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Influence of political orientations and national health strategies on resource mobilisation and the process of integrated community-based management strategy for childhood illnesses implementing in two districts of Burkina Faso

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Abstract

Background: *Burkina Faso has been providing integrated community care for childhood illnesses for many years, but the results of studies suggest that its use is low, and infant and child mortality is still high. The aim of the study is to analyse the influence of policies and strategies on the implementation of community-based management of childhood illnesses.*

Methodology: *This is a descriptive cross-sectional study and was carried out in Burkina Faso in the health districts of Boussouma and Boussé. Data were collected from 20 February to 30 March 2023 in the health districts of Boussouma and Boussé in Burkina Faso. Government officials and partners were interviewed using an interview guide. Data were coded and analysed using QSR Nvivo version 14 and SPSS version 25 software.*

Results: *There is effective ownership of policy orientations and guidelines. Stakeholders have adopted the sector's policies and strategies and incorporated them into their operational plans. However, our results show disparities between health regions, with some areas not covered at all. Despite the inclusion of community management of childhood illnesses in national planning and*

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financing frameworks, resources (financial and drug) and coverage have remained insufficient, limiting the effects of these measures, which were aimed at reducing inequalities in access to care.

Conclusion: *The study revealed that recent public policies (since 2016) haven't been able to improve the availability of resources (financial and inputs) needed for the proper implementation of community-based management of childhood illnesses Additional governance and financial investment actions with more community participation are needed.*

Keywords: community healthcare, community health workers, health policy, childhood illnesses, Health district, Burkina Faso.

1. INTRODUCTION

Burkina Faso, like many other countries, is facing a shortage of medical staff, which is limiting the population's access to healthcare (1). The security crisis that began in 2015 has worsened this access problem (2). The search for a solution to this challenge has been underway at international level since 1969 at the World Health Assembly (WHO) on rural health systems. The general recommendation emerging from the various discussions was that care should be provided as close to the community as possible (3). This led to the Alma Ata conference in 1978, which launched the concept of primary health care (SSP) (4), adopted in Burkina Faso in 1979, with particular emphasis on the development of community-based services (5). The ultimate aim of PHC is to reduce infant mortality, which remained at 81 per 1000 in 2003 (6).

The various National Health Development Plans (PNDS) developed between 2011 and 2020 have given priority to the development of community health in line with these political guidelines (7,8). These strategic decisions are justified by the need to eliminate the disparities in access to healthcare caused by geographical barriers (average distance of 6.1 km) (9) and financial ones indicated in the PNDS (2021-2030) (8).

These strategies for reducing disparities which are limiting people's access to healthcare facilities, should benefit from substantial strategic investment in the provision of community healthcare, with the use of community health workers in line with WHO recommendations (10). These strategies include community-based management of childhood illnesses.

Following policy orientations and guidelines on community health at national level, the Integrated Community Management of Childhood Illness (iCCM) was developed in 2008 to improve the control of malaria, diarrhoea, measles, acute respiratory infections and malnutrition at community level. iCCM comprises sixteen basic family practices (11). It aims to improve early referral to the health centre, the smooth continuation of treatment at home by the health worker, and access to services by well-trained community relays in communities without a health centre (12) in accordance with the principles set out in the guide drawn up jointly by WHO and UNICEF (13).

It aims to reduce infant mortality, in particular through early case management, reducing late access to care and mitigating the factors favouring the onset of the most common childhood illnesses (14,15).

According to the research carried out by Seck et al. in 2011, there are many shortcomings in the implementation of this iCCM, especially in terms of motivating stakeholders to work and also the availability of inputs for management. Also, according to Baya et al. in 2025 and Druetz et al., iCCM is not widely used by communities, and coverage is insufficient in Burkina Faso (16,17).

