THE DETERMINANTS OF HEALTH-SEEKING PRACTICES AFTER THE INTRODUCTION OF COMMUNITY CASE MANAGEMENT OF MALARIA IN BURKINA FASO

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COMMUNITY CASE MANAGEMENT OF MALARIA

- About 700,000 deaths in children under 5 years are attributed to malaria in SSA
- Regarding the mortality, access to prompt and effective treatment is a key issue
- The WHO has recommended CCMm since 2004
  - Renewed interest in community health workers
  - Presumptive treatments to febrile cases
  - Recommended in highly endemic areas (SSA)
- Trials have shown this strategy's efficacy to reduce child morbidity & mortality … but what about the effectiveness?

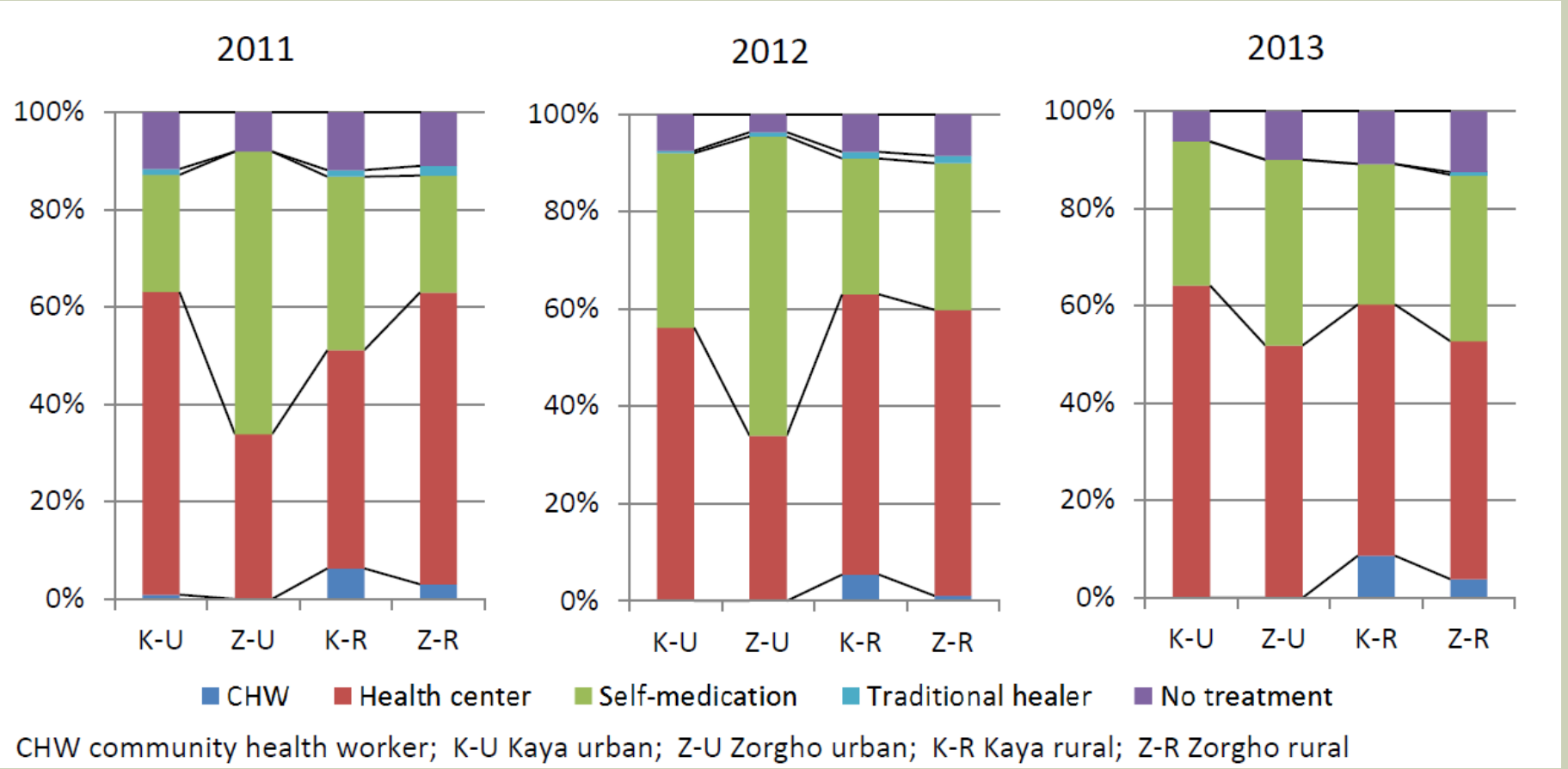
CCM IN BURKINA FASO

- Health authorities scaled up CCMm at the national level in 2010 (funded by the Global Fund)
- 1 CHW per village and per urban sector
- CHWs received 2 days of training, some material (bicycle, register, etc.) and drugs (ACT)
- Financial incentive (10$/month). Consultations are free, but treatments cost about 0.4$
- Objective : 80% simple malaria cases treated by CHWs in villages

