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Sources for Sick Child Care in 24 USAID Priority Countries

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Understanding if and where sick children are taken for care is critical to enhance interventions for treating childhood illnesses and improving child survival. Both the public and private sectors are important sources of care for sick children, and their role varies across contexts and socioeconomic statuses. This brief uses the most recent Demographic and Health Survey data from 24 of the 25 USAID maternal and child survival priority countries to examine where treatment or advice is sought for sick children who experienced at least one of three treatable illnesses that are leading causes of death in children under five: fever, acute respiratory infection, or diarrhea.

Key Findings

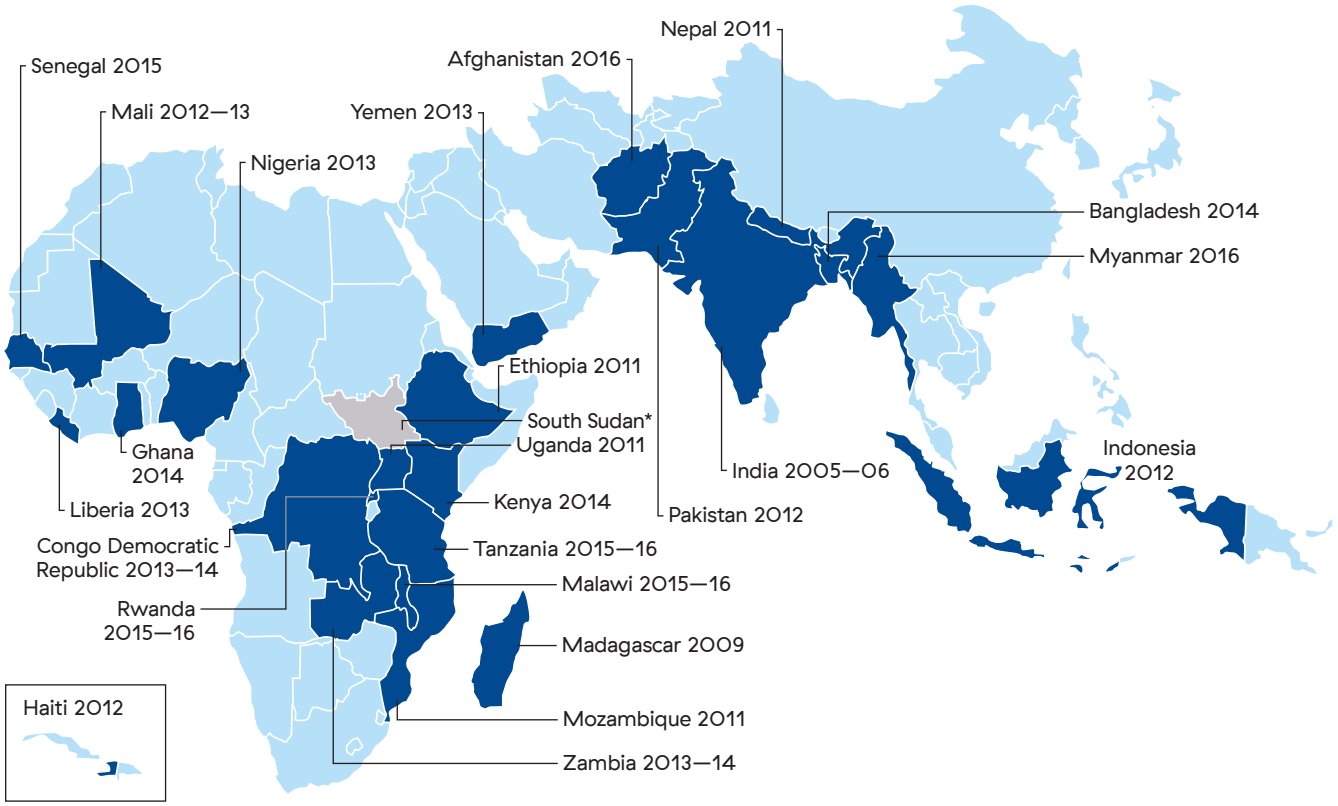
The following findings reflect averages across the 24 maternal and child survival priority countries analyzed.

