



# Deep Dive: An Exploration for Innovation

Improving Quality in the Private Sector

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## Case Study: Improving Private Practitioners' Case Management of Childhood Illness

Contributed by Johns Hopkins University Center for Communication Programs

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### Name of Project

Improving Private Practitioners' Case Management of Childhood Illness

### Country

Uganda

### Years of activities

1998 – 2002

In Uganda, private practitioners provide the majority of outside home care for childhood illnesses, such as diarrhea, acute respiratory illness, and malaria. However, it has been documented that the clinical quality of care provided by private practitioners in Uganda is generally sub-standard or harmful to patients. In response, the Ministry of Health's Integrated Management of Childhood Illness worked with stakeholders to first develop an appropriate strategy, followed by an intervention to improve the quality of private practitioners case management of childhood illnesses.



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## Background

In most developing countries, formal and informal private practitioners (PPs) are important sources of care for treating common childhood illness. Qualified private practitioners such as pharmacists, doctors, nurses and midwives, as well as unqualified practitioners such as drug vendors, village “doctors” and traditional healers, are, for better or worse, popular sources for seeking treatment for childhood diarrhea, acute respiratory infection (ARI) and malaria. It has also been documented that the clinical quality of care provided by PPs is generally sub-standard or even harmful. While technical treatment quality may be poor, the community’s perception of the services offered by PPs is favorable. PPs are often described as being more sensitive to patient needs, more accessible, and their working hours more convenient. Families report that PPs typically spend more time with them than do public sector providers. Given this favorable community attitude towards PPs’ services, coupled with some communities’ lack of access to governmental health services, PPs will likely to continue to play a prominent role in treating childhood illness. Thus, adopting interventions to improve the quality of their clinical services is important.

In Uganda, where governmental health services cover 50% of the population, PPs, such as private clinics and drug shops, provide the majority of outside home care for childhood diarrhea and fever. Cognizant of the prominent role of PPs, the Ministry of Health’s Integrated Management of Childhood Illness (IMCI) Unit worked with stakeholders to develop a national IMCI strategy, and then initiated an intervention to improve the quality of PPs’ case management of childhood diarrhea, acute respiratory illness (ARI) and malaria.

## How was the Intervention launched?

Luwero District, a predominantly rural district of 450,000 inhabitants located 50 kilometers north of the capital Kampala, was selected to pilot the intervention.

Due to the lack of reliable records/registry of PPs, an “**inventory**” of all formal and informal private health practitioners in the district was conducted. Twenty surveyors, each covering one of the district’s 20 sub-counties, were selected from sub-district community development assistants and health assistants. These community members participate on a semi-voluntary basis in community development and health support activities. The surveyors received a full day orientation and conducted the inventory in May and June 2002.

The inventory revealed the presence of different types of private providers. The intervention focused on private clinics and drug shops because these two categories manage most of the childhood illness cases.

## How did you get started?

### *Mystery Client Interviews*

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Six interviewers who received the one-day orientation training then conducted **base-line simulated visits** (mystery client interviews) with a sample of 20% of private clinics and drug shops. Using a list of private clinics and drug shops compiled during the inventory, the interviewers located and approached the private clinic/drug shop in the sample to seek treatment/advice for their supposedly sick children. The treatment/advice for six specific cases was investigated: simple diarrhea, severe diarrhea with dehydration, mild ARI, pneumonia, simple malaria and complicated malaria.

## What steps were used in the intervention?

### *Private Health Provider Inventory*

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The inventory revealed the presence of various types of private health providers in Luwero district: 386 traditional birth attendants (TBAs), 321 drug shops, 281 traditional healers, 74 private clinics, 19 maternity homes, 17 ordinary shops, and 7 other categories mainly pharmacies and laboratories. Most private clinics and drug shops were located in towns and trading centers while the traditional healers and TBAs practiced mainly in rural areas. Private health providers ranged from formal practitioners: 218 nurse/midwives, 90 clinical officers (physician assistants), 43 physicians, and 3 pharmacists, to informal practitioners: 268 nurse assistants/aides, 54 drug sellers and 27 ordinary shopkeepers. Private clinics were owned or registered under a formal private provider's name, usually a physician or a clinical officer, but managed on a day-to-day basis either by the owner or, in most cases, by another formal or informal provider such as a nurse/midwife or nurse aide. Drug shops were mostly owned or run by a nurse/midwife or nurse assistant/aide.

The inventory also revealed generally poor compliance with registration regulations. A large number of private practices were not registered at the district health authorities. Slightly over half the traditional healers (56%), private clinics (54%) and maternity homes (50%) were registered. Few drug shops (39%) and TBA practices (31%) were registered. In addition, numerous facilities were offering services that they were not authorized to provide. For instance, many drug shops provided clinical management services and clinics were selling drugs to clients.

