

Full Length Research Paper

Study of unqualified rural medical practitioners (URMPs) through scientific training in proper use of medicine

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India has a plurality of health care systems as well as different systems of medicine. India is drawing the world's attention. Unqualified medical practitioners (URMPs) treat people in rural, semi-urban and urban areas of India, which is seen only here and protected legally. There is no existence of this type of unqualified practitioners in other countries of the world. The study was undertaken to educate the URMPs in science of medicine use and rational use of medicine. The interventional study was started on 2000. For the study, workshops were conducted by medical graduates of modern medicine. Duration of the workshops was 1-5 days. A module/syllabus was prepared which was discussed in the workshops. Forty workshops were conducted in 15 districts of West Bengal in 13 years. Two thousand six hundred sixteen (2616) URMPs from 1450 villages were participated in the workshops. The educational activity has created awareness among the URMPs regarding rational therapeutics, URMPs association has been formed and rural medical libraries have been developed in different districts of West Bengal, a state in India. State is unable to deliver healthcare to all the people, on the contrary URMPs are illegal practitioners as per state laws. The URMPs may act as part of the state healthcare delivery system if they are educated properly through continuous interventional activities like one which we have initiated.

Keywords: Unqualified medical practitioners, rural areas, medicine use

INTRODUCTION

India has a plurality of health care systems as well as different systems of medicine (Kumar et al., 2007). India is drawing the world's attention, not only because of its population explosion but also because of its prevailing as well as emerging health profile and profound political, economic and social transformations. After 64 years of British rule, a number of urban and growth-orientated developmental programs having been implemented, nearly 760 million rural people (72% of the total population), half of which are below the poverty line (BPL) continue to fight a hopeless and constantly losing battle for survival and health. The policies implemented so far, which concentrate only on growth of economy not on equity and equality, have widened the gap between 'urban and rural' and 'haves and have-nots'. Nearly 70% of all deaths, and 92% of deaths from communicable diseases, occurred among the poorest 20% of the population. Interstate, regional, socioeconomic class and

gender disparities remain high. These appear significant, yet it must be stressed that these survival rates in India are comparable even today only to the poorest nations of sub-Saharan Africa. The rural populations, who are the prime victims of the policies, work in the most hazardous atmosphere and live in abysmal living conditions. Unsafe and unhygienic birth practices, unclean water, poor nutrition, subhuman habitats, and degraded and unsanitary environments are challenges to the public health system. The majority of the rural population are landless peasants, artisans and labourers, with limited resources that they spend chiefly on food and necessities such as clothing and shelter. They have no enough money left to spend on health. The rural peasant worker, who strives hard under adverse weather conditions to produce food for others, is often the first victim of epidemics.⁵ On the other hand public hospitals provide 60% of all hospitalizations, while

the private sector provides 75% of all routine care. The private sector is composed of an equal number of qualified doctors and non-qualified practitioners, with a greater ratio of unqualified to qualified existing in less developed states. The shortage of healthcare professionals in rural communities remains an intractable problem that poses a serious challenge to equitable healthcare delivery. Both developed and developing countries report geographically skewed distributions of healthcare professionals, favouring urban and wealthier areas. Rural communities are on average sicker, poorer and less well educated; they also have worse access to health care than people in urban areas. This discrepancy between health need and service provision is captured by Hart's 'inverse care law', which states that those with the greatest health needs usually have the worst access to healthcare services. Rapid urbanization is a global phenomenon but it poses particular problems in developing countries with poor infrastructure development; improved access to healthcare is often cited as one of the driving forces. In rural areas, qualified doctors are clustered in areas where government services are available and the most of the health management provided by the nonqualified practitioners. These non-qualified registered medical practitioners (NRMPs) are only seen in India only and no existence to this kind of practitioner anywhere in the world nations. Government is unable to provide health care services to rural India completely and that is reason why India only given existence to these NQRMP doctors. As per guidelines by WHO, in Cuba and sub-Saharan Africa have shown that proper training to grass-root health providers change the system in a large scale (Kumar et al., 2007 and Duggal 1994).

If government agencies work with the local practitioners and afford them the proper respect, their skills can be upgraded in selected areas and the whole community will benefit (Nath, 1994).