- **Treatable childhood illnesses are common in USAID priority countries.** One in three children experienced a treatable illness in the past two weeks.
- **Care-seeking rates outside the home are similar for fever, acute respiratory infection, and diarrhea.** Two in three caregivers seek care outside the home for their sick children.
- **Both the public and private sectors are important sources of sick child care.** When caregivers seek sick child care, 50 percent go to the public sector and 43 percent to the private sector.
- **The private sector serves the poor as well as the wealthy.** Two in five caregivers from the poorest households and three in five caregivers from the wealthiest households rely on the private sector for sick child care.
- **96% of public sector care seekers seek care from a clinical facility**, not from a community health worker.

The first Child Survival Call to Action in 2012 challenged the global community to end preventable child deaths by 2035. To act on this call, USAID undertook a series of strategic programming shifts to further accelerate efforts to prevent child and maternal deaths in 25 priority countries with the highest mortality burden (Figure 1). Within these countries, USAID has contributed to meaningful reductions in deaths by supporting interventions focused on newborn health; immunization; prevention and treatment of childhood illness including malnutrition; water, sanitation, and hygiene; and expanding access to life-saving family planning and maternal and child health commodities.

To build on these successes, USAID will need to facilitate further reductions in child deaths from malaria, pneumonia, and diarrhea. These three illnesses remain the leading causes of death of children under five in maternal and child survival priority countries ("USAID priority countries"). Scaling up preventive interventions and improving integrated case management of childhood illnesses are two strategies that are critical to lessen the burden of these illnesses. To support ongoing efforts to implement and improve these strategies, USAID and implementing partners must understand whether and where sick children are being taken for care outside the home and how care-seeking patterns vary by socioeconomic status.

Figure 1. USAID priority countries analyzed using Demographic and Health Survey data



*No DHS data are available for South Sudan.

Methods

In response to this need, SHOPS Plus analyzed the most recent Demographic and Health Survey (DHS) data available from 24 of the 25 USAID priority countries to examine care-seeking patterns for children who had recently experienced three common childhood illnesses—fever, symptoms of acute respiratory infection (ARI), or diarrhea.[1] The analysis focused on sources of care *outside* the home, not whether the child received an appropriate treatment for his or her illness.[2] To explore equity implications, the analysis also examined how care-seeking patterns differed by household socioeconomic status.[3]

This brief presents high-level results from the analysis. In some cases, it presents regional averages to summarize patterns observed in the data. To produce regional averages, all countries were weighted equally. The regions presented in this brief are Asia, East and Southern Africa, and West and Central Africa. Results for specific USAID priority countries are presented in separate, country-specific briefs, available at SHOPSPlusProject.org.

Findings

Illness prevalence

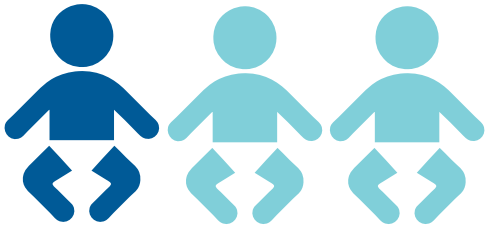
Fever, ARI, and diarrhea remain extremely common childhood illnesses across the USAID priority countries. The USAID priority countries in Asia have the highest average reported incidence of any of the three illnesses (35 percent). Across countries in East and Southern Africa, the average prevalence of the three illnesses is 31 percent. Countries in West and Central Africa have the lowest average prevalence at 27 percent.

Although the rates of illness range widely by country, the prevalence patterns for specific illnesses are the same across all regions. The illness with the highest reported rate of prevalence is fever, followed by diarrhea, and ARI is the least common of these three illnesses (Figure 2).

