Population Council
Knowledge Commons

Reproductive Health | Social and Behavioral Science Research (SBSR)

8-2-2021

Perceptions of community pharmacists, patent and proprietary medicine vendors, and their clients regarding quality of family planning services: The IntegratE Project

The IntegratE Project

Follow this and additional works at: https://knowledgecommons.popcouncil.org/departments_sbsr-rh
How does access to this work benefit you? Let us know!

Recommended Citation
The IntegratE Project. 2021. "Perceptions of community pharmacists, patent and proprietary medicine vendors, and their clients regarding quality of family planning services: The IntegratE Project," Project Brief. Abuja: Population Council.

This Brief is brought to you for free and open access by the Population Council.

project brief

Perceptions of Community Pharmacists, Patent and Proprietary Medicine Vendors, and their Clients regarding Quality of Family Planning Services: The IntegratE Project

BACKGROUND

In Nigeria, Community Pharmacists (CPs) and Patent and Proprietary Medicine Vendors (PPMVs) are the first point of care for many common illnesses within the community. Although CPs and PPMVs are not formally recognized as family planning (FP) service providers, 22% of modern contraceptive users report receiving their last method from a PPMV and 12% from a private pharmacy [1]. PPMVs are especially popular for FP due to their widespread availability, consistent drug stocks, extended hours, personable interactions, and no separate fees for consultations [2, 3]. As the Federal Ministry of Health (FMoH) explores expanding its task sharing policy to include CPs and PPMVs, evidence is needed on an effective regulatory system to support PPMVs and CPs to provide high quality FP services.

THE INTEGRATE PROJECT

The IntegratE Project is a four-year initiative (2017-2021) funded by the Bill & Melinda Gates Foundation and MSD for Mothers[1] that seeks to increase access to contraceptive methods by involving the private sector (CPs and PPMVs) in FP service delivery in Lagos and Kaduna states. IntegratE is implemented by a consortium of partners led by Society for Family Health and include others like Marie Stopes International Organization Nigeria, Planned Parenthood Federation of Nigeria, Population Council and PharmAccess. The project seeks to establish a regulatory system with the Pharmacists Council of Nigeria (PCN) to ensure that CPs and PPMVs provide quality FP services, comply with FP regulations, and report service statistics to the Health Management Information System (HMIS). To achieve this, the IntegratE Project in collaboration with PCN and the FMoH, is implementing three main activities: (1) a pilot 3-tiered accreditation system for PPMVs based on their healthcare qualifications; (2) a pilot hub-and-spoke supervisory model where CPs (the hub) provide support to PPMVs (spokes) to

[1] *This program is co-funded by, developed and is being implemented in collaboration with MSD for Mothers, MSD's $500 million initiative to help create a world where no woman dies giving life. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, NJ, U.S.A*

ensure standard drug stocking practices; and (3) building the capacity of CPs and PPMVs to provide expanded FP services and report service statistics to the HMIS. Under the pilot accreditation system, PPMVs were provided with a standardized FP training to enable them to offer certain FP services based on their tier (**Table 1**). CPs function outside of the pilot accreditation system but would receive the same training and provide the same services as Tier 2 PPMVs. The IntegratE Project is simultaneously raising awareness about the FP services that CPs and PPMVs provide. This brief focuses on quality of care received by women voluntarily seeking FP services from CPs and PPMVs. Additional information on IntegratE Project can be found on www.integrateeproject.org.ng.

METHODS

The IntegratE project conducted qualitative in-depth interviews with 11 CPs, 17 PPMVs and 31 clients of these providers in July 2019. Participants were selected through purposive sampling in Kaduna and Lagos states. Interviews were conducted by trained research assistants using semi-structured guides that assessed the supervisory structure of CPs and PPMVs, and their expectations of the PCN accreditation system. Clients who patronized these providers for FP were asked about their perception of the care they had received, their interaction with the provider, their satisfaction with the method they obtained, and the support of their partner for their choice to use modern contraception.

Themes were identified manually and findings synthesized in the present brief. The key themes addressed in this brief include: (1) Clients' perception of and satisfaction with quality of FP services received; (2) Providers' perception of quality of FP services rendered; (3) Supportive supervision is key for delivering quality FP services; (4) Streamlining drug stock practices; (5) Ensuring an enabling environment; and (6) PCN's proposed accreditation system.

