (MSH) under the African Strategies for Health (ASH) project with support from the Africa Bureau of the US Agency for International Development (USAID). It was implemented in close partnership with the Institut de Santé et Développement (ISED) of the Cheikh Anta Diop University (UCAD) in Dakar, Senegal. Field data collection, analysis, and preparation of this report were led by Dr. Anta Tall Dia, Dr. Ibrahima Seck, Dr. Adama Faye, Dr. Mamadou Makhtar Mbacke Leye, and Dr. Ndèye Marème Sougou (ISED). Stephanie Rotolo and Rebecca Levine (ASH) worked closely with the ISED team throughout implementation and documentation phases of the study. Sarah Konopka, Uzaib Saya, and JoAnn Paradis (ASH) also provided valuable technical and editorial input.

ASH is grateful for the contributions of various individuals and organizations at all stages of this study. Particular gratitude is extended to the Senegal Ministry of Health and Social Action (Division of Community Health), ChildFund Senegal (which leads the NGO consortium responsible for implementing community health services throughout the country), USAID/Senegal, and USAID Africa Bureau.

ASH would also like to acknowledge the valuable contributions of the community health workers, caregivers of young children, and other stakeholders at the community and district levels who participated in this study. The research team is grateful for their willingness to share their time, knowledge, and experiences on integrated community case management of childhood diseases in Senegal.

ACRONYMS

ACT	Artemisinin-based combination therapy
ARI	Acute respiratory infection
ASH	African Strategies for Health
CCW	Community Care Worker
CHNRI	Child Health and Nutrition Research Initiative
CHP	Community Health Program
CHW	Community Health Worker
DHO	District Health Office
DMT	District Management Team
FGD	Focus group discussion
ICCM	Integrated Community Case Management
ISED	Institute for Health and Development
MCHIP	Maternal and Child Health Integrated Program
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
ORS	Oral Rehydration Salts
PHC	Primary Health Center
SSA	Sub-Saharan Africa
UCAD	Chiekh Anta Diop University
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization

CONTENTS

1.	EXECUTIVE SUMMARY	7
2.	BACKGROUND	9
3.	COUNTRY CONTEXT	10
4.	STUDY OBJECTIVES	12
5.	METHODOLOGY	13
5.1	SITE SELECTION	13
5.2	DATA COLLECTION.....	13
5.3	DATA ANALYSIS	14
5.4	STUDY LIMITATIONS	15
6.	RESULTS: DISTRICTS WITH LOW-UTILIZATION LEVELS	15
6.1	SITES IN TIVAOUANE DISTRICT	15
6.1.1	Utilization	16
6.1.2	Access/Availability	16
6.1.3	Quality	17
6.1.4	Demand	18
6.2	SITES IN KEUR MASSAR DISTRICT	18
6.2.1	Utilization	18
6.2.2	Access/Availability	19
6.2.3	Quality	19
6.2.4	Demand	20
7.	RESULTS: DISTRICTS WITH HIGH-UTILIZATION LEVELS	20
7.1	SITES IN RANÉROU DISTRICT	20
7.1.1	Utilization	20
7.1.2	Access/Availability	22
7.1.3	Quality	22
7.1.4	Demand	22
7.2	SITES IN FOUNDIUGNE DISTRICT	23
7.2.1	Utilization	23
7.2.2	Access/Availability	24
7.2.3	Quality	25
7.2.4	Demand	25
8.	DISCUSSION & RECOMMENDATIONS	25
9.	CONCLUSION.....	28
	ANNEX 1. CALCULATION OF ICCM UTILIZATION RATES	29
	ANNEX 2. QUESTIONNAIRES.....	31
	ANNEX 3. INTERVIEWS CONDUCTED.....	56

I. EXECUTIVE SUMMARY

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—including malaria, diarrhea, and acute respiratory infections (ARIs)—before their fifth birthday. Integrated Community Case Management (iCCM) is an equity-based strategy aimed at improving access to basic treatment services for children with these illnesses outside the reach of health care facilities. Although the strategy has been adopted by several low- and middle-income countries, iCCM services appear to be under-utilized in many areas. Achieving high levels of iCCM service utilization requires careful attention to both supply- and demand-side elements, the latter of which often receive less attention in program design and implementation.

In order to enhance understanding of demand-side factors that influence the use or non-use of iCCM services and identify strategies to address them, USAID commissioned ASH to conduct a multi-country study in Africa. In close consultation with USAID, Senegal and the Democratic Republic of Congo were selected for inclusion because of their high child mortality rates and their heavy reliance on the iCCM strategy to improve child health outcomes. This report details findings from Senegal.

Objective

The objective of this study was to examine the demand-side determinants of use or non-use of iCCM services in Senegal and the Democratic Republic of Congo 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.

Methodology

Qualitative research was conducted in Senegal in two districts with relatively high iCCM service utilization rates (Ranérrou and Foundiougne) and two districts with relatively low iCCM service utilization rates (Keur Massar and Tivaouane). Two community sites (health huts/*cases de santé*) were chosen in each district. The four districts and eight intervention sites were selected by estimating utilization rates based on the prevalence of disease within the two weeks prior to the study, average duration, and the incidence of each illness targeted by the iCCM program.

The study team used qualitative methods, including a document review, key informant interviews, and focus group discussions conducted with caregivers of children under five, community health workers (CHWs) providing iCCM services, CHW supervisors, Village Health Committees (VHC), the district management team (DMT), traditional healers, community leaders, iCCM focal points, and officers working for implementing partners to support iCCM programs (consortium managed by ChildFund). The methodology and data collection tools developed by ASH are adaptations of those developed by USAID's Maternal and Child Health Integrate Program (MCHIP) for a 2012 study in Mali.

Key Findings

A total of 112 individual interviews and 36 focus groups (comprising a total of 181 people) were conducted during the study. The table below provides a summary of the key determinants of demand for iCCM services as well as best practices and innovations for increasing demand for iCCM services identified by participants in the four health zones and eight community sites.

Table I. Summary of Key Findings

Determinants of demand for iCCM services
<ul style="list-style-type: none">• Caregivers' understanding of warning signs of disease, options for treatment, and importance of early care-seeking• Availability of medicines (ACT, zinc/ORS, paracetamol, amoxicillin) and supplies (rapid diagnostic tests, Betadine, bandages) at health huts• Geographic accessibility of health huts and distance to other health care facilities: accessibility to larger facilities leads to fewer patients visiting health huts• Trust between CHW and the community: legitimacy of CHW is developed by involving community networks in his/her work (particularly necessary when CHWs operate in close proximity to other health care providers, as opposed to in insular communities)• Financial accessibility and flexibility of payment for services: flexible payment options enable access by low-resource and vulnerable groups• Satisfaction with the quality of services provided, which is also related to the diligence of CHWs• Involvement of head nurse in implementation and monitoring of the iCCM program in the community (leads advanced strategies, supervision, etc.)• Sensitization and engagement of mothers-in-law and other key household decision-makers• Engagement and legitimization of CHWs by community leaders, who are spokespeople and respected members of the community
Best practices and innovations
<ul style="list-style-type: none">• Flexible and adaptable payment options for patients• Home visits and consultations• Continuity and reliability of services offered by CHWs at community sites (alternation between multiple health workers, versatility of CHWs, diversified services)• CHWs with local ties to the communities• Formative supervision of CHW by the chief nurse• Village Solidarity Funds or other community financing mechanisms to share costs and facilitate greater access to health care services• Dues/donation system to motivate CHWs, who often volunteer their time to the community at the expense of their own activities• Education of caregivers on warning signs of illness and importance of early care-seeking

Recommendations

The findings of this study reveal a range of demand-side factors—often acting simultaneously—that influence care-seeking behavior of child caregivers across multiple districts in Senegal. Despite the introduction of the iCCM program in Senegal over a decade ago, many of these factors continue to prevent services for malaria, diarrhea, and ARIs from reaching populations most in need. Reported experiences of community- and district-level stakeholders in Senegal suggest the following key recommendations to improve the uptake of the iCCM program:

- Ensure consistent availability of medicines and supplies in health huts for distribution by CHWs.
- Increase and adapt awareness-raising efforts among different communities and target groups to better establish the legitimacy of CHWs.
- Engage local leaders (political, religious, and civic) to support and promote use of iCCM services.
- Provide training, periodic retraining, and regular formative supervision to CHWs and VHCs.
- Clearly articulate the relationship between the health hut and the health outpost by facilitating ties between head nurses and CHWs. Having a chief nurse supervise a health hut enhances its legitimacy and improves access to the health care inputs that the health hut needs.

2. BACKGROUND

Sub-Saharan Africa (SSA) is the region with the highest rate of child mortality in the world. While the region experienced promising acceleration in reducing the number of child deaths from 1990 to 2015, rapid population growth across SSA now threatens this progress.¹ Currently the 10 countries with the highest child mortality rate are all in SSA, where most deaths of children under five are due to preventable and treatable causes.² In 2015, malaria, diarrhea, and pneumonia accounted for an estimated 1.1 million deaths (37%) of children under five in SSA.³

Accelerating the reduction of under-five mortality will require a focus on expanding access to care for the most vulnerable populations, as evidence shows significant disparities in under-five mortality rates within countries. According to the 2010 UNICEF report entitled *Progress for Children: Achieving the MDGs with Equity*, the risk of a child dying before the age of five increases if that child is born in a remote rural area, in a poor household, and to a mother who did not go to school.⁴

iCCM is an equity-based strategy aimed at improving access to basic treatment services for children outside the reach of health care facilities. In 2012, UNICEF and WHO issued a joint statement supporting the iCCM strategy to train, supply, and supervise CHWs to treat children for malaria, diarrhea, and pneumonia using artemisinin-based combination therapy (ACT), oral rehydration salts (ORS) and zinc, and antibiotics.⁵ While appropriate and timely treatment of childhood malaria, diarrhea, and pneumonia is one of the most powerful interventions to reduce mortality among young children, facility-based services alone do not reach the populations most in need. A review by the Child Health Epidemiology Reference Group (CHERG) estimated that community management of these three diseases by CHWs could result in 70%, 60%, and 70-90% reductions in under-five mortality due to pneumonia, malaria, and acute watery diarrhea respectively.⁶

Despite the reported success of this strategy in several low- and middle- income countries, iCCM services in other countries appear to be under-utilized, as determined by utilization rates for iCCM services when compared to the incidence rates of those conditions among the catchment population at risk. Utilization of iCCM services is influenced by a variety of factors including: lack of recognition by family members of the condition or its severity; access issues once care-seeking behavior is initiated, such as financial barriers (e.g., user fees) or non-financial barriers (e.g., cultural norms or behaviors); system issues (e.g., actual or perceived concerns of lack of CHW skills, equipment, or drug stock outs); difficulties in accessing the CHW due to distance or lack of availability due to the CHW's need to work or provide other voluntary services.

The low use of iCCM services emerged as a major cause of concern at the 2014 *Integrated Community Case Management Evidence Review Symposium* in Accra, Ghana.⁷ Several publications in the 2014 Journal

¹ UNICEF. Levels and Trends in Child Mortality Report 2015. Available at: <http://data.unicef.org/child-mortality/under-five.html><http://www.data.unicef.org/child-survival/child-survival-and-the-sdgs.html>

² H, Wang, et al. Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 2014.

³ 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>.

⁴ 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.

⁵ M. Young, C. Wolfheim, D. Marsh, D. Hammamy. World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children. *American Journal of Tropical Medicine and Hygiene*. 87 (Suppl 5), 2012.

⁶ 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.

