

## Sources for Sick Child Care in 24 USAID Priority Countries



Both the public and private sectors are important sources of care for sick children, and their role varies across contexts and socioeconomic statuses. Understanding if and where sick children are taken for care is critical to improve case management interventions. This brief presents a secondary analysis of 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: fever, acute respiratory infection, or diarrhea. These illnesses represent some of the leading causes of death in children under five years old.

### Key Findings

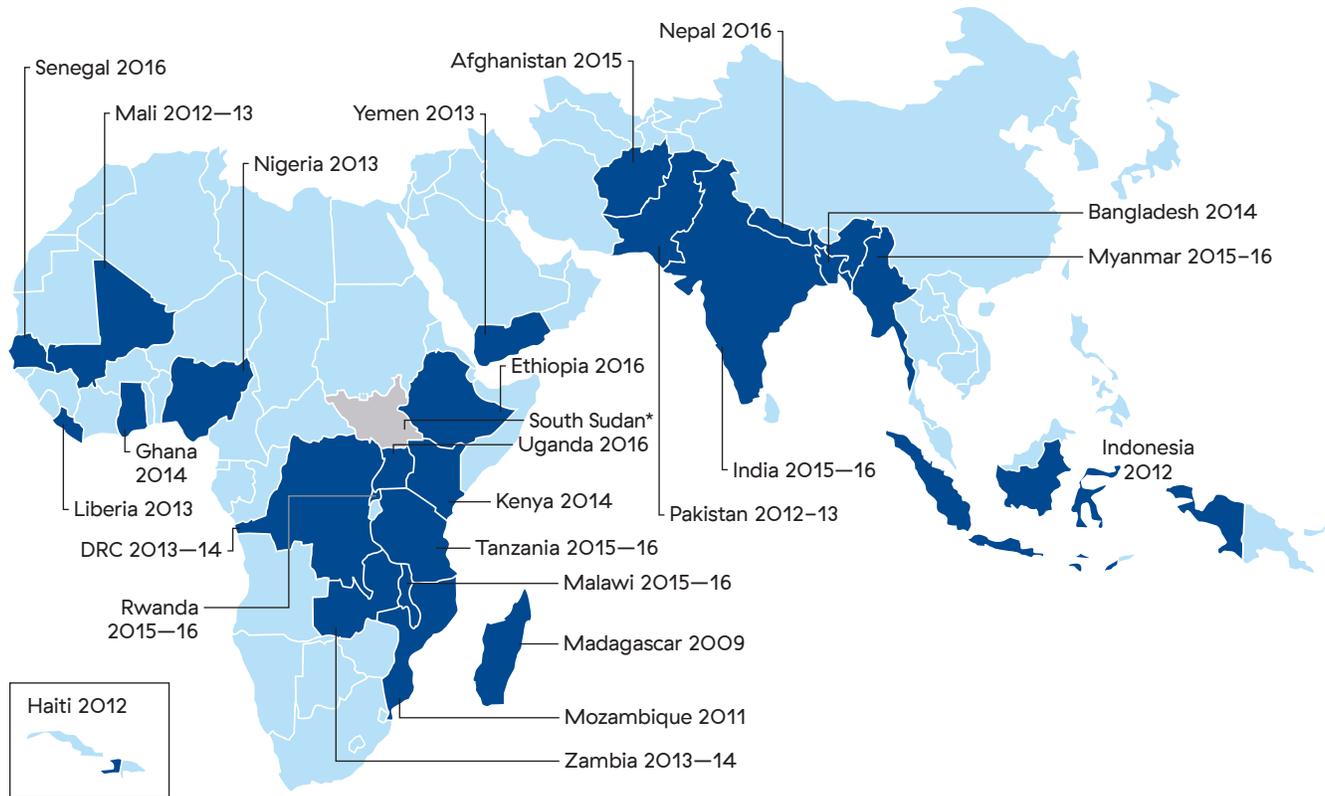
The following findings reflect averages across the 24 maternal and child survival priority countries analyzed.

