TOOLKIT TO IMPROVE PRIVATE PROVIDER CONTRIBUTIONS TO CHILD HEALTH

INTRODUCTION AND DEVELOPMENT OF NATIONAL AND DISTRICT STRATEGIES

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INTRODUCTION

WHAT IS THE ROLE OF THE PRIVATE SECTOR IN CHILD HEALTH AND MALARIA?

In June 2002, the World Bank published a discussion paper titled Working with the Private Sector for Child Health. The paper - developed with technical assistance from the USAID Bureau for Africa, Office of Sustainable Development (AFR/SD) through the Support for Analysis and Research in Africa (SARA) project – lays out a framework for analyzing the contributions of the private sector in child heath. The framework, outlined below, is designed to serve as a basis for assessing the potential of different components of the private sector at country level.

The framework identifies the following components of the private sector as being important for child health:

- Service providers (formal sector, other for-profit, employers, non-governmental organizations (NGOs), private voluntary organizations (PVOs), and traditional healers)



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A Community Health Nurse visits with an antenatal patient.

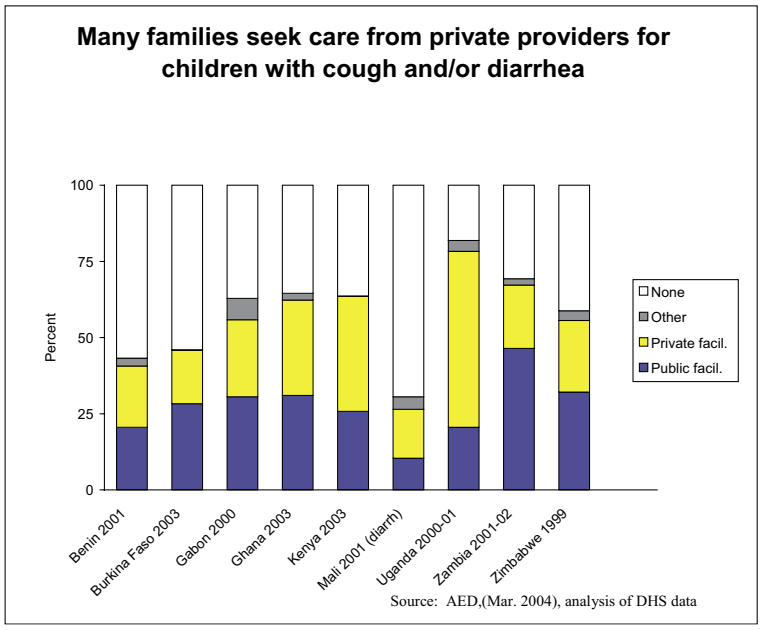
- Pharmaceutical companies
- Pharmacies
- Drug vendors and shopkeepers
- Food producers
- Media channels
- Private suppliers of products related to child health, e.g. ITNs
- Health insurance companies

The paper then identifies strategies for working with the private sector to improve child health, including:

- Contracting of essential child health services to NGOs, accredited private providers (PPs), etc.
- Regulation and setting standards
- Financing support to the private sector, e.g. direct payments to encourage the provision of services in disadvantaged areas
- Non-financial incentives, e.g. provision of extra staff or supplies to private companies for increased provision of child health services
- Coordinating service provision and financing to ensure that a standard minimum of

services is provided across geographic areas and social groups

- Commercializing child health products, e.g. partnering with private companies to increase the production and availability of essential products such as soap, bednets, Oral Rehydration Salts, other essential drugs for treatment of childhood diseases
- Training / negotiating with private providers to improve the quality of care
- Advocacy, e.g. with private companies, professional associations, etc. to encourage increased and improved provision of child health-related services
- Educating consumers to influence the demand for appropriate services from both private and public sector providers
- Community financing schemes, such as prepayment schemes to protect households from out-of-pocket expenses that restrict access to health care.



The paper concludes that "the private sector is enormously heterogeneous. At the country level, feasible strategies will depend on the potential of the different components of the private sector and the capacity of governments and their partners for collaboration."

WHAT IS THE BACKGROUND TO THE TOOLKIT?

Within this over-arching framework that shows the place of the private sector in child health, there has been a growing recognition that private providers constitute a huge resource for improving community health outcomes. Data from several countries show that formal and informal private providers provide a significant proportion of case management for common childhood illness such as diarrhea, malaria and acute respiratory infection (ARI). This is true even for the poorest population quintiles.

Working with these private providers offers important opportunities to increase the coverage of appropriate child health and malaria services, and can then contribute to reaching the Millennium Development Goals for child health and malaria.

Despite this, PPs are largely ignored by child survival programs in developing countries. Evidence from various sources shows that, for children under five, caretakers seek care from

private sector sources to a much greater extent than is reflected in current investments in child health and malaria.

Mothers and guardians of sick children often prefer PPs because they are more accessible, sensitive to their specific needs, have medicines, and can dispense these on credit. However, the quality of case management offered by PPs is frequently substandard. Studies show that PPs practices often deviate seriously from the recommended clinical guidelines for managing childhood diseases. Studies of practices in public facilities also show many problems, especially prior to focused quality improvement efforts.

USAID/AFR/SD, through the SARA project, in partnership with the World Health Organization Child and Adolescent Health (WHO/CAH) Department, has been working closely with the World Bank and other partners to draw attention to this situation. First, a global review of literature / situational analysis paper was produced to summarize lessons learned and promising interventions to improve the quality of PPS practice. This paper, published by the SARA project in 2002 with a foreword by Dr. Hans Troedsson of WHO/CAH, is titled Utilizing the Potential of Formal and Informal Private Providers in Child Survival: Situation Analysis and Summary of Promising Interventions."

Although several countries, with support from various international agencies, were undertaking demonstration projects that mobilize private providers, no example existed of a national framework for involving private providers. This was identified as an important obstacle to moving forward in this field.

To address this gap, the SARA project, in close collaboration with WHO/CAH, responded to interest from Uganda and provided technical and financial support in developing a national strategy. Uganda put together a situation analysis, based on careseeking behavior data and information on private providers. A national core team of Ministry of Health professionals from the Integrated Management of Childhood Illness (IMCI) and Public Private Partnerships Units engaged stakeholders from public, private, and NGO sectors. Advocacy and consultations led to national consensus-building. On this basis, Uganda developed a national strategy, and moved to more detailed district-level situation analyses, planning, and implementation.

This toolkit is intended to fill a need that surfaced in Uganda and elsewhere, for some basic guidance and reference materials to assist managers in developing public-private partnerships and interventions to improve the reach and quality of child health services by involving the private sector.

WHY DEVELOP A TOOLKIT?

Many developing countries are realizing the importance of including formal and informal private providers in child survival and malaria control interventions. Some of them, e.g. Bangladesh, are now developing national strategies, based on situation analyses. In addition, different types of interventions, some of them quite innovative, are being undertaken in several countries in areas such as child survival, malaria, and TB. Tools for situation analysis, advocacy, strategy development, planning, implementation, and monitoring / evaluation have been used in these processes, and could benefit other countries who decide to address this gap.

The purpose of the Toolkit is to

share these field experiences and tools, to accelerate national and sub-national efforts to involve private providers in national child survival and malaria programs and to work at scale, based on lessons from promising interventions.

WHAT DOES THE TOOLKIT CONTAIN?

The Toolkit consists of two parts:

1. An overview of the national strategy development process, with reference to relevant tools.
2. A CD-ROM containing:

- tools / examples for national strategy development (rapid assessment / situation analysis, advocacy, stakeholder involvement, planning, monitoring / evaluation)
- tools for interventions of different types of interventions (regulation, motivation, education/persuasion, negotiation, regulation, prepackaging, client education)
- general papers related to private providers (overviews, position issues, etc.)
- intervention-related documents (program descriptions, evaluations, research findings, etc.)

WHO WILL THE TOOLKIT SERVE?

The Toolkit will be useful for various types of people and organizations interested in increasing and improving the role private providers in child health and malaria:

- National level Ministry of Health staff (child health units, public-private partnership units, etc.)
- Provincial and District Ministry of Health staff and their partners
- NGOs
- Professional associations (medical, pharmacists, midwives, nursing, other paramedical, patent medicine vendors, etc.)
- Research institutes
- Donor and technical assistance agencies

HOW CAN THE TOOLKIT BE USED?

The overview of national strategy development is designed to assist countries in reflecting on and planning for their own situation analyses and national strategy development processes. Many people are interested in working with private providers at country level, but they often lack the information and tools required to spearhead a national effort. The Toolkit should provide ideas to these latent "champions" on how to identify and engage the relevant stakeholders in their countries, and present the locally-generated evidence needed for advocacy and consensus-building. The examples of national strategies from other countries will hopefully be useful for country teams in designing their own country-specific strategy to improve child health and malaria through increasing the involvement of PPs.

The CD-ROM is constructed as an archived web-cd. A user can indicate his/her area of interest, drawing from a table of contents, and download documents and tools for reference and local adaptation. In addition to program tools, the CD-ROM includes discussion papers, program overviews and evaluation and research findings. It should therefore be useful for a wide range of interested parties – those starting to reflect on policies and strategy development on one end of a continuum, and those preparing for program design, implementation, and evaluation at the other.

CARESEEKING BEHAVIOR

In many countries, formal and informal private providers are important sources of case management for common childhood illnesses, such as diarrhea, malaria, and acute respiratory infection (ARI). Parents and guardians of sick children often prefer PPs because they are more accessible (both geographically and financially), and are perceived as respectful and sensitive to their needs. The graphic to the left summarizes the use of private providers for childhood diarrhea and acute respiratory infections in Africa, taken from the most recent available DHS data on careseeking behavior.

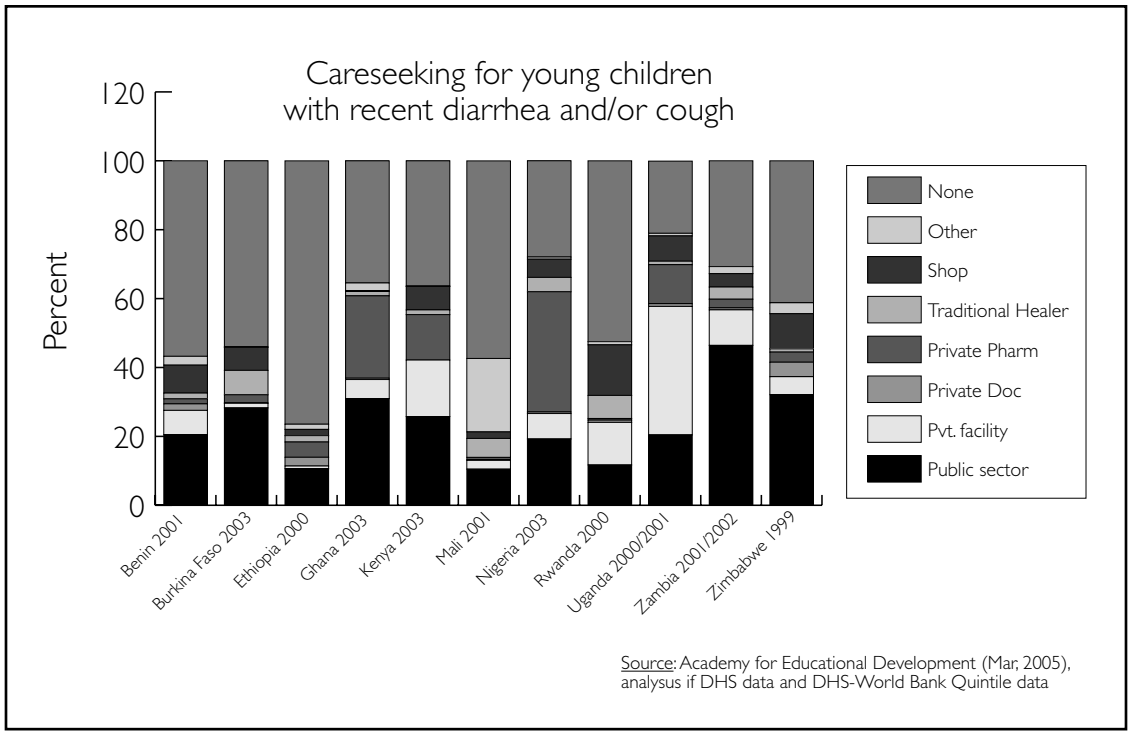
The graphic shows that, in many cases of childhood illness, no care is sought outside the home (white part of the columns). This tendency is even higher in rural areas. When caretakers do seek care, drug sellers or shops, private pharmacies, private clinics or doctors, or traditional healers are among the private sources consulted.