METHODS

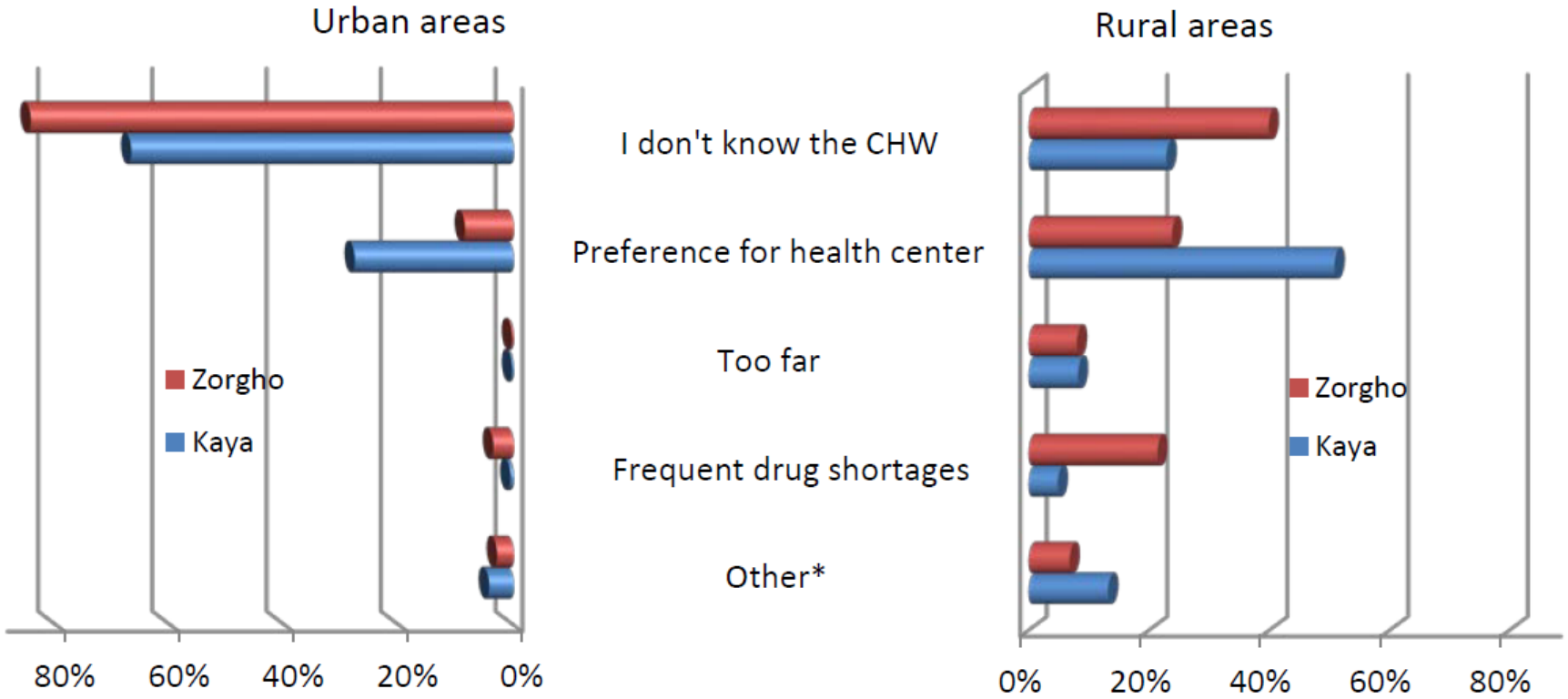
- Panel study of 3000 randomly selected households located in 2 health districts
- We surveyed households equally distributed:
  - In the urban area of 2 small cities (Kaya and Zorgho)
  - In villages located within a 20-km radius of these cities
- Cross-sectional repeated measures once a year during the peak malaria transmission season
- Household surveys documented health-seeking practices in children who had been sick during the previous 14 days

FIRST TREATMENT-SEEKING ACTION



CHW community health worker; K-U Kaya urban; Z-U Zorgho urban; K-R Kaya rural; Z-R Zorgho rural

CAREGIVERS' PRIMARY REASON FOR NOT CONSULTING A CHW



* The category "other" includes lack of trust, excessive costs, and poor service from CHW

DETERMINANTS OF CONSULTING A CHW (RURAL AREAS ONLY)

- 2 factors were significantly ($p<0.05$) associated with a higher odds ratio to consult a CHW:
  - The distance between a household and the health center
  - The fact that the CHW had visited the household in the previous 3 months
- In households far (> 5km) from a health center and that had been recently visited by a CHW, the predicted probability of consulting a CHW reached 30%.

CONCLUSIONS

- CCMm was completely unsuccessful in urban areas, despite a malaria prevalence of 11%. Geographical barrier is not the issue in urban areas.

  => Theory of intervention

- The analysis corroborates the idea that CHWs can be useful to reduce the geographical barrier

  => Not in urban sectors

  => Not in villages with a primary healthcare center

When caregivers consult CHWs, it is not because they are close, but rather because health centers are far

CONCLUSIONS (2)

- In rural areas, treatment coverage never exceeded 10%.

  => In trials, it reached 80%

- Importance of conducting evaluations under real-world conditions of implementation

- There are many implementation issues at play that could explain the lack of uptake of CHWs' services

  => Stock-outs seem to be a major issue

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