

Chapter 3

RHCPs: Current State of Affairs, Need for Training? How?

This chapter aims to analysis the knowledge-attitude-practice dimensions of the RHCPs in the absence of any intervention (i.e. without any training programme to improve them). While so doing it also analyses the knowledge, attitude and health seeking behaviour of the users of RHCP (i.e. patients/households) and how the later perceive the skill and knowledge of the former. The perspective of the government health workers and elected representatives of the local government towards the RHCPs are also analysed.

The analysis of this chapter is based on three sets of information: first, by reviewing the relevant literature, mostly in the Indian context; second, by analysing the data from a survey which was carried out by Liver Foundation itself in the beginning of the training programme; third, by analysing the information collected in our baseline survey (August-September 2010) and sub-sequent in-depth interviews conducted on various stakeholders of the health sector.

The chapter is organized in the following Section 3.1 presents available evidence from literature and an earlier survey carried out by Liver Foundation. Section 3.2 analyses the knowledge, attitude and practice of the RHCPs in the absence of any intervention (i.e. training programme). Section 3.3 analyses health seeking behaviour of the households (i.e. users of RHCPs) and their knowledge of and attitude towards the RHCPs. Section 3.4 presents the perspectives of the government health care workers and community leaders based on our baseline survey.

3.1 RHCPs: A Review of Literature & Available Evidence

Even though our evaluation study interviewed a total of 213 RHCPs with a structured questionnaire in its different rounds of survey, limited literature exists on RHCP mostly based on small surveys or micro studies. It may, therefore, be useful to present a brief review of the relevant literature in the Indian context. In addition to this, we also present

selective evidence from a survey which was carried out by the Liver Foundation in its initial phase of RHCP training programme.

3.1.1 Definition

The American Heritage Medical Dictionary defines quack as an untrained person who pretends to be a physician and dispenses medical advice. In the literature the quacks are also defined as unqualified medical practitioners or rural medical practitioners. The existence of the quacks is not new in the history of health care and so is the tension between quacks and qualified physicians. In the 17th century England, the label quacks were deployed by university-educated medical practitioners as a way to distinguish themselves from and disparage as dangerous those who advertised products on travelling stages and street corners or in broadsheets (Wear 2005). From the perspective of law or legitimacy, qualified healthcare practitioners are distinct from quacks on two accounts: (a) they are recognised by the state; and (b) they possess (or at least supposed to possess) the knowledge of best practice (Wear 2005).

In a landmark judgement of a case where a patient died after being administered injection by a homeopathic doctor, the Supreme Court of India has defined *a person who do not have knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan*. In India, apart from the mainstream Allopathic system, there are six other officially recognised alternative and indigenous systems of medicines. However, it is observed that persons trained in non-Allopathic system administers Allopathic medicines (such as steroids, opioids and antibiotics) because of patients' pressure for rapid results since these medicines produce an early sense of well-being. In India almost all drugs including opioids, steroids and antibiotics are freely available without prescriptions (Robbie George and Abraham 2002).

The definition of quack used by Kanjilal et al (2007) in their empirical work on West Bengal is rather useful for practical purpose. They have defined 'quacks' comprised of three types of health care providers: (a) who practice without any formal training on any

stream (allopathy, homeopathy, ayurvedic etc); (b) who graduated in medicine from any unrecognised organisation; and (c) who graduated in a non-allopathic system but practicing Allopathic system of medicine.

Quacks dominate the private healthcare market in the rural areas in India (National Sample Survey data 1995-96, 2004, Pratichi Trust 2006, Kanjilal et al 2007, Das 2007). Though a similar role is played by chemists or medicine shops in urban areas, quacks are not rare even in poor urban pockets. A survey of private providers in a Delhi slum shows that 41 per cent of the healthcare providers are unqualified (Das 2001). Though for the rural poor, it is often the quacks who are the first source of medical care (Das 2007), rich people also rely on quacks in the rural areas (Kanjilal et al 2007).

