SAS Journal of Medicine
Abbreviated Key Title: SAS J Med
ISSN 2454-5112
Journal homepage: https://saspublishers.com

OPEN ACCESS

Medicine

Evaluation of the Essential Community Care (ECC) Strategy in the Integrated Management of Childhood Illnesses 0-59 Months in the Diamarabougou Health Area in the Markala Health District from January to December 2018

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DOI: https://doi.org/10.36347/sasjm.2024.v10i08.014 | **Received:** 03.07.2024 | **Accepted:** 10.08.2024 | **Published:** 17.08.2024

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Abstract **Original Research Article**

***Summary*:** Following to summary an analysis of the situation of the community relays by the department (Ministry) of Health in 2008 and the holding of the national forum on the "Improving Access to Essential Care in the Community (SEC)", it has been decided in Mali to harmonize the community approaches and to put the emphasis on curative aspects (malaria, diarrhea, acute respiratory infections, etc.). The strategy aims to increase the coverage and access to curative, preventive and promotional services within the community and in households. ***Objective*:** Evaluate the implementation of the SEC strategy in the Diamarabougou health area in the Markala health district. ***Methods and Materials*:** This is a cross-sectional, quantitative and qualitative study of a descriptive type. Which took place from December 10, 2018 to January 9, 2019. the study population is made up of Community Health Agents (ASC), mothers or child caretakers, Technical Directors of the Health Center, Health Information System managers, ASC focal points and members of the Community Health Association (ASACO) of the health area. WHO three-stage cluster sampling was used to select mothers of children in the villages. ***Results*:** We found that malaria and diarrhea are the diseases best known by communities with 96.3% and 84.8% respectively. 91.6% of parents reported having sought care for their children under 5 years old in the event of illness compared to 8.4% who did not seek any care at all. Self-medication is the first recourse to care for the population of Diamarabougou in the event of illness in children aged 0-5 years with a rate of 33%. It is followed by the community center health and the ASC with 29% and 24 respectively. % of cases. 93.7% of those interviewed admitted to having had access to the services of the Community Health Agent without difficulty compared to 6.3%. Following our investigation, it appears that all the Community Health Workers interviewed are perfectly aware of the precise diagnosis of Malaria, Diarrhea and Malnutrition in accordance with their specifications. Regarding Acute Respiratory Infections (ARI), 60% manage to make the diagnosis of ARI. ***Conclusion*:** In this study, all Community Health Workers ensured the correct management of malaria, diarrhea and malnutrition. The average cost of prescriptions was appreciated by the community in addition to certain freebies in accordance with the directives of the Essential Care in the Community strategy.

Keywords: Essential Care in the community, integrated management of childhood illnesses 0-59 months.

INTRODUCTION

It is estimated that since the 1970s, the annual number of deaths of children under 5 has fallen by almost a third. But this reduction is not at all uniform and, in some countries, the infant mortality rate is currently increasing. In 1998, the infant mortality rate still exceeded 100 per 1000 live births in more than 50 countries [1]. In total, more than 10 million children die each year in developing countries before their fifth

birthday. Seven out of ten of these deaths are caused by acute respiratory infections (especially pneumonia), diarrhea, measles, malaria or malnutrition or, often, a combination of these conditions. According to projections based on a 1996 analysis entitled The Global Burden of Disease [2], these conditions will remain the leading causes of child mortality until 2020, unless significantly intensified. efforts to eliminate them. Every day, millions of parents bring their children suffering from a life-threatening illness to the hospital, clinic or first-level health center. In some countries, the five conditions listed above cause three out of four cases of childhood illness. Most sick children have signs and symptoms of more than one, making a single diagnosis difficult or impossible. Treatment is often complicated because it must combine therapies for multiple conditions.

Studies reveal that, in many cases, the child's illness(es) are not assessed and treated properly and parents are not given appropriate counseling [3].