Careseeking patterns vary considerably across and within countries. The use of private

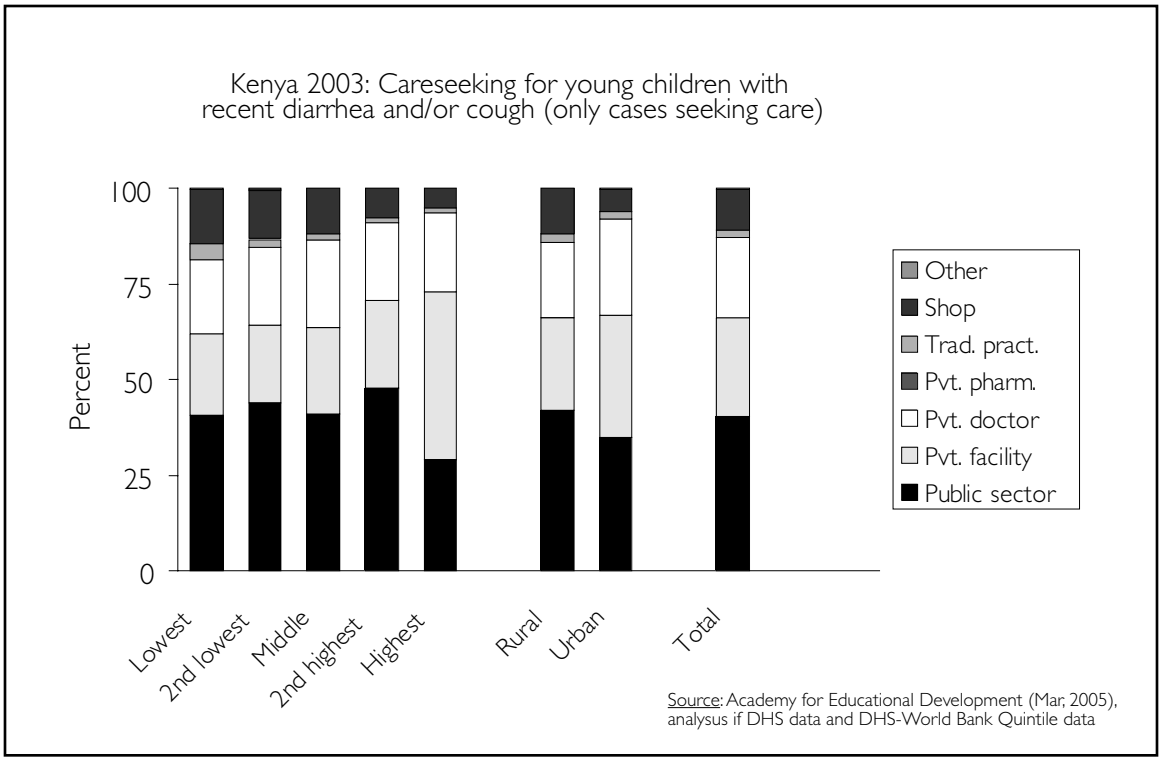


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A counselor discusses nutrition with a patient.



Source: Academy for Educational Development (Mar, 2005), analysus if DHS data and DHS-World Bank Quintile data



health facilities or private doctors in most countries is much higher in urban areas than in rural, e.g. almost double in Kenya (see graphic to the right), Benin, Malawi, and Zambia. Analysis of careseeking by economic quintiles shows much higher use of private clinics, doctors and, usually, pharmacies by the highest quintile (Kenya, Benin, Malawi, Zambia, and Zimbabwe). However, the use of shops seems to be fairly steady over the different quintiles in most cases, and is sometimes higher in lower quintiles, as is illustrated in the Kenya data shown here. The data show the source of care only for those cases where there was recourse to care outside the home.

Despite PP's important role in treating sick children in many developing countries, health authorities have, on the whole, not yet included them in child survival programs, such as IMCI and malaria control. As the data show, public health services tend to have limited coverage, requiring a much broader approach if countries are to reach the Millennium Development Goal to reduce childhood mortality by two-thirds by 2015. It is important to understand health careseeking behavior in order to orient the development of interventions towards the private providers that caregivers already use.

INTERVENTIONS

Suitable field interventions need to be developed and tested in each country context to improve private providers' willingness and ability to provide better case management and prevention services for children. Concomitantly, a national strategy appropriate to each country context is needed to guide the process of engaging private providers at scale.

This requires national-level recognition of PP's potential to contribute to improving child health. Very few countries have addressed this issue, and fewer still have developed a national strategy and policy framework to harness PP's potential contribution to public health goals. Uganda is perhaps the first country to engage stakeholders in developing such a strategy.

Countries currently face some or all of the following challenges as they contemplate developing national and district strategies and interventions:

- Information on the use of private providers for child health (careseeking behavior data, etc.) are rarely analyzed and presented for discussion and strategy development
- Few mechanisms exist to work with PPs; NGOs and others are often discouraged from approaching PPs
- National policies often treat PPs as nonexistent; especially informal ones
- Treatment guidelines and policy documents are often not disseminated by the MOH to the private sector
- Registration procedures are too complex
- Registration fees and taxes are high and constitute a barrier
- Attitudes of public sector authorities towards private health providers are often negative and hostile
- Uncertainty exists about which interventions will be effective
- Regulation of drug quality is difficult, and treatment given is not always safe
- Reaching PPs, especially informal ones, to involve them in interventions and monitor their practices over time is difficult
- Challenges exist in taking interventions to scale



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A Community Health Nurse visits with an antenatal patient.

The following table, based on literature reviews and some key informant discussions, summarizes the information available on approaches that have been implemented and their effectiveness. A brief description of each intervention approach is presented in Annex 1.

Table 1: Level of Testing, Evaluation, Effectiveness, Cost, and Replicability of Strategies and Interventions to Influence Providers' Practices

Approach /intervention	Adequately tested?	Impact adequately evaluated?	Proved effective?	Cost	Replicable on large scale?
Regulation: Deregistration of harmful drugs	Yes	Yes	Limited, with serious draw backs	Low	Not proved effective
Banning the practice of unqualified providers	Yes, most national policies restrict the practice of informal providers	No formal evaluation	No, generally ignored by providers and public and not enforced by authorities	Low, as usually difficult to enforce	Not proved effective
Inspections (Stenson, Syhakhang et al. 2001)[1]	Randomized trial	On limited scale	Improvements in availability of medicine and order of the pharmacy	No specific information	Not known
VAT elimination (Karymbaeva 2004)[2]	Yes	On limited scale	Reduced cost of drugs	Not reported	Theoretically yes
Motivation: providing free drugs /vaccines /supplies and /or other incentives	No	No	Not adequately tested	Cost of free drugs/supplies	Likely, needs further testing
Education/ Persuasion: Knowledge-based training	Yes	Yes	No impact on practice	Relatively low	Not proved effective
Training focused on limited number of specific practices	Limited Trials	Preliminary evaluation only	Yes, in pilot areas	Limited information on cost analysis	Potentially replicable
Face-to-face detailing visits to providers	Yes	Yes	Yes, in pilot areas	No specific cost analysis, likely to be costly, unless integrated into ongoing activities	To be proven

Negotiation: Education with participatory definition of target behaviors and informal "contracts'	Limited trials	Yes	Yes, in pilot areas	Limited cost analysis available	Needs further testing
Prepackaging: of appropriate drugs	Yes, for malaria treatment	Ongoing	Yes, preliminary results	Relatively low	Needs to be tested
Customer education:	No	No	Not adequately tested in care of sick children	Little information available	Needs to be tested
Franchising:	Limited studies	Ongoing	Data under review	High setup costs; cost analysis part of on-going evaluation	Needs further testing
Accreditation:	Limited studies	Ongoing	Data under review	High setup costs; cost analysis part of ongoing evaluation	Needs further testing

[1]*Real World Pharmacy: Assessing the Quality of Private Pharmacy practice in the Lao People's Democratic Republic*, Stenson B. et al, 2001.
[2]The Influence of VAT Elimination on Drug Prices in Kyrgyzstan, Karymbaeva, S. Powerpoint Presentation, 2004.

Source: adapted from Tawfik, Northrup, and Prysor-Jones. (2002). Utilizing the Potential of Formal and Informal Private Providers in Child Survival.

The following sections address some common issues that underlie the development of interventions aimed at increasing access to child health through private providers:

DEVELOPING POLICIES THAT ADDRESS INFORMAL PROVIDERS

National health policies in several developing countries have recently included general statements calling for involving the "private sector" in health programs. Here the "private sector" usually means private enterprises that may contribute to supporting some health interventions. It is usually assumed that "private sector" also includes formal private providers. However, most national policies and regulations prohibit informal (unqualified and/or unregistered or unrecognized) providers from practicing and, therefore, do not include them in interventions.

Not including informal or unrecognized PPs creates a dilemma for program planners, where careseeking behavior analysis shows these providers are important in treating common childhood illness. Analysis of careseeking behavior in urban / rural settings and by economic quintile shows that often the poor—the most vulnerable sections of the com-

munity—use informal providers, such as traditional healers and drug sellers[3]. However, given the constraints of many national policies, child health programs and their partners have been reluctant to contact and work with them.

To avoid delays in reaching agreement on this type of policy issue, it may be most appropriate to start with interventions addressing formal, registered providers. Advocacy for addressing informal providers can be carried out simultaneously and include presentations of careseeking data to stimulate the debate and open the door to involving them suitably in child survival programs.

DEALING WITH NON-REGISTERED AND INFORMAL PROVIDERS IN UGANDA

The approach adopted considered formal (qualified) private providers as partners in providing case management for childhood illnesses. Although only one-third of these were actually registered, it was agreed that interventions should include them all, with a view to increasing the proportion that would seek registration. In addition, by considering informal/unqualified providers such as drug sellers or nursing aids primarily as "community members", the door was opened for working with these PPs as other types of community groups that support priority health issues.

WORKING AT SCALE TO ENSURE IMPACT

As indicated in the summary table of interventions, most efforts have so far been implemented on a relatively small scale. They have often started as operations research efforts or demonstration projects, with minimal planning for how to move to work at scale. However, in order to have a significant effect on improving access to appropriate child health services, pilot interventions should be designed from the start with sustainability and large-scale implementation in mind. When countries wish to start with pilot projects or demonstration areas, it is important to:

- Engage stakeholders from the start (private associations, key private sector actors, public health and drug authorities, etc.)
- Create linkages with donor agencies, co-funding demonstration efforts where possible, thus increasing the likelihood of ongoing support for scale-up
- Create or reinforce management structures/mechanisms to handle interventions at a larger scale
- Mobilize local resources and minimize costs and the use of temporary external resources
- Pay close attention to the incentives systems, formal and informal, that may influence the motivation for scale-up of both private and public sector actors.