On average across the 24 priority countries,

1 out of 3 children

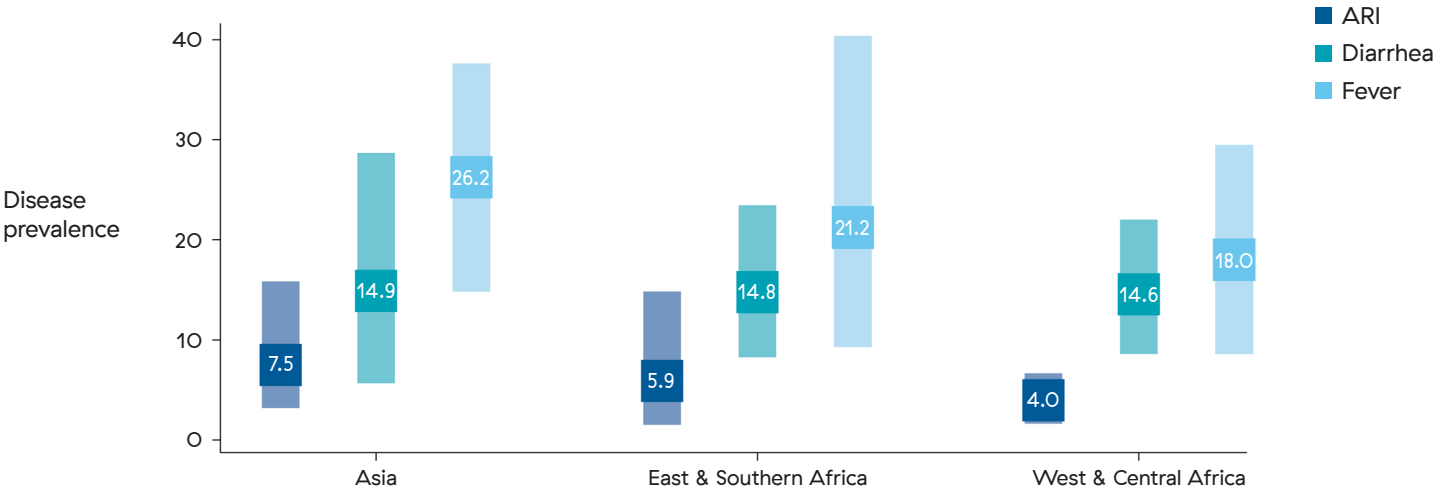
experienced a treatable illness in the last 2 weeks.



Children are sometimes sick with more than one disease at the same time. Clinically, this suggests it is important for health workers to make assessments across illnesses at each sick child visit.

Figure 2. Prevalence of acute respiratory infection, diarrhea, and fever by region (%)

The range of prevalence is indicated by the bars. The mean is noted in each square.



Out-of-home care seeking

On average across USAID priority countries, caregivers seek treatment outside the home for 67 percent of children with fever, 69 percent of children with ARI, and 63 percent of children with diarrhea. Care seeking for any illness was 67 percent. Care-seeking rates are fairly similar for the three illnesses, with slightly lower rates of out-of-home care-seeking for diarrhea that may be partially driven by the fact that this illness can be effectively managed with pre-purchased oral rehydration salts. Overall, there is not a strong association between care seeking rates and illness prevalence.

Although levels of out-of-home care seeking are similar across illnesses, the levels vary widely across countries. As depicted in Figure 3, compared with other countries, Indonesia, Uganda, Bangladesh, and Pakistan have particularly high care-seeking rates (80 percent or more), while in Ethiopia, Madagascar, and Haiti, less than half of caregivers seek treatment outside the home.

Sources of care

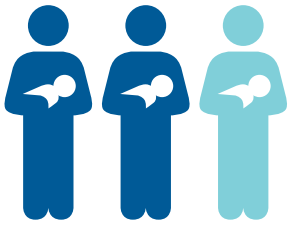
Across USAID priority countries, half of caregivers who seek out-of-home care go to a public source of care; 43 percent seek care from a private source, and 6 percent seek care from other sources (see categories on page 6). Other sources are informal providers and include traditional healers, friends, and family members. It is extremely uncommon for caregivers to seek care from both sectors; in cases where children were reported to have experienced more than one type of illness, 1 percent of caregivers sought care from both public and private sector sources.