Table 1: Description of tier accreditation system

Provider type	Description	Training received
Tier 1 PPMVs	PPMVs without healthcare qualifications	• FP counseling and referral • Refill of oral contraceptives only
Tier 2 PPMVs	PPMVs with healthcare qualifications	Same as tier 1 and; • Provide oral contraceptives to 1st time users • Injectable administration • Implant insertion and removal
Tier 3 PPMVs	PPMVs who are also pharmacy technicians	Same as tier 1 and; • Provide oral contraceptives to 1st time users • Injectable administration • Implant insertion and removal
CPs	Outside of accreditation system	Same as tier 1 and; • Provide oral contraceptives to 1st time users • Injectable administration • Implant insertion and removal

STUDY FINDINGS

Clients

Clients' perception of and satisfaction with the quality of FP services received

Clients' perception of the quality of FP services that they received included sub-themes related to the setting of the care, the process of care, and the outcome of care. Regarding the setting, clients were generally comfortable with the location of, and the ease of access to the community pharmacy or PPMV shop. Women reported that they perceived the setting to be private, but clear distinctions between visual and auditory privacy were not made. Women chose to visit these providers based on previous positive interactions, knowledge of the CP or PPMV's health training background, referral from other clients who were well known to them, referral from friends, proximity to their home, and short waiting time for services. Some female clients contrasted their experience with the CP or PPMV to previous experiences in a public health facility, particularly with regard to the provider's reception and the waiting time. Some of their experiences are exemplified by the following quotes:

> *"I went there [the health facility], the queue, I couldn't wait because of the queue, and the customers were waiting for me in the shop, so I have to come back and look for plan B, which I went to [the] chemist, she attends to me very well."*
> -- Client using 2-monthly injectable; Kaduna state

> *"… when you go the general hospital, they delay a lot; you will queue, wait to collect [a] card before you are attended to, but the chemist here, I use my money to collect it [the injectable] and I am satisfied with it. Anytime I get there, there is no delay, I don't have to queue, that's the reason."*
> -- Client using 3-monthly injectable; Lagos state

Clients described interactions with the CP or PPMV they visited in glowing terms, using expressions like 'motherly', 'friendly', 'warm', 'caring', 'patient', and 'respectful'. Several women expressed that their relationship had grown beyond that of a client and provider to that of a friend and confidante and noted that the provider would often call them to check on their welfare after their visit. Some women sought health care for other members of their family from the PPMV who provided them their FP services. One female client described her relationship with her provider in the following way:

> *"To be honest, even apart from the FP, all my children, if they are sick, it's there [PPMV shop] that I normally collect my treatment, even though I don't have money, she will treat them, any day I have money, I will take it to her."*
> -- Client using 2-monthly injectable; Kaduna state

Women recalled discussing potential side effects, what to do if they experienced side effects, and when to return to the CPs and PPMVs. Some women felt confident to continue their chosen method (injectable, implant) because they had been informed of the potential for side effects such as amenorrhea and bleeding. Many were also

informed that they could switch methods if the side effects experienced were bothersome. Additionally, most women on implants recalled being told they should return to any provider with training and skills in implant removal whenever they were ready to remove the implant.

Women expressed their satisfaction with the FP services received by saying they were 'very satisfied', 'satisfied', or 'happy' with the way they were treated, and with their experience with the PPMV. One female client said,

> *"I can recommend anyone to her. Because I truly enjoy her services."*
> -- Client using 2-monthly injectable; Kaduna state

Partner Engagement in Family Planning

Clients often referred to the PPMV's efforts to ensure that their husband/partner was at least aware of her decision to use FP, even if he was not willing to come with her to the PPMV shop. Some women commented that the CP or PPMV requested to talk to them together, as a couple. Many women reported that their male partners' involvement in their use of FP took different forms: by encouraging them to use a method, accompanying them to the PPMV shop or pharmacy, and paying for related expenses. A few women noted that their partners were not involved in their decision to use a FP method. Reasons given ranged from being a single mother who chose not to discuss her FP use with her current partner, to a woman choosing to use covertly due to her partner's lack of support for her choice.