Most private clinics and drug shops stocked essential child survival drug items: Sulphadoxine Pyramythamine (Fansidar) (70%), Chloroquine (67%), Paracetamol (63%), Cotrimoxazole (58%), and ORS (49%). A higher percentage of drug shops had child survival drug items in stock: Chloroquine (86%) Fansidar (86%), Paracetamol (82%), Cotrimoxazole (76%) and ORS (58%).

### *Negotiation Sessions*

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Were the intervention utilized to improve the PPs' quality of management of childhood illness. Modified from the documented PRACTION (Private Practitioner Treatment Improvement) Model described by Chakraborty and Northrup (2000), negotiation sessions seek to satisfy both public health interest in improving clinical care quality while at the same time remaining sensitive to the complex factors

influencing the practices of PPs, e.g., client expectations, profit, and promotional activities by pharmaceutical companies.

The negotiation sessions set a comfortable learning environment to encourage PPs to participate. Results from the base-line simulated visits were used to stimulate participants to think critically about their own practices as compared to a list of desired (target) standard practices for managing childhood diarrhea, ARI and malaria based on the National IMCI treatment guidelines, e.g., for every case of diarrhea, give or recommend oral rehydration salts or increased fluid intake.

### ***Intervention Training***

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Four negotiation sessions were held in September and October 2003 that included 104 PPs from private clinics or drug shops. Participants included a mix of formal and informal practitioners including physicians, medical officers, nurses/midwives and nurse assistants/aides. Each session lasted for 18 hours over a three-day period. Each participant received a certificate acknowledging his/her completion of the sessions. Eight public sector district health workers “moderated” the negotiation sessions. A two-day training enabled each to be familiar with the clinical content and to run the negotiation sessions in a participatory manner.

### ***Monitoring Tools***

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After completing the negotiation sessions, participants were asked to sign an individual “**contract**” agreeing that they would adopt the discussed desired practices. Participants were told that the “contract” served no legal purpose but included a summary of the specific practices they agreed to adopt during the negotiation sessions.

One to two months after the negotiation sessions, moderators conducted “**monitoring/support visits**” to the participating PPs. During the visits, moderators discussed with each PP his or her progress in adopting the desired practices. The individual contract was used to review the list of practices and to discuss with the PPs any difficulties experienced in adopting the practices and how to resolve them.

## **How did you measure change?**

### ***Post-intervention simulated visits***

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Were conducted three months after the negotiation sessions using the same methodology as the baseline visits, to measure change in PPs’ practices.

### ***Intervention Results***

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Results of the simulated visits before and after the negotiation sessions revealed that the intervention resulted in significant improvement in several key child survival practices. For diarrheal diseases, an important improvement was achieved in the proportion of PPs who recommended continued feeding, increased fluids or ORS. While the changes are significant, a large proportion of PPs still did not adopt the desired practices: most did not recommend continued feeding (80%) and did not advise giving more fluids or ORS (55%). Similarly, for severe diarrhea/dehydration, the proportion of those who discussed danger signs needing urgent referral improved significantly from 21 to 51%, yet these remaining PPs neglected to give this essential advice.

Regarding ARI, impressive improvements in the case management of mild ARI and pneumonia were documented. For example, most PPs advised continued feeding for pneumonia cases (81%), up from 24% (P <0.001) and most advised urgent referral (70%), up from 24 percent (P <0.001). For some practices, however, progress was still not satisfactory. For example, for mild ARI cases, most PPs did not ask if the child had difficult/rapid breathing (84%). Despite the significant improvements as compared to the baseline, in recommending the correct medicine and referral, over half of the PPs did not recommend the correct medicine (61%) and did not give advice on danger signs needing urgent clinical care (59%).

Regarding case management of malaria, an impressive improvement was achieved: most PPs (73%) gave the correct drugs (up from 2%), half gave the correct dose according to the national guidelines (up from 0%), and almost half (49%) explained how to give the medicine (up from 8%). However, only one-third of PPs advised on danger signs requiring immediate medical care for simple or complicated malaria cases and while this was a significant improvement as compared to the baseline, it was not satisfactory.

Results show that some PPs' practices seem resistant to improvement. For example, in cases of simple diarrhea and mild ARI, PPs continued to give/recommend medicine. For severe diarrhea, the majority of PPs continued to ignore giving advice on feeding; and in malaria cases, the majority of PPs did not advise making the child sleep under a bednet for protection against future attacks.

