An Evaluation of the

Rural Health Care Providers Training Programme

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Executive Summary

1. Our evaluation study started with a baseline survey which covered Rural Health Care Providers (RHCPs) from selected areas who were not covered by the training programme of the Liver Foundation till the time of survey. The average age of the RHCPs was found about 40 years. For most of the RHCPs, medical practice was found as a main profession and for those whose main profession was different were engaged in agricultural activities including petty business, LIC agent, compounding etc. On an average they have about 12 years of schooling and about 13 years of experience as RHCP.

2. The level of awareness of the RHCPs (who did not receive the training by the Liver Foundation) with regard to possible reasons for many illnesses is poor. Almost all the surveyed RHCPs (who were not covered by the training programme) expressed the need for undergoing a training programme by qualified doctors for improving their current knowledge and services, although they did not express any willingness to pay for obtaining such training. Majority of the RHCPs who were willing to join the training programme did not have well specified goals on what they expect to learn from the training programme. A significant number of them expressed goals which are not deliberately covered under the training programme.

3. ANMs' opinion about the skill of the RHCPs in treating ailments is very low. The opinion of the elected representatives (i.e. the GP members) on the quality of treatment rendered by the RHCPs is mixed. 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 suggest any such area where the help can be extended.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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. RHCPs had little direct influence in preparing the syllabus of 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.

11. There are scopes to improve the training programme to make it more focused and target oriented by redesigning it. Increasing the number of practical sessions in some forms will definitely improve the quality of the training programme. The trainers need to explore innovative ideas on how to increase the number of practical classes and how to make them more attractive. 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.

12. 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. 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.

13. There are many issues with regard to the sustainability of the training programme. 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, the government officials are well aware of their limitations in providing health care to the entire population, therefore, there is no explicit opposition from the (government) administration against this programme. Third, there are not many qualified doctors who are motivated and committed enough to work as resource persons for this training programme. Fourth, there is a concern about uncertainty of future funding for this training programme has also been expressed by many trainer-doctors.

14. 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.

15. 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.

16. 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. Unless these RHCPs are included, the *population* covered by them will be excluded from the benefit of the program.

17. 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).

18. 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.