CPs and PPMVs

Providers' perception of quality of services rendered to clients

Both CPs and PPMVs felt the care they offered clients was good, as evidenced by return visits, recommendations by previous clients, and appreciation by both clients and male partners who sometimes accompanied their wives. CPs and PPMVs appreciated the relevance of the FP training they received to their business, but some of the CPs regretted not yet being trained on the insertion and removal of implants, a method requested by some of their clients. Some of these CPs stated that they had schedule conflicts on the day of the training and were not aware of opportunities to attend other trainings on implant insertion and removal. CPs noted that they referred women because they lacked skills to administer a women's desired method (e.g. implant) or did not have the requested FP commodity or medicine. CPs noted that they chose which primary health care facilities and/or other pharmacists to refer to, based on their knowledge of the professional competence of the provider, and feedback received from previous clients who were referred to various places. PPMVs on the other hand generally preferred to refer to nearby government health facilities, and even when asked directly, most stated or implied their reluctance to refer clients to other PPMVs and CPs near them, as they were afraid they would lose these clients. For both CPs and PPMVs, reasons for referral were generally to obtain a drug or FP commodity they did not have in stock, or a service they did not have the skill or equipment to offer.

Supportive supervision is key for delivering quality FP services

For the most part, the relationship between CPs and PPMVs was not cordial. Both parties saw the other as rivals who were out to capture clientele that should rightly be

theirs. Several CPs felt there was no justification to have PPMVs in urban areas where there were enough pharmacists. These CPs felt that PPMVs were meant to be a stopgap to provide services in rural and hard-to-reach areas, not to compete with pharmacists in urban areas. Some CPs felt that the biggest challenge of training PPMVs was that they had the tendency to overstep boundaries and offer services that were not within their legal scope of practice. Even some PPMVs stated that they knew that their colleagues had the tendency to stock drugs they were not licensed to stock and offered services that were not in their purview. Some CPs suggested that they were aware of PPMVs who had been caught selling narcotics and other drugs. In frustration, when referring to PPMVs, a male CP said, *"…they are becoming a menace".* One CP reported that PPMVs were a threat to CPs because they could arrange for the pharmacy of a CP to be robbed if they felt the presence of the CP in the community was not allowing their own business to flourish.

Despite these perceptions of PPMVs, CPs generally felt the supportive supervisory system[2] could work, but that there would need to be efforts toward building trust, and helping each group see that the relationship could be mutually beneficial. While some PPMVs said they have a good relationship with CPs, and had a lot to learn from them, most appeared to be of the opinion that they had to make peace with the CPs practicing near them to guarantee the survival of their own business. Some PPMVs appeared to think CPs had a chip on their shoulder. One PPMV was very clear about what she thought:

> *"…there is no relationship. They even see us like an enemy. They feel that we are not professional…"*
>
> *"They [CPs] feel they should be the alpha and omega, they should be the only one selling [drugs], and that is the same problem they have with the nurse. They will say nurses are not supposed to sell drugs, even they are not supposed to treat."*
> --PPMV; Lagos state

Streamlining drug stock practices

While most CPs reported that they documented drug purchases, sales and stocks using ledgers, which assisted in decision making regarding when and what to restock, PPMVs were less likely to report such an organized system. Apart from demand, other considerations in drug stocking reported by both CPs and PPMVs included shelf life ("first in, first out" approach) and season, with anti-allergens being in great demand during the rainy season. Some PPMVs also noted that they took the purchasing power of their clients into consideration when deciding which drugs to buy. CPs generally bought their drugs from companies, medical drug representatives, distributors, and the open market while PPMVs mostly bought from pharmacies, medical drug representatives, and the open market.

Some CPs noted that they avoided stocking drugs that require refrigeration due to poor electricity supply. The National Agency for Food and Drug Agency was said to be concerned with ensuring CPs and PPMVs did

[2] The supportive supervisory system refers to the system whereby a pharmacist supports or supervises a group of PPMVs on pharmaceutical care and drug management. This system is also referred to as the hub-and-spoke supervision model where the CP is the 'hub', supervising several PPMVs, the 'spokes'.

not stock unlicensed or expired drugs and did this through unscheduled visits to pharmacies or shops. However, one CP reported that they sometimes harassed CPs. He described how they once showed up with guns to his pharmacy and he had to calm his staff down, explaining that he had done nothing wrong.

