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Sources for Sick Child Care in Madagascar

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The public sector is the primary source of care in Madagascar; however, care-seeking patterns vary by socioeconomic status. Understanding if and where sick children are taken for care is critical to improve case management interventions. This brief presents a secondary analysis of the 2009 Madagascar Demographic and Health Survey to examine where treatment or advice is sought for sick children who experienced at least one of three treatable illnesses: fever, acute respiratory infection, or diarrhea. These illnesses represent some of the leading causes of death in children under five years old.

Key Findings

- Less than half (44%) of Malagasy caregivers seek treatment or advice outside the home for their sick children, across all three illnesses.
- Care seeking is higher among the wealthiest caregivers in Madagascar (62%) compared to the poorest caregivers (38%).
- Among caregivers who seek sick child care, 62% seek care from public sector sources and 32% use private sector sources.
- This pattern varies by socioeconomic status: 51% of caregivers in the wealthiest quintile seek private sector care compared to 26% of caregivers in the poorest quintile.
- Madagascar's low care-seeking level and large socioeconomic differences should be taken into account when designing programs to improve child survival.

This is one in a series of briefs that examines care seeking in USAID maternal and child survival priority countries.

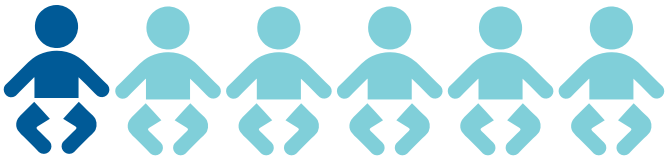
Illness prevalence

According to mothers interviewed across the country for the Madagascar Demographic and Health Survey, 16 percent of Malagasy children under five experienced one or more of the following illnesses: fever (9 percent), symptoms of acute respiratory infection (ARI)—a proxy for pneumonia—(3 percent), and/or diarrhea (8 percent) in the two weeks prior to the survey.[1]

Out-of-home care seeking

When children fall ill, less than half of caregivers in Madagascar (44 percent) seek advice or treatment outside the home.[2] For children with ARI symptoms or fever, care-seeking levels are slightly higher (49 and 47 percent, respectively). Comparatively, the level is slightly lower for diarrhea (41 percent), possibly because the illness can often be effectively managed at home. The overall level of care seeking in Madagascar is much lower than the average level (64 percent) across East and Southern African maternal and child survival priority countries ("USAID priority countries").[3] The prevalence of the three chilldhood illnesses in Madagascar (16 percent) is lower than the average regional prevalence (30 percent), which may contribute to the country's low care-seeking level.

1 out of 6 children in Madagascar experienced fever, ARI symptoms, or diarrhea in the last 2 weeks.

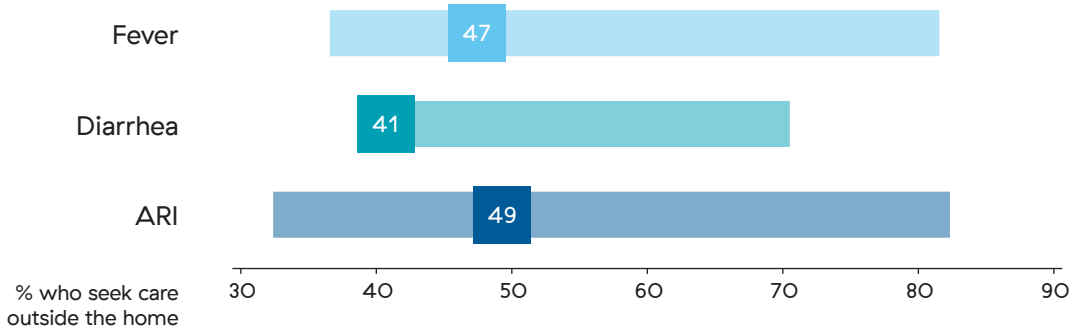


Sources of care

The public sector is the primary source of sick child care in Madagascar. Among caregivers who seek treatment or advice outside of their homes, nearly two-thirds (62 percent) use public sector sources and about one-third (32 percent) uses private sector sources. Very few caregivers (1 percent) seek care from both the public and private sectors. Five percent seek treatment from other sources of care, typically a traditional practitioner. Caregivers use other sources of care for diarrhea treatment (9 percent) more than they do for fever or ARI treatment (2 percent). Almost all public sector (99 percent) and most private sector (76 percent) care seekers visit a clinical facility such as a hospital or a clinic, rather than seeking care from a community health worker, pharmacy, or shop. This analysis shows where caregivers go for treatment, regardless of their level of access to different sources of care. It does not reflect where caregivers might choose to go if they had access to all sources of care.

Figure 1. Care-seeking levels in Madagascar are fairly low compared to other countries in the region

The bars indicate the care-seeking range in the region. Squares show the care-seeking rates in Madagascar.