Education of people in science of drug and also in using medicine is the key determinant to foster not only the concept of scientific use of medicines but also the concept of essential medicine and rational use of medicine. Most persons usually become bound to take medicines, selected by the prescriber, without having knowledge on science of medicine use. Sound and objective information about medicines are not available even to the prescribers and dispensers in India (<http://mednet2.who.int/edmonitor/edition/edm18a.html>). A major sector of prescriber (about 50 lakh or more) in India is unqualified rural medical practitioners who prescribe medicines in both rural and urban communities (Indian Health Report, 2003). They usually prescribe without having adequate knowledge on medicine and therapeutics. On the other hand, ineffective, banned medicines, irrational formulations of drugs cater about eighty percent (80%) of drug market in India (Banned and Bannable Drugs, 1996). Therefore, lack of knowledge of prescribers and availability of irrational

formulations are the important documented determinants which affects the process of scientific use of medicine and rational prescribing. This study is to disseminate objective information to unqualified rural medical practitioners about science of medicine use and rational prescribing; one of the under-reported but has enormous importance in Indian context as unqualified medical practitioners serve to a major sector of population in India.

MATERIALS AND METHODS

For the continued educational activities a module or syllabus was prepared in Bengali (local language of West Bengal) as well as in English. The module was discussed in workshops. The duration of the workshop were six hours each day for three days. A pre-tested, pre-validated questionnaire was also formed to assess the knowledge, attitude, practices of the participants with a same test within 30 days of post-training. Target localities were the rural and semi-urban areas of West Bengal. Target people were the unqualified rural medical practitioners who participate voluntarily without any allowance. Trainers were all Medical graduate and post-graduate in various health institutions and for arrangements of the workshops, the resource persons usually stayed in the localities. Funding was done by a NGOs and donation.

DISCUSSION

The programme was formulated and started on the year 2000. The first workshop was held in October, 2000 at Gadiara, a remote village in West Bengal. We collected the data up to November 2012. In the last 13 years 40 workshops in rural setup were conducted in 15 districts of West Bengal. Total number of unqualified medical practitioners attended the programmes were 2616. They came from about 1450 villages (Figure 1).

It was found that the private practitioners are almost always male, most of them practice mostly allopath (modern medicine) in or close to their birthplace i.e. son of soil (only 4 % were outsider) but almost 64% have no formal training which was very similar in previous study i.e. 50% (Rohde et al., 1994). Regardless of training, the patients were satisfied with the care they received because the private practitioners paid more constant attention to them and gave all clarification about suffering and management in understandable way. The practitioners are compensated by adding a surcharge to the fee for their low cost medicines i.e. generic drugs. The patients believe that they are simply purchasing medications. This system requires the practitioners to dispense medications, injections, or both to receive compensation. They dispensed the expired drug confidently because there was no harm in it, as they

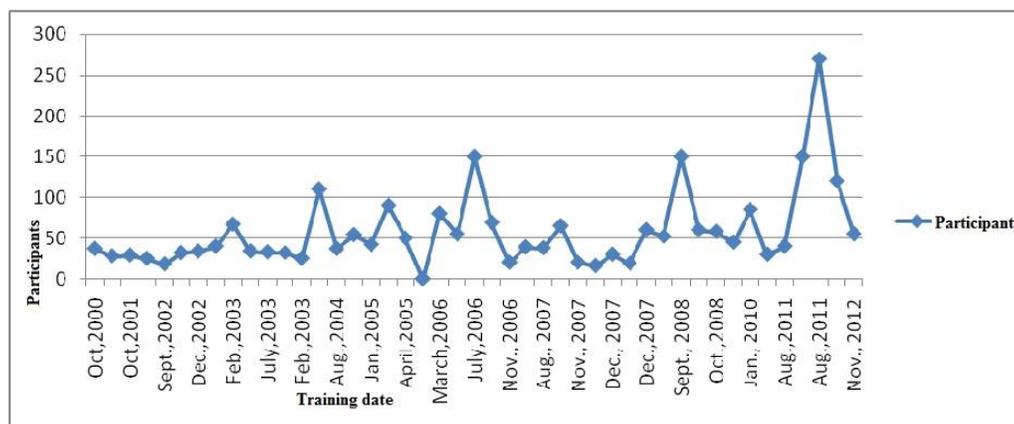


Figure I. Various workshops and the participants

believed up to 6 months to one year. Medications, including antibiotics, are given in small doses (a practice which is certainly harmful). The practitioners refer, guide or carry with as family member difficult cases to the government centres or higher private sector. Most of the practitioner, however, practices alone, with their only professional contact being the chemist and expressed interest in joining an association. In the association they meet once in month or emergency basis in crisis.

In pre-tested, pre-validated and post (20-30 days after) questionnaire was also formed to assess the knowledge, attitude, practices of the participants. Knowledge about drugs and diseases (50%), attitude to patients and party (70%), practice (50%) in has changed a lot (Figure 2). The entire post trained practitioners have latest CIMS/MIMS, a book contain names of all marketed drugs details. In every block they made association and communicate with other members regularly. They made medical library in block level by their own contribution contains English with translated books. They published journals from central office with lot of information related to drug, disease and practice in quarterly basis.