However, the political orientations and the various guidelines adopted within the framework of community health were intended to facilitate the scaling up and use of community care on a daily basis in order to improve access to care for rural communities. Previous studies conducted after the adoption of key measures such as the standardisation of the community-based health worker (CBHW) profile (CBHW PROFILE) and the extension of free health care to the community level, have not most often analysed the alignment of stakeholders with community health orientations and guidelines, including the iCCM. They have rarely assessed the capacity of these stakeholders to reduce problems of equity of access to healthcare in line with the country's commitments. In this study, we have tried to provide answers to the following evaluation questions: i) are the operational planning and types of intervention of the stakeholders aligned with the sector policy orientations and strategies for community-based management of childhood illnesses? ii) has the adoption of these policy orientations and strategies led to better coverage of the populations' needs? iii) what adjustments are needed to optimise the effects of the policy orientations and guidelines on the provision of more equitable care to communities through iCCM? conceptual model adapted from the health systems dynamics framework (figure 1) (18). We chose to study the interactions that could exist between i) on the one hand, leadership and governance, materialised in our case by these political and strategic orientations aimed at guiding initiatives to implement health interventions (including iCCM), ii) on the other hand, the resources to be mobilised and the services produced (these two also having an interrelationship).

2. MATERIALS AND METHODOLOGY

Study design

We conducted a descriptive cross-sectional study with data collected from 20 February to 30 March 2023.

Study framework

The study was carried out in the health districts of Boussouma and Boussé in Burkina Faso (figure 2). Boussé health district is located in the province of Kourwéogo (Central Plateau region). It has 33 health facilities and covers five (05) communities with a population of 199,999. The district of Boussouma is located in the province of Sanmatenga (Centre-North region). It has 29 health facilities and covers three (03) communities with a population of 239,894 (9). These districts were chosen because they offered the safest conditions for data collection. We chose a rural district in a region that benefited from specific support for the implementation of iCCM before the introduction of free community care in 2018 (Boussouma/Centre Nord) and a rural district that was not covered by this community curative management of childhood illnesses, iCCM, before the adoption of free community care (Boussé/Plateau Central).

Study population

The study population consisted of: i) agents and managers of the Ministry of Health at different levels (staff of the central directorates, staff of the regional health directorates, health district management teams and health centre teams); ii) agents and managers of the technical and financial partner institutions of the Ministry of Health (United Nations institutions, civil society including non-governmental organisations (NGOs), associations and institutions collaborating with the health districts in the implementation of activities financed by the global fund, called community-based organisations) listed in the districts' annual action plans as partners in the implementation of activities.

Sampling

Sampling was purposive. All the abovementioned stakeholders were included in the study on the basis of their responsibilities in the implementation of iCCM and their willingness to answer our questions. We allocated the interview quotas according to the levels of the health pyramid (central, regional, district and civil society).

Table 1 shows the sample size and number of responses per category for the qualitative method. For the quantitative method, we decided to include all health centre managers in the two districts, who were to be interviewed on the basis of security accessibility. Participation was free and voluntary, subject to knowledge of the study objective and confidentiality measures.

Data collection

The data was collected using a qualitative and quantitative method.

Data were collected using semi-directive interview grids and a questionnaire for health workers in the health facilities. Some interviews were conducted face-to-face, while others were supplemented by data collected by e-mail (for people who had been in charge of community health and were working outside Burkina Faso).

Socio-security risks prevented the use of a dictaphone during most of the interviews in the Centre-North region. We therefore collected the speeches on paper and, for those interviewees who gave their consent, we used an electronic recording, which was then transcribed.

The literature review grid enabled us to use the documents made available to us by the stakeholders, as well as those collected via digital platforms.

Data were collected on the following variables: i) the inclusion of iCCM in policy and strategy documents (policies, directives, strategic plans, etc. Data were collected on the following variables: i) the inclusion of iCCM in policy and strategy documents (policies, directives, strategic plans, etc.), ii) the integration of iCCM related policy and strategy guidelines into operational planning, iii) the influence of these policy and strategy guidelines on financial access (implementation of free community health care), iv) the geographical coverage of iCCM, v) changes in health care access disparities, vi) the perceived adequacy of resources to needs and vii) measures to strengthen the implementation of iCCM.