Ensuring an enabling environment

CPs complete an annual online license renewal form after their initial registration with PCN. Both CPs and PPMVs reported that after submitting an initial application in writing, PCN inspects their proposed premises to assess the suitability of the location for a pharmacy or patent medicine shop, using preset criteria. PCN makes both scheduled (every 2 years) and unscheduled monitoring visits. However, while most CPs and PPMVs felt PCN was effective in their work, a few expressed concerns that PCN under-performed due to delays in location inspection, inadequate manpower, an insufficient number of vehicles, and inadequate funds. This implied that PCN's mandatory site inspection prior to licensing a new pharmacy or patent medicine shop was sometimes not done, thus allowing pharmacies or patent medicine stores to be too close to each other (less than 200 m), which is against extant regulations [4]. Furthermore, CPs and PPMVs reported that PCN organized training and re-training exercises for CPs and PPMVs, though these did not occur as regularly as expected.

The National Drug Law Enforcement Agency was reported by both CPs and PPMVs to make only targeted visits, possibly related to information they obtained regarding who was selling medicines they were not licensed to sell. In general, CPs and PPMVs felt that these regulatory bodies were important for ensuring and improving quality and that they made most providers to work hard to stay within the ambit of the law. Some CPs complained that regulatory bodies were "over-regulating" whereby they would make repeated visits to some pharmacies within the same year, but not visit others (registered or unregistered) for years – possibly due to the ease of access or proximity to their office. One CP summarized his expectations of the regulatory bodies thus:

> *"So, that enabling environment, the regulators must be able to understand that it behooves them to create an enabling environment for every practitioner in the system, first and foremost to practice ethically."*
> --Community Pharmacist; Lagos state

Pharmacists Council of Nigeria's proposed accreditation system

While one CP did not know about PCN's proposed accreditation system, others had varying degrees of understanding. On the other hand, most PPMVs had not heard about the proposed accreditation system. Everyone expressed their acceptance in one way or the other, even if they were hearing about the accreditation system for the first time, and even if they had concerns. Most said the development was a "good thing" but were curious as to what the roll out would look like. Most CPs expressed serious concerns about whether PPMVs would remain within their legal scope of practice. However, they were willing to work with them under the right supervisory environment, as they appreciated the gap that PPMVs filled by providing services where there were no pharmacists.

IMPLICATIONS OF FINDINGS

The implications of these findings are that since CPs and PPMVs and their clients appear to be satisfied with the FP services offered by CPs and PPMVs, on-going learning opportunities, and a supportive supervision system that is properly coordinated should be sufficient to maintain the quality of services offered by CPs and PPMVs. The existing tension between CPs and PPMVs suggests the need for their respective professional bodies to work together to build trust and an amicable relationship between their members. PCN, as well as the professional national and local associations for CPs and PPMVs are responsible for ensuring the right enabling environment for these cadres of health workers to perform optimally. However, shortcomings of PCN as a regulatory body were identified, and these need to be addressed directly. The proposed accreditation system appears to be workable, provided the concerns and identified implementation challenges are addressed amicably.

CONCLUSIONS

Nigeria's low modern contraceptive prevalence must be addressed. One approach that has been shown to work is the shifting and sharing of tasks with other cadres of health workers who have not traditionally been part of Nigeria's FP service delivery program. CPs and PPMVs are already an important source of care for women and men in the communities they serve. When properly trained and supervised, these cadres of providers can help to improve access to FP information and services, and thus help to increase demand for, and use of FP methods.

Engaging multiple cadres of providers through training and supportive supervision will help to expand access and choice so that everyone can use their preferred FP method.

REFERENCES

[1] National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF.

[2] Brugha R, Zwi A (2002) "Improving the quality of private sector delivering of public health services: challenges and strategies." Health Policy Plan, 13:103-120.

[3] Adetunji JA (1991) "Response of parents to five killer diseases among children in a Yoruba community, Nigeria." Social Science Medicine 32:1379-1387.

[4] Government of Nigeria. Pharmacists Council of Nigeria, Inspection, Location and Structure of Pharmaceutical Premises, Regulation No.79, 2005