Chapter 4

How Well the Training Has Been Carried Out So Far?

This chapter intends to analyse the process of the training programme, right from its selection of trainees and course design to successful completion and satisfaction of the trainees. The analysis is completely based on information collected during our baseline and endline surveys, interviews with the training drop-out and in-depth interviews with the trainers.

The chapter is organized as follows: Section 4.1 tries to list out in detail the items on which RHCPs need to receive further knowledge given their limitations and for achieving various objectives laid down by the training programme. Section 4.2 critically analyses the syllabus of the training programme and the selection process for the training programme. Section 4.3 analyses the experience of the trainees with the training programme including experience of those who left the training before its completion. Section 4.4 presents the views of trainers and others involved in designing and conducting the training programme.

4.1 Designing the Course Training Curriculum: A Challenge

Designing a course curriculum for an unconventional programme like the RHCP training is expected to be challenging and ideally the design of such a programme should take into account mostly two criteria: ***First***, the training programme has a set of direct and indirect objectives which it aims to achieve. The course content of the training programme should do justice to those objectives. ***Second***, the content of the training programme should be attractive enough for the RHCPs not only to join the programme but also to complete the programme. Since for each batch of RHCPs the training programme continues for one year, it is indeed a challenge for the trainers to keep the programme interesting enough so that the RHCPs remain in the programme till its completion. It is important to remember in this context that the trainee RHCPs do not necessarily have any orientation to attend classes like students as most of them left their school many years ago. Moreover, many of

them also sacrifice their earnings for the time which they spend for attending the training programme.

Let us examine to what extent the course curriculum of the training programme has tried to address/link the course content with the objectives of the training programme. Although the emphasis on different components of the training programme varied between trainers groups, the major objectives of the training programme remained the following: (a) prevention of emergency deaths in the community; (b) reduce under-5 mortality; (c) strengthening maternal care; (d) establish a referral network in the locality; (e) harm reduction; and (f) improve Hepatitis B information and prevention.

4.2 What is Taught? A Brief Description of Training Curriculum

The syllabus of the training programme is divided into 9 parts and expected to spread across 156 classes/sessions including ANC (Antenatal Care), emergency observations and OPD (Outpatient Department) (Table 4.1). Because of its non-conventional nature, the first two weeks of the training programme is spent for making the trainees accustomed with reading habit, discipline and learn some health related nomenclatures. The training programme starts with a very encouraging and promising note that "the trainers should be their teachers, friends, source of behavioural changes and attitude also." The syllabus of the training programme also makes the ambitious promise that "the trainers should also be available for the students for 24 hours".

Table 4.1: Outline of the Syllabus of the Training Programme

Sections	Topic	Classes
1	Human anatomy	24
2	Physiology	24
3	Pharmacology	18
4	Baby care	19
5	Safe motherhood	30
6	Emergency medicine	18
7	Public health	28
8	Practical sessions	6
9	First aid	8

Source: Liver Foundation, West Bengal

The classes on human anatomy include a basic introduction to human body, knowledge of hollow visceras and solid organs of thorax, intra-abdominal organs, nervous system and knowledge of eye, nose and ear. The classes on physiology include cell, blood, immunity, respiration, site and items of examination, physiological variations, hypertension and digestive system. It also includes quite a detailed discussion of stomach, gastric glands, gastric juice, function of HCL, peptic ulcer and its clinical significance. With regard to jaundice/other symptoms of liver diseases, detailed discussion on possible reasons types, site of examination and clinical features are discussed. The classes under the physiology also include lessons on pancreas, function of peristalsis, excretory system, hormones, reproductive system and nervous system.

Although it is mentioned in the last part of the syllabus the training has got few dedicated lessons on first aid – an area which is very relevant because of two reasons. First, for many people in rural areas, RHCPs are the first contact points in emergency health care need. Second, RHCPs are the health care providers which live in better proximity with the community making the former easier accessible than government services in case of emergency health care need. The lessons on first aid include primary treatment for burn, snake bite, drowning, fracture, poisoning, wounds and dressing, among others. Since it is not only the first aid for which people visit RHCPs, the course has reasonably included a number of items to be taught under its pharmacology section. Not only knowledge of safe drug and their uses are taught, a number of classes are devoted to discuss the good and bad effects of drugs, anti-microbial agents, analgesics (*i.e.,* drugs relieve pain without loss of consciousness) including brief discussions on some safe antimicrobial agents. There is also a separate section on emergency medicines which deals with reading the right symptoms and emergency medicine. The list includes respiratory distresses, pneumonia, cardiac failure, unconsciousness, acute chest pain, hypertensive emergency, acute abdominal pain, diarrhea, poisoning, jaundice and fever, among others.