- **Treatable childhood illnesses are common in USAID priority countries.** One in three children experienced a treatable illness in the past two weeks.
- **Care-seeking levels 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% go to the public sector and 43% to the private sector.
- **The private sector serves the poor as well as the wealthy.** Approximately two in five caregivers from the poorest households and approximately three in five caregivers from the wealthiest households rely on the private sector for sick child care.
- **97% 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.<sup>1</sup> The analysis focused on sources of care *outside* the home, not whether the child received an appropriate treatment for his or her illness.<sup>2</sup> To explore equity implications, the analysis also examined how care-seeking patterns differed by household socioeconomic status.<sup>3</sup>

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](http://SHOPSPlusProject.org).

## Findings

### Illness prevalence

Fever, ARI, and diarrhea remain extremely common childhood illnesses across the USAID priority countries (32 percent). The USAID priority countries in Asia have the highest average reported incidence of any of the three illnesses (34 percent). Across countries in East and Southern Africa, the average prevalence of the three illnesses is 30 percent. Countries in West and Central Africa have the lowest average prevalence at 27 percent.

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

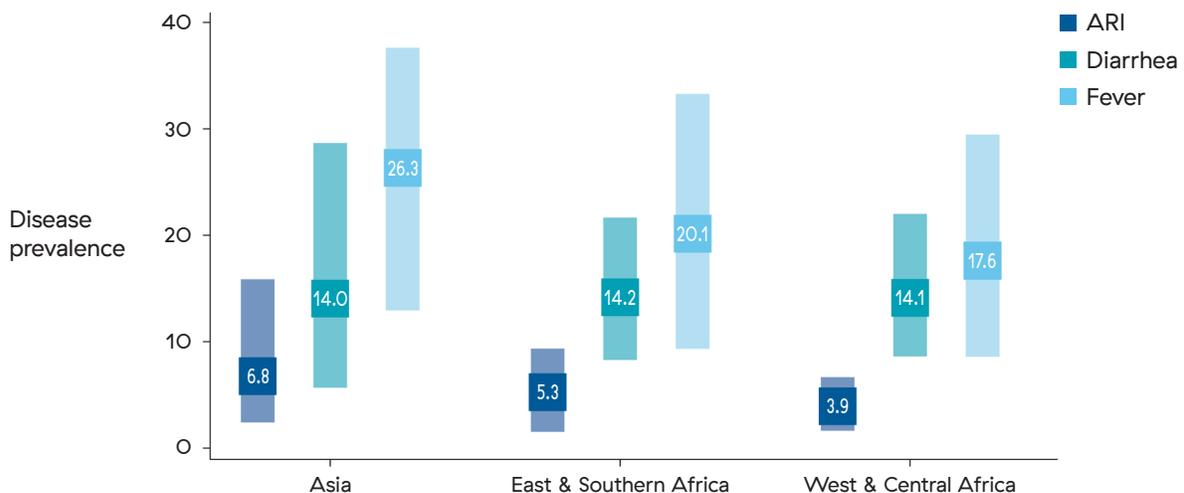
On average across the 24 priority countries,  
**1 out of 3 children**  
experienced a treatable illness  
in the last 2 weeks.



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 68 percent of children with fever, 70 percent of children with ARI, and 64 percent of children with diarrhea. Care seeking for any illness is 68 percent. Care-seeking levels are fairly similar for the three illnesses, with slightly lower levels 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 levels 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, Bangladesh, Pakistan, India, and Uganda have particularly high care-seeking levels (80 percent or more), while in Ethiopia, Madagascar, and Haiti, less than half of caregivers seek treatment outside the home.

