Subject: Sick child - clinical providers working in pharmacies/drug shops
Posted by jquinley on Wed, 26 Mar 2014 20:53:15 GMT
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1. The current core questionnaire can misclassify private providers as being pharmacies/drug shops when they are actually acting more as private clinics. For programs working to improve care of sick children a correct classification is important. This question came up in Nepal for the 2006 DHS survey. We noticed that many private providers worked in a clinic for which the front end was a drug shop (generally owned by the same provider). So we added the questions below to distinguish whether the family had made a "clinical" visit (ie the child was examined) or just a drug shop visit (ie not examined). We found that 60% of respondents who reported going to a pharmacy/drug shop said the child was examined. This led to a large shift in our understanding of the estimated proportion of sick child care away form pharmacy/drug shop to private clinical providers. In Nigeria we added the same question to the 2013 DHS, since it appears that perhaps 20% of drug shop owners ("patent medicine vendors") are actually medically trained personnel and that some pharmacies employ clinicians to see patients. We do not yet have the data to know whether this means that many children going to a "pharmacy/drug shop" are examined in Nigeria, but even a 20% shift of pharmacy/drug shop to private clinical provider would double the share of private clinical provider for treatment of fever.

2a. Clinical vs. non-clinical provider (fever/cough)

If 534 is "h=Pharmacy/drug shop" and no clinical location is marked (no for a-g and i-l) then ask:
534b. "was the child examined?" (Y/N)

2b. Clinical vs. non-clinical provider (diarrhea)

If 519 is "h=Pharmacy/drug shop" and no clinical location is selected (a-g and i are not selected) then ask:
519b. "was the child examined?" (Y/N)

3. In the case of Nepal, the finding that most "drug shop" visits were in fact clinical visits meant that improved case management needed to focus more of its efforts on private clinicians, who had medical training vs. drug shop owners with no or minimal training. The same would apply to Nigeria. In Nepal it also showed that the private clinical sector was actually a bit larger than the public clinical sector in the country, when the DHS without this question would have shown the public clinical sector to be larger.

In terms of indicators, the DHS currently provides little information on source of care for sick children (just "went to a provider") and tables should be provided giving this information, since knowing public, private clinical, pharmacy/drug shop etc. is important in deciding how to focus a improvement programs. Those answering "yes" to the proposed question should be added to the private clinical provider group.

4&5. In terms of priority please see the explanations above of the potential for large shifts in classification.

6. Countries. This problem of private clinicians working in what are labeled and reported as

pharmacies/drug shops may be only in certain countries.  If it is common in Nepal it may be common throughout South Asia.  ICF should check to see if it happens to a significant degree in Nigeria.  If yes, then we need to consider whether it occurs widely in other countries that have a large percentage of sick child care in pharmacies/drug shops.