On average across the 24 priority countries,

2 out of 3 caregivers

seek out-of-home care

for their sick children.



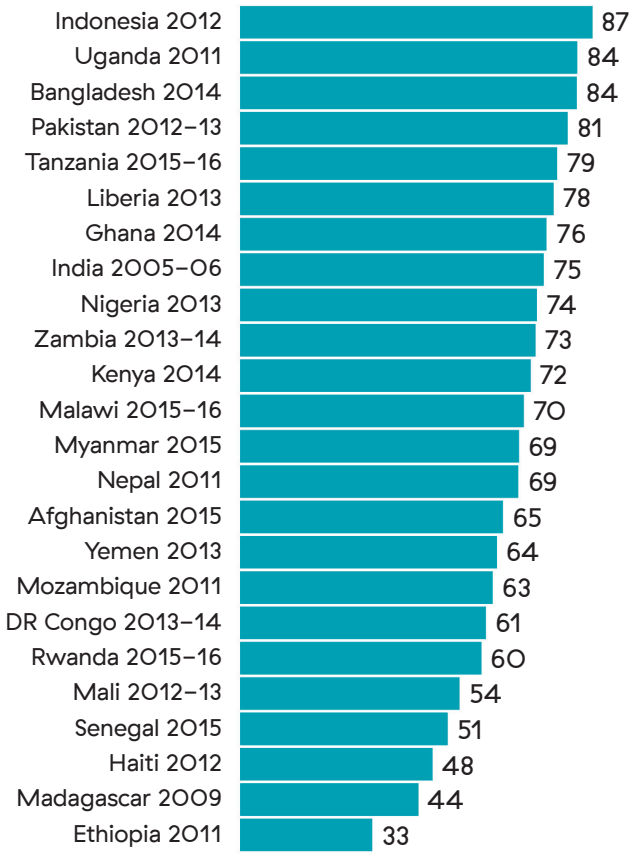
The rate of out-of-home care seeking is similar for each illness.

69%
Acute respiratory infection

67%
Fever

63%
Diarrhea

Figure 3. Out-of-home care seeking by country (%)



In examining care-seeking sources across illness types, the data indicate that caregivers go to the same sources of care no matter which type of illness their child experiences (Figure 4).

When examined at the regional level, however, care-seeking patterns across the private and public sectors vary substantially. Caregivers in East and Southern African countries are much more likely to seek care from a public sector source, while the opposite is true in Asia. In West and Central African countries, there is a more even split between care seeking in the public and private sectors. Although relatively few caregivers in any region seek care from other sources, there are notable exceptions: in Bangladesh, the rate of care seeking from other sources is 31 percent (predominantly "unqualified doctors"), while in Mali it is 21 percent (mostly "traditional practitioners").

On average across the 24 priority countries and among all caregivers who seek sick child care outside the home, 50% seek treatment or advice from public sector sources and 43% from private sector sources.

