Chapter 5

Effects of the RHCP Training
Assessment Using Case-Controlled Design

This chapter intends to examine the impacts of the training programme on the knowledge-attitude and practices of the RHCPs. It also examines how the training programme has impacted on the users of RHCPs, ANMs and the GP members. Only those RHCPs belonging to control and experimental groups that were present in both the baseline and post-intervention surveys are considered for the analysis. The analysis, therefore, is based on a comparison of sub-samples of pre-intervention and post-intervention surveys. The sub-set of pre-intervention survey includes RHCPs, households, ANMs and GP members. Similarly, the post-intervention survey includes RHCPs, households, ANMs and GP members. It is worth mentioning that while the pre-intervention survey was carried out in August-September 2010, the post-intervention survey was carried out in August-September 2011.

The chapter is divided into six sections. Section 5.1 briefly describes the basic method we are adopting for assessing the impact. Sections 5.2, 5.3, 5.4 and 5.5 try to analyse the impact of the training programme on the RHCPs, on its users (*i.e.*, households), on the ANMs and on the GP members, respectively.

5.1 Approaches to Measuring the Effects

As we have outlined in chapter 2, our approach towards measuring the effects of the training programme is based on the comparison of changes in the experimental and control groups before and after the training programme. Although, we tried to have an experimental group of RHCPs numbering somewhere between 40 and 50, we ended up finally with only 27 RHCPs. Since it is less problematic to retain the RHCPs in the control group, our control group has as high as 58 RHCPs. There is some advantage of having a control group with larger sample size as both pre- and post-intervention heterogeneity is expected to be higher for the group of RHCPs who do not undergo the training.

The effects of the training programme is assessed by comparing the experimental and control groups between two time points, that is, before starting the training programme and after completion of the training programme. The list of dimensions on which the effects of the training programme are assessed is derived from the stated objectives of the training programme. Even though RHCPs are the immediate target of the training programme, it is equally important to assess what changes the training is able to bring among the users of RHCPs and, in the perceptions and attitudes of the government health workers and the community leaders towards the RHCPs. Apart from the RHCPs, therefore, appropriate information are also sought from the users of RHCPs (*i.e.,* households), government health workers (*i.e.,* ANMs) and the community leaders (elected representatives at the lowest level of governments).

For any selected dimension on which the training has aimed an improvement either by increasing or by decreasing the relevant attribute is calculated as percentage separately for the experimental and control groups. For example, reduction in cross-practice is one of the indirect objectives of the training programme. The percentage of RHCPs involved in cross-practice is calculated for the experimental and control groups at two time points – pre-training survey and post-training survey. The difference in percentage between post and pre-training is computed for the experimental and control groups. For example, the percentage of RHCPs belonging to the experimental groups who are involved in cross-practicing is 7 and 4, respectively before and after the training programme. Similarly, the percentage of RHCPs belonging to the control group who are involved in cross practicing is 19 and 28, respectively. Therefore, in the control group cross practice has increased while in the experimental group it has decreased. In this case, we expect the training to reduce cross-practicing among the RHCPs. One can, thus, say that the training programme has made a change amounting to -12 percentage points (= -3 per cent – 9 per cent) in reducing the cross-practice among the RHCPs. In other words, the training's real contribution in reducing the cross-practicing is 12 percentage points. However, some caveats should be observed while interpreting these results.

5.2 Effects on the RHCPs

Although, our baseline survey interviewed 104 RHCPs practicing allopathic system, only 85 of them were available for the endpoint survey. The split of 85 RHCPs between experimental and control group is 27 and 58. In other words, the size of our experimental group of RHCPs is little less than half of the control group.

Table 5.1 shows that the RHCPs who have gone through the training programme (experimental group RHCPs) demonstrate some extra empowerment over the RHCPs who have not received the training programme (controlled group RHCPs) when assessed by certain indicators. After the training programme, higher percentage of experimental group RHCPs have own chambers, they are less likely to get involved in cross-practicing, increase in the average number of patients seen per day, and received more 'home call' from patients.' Surprisingly, control group RHCPs have experienced more hike in average earning per day measured before and after the training programme. As far as providing different services (such as injection, stitching, bandage, tooth removal, pregnancy test, antenatal advice, blood test and blood pressure check), experimental group RHCPs do not seem to show any advantages over the control group except their improved knowledge on pregnancy test and antenatal advice. One significant improvement is after the training programme experimental group RHCPs are more in touch with one another professionally in comparison to the control group. This is a desirable development given one of the objectives of the training programme has always remained to improve the professional interaction among the RHCPs and not treating each other just as a competitor. As far as procuring medicines directly from the dealers, the experimental group RHCPs show marginally better off position in comparison to the control group RHCPs. Procuring medicines directly from the dealers is expected to reduce the cost of treatment.