INTERVENING TO CHANGE SERVICE DEMAND PATTERNS

Interventions to improve the quality of care given by private providers must consider the range of pressures that moti-

[3]SARA/AED, *Analysis of Care-Seeking Behavior from DHS Surveys*, 2005.

vate and influence providers. In addition to financial and other aspects, patient pressure can often be a determining factor in prescribing practices. Client education, aimed at changing patterns of demand through community education and mass media, is therefore an important strategy for modifying provider behavior. Increasing the demand for particular types of care can reinforce any direct intervention with providers and help to create the momentum for changing and maintaining provider practices at greater scale.

CREATING FUNCTIONAL PARTNERSHIPS BETWEEN PUBLIC AND PRIVATE SECTOR ACTORS

Both the public and the private sector have key responsibilities in integrating private providers into national child health programs. Limited activities can occur without developing solid partnerships, but working at scale in a sustainable manner necessarily requires both private and public stakeholders to collaborate in their respective roles.

Even though the private sector is the focus of interventions to improve provider performance, the public sector, (including the drug regulatory authority, the central MOH, District Health Teams, etc.) is needed to provide a national framework to include PPs and to play a regulating role. The following public sector activities are needed, and many are best carried out in close collaboration with private sector partners, such as professional associations:

- Develop sound national health policies to facilitate harnessing private providers to improve child health
- Set clear and reasonable regulations for different categories of PPs
- Assure that drug classification facilitates access to appropriate essential drugs for PP clients
- Set simple and affordable licensing and registration procedures for PPs
- Set standards, e.g. in accreditation
- Share current case management guidelines and tools with PPs
- Include PPs in activities to update their knowledge and skills through training, continuing education, etc.
- Prepare effective referral system and sites that encourage PPs to refer severely ill cases
- Monitor and enforce regulations
- Monitor quality of service in private sector including the quality of medicines

On the other hand, the collaborative role of professional associations and providers includes the following activities:

Associations:

- Participate in national efforts to develop appropriate policies and regulations
- Represent the interest of PPs in dialogue with the public sector
- Create incentives for PPs to participate in associations
- Assist PPs with registration information and procedures
- Help to monitor and enforce regulations
- Supervise /monitor quality of service
- Share information, tools and guidelines on child health and related issues
- Organize training and/or continuing education activities

Individual providers:

- Obtain legal status for practicing, including being licensed and registered
- Provide effective high-quality case management services;

use existing national guidelines to perform essential tasks (e.g., history taking, examination, counseling, and appropriate referral)
- Expand services, if possible, to include essential preventive services, such as vaccinations and counseling on nutrition, careseeking, use of ITNs, hygiene, birth spacing, etc.
- Update knowledge and skills by participating in training courses, seminars, etc., offered by reliable sources.
- Train their staff on the job and monitor their practices

For public-private partnerships to be functional, it is important to take into account the interests of private providers, and not just to look at the objectives of the public sector. Interventions should try to appeal to the enlightened self-interest of PPs, and to factor in the context in which they work, including their financial motives.

Experience to date has shown that private providers can be drawn to contribute to public – private partnerships for some of the following reasons:

- being affiliated with national programs allows them to acquire greater credibility and status in the community, especially when proof of accreditation can be demonstrated to their clients (e.g. certificates, branding)
- private providers may be interested in showing to the public that they are concerned about quality of services and not just motivated by profit
- most private providers are pleased to have the (rare) opportunity to improve their knowledge and skills, and to play a public health role in the community.

There can, indeed, be some contradictions between the practices promoted as part of the public health agenda and the profit motive. Putting the emphasis on promoting essential, high impact, correct practices, rather than prohibiting negative practices has been found to be an effective strategy in dealing with these contradictions.

DEVELOPING A NATIONAL STRATEGY FOR CONSENSUS AND COORDINATION

A national strategy is important to provide an enabling framework for involving PPs in child health. The strategy development process should stimulate stakeholders to participate and facilitate agreement on intervention strategies and approaches that are appropriate to the country context. Both the process and the resulting strategy document will facilitate efforts to go to scale, through:

- Identifying approaches that can be used by NGOs, associations, and other implementers
- Sharing approaches, lessons learned, and tools across districts
- Mobilizing interest and resources among donors and country decision makers

DEVELOPING A NATIONAL STRATEGY



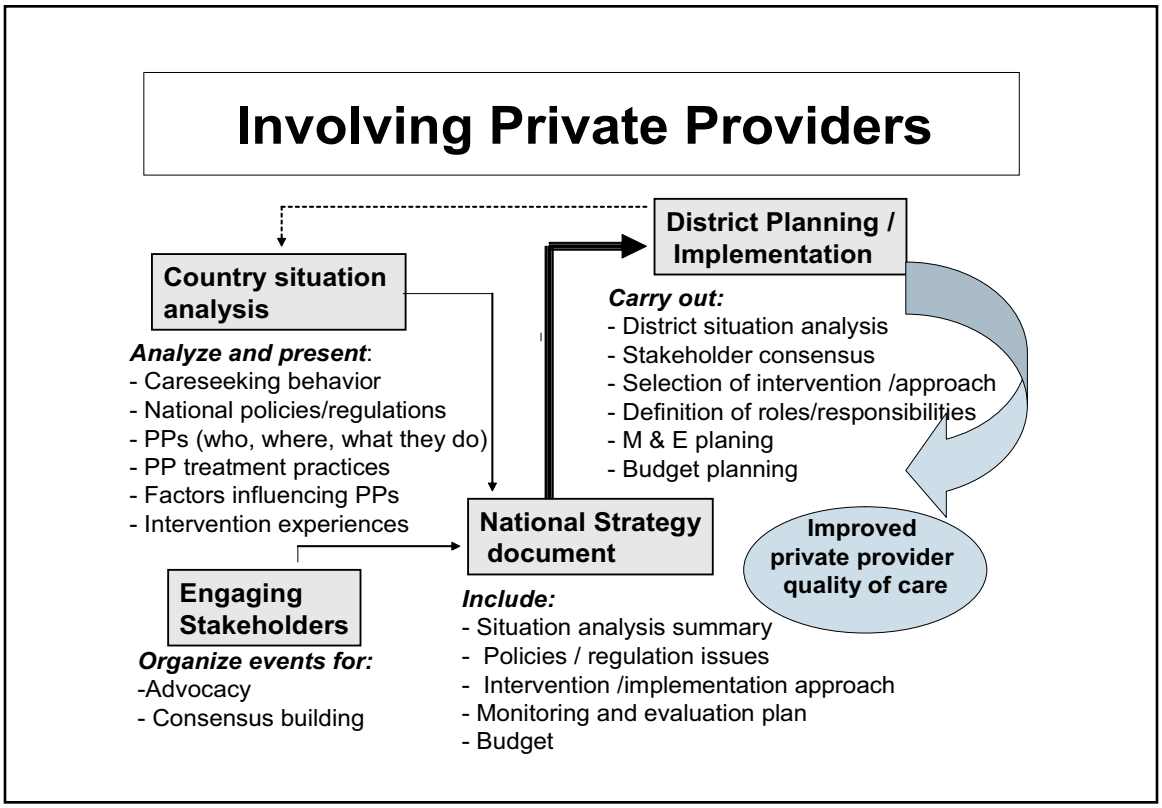
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Community health workers with the Kenya Medical and Educational Trust (KMET) hike miles each week in this rural community to provide emotional and minor medical support to home-bound AIDS patients.

Implementation at District or sub-District levels can take place at any time, since the process of involving private providers is not a linear one. Many countries, such as Bangladesh, Kenya, and Nigeria, have started with demonstration projects and used the results from these to sensitize stakeholders and engage them in going to scale. In this case, developing the national strategy may come much later, at a time when scaling up is being considered. Other countries, such as Uganda, worked on national consensus-building and strategy development at an early stage, and quickly moved to district-level implementation within a nationally accepted framework.

It is important to involve District health authorities and their potential private sector partners in the process of national consensus-building. This will prepare the ground well for local-level implementation.

THE STRATEGY DEVELOPMENT PROCESS



The graphic above indicates the main activities involved in developing a national strategy and moving to district implementation. As the interrupted line suggests, district or local level interventions may already be underway before a national strategy is developed. Pilot or operations research efforts may in some cases be essential to show decision makers that involving private providers effectively is possible in the country context. Information from such demonstration interventions will be considered in the country situation analysis, and important in shaping the national strategy. This strategy should then be a helpful advocacy tool and guide to stimulate activity in other districts.

In summary, each country may start this process differently as it is not always necessary or appropriate to develop a national strategy first. This will depend on the readiness of country decision makers. A small-scale district, NGO, or research field intervention may sometimes be the best entry point to pave the way for national-level consensus and programming at scale.

MANAGING THE STRATEGY DEVELOPMENT PROCESS AT NATIONAL LEVEL

A national entity must lead the national strategy development process. Identifying an exist-

ing unit or working group is preferable and usually possible, for example, a unit within the MOH, such as the IMCI Unit, the Malaria Control Program, or unit dealing with public-private partnerships. The selected entity should make sure to include representatives from government, NGOs, professional associations and, most importantly, formal and informal private providers already working in child survival and malaria.

Whatever unit takes the lead at national level will require support from a small, preferably inter-agency working group that will prepare draft plans, follow-up on needed action, implement activities, make suggestions, and bring issues for discussion to the larger group of stakeholders.

In Uganda, the Ministry of Health's IMCI Unit took the lead, in coordination with the Public-Private Partnership (PPP) Unit, to guide the strategy development process. The IMCI and PPP Units formed a working group that included representatives from the Malaria Control Program, WHO, and representatives from different groups: private medical practitioners, pharmacists, nurses and midwives, allied professionals and the informal sector.

In Bangladesh, an NGO, CONCERN International, worked with the IMCI Working Group to advocate for including formal and informal private providers in the IMCI national strategy. The working group was composed of MOH units, NGOs, and multilateral partners. Professional associations are invited to participate in selected meetings. CONCERN is giving technical support to the working group for implementing interventions in selected sites and developing a national strategy.

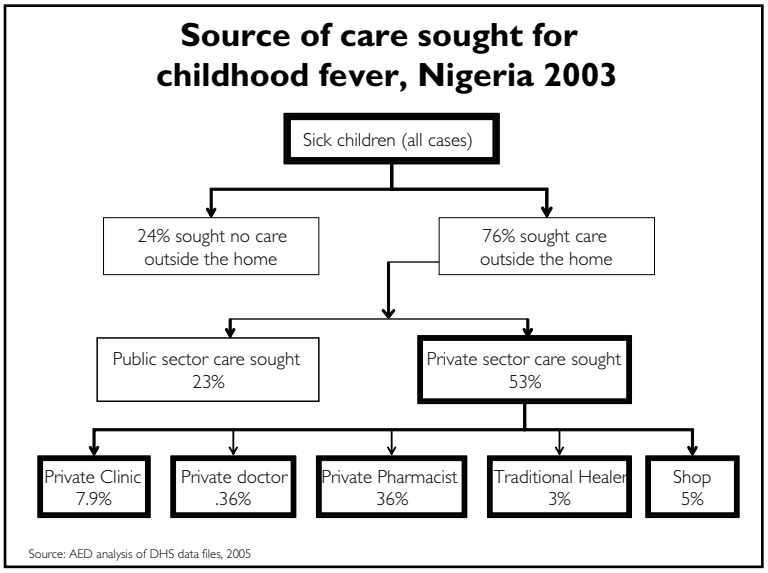
Supporting organizations, working closely with the MOH, may include: NGOs, professional associations (nursing or pharmacy) donors and partnering institutions such as WHO, USAID and CAs.