In most developing countries, first-level health facilities have few or no diagnostic facilities such as X-ray machines and laboratories; in addition, they also often lack medicines and equipment. This fact, as well as the irregular influx of patients, hardly allows health personnel working at this level to perform complicated clinical procedures. In general, history, signs and symptoms must be relied upon to determine the most appropriate management based on available resources.

Under these conditions, it is very difficult to properly care for a sick child. To overcome these obstacles, WHO and UNICEF have developed a strategy known as “Integrated Management of Childhood Illness” (IMCI). Although the primary goal of this strategy is to help provide necessary curative care, it also addresses nutrition, immunization and other important activities to prevent disease and promote health. It aims to reduce mortality, as well as the frequency and severity of illness and disability, and to help improve growth and development [4].

In Mali, until 2009, community health actions were mainly targeted at promotion and prevention (JNV, SIAN, fight against onchocerciasis, Guinea worm and schistosomiasis, CBD).

In 2008, the Ministry of Health, with the support of its partners, set up a process of reflection through an analysis of the situation of community relays, followed in March 2009 by the holding of the national forum on "improving the “access to Essential Community Care (ECC)”.

The recommendations resulting from this forum emphasized the need to harmonize community approaches and to emphasize curative aspects (malaria, diarrhea, Acute Respiratory Infections, etc.). To do this, the problem of human resources at the household and community level had to be resolved by the establishment of a Community Health Agent in addition to the relay. This Community Health Agent will be in charge of simple curative, preventive and promotional aspects. Tools for implementing an Essential Community Care (ECC) strategy have been developed. The interventions proposed through the guide have contributed to increasing coverage and access to curative, preventive and promotional services within the community and in households [5].

Implemented in the Markala health district since 2011 and not having been the subject of any evaluation until then, the objective of this study is to evaluate the implementation of the SEC strategy in the Diamarabougou health area.

This is structured around an introduction, a problem, a methodology, results, discussions, conclusion and recommendations.

Objective: Evaluate the implementation of the SEC strategy in the Diamarabougou health area in the Markala health district.

METHOD AND MATERIEL

1. Type of study:

This is a cross-sectional, quantitative and qualitative study of a descriptive type.

Which took place from December 10, 2018 to January 9, 2019.

2. Study population:

It is made up of CHWs, mothers or caregivers, DTCs, the SIS manager, the CHW focal point and members of the ASACO in the health area.

3. Inclusion criteria:

Were included in our study:

The targets cited above who agreed to participate in the study.

4. Exclusion criteria:

Will be excluded from our study:

People not residing in the Diamarabougou health area and those in the sample who refused to answer our questionnaire.

5. Sampling method:

WHO three-stage cluster sampling was used to select mothers of children in the villages.

- First stage of sampling: selection of villages/clusters.

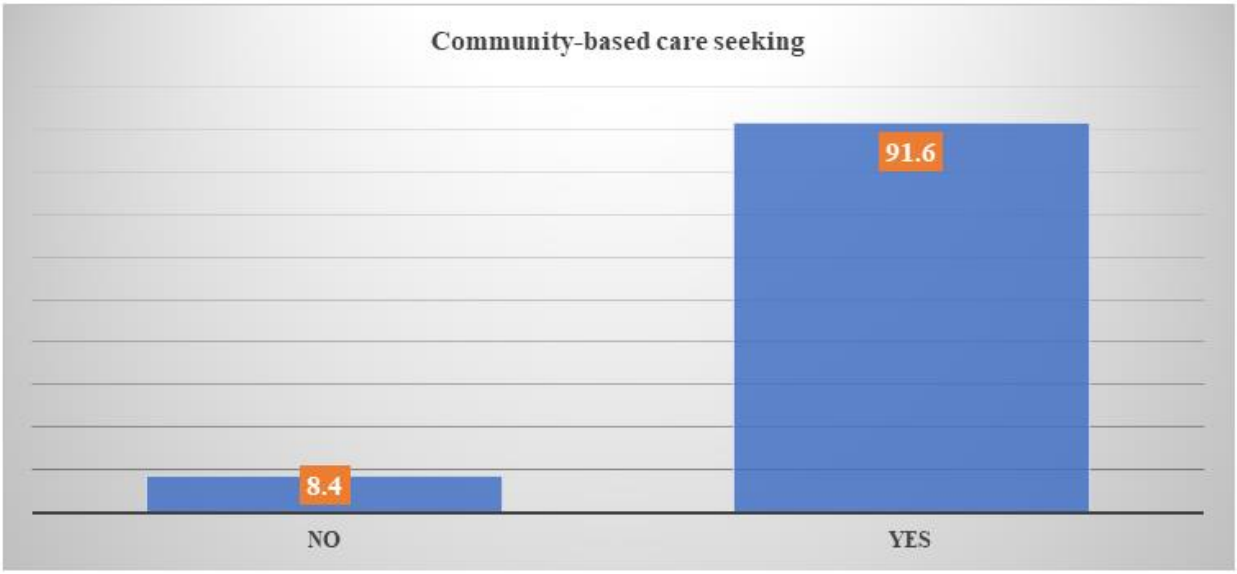
A random draw proportional to the size of the village made it possible to establish the clusters to be investigated in the health area.