The quacks offer treatment from a wide range of illness symptoms: Kanjilal et al (2007) found that most common diseases treated by UMP were diarrhoea / gastro-enteric disorders, common cold/cough/fever, cold, diarrhoea, stomach ailments, jaundice etc (Kanjilal et al 2007, Pratichi Trust 2006). For chronic chest symptoms (for more than a month: cough, expectoration, breathlessness, blood in sputum, wheezing, pain in chest) among urban and rural population, around 20.3 per cent of the patients were taking treatment from unqualified medical practitioners (Grover et al 2003). In rural areas the major source of care was unqualified medical practitioners. Quacks are also found to be largely utilised for accident or injury in Bangladesh (Rahman et al 1998) and for dental care in Trinidad (Naidu et al 2003). A significant number of patients seeking treatment from quacks are children below age 5 (Kanjilal et al 2007).

A review of empirical studies suggests that rural people prefer to visit the quacks because of the following reasons: they are closely located; (b) always available; (c) they are cheap; (d) their treatment is effective. There are reasons too such as they also provide medicines and poor people often get chance to pay fees in instalments. The physical proximity and close connection is the real advantage that the quacks enjoy in comparison public health facilities. On the availability dimension, quacks score much better than the public healthcare facilities. In India around 13 per cent of all medical posts and 38 per

cent of the posts of specialists lie vacant in primary health centres in rural areas (Madur 2007). Moreover, posted doctor or health staff does not always ensure their physical presence at the facilities. A survey of absenteeism in public health facilities in several Indian states, it was found a very high level of absence (43 per cent) of health care providers in public primary health care centres (Chowdhury et al 2003). In a study of 100 hamlets of Udaipur district in Rajasthan, it was found that on an average 45 per cent of the medical personnel are absent in sub-centres and aids posts and 36 per cent are absent in the (larger) PHCs and CHCs. They also found the sub-centres closed 56 per cent of the time during regular opening hours (Banerjee et al 2004)

Though it is a common perception that treatment from quacks are cheaper than treatment from other healthcare providers, Kanjilal (2007) found that visits to a quack costs as much as it costs to visit a government facility. People's preference for quacks over government health staff are often based on layman's perception about effectiveness of treatment and their understanding about the cost of treatment. First, the quacks also provide medicine which the health staff cannot provide in many situations. The patients are also satisfied with the care they receive from the quacks because the quacks pay more attention to the patients than they are accustomed to receive from primary health care doctors. The quacks are compensated by adding a surcharge to the fee for medicines. The patients believe that they are only paying for the medicines (Rohde and Viswanathan 1994). Second, people believe that the treatment by the quacks are more effective than government health staff as the formers are prompt in giving injection and intravenous drops as wanted by the people (Duggar 1998, 2004). It was found in the Indian state of Rajasthan that in 68 per cent of the visits to a private facilities appears the patient is given an injection; in 12 per cent of the visits he or she is given a drip. A test is performed in only 3 per cent of the visits. In public facilities, they are somewhat less likely to get an injection or a drip (32 per cent and 6 per cent respectively), but no more likely to be tested. Among private doctors, it does not appear that more qualified doctors are less likely to administer shots: if anything, it seems to be the opposite (Banerjee et al 2004). Third, the public health professionals are required to be qualified and there are precise rules what they can and cannot treat. For example, ANMs are not allowed to treat

malaria. By comparison, the private sector is often untrained and largely unregulated. Given the symptoms reported by the villagers, the treatment that they report receiving in these facilities appears rather heterodox

Whatever be people satisfaction with the treatment by quacks, there are counter evidences which clearly show their harmful practices. It was found that about 60 percent of rural hospitalised persons had initiated their treatment with quacks and there is strong indication that large section of rural patients hang on with the RMPs before they get hospitalised probably with more complications developed. (Kanjilal et al 2007). The quacks also do not have good record of physical examination (Rohde and Viswanathan 1994). In spite of the low cost of treatment under quack, there is no evidence that effectiveness is comparable to Allopathy (Das 2007).

3.1.2 General profile of the quacks

The quacks in the rural areas are almost always male, practice in or close to their birthplace, and have attended school. Very few of them are graduates and almost half of them do not have any kind of training and remaining half of them have acquired some kind training or degree from unrecognised organisations (Rohde and Viswanathan 1995, Kanjilal et al 2007, Banerjee et al 2004).