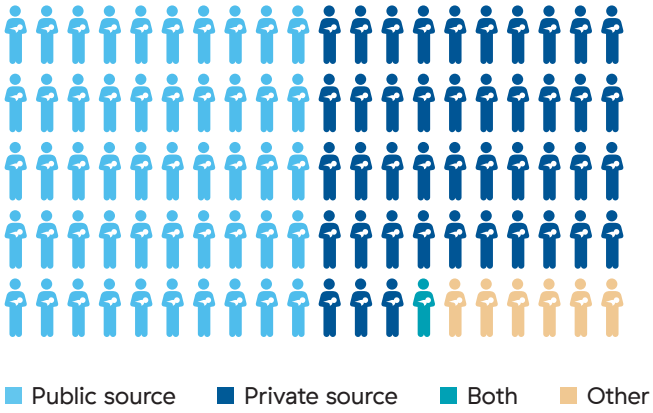
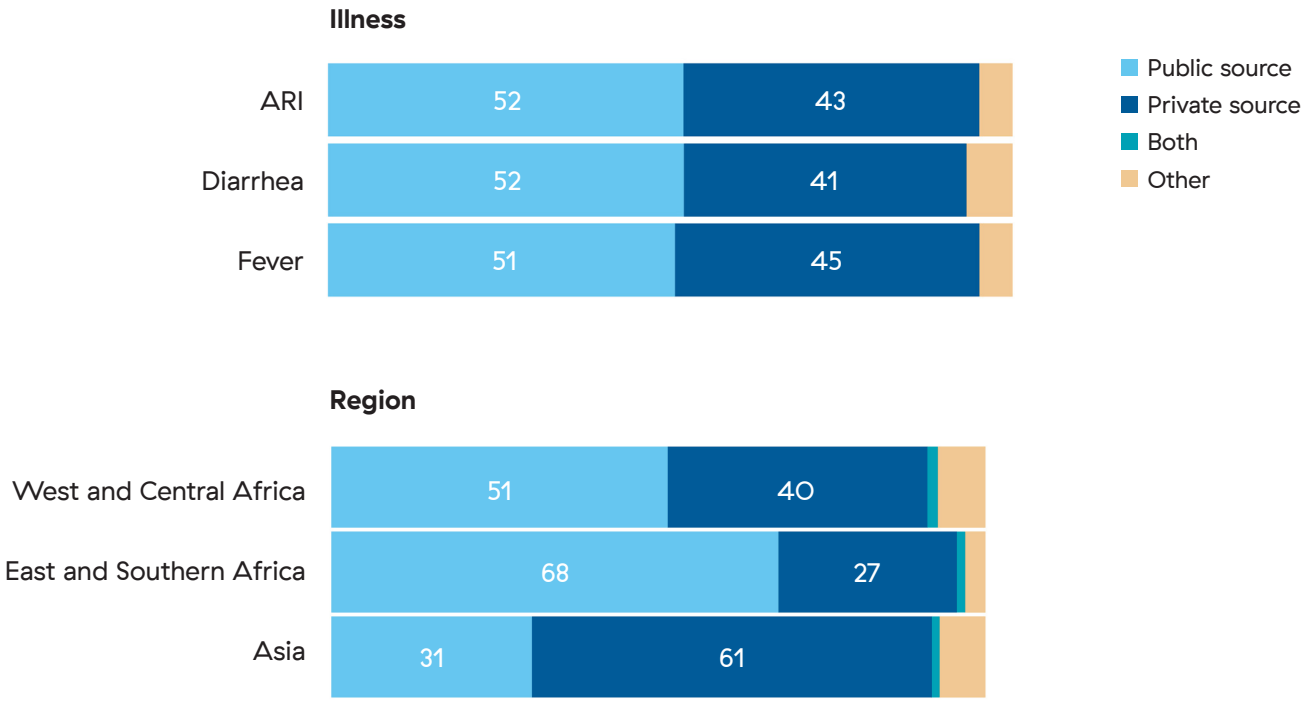


Figure 4. Sources of care vary by region, not illness (%)



Provider type within each health sector

As shown in the following table, both the private and public health sectors offer several types of providers to which caregivers can go for treatment or advice. In this analysis, SHOPS Plus researchers divided public sources into two broad types: public clinical facilities (such as hospitals, clinics, and health posts) and community health workers. Private sector destinations include private clinics and hospitals and those run by nongovernmental and faith-based organizations, as well as non-clinical sources such as pharmacies, shops, and markets. As Figure 5 shows, among caregivers who use the public sector, 96 percent seek care in a clinical facility rather than from a community health worker. In contrast, the breakdown among caregivers who use the private sector is even: half use clinical facilities and half rely on non-clinical sources. However, in USAID priority countries in West and Central Africa, 80 percent of private sector treatment and advice is sought from non-clinical sources.

Sources of care categories

Public sector	Private sector	Other
• Hospitals • Clinics • Health posts • Community health workers	• Private clinics, hospitals, and doctors • Nongovernmental and faith–based organizations • Pharmacies, shops, and markets	• Traditional healers • Friends or family members

Figure 5. Most public sector clients go to clinical sources

Public sector:

Clinical

96%

Almost all public sector care seekers go to a public clinical facility such as a hospital, clinic, or health post.