⁷ Diaz, T., Aboubaker, S., Young, M. Current scientific evidence for integrated community case management (iCCM) in Africa: Findings from the iCCM Evidence Symposium. *Journal of Global Health*, December 2014, Volume 4, No. 2.

of Global Health supplement further confirmed those concerns.⁸ An analysis of routine data from multiple countries with iCCM programs in SSA revealed that on average, only 27% of expected cases of malaria, diarrhea, and pneumonia were treated using the iCCM approach every year.⁹ In 2009, UNICEF Malawi conducted a bottleneck analysis which revealed that despite the availability of CHWs trained in iCCM of malaria (66%) and clinics supplied with ACTs (50%) only 26% of malaria cases were actually taken to a trained CHW and 13% were treated with ACTs.¹⁰

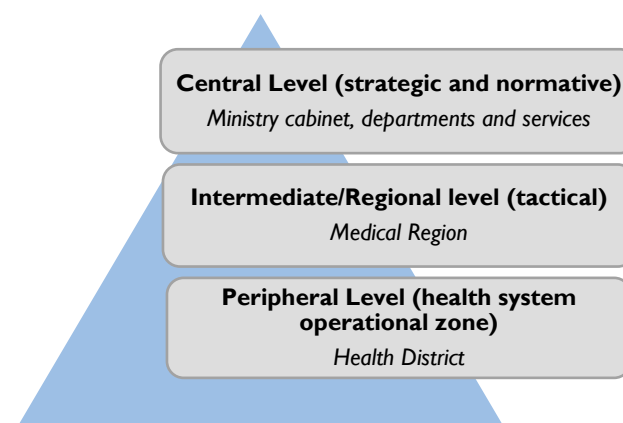
Lastly, a paper highlighting results from a Child Health and Nutrition Research Initiative (CHNRI) exercise on global research priorities for iCCM found the research objective to “identify determinants of non-use of iCCM services by caregivers and develop strategies to increase the uptake of iCCM” as the fourth ranked research priority amongst more than 70 global iCCM experts.¹¹

With funding from USAID, the African Strategies for Health (ASH) Project, in partnership with the Institut de Santé et Développement (ISED), conducted this study in Senegal to enhance understanding of the possible demand-side factors that influence the use or non-use of iCCM services. This report is completed by a similar study in the DRC.

3. COUNTRY CONTEXT

According to the 2014 Continuous Demographic and Health Survey, Senegal has a population of approximately 13.5 million (2013) and is growing at a rate of 2.7% (2002-13) per year.¹² Many of Senegal’s health indicators have improved in recent years, with notable declines in child and infant mortality. From 2000 to 2015, the under-five mortality rate dropped from 115 to 59 deaths per 1,000 live births. The infant mortality rate dropped from 68 to 39 deaths per 1,000 live births in the same time frame.¹³ Despite this progress, the burden of child death remains high, and every year an estimated 27,000 children die before their fifth birthday, mostly from preventable and treatable causes.¹⁴

Figure 2. Senegal’s health system pyramid¹



The health system in Senegal is structured in three levels including the central, intermediate/regional, and peripheral/district levels. The vast majority of health facilities are located at the peripheral level in

⁸ ⁸ Diaz, T., Aboubaker, S., Young, M. Current scientific evidence for integrated community case management (iCCM) in Africa: Findings from the iCCM Evidence Symposium. *Journal of Global Health*, December 2014, Volume 4, No. 2.

⁹ Oliphant, NP et al. [Multi-country analysis of routine data from integrated community case management \(iCCM\) programs in Sub-Saharan Africa](#). *Journal of Global Health*. Dec 2014.

¹⁰ Oliver, K., Young, M., Oliphant N., Diaz, T., Kim, J. Review of Systematic Challenges to the Scale-up of Integrated Community Case Management. UNICEF Maternal, Newborn and Child Health Working Paper. Apr 2012.

¹¹ Wazny, K, et al. Setting global research priorities for integrated community case management (iCCM): Results from a CHNRI (Child Health and Nutrition Research Initiative) exercise. *Journal of Global Health*, December 2014, Volume 4, No. 2.

¹² 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.

¹³ Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal] et ICF International. 2015.

Enquête Démographique et de Santé Continue (EDS-Continue 2015) : Rapport sur les Indicateurs Clés 3ème

année. ICF International Rockville, Maryland, USA. Data are representative of the five years prior to the date of the survey indicated.

¹⁴ UNICEF. Levels and Trends in Child Mortality Report 2015. Available at: <http://data.unicef.org/child-mortality/under-five.html><http://www.data.unicef.org/child-survival/child-survival-and-the-sdgs.html>

the form of health posts or units managed by a nurse or midwife. Health centers provide both outpatient and hospitalization services, which are primarily managed by a generalist physician. At the next level are regional hospital centers, which are located in the capital of each of Senegal's 13 regions and serve as referral facilities for their regions. Finally, nine national hospitals provide specialized health services in the capital city, Dakar. In addition to public facilities, the private sector and Armed Forces operate their own independent facilities at all levels of the health system.¹⁵

Senegal has a strong history of providing health services at the community level and its community case management program is well-recognized. Community-owned health huts (*cases de santé*) began providing preventive and curative services in the 1950s, including treatment for malaria, diarrhea, and other minor illnesses. In 1992, the Ministry of Health (MOH) enacted a legal framework for the organization and functioning of health committees, thereby formalizing community-based provision of health services.¹⁶ Following a feasibility study in the 2003, Senegal integrated antibiotics against pneumonia into the package of services provided at the community level.¹⁷ Between 2006 and 2010, iCCM package was finalized and the program rapidly expanded. Health huts currently are maintained and run by volunteer CHWs and *matrones*, who receive structured training to enable them to detect and manage malaria, diarrhea, and pneumonia in children using rapid diagnostic tests (RDTs), ACTs, ORS, zinc, and antibiotics. As indicated in the table below, health services provided by CHWs at the health hut are often accompanied by services provided by a range of other community health actors.

Table 2. Types of community health actors in Senegal

Title	Role
CHW	Trained to provide primary curative health services as well as preventive and promotional services at the health hut in the community
Matrone	Assists mothers before, during, and after childbirth; provides prenatal consultations; dispenses preventive and promotional health services alongside the CHW at the health hut
Community liaison/relay	Trained to sensitize the community and carry out information, education and communication (IEC) activities for behavior change
At-home care provider (DSDOM)	Trained to manage cases of malaria, diarrhea, and ARIs at the home and provides preventive and promotional services related to childhood illnesses
Bajenu gox	Neighborhood or village grandmother; assists liaisons in the promotion of maternal, neonatal, and infant health at the individual, family, and community levels
Traditional healer	Recognized by the community as competent in providing health services through spiritual means and manual techniques as well as through the use of substances with plant or animal origins

In 2013, Senegal's MOH created a Division of Community Health to determine the package of services to be provided at the community level, to coordinate community-based interventions, and to disseminate successful experiences. The division's activities are guided by the national policy on community health and the National Strategic Plan 2014-2018. The Plan's strategic objectives include improving the coverage and quality of community health services, reinforcing community participation in alleviating health issues, and ensuring the sustainability of community health interventions.¹⁸

¹⁵ Tine, J., Faye, S., Nakhimovsky, S., Hatt, L. April 2014. Universal Health Coverage Measurement in a Lower-Middle-Income Context: A Senegalese Case Study. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

¹⁶ Ministère de la Santé et de la Protection. Cellule de la Santé Communautaire. Plan Stratégique de Santé Communautaire 2014-2018.

¹⁷ Basic Support for Institutionalizing Child Survival Project (BASICS) for the United States Agency for International Development, République du Sénégal Ministère de la Santé de l'Hygiène et de la Prévention, UNICEF. CHWs in Senegal can appropriately treat pneumonia with cotrimoxazole. September 2006.

¹⁸ Ministère de la Santé et de la Protection. Cellule de la Santé Communautaire. Plan Stratégique de Santé Communautaire 2014-2018.

At present, community health services in Senegal are implemented by the USAID Community Health Program (CHP), which is run by ChildFund and a consortium of non-governmental organizations (NGOs) including Africare, Plan, World Vision, Catholic Relief Services, Enda Graf Sahel, and Enda Santé. The program is implemented in all of Senegal's 14 regions, 72 of 75 health districts, 2,245 health huts, and 1,917 community intervention sites. Health huts are recognized by the MOH and are linked to the public sector health facilities through supervisory and supply systems.

The supervision and reporting structure of CHWs is standardized across the program; community development agents from CHP supervise CHWs on issues relating to reporting, data use, and drug management, while chief health post nurses and/or midwives, employed by the MOH, provide technical supervision. CHWs complete monthly reporting forms to keep track of the number of services provided at the health hut. After completion at the community-level, reports are submitted to the health post, where they are compiled then submitted up to the district and national levels. Data are similarly reported through a CHP mechanism, which flows from the CHW to the community development agent, zone supervisor, then central level.

Senegal's community health program emphasizes community engagement and ownership. Communities are responsible for selecting CHWs and motivating them to carry out their work, as they are considered volunteers and do not receive regular salaries. VHCs, also consisting of volunteer members, play an important role in overseeing the functioning of the health huts. They manage finances and make many managerial decisions. As set out by the Bamako Initiative in 1987, community health services operate under a cost-recovery mechanism in which user fee revenues are used to replenish medicine stocks and cover health hut operating costs.¹⁹ Consultation fees vary by site and are determined by the VHC, in collaboration with the CHW. CHP community development agents are also responsible for working with the VHCs to mobilize financial support from the community for the health hut operations. As part of their reporting duties, CHWs are responsible for working with district level health facility personnel to estimate needs and submit purchase requests to refill medicine and materials stocks. The supply chain that provides medicines to the community level is directly linked to the national supply chain system, which ensures that those medicines conform to MOH standards.

4. STUDY OBJECTIVES

The specific objectives of this study were to:

- Identify demand-side factors that influence the use or non-use of iCCM services in Senegal and identify possible contributory supply-side factors;
- Solicit recommendations from target users, CHWs, and other key stakeholders to determine how to best use available resources (i.e., time, equipment, human, and financial) at all levels to increase the use of iCCM services; and
- Define best practices and innovations, as well as lessons learned from the most successful iCCM programs that could be adapted or replicated on a larger scale.

Findings from this study were analyzed to develop practical programmatic recommendations for increasing demand for and uptake of iCCM services in Senegal. Together with the findings from DRC, they may be relevant for other countries in the region.

¹⁹ Ministère de la Santé et de la Protection. Cellule de la Santé Communautaire. Plan Stratégique de Santé Communautaire 2014-2018.

5. METHODOLOGY


5.1 SITE SELECTION

This study was based on the collection of data in geographic areas where the iCCM program is implemented and where programmatic data on the use of services is available. The level of utilization of iCCM services was calculated by dividing the number of treated cases by CHWs by the number of expected cases. The number of expected cases was determined based on disease incidence among the target population of under-five children living in the catchment area and the proportion of expected individuals seeking treatment from the public sector.

Two districts with relatively high iCCM service utilization rates (87%, 90%) and two districts with relatively low iCCM service utilization rates (2%, 4%)—both included in USAID’s CHP—were selected for inclusion. Two health huts (*cases de santé*) were then chosen within each district as study sites. The four districts and eight community sites were selected based on (i) the proportion of children under five living in the intervention site area, (ii) the incidence of expected cases of malaria, diarrhea, and acute respiratory infections, (iii) cases of malaria, diarrhea, and acute respiratory infections actually received by CHWs, and (iv) the average utilization rate of iCCM services for all three illnesses. Calculations conducted for site selection are included in Annex 1.²⁰ The following table shows the districts and community sites that were selected for inclusion in the study.

Table 3. Selected study sites

Health district	Health hut sites	District iCCM utilization rate	USAID/CHP Implementing NGO
Foundiougne	Guagué Mody Maya	87%	ChildFund
Ranérrou	Belel Touffle Mbourlogne	90%	ChildFund
Keur Massar	Daroukhane ASECNA CCTAS	2%	Enda-Santé
Tivaouane	Yendane Ndiaye Bopp	4%	Enda-Santé



5.2 DATA COLLECTION

The ISED management team—led by the project coordinator, two researchers, and two supervisors—recruited a team of local data collectors and trained them on the study protocol and tools over a period of three days. A pretest of data collection tools at a non-study site was also conducted prior to beginning data collection.

