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3 Working with Private Providers to Reach Sick Children

The Challenge

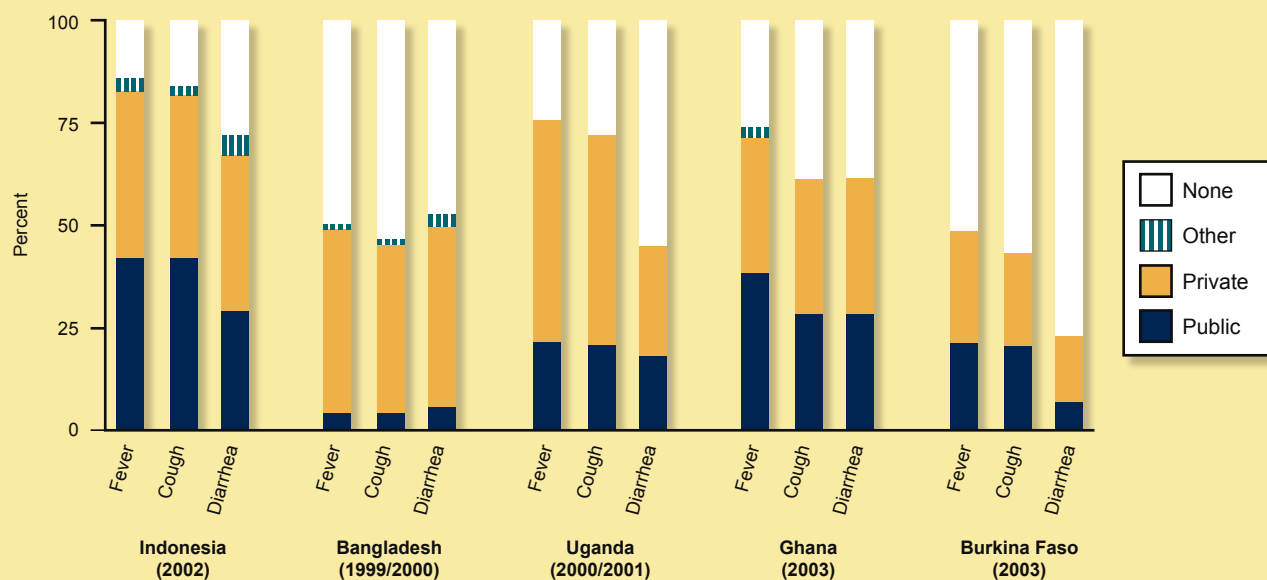
In order to reach poor families and children who are most vulnerable to illness and death in developing countries, government investments in health focus overwhelmingly on services provided through the *public sector*. The goal is to provide affordable care to those at highest risk.

The reality, however, is that from 50 to 70 percent of children who die never come in contact with the formal health system.¹ Some die before their parents realize how urgent it is to find care. But throughout all regions of the world, large numbers of even the poorest 20 percent of families seek advice from their pharmacists, rural drug vendors, traditional healers, or other local practitioners. The figure on this page shows the percent of poor families who seek care from the private sector for the three major causes of child death.

Parents often find private providers easier to get to, their hours and their supplies more reliable, and their treatment more respectful and in harmony with their own belief systems. But the care a child gets

¹ *Bustreo, F, Harding A., Axelsson H. Can developing countries achieve adequate improvements in child health outcomes without engaging the private sector? Bulletin of the World Health Organization 2003, 81(12): 886-894.*

Figure 3.1: Careseeking for young child illness* among the poor – public and private+ sector sources of care**



*For illness within the last two weeks. **Poorest 20 percent of the population
 +Private sources include shops, traditional healers, and private pharmacies, doctors, and clinics
 Source: A.E. Sommerfelt, Academy for Educational Development (2006), analysis of DHS data

may not be adequate. Efforts to reduce the 11 million preventable child deaths that occur each year will be severely limited until private providers become active partners in this challenge.

Governments are understandably reluctant to invest in training for certain kinds of practitioners—especially informal or traditional providers—and are often opposed even to “recognizing” those who aren’t properly registered. Collaborating means elaborating new policies and new training and monitoring programs for practitioners who operate under very different motivations and constraints than government employees. Many ministries of health in Africa and Asia have supported pilots to test strategies for improving treatment in the private sector. But most of the trials look at a single childhood disease. And most are never scaled up.

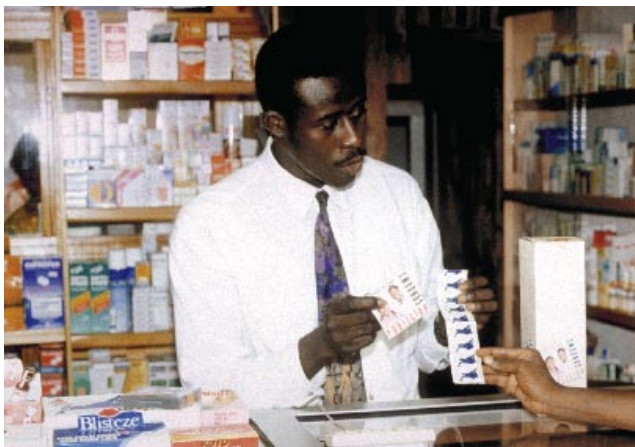
AED is collaborating with several countries to launch programs, and equally important, is helping to systematize this difficult process as more and more governments and donors gain interest.

