

Chapter 7

Conclusion

7.1 Summary of Important findings from the Evaluation Study

The evaluation exercise using semi-randomised experimental design shows that RHCPs who underwent the training programme (*i.e.* experimental group RHCPs) demonstrate additional empowerment over the RHCPs who did not go through the training programme (*i.e.* controlled group RHCPs) when assessed by certain indicators such as owning a clinic, less involvement in cross-practicing, average number of patients seen per day, number of home calls, remaining in touch with other RHCPs and procuring medicines directly from the dealers. The training has made RHCPs' understanding of possible reasons for illness more precise. However, the training does not seem to have improved RHCPs' understanding of doses of medicine.

The experimental group RHCPs' knowledge of 'right' and 'wrong' medicines has improved, especially for labour pain or delivery related health care. The training programme seems to have made tremendous improvement in RHCPs' capacity in identifying risky delivery. 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. The experimental-group RHCPs show remarkable improvement with regard to detailed information on the doses of vaccination.

The training seems to have some positive impacts on the users' opinion about their RHCPs' qualification and expertise. The ANMs' opinion about the capability of RHCPs in curing diseases has improved for the experimental group RHCPs as a result of the training programme. Although majority of the ANMs believe that RHCPs' performance can be improved by providing them training, former's belief in the usefulness of the latters in different health related activities is mixed. A large proportion of the ANMs believe that RHCPs can play important role in improving antenatal care, institutional

delivery, immunization coverage and health awareness programmes. GP members' positive perception about the quality/effectiveness of the RHCPs has improved in both experimental and control areas with experimental area shows improvement after the training programme. Higher percentage of GP members from the experimental area agree that RHCPs can help the government health workers in implementing health programmes.

In the absence of the training programme, RHCPs' knowledge about liver disease and possible reasons for liver diseases is encompassed with inadequate and wrong information. RHCPs have little information beyond knowing the name of Hepatitis B. The level of awareness on possible sources of Hepatitis B infection is alarmingly poor. It is worth noticing that out of those who have heard about the disease, a large percentage of them do not have any knowledge about the possible reasons for the disease. It is equally interesting to observe that significant number of household respondents think cold/cough/fever, contaminated water, regular consumption of rich/spicy food could be possible reasons for Hepatitis B.

The training did improve RHCPs' familiarity with Hepatitis B but there is still room for improving their knowledge. The training has made remarkable improvement amongst the experimental group RHCPs in improving their knowledge about other types of Hepatitis (*i.e.*, Hepatitis A, C and E). There is no evidence of widespread misconception among the RHCPs with regard to possible reasons for Hepatitis B, though their true understanding of possible reasons is very much limited. The training seems to have achieved limited success in improving the knowledge of the RHCPs with regard to Hepatitis B in particular.

There is some evidence that users' knowledge of Hepatitis B has experienced some improvement after the training programme. After their RHCPs went through the training programme, higher percentage of users are familiar with Hepatitis B and have the right knowledge that it is a disease related to liver. However, users' understanding about the

possible causes of Hepatitis B is alarmingly low. Awareness about liver diseases and Hepatitis B is an area where the training programme should give exclusive focus.

7.2 Background Rational for the Training Programme

India has highly developed centers for modern medical care, which are utilized even by patients from far away, including rich countries of Europe and North America (Chinai & Goswami, 2007). The private healthcare sector has also been flourishing in India in the last few decades (De Costa & al., 2008). The system of public health services is, in principle, accessible to everyone, and poor patients have, in principle, the possibility to obtain essential services free of charge (Howard & Roy, 2004). In addition, several formal schools of alternative or non-allopathic medical practice are recognized and offer outpatient and inpatient care (e.g., ayurveda, homeopathy, siddha, unani; Bhatt & al., 2004; Broom & al., 2009). However, most qualified, formal health services are concentrated in urban areas (Balarajan & al., 2011). In rural areas, where 70% of the population live, public health services are notoriously underused, though geographically relatively accessible. Rather, people prefer to consult informal, unqualified private practitioners (or quacks) as a primary source of healthcare (Kumar & al., 2007).