Data analysis and ethics

The qualitative data collected was then transcribed into Word, coded and the speeches linked to our variables were kept. The quantitative data was entered into Excel and then exported to SPSS version 25 for analysis. A thematic content analysis was carried out using QSR NVivo14 software, following the meaning conveyed by the respondents regarding the community management of childhood illnesses in Burkina Faso and particularly in these two health districts.

This study was authorised by the National Health Research Ethics Committee within the Ministry of Health and Public Hygiene of Burkina Faso (deliberation N°2023-03-061). Oral consent was requested, and participation was free and voluntary. The data collected were compiled in an electronic file secured by a code.

3. RESULTS OF THE STUDY

During this study, 29 people took part in the semi-structured interviews, according to the quotas shown in Table 1. We were also able to administer the questionnaire to 42 health centre managers or team members.

The nature of political orientations and guidelines relating to iCCM and their integration into operational plans

Several national guidelines in Burkina Faso govern operational planning by the various levels of the health system and the implementation of iCCM to improve access to care. Among these guidelines, we note that the sector policy indicates in strategic objective 1 and expected effect 1 that:

"Childhood illnesses must be properly managed or prevented (through, among other things, the IMCI approach (...). Neonatal and infant mortality must be reduced to a sufficiently low level in line with the targets of sustainable development objectives, through effective and efficient strategies" health sector policy page 37 of 73.

These operational plans are also based on the national health development plans (PNDS) and the national community health strategy, which were used to prepare the planning guidelines. This resulted in operational planning guidelines issued by the Ministry of Health and Public Hygiene for the preparation of annual action plans, which are intended to facilitate the incorporation of iCCM. These planning guidelines for 2024 instruct health districts to "*ensure the regular recruitment of human resources to run health facilities and the community level*", planning guidelines 2024_page 24.

State stakeholders and partners in the health system have stated that they rely on policy orientations and community health guidelines (table 2). Analysis of the annual plans prepared in the health districts over the last five years shows that iCCM is considered as a priority intervention to be planned and implemented.

A senior manager in charge of planning, monitoring and evaluation in one district confirms this inclusion of iCCM in annual action plans as follows: "*Community health is indeed integrated into the annual plans*" (Administrative Manager_E13). Other interviewees also stated that: "*community health is well integrated into the annual plans*" (Administrative Manager_E12) and these are "*aligned with the Ministry's national community health strategy*" (Administrative Manager_E11).

A review of the 2015-2023 annual action plans of Boussouma and Boussé health districts shows that iCCM is integrated into the districts' annual intervention planning documents.

A respondent, responsible at national level, confirms that the annual plans of the state structures are in line with the national orientations and guidelines for integrating iCCM into interventions.

"*These community health interventions are integrated into political programmes and reforms. Particularly in the current security context, community approaches are essential to the health system resilience*" (Administrative Manager_E24).

Another respondent added:

"*Community health is integrated into development programmes and political reforms such as free healthcare and the delegation of tasks*" (Administrative Manager_E22).

Integration of iCCM into the intervention strategies of partner structures in the health system

Table 2 summarises the partners' assertions, indicating that the majority of stakeholders have adopted iCCM in their projects and programmes. The components of the strategy are among the main priorities that the partner organisations have assigned themselves in their support for the health system. They say they use community-based health workers, the harmonised profile adopted by the Ministry of Health in 2014 and operationalised in 2016, as the main body for implementing their interventions.

The integration of iCCM into operational plans should facilitate the mobilisation of financial resources.

Speaking about this, one of our respondents said that "*funding costs are not taken into account very much*" (Administrative Manager_E5). The accounts given in table 2 reveal a lack of various resources (especially financial and health products).

Quality of iCCM implementation

In this section, we analysed the improvements made to the community care system by these political orientations and guidelines in terms of coverage of needy populations, according to stakeholders' perceptions of the geographical coverage of iCCM, and the adequacy of resources in relation to needs.

