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The need to train uncertified rural practitioners in India

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Abstract

Uncertified rural practitioners (URPs) without formal medical qualification occupy an indispensable yet dangerous position in the rural health care system in India. The low cost, close proximity, and higher health hazards in rural areas along with the inability of established health-care setups to fulfill existing demands have favored the flourishing trade of URPs. Irrational and dangerous drug prescriptions, unauthorized interventions, improper waste disposal, and several cases of malpractice by URPs are serious threats to the exposed population. However, because of the practical compulsion and real-world necessity of their existence, URPs should be scientifically trained and sensitized to regulate, qualify, and integrate them as a part of the existing health care system in India.

Keywords

Uncertified rural practitioners (URPs), health care system, rational, prescription, training, community

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Main text

The definition of uncertified rural practitioners (URPs) is inconsistent.[1] In this article, URPs are defined as all types of informal care providers who have not received formally recognized training with a defined curriculum from an institution but who have some level of informal training through apprenticeships, seminars, and workshops and are not mandated by any formal institutional norms. They are not typically registered with any government regulatory body and operate outside of the purview of regulation, registration, or oversight by the government or other agencies.[2]

In rural India, URPs provide more than 70% of all primary health care.[3] In 2004, one study revealed that 41% of individuals in the private sector claiming to be doctors had no medical degree, 18% had no medical/paramedical training, and 17% had not even graduated from high school.[4] Another recent study showed that 96% of URPs possessed no formal medical qualification.[5]

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The quality of service offered by URPs therefore remains both dubious and dangerous.

A study of the causes behind such a flourishing trade revealed that around 36% of medical or paramedical personnel were absent from government primary health centers and that 45% were absent from sub-centers, which were closed 56% of the time during regular working hours.[4] Although this scenario has greatly improved over the years, URPs often remain patients' first contact points because of their easy accessibility (determined by the number of URPs in a surrounding area, the likelihood that sick persons know the location of these practitioners, the distance between a sick person's home and the nearest practitioner, and access to affordable transport facilities), inherent embeddedness in the community, and greater health hazards in rural areas.[6] According to the latest data of the World Bank, India contains 0.702 certified physicians (as of 2012), 0.046 community health workers (as of 2005), and 1.711 nurses and midwives (as of 2011) per 1,000 population.[7] Although no India-wide surveys have been conducted to estimate the number of such unqualified doctors, regional surveys indicate that more than 70% of healthcare providers in rural India have no formal medical training.[8]

In reality, URPs fulfill the role of accredited social health activists contemplated by the Indian government; this role was introduced as a part of the National Rural Health Mission (now National Health Mission).[9] A cross-sectional study involving household surveys, focus group discussions, and key informant interviews with healthcare providers in two Indian states (Andhra Pradesh and Orissa) highlighted that most villagers seek their first level of healthcare near their home and use the composite convenient service of both consultation and dispensing of medicines.[10] Another observational study conducted in the state of West Bengal showed that around 29.3% of the population preferred to visit URPs because of their low cost and close proximity.[11]

Rural India depends on their omnipresent and indispensable URPs, who represent unintended and unpremeditated safety valves that compensate for the major limitations in the established health care setups.[12] Interestingly, a majority of these URPs know how to manage common disease conditions.[13] However, ignorance about rational drug selection, doses, frequencies, routes of administration, timing, and treatment duration as well as food–drug and drug–drug interactions lead to inappropriate responses and toxicities. The dispensing of teratogenic drugs during pregnancy and harmful drugs during lactation and the injudicious use of antibiotics and analgesics are serious concerns. Some reports have even described the unauthorized dispensing of narcotic drugs and psychopharmaceuticals and other malpractices.[14] One study showed that 25% of URPs were involved in unauthorized practices such as unsafe abortion, childbirth, and surgical interventions.[15] URPs also tend to treat serious medical conditions beyond their capacity and cause undue delay in referring patients to the proper medical setups. Other major concerns are unsafe injections and improper biomedical waste disposal practices.[5,16]

However, the widespread community acceptance of URPs and the inability of the government to ban or regulate their practices necessitate alternatives such as training and sensitizing URPs and utilizing their services in a beneficial way. This can induce a change in their knowledge, attitude, and practice. They can be trained in the management of common ''non-serious'' diseases, disease surveillance, rational drug use, identifying danger signals, timely referrals, and safe injection and waste disposal practices. They can be also sensitized and warned about their limitations in prescriptions/interventions and the risks of

malpractice. Through repeated training, URPs should also be expected to develop and maintain integrity, accountability, and good work ethic.

A randomized controlled trial in West Bengal provided 72 sessions of multi-topic training for 9 months to 152 URPs using a structured and scientifically sound method. The training increased the rate of correct case management by 14.2% but did not affect the use of unnecessary drugs, including antibiotics. At a nominal program cost of $175 per trainee, the results suggest that scientific training is an effective strategy with which to educate and change the ongoing practice of URPs.[3] In another study of the training and education of URPs in West Bengal, multiple workshops with a specific module/syllabus were conducted by medical personnel for 2616 URPs from 1450 villages. A URP association was formed and rural medical libraries were developed.[17] The training successfully created awareness among the URPs regarding rational therapeutics; however, the degree to which it was subsequently reflected in their real practice was not evaluated.

Notably, the Indian medical establishment unfortunately has a different viewpoint. It opposes the view that training of URPs might be a practical and expedient response to the severe shortage of trained providers, especially given that URPs are already inherently associated with the communities that they serve. The opinion that such training can complement better regulation and improve the public health care system contradicts the position of the medical establishment, which argues that such training will legitimize an illegal activity and worsen population health outcomes.[3]

However, we still believe that there is a need to introduce continuous medical training programs/workshops/courses that would improve the quality of services provided by URPs and prevent them from engaging in dangerous practices. The primary objective of such training programs would be to improve the quality of curative care provision (primary, lifesaving, and referral services). The focus would be on recognition of common diseases, provision of early primary care, identification of patients who require higher-level care, and proper referral and management of emergencies. These programs could also include theoretical classes supplemented with periodic patient simulations and clinical demonstrations of problems.

Periodic surveillance, re-evaluation analysis, and regular monitoring of performance improvement are advocated. Add-on or ''booster'' contact programs or training sessions might also be required. Thus, considering the practical compulsion and real-world necessity of their existence, URPs can be scientifically trained and sensitized to regulate, qualify, and integrate them into the existing rural health care system of India.

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