PREPARING THE SITUATION ANALYSIS

Preparing to develop a national strategy requires that stakeholders understand the country situation. This includes understanding or identifying:

- Health careseeking behaviors
- Current national policies and regulations that govern private practice
- Involvement of the MOH in supervision and oversight
- Role of the professional associations
- Who private providers are and their level of training
- Existing or potential channels for contacting PPs
- Problems of care quality given by PPs
- What influences PP behavior
- Country experiences in working with PPs and lessons learned

This type of information usually exists in some form in most countries, so it should not be necessary to conduct separate studies. Existing data can be identified and analyzed, and additional information gathered at this stage only where clearly necessary to fill gaps in knowledge and understanding of the country context. Sources of information will include the Demographic and Health Surveys (DHS) and other survey information, qualitative studies, program reviews and evaluations, student theses, etc., as well as stakeholder and key informant interviews. The information should be compiled and presented in a user-friendly manner so that stakeholders can discuss and build consensus on the way forward. The fol-



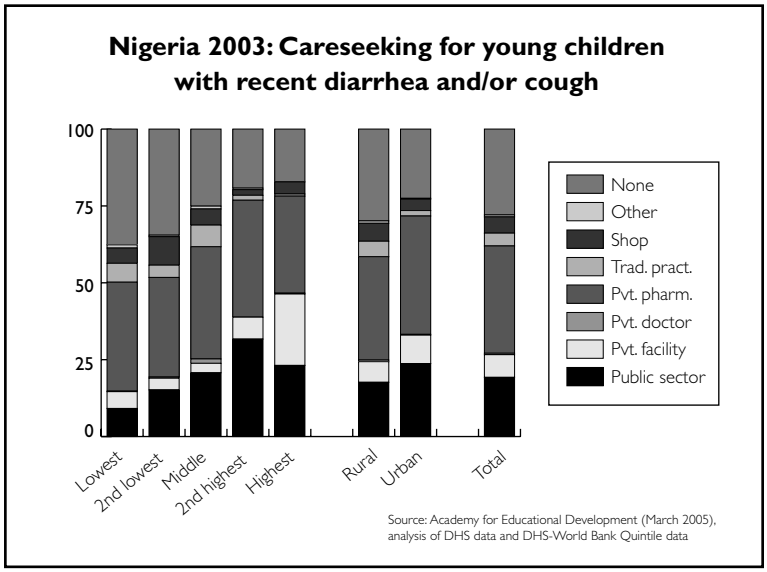
lowing sections elaborate how to complete a situation analysis, based on existing information and collecting additional data, as needed.

Understanding and Presenting Careseeking Behaviors

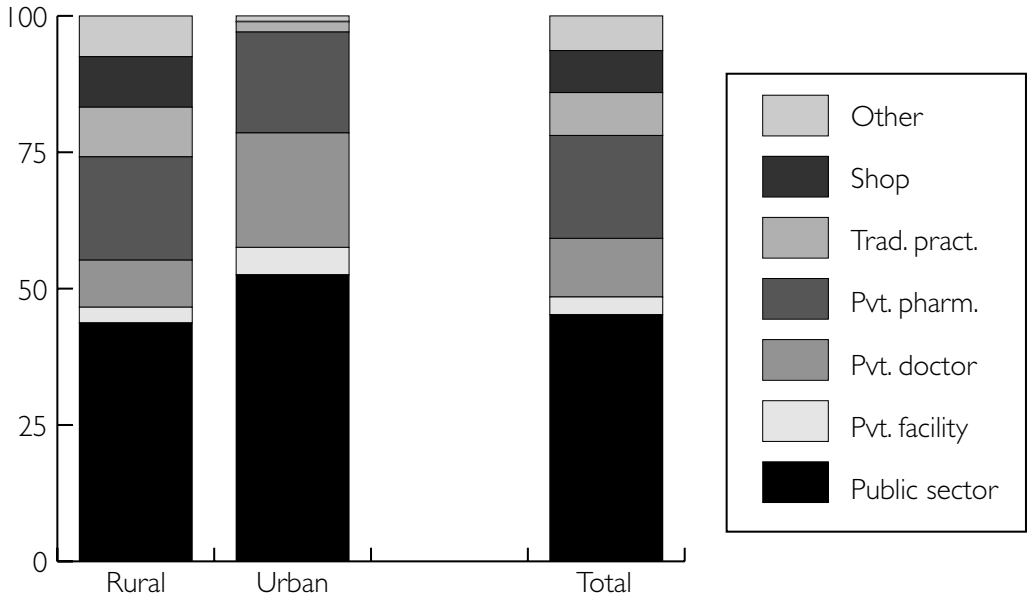
Understanding the health careseeking behavior for child illnesses is important in developing national strategies for child survival. It is particularly necessary to understand where parents and guardians go to get treatment and advice for their sick children, so that decision makers can use evidence to decide which group (s) of private providers should be the main target of interventions. Often this information already exists in studies, such as the DHS, university theses, or other household surveys. The graphics below show two ways to present data on careseeking behavior.

The first graphic draws particular attention to the total proportion of cases of childhood illness that are taken to private sources outside the home for care. The proportion of cases where no care is sought outside the home is also well highlighted, and can be used to point to the need for improved client education.

It is important that the graphics group private providers into categories (e.g. public clinics, private clinics / facilities, private doctors, private pharmacies, shops, traditional healers), to give enough detail to allow managers to decide on which provider groups to focus their attention. Decision makers may also be interested in considering issues of equity in the use of services. The graphic here shows that the lowest wealth



Ethiopia 2000: Careseeking for young children with recent diarrhea and/or cough (only cases seeking care)



Source: Academy for Educational Development (March 2005), analysis of DHS data and DHS-World Bank Quintile data

quintiles in Nigeria in fact make less use of public services than the higher quintiles.

Differences in careseeking between urban and rural areas

In almost all countries, careseeking outside the home is higher in urban than in rural areas. The differences are quite large in several countries, e.g. Burkina Faso (2003) and Mali (2001).

The Ethiopia data presented here above looks only at those who sought care outside the home (for diarrhea and /or fever). The data show that urban dwellers make much more use of private doctors, while rural populations tend to have more recourse to shopkeepers and traditional healers. The fact that overall careseeking outside the home is extremely low in Ethiopia (less than 25% of childhood illness is treated outside the home) is not conveyed here.

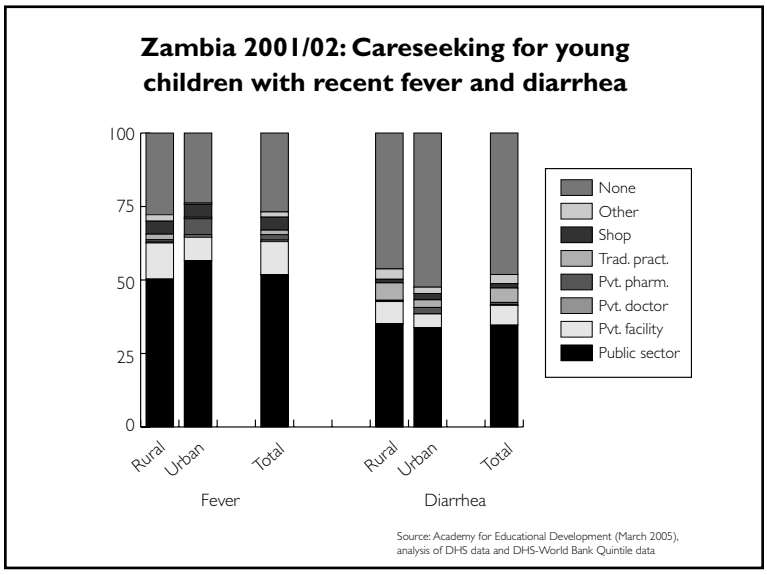
In Uganda, the public sector and shops are more widely used in rural settings, whereas private clinics and pharmacies are more used in urban areas.

Differences in careseeking by type of illness

In general, caretakers seek care outside the home equally often for fever and cough. Outside help is less often sought for cases of diarrhea.

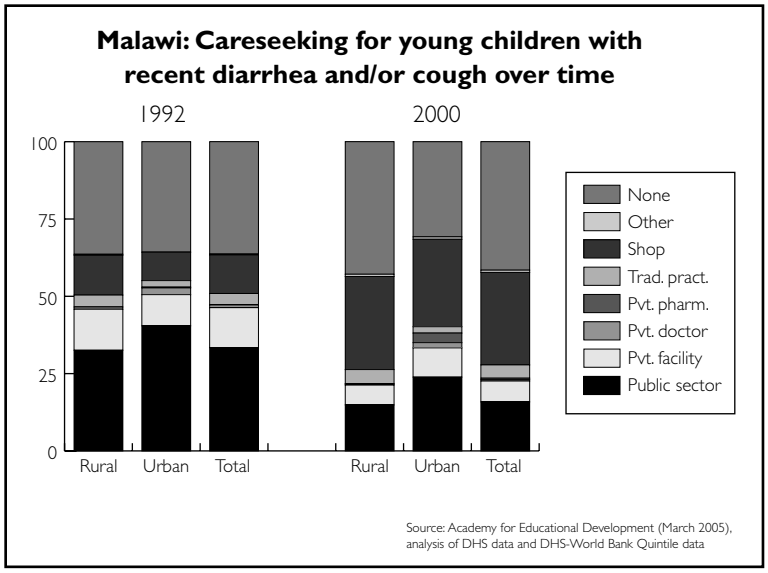
It is interesting to note that in some countries the patterns

of care are different depending on the illness. The graphic for Zambia to the right, for example, shows that drugs are bought in shops more often for fever, while traditional healers are more often sought out for diarrhea, especially in rural areas.



Changes in careseeking behavior over time

Patterns may change considerably over time, as shown in the two graphs below from Malawi. Malawi appears to have the highest use of shopkeepers in Africa, a trend that seems to have grown over time, with decreasing use of health facilities for childhood diarrhea and ARI. This information was collected five years ago, and may now be out-of-date.



Questions for data collection

How survey questions are asked is also important. To understand what people actually do, it is more effective to talk to parents/caretakers who have had a sick child recently rather than to ask parents about where they might seek care if their child were to get sick. Below is an example of questions that could be used to gather information on health careseeking behavior.

If it is necessary to collect additional information on careseeking behavior, a simple example of questions that can be used is offered below, (similar questions can be asked for recent diarrhea and recent fever). Such questions can be included in surveys that are being planned nationally or locally by government and/or its multilateral or NGO partners. The questions could also be part of a separate study or survey. Resources on how to plan and implement surveys can be found on the website for UNICEF's MICS surveys[4]. The

Questionnaires on this website (especially the MICS3 questionnaires) and on DHS' website[5] provide further examples of possible questions. The MICS website also provides guidance on data processing and analysis. The MSH Community Assessment tool (website and CD-ROM reference) can also be useful in looking at careseeking behavior questions.

The box below offers an example of the type of questions that can be asked of the mother or care-taker of children under five to establish careseeking behavior patterns. The questions are similar to those asked in DHS and MICS3 surveys.

Q1. Has [NAME OF CHILD] had an illness with a cough in the last 2 weeks?
1 Yes
2 No

Q2. When [NAME OF CHILD] was sick with cough, did you seek advice or treatment for the illness outside the home?
1 Yes
2 No

Q3. Where did you seek advice or treatment for [NAME OF CHILD]?

[Interviewer instruction: circle all providers/facilities mentioned, but do NOT prompt with any suggestions].