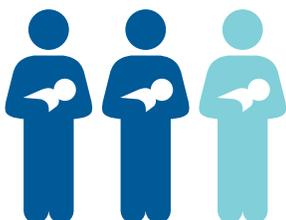
## Sources of care

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



**70%**  
Acute  
respiratory  
infection

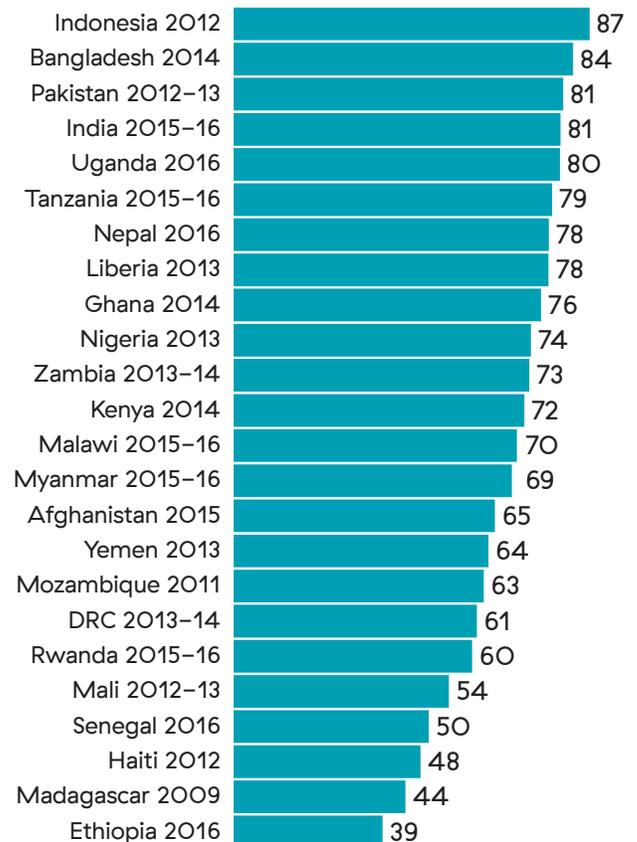


**68%**  
Fever



**64%**  
Diarrhea

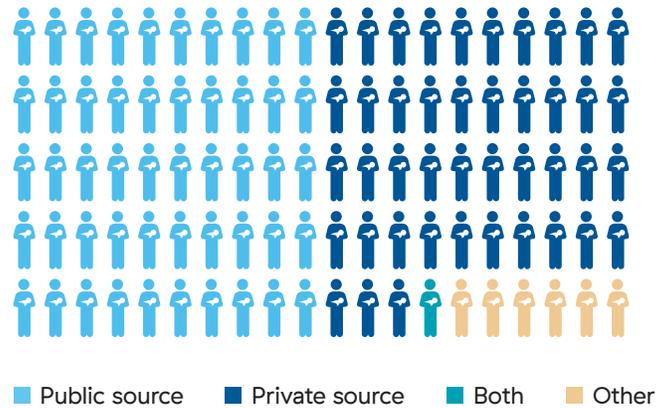
**Figure 3. Out-of-home care seeking by country (%)**



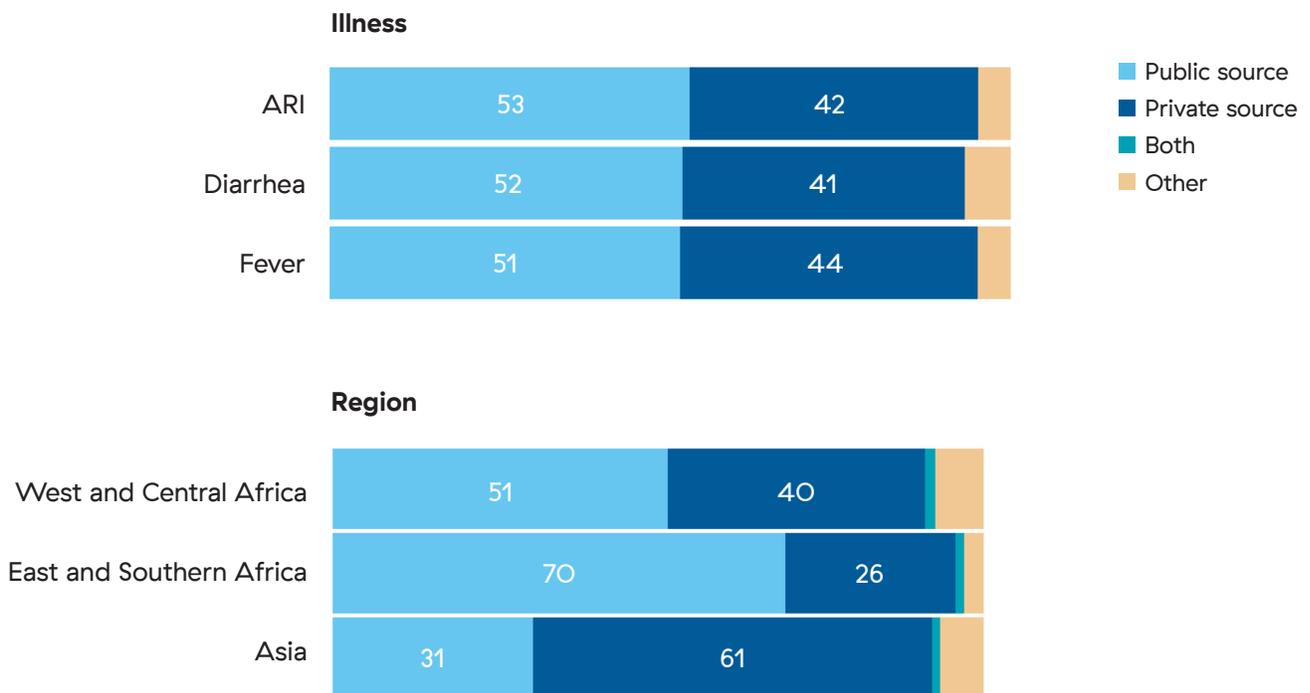
In examining care-seeking sources across illness types, the data indicate that caregivers go to the same sources of care no matter which type of illness their child experiences (Figure 4).