Using semi-structured questionnaires (Annex 2), data were collected through 112 individual interviews and 36 focus group discussions (FGD) with key stakeholders including:

²⁰ Lukacik (2008) : A Meta-analysis of the effects of oral zinc in the treatment of acute and persistent diarrhea, www.Pediatrics.org/cgi/doi/10.1542/

- Caregivers of children under five (80 interviews; 78 FGD participants)
- CHWs providing iCCM services (8 interviews; 19 FGD participants)
- CHW supervisors (5 interviews)
- Village Health Committees (34 FGD participants)
- District chief doctors (4 interviews)
- Traditional healers (8 interviews)
- Community leaders (50 FGD participants)
- iCCM focal points at district or community level (3 interviews)
- Officers working for technical and financial partners (4 interviews)

A detailed description of interview and FGD participants by site and district is provided in Annex 3. Guided conversations were conducted in the local language of each community site, translated into French, and recorded.

Ethical approval for this study was obtained from the National Ethics Committee for Health Research (*Comité National d'Éthique pour la Recherche en Santé*) and informed consent was obtained by all study participants prior to beginning each interview and FGD

5.3 DATA ANALYSIS

Data analysis was conducted manually using NVivo 10 software after review of interview and FGD transcripts and development of a coding scheme. Utilization, access and availability, quality, and demand were identified as key research themes for the analytical framework. Specific research questions pertaining to each theme are outlined in Table 4.

Table 4. Research themes and questions

Theme	Key Questions
Utilization	<ul style="list-style-type: none"> • What are the basic determinants of use and non-use of iCCM services? • When do families make a decision to seek care outside of the household for a sick child? • What is the decision-making process and who makes the final decision? • Why do families seek care for a sick child from alternative providers?
Access/ Availability	<ul style="list-style-type: none"> • How important is the financial barrier as a determinant of access for use of iCCM services? • What are communities' perceptions of CHWs? • What are the communities' perceptions of the services offered by CHWs? • How significant is the difference of geographic accessibility between CHW sites and other sources of care (health facilities, alternative providers, etc.) in making iCCM the first choice in care? • What supply-side issues exist and how much of an impact might these have on utilization
Quality	<ul style="list-style-type: none"> • How do mothers define "quality" services at CHW sites and health facilities and how does perception of "quality" influence use? • How does the quality of care delivered by alternative providers differ from that of frontline health workers in the public system? • Is care sought from certain alternative providers more for one disease than for others? If so, what and why?
Demand	<ul style="list-style-type: none"> • What kind of health promotion activities or events would users value most?

- | | |
|--|---|
| | <ul style="list-style-type: none"> • What do mothers know about CHWs and their roles in their communities? • Would the addition of other services to the CHW's current package of care, increase utilization of CHW services? If so, what services? • How willing are CHWs to offer additional services? |
|--|---|

5.4 STUDY LIMITATIONS

Due to time and geographical constraints, only four districts were chosen in four of Senegal's 14 regions. This small sample size therefore likely does not provide a comprehensive view of all demand-side factors impacting the use or non-use of iCCM services. Findings from this study are illustrative and cannot necessarily be generalized to the rest of the country. However, the diversity in respondents and study sites aims to reflect the typical experience in Senegal. The findings and recommendations should be relevant to program planners and donors in other contexts who seek to start-up or scale iCCM interventions.

In all districts and community sites included in this study, iCCM services are implemented by USAID's CHP. iCCM programs across the districts are managed by different NGO consortium members, whose varying organizational and management styles may impact the degree to which they engage with the communities and the quality of their engagement.

Study site selection depended largely on the availability and quality of routine programmatic data that is reported by community sites. Partial program data (i.e., data provided for one quarter, as opposed to the entire year) was used to calculate iCCM utilization rates, but may be missing seasonal trends in the services provided. For example, malaria rates are expected to peak during and just after the rainy season. iCCM service utilization rates were estimated using programmatic data collected just after rainy season (October-December). Interviews and FGDs were similarly conducted during Senegal's dry season. Further, calculations used nation-wide estimates of incidence rates of malaria, diarrhea, and pneumonia. Regional- or district-level incidence rates of these diseases would have provided a better estimate of the use of iCCM programs. Finally, in calculating such utilization rates, the study team did not account for the proportion of the population who may seek care from alternative providers; thus expected levels of iCCM utilization for each disease may not be precise.

6. FINDINGS: DISTRICTS WITH LOW ICCM UTILIZATION LEVELS

Sections 6 and 7 present findings from interviews and FGDs as they relate to each of the key research themes and questions outlined above in Table 4. Respondents identified several factors that influence care-seeking from CHWs for iCCM services. It is evident that behavior is not driven by one factor in isolation; rather, the relationship between the identified determinants is complex. As such factors often interact with one another, and discussion of them may overlap in certain areas of the following sections.

6.1 SITES IN TIVAOUANE DISTRICT

Tivaouane is situated in the Thiès region, about 100 kilometers (km) north of the capital of Dakar. The town is a regional transport hub and home to a primarily agricultural community. The district is characterized as a holy city, marked by the strong presence of Tidiane, a Sufi brotherhood of Senegal. Community-level health huts in the district cover a population of 103,406 people, including an estimated

17,579 children under five years of age (target iCCM population).²¹ Estimated iCCM utilization levels suggest that just 4% of expected cases of malaria, diarrhea, and pneumonia in children are seen by CHWs across Tivaouane. The illustrative findings below derive from interviews and FGDs at Yendane and Ndiaye Bopp health hut sites.

6.1.1 Utilization

Caregivers of children in Tivaouane generally have a good understanding of the causes and warning signs of key diseases; however, their decision-making process for seeking care varies. Respondents listed the following as danger signs requiring attention from a health provider: bloody and white/green stool; vomiting; fever; dehydration; headache; yellowing of the eyes; and rapid and difficulty breathing. While respondents agreed that such danger signs signify a need for immediate care, many caregivers take their children to a health provider earlier, as soon as they begin to feel ill. Alternatively, others begin with self-medication and only seek care outside of the home if the illness persists.

Reported experiences and the low iCCM utilization rate indicate that residents of Tivaouane do not regularly seek iCCM services from CHWs at health huts as the first point of care for sick children. Table 5 presents the basic determinants that lead child caregivers to seek treatment from CHWs or alternative providers, as reported by community stakeholders.

Table 5. Summary of basic determinants of use and non-use of iCCM services in Tivaouane

Determinants	Respondents							
	CHWs	CHW supervisors	Community leaders	VHC	District Medical Officer/Focal point	Child caregivers	Technical/financial partners	Traditional healers
Determinants of use								
Early treatment of childhood illness by CHWs	X	X			X	X	X	
Early care-seeking	X	X	X			X		
Understanding of danger signs and options for care	X	X			X	X	X	
Early communication on causes and signs of illness	X	X				X		
Geographic accessibility of health hut	X	X	X		X			
Availability of iCCM services at health hut level		X			X	X	X	
Determinants of non-use								
Frequent medicine stock-outs	X	X	X	X	X	X		
Irregular presence of CHWs at health huts		X	X	X		X		
Perceived lack of competency and legitimacy of CHWs		X	X			X		
Lack of drive and motivation among CHWs		X				X	X	
Lack of health care equipment at health hut	X	X	X			X		
Perceived poor quality of treatment provided by CHWs		X	X			X		
Irregular monitoring of CHW activities		X			X		X	

6.1.2 Access/Availability

In Tivaouane, iCCM service utilization is in part a function of the acceptability of CHWs and the services they provide. Interviews revealed that irregularity and lack of punctuality leads to a low level of trust in CHWs and a preference for other health facilities. Caregivers noted their dissatisfaction with CHWs

²¹ Estimates received by USAID/Senegal Community Health Program, December 2015.

that do not respect their work hours. Despite the expectation that they be consistently available to provide health services, they are often found absent from the health hut, engaged instead in their personal agricultural and business activities. Further, interactions between the CHWs and communities they serve are limited, which reduces communities' trust in their work. Focus groups of community leaders, traditional healers, and CHWs revealed their perception of greater trust in health workers from outside the community as opposed to natives, despite the community's involvement in CHW selection. Local CHWs must establish their legitimacy before they can be accepted as health care providers by users of health hut services. This lack of trust in CHWs is also due largely to comparison with other health care providers, known to have undergone significant training, who located within or close to the community.

"We need a big doctor [in the community] because those who are here go to work in their fields when the time is right for the fields. If your child gets sick and you go [to the health hut] you will not find anyone. If we had a doctor who stayed here all the time, we could take our children when they become sick." – Caregiver, Tivaouane

Community members perceive health huts to lack appropriate comfort and resources to motivate their attendance. The structures lack hygiene, ventilation in treatment rooms, appealing design, pictures for children, and a welcoming environment, all of which can be found at larger facilities. Importantly, health huts also often lack water, electricity, and materials (i.e., diagnostic tools) required to effectively respond to the needs of patients. Medicine stock-outs are frequent.

The presence and proximity of alternative health care providers and facilities in Tivaouane provides more, often competitive, options for care-seeking, thereby reducing the demand for iCCM services from CHWs. Health huts are located nearby private clinics and traditional healers. In Ndiaye Bopp, traveling medicine vendors were also observed, however people typically buy medicines from these salesmen only when the health hut experiences a stock-out.

Further, Senegal's Universal Health Coverage (UHC) initiative may facilitate access to larger health care facilities and deter use of iCCM services from CHWs. In 2013, a national initiative was launched to provide priority health services free of charge to children under five years of age at public hospitals and health centers and outposts. Such coverage, as well as many health insurance schemes, does not account for services received from CHWs at health huts. While health outposts and centers, where services are free of charge, may be farther away, availability and quality of care is regarded as better than that provided at health huts.

"If we join the health care mutual, we can get treated at the health outpost in the Tivaouane District and even at the hospital in Thiès, but the mutual does not cover the health hut." – Community leader, Tivaouane

6.1.3 Quality

The decision to seek care from alternative providers is also influenced by the perceived quality of care each option provides. Caregivers explained that they perceive CHWs to have a low level of education and a lack of formal training, which deters them from seeking iCCM services at the health hut. They are seen to be incompetent and frequent stock-outs of materials and medicines preclude the delivery of quality health services. Instead, caregivers prefer to take sick children to the health post or "Keur Soeur" (a private facility) where availability of quality services is perceived to be more certain. Illnesses treated by iCCM services can also be treated in the communities by alternative providers, including traditional healers. Malaria, diarrhea, coughs, and ARIs are traditionally treated with leaves, roots, blessed water, or talismans. Services provided by traditional healers, are perceived to be effective by caregivers of children in Tivaouane and appeal to caregivers primarily for their low cost.

6.1.4 Demand

In Tivaouane, district-level health workers, ChildFund, CHWs, community liaisons, and *bajenu gox* all play a role in educating the community on the value of iCCM services. Community leaders, such as the village chief and imam (in Nadiaye Bopp) facilitate IEC activities at community gatherings and the local mosque. A noted gap in the program is the reported irregular involvement of the head health post nurse in the implementation and monitoring of iCCM in this district, despite the position's established responsibility of supervising the health hut. As such, the population's understanding of iCCM service is relatively low. Caregivers' propensity toward seeking care from traditional healers and alternative providers leads to a limited understanding of iCCM services offered by CHWs.

6.2 SITES IN KEUR MASSAR DISTRICT

Keur Massar is a suburban district located on the outskirts of Dakar (10 km). The district is characterized by a high population density, which is due to rural-urban migration. The district is rich in its ethnic diversity and infrastructure, marked by the presence of health posts, private clinics and hospitals, and traditional healers. An estimated 320,601 people inhabit the catchment area for iCCM services, which includes 54,502 children under five.²² Across the district, iCCM services are underutilized at just 2% of expected cases being seen by CHWs. Daroukhane ASENCA and CCTAS health hut sites in Keur Massar were selected for inclusion in this study.

6.2.1 Utilization

Interviews with caregivers revealed that they are aware of the causes and warning signs of malaria, diarrhea, and ARIs. Warning signs necessitating care from a health facility include: high fever; vomiting; headache; loss of appetite; discolored and bloody stool; abdominal pain; rapid and difficulty breathing; and chest pain. Caregivers receive information on the transmission and manifestation of childhood illnesses primarily from gatherings led by representatives of Enda-Santé (implementing NGO) and community mobilisers, including CHWs, *bajenu gox*, and community liaisons.