The sampling frame consists of data from the 2018 health map of the Markala health district provided by the Reference Health Center. It is made up of the list of villages which are the primary units, i.e. 15 villages.

We wanted to have 30 clusters of 7 randomly proportional to the size of each village. So, we determined the sampling interval by dividing the total of the target population (=10132 which corresponds to 22% of the total population) by the number of desired clusters (=30). The calculated sampling interval is equal to 338. The first randomly drawn cluster was 85, the other 29 clusters were obtained by each time adding the sampling interval to the first cluster until the number was obtained. cluster needed per village. Of the 15 villages in the health area, the technique allowed us to exclude 4 because they did not have the necessary population to have a cluster.

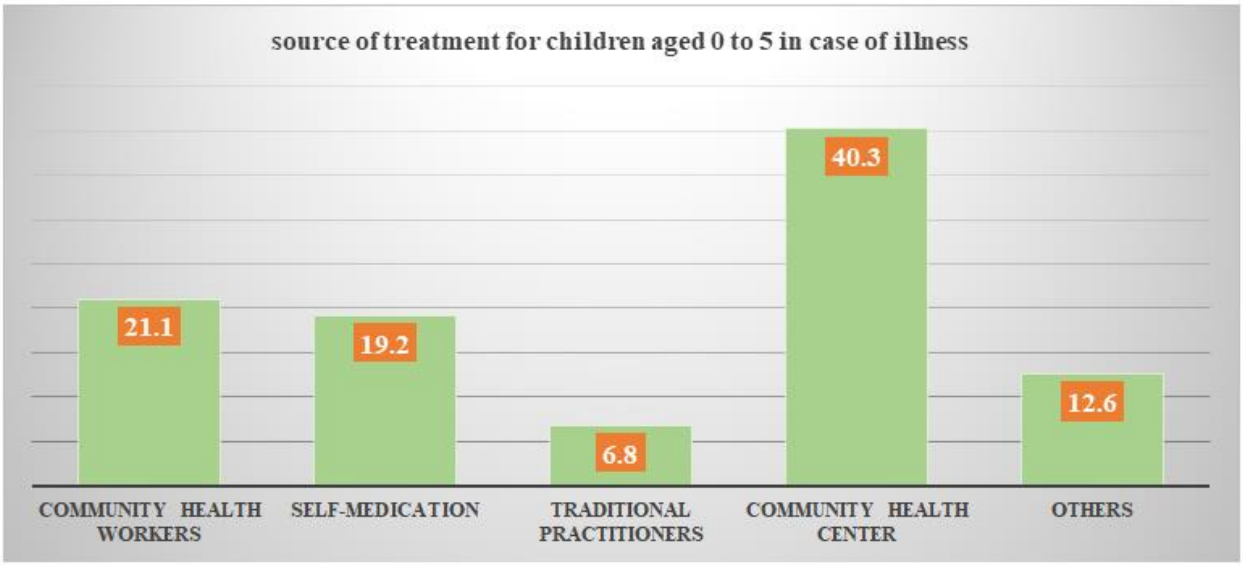
RESULT

During our survey, malaria emerged as the most common disease among children aged 0 to 5 years during the month of December 2018 with 53.9% of cases, followed by diarrhea with 31.9% of cases.