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 level of care seeking from other sources is 30 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 (%)**



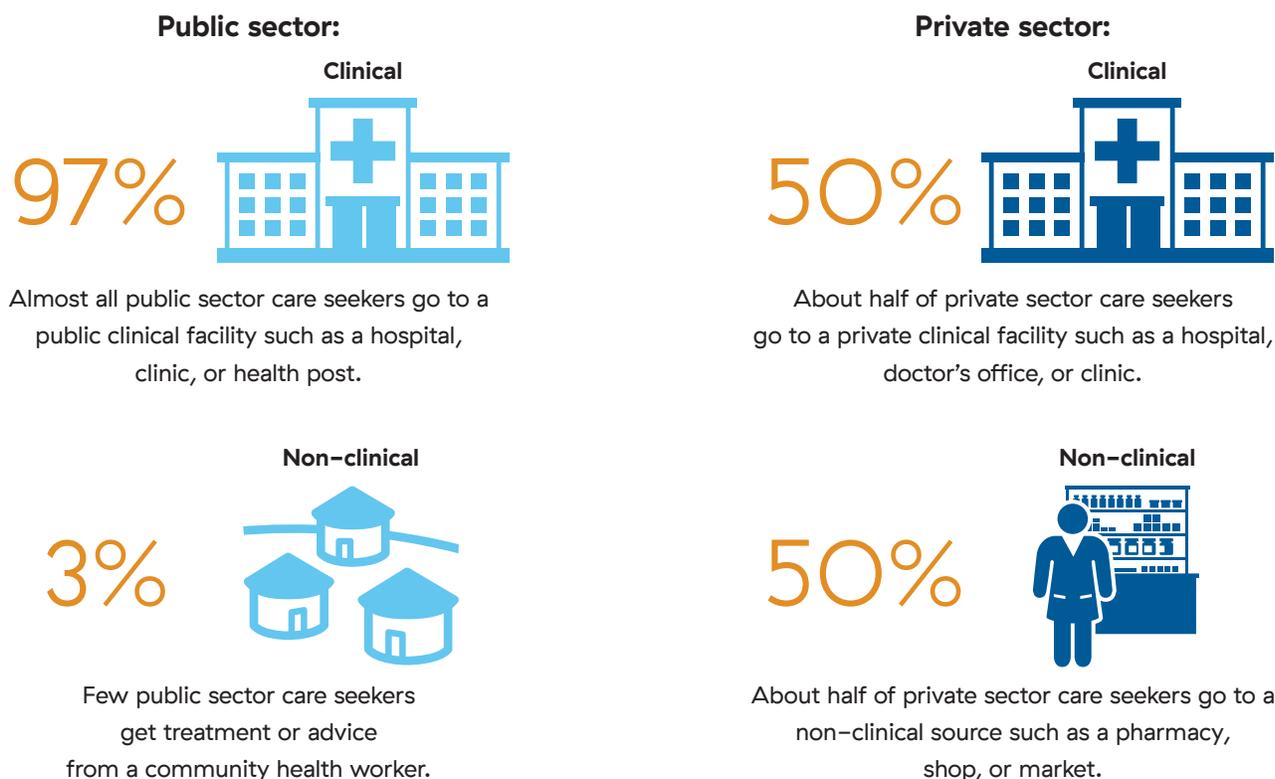
## Provider type within each health sector

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, 97 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, 81 percent of private sector treatment and advice is sought from non-clinical sources.