Non–clinical

4%

Few public sector care seekers get treatment or advice from a community health worker.

Private sector:

Clinical

50%

About half of private sector care seekers go to a private clinical facility such as a hospital, doctor's office, or clinic.

Non–clinical

50%

About half of private sector care seekers go to a non–clinical source such as a pharmacy, shop, or market.

Equity in care seeking

Across USAID priority countries, the prevalence of fever, ARI, and diarrhea tends to decrease as household wealth increases. While this is not a surprising pattern, the magnitude of the difference in illness prevalence between the rich and poor in USAID priority countries is relatively modest. Overall, the average difference between the wealth quintiles in each country with the highest and lowest illness prevalence is 5 percent in Asia and East and Southern Africa and 4 percent in West and Central Africa. These common childhood illnesses affect rich and poor alike.

The socioeconomic disparities in care seeking, however, exceed the disparities in illness prevalence. Overall, caregivers in the poorest quintile in each country are less likely to seek out-of-home care than caregivers in the wealthiest quintile, and this pattern holds regardless of the illness examined. Country-level differences in care seeking for wealthy and poor children vary considerably, as depicted in Figure 6. The graph compares country-level differences in out-of-home care seeking between the lowest and highest wealth quintiles; a longer bar indicates a greater degree of disparity between the poorest and wealthiest, and a shorter bar indicates a more equitable level of care seeking. Ethiopia, Madagascar, Haiti, Rwanda, and Nepal have the largest disparities—the gap in out-of-home care-seeking rates between rich and poor in these countries exceeds 20 percent. On the other end of the spectrum, there are several countries with much more equitable rates of care seeking: Liberia, Bangladesh, Nigeria, Uganda, Zambia, Kenya, Ghana, and Malawi all have disparities of less than 5 percent. Small socioeconomic disparities in care seeking do not necessarily mean that care seeking is sufficiently high. Countries with more equitable care seeking may still need to improve their overall care-seeking rates.

Figure 6. Care-seeking wealth disparities across USAID priority countries

Figure 7. Sources of care for treatment or advice sought by the poorest and wealthiest caregivers by region

Asia

Private sector use is high. On average across countries in the region, 74% of caregivers from the wealthiest quintile in each country and 52% from the poorest quintile in each country use the private sector.

More than 1/4 of the poorest households rely on the private sector for sick child care in Afghanistan, Myanmar, Nepal, and Bangladesh.

More than 1/2 of the poorest households rely on the private sector for sick child care in India, Indonesia, and Pakistan.

West and Central Africa

Care seeking is mixed between the public and private sectors. On average across countries in the region, 52% of caregivers from the wealthiest quintile in each country and 36% from the poorest quintile in each country use the private sector.

More than 1/2 of the poorest households rely on the public sector for sick child care in DR Congo, Ghana, Liberia, Mali, and Senegal.