The training programme has a detailed course on safe motherhood and as many as 30 classes are devoted to teach the RHCPs various aspects of antenatal care and safe

motherhood. The lectures on safe motherhood include teaching on female and male reproductive organs, fertilization, pregnancy, antenatal check up, various investigations such as blood groups and rH, blood sugar, urine/albumin. Antenatal care includes knowledge of immunisation, rest and diet. Although the important component of this section is detection of high risk pregnancies, considerable number of classes are spent on human granulocytic ehrlichiosis in early pregnancy, family planning and contraception, and some medical disorder of pregnancy. As an obvious continuation of lessons on antenatal care and safe motherhood, the training programme devotes good number of lectures on baby care which includes lessons such as taking case history of sick children, how to observe and identify congenital anomalies, understanding the real difference between healthy and unhealthy newborn, and understanding of normal neo-natal status. It also includes classes on neonatal care, neonatal recording, bad signs of a child and protein energy malnutrition.

The training also aims at giving the RHCPs a public health perspective of the health issues. The classes on public health includes some bit of epidemiology, disease prevention and control, immunisation (especially those covered under the national immunisation schedule), water born diseases, infection/disinfection and communicable diseases, and some rudimentary health indices such as infant mortality rates and maternal mortality rates/ratios.

4.3 RHCPs' Expectation and Experience with the Training

This section primarily focuses on the training related experience of the RHCPs and the analysis is based on data from a larger sample of RHCPs in order to capture as diverse views as possible. As per the data provided by the Liver Foundation, 689 RHCPs have successfully completed training programme in different blocks of West Bengal and Jharkhand till 2010-11 and our analysis in this section is based on a sample of 128 RHCPs which is roughly 18.6% of total number of RHCPs that were provided training by the Liver Foundation till 2010-11. Since our sample of 128 RHCPs come from three different districts and were trained by different groups of trainers in each district, it may

be appropriate to present some of the indicators separately for the districts so that trainer-group specific effects on the RHCPs can be partially analysed.

First the variations in expectations of the RHCPs at the beginning of the training programme is analysed. Almost 96% of the sample RHCPs joined the programme with an expectation to learn something new from the training programme, however not all of them were very clear about what should be learned (Table 4.2). Almost 40% of the RHCPs wanted to learn more about maternal care and a significant percentage wanted to learn more about treatment process and medicines in general.

Table 4.2: List of Topics the RHCPs Expected to Learn from the Training Programme

Topics expected to learn from the training programme	Percentage of RHCPs (frequency)
Learn more about maternal care	40 (51)
Learn more about treatment process in general	29 (37)
Learn more about medicine in general	22 (28)
Learn treatment of jaundice and liver disease	19 (24)
Learn basic treatment (cough, cold, fever, stomach problem etc)	16 (21)
Learn more about anatomy/physiology	16 (20)
Learn more about treatment of children	15 (19)
Learn more about diseases and their symptoms	13 (16)
Learn pathology	12 (15)
Learn injection, surgery, stitching, saline	11 (14)
Learn treatment of heart disease/chest pain	10 (13)
Learn treatment of tuberculosis	7 (9)
Learn when to refer a case	7 (9)
Learn treatment of asthma	6 (8)
Correction of wrong treatment	5 (6)
Learn more about critical care (maningitis, kidney, lungs etc)	2 (3)
getting government job	1 (1)
Did not mention about any expectation	4 (5)

Source: Primary Survey

A close comparison between the course contents of the training programme and expectation of the trainees at the beginning of their training programme indicates that a significant number of the RHCPs had not remained fully satisfied at the end of the training programme. However, a direct question addressed to the RHCPs did not give us such an impression. Table 4.3 shows that more than half of the sample RHCPs have found the training ‘very good’ and only one-third of them have found the training good or

okay. Since RHCPs in three districts were trained by three different groups of trainers, one gets an impression from the table that RHCPs in Birbhum are more satisfied with the training programme than the RHCPs in Nadia and Purulia. However, two points should be noted. First, RHCPs' satisfaction with the training programme cannot be perfectly captured with a structured questionnaire especially in a situation when the trainees develop close rapport with the trainers during the training programme. Second, RHCPs' satisfaction with the training in three districts may not be strictly linked to the efficiency with which the training was conducted in these three districts. Moreover, we have smaller sample size from Nadia and Purulia in comparison to Birbhum.

