Greater impact at lower cost: prioritizing support to Private Patent Medicine Vendors for increased quality fever case management in Ebonyi state, Nigeria.

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Background

In Nigeria, the majority of households seek basic health care through private sector health providers, known as Private Patent Medicine Vendors (PPMVs). Recent data from ACTWatch outlet surveys have found that PPMVs play a significant role in providing antimalarials, antibiotics and other medicines to the general population. This has raised concerns about the overall quality of care offered by PPMVs, as well as in the ability of PPMVs to correctly diagnose and prescribe drugs, given that large-scale support systems for PPMVs are incomplete and do not always emphasize quality of care.

Traditionally, improving the quality of care provided by health providers has relied on training and supervision, which includes performance assessments and coaching. This can be expensive, especially when trying to engage large networks such as PPMVs. Introducing real-time observation of case management can also increase costs, especially if all providers receive routine visits.

To better allocate available resources to support PPMVs, an integrated community case management (iCCM) pilot project that is being implemented at the community level through PPMVs in the Ebonyi state of Nigeria. The pilot project is being funded by the US President’s Malaria Initiative (PMI) through the MalariaCare partnership. The pilot aims to evaluate differences in provider knowledge and ability to provide quality case management care before and after training and mentorship. This paper seeks to provide evidence for ways in which routine visits can be designed more efficiently, making the training and mentorship of PPMVs more affordable and effective. Development of this poster has been led by MalariaCare partner Population Services International (PSI) and Society for Family Health (SFH).

Hypothesis

By segmenting providers we can better target capacity building efforts for PPMVs which will reduce costs and increase efficiencies.

Methods

Data sources

The following data sources have been used to classify and target PPMVs and to monitor the population they serve. The data have been generated based on PSI’s experience in other countries for use within the MalariaCare project:

I. Case management performance observations to classify providers (good, average and poor).
II. Commodity stock tracking as a proxy of caseload to separate PPMVs into two groups according to productivity (high= PPMVs accruing 80% of the overall caseload and low= the remaining 20%).
III. Routine expenditures allocated to supervision, including salaries, equipment and other visit costs.
IV. Proportion of the population accessing PPMV provided services by the quality of provider (good, average and poor).

Segmentation and targeting analysis

Three types of segmentation and targeting scenarios would be analyzed to determine how routine visits can be designed to more effectively support pilot implementation:

Scenario 1: Current Routine Support Visits

In the first scenario, no segmentation is used. All PPMVs would receive an equal amount of support in systematic rounds.

Scenario 2: iCCM Performance-Based Routine Support Visits

In the second scenario, PPMVs are segmented based on their malaria testing and case management performance. PPMVs with lower performance would receive a high number of visits each year.

Scenario 3: iCCM Performance vs. Productivity Routine Support Visits

In the third scenario, PPMVs are segmented based on a performance vs. productivity matrix. Using the matrix, providers with a higher caseload and lower performance would receive a higher number of visits each year.

Preliminary conclusion/results

Analysis of the three scenarios allows us to hypothesize the anticipated cost during year one and two of the pilot and to compare the benefits of introducing a different model for supervisory structures in the future (forecasting is based on similar PSI projects in Madagascar and Kenya). Modifying the current routine visit protocol to support PPMVs is expected to have an effect on cost when compared with the current “visit all every 3 months” model. According to the proposed model:

• Scenario 2 would likely incur a higher initially but have a reduction of 35% by year 2.
• Scenario 3 would have approximately the same initial cost and an expected reduction of 38% by year 2.
• Scenarios 2 and 3 would either increase the availability of better quality services in a shorter period of time or produce the same outcome at approximately one-third of the cost.

Figure 1: Estimated cost per scenario

Classifying PPMVs with lower performance and that are delivering 80% of the PPMV services in a targeted area allows for a more focused and better-tailored quality monitoring support effort that is geared towards the providers who will benefit the most. Utilizing this innovative approach leads to more cost-effective resource allocation and ensures populations most in need benefit from a better quality case management system.

Next steps

The pilot is now utilizing an electronic tablet-based system application developed by PSI called the Health Network Quality Improvement System (HNQIS). The system has been modified to cater to PPMVs. This technologically driven system is focused on enabling supervisors and project managers to:

• Effectively plan their support visits to PPMV outlets prioritizing where support is required, and where it will have most impact,
• Undertake assessments with comparable scoring and benchmarking mechanism,
• Provide effective and consistent feedback to providers following quality assessments,
• Monitor performance of providers over time in order to determine the frequency of support visits.

to date, with the collaborative support of Nigeria’s Federal Ministry of Health and the Ebonyi State Ministry of Health, 32 state level trainers and supervisors have been trained. An additional 325 enlisted PPMVs are being trained on iCCM in October 2015. Observations will continue using the HNQIS module to re-classify the PPMVs into the scenarios (2 & 3) to prioritize feedback and improvement of case management. Initial PPMV classifications, based upon malaria testing and fever case management performance scores and expected levels of performance in 2016, are shown in Figure 2 below.

Figure 2: PPMV classified by level of performance malaria testing and case management