These informal practitioners offer quick advice and typically sell modern, allopathic drugs. They have no or incomplete training in modern medicine; few of them are trained in some kind of non-Western medical practice (George & Abraham, 2002). They often have lived for long and know well their community and typically have attained a higher level of education compared to the rest of the community, but have no other source of income. In some respects one might be tempted to subsume these practitioners under “complementary and alternative medicine” (CAM), which has recently gained attention in contexts where multiple styles of healthcare are accessible. However, this is misleading, because the informal practitioners are for large parts of the rural population neither complementary nor an alternative but the primary source of healthcare.

India has for long acknowledged private healthcare providers as a necessary complement to the public system. Regulatory measures have been devised especially for the private

sector of medical practice (Bhat, 1996). However, there is a particular concern that informal practitioners escape these measures and may cause *harm* to some patients (Kumar & al., 2007; Kanjilal & al., 2007). Nonetheless, the informal practitioners are also considered as *potential resource* persons for improving the hitherto insufficient coverage of certain public health programs (Mills & al., 2002).

Addressing these issues may be difficult because it implies acknowledging the failure of the formal and public systems to sufficiently reach large parts of the population. Furthermore, it may be challenging to avoid reinforcing or institutionalizing unwillingly an undesirable practice, where more controlled health services are wanted. Measures to guide the practice of informal healthcare providers and to tap them as a supplementary resource for public health programs have been advocated, but little is known about how best to conceive them and what the potential effects are (Mills & al., 2002).

Measures to improve quality of care and to ensure adherence to certain essential procedures have been developed for long and widely applied to *all* kinds of healthcare practitioners, including formal, qualified, private and public professionals (Chassin & al., 1998; Chowdhury & al., 2005). However, a somehow different approach may be required for informal practitioners. While *training* the unqualified practitioners is an obvious need, other *supply-side measures* that normally accompanying quality improvement programs are difficult to apply to this target group who lacks an organized commercial structure. Regulation, improvements of the oversight by the public health system, and some form of externally imposed organization for the informal practitioners, e.g. franchising, have been discussed (Berlan & Shiffman, 2011; Bloom & al., 2011; Chakraborty & al., 2000; Kanjilal & al., 2007; Mills & al, 2002). Some put little hope on effective action from the Indian public health system (Kanjilal & al., 2007). In the absence of corporate or public avenues for training and oversight, *non-governmental initiatives* remain a realistic option.

Besides addressing the providers themselves, *demand-side intervention* has probably become necessary in order to keep the otherwise unsupervised unqualified rural practitioners motivated to follow certain practices. A combined supply- and demand-side

approach has already shown some success with mainly unqualified practitioners in north-east India (Chakraborty & al., 2000). Other experiences both underline the need for demand-side intervention components and provide inspiration on how it may be done, although much is left to be explored. For instance, campaigns informing villagers about their rights, differences between healthcare providers, and appropriate healthcare seeking strategies in typical situations promise some influence (Berlan & Shiffman, 2011, Pandey & al., 2007). Yet, such measures have not always been successful (Berlan & Shiffman, 2011). Undesired effects may be provoked, for instance, if the quality of care only improves with some providers these may then be able to increase their prices, and additional social inequity may be created (Mills & al., 2002).

Given this context, one might agree with the position that something should be done about unqualified rural healthcare practitioners. Although, these practitioners often lack necessary knowledge for dealing with potentially serious health problems and lack publicly recognized qualification, they are the first and sometimes only source of healthcare for a large part of the rural population. Even though these practitioners understand themselves as health workers, have close relationships with the community in which they live and, thus, are potentially effective mediators where the public health system has none. However, presently they are not involved in the strategies of most public health programs.

The interventions should remain *restrictive and balanced*. In the absence of an effective regulation of the rural informal practitioners it is desirable to avoid making them appear to their clients more qualified than they are, for instance by combining measures addressing the practitioners by demand-side measures. One may want to avoid attracting more individuals to informal practice. One may also want to avoid creating market advantages for a *subgroup* of unqualified practitioners who could then increase their prices and push the poorer patients to even less qualified practitioners.