Table 4.3: RHCPs' Satisfaction with their Learning during the Training Programme

How good you learned	Birbhum	Nadia	Purulia	Combined
Very good	62 (58)	31 (4)	33 (7)	54 (69)
Moderately good/okay	22 (21)	61 (8)	62 (13)	33 (42)
Not good/difficult to say	16 (15)	8 (1)	5 (1)	14 (18)
Sample size	*94*	*13*	*21*	*128*

Note: Figures in parentheses represent the respective sample size.
Source: Primary survey

The course content of the training programme shows that there were batteries of topics which were covered or at least supposed to be covered during the training programme. We also observed that RHCPs were quite heterogeneous in terms of their expectations from the training. Against this background, it is interesting to observe that six topics taught during the training programme were found valuable by one-fifth or more of the sample RHCPs. One of the major objectives of the training programme was to improve the scenario of maternal and child health care, led the training programme to have a strong component on maternal health care, especially, on the identification of high risk pregnancies. It is interesting to observe that more than half of the sample RHCPs found maternal care including the teaching on identification of high risk pregnancies valuable. It is equally interesting to notice that nearly a quarter of the sample RHCPs found knowing more about doses and side effects of medicines and, diseases and their symptoms valuable. Almost one-fifth of the RHCPs informed that knowing more about liver disease was valuable for them. It is evident that the RHCPs valued expansion of their knowledge in a broader area more than that on a particular illness or disease.

Table 4.4: List of Topics Taught during the Training Programme which the RHCPs Found Valuable

Topic	Percentage (frequency)
Knowing more about maternal care including identification of high risk pregnancies	51 (65)
Knowing more about doses and side effects of medicines	25 (32)
knowing more about diseases and their symptoms	23 (29)
Knowing more about children' illness and treatment	21 (27)
knowing more about primary treatment	21 (27)
Liver diseases	20 (26)
Symptoms and primary treatment of heart disease	18 (23)
Anatomy of human body	17 (22)
What should not be done and/or when to refer cases	14 (18)
Healthcare for critical illness	5 (7)
Treatment for asthma/breathing trouble	5 (6)
How to take case history	3 (4)
Others	6 (8)
Could not mention any topic found valuable	5 (6)

Note: Figures in the parentheses are frequency of the RHCPs
Source: Primary survey

It is quite natural that an unconventional training programme like the RHCP may be subject to many shortcomings despite the potential benefits it offers to the society, as perceived by many quarters. *Albeit*, it is not always easy to pinpoint specific limitations shared by many trainees as they were highly heterogeneous in terms of their expectations. However, there are 2 or 3 aspects of the training programme which were pointed out by a relatively higher number of trainees as weakness of the training programme. First of them was their displeasure with the insufficiency of classes. Here it is important to distinguish between two types of displeasure – one is related to insufficiency of practical classes and the other is with regard to the total number of classes. We argue that addressing the first type of insufficiency should be given more priorities over the second type of insufficiency. However, finding an appropriate set up to offer more practical sessions is a real challenge and one needs to think beyond attaching such sessions to clinics or OPD of government hospitals. It was observed during the survey as well as during the in-depth interviews that very few RHCPs have found the structure and content of the training

programme inadequate. A few weaknesses mentioned out by the RHCPs are beyond the scope of the training programme for right reasons. It should be noted that relatively significant number of RHCPs have cited poor infrastructure of the training place as weakness – an aspect of the training programme which can probably be improved easily.