Level of coverage

In the Centre Nord region, which includes the Boussouma health district, a district official told us that all villages located more than 5 kilometres away that are required to implement complete iCCM packages have two ASBCs. On the other hand, in the Plateau Central region, where Boussé health district is located, a health district official estimated that more than half the villages in this district were not covered by iCCM. Our results show disparities between health regions from an overall national viewpoint, with some regions not being covered at all. A national official provided some clarification:

"*In terms of regions, we have 7/13, or 54%. However, in terms of districts, this figure is plummeting. It means that not all districts in a given region offer iCCM. In the*

regions covered, the three diseases concerned are uncomplicated malaria, diarrhoea and cough in children under 5" (Administrative Manager_E24).

A programme manager from the community health department told us that " *we have gone from 5 regions to 7, with an extension underway to cover all the other regions*" (Administrative Manager_E6).

An officer from state partner structures recalled the importance of community health strategies in ensuring continuity of care.

"*These community-based services represent a continuum of primary healthcare. They complement the services provided by health workers*" (Partners_P9).

Measures to improve the quality of the services provided are implemented through training for CBHWs and monitoring by designated staff (table 4).

Matching needs and resources (human, material, input, financial) in community-based childcare services

Availability of human resources

The respondents' comments identified three major shortcomings: human resources (insufficient number of CBHWs), material resources and drugs used for treatment, and financial resources (Table 2).

Some respondents congratulated the government on its determination to motivate CBHWs despite the obstacles. These motivations are mentioned in the CBHWs profile document. There are shortcomings in the management of this motivation, with delays. Also, the use of CBHWs for tasks other than iCCM is a shortcoming noted by one of our respondents.

"A profile for CBHWs has been developed and revised, including the packages to be implemented and their remuneration. However, due to motivation problems and drug shortages, these CBHWs are being diverted from their intended duties and activities in some health facilities. Apart from supply problems, they are successfully carrying out their tasks despite low motivation, relatively strong skills and frequent overload due to the security crisis. The remuneration of CHWs must be improved and a CHW post should be created" (Partners_P5).

This problem of respecting the commitment to motivate CBHWs was confirmed by another respondent who felt that "*the State's contribution is effective but very inadequate (...); there are too many unpaid bills in the health facilities*" (Partners_P3).

The partner organisations interviewed were grateful for the State's commitment to honouring its own political commitments, but raised the issue of the involvement of local authorities.

"The contribution of government resources to community health is substantial. The provision of supervisory staff for CHWs and the financial incentives used in community health are proof that the state is investing (...). I also salute the political commitment of the government, which is sparing no effort to honour its commitment despite the difficulties (...). So, I agree with the remuneration of community relays. However, the strong involvement of local authorities is essential to ensure the sustainability of this initiative" (Partners_P4).

This commitment by the State and the efforts made to translate political guidelines into reality was also mentioned by State officials. They mentioned the

provision of human resources, in particular the motivation of CBHWs and the monitoring of these CBHWs by health facility staff, as well as the supply of medicines and equipment as the main contributions made by the State.

Besides the problems of managing these CBHWs, one respondent said that the population is not sufficiently covered by the services provided by CBHWs " *The contribution of CBHWs to case management remains low at national level (less than 15%*" (Administrative Manager_E24).

Availability and access to health products

To improve the availability of these community services and access to populations, the Burkinabè government has decided to extend free healthcare for children to the community component. "*It was decided that community services would be free from 2018 on a pilot basis*" (Partners_P9).

However, some of our respondents reported difficulties with the implementation of free community health care.

One of the main shortcomings noted was the lack of medicines and consumables used to implement iCCM and the lack of financial resources (table 2). These product shortages were confirmed by health workers who stated that they had been confronted with a shortage of the products needed to implement iCCM in (9/42) 21% of cases.

According to another person interviewed at regional health authority staff meetings, support differs depending on the relationship. " *The regions have different technical and financial partners*_E24).

"*Free healthcare at community level has been implemented in some regions, but not enough in others. This is linked to the difficulty of providing free healthcare at health facility level (shortages, non-renewal of medicines and poor mastery of the strategy by some health workers)*" (Partnaers_P9).

Respondents were unanimous on the fact that the resources provided by the state and local authorities were insufficient (table 2).