3.1.3 Government's attitude towards the quacks

The governments have not strictly dealt with the issue of these unqualified practitioners, except few instances in some states (Times of India 2003, 2009). It is not difficult to understand the reasons behind government's dilemma on taking strict policy lines on the quacks. On the one hand, the presence of quacks in the rural health care market is too strong to ignore. In the weak presence of public health care in many of the rural areas, these quacks are the sole health care provider. Therefore, banning these quacks with legal actions does not seem to be a feasible option for the governments. On the other hand, it is also not easy to legally accept their existence. The pressure from the physicians lobby and other quarters seem to prevent the governments from formally acknowledge these quacks and controlling and guiding them.

3.1.4 Arguments to accept the reality and give training to quacks

In order to improve rural people's access to health care, the government seems to have either of the two options: (a) either completely ban these quacks with strict law and provide standard health care package by qualified health staff to the people; (b) accept the reality about the existence of quacks and provide them with training on minimum essential issues of treatment and public health and integrate them with the national health goals. Since ensuring adequate basic health care facilities with qualified health care providers who would remain available round-the-clock for basic curative services and birth delivery in the rural areas does not seem to be feasible, the alternative of internalising these quacks (i.e. alternative (b)) look more pragmatic step, may be in the transition phase till we are in a position to go for alternative (a). Even as an experiment, a selected number of quacks can be trained with some elementary knowledge of treatment in order to reduce their current harmful practice as well as improve their practice. In this section, we try to argue why providing the quacks with training on elementary of treatment practices will be a wise move in the current situation instead of banning their practices.

First, the quacks procure medicine from the local chemist shops (Rohde and Viswanthan 1994, Kanjilal et al 2007). Since most of these quacks have no formal education, they learn about the new medicines from the drug company salesman. It has also been observed that the salesman not only supply them medicine but also teach them when and how to use. They generally buy those medicine which work and not very expensive (Dugger 2004). Even practice of the qualified doctors have been found highly influenced by the biased information from the pharmaceutical companies (Avorn et al 1982, Kamat et al 1997), such impact would be worse in case of quacks.

Second, there is evidence that quacks prescribe antibiotics in small doses - a practice which is harmful. In a study in Delhi slum it was found that a quack prescribing a two-day course of the antibiotic tetracycline for fever or a seasonal cough. The individuals who are treated so briefly with antibiotics often get better, but the bacteria they were

infected with can become drug resistant for a whole community, which complicates efforts to treat disease (Duggar 1998). It is found in various contexts that the quacks are unaware of inappropriate antibiotic use. According to some quarters various national programmes launched to eradicate disease such as malaria, tuberculosis and cholera are at the risk of becoming less effective because of the proliferation of quacks (The Hindu 2004). Unskilled personnel are less aware of the deleterious effects of inappropriate antibiotic use. For example the pharmacy technicians in Thailand prescribed rifampicin for arthritis and tetracycline for young children (Thamlikitkum 1988). Unqualified drug sellers offer alternative drugs when the prescribed drugs are out of stock or refill prescriptions without consulting the prescriber (Dua et al 1994). In India, traditional healers often dispense antibiotics (Singh and Rajee 1996). As many as 90% of the doctors qualified in non-allopathy systems are administering pharmaceutical drugs (Prasad 2007).

Third, since a significant number of patients treated by the quacks are children, mistreatment by quacks has larger implications for public RCH (Reproductive and Child Health) programme. It has been found that only 10 per cent of the children were referred to the formal provider, while another 20 per cent were not cured (Kanjilal et al 2007). This raises question about the current practices of the quacks with regard to proper referral. However, late referral of cases may not be confined to the child illness alone, there are anecdotal evidences that the quacks refer potentially or actual complicated cases to public facilities or qualified private doctors when cases go completely out of their control (Kanjilal et al 2007).