Promoting the practice of referring difficult-to-treat ailments to appropriate qualified doctors has been one of the direct objectives of the training programme. In the literature as well as news paper reporting, plenty of examples are found where the 'quacks' complicated and worsened patients' medical condition by wrong and trial-and-error

Table 5.1: Changes in some select indicators of the experimental and control group RHCPs before and after the training programme

	Pre-training		Post-training		Diff (exp)	Diff (con)	Diff-Diff
	exp	con	exp	con			
RHCPs having own chamber (%)	85 (23)	86 (50)	96 (26)	88 (51)	11	2	9
RHCPs involved in cross-practice (%)	7(2)	19 (11)	4 (1)	28 (16)	-3	9	-12
Average number of patients seen per day	15	16	20	12	5	-4	9
Average number of patients seen in last one week	83	82	81	66	-2	-16	14
RHCPs go on call/home visit (%)	100 (27)	86 (50)	100 (27)	89 (52)	0	3	-3
Average number of calls attended in last one week	14	12	20	12	6	0	0
Average earning per day (Rs)	134	138	160	180	24	42	-18
RHCPs providing the following services (%)							
Injection	96 (26)	100 (58)	100 (27)	100 (58)	4	0	4
Stitching	93 (25)	86 (50)	93 (25)	86 (50)	0	0	0
Bandage	100 (27)	100 (58)	100 (27)	100 (58)	0	0	0
Tooth removal	4 (1)	12 (7)	0 (0)	9 (5)	-4	-3	-1
Pregnancy test	56 (15)	62 (36)	70 (19)	50 (29)	14	-12	
Antenatal care & assisting in delivery	15 (4)	7 (4)	70 (19)	50 (29)	65	43	12
Blood test	11 (3)	9 (5)	7 (2)	3 (2)	-4	-6	2
Blood pressure check up	93 (25)	97 (56)	100 (27)	100 (58)	7	3	4
RHCPs In touch with other RHCPs in the same area (%)	79 (19)	76 (36)	93 (25)	78 (39)	14	2	12
RHCPs providing medicine themselves (%)	100 (27)	95 (55)	100 (27)	95 (55)	0	0	0
RHCP storing medicine (%)	96 (26)	95 (52)	100 (27)	100 (55)	4	5	-1
Source of purchasing medicine							
Mostly retailer (%)	48 (13)	35 (19)	37(10)	27(15)	-11	-8	-3
Mostly dealer (%)	52 (14)	65 (36)	63 (17)	72 (40)	11	7	4

Source: Primary survey

treatments. The contribution of the training programme in improving referral practice among the RHCPs who have gone through the training is clear (Table 5.2). When we observe their profile and behavior, and compare with control group RHCPs, it is clearly evident that (after they have gone through the training) they receive higher number of 'complicated' cases but attempt to treat fully on their own lesser number of complicated cases. In other words, after the training programme, the experimental group RHCPs are

less likely to treat a ‘complicated’ case fully and more likely to refer to an appropriate provider after providing primary treatment – a completely reverse trend is observed for the control group RHCPs. This pattern is observed for two specific types of ailments on which detailed questions were asked – breathing trouble related severity and stomach pain related severity.

One of the many objectives of the training programme has been to improve RHCPs’ knowledge about possible reasons for diseases. For the sake of collecting detailed information about RHCPs’ knowledge of possible reasons for various illnesses, we confined our questions to two health problems commonly reported by the RHCPs and villagers – breathing trouble and stomach problem. It is surprising to observe that Asthma as a possible reason for breathing trouble has been undermined by RHCPs with training (Figure 5.3). However, they have more knowledge about the other possible reasons for breathing trouble – a feature which is not observed among RHCPs without training. It is interesting to observe that training has made RHCPs understanding about possible reasons for illness more precise. Similar pattern is observed on possible reasons for stomach problem. It is surprising to notice that the training has not made RHCPs to have better understanding of doses of antibiotics. On what patient-characteristics should be considered for determining the doses of antibiotic, majority of the RHCPs (belonging to experimental and control groups) have mentioned of criteria other than weight.