Basic care-seeking determinants leading to the low level of utilization, as identified by respondents in the surveyed communities, are presented in Table 6.

Table 6. Summary of basic determinants of use and non-use of iCCM services in Keur Massar

Determinants	Respondents							
	CHWs	CHW supervisors	Community leaders	VHC	District Medical Officer/Focal point	Child caregivers	Technical/financial partners	Traditional healers
Determinants of use								
Geographic accessibility of health hut	X	X	X			X		
Availability of CHW		X	X					
Understanding of childhood illnesses and prevention		X		X		X		
Early and quick treatment of childhood illness by CHW	X			X		X		
Sensitization and education on iCCM services by <i>bajenu gox</i> and relays	X	X		X		X		
Provision of certain medicines free-of-charge	X		X	X		X		
Determinants of non-use								
Poor condition of the health hut	X	X	X	X		X		

²² Estimates received by USAID/Senegal Community Health Program, December 2015.

Frequent medicine stock-outs	X	X	X	X		X		
Presence of and proximity to alternative health care providers and facilities	X	X	X	X		X		
Preference toward traditional medicine as first point of care (for diarrhea and ARIs)	X			X		X		X
Availability of treatment and medicines at pharmacies	X					X		
Perceived lack of competency and legitimacy of CHWs	X	X	X	X		X		
Remote location of health hut (Darou Rakhmane only)	X	X		X		X		

6.2.2 Access/Availability

Community members in Keur Massar have a negative perception of CHWs' ability to provide treatment. Caregivers in particular think negatively of seeking care from someone who grew up alongside them; CHWs are seen as simple members of the community, lacking legitimacy to treat sick patients. According to community members, because CHWs did not previously work in the health sector and did not undergo significant training, their legitimacy as a health care provider is not initially evident. Respondents admit to not trusting CHWs due to this perceived lack of legitimacy and constant comparison with other health care professionals in the district. These other professionals—such as the head health post nurse—provide treatment close to the health huts and are considered better educated and more competent.

"I only see the doctor, because only he can provide a diagnosis and treatment, and if it doesn't get better, I go back, because sometimes the doctor prescribes medicine that can cause an allergic reaction in the child, and in that case, I go back to see the doctor so he can prescribe something different or tell me what to do." – Caregiver, Keur Massar

Health huts in Keur Massar are situated in close proximity to alternative providers and private health care structures, often no more than one kilometer apart. Caregivers indicated that distance from their home to the health structure is a large determinant in their choice of where to seek care for their sick children. Caregivers in CCTAS described their preference to seek care at a private Catholic clinic, instead of at the health hut. Both sites are close to each other, and caregivers explained that they can find all the iCCM services they would receive at the health hut at the clinic. The many private pharmacies in the district also present an alternative option for care, which many caregivers use. They often go to pharmacies to buy the medicines prescribed after visits to health outposts, private clinics, and health centers. In some cases they go without a prescription. In these pharmacies, children can be examined and their parents can buy medicines, which are sold to them onsite.

The integration of UHC in health outposts and centers also influences care-seeking behavior in Keur Massar and results in fewer visits to health huts. Caregivers are very familiar with UHC, having been informed through radio shows, television commercials, and community awareness-raising activities. They know that if they show their child's health card, the child can be treated free of charge. However, as these subsidized services are available only above the health hut level, the majority of sick children are taken to health outposts or the health center.

6.2.3 Quality

The satisfaction and perceived quality of services received at larger (public and private) health facilities makes caregivers doubt the competence of CHWs in their community. Respondents claim that because CHWs were not formally educated, they lack the competencies necessary to provide quality health services to their sick children.

Alternatively, several caregivers in Keur Massar described their tendency for taking their children to one of the many traditional healers in their communities, due to the perceived quality of services they provide in treating certain types of diarrhea and ARIs. Informants explained that some cases of diarrhea (accompanied by blood and abdominal pain) require the intervention of the local traditional healer, who makes charms out of red and white strings (traditionally used by herders to treat cases of diarrhea in sheep) that he puts around children's necks. According to the caregivers, after a day of treatment with the strings, children are cured of their diarrhea. Similarly, many community members go to traditional healers to treat ARIs using magic spells (*mothie*). Parents do not know that their children have ARIs, but when they cough and have chest pain, the parents take them to the traditional healer for *mothie*.

6.2.4 Demand

Community members are not aware of the term or notion of “iCCM,” however they do have a strong understanding of the program’s components—including treatment for malaria, diarrhea, and ARIs provided by CHWs at the health hut level. People typically recognize CHWs and health huts as providers of simple prevention activities, such as weight checks, fever control, and communication activities (i.e., talks, awareness-raising, social mobilization) as opposed to curative services.

In Keur Massar, the district management team, implementation partners, and community actors play a role in health promotion activities and in generating demand for services. Community liaisons, *bajenu gox*, and CHWs are responsible for communication on and promotion of iCCM within their communities. CHWs manage cases of childhood illness and conduct sensitization during consultations and social mobilization activities. Culinary learning sessions—in which mothers learn to cook nutrient rich food for their children—provide another opportunity for CHWs to share health information and advice. However, a significant gap in the district is the irregularity of involvement of the head nurse in iCCM promotion, implementation, and monitoring. In the hierarchical structure of the health system, head nurses are responsible for training, supervising, and assisting CHWs in times of need. A stronger involvement of the head nurse in iCCM activities could help generate demand for services at the health hut.

7. FINDINGS: DISTRICTS WITH HIGH ICCM UTILIZATION LEVELS

7.1 SITES IN RANÉROU DISTRICT

Ranérou is located in the Matam region, in the north of Senegal, about 400 km from Dakar. The district is relatively isolated and covers a vast geographic area with low population density. Ranérou is a target district for the MOH’s Division of Community Health. Health huts within the district cover a total population of 5,556 people, including 945 children under five.²³ The estimated utilization rate of iCCM services is relatively high, at 90%. Stakeholders from Belel Touffle and Mbourlogne health hut sites, both located more than 50 km from their respective health post, were interviewed as part of this study.

7.1.1 Utilization

In Ranérou the decision-making process for care-seeking involves multiple actors. Typically, caregivers consult their spouses or the heads of household before seeking care for a sick child. This is due to the financial implications of accessing services and it is also seen as a sign of respect for one’s husband. When the husband is absent, community liaisons direct families toward the health hut for care. While spouses, in-laws, and community actors and liaisons may be involved in the decision-making process, it is

²³ Estimates received by USAID/Senegal Community Health Program, December 2015.

the mother who ultimately takes the child to seek care for an illness. When mothers take their sick children to the health hut early, they are often criticized by mothers-in-law, who promote self-medication with plant-based remedies, for liking health services too much.

CHWs are most often the first point of care in Ranérou as they represent one of the limited options available in the community to treat common childhood illnesses. Respondents indicated lethargy, high fever, fainting, yellow eyes, difficulty breathing, and sleeplessness as danger signs of illness that require attention from a health care provider. Traditional healers are not seen as providing the same caliber of treatment as CHWs, however families may occasionally attempt to treat a sick child at home before seeking care elsewhere or if unable to travel to a health facility. In the case of stock-outs at the health hut, the second choice for care-seeking is typically the health post. These facilities are perceived to provide effective care and community actors succeed in establishing the community’s trust in them. Further, treatment for children is free of charge at health posts. Despite their distance from the community, caregivers prefer to seek care at the health post over traditional healers when their children fall sick. Because health huts in many villages of the district are used so frequently for primary health needs, residents have expressed their desire for them to be converted into a health outpost.

“We start at the health hut or the health post. Before, you could see children with many charms around their necks, but that practice is over now in Senegal, we only use modern medicines.” – Mother/guardian, Ranérou

Table 8 outlines the basic determinants, as indicated by community stakeholders, impacting treatment-seeking behavior of care-givers of sick children.

Table 8. Summary of determinants of use and non-use of iCCM services in Ranérou

Determinants	Respondents							
	CHWs	CHW supervisors	Community leaders	VHC	District Medical Officer/Focal point	Child caregivers	Technical/financial partners	Traditional healers
Determinants of use								
Positive perception of and trust in CHWs	X	X	X	X		X		X
Possibility of delaying payment through a loan system	X			X		X		X
Proximity of population to health hut	X	X				X		X
Integration of community stakeholders in the implementation of the iCCM program	X	X		X		X		
Involvement of community leaders in establishing the legitimacy and promoting the use of iCCM services	X	X	X	X		X		
Early treatment of simple cases at the health hut	X	X			X	X		
Distance between health huts and larger facilities						X	X	
Determinants of non-use								
Medicine and material stock-outs	X					X	X	X
Medicines for children under-five not provided free of charge at health hut		X			X		X	
Irregularity and difficulty of supervision of CHWs		X			X		X	
Non-payment and lack of motivation of CHWs	X							
Conflicts in health hut management (VHC)	X			X				

7.1.2 Access/Availability

The frequent use of health huts and CHWs in communities suggests that these facilities are perceived positively. It also indicates an appreciation for decentralization of certain health activities to the community level. These huts are perceived as an important element of the community, evoking a sense of ownership by those who seek services there. Being from the area, knowledgeable of the environment, and well-known by families in the community facilitates the integration of CHWs and establishes a sense of mutual trust and collaborative attitude. Negative perceptions of CHWs were rarely portrayed during interviews. CHWs have a strong relationship with their communities.

The Ranérou District's expansiveness and great distance between health outposts and health huts is also favorable to the uptake of iCCM services provided by CHWs. Despite somewhat challenging geographic accessibility due to long distances between one's home and the health hut, people are most likely to seek care from the health hut for their children because it is the only community-level facility that exists in the district. There are no alternative health care providers (i.e., private clinics, medicine salesmen, or religious hospitals) within Ranérou, except for traditional healers.

The availability of medicines is another important factor for uptake of iCCM services, according to local residents, whose perception of the effectiveness of CHWs is associated with the availability or non-availability of medicines.

"If medicines are available at the health hut, everyone goes there. People come here when they can't get what they need at the health hut... Since our practices were passed down to us by our ancestors, we use leaves to treat people's illnesses. If the health hut has medicines to treat an illness, we go there, because what they do [there] is based on solid, written evidence. So we all trust the health hut. And if it were only up to us, health huts would continue to provide treatment." – Traditional healer, Ranérou

Flexible payment methods also encourage the use of CHWs. CHWs in Ranérou have established a system of loans (by which people who do not have money can get treatment for their children and pay for it later) that is attractive to the community. According to families' financial situations and because of the trust that exists between the CHW and the community, the CHW may treat a child while his/her family looks for a solution.

7.1.3 Quality

The perceived quality of services provided by CHWs is a function of the availability of medicines at the health hut. CHWs' practices are understood to be based in proven science, thereby generating a trust in the quality of services provided by them. Users mentioned that medicine stock-outs can limit the capacity of CHWs to provide effective services, which causes them to turn to alternative health care providers. Caregivers typically only turn to traditional healers in the case of diarrhea, as healers are not perceived to be effective in treating malaria or ARIs. On occasion, instances of referral and collaboration between CHWs and traditional healers were described, in response to limited resources and care providers within the communities. However, when possible, the first level of referral—in the case of a medicine stock-out or severe illness—is to a health post or hut in a nearby village.

7.1.4 Demand

The community is generally aware of the services offered by CHWs for treating malaria, diarrhea, and ARIs. In particular, respondents noted the role of the CHWs in the prevention and follow-up of illness and the possibility of treatment at the health hut. However, the term "iCCM" and the offering of services as an integrated program are not well known at the community level, as CHWs and other leaders may not understand its meaning and do not address it as such. Only health providers and partners at the district level and above reported knowledge of the term and its objectives.

Demand for iCCM services is generated largely by the involvement of community actors and leaders. Community actors, including *bajenu gox* and community liaisons, conduct home visits and other promotional efforts to raise the visibility of the program. As spokespeople and key influencers, community leaders have also encouraged the use of iCCM services. In Belel Touflé, for example, the village chief specifically urged his community to go to the health hut for their health care needs.

