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Pilot Project on Capacity Development of the Unqualified/semi-qualified Allopathic Healthcare Providers

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Pilot Project on Capacity Development of the Unqualified/semi-qualified Allopathic Healthcare Providers

(Interim Report of an on-going Intervention)

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ABSTRACT

The study conducted in the CFPR/TUP areas of the first phase has shown that the sales people at drug retail outlets and the village doctors *(Palli chikitsak)* are one of the major sources of allopathic healthcare for the poor and the disadvantaged people in Bangladesh, besides community health workers/volunteers (CHW/CHV) (Ahmed 2006). As a follow-up of this finding, a pilot research project was undertaken to improve the quality of care provided by the above-mentioned categories of providers. The participatory training intervention began in September 2006 in Domar *upazila* of Nilphamari district. Pre-training activities included an inventory of the informal providers, a survey on their current knowledge and practices, and need assessment workshops. A comprehensive training package was developed.The six modules of the training package are: i) Fever and rational use of drugs (reducing misuse/overuse of drugs), adverse drug reaction and pharmaceutical care; ii) Diarrhoea, dysentery and digestive problems; iii) Pain and body aches (rheumatism); iv) Pneumonia/ARI in children; v) Reproductive health, RTI/STI/ and HIV/AIDS; and vi) Food, nutrition, and healthy life style. The sessions were fully participatory. The training manual of the respective topic was distributed among the participants after completing the sessions. Some other IEC materials such as leaflet, poster, etc. were also given as reference material. Modest monetary incentives including actual travel cost and daily allowance were provided to the trainees. It is also expected that the participants who would successfully complete all the sessions would be awarded certificates.The first phase (fever, rationale use of drugs and medicine dispensing) and the second phase (diarrhoea, dysentery and gastric ulcer) of the training were completed in December 2006.

INTRODUCTION

A recent study, conducted in the first phase Challenging the Frontiers of Poverty Reduction/Targeting the Ultra Poor (CFPR/TUP) areas[1], has shown that the salespeople at drug retail outlets and the village doctors (*palli chikitsak*) are one of the major sources of allopathic healthcare for the poor and the disadvantaged population in Bangladesh, besides community health workers/volunteers (CHW/CHV) (Ahmed, 2006). Almost all of these drug sellers are untrained and not licensed for drug dispensing, not to speak of diagnosis and treatment. Village doctors have had few months training on common illnesses and diagnoses mostly from private institutions. But the quality of training is still questionable. Together, these providers are often blamed for doing over prescribing, multi-drug prescribing, misuse of drugs, etc. (Guyon *et al.* 1994, Ronsmans *et al.* 1996). Studies from Vietnam, Laos, Thailand and Nepal have shown that it is possible to improve the knowledge and practice of these providers if they receive appropriate support to fulfill their public health role in rational use of drugs, including prevention of resistance and misuse of antibiotics (Chuc 2002, Syhakhang 2002, Chalker 2003). Given the above facts, a pilot operation research project on improving the capacity of these providers was undertaken. This paper reports on the on-going interventions being implemented under the pilot project 'Capacity development of the unqualified/semi-qualified allopathic healthcare providers in the CFPR/TUP areas' which began in September 2006.

[1] "Challenging the Frontiers of Poverty Reduction/Targeting the Ultra Poor (CFPR/TUP)" (BRAC 2001).

BACKGROUND

Three sub-districts (*upazilas*) from the three northern districts of Bangladesh (Domar of Nilphamari, Gongachara of Rangpur, and Rajarhat of Kurigram) were conveniently selected for this study. In these three districts a targeted poverty alleviation programme for the ultra-poor is in place since 2002 which delivers a customized package of grants-based intervention comprising social protection and health protection measures (BRAC 2001). The idea for this study originated from search of pathways to provide an acceptable level of healthcare services for the targeted population. The pilot project aimed to develop an informed, need-based intervention module to improve the quality of care provided by the above categories of informal allopathic providers through participatory training activities. Most important is to ensure that the providers do not cause harm to their clients through irrational practices and make referrals to formal sector when due.