Forth, a study in a Delhi slum, it was found that the mothers are not able to discriminate among many sources of health care for their children and give preference to local unqualified private practitioners. The continuity and effectiveness of care is further compromised by caretakers' expectations of rapid cure, which result in discontinued treatment courses and frequent changes in practitioners and by their reluctance to seek hospital care. (Isabell de Zoyasa 1998). Girl children are often face discrimination in rural areas when it comes to getting good quality health care. A study in rural West Bengal found that for diarrhoea, acute respiratory infections and fever, qualified

professionals were consulted more often and sooner for boys than for girls, for which parents also travelled longer distances (Pandey et al 2002). Improving the treatment practice of the quacks is definitely going to be beneficial for the girl children who are otherwise discriminated in household health care seeking behaviour.

Fifth, there are other criticisms against the harmful practices of the quacks. They are also alleged for reusing syringes/needles or using un-sterilised syringes which could cause infection with blood born viruses and result in spreading of Hepatitis B and HIV. It is estimated that 50% of injections given in the developing world. A study of unlicensed medical practitioners in southern India demonstrated that the contamination of medical injection paraphernalia is common. The unlicensed medical practitioners were frequently observed using unsterile syringes, reusing disposable syringes and contaminating multidose medicine bottles through inappropriately flushing drawing needles with warm water (Becker et al 2005). It is estimated that up to 16000 HIV, 4.7 million hepatitis C and 16 million hepatitis B infections each year are attributable to these practices (Kermode 2004). It has been argued that the declining rates of HIV infection in Uganda are the result of improvement in injection safety and not increased rate of condom use and other changes in sexual behaviour (Becker et al 2005).. The quacks are also allegedly involved in causing environmental pollution by their inability to dispose of biomedical wastes in a scientific and authorised manner.

Sixth, quacks are also crucial for treating injury because of their widespread availability and easy accessibility. In a study on medical health care seeking behaviour of patients with injury in Bangladesh, it was found that allopathic quacks or medicine shop owners were consulted by 42 per cent of the injury of patients. Most of the educated people preferred hospital treatment for moderate injury cases (Rahman et al 1998).

Finally, studies done in the various contexts show that it is possible to minimise the risk by providing hands on training to unqualified medical practitioners. . Training has improved the diagnosis and counselling practices of informal provider in India (Chakraborty et al 2000), the provision of anti-malaria drugs by shopkeepers in Kenya

(Marsh et al 1999) and the management of diarrhoea and acute respiratory infections by private medical practitioners in Mexico (Bojalil et al 1999). In a control-intervention study it was found that as a result of training the traditional bonesetter could considerably reduce the rate of gangrenous limbs, infection, non-union and malunion (Onuminya 2006).

3.1.5 Constraints to providing training

Though the previous section presents a strong case in favour of a training programme for the quacks, such an initiative may face socio-political and administrative constraints and questioned on rationality ground.

First, any attempt on the part of government to facilitate providing medical services by unqualified personnel can always predictably face the opposition of the mainstream qualified medical fraternity. In 1970s when oral rehydration salts (ORS) solution was experimentally introduced in Africa and South Asia during the passive outbreak of cholera, it was not possible to provide intravenous saline by trained doctor. Therefore ordinary persons were trained to administer ORS and the hospital-based clinicians were against allowing untrained people to use oral rehydration and the qualified hospital doctors regarded oral rehydration therapy as a second class treatment (Bulletin of WHO 2009). The recent proposal of an Indian health ministry panel to create a parallel stream of medical practitioners to improve the delivery of health care in rural areas has triggered a debated across the nation's medical community. The panel has proposed a three year training course to produce community health practitioners who would be deployed in rural areas that have an acute shortage of graduate doctors (Madur 2007). Apart from expected resistance from the qualified private medical practitioners, there are legal dimensions which may limit the involvement of the quacks in the formal medical care programme of the government.

Second, the low education base of the quacks may impose a constraint on educating them through a training programme. There is also the issue of sustaining the knowledge which is provided through the training programme, especially if changing practices is cost

enhancing. It was found in different context that even the performance of qualified doctors diminished few months after the training (Mohan et al 2004). Therefore, it is also important to ensure that the quacks do not continue their old practice and improve their practice with the acquired knowledge from the training.

Third, one may also raise the point that a quack may not have enough incentive to refer many of his cases to government hospitals or to qualified private practitioners as it may affect his credibility negatively.