PUBLIC SECTOR
A Government hospital
B Government health center
C Government health post/dispensary
D Government mobile clinic
E Government community health worker
F Other public _____ (specify)

PRIVATE SECTOR (INCLUDING FAITH-BASED)
H Private hospital/clinic
I Faith-based (mission, mosque, church) hospital/clinic
J Private doctor
K Pharmacy

[4] http://www.childinfo.org
[5] http://www.measuredhs.com

L Private medical mobile clinic
M Private medical community health worker
O Other private _____ (specify)

OTHER SOURCE
S Shop
T Traditional practitioner/healer
U Relative/neighbor

X Other _____ (specify)

NOTE on adaptation of questions: Additional categories can be included or categories altered. For example, in some countries the category "Municipal dispensary" could be added under public sector. In this example, multiple response categories are shown, using the convention that letters (not numbers) are shown next to each response category for multiple response questions. However, interviewers are instructed to only record spontaneous responses (see Q3.)

Understanding the current national policies and regulations that govern private practice[6]

Any intervention must be implemented in the context of national policies. Therefore examining the existing policies and regulations is critical to understanding how these might positively or negatively affect greater involvement of private providers in child health.

It is important to review all policies and regulations that affect private providers and the environment in which they work. Most countries have general policies governing private practice. While these are usually broadly enabling, the regulations involved in actually implementing the policies may be quite restrictive and/or burdensome.

Regulations should be reviewed and analyzed to assess whether they facilitate the registration of the different professional and para-professional groups, and thus provide a basis for encouraging good practices by working through professional associations or other means of reaching providers. Some regulations may rather be perceived by private providers as obstacles, and therefore have the effect of keeping registration rates low. In some cases, regulations are in fact used as mechanisms to harass and to periodically 'milk' them.

The review should include regulations governing the following issues:

- Requirements for registration and licensing
- The process of registration and licensing (clarity and ease of the process)
- The cost of registration
- Taxes levied on private practice

[6] Sources of information include: 1) Ministry of Health, Uganda, IMCI Unit, *Utilizing the Potential of Formal and Informal Private Practitioners in Child Survival in Uganda: Situation Analysis and Outline for Developing a National Strategy*, Uganda, August 2001. 2) Concern, Bangladesh, *Utilizing the Potential of Formal and Informal Private Practitioners in Bangladesh*, 2003. 3) Tawfik, Y. *Including Formal and Informal Private Practitioners in Child Survival Programs in Cambodia: Outline for developing a national strategy and a plan of action*, November 2002.

- Fee structures for services rendered
- Technical functions / procedures that each cadre is permitted to carry out
- Sales of drugs (e.g. classification and pricing guidelines)

The purpose of this exercise is to identify policies that do not facilitate the increased role of private providers in child health and to identify modifications that may be required to move the agenda forward. For example, Community Drug Management for Childhood Illnesses assessment[7] (C-DMCI) in Senegal uncovered the fact that ORS was not available in private pharmacies as it was not registered, and so no wholesalers could import it. The review will also help identify areas where a policy or regulation exists but is not being effectively monitored and enforced.

Untrained / unregistered providers

Regulations should be analyzed to determine whether they facilitate registering different professional and paraprofessional groups, and thus provide a basis for working with them through professional associations. Private providers may perceive some regulations as obstacles, and in effect keep registration rates low. In Uganda[8], the situation analysis estimated that only 30 percent of qualified providers were actually registered, partly because they feared

Excerpt from the Uganda Situation Analysis:
POLICIES AND REGULATIONS RELATED TO PRIVATE PROVIDERS

The most relevant laws regulating private practice are the National Drug Policy and Authority Statute (1993), the National Medical Stores (NMS) Statute (1993), and the three professional bills of 1996. The National Drug Policy and Authority Statute and the NMS Statute established a national pharmaceutical policy body, the National Drug Authority, to oversee the compliance with…drug policy.

..[the] professional bills… require all health professionals to register with their respective councils.…Private health facilities/consulting rooms must meet certain standards to be licensed. Provisions for revoking a private practice license and for disciplining health professionals are included… [However], …government lacks the resources to enforce regulations.

Many unlicensed drug shops and private clinics sell… prescription-only drugs quite openly. A wide gap between policy and practice is a general characteristic of drug use… many clinics outside ….were registered under the name of a doctor, they were run by very junior staff.

Private practitioners complain that registration procedures are complex and expensive …. [they are] estimated to be equivalent to about 11 days of work for a health worker in a clinic and about 6 days for a drug shop keeper. [8]

[7] Community Drug Management for Childhood Illnesses, Assessment Manual, Management Sciences for Health, September, 2004.
[8] Ministry of Health, Uganda, IMCI Unit, *Utilizing the Potential of Formal and Informal Private Practitioners in Child Survival in Uganda: Situation Analysis and Outline for Developing a National Strategy*, Uganda, August 2001.

that registration would oblige them to pay taxes. Registration procedures are sometimes cumbersome, e.g. Nigeria has federal, state, and local government registration authorities and providers are confused as to where to apply.

Understanding Who Private Providers Are

Many different types of private providers are involved in child health and malaria, ranging from qualified medical doctors, nurses, and midwives with formal degrees, to traditional healers and informal providers, such as drug sellers, who are often unlicensed and unqualified but more accessible to both urban and rural communities. To complement country data on careseeking behavior, the following information can be useful in illuminating the pattern of providers in a given context:

- Numbers and types of providers (doctor, nurse, midwife, nursing aide, pharmacist, traditional healer, drug seller, etc.)
- Where they practice (specific locations, if available)
- Qualifications of the various types of provider (level or type of training)
- Whether they are registered/licensed and if so, where
- What type of medicines and supplies they handle (particularly the essential drugs for childhood illnesses)

While some of this information may be difficult to obtain, it will be most helpful in identifying the accessibility of various providers (e.g., urban vs. rural coverage), which providers to target for interventions, and what types of interventions to choose.

In most countries, some information is already available in studies that have been done by government entities, NGOs, universities, etc. The data have commonly not been compiled and analyzed in a way that is useful for decision-making. In both Bangladesh and Uganda, for instance, sufficient information was already available for developing the national strategy.

In some countries, it may be necessary to collect additional data at national level and/or perhaps also to do detailed inventories in one or two districts, to inform the strategy development process (see section on district implementation on page 37).

More detailed information will be necessary, at any rate, before designing and implementing an intervention at district level. [9]

Understanding the Quality of Care Given by Private Providers

Knowing the quality of care currently provided for childhood illnesses helps to target key practices that need improvement to affect child health outcomes positively. Table 2 indicates common quality-of-care problems encountered in the private sector. In fact, the issues presented are similar to health facility survey findings in the public sector.

As mentioned, specific studies on private sector quality of care may already be available in the country, from universities, NGOs, etc. These should be identified and analyzed before considering any new research. In Bangladesh and Uganda, ICCDR/B and Makerere University respectively had already studied the quality of care given by a range of private providers, which helped inform the national policy development.

More detailed information may be required on the status of services / quality of care

[9] Ministry of Health, Uganda, IMCI Unit and Malaria Control Program, *Inventory of Private Health Practitioners in Luwero, Ntungamo and Rakai Districts*, Uganda, August 2002.

Table 2: Key Problems with Private Provider Quality of Care that can affect Child Survival

Diarrhea	Acute Respiratory Infection	Malaria
• ORT is rarely recommended and available • No advice on feeding given to mothers • No inquiry on blood in stools or diarrhea duration • Skin pinch to verify dehydration not done	• No counting of respiratory rate • First-line antibiotic is not given or is not given in the correct dose for pneumonia cases • No counseling on feeding	• Inappropriate/incorrect dose of antimalarial drugs • No verification of other causes of fever
No advice on danger signs that require urgent medical care		

Source: Tawfik, Northrup, and Prysor-Jones. (2001) Utilizing the Potential of Private Practitioners for Child Health. SARA Project.

before designing a specific intervention and developing training / educational materials. A baseline picture of current quality of care will also be useful to assess impact, if the same methodology is repeated after the intervention occurs.

Two relatively low-cost methods are available to gather the information. One is to use a **verbal case review** in which mothers are interviewed to obtain information on where they went when their child was sick, and what happened during the visit. Mothers are asked questions on whether the PPS examined child, what advice was given, and what drugs were given. The quality of care is deduced from the mothers' recall. This method requires finding approximately 30 cases for each childhood illness under study, e.g. diarrhea, ARI, malaria.

The other method is the **mystery/simulated visit** where trained persons visit a sample of selected private providers to seek treatment advice for their "supposedly" sick child. Visitors record the private providers' advice and treatment immediately after the visit. A tool for conducting simulated visits is available in on the accompanying CD-ROM. The advantages and disadvantages of the two methods are laid out on page 35.

Another potential assessment tool to use is the C-DMCI which assesses medicine use practices of both caregivers of recently sick children and of providers' medicines, as well as availability of medicines. [10]

In all cases, any study should be planned with the district health team (DHT), and most likely involve NGOs and local associations. Local organizations will have a sense of what types of interviewers / mystery visitors would be most acceptable in the community and likely to obtain good information, In general, using known health staff as interviewers is unwise. Students, NGO workers, teachers or other community

[10] *Community Drug Management for Childhood Illnesses, Assessment Manual*, Management Sciences for Health, September, 2004.

members may do a better job, with a relatively small amount of training beforehand.

Understanding what influences private providers

The international literature[11] on what influences private provider behavior identifies three main factors, in addition to any training providers receive:

1. Client expectations and demand
2. The pricing of drugs and margins of profit
3. The marketing strategies of drug companies

Client expectations must be considered. For example, if clients with sick children expect to receive a particular type of medicine or an injection, they may not continue to patronize the private provider if he or she does not give it. Providers desire prestige in the community, and to be perceived as doing good work. Drug companies also can influence the way a provider prescribes certain medicines. Detail men are often quite persuasive, and offer free samples as incentives for prescription practices. The profit motive naturally must also be considered, in examining behavioral motivation. This involves reviewing the pricing structure of products to assess profit margins, especially where drug sellers are involved.

Experiences to date and current literature suggest that regulation rarely has a consistent influence on private provider behavior. This is partly because regulatory authorities have difficulty monitoring how regulations are applied in many countries. Also, many private providers are not registered and, therefore, not subject to any controls.

While it is essential to understand PPs' motivations when identifying interventions to involve them and improve their quality of care, an elaborate study is generally unnecessary. Low cost information gathering methods, such as key informant interviews and/or focus groups carried out with providers, will provide sufficient understanding in most cases.

Identifying Communication Channels to Reach Private Providers

Identifying communication channels for contacting private providers will be useful:

- To reach influential private providers who can par-

IN NIGERIA, community-based organizations have helped facilitate workshops with medicine vendors. **IN BUNGOMA, KENYA**, wholesale distribution channels were well-organized and most drug sellers obtained their produce from the same 10 sources. The intervention therefore worked through the wholesalers to reach retail shops and improve the quality of their services. **IN UGANDA**, wholesaler networks of this nature did not exist. Drug sellers bought from a large range of sources. Thus, local NGOs and CBOs were better suited to work with them to change practices. **IN BANGLADESH**, private provider associations are particularly well-organized and were an obvious structure with whom to work. For instance, an association of "village doctors" was formed. These have two years of training and are now officially recognized.

[11] Articles that refer to the factors influencing private providers include: Inayat H. "Private practitioners in the slums of Karachi: What quality of care do they offer?" *Soc. Sci. Med.*, (46)11 and Bruga R. and Zwi A. "Improving the quality of private sector delivery of public health services: Challenges and strategies." *Health Policy and Planning*, (13)2.

ticipate in developing the national strategy, and
- To target providers with information, training, monitoring, etc. (not clear)

Influential structures may serve as communication channels and include:

- Professional associations (medical, nursing, midwifery, pharmacists)
- Societies of rural medical practitioners or homeopaths
- NGOs and CBOs who work with private providers in their programs
- Government structures at the district level
- Drug distribution mechanisms

In choosing structures with which to develop partnerships, preference should be given to those that maintain continuous contact with private providers (or at least have the potential to establish such contact). More importantly, the providers cannot perceive the chosen structures as threatening. The following box indicates the variety of channels used in developing interventions, according to the country or district context.