Table 4.5: Weakness of the Training Programme as Pointed out by RHCPs

Comment on weakness	Frequency of trainees
Practical classes are insufficient	21
Number of classes should be more	12
Infrastructure of training was poor	5
Did not cover eye treatment	3
Did not teach administering injection or drip	3
Teaching on medicine was weak	3
Training should be provided by specialists	3
Study materials provided were not sufficient	3
Teaching on critical care was absent	2
Did not teach about process of delivery	2
Insufficient teaching on functioning of organs	2
How to perform minor surgeries was not taught	2
Huge mismatch between theory and practical sessions	1
Certificate was not provided	1
Loss of earning was not compensated	1
Teaching on pathology was weak	1

Source: Primary survey

Interestingly, it was observed that the RHCPs, who have just finished the training programme, were not very comfortable in criticizing any component of the training programme. However, when the principal investigators had in-depth interview with the RHCPs without any questionnaire, RHCPs were more comfortable in pointing out constructive criticism with regard to the structure and content of the programme.

For redesigning the training programme with the objectives of making it more target oriented, it is imperative that the major weaknesses of the training programme as pointed out by the trainee RHCPs are addressed along with the suggestions made by them. As is evident from the previous discussion, as large as 55 RHCPs are of the opinion that increasing the number of practical sessions in some form will definitely improve the

Table 4.6: List of Areas Suggested by the RHCPs to Improve the Training

Areas	Frequency
Introduce more practical sessions	56
More number of days and more hours	38
Continuing education or organizing rural education camp	21
Improve infrastructure and environment of training centre	18
More explanation in the class	13
Training administer injection, stitching, removal of teeth	11
Increase in number of trainers, teaching by specialist	9
Teaching more about emerging diseases and their symptoms	8
Exclusive antenatal training & delivery & treatment for children	8
Stipend and/or certificate	7
More training on medicines	4
Monitoring of the training procedure	4
Selection of right candidates, RHCPs from backward class	3
Start late in the winter	1
Medium of training should be in English	1
Psychiatric disease	1
Treatment of eye	1

Source: Primary Survey

quality of the training programme. Less but significant number of RHCPs have suggested to increase the number of days as well as duration of classes in each day. Although both the suggestions have some similarities, as it will require more human resources, there is a crucial difference between them. The trainers need to explore innovative ideas on how to increase the number of practical classes and how to make them more attractive. A significant number of RHCPs have suggested that the infrastructure of the training programme needs to be improved including improvement in classroom environment. This is an aspect of the training programme which can easily be improved and probably would not require huge resources. Lack of continuing education is an issue which has repeatedly come up during numerous in-depth interviews of the trained RHCPs by the principal investigators as well as during the survey carried out by hired field investigators. This 'follow up' aspect of the training programme must be strengthened. It is worth noticing that relatively less number of trained RHCPs has emphasized on suggestions which the

training programme has kept out of its purview. First, suggestions like training on how to administer injection, stitching and removal of teeth (11 out of 128). Second, provide stipend and/or certificate (7 out of 128). Third, items like how to identify cases for eye problem and cases which require psychiatry care.

A close comparison between the list of items what RHCPs expected to learn at the beginning of the training programme and what they have suggested to improve the programme at the end of the training makes one point clear. The training programme has at least been successful in the reorientation of RHCPs' expectations from the training programme. They are now more-or-less clear about what is feasible to learn in this kind of training programme and what cannot be learned or achieved. This itself may be considered as a countable achievement.

4.4 Trainers' perspective

It is essential to present and discuss the trainers' viewpoints in the light of the evidence on expectation and realization on the part of the RHCPs. This section tries to provide a trainers' perspective with regard to designing the training programme, targeting and selecting RHCPs and providing them a year long training programme. The discussion of this section is based on in-depth interviews with the trainers who were involved in the training programme in Birbhum, Dumka, Purulia and Nadia district.

It is evident from our qualitative survey that people's dependence on RHCPs developed and flourished for curative care in areas where public health care network miserably failed. Failure of public health network does not necessarily mean lack of existence of physical structures, rather it is a failure to provide care with acceptable inter-personal quality on a continuous basis.