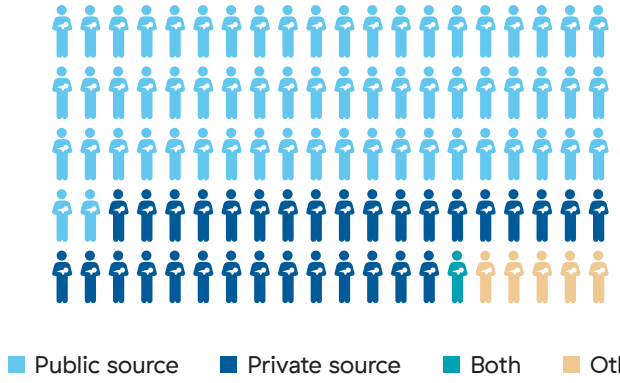


[1] All Demographic and Health Survey data used in this analysis are reported by mothers who were asked if their children under age five experienced fever, ARI symptoms, or diarrhea in the two weeks before the interview. These data do not report whether children recently had pneumonia or malaria because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

[2] In this analysis, out-of-home sources of care comprise public sources (hospitals, health centers, health posts, mobile clinics, and community health workers), private sources (clinics, hospitals, doctors, health centers, and mobile clinics; nongovernmental organizations; and pharmacies, shops, and kiosks), and other sources (traditional practitioners). This brief focuses on sources of care *outside* the home, not whether or not the child received proper care, which could include at-home use of oral rehydration salts for diarrhea.

[3] The USAID priority countries in East and Southern Africa are Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Tanzania, Uganda, and Zambia.

Among caregivers who seek sick child care outside the home, 62% seek treatment or advice from public sector sources and 32% from private sector sources.



Equity in illness prevalence and care seeking

In Madagascar, the burden of fever, ARI symptoms, and/or diarrhea is similar in the poorest and wealthiest households (15 percent and 20 percent, respectively). However, poorer children in Madagascar who experience one of these illnesses are much less likely to receive treatment than their wealthier peers (38 percent versus 62 percent, respectively). The magnitude of the care-seeking disparity between the poorest and wealthiest quintiles in Madagascar is larger than in most other USAID priority countries in East and Southern Africa.

Figure 2. Madagascar has a large socioeconomic disparity in care-seeking levels

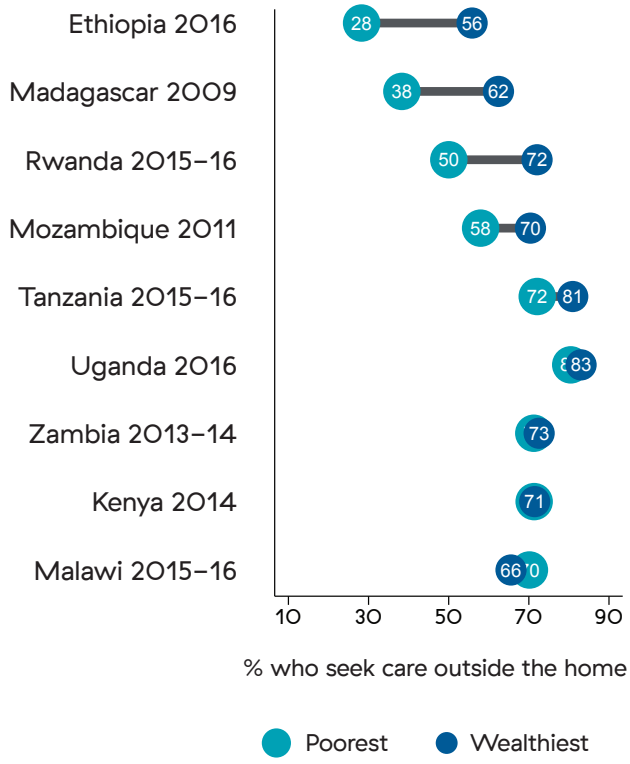
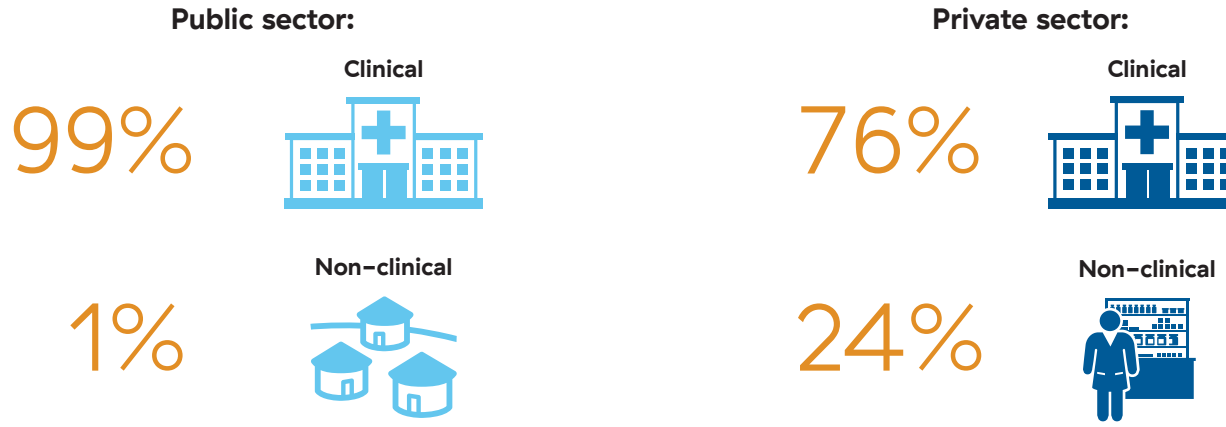