### Sources of care categories

Public sector	Private sector	Other
<ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Clinics</li> <li>• Health posts</li> <li>• Community health workers</li> </ul>	<ul style="list-style-type: none"> <li>• Private clinics, hospitals, and doctors</li> <li>• Nongovernmental and faith-based organizations</li> <li>• Pharmacies, shops, and markets</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional healers</li> <li>• Friends or family members</li> </ul>

**Figure 5. Most public sector clients go to clinical sources**

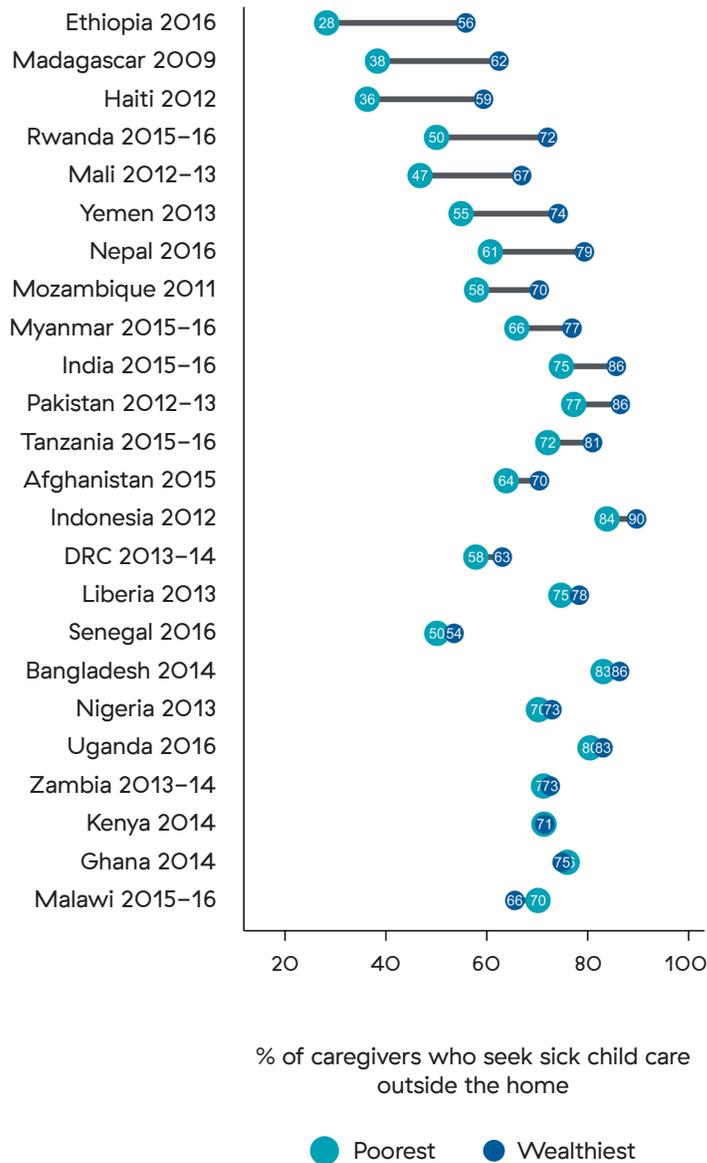


## Equity in care seeking

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 East and Southern Africa and 4 percent in West and Central Africa and Asia. 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, and Rwanda have the largest disparities—the gap in out-of-home care-seeking levels between the richest and poorest in these countries exceeds 20 percent. On the other end of the spectrum, there are several countries with much more equitable levels of care seeking: Liberia, Senegal, 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 levels.

**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, 73% of caregivers from the wealthiest quintile in each country and 55% 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, 51% of caregivers from the wealthiest quintile in each country and 35% 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 DRC, Ghana, Liberia, and Senegal.

