CHILD SURVIVAL

Viviana Azankposso holds her child Marie, two months, next to the infant's mosquito-protected bedding in the village of Sochanoue, near Cotonou, Benin. She assists with Catholic Relief Services' program in the village to help fight malaria through education, medication and mosquito nets for bedding. Photo courtesy of CNS/Paul Haring

PROJECT SNAPSHOT: Benin

Saving lives through rapid diagnostic testing

Malaria continues to be a major cause of child death. Worldwide, the mosquito-borne disease killed 450,000 children under five in 2012, 97 percent of them in sub-Saharan Africa. To prevent these unnecessary deaths, parents need to have children sleep under insecticide-treated bed nets, and they need to know how to recognize when a child has a fever and seek early treatment.

Although malaria is one of the three primary killers of children under five in Benin, only 40 percent of people use government health services because they are located far away. To bring treatment closer to people's homes, the National Malaria Control Program introduced a policy in 2011 to have community health workers (CHWs) conduct tests to confirm malaria before treatment.

Catholic Relief Services is supporting this policy through a four-year project that will enable CHWs to administer rapid diagnostic testing (RDT) services to 26,265 children under five who have a fever. This testing will save lives by allowing for accurate, immediate treatment of uncomplicated cases and supporting timely referrals to health centers for children with severe malaria symptoms.

Making a difference

Community-based organizations are critical players in CRS' Communities Accessing Testing for Child Health (CATCH) project, funded by USAID. By training CHWs to rapidly test children under five with a fever, provide treatment and educate parents on danger signs, CRS aims to decrease malaria-related morbidity and mortality in children under five in the intervention area by 2016. Additional training in Community Integrated Management of Childhood Illnesses (C-IMCI) will allow CHWs to screen all children with fever, cough or diarrhea and provide appropriate diagnosis and treatment.

Children with malaria who receive treatment within 24 hours of the onset of fever have a much higher likelihood of surviving. Knowing this, CHWs currently provide artemisinin combination therapy (ACT) to all children who have a fever without confirming that malaria is the cause. This is dangerous, because children suffering from illnesses other than malaria will not receive correct

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treatment and can die as a result. Malaria can also become resistant to the ACT drugs, putting children at greater risk if they contract malaria in the future.

CATCH enables CHWs to avoid these problems by quickly testing children who have a fever for malaria with a simple finger or heel prick. CHWs can then either provide malaria treatment to those who test positive or use the C-IMCI checklist to correctly diagnose other illnesses and treat the sick children accordingly. Use of C-IMCI also enables CHWs to identify the danger signs of primary childhood illnesses, including severe malaria symptoms, and make prompt referrals to the nearest health center.

With rapid diagnostic testing at the community level, CHWs can be sure they provide lifesaving antimalaria drugs only to those children who truly need them, preventing drug resistance. Photo courtesy of CNS/Paul Haring

Current situation

In four villages where formative research was conducted, CHWs have been trained to administer RDTs. They are assessing and treating children with positive malaria test results and referring severe cases to a health facility. CHWs have also reduced their use of ACT among children with fever when the RDT is negative and are referring those children to health facilities for follow up.

A qualitative study performed by the Regional Institute of Public Health revealed that mothers accept RDTs performed by health facility staff but have low confidence in CHWs' ability to perform the same tests. In addition, they are reluctant to pursue further treatment for feverish children if the RDT is negative, despite the fact that the fever could be due to a serious illness other than malaria. The cost of transport to a health center is the primary reason they refuse referrals, even though they may have access to vouchers to pay for transport.

These results indicate the need for a behavior change communication strategy to increase knowledge and promote care-seeking and adherence behaviors for services offered at the CHW level. Project staff will roll out RDTs and C-IMCI in 100 villages and conduct a baseline evaluation to determine what factors influence uptake of these services. The results will inform a BCC strategy designed to encourage confidence in CHWs and compliance with referrals to health centers. Ultimately, as community-based RDT and C-IMCI become more prevalent and accepted in Benin, children under five will have better odds of survival.