3.1.6 Evidence from the Liver Foundation's Survey

The RHCPs are the most dependable to the villagers in need, in time of crisis. It is observed that 97% of the rural population depend on the RHCPs for their curative health care need. It appears that improving their scientific understanding might benefit the society. Liver Foundation's own study is based on a sample of 197 sample RHCPs. As far as educational qualification of the RHCPs is concerned, it was found that 31% of the them had school final (10 years of schooling), another 30% were with higher secondary education (10+2 years of schooling) and the remaining 31% were having education more than 12 years of schooling. As far as system of medicine is concerned, more than 80% of them are basically unqualified allopathic practitioners and only about 45% of them were associated with some health care providers (a majority of them are unqualified private health care providers) before starting his/her own practice. As high as 30% of the currently practicing RHCPs have not received any sort of training before starting their practice. The RHCPs also show an inter-general occupation aspect. For more than 70% of the sampled RHCPs, either their father or some relative was in the same profession. As far as practice of the RHCPs is concerned, more than 80% provides medicine and more than 40% are also involved in doing minor surgeries. Medicine shops are the major source for procuring required medicines for the RHCPs but a quarter of them also procure medicines from the wholesale suppliers. RHCPs do refer to patients on a regular basis which is a good sign. It was found that in last three months, more than 80% of the RHCPs did refer patients to other formal facilities and majority of the referrals (almost 60%) were to the government facilities.

3.2 RHCP: Evidence from Baseline Survey

3.2.1 Basic Profile of Sample RHCP

Initially our baseline survey covered 110 RHCPs. Later six of them were dropped from the analysis as it was found that they were predominantly involved in practice of homeopathy. So our final analysis is restricted to 104 RHCPs who are basically practitioners of allopathic system of medicines. The basic profile of the sample RHCPs is presented in Table 3.1. Our sample did not include any female since females were not found to be professionally active. The average age of the RHCPs is around 41 years (median age is 39 years). Approximately 60% of the RHCPs are 40 years or less and around 80% are 50 years or less. For around 80% of the RHCPs this is the main profession. Those whose main profession is not providing health care, are engaged in agricultural activities including petty business, LIC agent, compounding etc. On an average the RHCPs have 12.5 years of education (median years of education is 12 years). There are around 30% RHCP having 10 years or less schooling and around 30% having graduation and above degrees.

3.2.2 Knowledge and Practice

The average experience of the RHCPs is 13 years. About 25% of the RHCPs are practicing for 5 years or less and more than 40% are practicing for 15 years or more. As a source of knowledge required for the practice, little more than one-third of the RHCPs got it from the working experience with qualified doctors in some capacity and more than 50% of the RHCPs have either learned from other RHCPs or from medical training institution of questionable credibility. Around 93% of the RHCPs only practice Allopathic system and 85% of them are having their own place (something like a clinic/chamber) to see patients. About 15% of them are involved in cross practicing, mostly Ayurvedic and Homeopathic system of medicines along with the Allopathic. On an average, they attend 15 patients and earn 135 rupees per day. Little more than 60% of the RHCP earns Rs 100 or less and only 7% earns more than 300 rupees per day. About 39% of the RHCPs have reported that they have no professional relation with other RHCPs practicing in the same area. More than 75% of the RHCPs provided almost all

the required medicines. More than 90% of the RHCPs store their own medicines and around 58% of them procure medicines from the wholesaler or dealers. About 70% of the RHCPs administer intravenous injection and 64% of the RHCPs administer drip. Most of the RHCPs (95%) provide antibiotic in course of their treatment, though many of them do not seem to have proper understanding what criteria they should consider in deciding about the right dose of antibiotic.

About 64% of the RHCPs reported that they had received at least one 'complicated case' in last three months preceding the survey. In half of the cases they had referred those cases to the government health facilities or to the qualified doctors after providing the primary treatment. It may be a matter of concern that one-quarter of the complicated cases are were reported to be retained and provided full treatment by them. About 90% of the referred 'complicated cases' were sent to government facilities. Almost all RHCPs believe that by referring patients with complicated illness (i.e. illness which they perceive beyond their capacity to treat) is not harmful to their practice.