The contribution of partners in terms of inputs seems to be predominant, as one of our respondents put it. "As *the State does not manage inputs, it is the region with the most partners that will do best*" (Administrative Manager_E24).

The contribution of local authorities in terms of inputs is considered to be almost non-existent.

Availability of financial resources

Those involved in implementing these interventions at operational level are not satisfied with the level of mobilisation of resources allocated to these community interventions. "*There is not enough mobilisation of financial resources* " (Administrative Manager_E11). And we were told that "*as far as partner investment is concerned, these are occasional actions*" (Administrative Manager_E15).

A national manager confirmed these shortcomings in the mobilisation of financial resources.

"*The mobilisation of resources has always been insufficient for successful implementation*" (Administrative Manager_E21).

One respondent commented:

"*As regards resource mobilisation, advocacy has been successful. However, the management of resources for community components often raises questions and slows down the momentum of technical and financial partners*" (Administrative Manager_E24).

In addition to all these shortcomings in the implementation of the State's commitment to ensuring equitable access to care through iCCM, the majority of respondents noted the absence of regular and functional statutory frameworks to ensure proper accountability to communities and to encourage endogenous contributions.

4. DISCUSSIONS

The implementation of iCCM has been driven by political guidelines and strategies adopted by the country following international initiatives (13).

This integration of iCCM at all levels is a sign of strong ownership of these initiatives by the government of Burkina Faso and its partners. The government's commitment had already begun with the adoption of the primary health care concept in 1979 (4,19) which laid the foundations for the majority of community health interventions.

The commitment was renewed in Burkina Faso's health sector policy (2018-2027), which adopted as a strategic direction that the skills, support and motivation of the 17,000 CHWs recruited in 2016 be strengthened in order to effectively implement the package of community activities (20,21). This policy direction created better conditions for the further development of iCCM. It was then translated into national health development strategies and operationalised in the national health planning guideline (8,21,22).

The 2024 planning guidelines encouraged operational structures to provide for the development of community-based health services and to ensure continuity of treatment for populations with difficult access to care (22). As a result, iCCM has been well integrated into the annual action plans of Boussouma and Boussé health districts. This political orientation and the resulting strategies are perfectly in line with the major orientations and milestones of the international agenda of the last five years. The WHO's drive to develop national community health worker programmes (23) and the World Health Assembly's latest resolutions on community-based primary health care as a participatory and inclusive approach to universal health coverage all aim to support countries in closing the human resource gaps that are difficult to fill in most of sub-Saharan Africa (24). The availability of political and strategic guidelines has enabled iCCM to be properly included in priority health interventions in Burkina Faso, but above all to harmonise the profile of the community-based health worker responsible for this curative care. The adoption by the government of free community health care as a complement to free health care is undoubtedly one of the major effects of this political orientation. The inadequacy of human and financial resources observed during this study mitigates the significance of these political orientations in terms of their real capacity to resolve the chronic problems of availability of inputs and other resources experienced by various community-based care programmes (5,23,25,26), inputs being essential to the proper implementation of iCCM.

With regard to harmonising the profile of CBHWs responsible for implementing iCCM and the actions of health facilities identified during this study, which should be able to improve the quality of services provided by these CBHWs, we can say that the results of other previous studies suggest such reforms. WHO suggests better-structured health worker programmes and the granting of incentives to guarantee a certain availability of these community human resources in the provision of care to hard-to-reach communities (24). It offers a way of correcting shortcomings in the use of community health workers to implement iCCM in other programmes, such as in Benin (12). The profile of this staff is also very well suited for providing an adapted package with the delegation of tasks formerly carried out by qualified health centre staff, such as immunisation or family planning (2) which goes beyond iCCM and contributes to the integration of services that form the basis for building the resilience of the health system in Burkina Faso (27). These CBHWs constitute a unique bridge between the health services and their communities (28) whatever the profile described in the country. They need to be skilled in communication techniques adapted to their role as a bridge.