There is a need to have a periodic evaluation of this type of interventions. Unqualified practitioners are a relatively new target group for intervention. Any measures addressing

them are hoped to produce positive results for the rural population, but *efficacy* and *best conditions* for effectiveness of such measures remain to be identified. *Unintended effects* are a concern with any intervention. But they could be more likely here, in view of the mentioned ambiguities and the innovative nature of intervention; close monitoring is needed to facilitate timely alert. The intervention to be evaluated begins addressing the issue by training the unqualified practitioners, the obvious point of departure for this target group who by definition has little or no recognized training.

7.3 RHCP Training Programme carried out by Liver Foundation

This evaluation study has made an attempt to evaluate the Rural Health Care Providers (RHCP) Training Programme which has been implemented by the Liver Foundation West Bengal and funded by the Bristol-Myers Squibb Foundation. It has been active since 2007 in several districts of West Bengal and one district of Jharkhand. The target group for this training programme is the allopathic rural unqualified healthcare providers. The *trainees* are selected by batches. For logistic reasons, class and batch size is around 50 trainees, recruited often from a single administrative block, sometimes from several blocks mixed. In order to be eligible, candidates must have attained at least grade 10 in school and pass a combined written-oral test. They should not be practicing any recognized system of alternative medicine like (like ayurveda, unani or homeopathy). Our evaluation study points to a few areas where the RHCP training programme or training programmes with similar objectives needs revamping with a fresh look.

7.3.1 Selection of areas/blocks for training

It is clearly observed that dependence of the rural population on the RHCPs is higher in areas where there is no primary health centre nearby or they are not well functioning in case they exist. Therefore, selection of a whole administrative block irrespective of areas of poor and better access to government health facilities may not be an efficient and equitable targeting, although it may be efficient from organizational or logistic point of view. Selection of areas with very poor access to government health facilities and/or higher incidence of poverty within a block may meet our equity as well as efficiency criteria for ensuring better outcome of the training programme at the community level.

7.3.2 On Selection of RHCPs:

The present criteria for selecting RHCPs for the training programme allow selection of only those RHCPs in a block who have 10 or more years of schooling and who score above a pre-determined cut-off marks in the admission test on general health and health-system level awareness. Although this process seems to be better suited for selecting only those RHCPs who probably have the capability of improving themselves by undergoing a training programme, it has the risk of excluding those who are in higher need of intervention through a training programme, especially if we are more concerned about reducing their harmful practices. Therefore, the selection criteria should also focus on exclusiveness and coverage aspects of the training programme so that RHCPs with stronger potential to do harm should not be totally left out from any form of intervention.

The admission criteria for the training ensured feasibility of first training batches. Nevertheless, in future a more inclusive training policy may be desirable. Considerable proportions of the rural (unqualified) health care providers (RHCPs) were excluded from several batches. Notably, those unable to pass the entry test account for more than half of those tested in several blocks. Even though, the proportion of those who were ineligible for the test is not documented, it may not be negligible. These hitherto excluded RHCPs may be less knowledgeable in allopathic health matters than those who were eligible for training and may, therefore, pose higher risk to their patients. Training the remaining RHCPs appears, thus, even more urgent, though it may turn out more difficult. Unless these RHCPs are included, the *population* covered by them will be excluded from the benefit of the program. Moreover, if the trained RHCPs succeed in realizing a market advantage over the untrained RHCPs, their prices may increase and the poorer patients may turn to the untrained RHCPs. As a result, additional price-quality segments and additional inequity could result in the economy (Mills & al., 2002. pp. 327 and 328).

7.3.3 Need for Reformulating the Course Curriculum

The complete training session of each batch lasts roughly for 10 months to one year. A preparatory phase is followed by phases of enrichment and consolidation. The training is

part-time, that is, trainees continue to work between classes. Trainers are volunteering doctors from the public health system. There are different groups of trainers for each training location with some common trainers who have served in more than one location. The curriculum proposes 156 classes of basic and application-oriented topics. Whereas the basic topics include anatomy, physiology and pharmacology, the applied topics cover; baby care, maternal health, emergencies and public health. The selection of applied topics indicates that the course aims to make the participants aware and knowledgeable of important public health issues. The pharmacology section puts emphasis on dose and side effects of certain drugs frequently handled by the RHCPs. The syllabus mentions in the anatomy section includes a hand-out for trainees, a “practical copy” containing mainly pictures. The document which is known as “Syllabus” looks like a reminder for the trainers rather than a reference for the trainees. The course actually taught might have differed across batches and across trainers. It is felt during the process evaluation that reducing certain abstract topics may benefit the topics interesting to the participants of the actual batch.