7.2 SITES IN FOUNDIUGNE DISTRICT

Foundiougne is situated in the central region of Fatick, which is about 200km from Dakar. Located on the coast, the district is comprised of multiple remote island communities. Villages are surrounded by mangroves and require the use of boats to travel between them. The health huts in the district serve a total population of 13,434 people, of which 2,284 are children under five years of age.²⁴ Two of the district's health huts are located on the mainland of Senegal, while six others are situated on islands. Foundiougne has a relatively high estimated iCCM utilization rate at 87%. The following findings derive from interviews and FGDs with stakeholders in Guagué Mody and Maya health hut sites.

7.2.1 Utilization

The community is well-versed in the causes, warning signs, and symptoms of illness. Care-seeking behavior is predominately determined by the type and severity of disease. Respondents in Foundiougne indicated that warning signs such as fever, headache, vomiting, loss of appetite, yellow eyes, discolored or bloody stool, lethargy, muscle pain, frequent coughing, and irregular heartbeat demand attention from a health care provider. Caregivers have the knowledge and ability to detect illness and seek care early, most often by taking their children directly and immediately to the health hut. Their experience has also taught them the signs of more serious illness (i.e., high fever or severe cough) that requires a higher level of care, for example from a health post or district hospital.

Further key enabling determinants of the community's propensity toward seeking health services from CHWs, as well as deterrents from doing so, are detailed in Table 10.

Table 10. Summary of determinants of use and non-use of iCCM services in Foundiougne

Determinants	Respondents								
	Alternative care providers	CHWs	CHW supervisors	Community leaders	VHC	District Medical Officer/Focal point	Child caregivers	Technical/financial partners	Traditional healers
Determinants of use									
Community knowledge of causes and danger signs of illness	X	X		X			X		
Early care-seeking (health hut first point of care)		X	X	X		X	X		
Availability of CHWs (Guagué Mody)		X	X	X	X		X		
Early treatment of all simple cases by CHWs		X		X	X		X		
Proximity of population to health hut		X				X	X		
Perceived quality of care provided by CHWs				X	X		X		
Regular monitoring of CHW activities			X			X		X	
Subsidization of certain medicines		X		X			X		
Mutual assistance between CHWs and the community (free consultations and loans)		X					X		
Integration of community stakeholders in the		X		X	X		X		

²⁴ Estimates received by USAID/Senegal Community Health Program, December 2015.

implementation of the iCCM program									
Determinants of non-use									
Medicine stock-outs (specifically ORS)	X	X	X	X	X	X	X	X	
Limited involvement of head health post nurse			X				X		
Lack of equipment and poor state of health hut	X	X		X	X			X	
Strong presence of traditional healers		X		X	X			X	
High cost of medicines								X	
Absence of CHW from health hut (Maya)	X			X				X	
Lack of ambulance for referral transport		X	X	X				X	
Limited engagement of mothers-in-law and grandmothers		X		X				X	

7.2.2 Access/Availability

The proximity of CHWs to the community directly correlates with the community's trust in them and the demand for services at the health hut level. CHWs are selected by the community they serve, which leads to a relationship of solidarity. CHWs in the district are active members of their communities. For example, female CHWs are often members of associations or working groups. As a result, they are in frequent contact with other women and mothers. Their involvement in community marriages, religious ceremonies, and funerals gives them visibility and legitimacy. In the insular health zone, despite a lack of formal qualification or diploma, CHWs are perceived by their communities as their doctor's representative.

The geographic context in Foundiougne is favorable to the use of iCCM services, as the district is made up of 21 islands. The minimum distance between the closest islands is 20 km, or one hour travel by boat. The nearest health outpost or district health center can require a mother and her child to travel more than two hours and pay more than 5,000 francs for fuel to access health services. Boats traveling to the district health center often only run once a week on market day. Therefore, the existence of health huts and CHWs throughout the island communities is critical. Caregivers consistently reported taking their sick children to the health hut when ill.

"It is very hard for us to access services...if the CHW can't treat your illness, you have to go to Djirnda and pay for gas. You have to buy more than 10 liters, at 6,000 francs. Those 10 liters will only get you to Djirnda. To get to Foundiougne, you need to buy 15 liters. Fifteen liters cost 9,000 francs, so it's very hard if you don't have the means to pay. It's really hard." – Caregiver, Foundiougne

"There are boats if you have money to pay for gas. If you don't, you walk." –Caregiver, Foundiougne

Many families in Foundiougne with limited resources are faced with difficulty paying for health services from CHWs, despite them being relatively inexpensive. To cope with this constraint, CHWs and caregivers came to an agreement by which they can cover costs or expenses through a flexible payment system. With the VHC's approval, CHWs have agreed to treat patients and receive payment at a later date. The waiving of consultation fees, which was once only done in higher-level health care facilities (health outposts, health centers, regional hospitals, etc.), is gradually becoming more common at the community level. This initiative aims to prevent women from attempting to treat their children at home and to encourage them to visit the health hut at the first sign of illness, regardless of their ability to pay for services.

In Guagué Mody, the community is actively involved in maintaining the health hut, thereby motivating CHWs and generating demand for their services. The community's social convention of intergroup solidarity allowed them to establish a donation system. This mechanism—developed within and by the community—involves the participation of each member. At the end of the rainy season, each family is

asked to donate part of his harvest to the health hut. The revenue from the sale of these gifts then supports the VHC to purchase medicines and equipment for the health hut.

7.2.3 Quality

According to the district-level doctor and focal point, iCCM enables improved quality of health services at the community-level. The program allows for universal management of malaria, diarrhea, and ARIs in children under five. Caregivers indicated their satisfaction with the quality of services received at the health hut level. Care-seeking from alternative providers within the community—namely traditional healers—reinforces the quality of care provided by CHWs. Their training creates a sense of perceived professionalism among community members.

7.2.4 Demand

The role of CHWs and the iCCM services they provide are very well known in the district. *Bajenu gox*, community liaisons, health committees, and CHWs all serve as intermediaries between partners and the population in generating demand for iCCM services. Community liaisons gather small groups of community members to discuss and raise awareness of management of common childhood illnesses, including recognizing causes, danger signs, options for treatment, and prevention methods. *Bajenu gox* conduct home visits to target similar messaging at mothers, fathers, guardians, and heads of households. Community members also host culinary sessions to teach mothers how to cook vitamin-rich meals to prevent malnutrition in their infants. This setting also provides another opportunity for messaging on the use of CHWs and iCCM services when faced with childhood illness. Finally, CHWs take advantage of patient visits to health huts to reinforce the importance of identifying signs of illness and seeking care for children early.

8. DISCUSSION & RECOMMENDATIONS

This study was undertaken to identify demand-side determinants that influence the use or non-use of iCCM services in Senegal. While the expansion of the iCCM program in Senegal has seen marked success in reducing under-five mortality, addressing the care-seeking barriers identified in this study is critical to achieving maximum impact.

Findings reveal that in the four study districts, uptake of iCCM services is driven by a range of interconnected factors, predominately: 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. .

The table below details key facilitators of and barriers to the use of iCCM services, as identified by study participants. It also provides practical programmatic recommendations—aimed primarily at community stakeholders, iCCM program implementers, district management teams and facility staff—for increasing demand for and uptake of iCCM services in Senegal and other countries in the region.

Table 11. Key Facilitators, Barriers, and Recommendations

UTILIZATION	
Facilitators	Barriers
<ul style="list-style-type: none"> • Understanding of causes, symptoms, and danger signs of illness leading to recognition of manifested conditions as requiring professional treatment • Early care-seeking (prior to emergence of danger signs requiring higher level of care) • Early communication on the causes and signs of illness 	<ul style="list-style-type: none"> • Delayed care-seeking (only at appearance of warning signs) • Use of traditional healers or self-medication as first point of care
Recommendations	
<ul style="list-style-type: none"> • Improve community understanding of disease and options for care: Health workers, community mobilizers, and community leaders should engage in sensitization activities to improve caregivers’ understanding of prominent childhood diseases, best practices in prevention as well as identification of symptoms and warning signs necessitating care, and options for care including the role and services that CHWs provide. Messaging from different sources should be streamlined to prioritize prevention and early treatment at the health hut. 	
ACCESS / AVAILABILITY	
Facilitators	Barriers
<ul style="list-style-type: none"> • Distance of health hut to other facilities • Proximity of health hut and iCCM services to the community • Availability of CHWs at health huts and labor-sharing between multiple CHWs at high-use sites • Positive perception of and trust in CHWs • Flexible payment options (e.g., deferral of payments or elimination of user fees) • Subsidization of certain medicines at health hut • Versatility of CHWs and diversification of services offered, including willingness to conduct home consultations and follow-up visits • Integration of CHWs in community’s social activities and networks, thereby establishing presence outside of health hut setting 	<ul style="list-style-type: none"> • Proximity of health huts to other facilities and providers • Cost of treatment (health huts not included in national UHC initiative) • Lack of trust and perceived legitimacy of CHWs • Perceived supply-side issues (lack of drugs, equipment, diagnostic capability) • Irregular presence of CHWs at health huts • Availability of treatment and medicines at nearby pharmacies • Remote location of health hut
Recommendations	
<ul style="list-style-type: none"> • Reduce perceived supply-side issues: <ul style="list-style-type: none"> ➤ <i>Availability of supplies</i> – This barrier can be addressed by guaranteeing the consistent availability of medicines and supplies in health huts and by strengthening and systematizing the management of those supplies and their storage. The MOH should strengthen the integration of health huts into the national public health care system. A clearly articulated relationship between the health hut and the health outpost (lowest level MOH-managed facility), facilitating ties between the head nurse and CHW, can enhance the health hut’s legitimacy within the community and improve access to medicines and materials through the national supply chain. CHWs and head nurses should work together to ensure more accurate monitoring/record-keeping of service utilization to inform requests for replenishment of medicine stocks. The capacity of the VHC in monitoring services provided by the health hut should also be strengthened. ➤ <i>Availability/capacity of CHWs</i> – Mechanisms to motivate CHWs to maintain regular working hours at the health hut (thereby ensuring more consistent availability of services) must be established. While communities have a responsibility to motivate their CHWs, the MOH and partners should also contribute 	

through the recognition and promotion of CHWs' work (e.g., facilitating training and providing badges and basic equipment to CHWs).

- Strengthen CHW relationship with the community, establish legitimacy of CHW and iCCM services, and reduce comparison to other providers:** Findings reveal that the distance or proximity to other health sources is a critical determinant of a health hut's utilization and should be taken into account when establishing community sites. 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. Where higher level public facilities are accessible, and patients regularly bypass CHWs to go there, the cost-effectiveness and technical quality of iCCM service provision in the community are compromised (due to low levels of consultations). District health teams should also coordinate with the private sector to avoid placing CHWs in close proximity to private health structures. Doing so will prevent the overlap of primary health services, reduce users' comparison of providers and services, and better meet the needs of rural and hard-to-reach communities. In communities marked by the presence of alternative health care providers, where perceived competencies of CHWs are compared to those of formally educated health care professionals, attention must be paid to establishing the legitimacy of the CHW and the unique role she/he plays in the larger health system. This can be achieved at the local level through integrating CHWs into communities' social activities and involving communities in health hut operations. Formal recognition of CHWs from the MOH as valuable contributors to the national health system can also increase their perceived legitimacy.
- Improve financial accessibility of iCCM services:** The MOH should enhance the coordination of financial contributions from the state, communities, and technical and financial partners to redistribute the financial burden and improve the 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 UHC initiative to the health hut level. To ensure long-term sustainability of the program and maintain emphasis on community participation, the state should also enhance its promotion of cooperatives, community support funds, other forms of local-level solidarity to contribute to the costs of health hut operations, CHW motivation, and medicine and materials stocks. High utilization districts of this study demonstrated success in community financing mechanisms, such as a community fund to pool resources, which could be replicated and/or adapted in other sites.