Unfortunately, our results show significant geographical disparities in the implementation of the full iCCM package. In a survey of community health in Burkina Faso in 2011, Seck et al. found wide gaps in the geographical coverage of iCCM. More than a decade later and after the reforms translated into political orientations as developed in the previous sections, our results show that these problems have become chronic. Shortages of health products are confirmed by health workers, and geographical coverage is not yet complete. The geographical disparities in implementation seem to be rooted in the State's inadequate financial contribution to the supply of specific health products for the implementation of iCCM.

The drug gaps were highlighted by a mapping of community interventions conducted by the Ministry of Health and its partners (29), which also shows a low level of mobilisation of funds for the procurement of the inputs needed to provide community-based services (30). The comments of our respondents also show that the availability of medicines depends on the target areas for intervention by the partners identifying the inadequacy of the State's efforts in this area. As the partners are masters of this vital aspect, they influence the choice of areas to be covered, and the leadership of the State is thus weakened in this process: community health governance must be strengthened. The mapping of interventions and gaps should be the compass for the implementation of projects and programmes in order to facilitate the scaling up of this iCCM.

Our results show that the level of funding for iCCM is not optimal, and the state is absent from funding in some key areas, such as the health products needed to implement the CBHWs curative care package.

The estimated cost in 2018 for adequate coverage of the country with community-based interventions is USD 177.7 million. The needs of the iCCM dominated this overall cost and amounted to at least USD 8.6 million, according to the scenarios in the community health investment file. Resource mobilisation has probably been impacted by the COVID-19 pandemic (31) and the security crisis that has been exacerbated since 2017 (Ministry of Health, 2019c). This mobilisation has been insufficient and gaps in medicines and other resources have also been noted in other countries such as the Democratic Republic of Congo (Maternal and Child Health

Integrated Program (MCHIP) and USAID, 2012). The extension of free health care to communities in 2018 (33) has unfortunately not solved the problem of making financial resources available.

The implementation of a system for purchasing results, progress indexed to the performance of health districts in implementing iCCM, and the genuine operationalisation of free community health care, with an alignment of partners' funding for this component, will improve the availability of health products and the move towards universal health coverage, whose relationship with primary health care has been sufficiently demonstrated (23,34,35).

Also, the literature review showed that the mapping of health sector resources in 2022 did not include iCCM as a specific intervention. This does not give a clear picture of resource mobilisation for iCCM and makes it difficult to develop sound strategic forecasts (36). Future maps should better segment community health in order to better inform strategic choices.

In another aspect of iCCM implementation, our respondents pointed to a lack of accountability. Regular consultation forums at local level on these community interventions should facilitate reporting and participatory monitoring and evaluation. To this end, formal strategic partnerships between the health planning sector and the sector responsible for local governance should be developed, facilitating the development of transparent and highly collaborative governance mechanisms involving local authorities as much as possible. This could improve the support of partners in the health sector and proper mobilisation of endogenous resources, which is more than necessary (UNICEF, 2016) for flagship community interventions including iCCM (38).

In the search for a better way forward, as with the forecasts, greater decentralisation and community involvement in the management of CBHWs, could bring real ownership and financial support for the strategy from communities, rather than confining them to their recruitment role (35). This could lead to greater community involvement, which in turn would help mobilise the financial resources that are so vital to the sustainability of iCCM.

This study was conducted in the districts of Boussouma and Boussé, but we were unable to carry out an in-depth economic evaluation to better guide the mobilisation of resources to finance the various components of iCCM implementation. One of the limitations is that we were not able to interview the beneficiaries and the perceptions of the CBHWs were not taken into account and will be the focus of future studies. In addition, the confidentiality of information and the reluctance of some respondents prevented us from obtaining financial figures for the funding shares of iCCM supporting partners.