Figure 3. Almost all public sector clients and most private sector clients use clinical sources

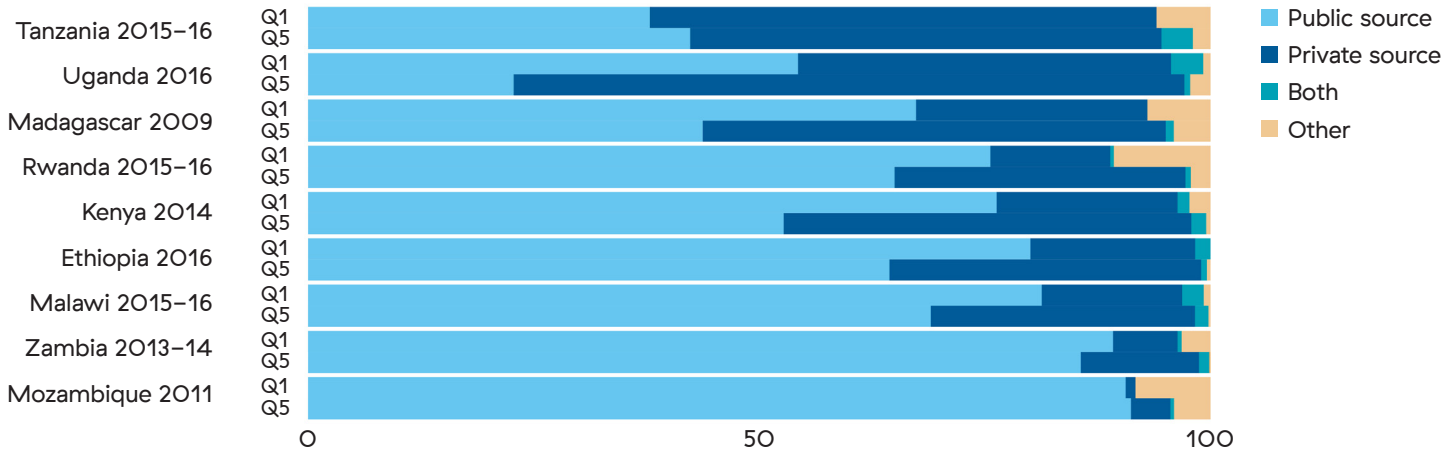


Sources of care categories

Public sector: Hospitals, health centers, health posts, mobile clinics, and community health workers
Private sector: Clinics, hospitals, doctors, health centers, and mobile clinics; nongovernmental organizations; pharmacies, shops, and kiosks
Other: Traditional practitioners

The majority of care outside the home for sick children is accessed from the public sector. This pattern varies by socioeconomic status: about one-half (51 percent) of caregivers in the wealthiest quintile seek private sector care compared to about one-fourth (26 percent) of caregivers in the poorest quintile. Likewise, the poorest caregivers are more likely to use the public sector than the wealthiest caregivers (67 percent versus 44 percent, respectively). Compared to most other East and Southern African USAID priority countries, the wealthiest caregivers in Madagascar are more likely to seek care in the private sector.

Figure 4. Care-seeking sources vary substantially across wealth quintiles in Madagascar



Q1: Poorest, Q5: Wealthiest

Conclusion

Fever, ARI, and diarrhea are common illnesses in Madagascar, affecting 1 out of every 6 children. However, care seeking outside the home is uncommon. Caregivers from the poorest households are far less likely to seek care outside the home than those from the wealthiest households. The public sector is the primary source of out-of-home treatment or advice for sick children. However, use of the private sector for childhood diseases increases with wealth; the level of private sector care seeking among the wealthiest Malagasies is nearly double the level of private sector care seeking among the poorest. The majority of public and private sector care seekers use clinical sources of care. Madagascar's low care-seeking level and large socioeconomic differences should be taken into account when designing programs to improve child survival.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

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July 2018