Table 5.2: Referral practices by the RHCPs before and after the training programme

	Pre-training		Post-training		Diff (exp)	Diff (cont)	Diff-diff
	exp	con	exp	con			
RHCPs who faced 'complicated' cases in last 3 months	56 (15)	59 (34)	70 (19)	64 (37)	14	5	9
What did they do?							
Treated himself fully	33 (5)	21 (7)	16 (3)	43 (16)	-17	22	-39
Referred after primary treatment	60 (9)	50 (17)	74 (14)	35 (13)	14	-15	29
Referred directly	7 (1)	29 (10)	10 (2)	22 (8)	3	-7	10
Received patients with breathing trouble	78 (21)	76 (44)	93 (25)	83 (48)	15	7	8
What did they do?							
Treated themselves fully	33(7)	34(15)	28(7)	42(20)	-5	8	-13
Referred after primary treatment	57(12)	57(25)	68(17)	58(28)	11	1	10
Referred directly	10(2)	9(4)	4(1)	-	-6	-9	3
Where did they refer?							
Nearest PHC/SC	14(2)	10(3)	-	4(1)	-14	4	-18
Other Govt hospital	64(9)	52(15)	100(17)	75(21)	36	23	13
Private qualified doctor	7(1)	24(7)	-	7(2)	-7	-17	10
others	14(2)	14(4)	-	14(4)	-14	0	-14
Received patients with stomach problem	89(24)	98(57)	96(26)	97(56)	7	-1	8
What did they do?							
Treated themselves fully	75(18)	60(34)	54(14)	71(40)	-21	11	-33
Referred after primary treatment	25(6)	39(22)	46(12)	29(16)	21	-10	31
Referred directly	-	2(1)	-	-	-	-2	2
Average no. of patients referred to govt. facility	9	9	10	7	1	-2	3

Source: Primary survey

Table 5.3: Select indicators of knowledge of the RHCPs before and after the intervention.

	Pre-training		Post-training		Diff (exp)	Diff (cont)	Diff-diff
	exp	cont	exp	cont			
Possible reasons for breathing trouble							
Asthma	78(21)	53(31)	59(16)	62(36)	-19	9	-28
Heart disease	48(13)	41(24)	89(24)	40(23)	41	-1	42
Acute manifestation of respiratory track infection	56(15)	28(16)	70(19)	28(16)	14	0	14
Anemia	19(5)	10(6)	70(19)	7(4)	51	-3	54
Psychogenic – origin from reaction to acute stress	7(2)	10(6)	30(8)	10(6)	23	0	23
others	67(18)	55(32)	48(13)	76(44)	-19	21	-40
Possible reasons for stomach problem							
Gastritis and ulcer	67(18)	74(43)	78(21)	84(49)	11	10	1
Worm	44(12)	41(24)	48(13)	31(18)	4	-10	14
Stone in gallbladder	44(12)	41(24)	85(23)	47(27)	41	6	-35
Diarrhea	22(6)	19(11)	37(10)	21(12)	15	2	13
Dysentery	63(17)	57(33)	41(11)	53(31)	-22	-4	-18
Appendicitis	63(17)	53(31)	85(23)	66(38)	22	11	11
Stone in kidney	37(10)	34(20)	67(18)	28(16)	30	-6	36
Others	59(16)	38(22)	63(17)	41(24)	4	3	1
Criteria to be considered for deciding about antibiotic doses							
Weight	81(22)	53(31)	78(21)	55(32)	-3	2	-5
Age	81(22)	83(48)	71(19)	83(48)	-10	0	-10
Other	7(2)	17(10)	11(3)	19(11)	4	2	2

Source: Primary Survey

Table 5.4: Knowledge and Practices of the RHCPs on Select Medicines before and after the Training Programme