PRE-TRAINING ACTIVITIES

Inventory

A comprehensive inventory was carried out to record the unqualified/semi-qualified healthcare providers in the three *upazilas* using free listing technique. Field workers visited all the villages, markets, and healthcare facilities. Records and documents of different healthcare facilities, NGOs and indigenous organizations of healthcare providers were also used to gather information. Cross-checking was done for proper identification and to avoid duplication. Finally, compilation of the inventory data yielded a final list of all unqualified/semi-qualified healthcare providers working in each *upazila*.

The inventory registered 1749 healthcare providers of the above categories in the three *upazilas* (Table 1). Of these, the medical assistants/sub assistant community medical officer(SACMO), the family welfare visitors (FWV), and some CHWs were employed in the public sector. The data also revealed that village doctors (524), CHWs (502) and allopathic drug retailers (463) were the most common allopathic care providers in the areas. A substantial number of homeopathic practitioners (214) were also identified during the inventory. CHWs/CHVs include *Shasthya Sebika* (*SS*) and *Shasthya Karmi* (*SK*) of BRAC, health workers of RDRS and PHC, health assistants (HA), family welfare assistants (FWA), and family planning inspectors (FPI).

Table 1. Distribution of healthcare providers by their type and study areas

Type	Study Area			Total
	Domar	Gongachara	Rajarhat	
Allopathic Drug retailer	122	232	109	463
Palli Chikitsak (PC)	163	231	130	524
Medical Assistant /SACMO	7	6	4	17
Family Welfare Visitor (FWV)	12	10	7	29
CHWs (SS/SK/HA/FWA/FPI)	210	196	96	502
Homeopath	58	107	49	214
Total	572	782	395	1749

Need assessment

After completing the inventory, the field workers were further deployed to visit the healthcare providers for rapport building in Domar and Gongachara *upazila*. During the visits, they informally discussed with the HCPs about their practices, common illnesses encountered, problems faced, continuous education and willingness to participate in a proposed capacity building training. In addition, some need assessment workshops were conducted in Domar *upazila* to assess their competencies and training-related needs so that an informed intervention can be developed. Finally, the data were compiled and the summary findings are briefly described below.

Informal discussions with the HCPs revealed that almost all village doctors, MAs/SACMOs, FWVs and CHWs have had training of one to six months on some specific diseases and basic health problems provided by various organizations. But all the salespeople at drug retail outlets stated that they had no formal training. Most of the providers were highly fascinated at the prospect of a training programme to be offered by the project, and were enthusiastic in attending the training. They mentioned that they needed training to develop their capacity so that they could properly diagnose diseases and provide appropriate treatment to the patients. On the other hand, a small portion of village doctors, MAs/SACMOs and community health workers reported that they attended several courses offered by different agencies. They needed training on some specific diseases. Some CHWs also mentioned that they needed detailed training because they started their profession without any formal training in medicine and health. Here are some quotes:

> *Everyday many patients come to me for treatment. I provide them treatment as much as possible. But I have no training on medicine and health. Sometimes I can not diagnose the diseases. I think if I have training I could provide them treatment properly*. (a 26-year old drug seller of Gongachara)

> *I have three months' training on common diseases. But I have not any training on heart disease, diabetes and hypertension. If I get training on these diseases then I can provide them treatment properly.* (a 42-year old village doctor in Domar)

The healthcare providers who did not attend any training mentioned a number of impediments such as lack of time, geographical distance and opportunity costs. They pointed out that most of the agencies offered long training rather than short courses. As a result, they could not attend these training because of time and money constraints. Geographical distance was believed to be another crucial barrier. According to them, almost all training providing agencies was far away from their locality. These agencies provided training from district headquarters. Only a few organizations offered training at thana headquarters.

> *There are some organizations in Rangpur and Nilphamari who provide training. But it is difficult to attend those training, because they are far away from here. We can not stay there for a long time for training. If BRAC provide us training in the locality, we all can attend the training. (*a 28-year old drug seller in Domar)

> *I am running a small medicine shop. I have not enough money to spend for training. If the training is free of cost then we can participate. (*A 30-year-old drug seller).