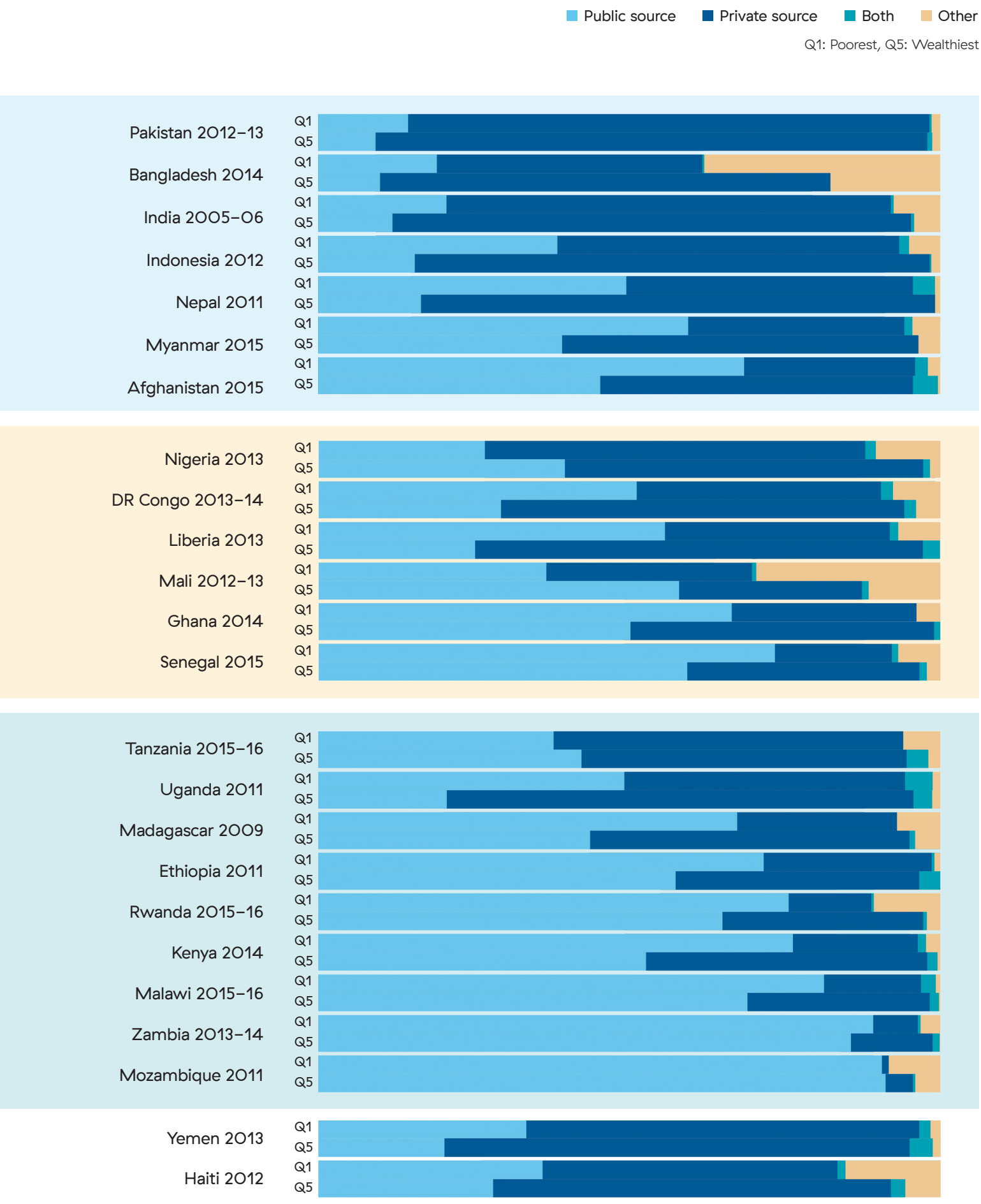
Nearly 2/3 of the poorest households in Nigeria rely on the private sector for sick child care.

East and Southern Africa

The public sector is dominant, with few exceptions. On average, 38% of caregivers from the wealthiest quintile in each country and 23% from the poorest quintile in each country use private sector sources.

More than 3/4 of the poorest households rely on the public sector for sick child care in Kenya, Malawi, Mozambique, Rwanda, and Zambia.

In Ethiopia, Madagascar, Tanzania, and Uganda, the private sector serves 1/4 or more of the poorest households for sick child care.


Public source
Private source
Both
Other
Q1: Poorest, Q5: Wealthiest
Pakistan 2012–13
Bangladesh 2014
India 2005–06
Indonesia 2012
Nepal 2011
Myanmar 2015
Afghanistan 2015
Nigeria 2013
DR Congo 2013–14
Liberia 2013
Mali 2012–13
Ghana 2014
Senegal 2015
Tanzania 2015–16
Uganda 2011
Madagascar 2009
Ethiopia 2011
Rwanda 2015–16
Kenya 2014
Malawi 2015–16
Zambia 2013–14
Mozambique 2011
Yemen 2013
Haiti 2012
Q1
Q5

Equity in sources of care

To assess variations in sources of care by wealth quintile, SHOPS Plus researchers examined care-seeking rates for sick children for any illness in the poorest and wealthiest quintiles in each of the 24 USAID priority countries in the study. The rates show that caregivers in the poorest quintile in each country are generally more likely than those in the wealthiest quintile to seek care in the public sector. They are also more likely to seek care from other (not public or private sector) sources. Nevertheless, the data show that the private sector does not exclusively serve the wealthy and vice versa. As Figure 7 showed, substantial proportions of caregivers from the lowest wealth quintile seek care from the private sector.