	Pre-training		Post-training		Diff	Diff	Diff-diff
	exp	cont	exp	cont	(exp)	(cont)	
Administer drip	56(15)	72(42)	63(17)	74(43)	7	2	5
Administer intravenous injection	48(13)	86(50)	78(21)	84(49)	30	-2	-32
Knowledge of synoticin	48(13)	62(36)	52(14)	66(38)	4	4	0
When to give synoticin							
Labour pain	22(6)	19(11)	7(2)	19(11)	-15	0	-15
Other reasons	4(1)	0(0)	4(1)	0(0)	0	0	0
Doesn't administer	0(0)	0(0)	37(10)	45(26)	37	45	-8
No answer	74(20)	81(47)	52(14)	36(21)	-22	-45	23
Knowledge of epidocin injection	37(10)	57(33)	68(18)	69(40)	31	12	19
Labour pain	22(6)	12(7)	40(11)	10(6)	18	-2	20
Other problem	0(0)	0(0)	0(0)	10(6)	0	10	-10
Does not administer	0(0)	0(0)	26(7)	48(28)	26	48	22
No answer	78(21)	88(51	33(9)	31(18)	-45	-57	12
Knowledge of decadon injection	81(22)	95(55)	96(26)	100(58)	15	5	10
Breathing Problem	52(14)	45(26)	44(12)	67(39)	-8	22	-30
Breathing & other problem	7(2)	22(13)	7(2)	12(7)	0	-10	10
No answer	41(11)	47(27)	48(13)	21(12)	7	-26	33
Knowledge of deriphilin	81(22)	95(55)	96(26)	100(58)	15	5	10
Breathing Problem	74(20)	88(51)	93(25)	97(56)	19	9	10
Breathing & other problem	4(1)	3(2)	4(1)	2(1)	0	-1	1
No answer	22(6)	9(5)	4(1)	2(1)	-18	-7	11

Source: Primary Survey

On questions about their knowledge and practice on select medicines, the difference between experimental and control groups is encouraging. However, the changes which apparently look like success do have the potential to harm in future. For example, percentage of RHCPs who are confident enough to administer drip or intravenous injections is higher among the experimental group than the control group (see Table 5.4). This sort of development is not surely envisaged in the training programme. It is also evident that experimental group RHCPs' knowledge of 'right' and 'wrong' medicines has improved, especially for labour pain or delivery related health care. However, it should also be remembered that the training programme might have made them more careful about reporting of what they practice.

The training programme seems to have made tremendous improvement in RHCPs' capacity in identifying risky delivery (Table 5.5). Although the RHCPs who joined the

training programme were much better endowed in terms of this knowledge, the improvement made by the control group RHCPs (who did not undergo any such training) cannot be undermined. Similarly, with regard to the knowledge of essential antenatal care the improvement experienced by the experimental group RHCPs is remarkable but the improvement of the control group RHCPs cannot be ignored too. People's visit to the RHCPs for child care has increased significantly more for the experimental group RHCPs after the survey. The experimental-group RHCPs show remarkable improvement with regard to detailed information on the doses of vaccination.

Table 5.5: Knowledge and Practices of RHCPs on Reproductive and Child Health Care before and after the Intervention.

	Pre-training		Post-training		Diff	Diff	Diff-diff
	exp	cont	exp	cont	(exp)	(cont)	
Maternity care							
RHCPs examined pregnant women in last one month (%)	73(11)	79(22)	74(17)	87(27)	1	8	-7
RHCPs knows identification of high risk pregnancies (%)	73(11)	43(12)	100(23)	58(18)	27	15	12
RHCPs having knowledge of different high risk characteristics (%)							
Anemia	30(8)	12(7)	100(23)	58(18)	70	48	22
Bloating	22(6)	9(5)	70(19)	5(3)	48	-4	52
Short height	0(0)	3(2)	48(13)	17(10)	48	14	34
Pulse	4(1)	2(1)	85(23)	9(5)	81	7	74
Low body weight	7(2)	3(2)	48(13)	-	41	-3	44
High blood pressure	22(6)	12(7)	63(17)	5(3)	41	-7	48
Jaundice	4(1)	5(3)	70(19)	22(13)	66	17	49
Others	22(6)	10(6)	70(19)	9(5)	48	-1	49
RHCPs' knowledge of essential antenatal check up (%)							
3 or more check up	67(18)	50(29)	96(26)	74(43)	29	24	5
Tetanus injection	70(19)	45(26)	93(25)	69(40)	23	24	-1
IFA tablets	70(19)	55(32)	96(26)	74(43)	26	19	7
Child care							
RHCPs treated a child in last one month (%)	48(13)	78(45)	78(21)	84(49)	30	6	24
RHCPs' having right does of child vaccination							
BCG D18	41(11)	47(27)	93(25)	57(33)	52	10	42
OPV D19	4(1)	5(3)	81(22)	3(2)	77	-2	79
DOS D20	11(3)	29(17)	89(24)	33(19)	78	4	74