Issues to be addressed

It was observed that the training needs were not uniform for all categories. Different types of healthcare providers wanted different kinds of issues to be addressed. Almost all drug sellers, homeopathy practitioners, CHWs and some *Palli chikitsaks* emphasized training on common

diseases such as fever, diarrhoea, gastric ulcer, pneumonia, dysentery, loss of appetite, arthritis and primary healthcare. They were also interested to have training on pregnancy-related ailments, menstrual problems, and issues related to mother and child health. Here are some quotes:

> *Most of the patients who come to me for treatment have fever, diarrhoea, gastric and arthritis. So, I need training on those diseases. I also need basic concept on medicine and primary healthcare. (*a 26-year old drug seller in Gongachara)

> *We provide counselling and treatment mostly for women in the villages. Though I have basic training on health, I need more training on pregnancy and child health. (*a 45-year-old health volunteer of BRAC in Domar)

The other group including some *Palli chikitsask,* MAs/SACMOs and FWVs reported that they had basic training on medicine and health. Now they needed more training on some specific diseases such as asthma, high blood pressure, diabetes, heart disease, mental depression, pregnancy-related ailments, HIV/AIDS, and some communicable diseases like malaria, diphtheria, measles, cholera, anemia, tetanus and leprosy. They also mentioned that they needed training on primary healthcare (PHC), medicine, sanitation, mother and child health and family planning. In addition, training on some pathological tests including urine test, stool test and blood test were also expected by the providers.

> *Now a days patients have different sorts of diseases. Some are new to us. Some patients have syphilis, gonorrhoea. But we know a little about these diseases. If we get training on these diseases many patients can be cured from the locality. (a* 43-year old village doctor in Gongachara)

Training procedure

Almost all providers stated that they would not be able to participate in a long training course, as well as day-long schedules. Rather, they would like to attend short training courses, for two to four hours a day and two to three days a week. To quote:

> *The training programme should not be large. It should be short and concise. 2-3 days a week is good for us. (*a 34-year old drug seller in Domar)

> *The training programme should not be day-long. We may lose our income in a long training. I think 2-4 hours a day is enough for us.* (a 45-year old village doctor)

On the other hand, few of the HCPs opined that the training programme should be run for 1-3 months. They argued that the training should be extensive and detailed. They believed that no comprehensive concept could be gained in a short training.

> *If BRAC offers training programme for us, then I request them to make the programme long. I think it should be for 3 months. Because many issues can be discussed in a long training. (*a 38-year old village doctor)

The HCPs also opined that the most convenient time of training would be from 10 a.m. to 2 p.m. because they remain less busy with the patients/clients during that time.

> *We remain busy in the afternoon and evening. Many patients come during that time. If we go for training in the afternoon, we may lose many patients. 10.00 a.m. to 1 p.m. is suitable for us. (*a 27-year-old drug vendor in Domar)

Some medical assistants/SACMOs, family welfare visitors and community health workers suggested that the training should be arranged on public holidays (e.g. Friday) because they are to provide services in their organizations on the office day. Some drug sellers reported that the market day (*hater din)* should be avoided for training. They remain busy with the patients or customers on those days.

> *We do our duties for our clinics from Saturday to Thursday. So, we can not attend the training on those days. We request BRAC to arrange training on Friday. (*a 33-year old FWV in Domar)

The healthcare providers also realized the need of refresher training. Most of the providers desired to attend refresher training. According to them, it would help them to remain updated throughout year.

Majority of the providers expected that the training should be provided by experienced MBBS doctors. A few providers mentioned that a medicine specialist from a medical college should be involved in the training. Also, very few providers wanted to attend the training under government medical officer working in the Upazila Health Complex (UHC).

> *The first thing to be considered is that who will provide training. If experienced medical officer from anywhere facilitates training, then it would be easy to understand for us. (*a 32-year old drug seller in Gongachara)

They also expected some incentives from the project including pen, notebook, health manual, and reference books. They suggested that they should be awarded certificate from BRAC at the end of the training. They were supposed to have some honorarium and travel cost related to training as well.

> *I do not have any good health books. They are costly. BRAC can give us some health books during training. (*a 40-year-old village doctor in Domar)

> *BRAC should provide us certificate at the end of the training. We will keep them in our shops. Then, nobody can say we are not trained. (*a 28-year-old drug seller)

Survey

A baseline quantitative survey on the knowledge, attitude and practice of the unqualified/semi-qualified HCPs was carried out in the study areas (Ahmed and Hossain 2006). Two sets of semi-structured questionnaire were used to collect the information. Socioeconomic and demographic information of the HCPs, current skills, training received, needs for continuous education and management of some common illnesses were covered in the baseline survey.