The level of awareness of the RHCPs with regard to possible reasons for breathing trouble is very poor. Although more than 60% of the RHCPs could name Asthma as a possible cause for breathing trouble. Only 3% of the RHCPs could tell four possible causes for breathing trouble and as high as 22% of the RHCP could not tell even a single possible reason for breathing trouble. However it is observed that RHCP's level of knowledge and awareness is better on the possible reasons for stomach pain. Almost 50% of the RHCP could tell four or more possible right reasons for stomach pain.

Almost half of the RHCPs in the sample said that pregnant women come to them for health care. When a similar question was asked with one month recall period, 75% RHCPs answered in affirmative. Almost all RHCPs reported that they always refer the pregnant women to health centre or qualified doctors after doing the initial check up.

3.2.3 Need for training programme

Almost 95% of the RHCPs feel the need for undergoing a training programme by qualified doctors for improving their current knowledge and services, although they do not express any willingness to pay for obtaining such training. An in-depth analysis of the non-willing RHCPs does not indicate that they are better off in terms of knowledge and practice. Therefore, one of the challenges of the training programme to motivate this group as well those RHCPs who are excluded at the screening level prior to the training programme. Majority of the RHCPs who are willing to join the training programme do not have well specified goals on what they expect to learn from the training programme. A significant number of them have expressed goals (such as learning teeth removal or small surgery) which are not covered under the training programme for obvious reasons.

3.2.4 Maternal and child care

One of the long-term objectives of the training programme is to reduce maternal and child health by strategically utilizing the better community connection of the RHCPs. Since the RHCPs enjoy close rapport with the community, it is argued that the social network built up by them can effectively be utilised for achieving complete antenatal care and immunisation coverage and for promoting institutional delivery. Utilisation of the RHCPs as motivators for promoting higher use of antenatal care, institutional delivery and immunisation makes sense as the rural communities are in greater contact with the RHCPs in comparison to the government health workers for curative health care need. Though it is subject to detailed empirical investigation to see what extent the RHCPs can influence the health care seeking behavior of the rural population for preventive health care need, the current utilisation pattern does not indicate that RHCPs are predominantly utilised for reproductive and child health care need. Even though half of the RHCPs in the sample have reported that pregnant women do come to them for check-up, a similar question with one month recall period resulted in 75% negative response. Almost all RHCPs have reported that they always refer the pregnant women to health centres after doing the essential primary check-up. However, doubts can be raised both about RHCPs' knowledge of what constitute the essential check-up package as well as about their capacity to carry out the essential primary check-up. Although checking of blood

pressure, anemia, pulse rates were reported by large number of RHCPs, an equally good number has mentioned of checkups which required skilled knowledge and appropriate technology. RHCPs' lack of knowledge with regard to the reproductive health care is supported by the evidence that only little more than one-quarters of the RHCPs is rightly able to read the symptoms of risky pregnancy.

3.2.5 On referral

An analysis of baseline data shows that in last three months preceding the survey almost three-fourth of the RHCPs came across patients with illness which they apparently found complicated or difficult to treat. Although for one-quarters of the patients were directly referred to the government health facilities, in half of the cases they referred the patients to the government health centres/hospitals or qualified doctors only after providing them the essential minimum primary care. It may be a matter of concern that one-quarter of the complicated cases were retained by them and they provided the full treatment. None of the RHCPs thinks that his act of referring patients to government health facilities or qualified doctors has the potential to damage his reputation or business. Rather they use the referral as a source of their learning since the patients always get back to them after availing the treatment at government health centres or qualified private doctors

3.2.6 Level of awareness

An analysis of the baseline data points to areas where the RHCPs have limited awareness or no awareness at all. Suffering from illnesses which have breathing trouble as a symptom is common in the rural areas. Almost three-quarters of the RHCPs received at least one patient with breathing trouble in one month preceding the survey. It is observed that in most of the cases they either provided full treatment or partial treatment with very few referrals. The level of awareness of the RHCPs with regard to the possible reasons for breathing trouble seems incomplete. Although more than 60% of the RHCPs could name asthma as the most probable cause for breathing trouble, nearly one-quarter of the RHCPs could not tell a single possible reason for breathing trouble. However, when asked about the stomach problem, the level of knowledge was found much better. Almost all RHCPs use antibiotics, though many of them do not have a clear understanding of

what criteria of the patients they should consider while deciding the right dose of antibiotics.

