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FORMATIVE RESEARCH FOR DELIVERING EARLY CHILD DEVELOPMENT CARE AT PRIVATE CLINICS IN POOR URBAN OCALITIES OF PUNJAB, PAKISTAN

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ABSTRACT; *In Pakistan, private clinics are a major source of care for minor ailments. Individuals generally pay for the services. Provision of child development care at private clinics can make these services available more widely. The study explored the potentially feasible arrangements and modalities for delivering early child development care at private clinics. A small-scale exploratory formative qualitative research was conducted in January 2016 addressing care provider and consumer perspectives. The focus group discussions with clinic staff were conducted at the research head office, whereas discussions with mothers and community advocates were arranged in the respective communities. A total of four focus group discussions (each with 6 – 8 participants) were conducted: private clinic doctors; paramedics; mothers; and community advocates. The key dimensions covered were: clinic setup, management and business model. The space for consultation, drug-dispensing and waiting do provide visual privacy without adequate conversation privacy. Majority of private clinics operate in evening, whereas mothers prefer morning-time to visit clinic. Less qualified clinic assistants necessitate a set of structured care delivery products for quality ECD care. The findings have been used to inform the ECD care delivery modalities (e.g. staff role, consultation, community-advocate engagement) and products (e.g. pictorial counseling tool and staff training) in Pakistan.*

Keywords: *Child Development, Child Nutrition, Maternal Health, Health Care delivery*

INTRODUCTION

In Pakistan, private clinics are a major source of primary health care for minor ailments, especially in urban and peri-urban localities. Individuals generally pay (out of pocket) for clinical services at private hospitals [1]. Private sector engagement in education and health care delivery is a national strategy for universal coverage of social services in Pakistan. The social franchise model for private clinic engagement has faced two main challenges: inadequate linkages with the district health services and continued dependence on external agent. So an alternate public-private partnership model has been developed, with a sustainable stewardship role for the district and time-bound catalyst implementation role for the non-government partner [2]. Private clinic engagement in the provision of communicable (TB, malaria) and non-communicable disease (e.g. diabetes, hypertension) care has already been piloted for feasibility and effectiveness [3].

However private clinic engagement in the provision of preventive health care is relatively less well piloted and understood. Provision of early child development care through a network of private clinics can potentially make these services available to the population living in urban and peri-urban localities [4]. There is an increasing amount of evidence from low resource settings that programs to improve infant stimulation and enhance parenting have a beneficial effect on children's long term development [5,6]. However, guidelines and tools need to be developed for the private clinic context in urban Pakistan, to effectively deliver nutrition counseling and maternal mental health care components of the integrated child development care package.

In partnership with the Directorate of Health Punjab, an initiative to improve childhood attainment of developmental milestones at 12 months is being developed through a primary care intervention at selected private urban clinics in Lahore and Rawalpindi. It will focus an integrated early child development preventive care package for children ≤12 months of age, which includes: 1) child development counselling, 2) nutrition counselling, and 3) assessment and counselling of maternal mental health

This small-scale formative qualitative research was designed and conducted to understand the contextual realities and inform the care delivery modalities accordingly.

Study Objective

The study explored the potentially feasible arrangements and modalities for delivering early child development care at private clinics. The exploratory study covered both the private clinic and consumer perspective of delivering early child care at private clinics. The findings of the study have been used, through technical working group process, to inform the operational guidelines and tools for delivering early child development care at private clinics.

METHODS AND MATERIALS

This study was conducted in January 2016. We conducted four focus group discussions- one each with private clinic doctors; paramedics; mothers; and community advocates in the selected study population. Each focus group discussion had 6 – 8 purposively selected participants. Eight private clinics located in selected urban poor areas were randomly selected to invite the doctors and clinic assistants for the focus group discussions. In the same communities, mothers with children aged one or under were selected and accessed through the lady health workers in the respective communities. Agreed categories of community advocates (i.e. grocery store, pharmacy store, vaccinator, lady councilor, barber, imam masjid) were also identified and accessed through health workers in the respective community.

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The focus group discussions with clinic staff were conducted at the research head office, whereas discussions with mothers and community advocates were arranged in the respective communities.

