ABSTRACT

Background

Community involvement has long been identified as an integral component of community intervention programs, and the use of Community-Based Agents (CBAs) in Integrated Community Case Management (iCCM) has since been the focus and reliance for most countries with limited access to facility-based case management services. iCCM utilization in Ghana remains low and the development of its sustainability is a concern to stakeholders. This study describes the inherent role and value of the community to iCCM program.

Objectives

The general objective of this study is to describe community involvement and utilization of iCCM services in rural communities in Upper West Region of Ghana.

Specific objectives are:

1. To ascertain the extent of Community Health Actors' involvement in iCCM program implementation in rural communities.
2. To assess care-givers' awareness and utilization of iCCM in rural communities.
3. To describe the relation between community involvement and utilization of iCCM.

Method

The study applied a cross-sectional mixed of qualitative and quantitative methods in two districts in Upper West Region of Ghana. The qualitative strand used 13 interviews and 10 Focus Group Discussions (FGDs) to collect data on needs assessment, CBA selection, community-driven monitoring, resource mobilization, and leadership. Applying the Rifkin's framework approach, spidergrams were constructed to visualize the levels of community involvement in iCCM.

The quantitative study assessed 277 care-givers' awareness and utilization of iCCM. The STATA 13.0 was used for the quantitative analysis. Results from both quantitative and qualitative strands were integrated to describe the congruence of community involvement and utilization of iCCM.

Result

As for community involvement in iCCM, community members were consulted for their consent and informed about iCCM before its introduction. Selection of CBAs as human resource for iCCM and the criteria used were entirely managed with community members' involvement. CHAs perceived the monitoring of CBAs as mainly the responsibility of health professionals and rarely participated. There was no resource support for iCCM in any community and functioning CHAs' groups such as Village Health Committees (VHCs) coordinating iCCM were weak and almost nonexistent in most communities.

About 30.3% of the 277 care-givers utilized iCCM for illness of their children while 38.3% of them utilized facility health services. Awareness of iCCM was very high at 79.1% and majority of care-givers (90.5%) were satisfied with the services under iCCM. Drug non-availability was reported in 50% of communities and only two communities had complete medications for all iCCM conditions. Many of caregivers (52.3%) who did not utilize iCCM indicated non-availability of medicines as their major reason for not utilizing iCCM during the most recent child's illness episode. None of the care-givers' demographic variables considered in this study had significant association with iCCM utilization. Using regression analysis, community involvement in iCCM had significant tendency of correlation with iCCM utilization (Coef = 0.11, 95% C.I= 0.07 – 0.15 $P < 0.001$) and the Wilcoxon

Rank Sum test also suggests the likelihood of correlation between community involvement and iCCM utilization (P-value < 0.05).

Conclusion

This study demonstrates low utilization of iCCM though care-givers were mostly aware and satisfied with iCCM services in the community. Non-availability of medicines was a major challenge to iCCM utilization. Community involvement in iCCM was limited in most communities and effective coordination of iCCM by CHAs was only evident in two communities through VHCs and rarely existed in others. Community involvement correlated somewhat with iCCM utilization. Community involvement in iCCM therefore could be improved if efforts are made to strengthen community supportive structures such as the VHCs to harness supports toward iCCM sustainability.