Demonstrating and Scaling up Country Strategies

Nigeria

In Nigeria, malaria is responsible for 25-30 percent of child deaths. As in many African countries, inappropriate treatment of childhood fever, as well as poor adherence to drug treatment advice, is leading to widespread resistance of malaria to first line drugs. About 60-80 percent of childhood fever is treated in the private sector.

In 2002, the Academy joined with the Ministry of Health and several USAID projects to improve



Pharmacists and drug sellers provide medicines as well as advice to large numbers of people from every socioeconomic group.

key behaviors among both families and patent medicine vendors (PMVs) who sell the majority of anti-malarials. The program aimed to deal with two particularly knotty dilemmas of such training programs: designing a system that doesn’t put impossible burdens on the government, and using approaches that are credible to private sector trainees.

The first phase of the program relied heavily on an innovative community-focused health planning process the Academy had supported as early as 1994.² The planning groups, known as Catchment Area Planning and Action Committees (CAPAC), consist of 20 to 30 representatives who advocate for health-related resources and supervise community health promoters. The project worked with CAPACs serving a population of around 750,000. Their first task was to identify over 1000 patent medicine vendors in their local areas.

Academy malaria experts working through USAID’s BASICS project conducted training-of-trainer workshops for selected PMVs. The principle was to create a cadre of peer trainers who would be credible to their colleagues and could communicate well with them. The local CAPACs then organized one-day workshops in their own areas for local drug vendors using a participatory peer-educator approach. The training emphasized signs and symptoms of malaria, treatment with appropriate drugs, and referral of children with severe illness to a health facility.

The training was coordinated with the launch of a new product—prepackaged anti-malarials—that make it easier to dispense accurate doses and also easier for caregivers to understand what a “complete” dose is. Radio spots, billboards, and road shows promoted the product.³ The radio campaign also publicized the special training PMVs had received. Special stickers identified shops where someone had completed the course. Many PMVs proudly displayed their certificates of training.

An evaluation was carried out through simulated visits by “mystery clients.” Four months after the intervention, the percent of PMV clients given the correct dose of anti-malarial rose from 9 to 53 percent. PMV knowledge of severity rose from 32 to 71 percent and from 11 to 45 percent for the two major symptoms, respectively.

²The Academy introduced the CAPAC process in Nigeria under the BASICS I Project, funded by USAID.

³Media activities were designed by JHU/HCP; distribution of the pre-packs was managed by SFH/PSI (both funded by USAID).

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A unique aspect of this program was the second phase, which focused on scaling up. The rollout to nine additional local government areas relied heavily on collaboration with the PMV professional association (NAPPMED). They provided their membership list as a basis for identifying and inviting trainees. They also managed the logistics of local training during the scale up. This collaboration, and the reliance upon peer-educators, makes the approach both more cost-effective and more sustainable than many previous training models.

Uganda

Systematic Planning. In Uganda, government health services reach about 50 percent of the population. Even within the public sector, more than half of trained staff are concentrated in hospitals. Private providers manage the majority of childhood illnesses. The Academy has been helping the government develop a strategy to assess and improve their practices.

In 2001 AED's SARA Project began collaborating with the Ministry of Health, Department on Integrated Management of the Sick Child Initiative (IMCI). Together, they carried out an extensive *situation assessment* that included analysis of regulations that affect the private sector, careseeking patterns for different illnesses, and the effectiveness of treatment in the private sector.

The Academy then worked with the Ministry of Health and the National Malaria Control Program to involve a wide range of stakeholders, organize policy dialogue, and draft a *national strategy* for involving private providers country-wide. The draft outlined principles for effective at-scale interventions and implementation guidelines for moving ahead in five specific program areas.



This vendor in Nigeria sells drugs of various kinds, along with soap and other items.

The next step was a detailed *inventory* in three districts of the numbers and types of all formal and informal private health practitioners and the drugs they dispense. Community informants helped conduct these mapping exercises. The inventory also identified existing channels for reaching each of the major types of provider and “change agents” that would be credible to them. (For example, most providers either belong to professional associations or can be contacted through wholesale distribution networks of some kind.)

Collaboration across departments of the ministry laid the basis for a long-term approach that integrates training to improve care for common childhood killers—rather than just a single disease.

Targeting Three Major Killers. Together, malaria, pneumonia, and diarrheal disease are responsible for more than half of all childhood deaths in Uganda. And symptoms of the conditions often overlap. Severe

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pneumonia is responsible for up to a quarter of child deaths but often goes untreated in malaria endemic areas because fever is presumed to indicate malaria.