DEVELOPMENT OF TRAINING MATERIALS

Based on the insights gained from the need-assessment workshops, findings from the baseline survey and informal discussions with the HCPs, a comprehensive training package divided into six modules was developed. A group of researchers/practitioners developed the package over a period of about six months which have been pre-tested in mock training sessions with some HCPs. The manual has rigorously been reviewed by several physicians as well as public health researchers. The training is initially focused on *Palli chikitsaks* and allopathic drug retailers as they form the major proportion of the informal allopathic care providers for the poor and the disadvantaged. The six modules of the training package are i) fever and rational use of drugs (reducing misuse/overuse of drugs), adverse drug reaction and pharmaceutical care, ii) diarrhoea, dysentery and digestive problems, iii) pain and body aches (rheumatism), iv) pneumonia/ARI in children, v) reproductive health, RTI/STI/ and HIV/AIDS, and vi) food, nutrition and healthy life style. Each phase continues for about two months (each session comprises three days a week, three hours a day) to cover all the targeted HCPs. Thus, 8-10 sessions are arranged in a month and 15-20 participants attend each session. Flip charts and leaflets were developed to disseminate information.

THE TRAINING SESSIONS

Finally, the training commenced in Domar *upazila* in early September 2006. An MBBS doctor from the locality has been recruited on ad hoc basis to conduct the training. He is being involved in the preparation of training modules from the beginning. Also, a field organizer has been recruited to take care of the logistics and relevant activities. He has regular contact with the HCPs and motivates them for attending the training. He also visits the HCPs two-five days before a particular training session is arranged. An official invitation letter from Project Coordinator requests the HCPs to attend the training. It is arranged at BRAC Research and Evaluation Division's field office. Geographical distance and time constraints of the HCPs are considered when the sessions are arranged. The entire study area is divided into some catchments areas (e.g. 2-5 kilometers radius). All the targeted providers of a catchment area are invited in the same session. Moreover, HCPs are given choice to attend the session in a day convenient to them. For example, if some one is not available to attend a session due to unavoidable circumstances, he/she is offered to attend the next session of the same module. In addition, the participants are from mixed groups (*Palli chikitsa*k and drug retailer) so that they can exchange their experience and views among themselves.

The sessions are fully participatory and the participants are offered to describe their practices on specific illness in a pre-designed format. After transcribing of practices in the format, they present their practices before the participants and comments and feedbacks are received from the participants. The MBBS doctor gives his comments and makes necessary corrections in their exercises. Finally, he discusses the issue in a comprehensive way. The training manual of the respective topic is immediately distributed among the participants after completing the sessions. In addition to training manual, some other IEC materials such as leaflet, poster, etc. are offered to the HCPs as reference material. Besides, modest monetary incentives including actual travel cost and daily allowance are being provided to the trainees so that they are encouraged to seek training. It is also expected that the participants who would successfully complete all the sessions would be awarded certificate from the project.

Monitoring

After classroom sessions, the practices of the HCPs are also monitored through spot observation by the field workers of the project. A semi-structured observation checklist is being used. The field worker compiles the monthly collected observation data and sends it to project management including project coordinator and the trainer. The observation findings are discussed in the following sessions with the respective participants.

PRESENT STATUS

The first phase training on fever, rationale use of drugs, and medicine dispensing are completed and 239 participants attended 15 sessions in this module. The remaining 46 HCPs are still out of training where most of them are not found in the areas because of out migration to different places for jobs. Some HCPs have changed their profession in the meantime while very few HCPs are not interested to attend the training. Currently, 2nd phase training on diarrhoea, dysentery and gastric ulcer is underway and 165 participants are attending 11 sessions. The 2nd phase training will be continued till the end of December 2006. It is expected that the 3rd phase training on pain/rheumatism and ARI in children will be started from early January 2007. The training is expected to be completed in June 2007 followed by a post intervention KAP survey to assess the impact of the training.

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