## **Discussion and Lessons Learned**

### ***Reaching Target PPs***

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One major challenge facing the intervention was reaching the target PPs. Since most are not registered with district authorities a survey (inventory) was carried out to identify them. The inventory revealed several different types of PPs actively practicing in the community. Drug shops and private clinics are particularly important sources of care for childhood illness. Both categories are places that store drugs and have an attendant, but the private clinics, unlike the drug shops, have a bench or a bed. Both facilities provide case management counseling and sell drugs. The attendants are often not the owners. Private clinics are frequently registered under a physician's name yet the attendants are nursing aides. This points to the need for detailed inventories and for interventions to address both owners and attendants.

### ***Results of the Negotiation Sessions***

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The results of the negotiation sessions revealed the presence of three types of practices: 1) those that were adopted satisfactorily (the majority of participants adopted the practice); 2) those that improved significantly as compared to the baseline, yet not satisfactorily; and 3) those practices that did not improve despite the intervention. This observation suggests that changing PPs' practices may require more than one round of negotiation and follow up. Keeping close contact with PPs is required through ongoing support visits to continue the process of behavior change and to help PPs continue to improve quality of care. Further dialogue with participating PPs on why certain practices did not change could be valuable in shaping the content of future negotiation sessions.

## *Pilot Intervention Modifications*

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Modifications to the pilot intervention are needed to make it more suitable for a large scale-implementation. Involving local organizations, such as community-based and non-governmental organizations can be important in maintaining ongoing communication with PPs. Strengthening the presence of professional associations, e.g., the Uganda Medical Association and the Uganda Private Midwifery Association may be a worthwhile investment to provide a long-term vehicle to reach out to and work with PPs.

## *Scale Up*

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In addition, national authorities must endorse scaling up the intervention. This may be difficult at the present time since most PPs are not registered. PPs' status include three main categories: 1) qualified and registered (easiest to endorse); 2) qualified but not registered (can be endorsed if registered); and non-qualified; and 3) non-registered (hardest to accept by national authorities). The Uganda "National Strategy for Utilizing the Potential of Private Practitioners in Child Survival" includes a process to simplify registration procedures and reduce associated fees and taxes to encourage qualified PPs to register with health authorities. However, the strategy does not consider unqualified practitioners as "partners." Rather, they are considered as special community members who can deliver health messages but not clinical services.

## *Intervention Cost*

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The annual cost for this intervention to cover all private clinics and drug shops in one Ugandan district was estimated at \$8,600. The components are: inventory (suggested frequency is once every five years) \$440; simulated visits (twice per year for a 20% sample of PPs for six childhood conditions) \$2,880; negotiation sessions (once every five years for all target groups in the district) \$1,280; ongoing visits to PPs (twice per PP per year) \$4,000. No cost is calculated for developing communication materials or for communicating with clients since this was performed as part of the district's ongoing community IMCI program. Thus, in total, the intervention cost \$21 per PP working in private clinics or drug shops per year not including the cost of communicating with clients. These costs need to be examined against the intervention steps and suggestions for practical cost reduction measures need be tried. Also, the suggested frequency for conducting the inventory, negotiation sessions, and ongoing visits could be modified based on program evaluation results.

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## **References:**

1. Northrup R., *Reaching the private practitioner*, Issues Paper #2, PRITECH (Technologies for Primary Health Care) Project, Management Sciences for Health, Boston, July 1993.

2. Inayat H., Private practitioners in the slums of Karachi: what quality of care they offer?, *Soc. Sci. Med.*, 1998, Vol. 46, No. 11.
3. Bruga R., Zwi A., Improving the quality of private sector delivery of public health services: challenges and strategies, *Health Policy and Planning*, Vol. 13, Issue No. 2, June 1998.
4. Roemer, Private medical practice: obstacle to health for all, *World Health Forum* 1984, No. 5: 195-210.
5. Bhutta, Balchin, Assessing the impact of a regulatory intervention in Pakistan, *Soc. Sci. Med.*, 1996, Vol. 42, No. 8, pp. 1195-1202.
6. Bennett S., Carrot and stick: state mechanisms to influence private provider behavior, *Health Policy and Planning*, 1994.
7. Chakraborty S., Sister Ann D'Souza, Robert Northrup, Improving private practitioners' care of sick children: testing new approaches in Bihar, *Health Policy and Planning*, 2000, 15(4), pp. 400-407.
8. Bennett S., Promoting the private sector: a review of developing country trends, *Health Policy and Planning*, 1992.
9. Berman P., The role of private providers in maternal and child health and family planning services in developing countries, *Health Policy and Planning*, 1996.