Source: Primary Survey

5.3 Effects on the Users of RHCPs

The comparison of pre-training and post-training experimental and control user groups are based on information from 633 households - 220 households belonging to the experimental group and 413 households belonging to the control group. The impact of the training programme on health seeking behaviour of RHCP-users is mixed (Table 5.6). There is no evidence that the share of serious illness in total treated illness burden is higher for the experimental group RHCPs after attending the training programme. However, this piece of finding should not be interpreted as a patient with serious illness is less likely go to a trained RHCP than an untrained RHCP. After attending the training programme, now less percentage of RHCPs seem to explain to their patients about the cause of illness. This is not surprising as improved knowledge might have reduced their false confidence to explain each and every symptom. Trained RHCPs seem to do a better job than the untrained RHCPs in advising patients on how to avoid similar illnesses in future. A comparison of users' opinion between pre-training and post-training surveys shows that higher percentage of users feel that their RHCPs do not charge excessive money but the feeling of not being charged excessive money is now higher for control group RHCPs. Users' overall satisfaction with the RHCPs is significantly more impressive for experimental group RHCPs. Whereas the percentage of users who are very satisfied with the treatment increased from 55 before the training programme to 69 after the training programme for the experimental group RHCPs, it decreased from 72 to 66 for the controlled-group RHCPs.

The users of the experimental group RHCPs seem to be aware of the training programme that their 'doctors' were going through. It also looks like users of the controlled group RHCPs were aware that their 'doctors' were not going through such a training. The training seems to have some impacts on the users' opinion about their doctor's qualification and expertise.

Table 5.6: Changes in the Opinions of the Users of RHCPs (Household Respondents) before and after the Training Programme.

	Pre-training		Post-training		Diff (exp)	Diff (cont)	Diff-diff
	exp	cont	exp	cont			
Patients with serious health problems	32 (71)	48 (200)	41 (88)	66 (274)	9	18	-9
RHCPs explained about possible cause of illness	41 (91)	67 (276)	32 (70)	50 (209)	-9	-17	8
RHCPs explained about how to take future precaution	44 (96)	76 (312)	52 (113)	71 (296)	8	-5	13
RHCPs provided all or most of the medicines	82 (180)	85 (352)	87 (188)	93 (388)	5	8	-3
Did not charge "excessive" money/fees	92 (202)	89 (368)	86 (186)	76 (316)	-6	-13	8
patients' satisfaction (very satisfied)	55 (122)	72 (298)	69 (149)	66 (276)	14	-6	19
To visit the RHCP in future for similar health care need	84 (185)	87 (359)	86 (186)	90 (375)	2	3	-1

Source: Primary Survey

Table 5.7: Users Opinion on RHCPs' Competence

	Pre-training N=633		Post-training N=633		Diff (exp) N=	Diff (cont) N=	Diff-diff N=
	Exp N=220	Cont N=413	Exp N=216	Cont N=417			
RHCPs have necessary qualification to treat them	74 (162)	72 (297)	65 (141)	48 (199)	-9	-24	15
RHCPs have necessary experience to treat them	78 (171)	85 (350)	78 (169)	74 (309)	0	-11	11
RHCPs need further training to improve their service	92 (202)	81 (336)	75 (161)	83 (347)	-17	2	-19

Source: Primary survey

5.4 Effects on the ANMs

RHCPs mostly provide curative health care whereas ANMs functioning in the same areas offer mostly preventive care to the rural population. Since they operate in the same areas, one group of health care providers is expected to have some familiarity with the other group. One does not know to what extent RHCPs are acceptable to the ANMs as community health care providers. But one would expect that any step to improve the capacity of the RHCPs would be taken by the ANMs as a positive step for the community. One would also expect that ANMs would show more interest in gathering information about those RHCPs who become part of the training programme. Opinions of

the ANMs on RHCPs before and after the training programme is presented in Table 5.8. There is a clear evidence that being part of the training programme increases the chance of a RHCP known to an ANM. On an average ANMs' opinion about the capability of RHCPs in curing disease has improved for the experimental group RHCPs after the training programme. Although majority of the ANMs believe that RHCPs can be improved by providing them training, former's belief in the usefulness of the latters in different health related activities is mixed. Even though it varies, not a huge proportion of the ANMs believe that RHCPs can play important role in improving antenatal care, institutional delivery, immunization coverage and health awareness programmes. The training seems to have increased ANM's faith on the RHCPs in helping the former in the health awareness programme.

Table 5.8: Changes in the Opinions of Government Health Workers (Auxiliary Nurse Midwives) before and after the Training Programme.