QUALITY	
Facilitators	Barriers
<ul style="list-style-type: none"> Satisfaction with and trust in the quality of services offered by CHWs (in insular communities without alternative providers) Regular monitoring of CHW activities 	<ul style="list-style-type: none"> Perceived lack of competency and satisfaction with CHWs and the services they provide (esp. when compared to other nearby, competing health care providers) Irregular monitoring of CHWs and supervisory visits from head health post nurse or CHP agent Perceived lack of motivation among CHWs Poor condition of the health hut Conflicts in health hut management
Recommendations	
<ul style="list-style-type: none"> Implement more accurate monitoring of quality of care: In line with national policy, head nurses should be more involved in the training, monitoring, and assisting of CHWs. In particular, head nurses should engage more regularly in close, formative supervision of CHWs. The MOH could also explore the feasibility of implementing and institutionalizing alternative supervisory methods that have been successful in other programs or pilots to complement the current approach and reduce the burden on head nurses. For example, a peer mentoring model in which high performing CHWs visit surrounding communities' CHWs, periodic mentoring visits to the health center, and the use of information and communication technology align with the 	

national strategy by contributing toward enhanced community participation, improved quality of services, and integration with the national health system.²⁵ Tools such as checklists and job aids should also be provided to CHWs to more accurately monitor quality of care as well as appropriateness and timeliness of case referral. At a higher level, collaboration should be strengthened between iCCM implementing partners and the district management team in decision-making and changes to the iCCM program.

DEMAND	
Facilitators	Barriers
<ul style="list-style-type: none"> • Involvement of community actors (e.g., relays, <i>bajenu gox</i>, village chiefs, public figures, religious leaders) in establishing the legitimacy and promoting the use of iCCM services 	<ul style="list-style-type: none"> • Limited understanding of the curative role of CHWs (as opposed to prevention and health promotion)
Recommendations	
<ul style="list-style-type: none"> • Enhance IEC activities to increase demand for iCCM services: Caregivers should be educated on the availability and scope of services offered at the health hut. Fathers, parents-in-law, and other household decision-makers should also receive targeted communication on the value of iCCM services. Community mobilizers should tailor IEC activities to target specific groups and their differing roles in iCCM service utilization, paying particular attention to setting 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. 	

9. CONCLUSION

In order to provide more equitable coverage of iCCM and other proven child survival interventions, attention must be paid to the demand-side barriers and enablers encountered by caregivers when seeking health care for their children. Many caregivers included in this study indicated that, despite the availability of CHWs and iCCM services in their communities, a range of factors influenced their decision if, 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 caregiver knowledge and awareness, cultural and societal norms, community engagement, and access, availability, and quality of services, among others.

While this study examined demand-side drivers of the use or non-use of iCCM services across four districts and eight community sites in Senegal, its findings and recommendations may be relevant for other low-resource settings and 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 iCCM strategy alongside an appropriate supply of child health services in order to promote equitable access to health care for children.

²⁵ Maternal and Child Health Integrated Program. Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policymakers. May 2014. Available at: <http://www.mchip.net/node/2140>.

ANNEX I. CALCULATION OF ICCM UTILIZATION RATES

Utilization (U) = # of iCCM cases received by CHW (n) / total # of expected cases of ARI, malaria, and diarrhea (z)

The total # of expected cases (z) is calculated using the following data points:

- 1) Total village population (v)
- 2) Percentage of village that is under-five years of age (2014 Senegal DHS has 17% of the population under-five years of age)
- 3) Total target population (p) = v * 17%
- 4) Disease incidences for ARI, diarrhea, and fever (i) (see explanation on incidence calculation below)
- 5) Total number of cases in target population based on incidence (x)
- 6) Percentage of target population that would seek care from alternate health provider such as health facility or traditional healer (r). This percentage will be an estimate based on 'expert opinion' and may vary from village to village and even by disease.

$$p * i = x$$

$$x * r = z$$

Incidence Rates for the iCCM Interventions

Incidence rates for each intervention are calculated based on the prevalence rates reported in the 2014 Demographic Health Survey (DHS) for Senegal. These incidence rates are national averages for the country and relate to each of the three intervention areas overall. Thus, if 19% of children were reported to have diarrhea, these cases could be treated through iCCM or other means, such as at a health post. For each disease the DHS reports the percentage of children who had symptoms in the two weeks prior to the survey. To convert from prevalence to incidence rates, we took the two-week prevalence figure and annualized it based on the average duration of each disease. For example, 19% of children were reported to have had diarrhea in the two weeks prior to the DHS survey. A meta-analysis of zinc treatment for diarrhea (Lukacik, 2008) shows that the average duration of an episode is 4.07 days. To adjust to an annual figure, we divided 52 weeks by 2.6 (the number of two-week periods including the duration of the episode) to arrive at 20.15. This figure is then multiplied by the 19% prevalence rate to arrive at an incidence rate of 3.85 episodes per year.

	Prevalence - DHS ²⁶	Average Duration (Days)	Adjustment Factor to Annual Figure	Incidence (Episodes per Year)
Diarrhea	19%	4.07	20.15	3.85
ARI	3%	5.00	19.16	0.54
Fever	11%	5.00	19.16	2.18

²⁶ Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], et ICF International. 2015. Sénégal : Enquête Démographique et de Santé Continue (EDS-Continue 2012-14), Rapport Régional. Rockville, Maryland, USA : ANSD et ICF International.

Region	Dakar	Thies	Fatick	Matam
District	Keur Massar	Tivaouane	Foundiougne	Ranerou
Sites	320,601	103,406	13,434	5,556
% pop <5	54,502	17,579	2,284	945
# expected malaria cases (calculated using above formula)	118,815	38,322	4,979	2,059
# malaria cases seen (Oct-Dec 2015)	104	53	234	644
x4 (annual adjustment)	416	212	936	2576
Malaria utilization	0%	1%	19%	125% ²⁷
# expected ARI cases	29,431	9,493	1,233	510
# ARI cases seen	277	159	740	159
x4	1108	636	2960	636
ARI utilization	4%	7%	240%	125%
# expected diarrhea cases	209,833	67,679	8,793	3,636
# diarrhea cases seen	272	809	77	170
x4	1088	3236	308	680
Diarrhea utilization	1%	5%	4%	19%
Average	2%	4%	87%	90%

²⁷ A utilization rate greater than 100% of expected cases could be attributed to over-treatment of non-confirmed cases. It could also be a result of not accounting for seasonality of disease (e.g., malaria is more prevalent in the rainy season than the dry) in estimating expected cases treated by CHWs and non-use of health zone level disease incidence.

ANNEX 2. QUESTIONNAIRES

Free and Informed Consent Form

INFORMED CONSENT

My name is _____, and I am working for the African Strategies for Health project to conduct a survey on the use of community health services for children in the health district of _____.

We would appreciate your participation in this survey. The information gathered will help the health zone and district to plan and improve health services. The interview will take approximately 40 minutes.

Participation in this survey is completely voluntary and you can decide not to answer any individual question or any questions at all. However, we would like you to take part in this survey as your opinions are important to improve the delivery of health services. Once we have analysed all the interviews, we will leave the results with the district health office of _____ from X 2015 if you would like to find out more.

With your permission, we will record the interview with an audio recorder so we can study the issues discussed here in more depth. Be assured that everything that is said here remains strictly confidential and anonymous.

Do you have any questions about this survey?

Do you agree to take part in this survey? YES /___/ NO /___/

If yes, thank the person ask them to sign or mark below and begin the survey

Signature or mark of Interviewee _____

If no, then thank the person and let your supervisor know so appropriate measures can be taken.

Date

Signature of the data collector.....

If you have any questions about this survey, you can contact xxxxxxxx

A. INDIVIDUAL INTERVIEW FOR CARETAKERS WITH SICK CHILDREN AGED 0 TO 59 MONTHS

Individual Interview Guide: Caretaker of sick children aged under 5

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographic Information

Gender _____

Age _____

Relationship to sick child aged 0 – 59 months _____

of persons living in household _____

of living children under the age of 5 _____

of deceased children _____

years of school attended _____

Please list all sources of household income (including ownership of livestock)

TOPIC 1: Perception of healthcare and services

Can you tell me about the concerns of people in your community regarding treating childhood diseases such as diarrhea, malaria, and pneumonia?

What changes have you noted in the treatment of childhood diseases over recent years? (Explore: in terms of access, cost, quality, diversification of services, health workers' skills, etc.)

Tell us about your sources of information on child health?

What do you think of the level of information for women on the prevention and treatment of disease?

Do you know the danger signs indicating that the sick child should be taken for treatment? (Explore: if the new generation is better informed about diseases such as: malaria, diarrhoea, ARIs and malnutrition, the procedure for seeking care for children under 5)

Do you know what kind of services your local CHW can provide for sick children?

Do you think that CHWs are respected providers for sick children within your community? Why or why not?

TOPIC 2: Care possibilities

Can you tell us what services are available in your community for treating sick children? (Explore this for the health centers, CHWs, traditional healers, itinerant care givers, etc.)

What do you think are the benefits of consulting each of these types of providers?

NB: If possible draw up a list of care providers in order of preference, and ask them to justify the rank of each provider.

(Explore to see: the difference between the quality of care offered by alternative caregivers and those of first line health workers (CHW, facility-level staff)?

Are the services of certain alternative care providers more sought for certain diseases or health problems, compared to others? If so, which health issues and why?

Tell us which care providers are usually consulted by mothers of children under 5 and for which problems? (If the CHWs are not mentioned, ask why not? Explore: the nature of the disease, the geographical location of the care provider, reasons for the choice, etc.)

Do mothers often advise each other to go to certain care providers? If so, for which kinds of health issues?

TOPIC 3: Experiences/use of services

Can you tell us about your experiences in dealing with a sick child? (Explore: the nature of the disease, person who chose the care provider, person who paid the costs, satisfaction etc.)

In your experience, with which care providers have you been satisfied? And with which care providers have you not been satisfied? Give your reasons. (Explore: diversification of services, quality of services, attitudes of the care providers, cost of treatment etc.)

What do you think the determining factors are for quality health care?

What kind of care provider would you recommend to other mothers? Does your recommended provider differ based on the health problem? (Explore which illnesses/diseases the respondent lists and how they correspond to different care providers.)

Can you tell us about the main constraints you have most often had to face in ensuring care for your child? (Explore: distance from the site/lack of transportation, shortages of inputs, cost of medicines/services, social constraints, etc.)

Do finances play a role in where you decide to take your sick child for treatment?

What about your location and distance to nearest health facility? Does this have an impact on who you seek out for care?

Have you ever taken your child to be treated by a CHW and they did not have the drug your child needed? If yes, what did the CHW do?

Do the current services that CHWs can provide for your sick children meet your expectations? If so, how? If not, why?

TOPIC 4: Decision to seek treatment

At what point, in your family, do you decide to take a sick person to a care provider? What is the decision making process and who makes the final decision? (Explore: example of a recent care of seeking treatment for a sick child)

In your family, who has the final choice in selecting a care provider for the treatment of your children? Is your opinion taken into account?

What do the decision-makers in your family think of the services offered by CHW versus those at the health facility? What kind of care provider do they prefer? Why?

Why do families bring their children for treatment by alternative care providers even though treatment is available from trained CHWs or from the local health center?

TOPIC 5: Prospects for improvement

Do you think there are some aspects of the CHW services that could be improved? If so, which ones?

What can be done to encourage decision-makers to bring their child to the CHWs for treatment for diarrhea, malaria, and pneumonia?

What do you think of a possible diversification of CHW services? What kind of services should be prioritised?

Are there any other issues that we did not discuss that influence your decision on whether or not to seek care for your sick child from a CHW?

B. INDIVIDUAL INTERVIEW FOR COMMUNITY HEALTH WORKERS

Individual Interview Guide: CHWs

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographic Information

Gender _____

Age _____

years of school attended _____

TOPIC 1: Roles and responsibilities of a CHW

Can you tell us a bit about your role and responsibilities in your village as a CHW? How long have you been doing this work?

Can you tell us about the various training courses you have attended as well as the technical skills that you have acquired in child healthcare?

Can you describe the specific training(s) you have had in iCCM?

Do you believe there is high burden of childhood illness in your village? If so, do you believe the iCCM services you provide meet the demands of your target population? If not, why not?

On average how many sick children do you see a week? How many of those, do you refer to health centers for treatment?