Learning lessons from in-country interventions

ILLUSTRATIVE FINDINGS FROM REVIEWING EXPERIENCES IN UGANDA

In 2002, a Uganda situation analysis document identified seven existing interventions, ranging from training traditional healers and drug sellers to radio messages for anti-malarial drugs. Lessons learned included:

- Attempts to train traditional healers and drug sellers in one district was not evaluated, so could not show impact on the practices of those trained
- Few details were available on the costs of the different interventions
- A family planning training program for private midwives had worked successfully with the midwives association, although a limited percentage of midwives could be reached as not all are members
- The Ugandan community IMCI and malaria materials were suitable for use with private providers
- Many implementers of ongoing interventions were included and contributed to national strategy development
- Simple job aids and training materials from nearby Kenya (Bungoma) were found suitable for use with private providers in Uganda.

A key part of the situation analysis is a review of what has already been done in the country to involve private providers in health programs. Program descriptions, reports, evaluations, etc. from districts, research organizations, or NGOs will be invaluable. Some key informant interviews will add depth of understanding.

Information gathered will allow learning from positive experiences and from mistakes. This will help to avoid pitfalls and build on successes, adapt them and take them to scale. In addition, the review will uncover individuals and organizations in-country with an interest in the area. Many will be important stakeholders, and will have

valuable contributions to make during the national strategy development.

On the basis of available information, a summary should be included in the situation analysis covering the following:

- The types of interventions that have taken place and where
- Which organizations have been involved
- Intervention strategies used
- Results obtained
- Lessons learned from implementation
- Costing information
- Tools developed
- Assessment of what can best be built on and / or replicated

ENGAGING STAKEHOLDERS IN STRATEGY DEVELOPMENT

Identifying Stakeholders

Involving private providers in efforts to improve child health outcomes is clearly a public health agenda. A leadership / stewardship role naturally falls to the Ministry of Health in each country to identify the different stakeholders (public, NGO, and private) who should be involved in developing strategies and interventions, and to engage them in the process.

Stakeholders should include representatives from most of the following groups:

- Professional associations
- Associations /groupings of informal providers
- Other private providers (both formal and informal)
- Donors and NGOs working in child health
- Drug wholesalers and retailers
- District health staff
- Ministries of Health personnel involved in child health, partnerships, planning, etc.
- Drug regulatory bodies
- Organizations implementing activities that affect private providers in any health field
- Health research institutions and training schools

Organizing Information Sharing and Advocacy within the Ministry of Health

Presenting careseeking behavior and data to highlight the importance of the private sector for child health is often an important first step in encouraging the Ministry of Health to be more inclusive. To strengthen the case for involving private providers, the sources of care for sick children must be compellingly presented to help decision makers understand that private provider involvement is critical to reach child health outcomes.

The situation analysis results will also help argue for involving multiple stakeholders, showing the diversity of private providers and the opportunities and challenges for working with them, with the help of a range of partners.

The 'knee-jerk' reaction from health authorities and professional associations is to deal with PPs through increasing regulation. To engage the wider range of stakeholders, examples from other countries should be used to showcase approaches that have had greater impact, and the limitations of interventions that are purely regulatory. Reference provides a sample presentation that could be adapted for Ministries of Health and other partners.

Ideally, a 'champion' from within the Ministry of Health should organize the discussions with and/or presentations to ministry officials. Partner agencies—e.g. donor agencies, technical partners, professional

associations—can help to prepare the ground and support this internal advocacy.

Objectives of discussions and/or advocacy meetings will be to:

- Increase awareness of care-seeking patterns for child health and the importance of involving private providers
- Discuss preliminary ideas on possible program approaches
- Consider developing a national strategy
- Consider involving relevant stakeholders and organizing stakeholders' meeting(s)

Expected outcomes:

- An endorsement of the need to involve private providers in child health
- A commitment from the MOH to take some leadership in this initiative
- A decision to develop a national strategy
- A decision to hold a national stakeholders meeting

Organizing Information Sharing and Consensus-Building with other Stakeholders

Following internal MOH advocacy, broaden the debate to the wider range of stakeholders and partners involved in child health. Different channels can be used to present the findings from the situation analysis.

Informal discussions, using some compelling data and written materials, may be useful to introduce the idea and encourage partners to attend more formal presentations and meetings. One or more stakeholders' meetings will be necessary. These should be well-prepared and allow enough time to review the situation analysis and to discuss the roles of different stakeholders, the need for a national strategy, and the next steps required to develop it. In Uganda, two national meetings galvanized the stakeholders, over a period of three months when the situation analysis was finished.

The objectives of a national stakeholders' meeting will include:

- Share the situation analysis with all stakeholders
- Increase awareness among stakeholders on the need to address current issues affecting private providers
- Reach an agreement on the need for a national strategy and a participatory process for developing it
- Discuss the establishment of a working group to draft the strategy as part of this process

Expected Outcomes:

- Endorsement by stakeholders of the need to address the issues
- Decision to develop a national strategy
- Agreement on a strategy development process
- Commitment from stakeholders to participate in the strategy development process (working group, review activities, etc.).

Drafting and Sharing the Strategy

Drafting the strategy will be an iterative process, involving stakeholders at various stages to build consensus and ownership.

The first step is to create a small committee or working group to draft the strategy. The working group should involve some key stakeholders from the start. In addition to national level Ministry of Health staff, representatives should come from:

- Professional associations
- Private providers
- District health staff
- Drug regulation authorities
- International organizations
- Key NGOs, especially those

with experience involving private providers in the field

The working group members will organize a series of meetings to develop the strategy, based on the situation analysis and decisions from stakeholders' meetings. The strategy should include an initial action plan and budget.

A wider group of stakeholders should be invited to vet the strategy and offer input, either in writing, and/or during individual and small group meetings. To culminate this process, it might be useful to present the strategy to all stakeholders. The expected outcomes at this stage will be to:

- Endorse the strategy by stakeholders
- Commit support and mobilize resources to implement the strategy

CONTENT OF NATIONAL STRATEGY

Attached in the CD-ROM is the *Ugandan National Strategy for Utilizing the Potential of Private Practitioners in Child Survival*[12]. This example was the product of a series of stakeholder meetings, organized by the Ministry of Health IMCI Unit and the Public Private Partnerships Unit, to discuss the country situation analysis and its implications. The outline of the strategy is presented below as a possible model but the strategies must, of course, be tailored to each country context.

- Summary of situation analysis (background, careseeking behavior, types of private providers, regulation issues, lessons learned from interventions, etc.)
- Actions to revise national policies and regulations
- Selection of interventions to improve quality of care of PPs
  - identify current gaps and problems in case management
  - select priority groups of providers
  - select mix of interventions (see Annex 1 for menu of interventions)
- Implementation approach for field interventions
  - Roles and responsibilities of government stakeholders (different levels)
  - Criteria for demonstration /pilot districts if appropriate
  - Who will take lead; involvement of stakeholders/partners (donors, NGOs, CBOs, associations, other, drug producers and distributors)
  - Time frame for implementation and expansion
- Monitoring and Evaluation Plan
  - Key indicators
  - Methods of collection
- Costs and budget

MONITORING AND EVALUATION

Monitoring and evaluation (M&E) are important to understand how well the national strategy is been implemented and what effect interventions are having. Information from M&E efforts should enhance accountability, decision-making and learning, crucial to ensuring the high quality of the national strategy implementation and scale up.

To the extent possible, M&E should use participatory mechanisms so stakeholders can discuss the information gathered and share their feedback. This promotes learning among those involved in the national strategy.

The national strategy should have a specific M&E component that includes ongoing monitoring of providers'

[12] Ministry of Health, Uganda, IMCI Unit and Malaria Control Program, *National Strategy for Utilizing the Potential of Private Practitioners in Child Survival,* Uganda, August 2002.

practices by a suitable local entity (e.g., District Health Team, NGO, CBO, etc.). The requirements for effective monitoring are baseline data, indicators of performance and results, and mechanisms or procedures that include such planned actions as field visits, stakeholder meetings and systematic reporting. To emphasize monitoring as an essential management function, monitoring actions must be adequately planned, and undertaken throughout the lifetime of a specific program.

The national strategy's evaluation component must include specific outcome indicators (e.g., changes in a select number private provider practices) and targets that are expected to be reached in a given time period. Determining the specific practices to target before designing the interventions and how changes in those practices will be measured is important.

Monitoring the costs of interventions should be an important part of the M&E plan, since information on costs will be useful to guide decision making and fund raising for implementing at scale.

Setting indicators

As mentioned earlier, for an intervention to succeed it needs to focus on improving a few key target practices that have direct impact on child survival. Hence, it is important to determine these target practices before designing the interventions and how the change in those practices will be measured. The following are examples of practices that should be targeted and used as M&E indicators for childhood diarrhea, ARI and malaria:

Key Target behaviors (indicators) for childhood diarrhea:

Percent of private practitioners who:
1. Check or inquire about signs of severe illness (IMCI danger signs)
2. Give/recommend fluids and refer immediately if the child is severely ill
3. Inquire about blood in stools.
4. If blood in stool present, give correct dose of antibiotic and explain how to give to the child or refer.
5. Inquire about diarrhea duration and refer if more than 2 weeks.
6. Give or recommend ORS or increased fluid intake.
7. If ORS is given or recommended, explain how to prepare and give to child.
8. If dehydration is suspected, refer and give ORS/fluids on the way.
9. Recommend continuation of feeding/breast feeding during illness.
10. Explain signs to watch for which require urgent medical care.

Key Target behaviors (indicators) for childhood ARI:

Percent of private practitioners who:
1. Check/ inquire about signs of severe illness (IMCI danger signs).
2. Refer the child immediately if there is any sign of danger.
3. Check/ inquire about difficult/rapid breathing.

4. Refer or give/ recommend the appropriate antibiotic* (which in most countries is often cotrimoxazole) in correct dose if the child has difficult/rapid breathing.
5. Check/inquire about fever.
6. In children with fever living in malaria endemic areas**, give/recommend correct anti-malarial drug/s in correct dose and duration.
7. In children with high fever, give/recommend paracetamol in correct dose.
8. Recommend increased fluid intake.
9. Recommend continuation of feeding/breast feeding during illness.
10. If drugs are given / recommended, explain how to give to the child.
11. Explain signs to watch for which require immediate medical care.

**according to national treatment guidelines*
***National IMCI guidelines in malaria endemic areas recommend giving anti-malarial drugs to all children presented with fever above 38 degrees Centigrade.*

Key Target behaviors (indicators) for childhood fever/malaria:

Percent of Private Practitioners who:
1. Check or inquire about signs of severe illness (IMCI danger signs)
2. Refer immediately if there is any sign of danger.
3. Recommend giving the child plenty of fluids.
4. Recommend continuing feeding/breast feeding during child's illness
5. In malaria endemic areas, give/recommend correct anti-malarial drug/s in correct dose and duration.
6. If there is high fever, give/recommend paracetamol in correct dose:
7. Explain how the drug/s should be given to the child.
8. Explain the signs to watch for which require immediate medical care.
9. Give or recommend buying insecticide treated net (ITN) and advice that the child sleeps under it every night.