3.2.7 Interaction with ANMs and GP Members

Most of the RHCPs personally know the ANMs who are working in their areas, even though the level of their communication is expectedly low. When they were asked if they have visited the local SC or PHC for purposes not related to their or their family member's illness, 56% responded answered in negative. The RHCPs visit the nearby health centres for admitting patients including pregnant women. Very few of them also visited health centre for attending meeting of public health programmes such as pulse polio, malaria or Filaria. Their association with the local governments also looks weak.

Though RHCPs enjoy good relation with the community leaders (GP members) at the personal level, their formal communication with local governments at the institutional level is still weak. More than 80% of the RHCPs do not have any knowledge if any health related meeting has taken place in their Gin their GP any meeting to discuss health took place in last three months. Only 17 RHCPs (out of 109) who had specific information that some meeting took place in the Panchayat to discuss health, 5 were called for the meeting.

3.3 Perspective of Households

Although the original survey collected information from 781 households, our analysis is limited to 764 households who are the sample users of 104 RHCPs covered in final analysis. The average family size of the sample households is 4.6 but only one respondent is selected from each sample household. Though we tried to have adequate representation of pregnant women and mothers with young child in our sample, the effective sample households consist of 14 pregnant women, 148 mothers with young children and 602 other respondents out of which 472 are males and 130 are females. In all, our sample respondents consist of 472 males and 292 females. One of the reasons for getting such an unbalanced sample is it is obverted that visiting RHCPs were not a preferred option for the pregnant women and instead they preferred to visit Sub-Centre or PHC. The average

age of women who either went for pregnancy or child health related problems is 26. 5 years.

Our sample is not statistically representative to tell us what proportion of the rural population goes to the RHCPs when they fall ill. However, evidence from other studies indicate that such percentage could lie anywhere between 60% and 90% in the rural areas. Since our sample of households include only those who happened to visit a RHCP in the last three months, it allowed us to study the reasons behind rural population's choice of RHCPs. The major reason why rural people go to the RHCPs instead of the government facilities is the easy accessibility of the former (see Table 3.1). The second major reason is related to the poor quality of the government facilities as perceived by the rural people.

Table 3.1: Reasons for households' non-utilisation of government facilities

Reasons	percentage distribution	
	major reason	Reason (all)
Long distance/ difficult to travel/ no time	49	38
PHCs are not open all the time/ Long queue/Non-availability of good doctors	15	18
Non-availability of all kind of medicines/bad quality of medicine at SC and PHC	10	14
RHCPs are easily accessible	10	12
Treatment is bad / no trust on quality /some required facilities are not available	9	12
Treatment of the RHCPs is effective	6	5
Health workers do not behave properly	1	1
RHCPs have all kinds of medicines	1	1

Source: Primary Survey

Those who visited RHCP in last one month for their own health problem, almost 38% of them had felt their illness as serious before going to RHCP. Those respondents who visited RHCPs for their children's health problem, for 45% of them the illness was considered as serious. Therefore, there is no ground to comment that people visit the RHCP for illnesses which they consider not serious enough to go to a government health facility or a qualified doctor. As far as people's opinion about the efficacy of the treatment provided by the RHCPs is concerned, the response has been highly affirmative.

For all those respondents who fell sick and were treated by the RHCPs in one month preceding the survey, 88% reported improvement in health status after they were treated by the RHCPs. About 53% of the respondents reported that RHCPs explained the reasons for the illness and about 60% of the respondents reported that RHCPs advised them how to prevent such illnesses in future.

On an average, a single visit to a RHCP costs Rs 61 for an adult (Median cost is Rs. 50) and Rs. 52 for a child (Median cost is Rs. 45). The price charged by the RHCPs seems to be affordable to their users as 91% of the respondents have reported that RHCPs charge fair or charge less. Although two-third of the users are satisfied with the treatment provided RHCPs, little less than one-third of the respondents are moderately satisfied with the treatment. This is reaffirmed by the finding that 88% of the respondents have expressed their willingness to visit the same RHCPs in similar health care need in future.