The motivation to initiate an unconventional programme like RHCP training programme stems from a number of disturbing observations made by the doctors-activists who later led the initiative as trainers. ***First***, it was observed that the RHCPs were mostly unregulated. As their very existence was not approved by the law of the country, there

was no question of regulating them formally by the state in any way. There was also no non-state agency which existed to exercise any positive control over their activities. ***Second***, in spite of the unacceptability either by the state or by the formal medical fraternity, RHCPs' acceptability among the rural population, especially among the poor was unquestionable. They are 'the health care providers' on whom the villagers can often rely at the time of their health care need when they do not visit the formal health care providers because of various reasons ranging from lack of confidence to lack of money. This has made the RHCPs very much part of the rural society – a place which somehow formal health care providers have failed to take. It was thought that this strong community involvement of the RHCPs could be utilised for promoting various health programmes of public health importance by reaching more and more rural population. ***Third***, one disturbing aspect of the RHCPs as observed by the doctors-turned-trainers was various harmful practices by the RHCPs. As doctors they received many patients who were wrongly treated by the RHCPs and were brought to the formers in critical conditions. These doctors felt that RHCPs would not make a patients' health condition deliberately. Probably the RHCPs lack clear understanding about the severity of an illness and what they can and cannot handle. However, it is also observed by the doctors that apart from unintentionally making a patient's health condition more critical by giving wrong treatment, RHCPs intentionally get engaged in harmful activities. For instances, in case of stomach pain, pregnancy and breathing problem, RHCPs sometime provides medicine which they are not supposed to administer. There are many cases where they prescribe nimesulide for speedy reduction of body temperature in case of fever. ***Fourth***, although it was observed that RHCPs, especially those with few years of experience had good understanding about what types of medicines need to be provided based on symptoms of illness, their understanding of basic science especially that of anatomy and physiology was very poor. All these factors made the doctors think RHCPs' training a positive and meaningful initiative.

We observed that almost all the trainers joined this initiative because of an internal motivation that the training would do well for the society, especially mother and children in the rural areas, although often they could not distinguish between the direct and

indirect beneficiaries of the training programme. Another important observation came out from the detailed interviews with the trainers that RHCPs had little influence in making syllabus for the training programme and it was mostly a one-sided exercise by the trainers. However, it seems that the trainers did consider the requirements of the RHCPs while deciding about the focus of practical sessions.

With regard to the sustainability of the training programme, the following issues were raised and discussed at length. ***First***, the trainers feel that there will be no lack of demand from the RHCPs for joining this type of training programme even if they know that they will not receive any certificates from the trainer organization at the end of the training programme. ***Second***, there is no explicit opposition from the (government) administration against this programme. The government officials are well aware of their limitations in providing health care to the entire population. ***Third***, there is some curiosity from the public in general but certain amount of opposition from private qualified doctors. The trainers believe the objection is mostly because of the conflict of interest. An improvement in RHCPs' knowledge and quality of service will eventually reduce the demand for private qualified doctors by the rural population. Further, there were many instances where the RHCPs functioned as agents of the private doctors who practiced in nearby town or semi-urban locality. Since these private doctors are not available all days of a week, they rely on these RHCPs for the follow up and medication in case of minor illnesses. Since the RHCP training has strongly emphasised referral to government hospitals in case of 'critical cases', one can understand the reasons behind private qualified doctors' resistance. ***Fourth***, there are not many qualified doctors who are motivated and committed enough to work as resource persons for this training programme. Since the training does not offer substantial financial incentive to the qualified doctors to work as resource person, only those who are convinced by the philosophy of this training programme have opted as volunteers. ***Fifth***, concern about uncertainty of future funding for this training programme has also been expressed by many trainer-doctors. ***Sixth***, since the training programme does not admit all the applicants who are willing to go through the programme, they screen suitable candidates through a mechanism. There have been instances of political pressure to include

disqualified candidate for the training programme. The trainers admitted that in situations they had to look beyond test scores in selecting training participants.

During the training programme, the most serious problem that trainers often face is lack of capacity and patience among most of the RHCPs to absorb the new knowledge. It is a challenging job to make them sit through all the classes. Many of them are often inattentive and irregular. Capacity to remember lessons from the course materials and class lectures is always found to be limited for almost all participants. Most of the training batches selected few women trainees. Although women trainees were found to be far better than men trainees in regularly attending classes and remembering details, in most of the cases they do not engaged in practice at the end of the training. It is more difficult to train the tribal participants. Apart from their poor capacity to comprehend the training lessons, they are very irregular and in the most of the cases they drop out before the training programme ends. High opportunity cost of time of the tribal participants is also a strong reason for their dropout.

RHCP Training Programme at Suri (Birbhum district)