Two separate discussion guides were developed for the clinic staff and the consumers/ community. The three key dimensions covered in these discussions were: a) clinic setup; b) business model; and c) clinic management. The contents of discussion on each of the three dimensions varied between the care providers and the consumers/communities. These focus group discussions were facilitated by the authors, who are all experienced qualitative researchers, and the proceedings were recorded (after participants' consent) with the help of digital audio recorder. Hand-written notes were taken during these discussions. Each focus group lasted for about an hour and half to two hours.

The audio-recording and hand-written notes were transcribed. A coding frame, based on the three dimensions, was developed. The coding frame was applied to the transcribed data and data was extracted and summarized into major themes and sub-themes.

RESULTS

The findings below are discussed in three major themes i.e. clinic setup, business model, and clinic management.

Clinic Setup

The private clinics generally have three demarcated spaces; one part is dedicated for the doctor consultation, another is used for the clinical assistant cum dispensary, and the third part is used as patient waiting area (with seats for about ten patients). Generally this segregation of clinic space provides acceptable visual privacy for the clinical consultation; but seems inadequate for the privacy of conversation between doctor or clinic assistant and patient. Majority of women showed preference for both visual and auditory privacy during their clinical consultation. Most clinics do arrange drinking water, but lack the wash room facility for their patients.

Majority of clinics operate in the evening (between 4.00pm and 11.00pm), mainly because of the doctor's engagement elsewhere in the morning. On other hand, most mothers showed preference for the morning-time clinics, because of their fewer load of house-wife tasks/ responsibilities and lesser dependence on another family member (to accompany them to the clinic).

Clinic management

Clinic assistants are generally modestly educated (i.e. 10 – 12 years of schooling) males from the respective catchment population and without any formal paramedic training. The reasons for this preference are relatively low-cost, high social acceptance, and low attrition of such individuals. The male-preference was also found associated with their ability to manage late-night clinic working, and carry out other logistic responsibilities for smooth clinic operations. Generally the number of clinic assistants for outpatient care at a clinic is determined on the basis of daily outpatient attendance i.e. two clinic assistants if daily attendance is around 25 patients or more.

Patients are generally consulted on the "first-come first served" basis, with an average waiting time of about 1 – 2 hours. On average doctor takes about 3 – 5 minutes for his consultation to: a) examine the patient, b) take patient history, c) review the investigation report (if any), d) decide and explain the diagnosis and treatment, and e) respond to patient query (if any). On average the patient-clinic assistant session lasts for about 5 – 10 minutes for him to: a) educate patient about administering treatment, b) dispense drugs (if recommended), c) administer injection (if required), and d) respond to patient queries (if any). In cases where elaborate education session is required, the patient can be asked to come just before or after the clinic working hours. However, both clinic staff and mothers were found less-enthusiastic about any such arrangement. In most cases, male gender of doctor and/or clinic assistant does not seem to hinder their provision of clinical care to women clients.

Communities seem to judge the ability of the clinic staff (i.e. doctor and clinic assistant) on the basis of two main proxy indicators i.e. number of years of practice/ experience and the rapport during the past years. The non-clinical abilities and traits (e.g. language, empathy, dress) of the clinic staff also seem to affect the client preferences. Communities seem to acknowledge and respect doctors for their social welfare and poor-friendly deeds e.g. subsidizing patient care.

Keeping records of individual patients is not a routine practice at most clinics, mainly because of staff workload and other administrative considerations. There has been precedence of selected private clinics maintaining patient records (e.g. TB, malaria, NCD etc.), with some added project encouragement. Both clinic staff and women indicated the feasibility and acceptability of the clinic assistant to call child family for reminding about follow-up visit, provided such arrangements are discussed and agreed in advance between the woman and the clinic staff. The SMS message was considered relevant more for the literate clients.

Most clinics currently lack any referral linkage with a public institution. The clinic staff showed interest in their getting linked with a specialist institution for referral care of complicated cases. However, the quoted challenges for a patient to avail the referral care included: a) lack of any mutually agreed/ known existing referral arrangement; and b) risk of patient: i) not getting quality care at the public institution being referred to; ii) facing high opportunity cost i.e. too many visits/ other requirements etc.; and ii) getting prescribed costly investigations/ treatment.

Clinic business model:

Both clinic staff and women identified child health as a priority family consideration; thus important for the clinic to respond. Majority of clinic staff showed interest in getting their clinic branded (endorsed by District Health Office) for a set of child health care activities. Many women also showed relative trust in child health care at a public-endorsed clinic.