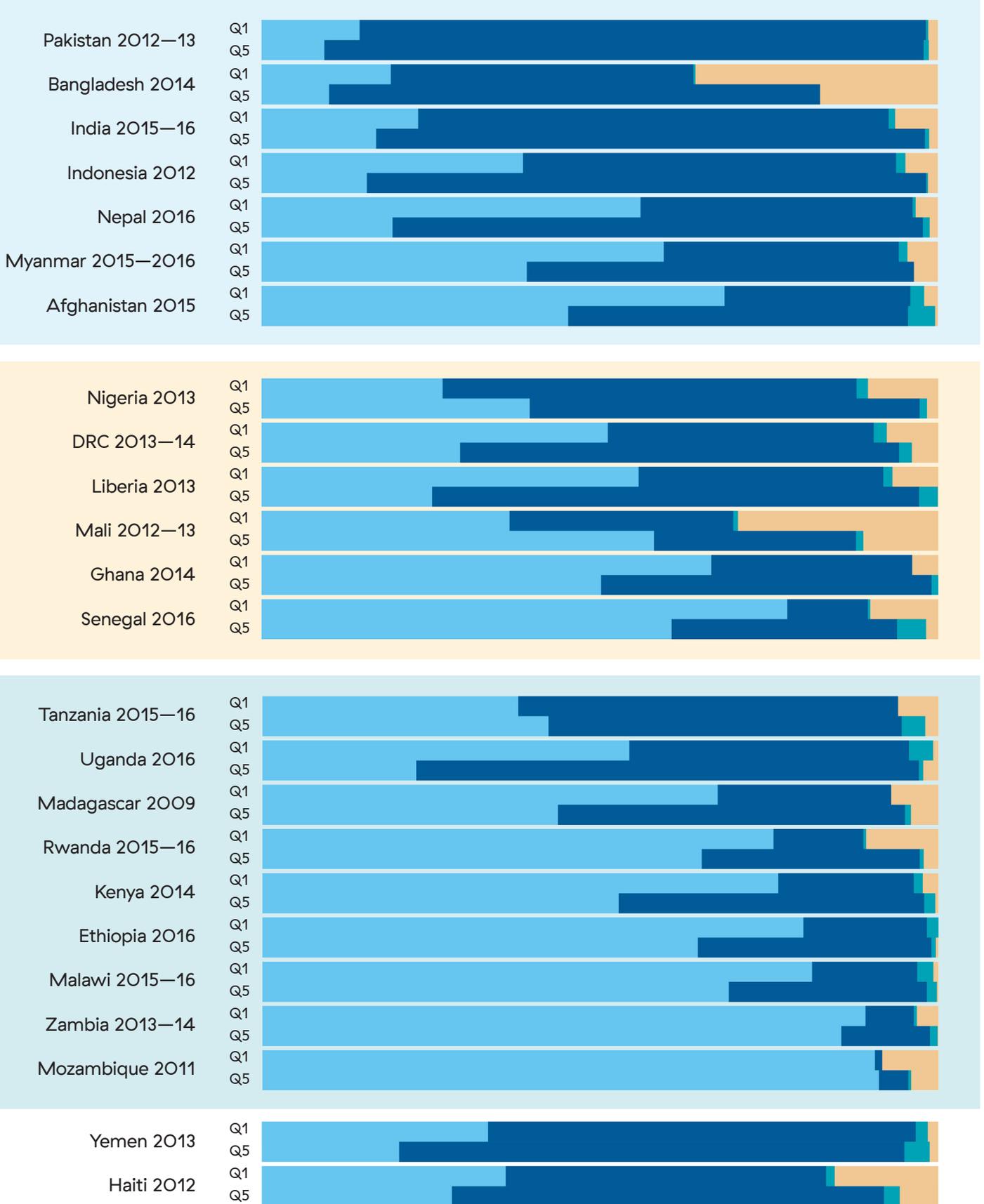
Nearly 2/3 of the poorest households in Nigeria rely on the private sector for sick child care.

### **East and Southern Africa**

The public sector is dominant, with few exceptions. On average, 37% of caregivers from the wealthiest quintile in each country and 22% 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 Ethiopia, Kenya, Malawi, Mozambique, Rwanda, and Zambia.

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



## Equity in sources of care

To assess variations in sources of care by wealth quintile, SHOPS Plus researchers examined care-seeking levels for sick children for any illness in the poorest and wealthiest quintiles in each of the 24 USAID priority countries in the study. The levels 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. Approximately two out of five caregivers from the poorest households and approximately 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 levels 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 levels 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 except for Senegal and Ghana. 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 in this region (Uganda and Tanzania) in which less than 60 percent 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, 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.



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## Endnotes

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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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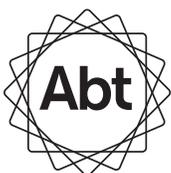


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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector 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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