Nevertheless, one wonders if the training contents could be further streamlined according to the orientation of the program. For instance, the information of “5 to 7 liters secretion in 24 hours” into the intestinal tract is very important for understanding the threat exerted by profuse watery diarrhea; but it occupies relatively little room in the syllabus, compared to rather theoretical information about the bio-chemical composition of the saliva and, gastric and pancreatic juices. Also, the pharmacokinetics section is rather abstract. It is unclear how much weight the more applied paragraphs on side effects and dosages will receive in the actual training. We missed the subject of provider-patient relationship and effective communication with patients (who may, for instance, feel unprepared to accept the referral to a more equipped source of health care).

The grouping of topics may be very important. Some contents are arranged according to medical sub-disciplines, for instance, “bad effects” and dosages of specific drugs (pharmacology section) are separate from the clinical situations to which these drugs apply (baby, motherhood and emergency sections). This structure of the syllabus leaves it

to the trainers, to *integrate* both aspects into *problem-oriented* training sessions. These aspects of training content and structure may become even more important if opening the program for a wider target group is considered, including also less schooled RHCPs.

7.3.4 Inclusion of female RHCPs in the training programme

In the first two years of the training programme, few women trainees were selected mostly from the backward pockets. Later it was found that training women did not yield much effectiveness since most of them would not remain engaged in providing health care services. This finding probably made the training organization to give a second thought on the selection of women for the training programme and as a result now it is mostly the male RHCPs who are covered by this training programme. Our study found that women RHCPs not practicing after receiving the training is not always due to unwillingness to practice on their part, rather there are various social-sigma and gender relations which prevent the women from practicing. Irrespective of the fact that women who have received training are not practicing health care in male dominated informal health care market, there is evidence that they are playing proactive role in spreading prenatal and immunisation related health awareness among the poor women.

7.3.5 Need for greater sensitization at the local government levels

Surprisingly, there is no evidence that government health workers always possess strong negative opinion against RHCPs providing health care to the rural population. Almost all government health workers that we have interviewed believe that training can reduce the harmful practices of RHCPs and even improve their medical knowledge. In spite of government health workers have taken a pragmatic position with regard to the medical practices by RHCPs, the Gram Panchayats are yet to take any supportive role in getting RHCPs involved in various public health programmes at the community level. There is a need at the local level to sensitise the GP functionaries to take advantage of RHCPs wherever it is feasible and safe.

7.3.6 Need for continuing education

There is a need for some type of ‘continuing education programme’ for the RHCPs who have successfully completed the training. This is required not only for refreshing and updating their level of knowledge and awareness, but also for bringing them under some kind of surveillance system in order to monitor their activities. More than two-third of RHCPs have expressed the need for a *continuing education* system at least once in a month.

7.3.7 Need for more practical sessions

The need for more practical sessions has been expressed by more than 80% of the RHCPs who have successfully completed the training. Although, one could understand the institutional and socio-political constraints which prevent organising practical sessions in government facilities, keeping in view the greater need for having such practical session alternative ways could be explored.

In a nutshell, the training has been successful in achieving some of its objectives. However, there are few areas in which the training needs to shift its focus and emphasis on an urgent basis. Moreover, there is a need for rethinking about the criteria for coverage and selection of RHCPs as well as restructuring the course syllabus. Our evaluation study clearly finds that there is a strong demand for this training programme among RHCPs who have heard about its structure and contents. Our quantitative and qualitative analysis clearly finds that community leaders and government health workers find merits in the contribution of the training programme and they are in favour of RHCPs in their areas joining the programme.



Dissemination workshop at Zilla Parishad Hall (Suri, Birbhum district)