Each clinic has evolved some informal mechanism for them to take into account patient inability to pay for his/her medical care. Generally private clinics respond to such situation by subsidizing their consultation fee and/or investigations and drugs charges. The doctors consider

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respective catchment localities as their potential client populations; thus generally willing to make long-term investment for their clinic rapport building.

Many of the clinic staff looks at the early child development care as an activity to build their rapport, rather than to generate revenue. Most clinics do manage patient counseling within their existing setup; however provision of communication tools and training can potentially enhance their staff ability to offer health promotion care.

Likelihood of mother visiting health promotion activity at a clinic can potentially be influenced by: a) authenticity of advice source; b) quality of her first health promotion (ECD) contact at the clinic; c) possible linkage with a more tangible healthcare activity e.g. examining child, administering vitamin-A drops; d) personal circumstances e.g. more number of living children may reduce her likelihood to attend; and e) other personal experiences e.g. ill child.

The clinics showed interest in their engaging community advocates for raising ECD awareness in the respective populations. The clinic staff and respondent women also indicated the possibility of engaging broader community-based institutions (e.g. grocery shop, fruit/vegetable shop, barber shop etc.) to supplement the individual health workers' endeavors for informing people about ECD care. The logic was to use their daily life interactions with people as an opportunity to inform clients about ECD. The respondents also suggested the use of a pictorial brochure in the community awareness activities.

DISCUSSION AND RECOMMENDATIONS

Most clinics maintain adequate "setups and arrangements" for delivering acceptable care to mothers and their children. Most assistants at private clinics, being not formally trained as paramedic, will require more structured inputs/tools to maintain their quality of care provision. In light of experiences with other health care interventions in Pakistan (e.g. TB, malaria, NCD), the structured enabling of clinic assistants may include: pictorial counseling tool, skilled-based training, and regular supervision support. A similar package of structured enabling may be considered to make the unqualified clinic assistants counsel mothers for ECD care (0 – 12 month), as per program guidelines.

The private clinics generally show at least some level of consideration and commitment to the rapport building, as a mean to expand their clientele. The rapport building, in addition to quality of care, includes their empathy for the well being and welfare of patients and their families. The poor patient access to subsidized care (including drugs), is the most widely used tool for the clinic rapport building. Most clinics, recognizing child health as a sensitive family matter, can be made to consider offering subsidized ECD care to poor patients as a rapport building activity.

Community advocates have already been used in many health care interventions in Pakistan. Most of the interventions so far focused mainly on health workers and institution-based individuals e.g. school, mosque. However, keeping in view the nature of the intervention, the scope of institution-based advocates may consider expansion to include those who happen to get visited by many for routine daily life activity e.g. local grocery store, vegetable/fruit shop, meat-shop, barber shop etc. Furthermore, a simplified pictorial brochure may also be considered to make their communication more structured and efficient.

The response to the public sector branding of private clinics has also been piloted and found positive in few other health care interventions (e.g. TB care) in Pakistan. However, consultation with district and provincial health officials revealed certain requirements for the public branding, which seemed beyond the scope of a smaller implementation research project. So a milder practical version of the clinic branding was recommended for further consideration i.e. to display a poster at each participating clinic, showing program-endorsed ECD care available at the respective clinic.

The referral linkage between primary and tertiary health care facilities has always been a challenge in many developing countries, including Pakistan. Recent experiences indicate effective use of computers and mobile phones for improved patient referral across hierarchy of health facilities. However, many such efforts have been more helpful in making the specialist care accessible without necessarily affecting the quality of care made available at these public institutions. In more realistic terms, the best that any basic ECD care delivery project may aim is to improve the access, through better referral arrangements, to the specialist services at public institutions for mothers and children attending the private clinics.

The findings of quick formative research have been used to inform the ECD care delivery modalities (e.g. staff role-distribution, consultation process and time, community advocate engagement etc.) and products (i.e. development of pictorial counseling tool, staff training materials, and material for community advocates etc.) in Pakistan. As in multiple past experiences, this relatively small additional effort (i.e. design and conduct formative research) has been found to add value to the overall exercise of developing and evaluating a potentially replicable intervention for early child development care.

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