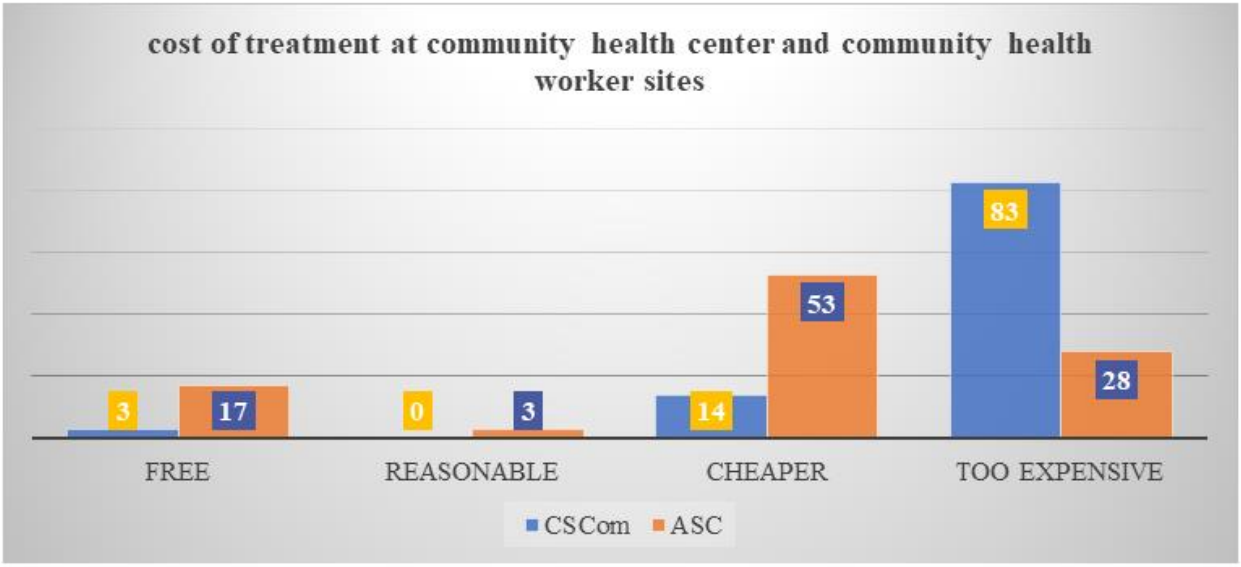
Graph I: Seeking care by the community: the following graph determines the seeking of care by the community in the event of illness of children aged 0 to 5 years

We note that 91.6% of parents reported having sought care for their children under 5 years old in the event of illness compared to 8.4% who did not seek any care at all.



Graph II: Community Treatment Source

We note that 40.3% of the population treated their children at the community health center and 21.1% treated them at a community health worker. On the other hand, 12.6% and 19.2% resorted to self-medication and traditional practitioners respectively 6,8.



Graph III: Cost of treatment

The highest treatment costs according to the community's assessment were observed at the CSCOM level with 83% of cases compared to 28% at the site level. Free treatment is much higher at the ASC site level with 17%. cases compared to 3% for the CSCOM.

On ASC sites, the majority of treatment costs are considered reasonable with 53% of cases and they are considered too expensive in 26% of cases.

DISCUSSION

Services offered by CHWs in the Diamarabougou health area:

Our study found that the services offered by CHWs were:

- The curative service which results in the management of childhood illnesses for the least complicated cases (Malaria, ARI, Malnutrition and Diarrhea) for which each of the CHWs was trained before their installation.
- Promotional and preventive by carrying out targeted or collective awareness sessions for communities on several themes, some of which are: malaria, diarrhea, ARI, malnutrition, ANC, family planning, sanitation, vaccination, etc.
- The media and inputs management service.