Based on the preparatory work described above, in 2002 the Academy joined with the government in Luwero district to improve the disease management practices of private clinics and drug shops—places most often visited by parents when their children are ill. “Mystery clients” gathered data for a baseline study on treatment and counseling practices related to six specific illness scenarios.

The training approach was actually a process of negotiation—taking into account the realities faced by private practitioners, including the pressures of profit, the promotional activities of pharmaceutical companies, and client expectations.⁴ “Moderators” sensitive to these constraints explained standard IMCI care guidelines and identified a limited number of changes in common practices providers could take that would have an impact on child survival. Participants signed individual “contracts” to make specific changes. The three-day trainings were followed by monitoring and support visits. Mystery clients visited the participants once again after three months to assess change.

The most impressive results occurred in malaria treatment.⁵ Most practitioners (73 percent) dispensed the correct drugs, as opposed to 2 percent at baseline. Advice for severe pneumonia also improved: 70 percent referred children, up from 24

⁴ This process was modified from the PRACTION (Private Practitioner Treatment Improvement) Model originally developed in the 1990s under USAID’s PRITECH Project.

⁵ Tawfik Y., Nsungwa-Sabitii, J., Greer, J., Owor, J., Kesande, R., and Prysor-Jones, S. Negotiating improved case management of childhood illness with formal and informal private practitioners in Uganda. Accepted for publication by Tropical Medicine and International Health.

Tools for National Strategies

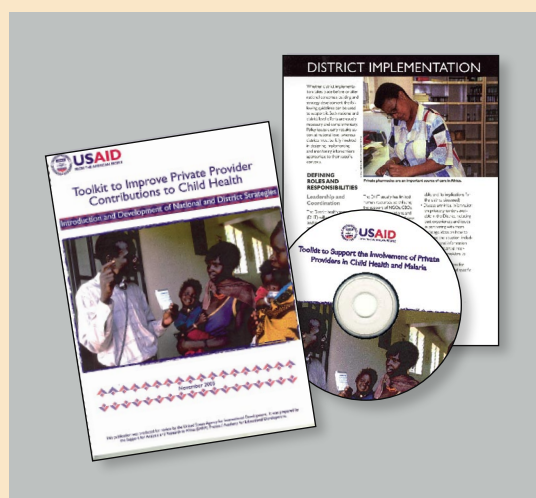
Working with private providers requires a fundamental shift within most ministries of health. It requires recognizing the *need* to collaborate across sectors, consensus on necessary changes in *policy* to allow this partnership, and new *strategies* for both reaching and “teaching” providers.

Comprehensive Tools

The Academy has developed a comprehensive *Toolkit to Improve Private Provider Contributions to Child Health* that provides an overview and helpful resources for the entire national strategy development process. The CD-ROM contains guidelines on 1) investigating care-seeking behaviors; 2) the development of policies and strategies; 3) the stages of program implementation; 4) the district planning process; 5) advocacy; 6) monitoring and evaluation; 6) logistics and drug management; and other areas. It also includes data sets for 40 African countries that are crucial for initial country analysis and advocacy purposes.

State-of-the-Art Review

Numerous countries have carried out training programs for private providers, and many of these have been evaluated to some degree. In 2003 the Academy completed a literature review of the state-of-the-art regarding partnerships with private practitioners to improve child survival. The review supplies valuable information to ministries on what has been done, what works, and common challenges.



percent. Practices most resistant to change were for diarrhea, but these also improved. The proportion who discussed danger signs for a case of severe diarrhea rose from 36-52 percent. Recommendations of oral rehydration salts rose from 62 to 70 percent. Dispensing of unnecessary (and often harmful) medications dropped from 77 percent to 22 percent.

Many providers continued to recommend unnecessary antibiotics for mild respiratory infections. The majority failed to give important advice on feeding for children with severe diarrhea. The pilot was therefore also important in helping to identify behaviors needing special attention in the training before scaling up.

Advocacy and Tools for Change

Donor support is critical if governments are going to take the many “leaps” necessary to begin working effectively with the private sector. AED has played an active role in moving this process ahead through consultations and working groups with the World Bank, the World Health Organization, PAHO, Roll Back Malaria, as well as USAID.

One of the first challenges for both donors and governments is to provide the hard data needed to justify the major new strategies and financial commitments needed to work with private providers. The Academy has helped make a clear case for engaging formal and informal practitioners by supplying evidence of careseeking patterns, as well as new tools for investigating practices at the local level. (See box on previous page.) In 2004, at the request of the World Bank, Academy staff conducted a special analysis of data from Demographic Health Surveys regarding treatment-seeking for several child diseases. The analysis, carried out for more than 40 African countries, provides details according to the socioeconomic and urban/rural status of caretakers, along with careseeking information for up to ten categories of private provider—from drug vendor, to traditional healer, to pharmacist.

The figure at the beginning of this chapter was drawn from that research. The complete dataset is just one resource available on the Academy’s comprehensive CD-Rom toolkit for governments, donors, nongovernmental organizations, and others interested not only in making the case for collaborating with this “silent majority” of health providers, but also taking concrete steps in that important direction.■