TOPIC 2: Problems and challenges

What is the degree of support and level of community involvement in your activities?

What problems or challenges do you most often face in your role as a CHW? How have you managed these problems? What support do you receive and from who?

What have been the main challenges for you as a CHW in providing iCCM services? Have you been able to find solutions to overcome these challenges? If so, what?

Do you experience drug-stock outs for iCCM medicines frequently? If yes, how do you think drug stock-outs can be minimised?

What do you think the barriers are to accessing healthcare in your community? (Explore: drug stock-outs; cost of services/medicines, remoteness of the site etc.)

How are CHWs perceived by the community? Are CHWs respected? (Explore: trust, appreciation of skills, sociability etc.)

How important is the financial barrier, or means to pay, in accessing iCCM services?

How does the presence of other care providers (health facilities, itinerant caregivers, traditional healers, etc.) influence the use of iCCM services? Are the services of certain alternative care providers more sought for certain diseases or problems than others? If so, which ones and why?

Are certain alternative care providers more affordable than others? (Explore who and if they believe this has an impact on utilization of services by this type of provider)

Do you think the public is adequately informed about the iCCM services you provide? If yes, how so? If not, why not?

What channels of communication have you used to raise awareness of the services you provide amongst the population? In collaboration with whom? Are they effective?

TOPIC 3: Supervision

Tell us about the kinds of support you have received from your supervisors or local NGO workers?

(Explore further to know the frequency, areas, time allocated, etc.)

Can you describe the supervision mechanism and frequency for iCCM?

(Explore: actors involved, frequency, location, monitoring methods etc.)

Which aspects of your iCCM services does the supervision focus on?

What do you think are the strengths and weaknesses of the supervision activities?

How do you report on your iCCM services?

What specifically, do you report? How frequently? And to whom?

TOPIC 4: Motivating CHWs

Can you tell us about any issues related to your working conditions that you feel have an impact on the quality of services you can provide? Are you satisfied with your working conditions? If so, why? If not, why not?

Is there support or are there materials/equipment that you need to improve your working conditions and performance as a CHW providing iCCM services?

What are the advantages and disadvantages linked to your work? Explain?

Can you tell us about your expectations in terms of remuneration?

What types of remuneration do you receive as a CHW? (Explore: per diems, salaries, performance incentives, in-kind gifts from community)

TOPIC 5: Suggestions and recommendations

What would you suggest is needed to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

How can iCCM services provided by CHWs be improved and/or sustained?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

Are there any other issues that we did not discuss that you believe influence your ability to provide care for sick children?

C. INDIVIDUAL INTERVIEW FOR CHW SUPERVISORS

Individual Interview Guide: CHW Supervisor

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics

Gender _____

Age _____

years of school attended _____

TOPIC 1: Roles and responsibilities

What do you know about your district's iCCM strategy? Have CHW supervisors been involved? If so, what role have they played?

Can you tell us about the CHWs' iCCM activities in your health district? What are the CHWs' roles?

Do you think the implementation of the iCCM has taken into account the community's concerns about treating childhood illnesses? If yes, why? If not, why not?

Can you tell us about the various training courses you have attended or conducted as part of supervising CHWs provision of iCCM services? What were the aims of these training courses? Were they adequate?

TOPIC 2: Problems and challenges

What are the main challenges that the CHWs face in providing iCCM services? What have you done to help address these problems?

What are the main challenges you face as a stakeholder in implementing and supporting the provision of iCCM services? Have you been able to meet these challenges? If so, how?

What do you think are the barriers to accessing iCCM services offered by the CHWs? (Explore: drug and FP input stock-outs; cost of services/medicines, remoteness of the site, etc.)

How important is the financial barrier as a determining factor in the low use of iCCM services?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

How does the presence of other service providers (health facilities, itinerant caregivers, traditional healers, etc.) influence the use of iCCM services?

Are the services of certain alternative care providers more sought for certain diseases or health problems than others? If so, which health issues and why?

Do you think the public is adequately informed about CHW services? If so, how? If not then why not? What channels of communication are used to raise awareness amongst the population? Are they effective?

TOPIC 3: Stakeholders' roles in improving iCCM services

What groups or categories of people should be involved to encourage the use of iCCM services provided by the CHWs? (Explore: nature of the potential groups, ages and positions of the resource people)

What role could do you think CHW supervisors should play in promoting iCCM?

In what way should primary health centers be involved in promoting the iCCM services? What should they be doing and how?

What kind of health promotion activities or events might users appreciate the most?

TOPIC 4: Support/Monitoring/Assessment

Tell us about the kind of support CHWs receive from their supervisor? (Explore to know the frequency, the areas covered, the time apportioned, etc.)

Can you describe the supervision mechanism for supervising the CHWs' iCCM services? (Explore: the actors involved, the frequency, the monitoring means, etc.)

What do you think are the strengths and weaknesses of your supervisory activities?

How are the CHWs' iCCM services assessed? By whom and how frequently? (Explore: can the results of the supervision and assessments contribute to decision-making and correcting deficiencies.)

TOPIC 5: Suggestions and recommendations

What would you suggest is needed to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns should be taken into account?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM? If so, what are they?

What needs to be done to improve the quality of the supervision?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

D. INDIVIDUAL INTERVIEW FOR ALTERNATIVE CARE-GIVERS

Individual Interview Guide:

Alternative Care-Givers

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics

Gender _____

Age _____

years of school attended _____

TOPIC 1: iCCM Services

Can you tell us about your role and responsibilities in your village? How long have you been doing this work?

Can you tell us about the services you offer? What are your skills in treating childhood illnesses such as diarrhea, malaria, and pneumonia?

What specific training(s) have you received?

Which health issues are you consulted for by the people in your community?

Can you tell us about the characteristics of your clients/patients? (Explore: age, income, sex, distance from the care provider, etc.)

What do you think is distinctive about the services you provide, compared to other care providers?

Have you heard about iCCM services? If so, what have you heard?

What do you know about the CHWs and the mission they have been assigned? Who are their target groups? What kind of care are they consulted for?

TOPIC 2: Perception of the CHWs

How do care providers such as you perceive the CHWs?

Do you think the members of your community have a preference between you and the CHWs? If so, what is the preference and why?

What do you think of the CHWs' skills? Do you think that the services treating childhood illnesses that the CHWs offer are appropriate for the demands of the people in your area? If not, what are the population's expectations?

Is there any collaboration between you and formal service providers? If so, can you describe the nature of this collaboration?

TOPIC 3: Problems and challenges

Do you think the implementation of iCCM services has taken into account the presence of alternative care providers? What is the level of support and involvement of alternative care providers in iCCM services?

What do you think are the main barriers to utilising healthcare for the people in your community? (Explore: geographic access, medicine and FW input stock-outs, cost of services/medicines, distance from the site, rivalry between care providers, etc.)

How important is the financial barrier as a determinant low use of community-based health services?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

Are the services of certain alternative care givers sought more for a particular disease or health problem than another? If so, which health issues and why?

Which communication channels do you use to raise awareness about childhood illnesses amongst the population? Are they effective?

TOPIC 4: Prospects for improvement

Which groups or categories of people should be involved to encourage the use of your services? (Explore: nature of the potential groups, ages and positions of resource people)

Can you tell us which aspects of iCCM services provided by CHWs are not appreciated by the community? And which aspects should be strengthened?

Do you think alternative care providers should play a role in promoting iCCM services? If so, how? Who should define this collaboration framework?

What kinds of health promotion activities or events might users appreciate the most?

TOPIC 5: Suggestions and recommendations

How do you think iCCM services offered by the CHWs could be improved?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

E. INDIVIDUAL INTERVIEW FOR DISTRICT CHIEF MEDICAL OFFICERS AND DISTRICT iCCM FOCAL POINTS

Individual Interview Guide: District Chief Medical Officer and iCCM Focal Person

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics

Gender _____
Age _____
years of school attended _____

TOPIC 1: Knowledge of iCCM Services

Can you tell us about your role and responsibilities within your facility? How long have you been working in this facility?

How long have you been a stakeholder in implementing iCCM services?

What do you know about the main objectives of the iCCM approach?

Who do you think the beneficiaries of iCCM are and how/why do they benefit?

TOPIC 2: Problems and challenges

What are the main problems/challenges you have had to deal with in supporting implementation of iCCM? Have they been resolved? If so, how? If not, why not? (Explore: are there planning problems, input shortages for the activities, etc.)

What do you think are the barriers to accessing iCCM services offered by the CHWs?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

What channels of communication are currently used to raise awareness of iCCM services amongst the population? Are they effective?

TOPIC 3: Stakeholders' role in improving iCCM

Which groups or categories of people need to be involved to encourage the use of iCCM services offered by CHWs? (Explore: the nature of potential groups, ages and positions of resource people)

What role can partners play in promoting iCCM? Who should define the framework of this collaboration?

TOPIC 4: Support and Monitoring Initiative

How are the CHWs' iCCM services coordinated at village level, in the local health zone and at the level of the health district?

Can you describe the supervision mechanism for iCCM? Does your facility supervise the CHWs' activities? If so, how?

Tell us about the kind of support planned to help the CHWs improve the quality of the iCCM services they provide? By whom and how? (Explore: frequency, areas, time allocated, actors involved, the monitoring means, etc.)

What do you think are the strengths and weaknesses of your supervisory activities? (Explore: lack of funds, logistics, resources, planning failures, etc.)

Do the CHWs report iCCM data to the district level? If so, how frequently? What kind of information is included?

TOPIC 5: Suggestions and recommendations

What needs to be done to ensure the success of iCCM?

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM services? If so, what are they?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

F. INDIVIDUAL INTERVIEW FOR TECHNICAL & FINANCIAL IMPLEMENTATION PARTNERS

Individual/Small Group Interview Guides: Technical and Financial Implementing Partners

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

TOPIC 1: Project Relevance

Please tell us about the objective of your project. What are your specific roles and responsibilities on the project?

In what ways does your project support implementation of iCCM in the district?

What do you hope to achieve in terms of support to iCCM services?

Who do you coordinate and collaborate with and at what levels?

TOPIC 2: Problems and challenges

What are the main problems/challenges you have faced or observed with regards to iCCM implementation? (Explore: are there planning problems, input shortages for the activities, availability of the population etc.)

Why do you think there is low utilization of iCCM services in this district? In your opinion what are the obstacles to utilizing iCCM services? (Explore: drug and FP input stock-outs; cost of services/medicines, remoteness of the site etc.)

What channels of communication are used to raise awareness of iCCM services amongst the population? Are they effective?

TOPIC 3: Stakeholders' Role in improving iCCM

Which groups or categories of people need to be involved to encourage the use of iCCM services offered by the CHW? (Explore: the nature of potential groups, ages and positions of resource people)

What role can partners like you play in promoting iCCM?

What role could partners play in making iCCM implementation sustainable?

What kind of health promotion activities or events might users appreciate the most? Can you talk about some examples of strategies for effective community mobilization?

TOPIC 5: Suggestions and recommendations

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

Are drug-stock outs an issue for CHWs providing iCCM services? If so, how can drug stock-outs be minimised?

Do you have any suggestions for managing progress made in iCCM?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM? If so, can you explain them?

What needs to be done to improve the quality of supervision of iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

G. FOCUS GROUP DISCUSSIONS FOR CARETAKERS WITH SICK CHILDREN AGED 0 TO 59 MONTHS

Focus Group Discussion Guide: Caretakers of sick children 0 – 59 months

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics (record for all participants)

Gender _____
Age _____
of children _____
years of school attended _____

TOPIC I: Healthcare services and providers

Can you talk about the concerns of people in your community regarding treating childhood diseases such as diarrhea, malaria, and pneumonia?

Do you know the danger signs indicating that the sick child should be taken for treatment? (Explore for malaria, diarrhoea, ARIs and malnutrition, the procedure for seeking care for children under 5?)

Can you tell us about the kinds of care providers sought by the people in your community to treat sick children? (Explore this for the health center, CHW, traditional healers, travelling salesmen, etc.)

What do you think are the benefits of consulting each of these types of providers?

NB: If possible draw up a list of care providers in order of preference, and ask them to justify the rank of each provider.