5. CONCLUSION

Improving access to healthcare for all population groups is a challenge for Burkina Faso. Inequalities in access to healthcare have been identified in a number of studies and have led the country to adopt various policies and strategies (health sector policy and the various strategic development plans) aimed at facilitating the operationalisation of the primary healthcare concept. The commitment of the various governments has resulted in the development and adoption of strategic documents to

integrate the concept into planning frameworks with a view to mobilising significant financial resources. One of these strategies is iCCM, which is a specific intervention promoted to bring basic healthcare closer to communities. Its implementation has benefited from several actions from the State. This study has enabled us to appreciate the efforts made by Burkina Faso in translating its political and strategic orientations into operational actions that were very well received by stakeholders at the operational level of the health system, as well as its technical and financial partners. Despite this commitment of the Government and the stakeholders involved in implementing this strategy, major shortcomings have been identified. Geographical coverage is still inadequate, with persistent gaps in access to care. Insufficient resources have been mobilised to meet the needs required for full implementation of iCCM. Weak accountability frameworks also limit the commitment of partners and communities to funding. In short, the government and its partners have taken ownership of the various political guidelines and incorporated them into operational planning. But these actions of governance and leadership in performing public health policies remain insufficient to eliminate geographical disparities in the implementation of iCCM and ensure equity of access to healthcare for all population groups. This study has enabled us to see the influence limits of traditional guidelines, and implies lobbying to obtain budget lines that meet the challenges. One lesson is that ministries' resource maps must specifically include iCCM and propose funding allocation keys that facilitate scaling up. International partners need to put in place an advocacy framework to influence different governments to prioritise these community investments, which are the best means for moving towards universal health coverage in the current context.

Greater decentralisation of healthcare and better mobilisation of community resources to finance this iCCM.

The efforts of Burkina Faso's government to fund incentives for CBHWs must be maintained, and a better strategy for funding the community component of the NHDP must be established to ensure its full implementation. In addition, the United Nations report (34) on community-based healthcare, which encourages countries to strengthen this system and calls on donors to provide appropriate resources, gives hope for an increase in funding and the development of a national platform for community-based healthcare.

Table 1: Breakdown of participants by category and role

Stakeholder categories	Stakeholder	Role	Number
Heads of local authorities	Head of town councils	Local governance, Advocacy, guidance and decision-making, implementation monitoring, funding	**3**
Ministry of Health/central level	Community health directors (current and former) Staff from the department responsible for community health and child health	Community health governance, Policy development and translation into strategy Planning, monitoring implementation and mobilisation of financial resources	**5**
Health regions and districts	Regional managers and members of district health management teams	Coordination at regional and health district level, advocacy, planning and monitoring of implementation, mobilisation of financial resources	**11**
United	National and regional	Advocacy, participation in the	

Nations agencies	programme officers	development of strategies, participation in the planning and monitoring of implementation, mobilisation of international financial resources	**4**
Civil society (NGOs and associations)	NGO managers and staff; associations (including community-based organisations working with the concerned districts)	Advocacy, participation in the development of strategies, participation in the planning and monitoring of implementation, mobilisation of financial resources	**6**

Table 2: The areas of intervention, the key players in implementation and the gaps in resources mentioned by the respondents in relation to community care for children under five in the health districts of Boussouma and Boussé