One of the most important but under-reported and neglected field of study is education of prescribers and consumers in rational therapeutics and scientific use of medicines. In previous studies, the theme of the projects varied widely. The themes of the projects included: general studies on rational use of drugs (70%-90%), specific problem drugs (antidiarrhoeals, antibiotics etc.), specific illnesses, treatment or health problems, consumer rights and responsibilities (Rohde et al., 1994).

Achievements/indirect outcome of intervention

Indirect outcome of this study is not measurable by any statistical test. But the indirect results have caused tremendous, long-lasting social impact and which have

created awareness among the URMPs and now they have raised the slogan –‘We want to learn’. The important indirect results of this study are:

i) Rural medical practitioners association (RMPA) has been formed in many districts of West Bengal. RMPA members have been practicing RUD since 2000.

ii) RMPA members’ independently organizing school programs on science of drugs in different schools of Hoogly district, a district in this state. They have become pioneers to organize this type of program.

iii) For continuing medical education, also to update their knowledge a syllabus and curriculum has been prepared by the RMPA members, with the help of experts. A six months course has also been prepared to teach new students.

iv) RMPA regularly publishing their preface Gramin Swasthya Samachar (in English: **Village Health News**), the recent two issues of which published EML and banned drug list of India.

v) RMPA members of various district established many Rural Medical Library.

vi) RMPA members are follower of Dr Norman Bethunes philosophy and are practicing the principle of Norman Bethune to maintain the doctor-patient relationship.

The reason for selecting the theme noted were: perceived need, recommendations of an advisory group or board, based on existing data or on a literature search (Fresle and Wolfheim, 1997). In this study, the theme was selected and interventions were undertaken to improve and upgrade the knowledge of the unqualified medical practitioners so that the consumer may be benefited on every therapeutic encounter, which was success in a large form. In this study, we included unqualified medical practitioners as the primary target. Therefore in conclusion, as we unable to ban the unqualified medical practitioners, we should train them for our own benefit and should use them as grass-root workers in health planning and formulation.

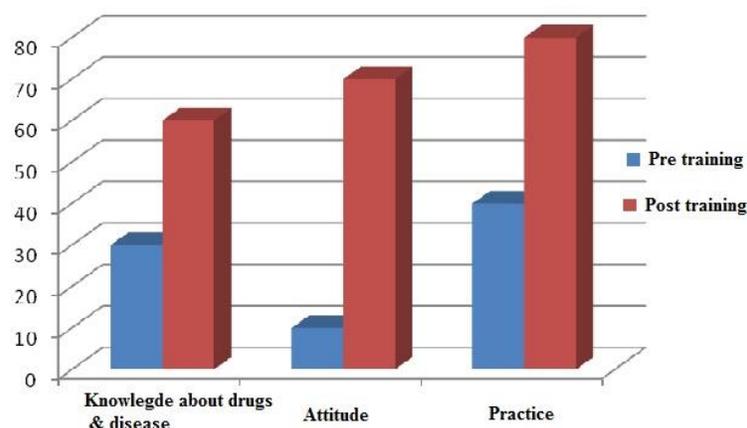


Figure 2. Changes of knowledge, attitude, practices among the participants by pre and post test.

Syllabus/module:

Part-1/Session-1:

- 1.Auditing of prescriptions served by doctors.
- 2.History of pharmacology-source of drugs.
- 3.Evolution of modern drugs :role of medicinal plants.
4. Development of drug supplies and marketing-the drug companies and advertisement.

Part-2/Session-2

- 1.General ideas about animal cell, tissues and organs.
- 2.Constitutions and interrelations of different disciplines of medical science.
- 3.When a chemical is called a drug?
- 4.Essential drugs, non-essential drugs, unscientific drugs, banned drugs, OTC drugs etc.

Part-3/Session-3

- 1.Diseases and treatment.
- 2.General ideas about different systems of medicine: Allopathy, Homeopathy, Ayurveda, Unani, Acupuncture, Indigeneous system, Modern medical science, Holistic medicine.
- 3.Role of WHO, different organizations, states and government.
- 4.Drug regulation acts in different countries.

Part-4/Session-4

- 1.Drug profiles in our country.
- 2.Health profiles in our country.
- 3.Health problems: Various peoples organization and state.
- 4.Solution of health problems.

Limitation

We had trained them in some area more than the time allotted in protocol due to demand on their side. In some areas we had trained in two or three stages due to large numbers of trainee. Some time we deferred the date due to natural calamity or political pressure. This sort of failure was beyond our control.

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