Globally, the private sector serves the poor as well as the wealthy. Two out of five caregivers from the poorest households and three out of five caregivers from the wealthiest households rely on the private sector for sick child care.

In Asia, the USAID priority countries with the highest rates of dependence on the public sector are Afghanistan and Myanmar. Conversely, in Indonesia, India, and Pakistan, the majority of the poorest caregivers depend on private sector sources of treatment and advice. Bangladesh is an outlier because it has notable rates of care seeking from other informal sources of care, which includes untrained providers.

In West and Central Africa, the private sector is a source of treatment and advice for at least one-third of the poorest sick children in all of the USAID priority countries. Mali and Nigeria stand out because care-seeking patterns observed elsewhere are reversed: in the two countries, the wealthiest are more likely to seek care from the public sector than the poorest and vice versa.

The public sector is a major source of treatment and advice for sick children from East and Southern African USAID priority countries. It is a particularly prominent source for the poorest caregivers. There are only two countries (Uganda and Tanzania) in which less than two-thirds of caregivers seek treatment or advice from somewhere other than a public source. Even among the wealthy, the public sector dominates; only Madagascar, Tanzania, and Uganda have a majority of wealthy caregivers who seek care in the private sector.

Conclusion

Fever, ARI, and diarrhea remain extremely common childhood illnesses across USAID priority countries. On average across the countries studied, two-thirds of caregivers seek treatment or advice for their sick children. Among those who seek outside care, approximately one-half of caregivers use public sources of care, just under one-half seek care from the private sector, and the rest go to traditional sources. Among those who seek care from the private sector, private pharmacies, markets, and shops are commonly reported as sources for treatment. Although wealthy caregivers are more likely to seek care in the private sector, the sector does not only serve the wealthy. On average across USAID priority countries, 37 percent of caregivers from the poorest quintile in each country seek care from private sector sources. Care-seeking patterns vary across countries and regions, which is unsurprising given that care seeking is influenced by a multitude of factors including policy, socioeconomic status, cultural considerations, seasonality, and health system functioning. However, care-seeking patterns are similar across illness type and support the use of integrated case management approaches to achieve maternal and child survival goals.

Both the public and private sectors are important sources of care for sick children, and their role varies across contexts and socioeconomic statuses. Stakeholders should understand care-seeking patterns in their countries to ensure resources are effectively programmed to improve child survival.

Jessica Scrantpn

Endnotes

[1] All DHS data used in this analysis are reported by mothers who were asked if their children under age five experienced fever, ARI, or diarrhea in the two weeks before the interview. DHS data do not report whether children recently had malaria or pneumonia because both of these illnesses must be confirmed in a laboratory. Instead, the DHS reports whether or not children had recent fever as a non-specific proxy for malaria or symptoms of ARI as a non-specific proxy for pneumonia. ARI is defined as a reported cough with chest-related rapid or difficult breathing.

[2] Mothers whose children were ill in the past two weeks were asked if they sought advice or treatment from any source. If yes, they were asked where they sought care or treatment.

[3] The analysis builds on the following:

Hodgins, S., T. Pullum, and L. Dougherty. 2013. "Understanding Where Parents Take Their Sick Children and Why It Matters: A Multi-Country Analysis." *Global Health: Science and Practice* 1 (3): 328–356.

Montagu, D. and A. Visconti. "Health Care Utilization around the World." Unpublished slides.

Winter, R., W. Wang, L. Florey, and T. Pullum. 2015. *Levels and Trends in Care Seeking for Childhood Illness in USAID MCH Priority Countries*. DHS Comparative Reports 38. Rockville, MD: ICF International.

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