Respondents	Scope of intervention	Stakeholders in the process	Identified gaps
Partner_P7	- Community health: management of malaria, diarrhoea and pneumonia; - Nutrition: infant and young child feeding, food distribution, supervision of community-based health workers, technical and material support for centres; - Monitoring malnutrition recovery centres ;	Community-based health workers, health workers from health facilities/health districts and regional health departments, and volunteers from Burkina Faso's Red Cross;	- Human resources: traditional health staff, especially those responsible for supervising community-based health workers; Community-based health workers: relative to locality Community volunteers; - Inputs and equipment: Diagnostic inputs, drugs, especially Amoxicillin dispersible;
Partner_P6	- Nutrition: raising awareness of good nutritional practices for pregnant and breastfeeding women, - Behaviour changes communication, hygiene and nutrition - Infant and young child feeding (community dialogue, GASPA); - Community health with training and distribution of flour, provision of care kits (malaria test, disinfection products, masks, etc.); - Innovation with large women's dialogue centres; - Strengthening the system: strengthening the health system (medico-technical materials) in 10 health facilities, -Rehabilitation of 10 health facilities;	Community-based health workers, volunteer resource persons (community leaders such as village development committee chairpersons, traditional and religious leaders, village councillors) Health workers ;	- Human resources: Community-based health workers;
Partner_P3	- Communication: Awareness-raising (Activities organised on the use of long-lasting impregnated mosquito nets (LLINs), nutrition (6-59 months) and vaccination;	Associations/organisation à base communautaire, Agents de santé à base communautaire ;	- Human resources: Community-based health workers and community volunteers - Inputs and equipment: Rolling stock, Inputs ;
Partner P1	-Communication: raising awareness of malaria and diarrhoea treatment; vaccination awareness campaign; - Data management: data collection on free health care;	Association coordinators, health workers and community leaders	- Human resources: Skilled workers: midwives and nurses Community HR: Increase the number of CBHWs to 3/village Consider large conurbations Other: OBC coordinators - Inputs and equipment: Inputs; reasons: Too many gaps in areas with security challenges (nomads, difficult access).
Partner_P5	Health and nutrition, WASH, Civil Status, management of acute malnutrition using the simplified protocol, Delegation of immunisation tasks;	Community-based health workers, Mothers as leaders, Village leaders, Community volunteers, Vaccination champions (local chiefs)	- Human resources: Community-based health workers; - Inputs and equipment: Inputs including medicines (Amoxicillin, ORS zinc, Artemisinin-based combination therapies, etc.), registers;
Partner_P2	Support for the health district in the integrated community plan for monitoring malaria care (community theatres and forums, mobilisation, training; provision of equipment such as hand-washing facilities and banners, etc.). Ensuring that malaria treatment is free	Community relays for the "Husbands' School" project, Community-based health workers, communication and child protection units;	- Human resources: Care staff: (Nurses) CBHWs: improve their workforce Others: psychologists -Inputs and equipment: Care inputs -Financial resources: Many drop out due to motivations;

	of charge;		
Partner_P9	Community IMCI: care for newborn babies at home, vaccination, promotion of birth registration	Health workers (including community-based health workers) and community leaders, as well as a number of operational stakeholders, particularly state and non-governmental organisations (NGOs)	- Human resources: Traditional staff (CHWs, nurses) and community-based health workers (CBHWs), with a target workforce of around 370 people for the two health districts
Partner_P4	Community-based management of childhood illness; Nutrition	Leaders, community-based health workers	- Human resources: Community-based health workers -Inputs and equipment: Registers, timers, weighing scales, medicines
Partner_P8	Technical support and inputs for iCCM management in emergency areas	Community-based health workers, health staff, coordination structures	- Human resources: Community-based health workers to be recruited by the State

FIGURES

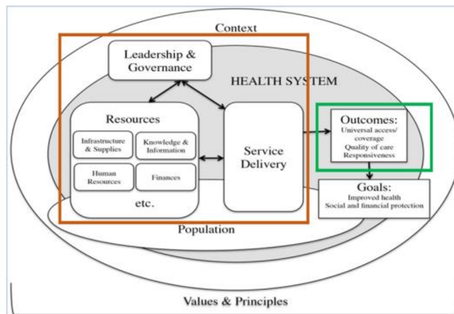

Figure 1: **Conceptual framework adapted from the health systems dynamics framework (Olman et al.)**

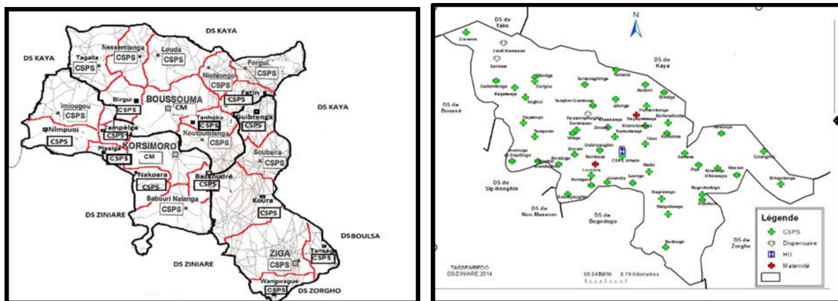

Figure 2 : **Health maps of Boussouma (left) and Boussé (right) health districts**

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