Measuring the selected indicators:

It is essential to have inexpensive, practical, easy-to-use tools that can be implemented on a large scale. Complex tools can be valuable in research, or pilot settings, but their application can be expensive, complex, and time-consuming, making them unsuitable for large scale programs with limited human and financial resources. Programs need to find a reasonable balance between being thorough and accurate and being simple and practical. Hence the following two simple tools are recommended:

1. **Simulated Visits**: Trained persons visit a sample of selected private practitioners to seek advice/treatment for their "supposedly" sick child. Visitors record the PP's advice and treatment immediately after the visit.[13]

[13] Simulated Visit Tool, 2003. Adapted from Uganda MOH simulated visit tool for Luwero District.

2. **Verbal Case Review**: A household questionnaire is filled in by interviewing mothers/caretakers of children under five who have been sick during the two weeks preceding the interview. The source/s of care sought outside home, if any, are obtained with precision as well as the type of examination performed on the child, the advice given and the treatment recommended/given.[14]

Comparison of the advantages and disadvantages of the two recommended methods

Criteria	Simulated Visits	Verbal Case Review
How easy are they to conduct?	Relatively easy to find targeted providers and to train interviewers.	An effort is needed to find households with sick children in the last 2 weeks
How accurate and useful are the data?	Not an observation of a real life situation (no sick child present) so no evaluation of PPS's examination skills	Investigates specific recent sickness
	The trained interviewer records PPS's response/ advice immediately after the interview and usually gives reliable information.	Depends on the level of alertness of the mother/ guardian of the sick child and her ability to remember details of her visit to the PPS.
How easy are they to analyze?	Very easy and can be done manually by the interviewers themselves, with some guidance.	Comparable to other household surveys. May need specially trained persons to analyze.

[14] Verbal Case Reviews. BASICS Nigeria and BASICS Bangladesh. VERIFY

Example of Using Simulated Visits to Evaluate the impact of Intervention

The following table presents results of two simulated visits conducted to a sample of informal private practitioners who participated in negotiation sessions in Uganda. The first round of simulated visit was conducted before the intervention and the second round was conducted three months after.

Private practitioners who:	Simulated visits Baseline N=57	Simulated visits 3 months after intervention N=66
Asked if the child had convulsions	21%	23%
Gave correct medicine	2%	73%
Gave correct dose	0	50%
Explained how to give medicine	8%	49%

Source: Uganda Ministry of Health, IMCI Unit, Luwero District Negotiation Sessions. 2004.

The C-DMCI is also a useful analysis tool.[15] It covers the information gathered by the tools discussed above plus some other important information, such as availability of medicines and knowledge gaps. But it is necessarily more complex and costly to use.

[15] *Community Drug Management for Childhood Illnesses*, Assessment Manual, Management Sciences for Health, September, 2004

DISTRICT IMPLEMENTATION

Whether district implementation takes place before or after national consensus building and strategy development, the following guidelines can be used to support it. Both national and district level efforts are usually necessary and complementary. Policy issues clearly require action at national level, whereas districts must be fully involved in designing, implementing, and monitoring interventions appropriate to their specific contexts.



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A Community Health Officer provides home health care in Ghana.

DEFINING ROLES AND RESPONSIBILITIES

Leadership and Coordination

The District health team (DHT) will usually take the lead in engaging private providers at local levels. This is especially important when private provider initiatives are heavily supported by short-term outside funding and technical assistance. In some cases, professional associations or NGOs may take the lead. In all cases, the public sector local health and governance structure should own the process.

The DHT usually has limited human resources, so enlisting the support of NGOs, CBOs, professional associations, and other groups ensures sufficient resources are available to "get the job done." A first meeting with the DHT will be necessary to:

- Share the rationale for working with private providers, including any available data on careseeking behavior, potential interventions, etc. (the national situation analysis should be presented, if available, and its implications for the district discussed)
- Discuss any initial information on private providers available in the District, including past experiences and issues in partnering with them
- Exchange ideas on how to improve the situation, including additional information required, potential interventions, stakeholders to contact, etc.
- Decide on a process for moving forward and specific next steps

Involving Stakeholders from the Start

Contact and involve stakeholders as early as possible to obtain their input in the planning process and their commitment to participating in implementation. Important stakeholders at local levels include representatives from:

- Pharmacy and other private associations
- Other private provider groupings (e.g. traditional healers, if important in the district)
- Political and/or administrative authorities
- NGOs and CBOs working at community level
- Donor agencies working in the district
- Community leaders, e.g. from health committees, women's groups, religious groups, etc.
- Local health staff

An initial meeting with all stakeholders and individual preparatory contacts will cover much of the same ground described above for the DHT meeting. Ensure that enough time is allocated to listening to the concerns of the stakeholders. The outcomes of the meeting(s) should include:

- A common understanding of current issues and problems
- Agreement on the objectives of working in partnership to increase private provider involvement in child health outcomes
- Consensus on the need to work together
- Agreement on a district approach and an implementation process (including next steps)
- Clarity of roles and responsibilities
- Initial human resource and financial commitments.

PREPARING SITUATION ANALYSIS

Each District can undertake a brief situation analysis to help decide on its strategy and choice of interventions. The analysis will consist of the same sections as described above for the national level. These will include therefore:

- Gathering and/or compiling health careseeking behaviors for key childhood diseases in the District
- Finding out who the are the private providers (formal and informal) in the District and where they work
- Assessing issues of the quality of care given by PPs
- Identifying existing or potential channels for contacting PPs
- Considering any lessons learned from other experiences in working with PPs
- Identifying partners who are interested and/or well-placed to contribute to implementation (pharmacy and other private associations, NGOs, wholesalers, etc.).

Since much more detail will be needed to guide district-level decision making, this section details information collection strategies.

Inventory Private Providers

To design and implement interventions at district level, detailed information is needed on the different types of private providers, how many there are, and where they are located throughout the district or prescribed intervention area. This information may be available from a variety of sources, such as medical, nursing, and midwifery professional associations operating in the district or NGOs and CBOs that run projects in the district. For example, in Bangladesh, a list of village doctors was available through the rural medical practitioners association.

If such lists are not available, it

will be necessary to conduct an inventory (a physical survey) of private providers. In Uganda, for instance, pre-intervention inventories carried out in selected districts surprised local health authorities who found that many private pharmacies/drug shops were actually staffed by nursing aides with very little training, even though many shops were registered under the names of qualified professional pharmacists. In consequence, the local interventions were designed to address this provider category. [16]

The district inventory should be led by the district health team to ensure they fully own the process. Door-to-door surveys will be needed to find names and locations of local private providers, as well as the other details listed above. To obtain the maximum amount of information, the study team should identify key informants in each sub-district, from among community leaders, NGOs, FBOs, CBOs, community groups, and health staff, etc. These informants will most likely know the private providers in their area, including non-registered professionals, traditional healers, and informal drug sellers.

When working with key informants and also with private providers, always explain why the survey is being done, to reassure them that no punitive action is intended, such as reporting them to tax authorities, etc. The stated purpose may rather be to interest the providers in participating in some type of orientation / discussion / training to improve child health in the community. A tool for completing an inventory is available on the accompanying CD-ROM[17] , it is an example of an inventory for Luwero District in Uganda.

Documenting Current Practices of Private Providers

Learning about the current practices of private providers regarding case management of childhood diarrhea, ARI, and fever/malaria is helpful. The quality of practice can be documented through simulated visits (sometimes called mystery visits) to a sample of private providers or through verbal case reviews with mothers/care givers. This highlights specific treatment practice problems to focus the intervention and establishes a baseline to measure the intervention's impact.

Simulated visits

Trained persons visit a sample of selected private providers to seek advice/treatment for their supposedly sick child. Visitors record the PP's advice and treatment immediately after the visit. [18]

Verbal case reviews

As an additional way to assess private provider behavior, a household questionnaire is used to interview mothers/caretakers of children under five years old who were sick during the two weeks preceding the interview. The survey documents specific sources of outside home care, if any, and the type of examination performed on the child, the advice given, and the treatment recommended or given.

The table on page 36 presents the advantages and disadvantages of verbal case reviews and simulated visits. Tools for simulated visits and verbal case reviews are included in the CD-ROM.

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[16] Ministry of Health, Uganda, IMCI Unit and Malaria Control Program, *Inventory of Private Health Practitioners in Luwero, Ntungamo and Rakai Districts*, Uganda, August 2002.
[17] Inventory Tool (2002). SARA, Adapted from Uganda MOH inventory tool for Luwero District, and *Mapping Private Providers, Forsberg PENDING VERIFICATION*
[18] Simulated Visit Tool, 2003. Adapted from Uganda MOH simulated visit tool for Luwero District.

DISCUSSING THE SITUATION ANALYSIS AND BUILDING CONSENSUS

The results of the situation analysis should be fully discussed with all stakeholders to:

- Share the results of the situation analysis and the district-level inventories,
- Prioritize the types of providers to target
- Decide which interventions are most appropriate to reach them
- Discuss the role that each actor will play
- Agree on the preparation of a district-specific plan of action

The following considerations are designed to assist the stakeholders in their decision making process.

SELECTING TARGET GROUPS

Once the district team has reviewed the health careseeking behavior and the private providers' practices, the key district-level stakeholders at the district level must determine which private providers to target with what type of intervention. They must also determine how many private providers to target.

Interventions will be effective in improving child health outcomes only if they target the providers who treat significant numbers of children. This should be an important criterion. For example, in Uganda, traditional healers are a very important private provider, but this group of providers does not see many sick children so was not targeted. In Bangladesh, three different groups were identified as seeing most sick children: rural medical practitioners/drug sellers, homeopaths, and qualified physicians. However, not all these groups were equally active, and this determined who was selected.

SELECTING INTERVENTIONS

Once a target group of private providers has been selected, the next step is to choose an effective intervention (or mix of interventions) sensitive to the complex factors that influence the interaction between providers and their clients. Remember that the intervention aims to improve key practices that may make a difference between life and death and not to create the "perfect" treatment package.

As noted below, several types of interventions can improve case management practices of private providers. No matter which intervention is chosen, lessons learned from previous work suggest that successful interventions need to follow these guiding principles:

- Focus on the practice and not just knowledge
- Be realistic, consider the private providers' interests

In most countries, including informal providers in a national program is a sensitive issue. Therefore, it is recommended that formal private providers be considered as partner health providers, while informal providers be considered as special community members who are convenient to the community. (In this way, informal providers are not recognized as partner providers.)

and motives, and be limited to key practices
- Use simple, clear tools and use / adapt tools already developed
- Conduct intervention in a non-threatening manner
- Respect the time limitation of private providers
- Use innovative techniques of persuasion and negotiation and avoid traditional lecture-style training
- Evaluate intervention based on how the actual private providers' practice changes.

Criteria for selection should include:

- Stakeholder acceptability, especially by the private providers themselves
- The likely impact on child health outcomes
- Feasibility in terms of implementation ease and cost
- Level of interest of potential partners in implementation

In Uganda, stakeholders decided to implement **negotiation sessions** followed by signing individual 'contracts' with private providers.

A negotiation session is participatory discussion with private providers based on specific quality of care issues, identified through simulated visits or verbal case reviews of case management of diarrhea, ARI, malaria. The discussion is conducted around a specific list of key desired practices. For example, to get providers to recommend giving children with diarrhea plenty of fluids or continuing feeding during ARI illness. Private providers themselves identify what steps they can make to improve case management. This is "negotiated" and then informal 'contracts' are signed by the providers and their trainers. See the CD-ROM for tools and details on how to implement this.

It is important to include the **demand side** in selecting the mix of interventions. Private providers are influenced by client expectations, and these can be modified by communication efforts that involve and reach into the community. A range of activities exist to target behaviors of mothers and other primary care givers. These can sometimes be implemented as part of an ongoing district community child health/ IMCI program.