(Explore to see: the difference between the quality of care offered by alternative caregivers and those of CHWs)

Are the services of certain alternative care providers more sought for certain diseases or health problems than others? If so, which health issues and why?

TOPIC 2: Knowledge of iCCM services

Are you familiar with iCCM services? If so, what can you tell us about them? (who are they provided by, what illnesses do they treat, etc.)

For those of you who have heard about iCCM services, how did you hear about iCCM services? From whom?

What kind of information would you like to know about the services CHWs can provide for sick children in your community?

Do you believe the information on CHW services is currently adequate?

TOPIC 3: Perception of the CHWs

How is the CHW perceived by the members of your community?

Is it important to members of your community if the CHW is male or female? If yes, which is preferred and why? Is any other characteristic of the CHW important to the community?

Can you tell us about your expectations and your definition of quality service from the CHWs treating sick children? Do the CHW's current services meet your expectations? If so, why and how? If not, why not?

If you do not currently utilize CHWs when your children are sick, where do you take your sick child? Why?

What does the community think of the CHW's skills? What does the population think of the quality of iCCM services provided by the CHWs?

Tell us about the aspects of his/her services that you appreciate and the aspects that you don't. What do you expect from a CHW? (Explore the following aspects: skills, approach, attitude to patients and carers, etc.)

Do you think there is any difference between the iCCM services offered by the CHWs and those offered by health center health workers and private health workers? If so, please explain?

Do families not comply with the treatment and/or advice and guidance given by the CHWs? If yes, why not?

Do families ever refuse referral by the CHW of serious cases to the health center? If yes, what can be done and how?

TOPIC 4: Access to care

Can you tell us about the main problems linked to accessing health services for sick children? (Explore: distance from the site, shortages of inputs, cost of medicines/services etc.)

Are iCCM services adapted to the demands of the community? If so, how? If not, why not?

How important is the financial barrier as a determining factor for low utilisation of iCCM services?

Have you ever taken your child to be treated by a CHW and they did not have the drug your child needed? If yes, what did the CHW do?

TOPIC 5: Decision to seek services

In general, when do families decide to seek care outside the household when a child is ill?

What is the decision-making process and who takes the final decision?

Why do families get their children treated by alternative care providers even though treatment is available from trained CHWs?

Do you think that the distance between CHW sites and other sources of care (healthcare facilities, itinerant care givers etc.) come into the decision-making process for the first choice of services?

TOPIC 6: Prospects for improvement

Do you think there are some aspects of the CHWs' provision of iCCM services that could be improved? If so, what?

Which strategies do you think would be effective to attract and encourage people to consult the CHWs? What kind of health promotion activities or events might users appreciate the most?

Are there any other issues that we have not yet discussed that influence your decision on whether or not to seek care for your sick children from a CHW?

H. FOCUS GROUP DISCUSSION FOR CHWs

Focus Group Discussion Guide: CHWs

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics (record for all participants)

Gender _____

Age _____

years of school attended _____

TOPIC 1: Roles and responsibilities of a CHW

Can you tell us a bit about your role and responsibilities in your village as a CHW? How long have you been doing this work?

Can you tell us about the various training courses you have attended as well as the technical skills that you have acquired in child healthcare?

Can you describe the specific training(s) you have had in iCCM?

Do you believe there is high burden of childhood illness in your village? If so, do you believe the iCCM services you provide meet the demands of your target population? If not, why not?

On average how many sick children do you see a week? How many of those, do you refer to health centers for treatment?

TOPIC 2: Problems and challenges

What is the degree of support and level of community involvement in your activities?

What problems or challenges do you most often face in your role as a CHW? How have you managed these problems? What support do you receive and from who?

What have been the main challenges for you as a CHW in providing iCCM services? Have you been able to find solutions to overcome these challenges? If so, what?

Do you experience drug-stock outs for iCCM medicines frequently? If yes, how do you think drug stock-outs can be minimised?

What do you think the barriers are to accessing healthcare in your community? (Explore: drug stock-outs; cost of services/medicines, remoteness of the site etc.)

How are CHWs perceived by the community? Are CHWs respected? (Explore: trust, appreciation of skills, sociability etc.)

How important is the financial barrier, or means to pay, in accessing iCCM services?

How does the presence of other care providers (health facilities, itinerant caregivers, traditional healers, etc.) influence the use of iCCM services? Are the services of certain alternative care providers more sought for certain diseases or problems than others? If so, which ones and why?

Are certain alternative care providers more affordable than others? (Explore who and if they believe this has an impact on utilization of services by this type of provider)

Do you think the public is adequately informed about the iCCM services you provide? If yes, how so? If not, why not?

What channels of communication have you used to raise awareness of the services you provide amongst the population? In collaboration with whom? Are they effective?

TOPIC 3: Supervision

Tell us about the kinds of support you have received from your supervisors or local NGO workers?

(Explore further to know the frequency, areas, time allocated, etc.)

Can you describe the supervision mechanism and frequency for iCCM?

(Explore: actors involved, frequency, location, monitoring methods etc.)

Which aspects of your iCCM services does the supervision focus on?

What do you think are the strengths and weaknesses of the supervision activities?

How do you report on your iCCM services?

What specifically, do you report? How frequently? And to whom?

TOPIC 4: Motivating CHWs

Can you tell us about any issues related to your working conditions that you feel have an impact on the quality of services you can provide? Are you satisfied with your working conditions? If so, why? If not, why not?

Is there support or are there materials/equipment that you need to improve your working conditions and performance as a CHW providing iCCM services?

What are the advantages and disadvantages linked to your work? Explain?

Can you tell us about your expectations in terms of remuneration?

What types of remuneration do you receive as a CHW? (Explore: per diems, salaries, performance incentives, in-kind gifts from community)

TOPIC 5: Suggestions and recommendations

What would you suggest is needed to improve the quality of iCCM services provided by the CHWs?

Which of the population's concerns related to childhood illnesses do you believe are not currently taken into account but should be?

How can iCCM services provided by CHWs be improved and/or sustained?

Do you know of any appropriate mobilisation strategies to ensure effective ownership by the communities for iCCM?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

I. FOCUS GROUP DISCUSSION FOR COMMUNITY LEADERS

Focus Group Discussion Guide: Community Leaders

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics (record for all participants)

Gender _____
Age _____
years of school attended _____

TOPIC 1: Knowledge of iCCM

What is your role in the community?

What do you know about iCCM services? Has the Village Health Committee been involved? If so, what role does it play?

Can you tell us about the iCCM services CHWs' provide in your health zone?

Do you think the implementation of iCCM services has taken into account the community's concerns about treating childhood illnesses disease? If so, why? If not, why not?

TOPIC 2: Perception of the CHWs

How are they perceived by the people in the community?

What do you think prevents people from consulting CHWs for childhood illnesses?

Can you tell us about the strengths and weaknesses of the iCCM services in your area?

Do you believe your village/community benefits from the iCCM services that CHWs provide? Why or why not?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

What do you think of the quality of the iCCM services offered by the CHWs compared to the services offered in your local health center?

TOPIC 3: Roles of Community Leaders

Do community leaders play a role in monitoring the CHWs in the local health zone? If so, what role?

Can community leaders play a role in promoting iCCM services in the community? If so, what role and how? If not, why not?

TOPIC 4: Suggestions and recommendations

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Do you have any suggestions for increasing utilization of iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

J. FOCUS GROUP DISCUSSION FOR VILLAGE HEALTH COMMITTEES

Focus Group Discussion Guide: Village Health Committees

1. This is a guide and not a script. The key is to facilitate and lead rather than direct.
2. Begin the interview with a minute or two of general conversation.
3. The purpose is to get the person(s) engaged in a conversation.
4. Maintain a non-judgmental approach to the interviewee and her viewpoints.
5. Questions requiring opinions and judgments should follow factual questions, after some level of trust has been established and the atmosphere is more conducive to candid replies.
6. Questions should be simply worded, kept short, and phrased in the vernacular. Generally, they should be phrased to elicit detailed information, not just a simple 'yes' or 'no' answer.

Demographics (record for all participants)

Gender _____
Age _____
of Children _____
years of school attended _____

TOPIC 1: Knowledge of iCCM

How long have you been members of the Village Health Committee?

What are your roles and responsibilities as part of the Village Health Committee?

What do you know about iCCM services? Has the Village Health Committee been involved? If so, what role does it play?

Can you tell us about the iCCM services CHWs' provide in your health zone?

Do you think the implementation of iCCM services has taken into account the community's concerns about treating childhood illnesses disease? If so, why? If not, why not?

TOPIC 2: Perception of the CHWs

How are they perceived by the people in the community?

What do you think prevents people from consulting CHWs for childhood illnesses?

Can you tell us about the strengths and weaknesses of the iCCM services in your area?

Do you believe your village/community benefits from the iCCM services that CHWs provide? Why or why not?

Are drug-stock outs of iCCM medicines an issue? If yes, how do you think drug stock-outs can be minimised?

What do you think of the quality of the iCCM services offered by the CHWs compared to the services offered in your local health center?

TOPIC 3: Roles of the VHC

Does the Village Health Committee play a role in monitoring the CHWs in the local health zone? If so, what role?

Can the Village Health Committee play a role in promoting the iCCM services in the community? If so, what role and how? If not, why not?

TOPIC 4: Suggestions and recommendations

What would you suggest to improve the quality of iCCM services provided by the CHWs?

Do you have any suggestions for increasing utilization of iCCM services?

Are there any other issues that we did not discuss that you believe influence caretakers decisions on whether or not to seek care for their sick children from a CHW?

ANNEX 3. INTERVIEWS CONDUCTED

District	Site (health hut)	Respondent	Number of Individuals Interviews	Number of Focus Group Discussions (FGD)	Number of FGD Participants
RANEROU	Mbourlogne	Mother/guardian	10	1	10
		Traditional healer	1	0	0
		CHW	1	0	0
		Community leader	0	1	6
		Health committee	0	1	4
	Bélel Touflé	Mother/guardian	10	1	10
		Traditional healer	1	0	0
		CHW	1	0	0
		Community leader	0	1	8
		Health Committee	0	1	7
	Niveau Supérieur	District chief doctor	1	0	0
		Technical and financial partners (Childfund)	1	0	0
Supervisor (Chief nurse)		1	0	0	
FOUNDIOUNE	Guagué Mody	Mother/guardian	10	1	12
		Traditional healer	1	0	0
		CHW	1	1	6
		Community leader	0	1	7
		Health committee	0	1	5
	Maya	Mother/guardian	10	1	10
		Traditional healer	1	0	0
		CHW	1	0	0
		Community leader	n/a	1	8
	Niveau supérieur	Health committee	0	1	5
		District chief doctor	1	0	0
		Focal point	1	0	0
		Technical and financial partners	1	0	0
		Supervisor	2	0	0
KEUR MASSAR	CCTAS	Mother/guardian	10	1	10
		Traditional healer	1	0	0
		CHW	1	0	0
		Health committee	0	1	5
		Community leader	0	1	7
	Darou Rakhmane	Mother/guardian	10	1	12
		Traditional healer	1	0	0
		CHW	1	1	5
		Community leader	0	1	5
		Health committee	0	0	0
	Niveau Supérieur	District chief doctor	1		0
		Focal point	1	0	0
		Technical and financial partners	1	0	0
		Supervisor	1	0	0

TIVAOUANE	Ndiaye Bopp	Mother/guardian	10	1	8
		Traditional healer	1	0	0
		CHW	1	1	4
		Community leader	0	1	4
		Health committee	0	1	3
	Yendane	Mother/guardian	10	1	6
		Traditional healer	1	0	0
		CHW	1	1	4
		Community leader	0	1	5
		Health committee	0	1	5
	Niveau Supérieur	District chief doctor	1	0	0
		Focal point	1	0	0
		Technical and financial partners	1	0	0
Supervisor		1	0	0	
Total			112	36	181

African Strategies for Health
4301 N. Fairfax Drive, Suite 400, Arlington, VA 22203
Telephone: +1-703-524-6575
AS4H-info@as4h.org
www.africanstrategies4health.org