It is important to note that our sample of households were not independently drawn, rather it was selected from a list of households provided by the RHCPs. Therefore, it is more likely that RHCPs listed only those cases favourable to them. However, it is worth noting that more than one-quarter of the respondents (26.8%) have mentioned illness cases happened in their families where the RHCPs were not able to cure the patients. These failed cases were mostly shifted to private qualified doctors (53%), followed by the government hospitals (36%) and other sources.

The level of awareness of the respondents with regard to Hepatitis is extremely poor. Only one-quarter of the respondents have reported to heard about Hepatitis B, but only 16% could rightly say that it was a liver disease. Out of all those who could rightly say that Hepatitis was a liver disease, little more than one-third (37%) could not say anything about the possible reason for Hepatitis B infection. Out of those who could mention about at least one possible reason – right or wrong – half of them mentioned unsafe water as a source of Hepatitis B, followed by the reasons intake of rich food, contaminated blood, drinking etc.

3.4 Perspectives of the ANMs and GP Members

3.4.1 Sample Profile

Our baseline survey interviewed 48 ANMs and 188 GP members. The average age of the surveyed ANM is 35 years. The average experience of the ANM is 12.5 years. Since our survey included a few ANMs with exceptionally long years of experience, the median value would probably be a better summary measure. The median years of experience as an ANM and working in the present Health Centre is 5 years and 3 years respectively. Our sample of GP members consist of 60% males and 40% females. The average age of the GP members is 37 years with two-third of the members aging 40 years or below. On average, GP members have 8 years of schooling with male members having two additional years of education in comparison to the female members (9 years vs. 7 years).

3.4.2 ANMs

Although majority of the ANMs do not seem to be fully aware of all the RHCPs practicing in their areas, most of them know at least one or two RHCPs (see Table 3.2). ANMs' opinion about the skill of the RHCPs in treating ailments is very low. Only 5 out of 48 ANMS (roughly 10%) believe that RHCPs can properly treat patients, however about 21% of them have sought the help of RHCPs in various occasions such as pulse polio or other health related programmes. More than the unavailability of government doctors, ANMs believe easy accessibility of RHCPs and rural people's higher trust of them is responsible for the bypassing of the government facilities. It is interesting to observe that more than 80% of the ANMs believe that the role of the RHCPs can be improved by providing them training.

3.4.3 GP Members

The opinion of the elected representatives (i.e. the GP members) on the quality of treatment rendered by the RHCPs is mixed (Table 3.3). More than 50% of the RHCPs find either the quality of treatment as average or are not in a position to comment on the quality of treatment. Even though little less than one-third of the GP members are of the opinion that RHCPs can help the government health workers on various health-related

activities, they could hardly any such area where the help can be extended. However, like the ANMs, majority of the GP members (77%) believe that RHCPs need training and such training can improve the quality of service provided by them.

Table 3.2: Views of the ANMs on RHCPs in their areas.

	Frequency	Percentage
Know the RHCPs in her area		
<i>Know all of them</i>	9	19
<i>One/some of them</i>	35	73
<i>Don't know anybody</i>	4	8
Believe that RHCPs can treat some ailments	5	10
Reasons why people go to RHCPs		
<i>Easy accessibility and availability</i>	26	45
<i>More trust on RHCP</i>	17	29
<i>Availability of medicine with RHCPs</i>	4	7
<i>Unavailability of govt. doctors</i>	11	19
Ever took help of RHCP	10	21
Training can improve treatment of the RHCP	39	81

Source: Primary Survey

Table 3.3: Views of GP Members on RHCPs in his/her area.

	Frequency	Percentage
Opinion about the quality of treatment provided by RHCPs in his/her area		
Very good	16	9
Moderately good	70	37
Average	31	16
Cannot say	71	37
Think that RHCPs can help government health workers	58	31
Think that RHCPs can be improved by providing training	144	77

Source: Primary survey



Clinics of RHCPs