Activities may involve sensitizing community/opinion leaders including women's groups, religious groups, schools, etc. Other activities might include drama/music presentations, TV or radio programs or spots, video shows, or distributing printed materials such as posters, fliers, etc.

TYPES OF INTERVENTIONS (see pages 10-11 above, and Annex 1)

- Negotiation / education / training of providers
- Client education
- Regulation
- Motivation of providers
- Pre-packaging of drugs
- Accreditation / franchising

DEVELOPING A MONITORING AND EVALUATION PLAN

See the suggestions on monitoring and evaluation on page 33.

DEVELOPING A BUDGET

Calculating the intervention's cost at the district level and later at the national level is important because it will help determine the intervention's reach. In various parts of the world, the costs to implement these activities are radically different. However, the cost elements are almost the same as outlined here.

Activity	Cost Elements
• Conducting an inventory • Adapting materials for negotiation session • Preparing moderators • Providing on-going monitoring • Simulated visits (before and after intervention) • Community sensitization	• Training costs for interviewers, supervisors, etc. • People's time and printing • Transport • Food allowances • Communications materials • Community meeting costs

Summary Cost of Field Interventions in Two Municipalities in Bangladesh

Saidpur municipality in Bangladesh chose to do negotiation sessions with 20 private providers at a time, to cover 60 rural medical practitioners, 65 homeopaths, and 40 doctors. The table below shows the cost estimate of doing this in Saidpur and also in Parbatipur municipality.

Activity	Saidpur*	Parbatipur**
Simulated Visits (2 rounds)	$350	$320
Negotiation Sessions (including moderator prep)	$860	$375
Ongoing Monitoring/support visits	$1685	$740
Community meetings	$800	$480
Total	$3695	$1915

*Characteristics of Saidpur
**Characteristics of Parbatipuar

Cost of negotiation sessions for one District in Uganda

Saidpur municipality in Bangladesh chose to do negotiation sessions with 20 private providers at a time, to cover 60 rural medical practitioners, 65 homeopaths, and 40 doctors. The table below shows the cost estimate of doing this in Saidpur and also in Parbatipur municipality.

Illustrative Cost of Intervention in Luwero District*, Uganda

Activity	Cost
Conduct Inventory	$2200
Simulated visits (2 rounds)	$3600
Preparation of Communication materials	$800
Negotiation Sessions (5 with 20PPs each)	$1600
Ongoing site visits (2/PPs site/year, 1 year)	$4000
Client communication (community) part of c-IMCI activities	$00
Total	$12,200

*500,000 population, 397 drug sellers and private clinics, 100 targeted

CONCLUSION

The data show that mothers and caretakers seeing care for sick children do so from private sources in over 50% of cases in many African countries. However, most child health resources and attention has been focused on public sector providers. If Africa is to approach the Millennium Development Goal of reducing childhood mortality by two thirds by 2015, it is clearly necessary to take into account all those who treat childhood illness, and to include the various types of private providers in efforts to increase access to good quality care in both urban and rural areas.

This requires the establishment of solid public-private partnerships at country level. Government authorities must assume their role of improving the policy and regulatory environment and ensuring quality of health care in all sectors. Private sector organizations and associations must join with the public sector to influence policies and work with their members so that they contribute fully to the public agenda. Where private providers are operating informally, practical, non-threatening approaches are needed to encourage them to participate in quality improvement activities.

Evidenced-based advocacy is needed in most countries to stimulate the policy dialogue needed for the involvement of PPs. Analysis of local careseeking behavior can provide useful evidence on what types of providers are already most active in child heath. In addition, program approaches and lessons learned from interventions to involve PPs are now available from several countries, and can be shared for advocacy.

Planning interventions for PPs is similar to planning any public health intervention, requiring situation analyses, selection and costing of interventions, resource mobilization, etc. Given the different interests represented by the range of public and private sector actors, it is particularly important to involve stakeholders early on in the situation analysis and strategy development stage.

The suggestions and examples offered in this toolkit are designed to help public sectors managers, along with their donor and private sector partners to:

- Advocate for private sector involvement in child health
- Develop a national strategy, with stakeholder involvement
- Design and implement appropriate interventions at District and local levels.

The attached CD-ROM contains documents relevant to all stages of efforts to work with private providers, and includes overview papers, meeting reports, research and program evaluation reports, program tools, and examples of their use. It should assist managers in the strategy development and implementation process, allowing them to build on what already exists or has been tried, in the effort to improve the access to quality child health services in Africa.

ANNEX 1: MENU OF POTENTIAL INTERVENTIONS

A global situation analysis to identify promising interventions suitable for large-scale implementation revealed that involving local entities, such as District Health Teams, NGOs, and community-based organizations, in the intervention and the evaluation is important. The analysis also revealed that interventions focusing solely on improving the knowledge of PPs, or over-ambitious interventions that seek to make private providers 'perfect prescribers' are not likely to succeed. Realistic interventions that focus on improving a limited number of key practices, that are sensitive to the complex factors influencing the interaction between providers and their clients are more likely to succeed.

Another challenge for scaling up programs to improve PPs' practices is the lack of suitable approaches that can reach a large number of geographically disbursed providers, who may or may not belong to an association, with effective and sustainable interventions to change their behavior.

Types of interventions

The interventions developed will probably target one of two distinct audiences: private providers and their clients. These interventions need to be coordinated so that messages are consistent across both audiences. Various tools and examples are available on the accompanying CD-ROM under each category.

Motivation

As the name infers, such strategies are designed to motivate the provider to practice in a certain way. Not much research exists on how well motivation strategies work, however, things such as certificates and incentives have been tried in limited settings to encourage the provider to adhere to a prescribed practice. For example, in Kenya, shopkeepers who demonstrated certain skills they acquired through training posted certificates in their shops. In India, providers who believed they were being monitored had an incentive to use correct practices.

Pre-packaging

For certain illnesses, pre-packaging has been used to ensure that the client has the correct dose of medicine for each episode. Pre-packaging in child health has been used with antimalarial drugs such as chloroquine and paracetamol and seems to reduce over- or under-prescribing practices.

Regulation

Two types of regulation exist:

- Limiting the availability of harmful or commonly misused drugs. "Drug regulations in many developing countries prohibit the sale of antibiotics without prescription and prohibit the use of unregistered drugs. Deregistering such harmful drugs creates scarcity and indirectly raises demand that encourages illegal marketing and smuggling."[19]
- Accrediting health facilities to improve quality of care.

[19] *Utilizing the Potential of Private Practitioners in Child Survival*, p 11.

While this strategy may improve practice in private clinics and hospitals, there is no clear information as yet showing that it improves care in free-standing entities such as pharmacies, drug shops, etc.

Education/Persuasion

One avenue to improving provider performance is to educate them about current standard practices. Provider education can include distributing clinical guidelines, training sessions, small group meetings, and one-on-one detailing. Training alone is generally not enough to provide sustained behavior change and is more effective when coupled with follow-up visits or peer monitoring.

- Training unlicensed drug retailers (explain in more detail?)
- Vendor-to-vendor training
- Detailing to PPs to persuade to prescribe more effective, less expensive drugs

Negotiation

This strategy involves a three-step process to achieve sustainable improvements in providers' treatment of child illnesses, especially diarrhea, acute respiratory infection and fever.

- Verbal case review gathers information from a household survey in a community about which providers they use and the problems related to treatment quality (see page 33).
- Information sharing and feedback is an interaction between a selected community entity and the private providers. The approach involves sharing information about standards and guidelines and feedback from verbal case reviews.
- Contracting—through a negotiation process, providers agree to adopt target behaviors.

Franchising and accreditation

Quality control of products and services, definition and standardization of appropriate inputs and practices, effective oversight and strong management, and compliance with regulations and standards underlie **both franchising and accreditation** approaches to enhance access to quality pharmaceuticals.

Franchising in the health sector of developing countries originally developed as a mechanism for improving access to reproductive health services, particularly in poor urban areas. Franchising sets up a network of standardized service providers. Each franchised service delivery point requires an investment of private sector equity in return for the right to offer a uniform set of defined and usually branded services and a franchise logo. In recent years, the developing country franchise concept has been applied to pharmaceuticals and other health commodities.

Franchising components include training, branding of facilities, and licensing participants to sell a pre-defined variety of essential drugs. Supervision and ensuring quality services and products is essential in the branding of the essential medicines franchise and maintaining standards and public expectation and reputation. In addition, effective product sourcing and favorable pricing can lead to enhanced access to medicines in traditionally underserved rural areas.

Franchisees own their shops, and invest in their success. The outlets operate at convenient hours in easily accessed locations. The Franchiser provides support for supervision, continuing education, updated treatment guidelines, and other activities.

Evaluations of several franchise models to improve access and

use of essential medicines are underway.

Accreditation is an approach under study to improve access to quality medicines and services through independent privately-owned drug shops that are not part of a franchise operation. While in the franchise model the Franchiser is the major control point for ensuring quality products and services and reasonable prices, in the accreditation model compliance with government defined and enforced regulatory standards is the major motivator.

Client Education

The other way to improve child health is to educate clients to demand better services and quality of care. Clients sometimes have inappropriate expectations for treating certain childhood illnesses. But when clients/care-takers are empowered with information about correct practices, they can demand quality care from providers. Behavior change and communication techniques are used to influences communities and care-takers to demand better care from health providers. Communications efforts focus on the desired health care-seeking behaviors, prevention and treatments for childhood illnesses. The client education can take one of two forms:

- Educating parents and care-takers on appropriate practices so they can demand appropriate care
- Ensuring that the community knows who the private providers are with the best care management practices.

ANNEX 2: GUIDELINES FOR CONDUCTING NEGOTIATION SESSIONS

Preparing for the Negotiation Session

Negotiation sessions can be run in different ways depending on what type of provider is being targeted (doctors, drug sellers, etc.) and the specific context of the session (e.g. number of diseases and practices to be addressed). The learning materials to be used in each negotiation session will need to be adapted to fit the level of the participants and the themes covered. Materials should focus on a limited sub-set of the specific practices laid out on pages 28-29. The practices should be selected on the basis of the impact they will have on treatment outcomes, and the ease / feasibility of changing the practice in the given context.

Selecting and Preparing Moderators

The most effective moderators often come from within the group being trained. Identifying dynamic drug sellers to moderate drug seller groups and selecting doctors to work with other medical doctors can help greatly to increase levels of trust between 'trainers' and 'trainees'.

Moderators will require some training on the participatory nature of these negotiation sessions. Sessions are centered on the learner and build on the participant's existing knowledge. Since some private providers may not be practicing "legally," it is important to conduct all activities in a non-threatening manner and so that they feel encouraged to participate without fear of negative consequences.

Moderators must be thoroughly familiar with the negotiation session content, and must have a guide to follow on how to run it.

Hold Negotiation Sessions and Sign Contracts

The ideal session should include about 20 people. The length of the session will depend on the participants and the content. In Bangladesh, sessions covered ARI and diarrhea practices in 6-8 hours, while in Uganda, 12-hour sessions covered malaria practices also.

Following the session, each participant is asked to sign a contract that specifies the method of treatment for each childhood disease addressed. By signing the contract, the participants are agreeing to follow these procedures. Experience has shown that signing these 'contracts' helps the participants to maintain the new behaviors, even though they are not legally binding.

Conduct Ongoing Monitoring/Support Visits

Providing ongoing follow-up and monitoring visits is key to ensure that the private providers sustain the behavior change over time. Simulated visits

some time after the session are a useful monitoring approach. The individual contracts can be used to monitor specific practices, identify problems, and discuss them with the providers.

See CD-ROM for negotiation tool, sample contract, etc.