	Pre-training		Post-training		Diff (exp)	Diff (cont)	Diff-diff
	exp	cont	exp	cont			
Familiarity with local RHCPs							
Know all of them	18(5)	2(4)	37(10)	10(2)	19	8	11
Know one or some	75(21)	7(14)	59(16)	80(16)	-16	73	-89
Don't know	7(2)	1(2)	4(1)	10(2)	-3	9	-12
RHCPs' can cure some illnesses							
Agree	68(19)	55(11)	26(7)	20(4)	-42	-35	7
Do not agree	7(2)	15(3)	33(9)	50(10)	26	35	-9
Cannot say	25(7)	3(6)	41(11)	30(6)	16	27	-11
ANMs believe that RHCPs can help in improving antenatal care coverage	18(5)	45(9)	30(8)	35(7)	12	-10	22
ANM believe that RHCPs can help in improving institutional delivery	32(9)	50(10)	30(8)	35(7)	-2	-15	13
ANM believe that RHCPs can help in improving immunisation coverage	21(6)	50(10)	30(8)	30(6)	9	-20	29
ANMs actually take help of RHCP in health camp/awareness programme	7(2)	40(8)	30(8)	2(4)	23	-38	61
ANMs who think that RHCPs can be improved by providing training	75(21)	90(18)	81(22)	85(17)	6	-5	11

Source: Primary Survey

5.5 Effects on the GP Members

Table 5.9 summarises changes in perceptions of the local elected representatives with regard to the RHCPs. As expected GP members' familiarity with the RHCPs is much higher than the ANMs. Contrary to our expectation, it was found that not all community leaders were well familiar with the qualification, experience and activities of the RHCPs functioning in their areas. GP members' familiarity with the RHCPs improved with time as it is evident that GP members belonging to both experimental and control areas report greater familiarity with the RHCPs.

Table 5.9: Changes in the Opinions of Community Leaders (GP members) before and after the Training Programme.

	Pre-training		Post-training		Diff (exp)	Diff (cont)	Diff-diff
	exp	cont	exp	cont			
Well aware of the RHCPs operating in his/her area	63(63)	68(60)	94(90)	80(74)	31	12	19
Opinion about the treatment provided by the RHCPs in his/her area							
Very good	6(6)	11(10)	7(7)	3(3)	1	-8	9
Moderately good	32(32)	43(38)	64(61)	58(53)	32	15	17
Average	22(22)	10(9)	23(22)	13(12)	1	3	-2
Don't know/cannot say	40(40)	36(31)	0(0)	26(24)			
RHCPs can help the government health workers in some areas/fields							
Agree	9(9)	56(49)	29(28)	59(54)	20	3	17
Don't agree	4(4)	5(4)	7(7)	9(8)	3	4	-1
Cannot say	87(87)	40(35)	64(61)	33(30)	-23	-7	-16
Types of help							
Various health campaign (polio *etc*)	3(3)	15(13)	9(9)	21(19)	6	6	0
Providing primary treatment or distribution some basic medicines	0(0)	18(16)	11(11)	23(21)	11	5	6
Monitoring pregnant women for maternal care	0(0)	0(0)	7(7)	9(8)	7	9	-2
Others	1(1)	1(1)	3(3)	3(3)	2	2	0
Could not say anything	97(97)	58(66)	66(69)	53(49)	-31	-5	-26
RHCPs can be improved by providing training by qualified doctors							
Agree	61(61)	94(83)	77(74)	84(77)	16	-10	26
Don't agree	39(39)	1(1)	0(0)	0(0)	-39	-1	-38
Difficult to say	0(0)	5(4)	23(22)	16(15)	23	10	13

Source: Primary survey

However, it is clear that GP members living in the experimental area demonstrate exceptionally higher familiarity with the RHCPs present in their areas. GP members'

positive perception about the quality/effectiveness of the RHCPs has improved in both experimental and control areas with experimental area showing more improvement. What is worth noticing is that in the post-intervention survey no GP member living in the experimental area reported lack of idea about the quality of treatment offered by the RHCPs. Higher percentage of GP members from the experimental area agree that RHCPs can help the government health workers in implementing health programmes. However, not many GP members are clear on what kinds of support/help the RHCPs could render to the health workers. The training does not seem to have contributed in improving the situation. By and large the GP members believe that training can improve the quality of RHCPs.

(above) Dr Bidhan Kanti Das (Anthropologist, IDSK) is interviewing a RHCP. (Below) IDSK team consisting of faculty members and MPhil students are conducting a focus group discussion