The same activities are recognized as part of the ASC package in the studies carried out by Drs A. SECK and DIEUDONNE in Burkina Faso in February 2011 [31] as well as by Dr Biéter DEMBELE in Kita in 2012 [32] and according to the University Research Co., LLC (URC) report.

Accessibility of populations to care from ASCs:

Before the installation of ASCs in the villages, the community of Diamarabougou had difficulties accessing care for the management of illnesses of children aged 0 to 5 years which is due to geographical accessibility in 81% of cases, the excessive cost of treatment in 11% of cases and ignorance in 6% of cases.

The installation of ASCs made it possible to cover 57.1% of the population of Diamarabougou, which also represents the population living beyond 5km from the CSCOM. We also find this at Dr A. SECK and DIEUDONNE in Burkina Faso in February 2011.

In our study, 52.9% of those interviewed knew the attributes of CSA while communities in Madagascar did not know the attributes of CSA according to the University Research Co., LLC report.

Costs of care on ASC sites:

Providing ASC sites with medicines is the responsibility of the CSCOM. Thus, certain products are sold and others are free depending on the programs. During our study, on the ASC sites, the average cost of the prescription was less than 1000 CFA francs in 52% of cases while in Burkina Faso according to the study by Dr A. SECK and DIEUDONNE, the coverage of all IMCI diseases are free on SEC sites.

Curative activities of SEC sites:

In our study, all CHWs received initial training before their installation and this is also reflected in the University Research Co., LLC (URC) report in April 2013 in Madagascar.

During our study, 50% of ASCs had medication shortages, which was also reflected in the University Research Co., LLC (URC) report according to which the majority of ASCs had medication shortages.

The number of cases of illnesses treated by ASCs changed significantly from 2016 to 2018, going from:

79% to 87% for malaria,
61% to 82% for diarrhea,
53% to 66% for IRAs,
41 to 54% for MAMs.

In addition, a drop in incidents of Malaria, Diarrhea, ARI and Pneumonia was noted over the same period. This trend is also noticed at Dr Biéter DEMBELE in Kita in 2012.

The people surveyed judge the quality of the service provided by the ASC "Good" in 52.4% of cases, 44.5% find it "acceptable".

Sixty percent (60%) of ASC sites had an average monthly consultation of (20 to 28) higher than the national average (20).

Community knowledge of IMCI diseases:

The signs of malaria, diarrhea and pneumonia are known by the communities with respectively 96.3%, 84.8% and 71.2% of those interviewed while they were respectively 70%, 80% and 90% at Dr Biéter DEMBELE in Kita in 2012. On the other hand, our study revealed that malnutrition was the disease least known by the communities in 72.3% of cases while it was known by 69.20% of the communities at M. AG in 2017.

Preventive activities on ASC sites:

In terms of awareness, it emerged in our study that the population receives more messages through the ASCs than at the CSCOM.

Supervision of ASCs:

Our study showed that all the ASCs received a supervision visit from the CSCOM, 40% of the ASCs received a visit from the district and 60% received from the region of the region while the absence of supervision was notorious (only supervision in one year) among CHWs in Madagascar according to the University Research Co., LLC (URC) report.

CONCLUSION

This study made it possible to understand the implementation of the strategy, particularly the strengths and areas for improvement. More than half of the people surveyed reside in an area covered by a Community Health Agent. This need for geographical access to care was felt by the majority of communities before the installation of Community Health Workers.

All ASCs ensured the correct management of malaria, diarrhea and malnutrition. The average cost of prescriptions was appreciated by the community in addition to some freebies in accordance with the SEC strategy guidelines.

Properly supplying Essential Care sites in the Community with inputs and support constitutes the challenge facing the Community Health Association and the Markala health district.

At the end of this study, the implementation of Essential Care in the Community in the Diamarabougou area contributed to the improvement of health indicators.

Acknowledgments: We thank all the staff of the Diamarabougou community health center, especially its first manager.

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