Original Article

Perspectives of the Community and PHC Doctors from Three Southern States in India on Community Preference for Health Services Provided by Rural Medical Practitioners

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Abstract

Research question: Study to determine the reasons why community members continue to access healthcare through Rural Medical Practitioners (RMPs). *Objective :* To find out the impression of stakeholders i.e. community leaders, PHC doctors and members of community on the need of RMPs cater to the health needs of the communities. *Study design :* Cross sectional study. *Setting :* Remote and rural villages in Andhra Pradesh, Tamilnadu and Kerala. *Participants :* 322 persons who include 59 RMPs, 81 village heads, 55 PHC doctors and 127 patients

Keywords

rural medical practitioners, village heads, PHC doctors,utilization of government healthcare services, accessibility,familiarity, availability and affordability

Result and Conclusion

More than seventy three percent of RMPs in Tamilnadu and 60% in Kerala and only 20.8% in Andhra Pradesh have done a medical course to practice medicine. Among these RMPS 53.3% of Tamilnadu, 20% in Kerala and 87.5% Andhra Pradesh have experience with General practitioners. The village heads, and the community responded that the reasons why they seek the services of RMPs are easilyaccessibility, familiarity to villagers, availability round the clock and affordable services. The PHC doctors also concurred on this: availability (90.9%), accessibility (85.5%) and affordability (81.8%). Rural medical practitioners (RMPs) who provide 80% of outpatient care have no formal qualification for it. They sometimes lack even a school education Over seventy eight percent PHC doctors feel that RMPsuse improper medication, make wrong diagnosis (65.5%)and give unnecessary injections/IV (36.4%).

The Public health system in the rural areas is plagued with dilapidated state of infrastructure and poor supply of drugs and equipment.The nationwide average absentee rate is 40 %. Though at present private doctors provide more than 80% of health care, in the hard to reach areas, it should be based on scientific knowledge but made easily accessible and available to the people at a cost that they can afford, and suitable strategies should be developed by the government towards this.

Introduction

The state of human resources for health in India is diverse and multifaceted. They range fromrigorously trained biomedical specialists and super-specialists at one end to an assortment of communityand household based healers at the other.

Today, rural healthcare in India faces a crisis unmatched by any other sector of the economy. Despite elaborate network of facilities in the form of subcentres, Primary Health centres (PHC) and Community health centres (CHC),

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only 20% of those seeking outpatient services and 45% of those seeking indoor treatment avail of public service. While dilapidated state of infrastructure and poor supply of drugs and equipments are partially to be blamed, the primary culprit is the rampant employeeabsenteeism, nationwide average absentee rate is 40%[1].

Rural medical practitioners (RMPs) who provide 80% of outpatient care have no formal qualification for it. They sometimes lack even a school education[2]. In village, RMPs constitute even local medicine men /women, traditional birth attendants, priests and magico- religious faith healer. Even knowledgeable family or community leaders perform ojha-tona (faith healing)[3]. The fact that the majority of RMPs live in the village of their practice, and are easily accessible to community round the clock positively influences the utilization of services they provide.

With this background, it was thought appropriate to find out the impression of stakeholders i.e. community leader, PHC doctors and members of the community on the need for Rural medical practitioners tocater to their health needs.

Methodology

Questionnaires were prepared addressing the RMPs, and the stakeholders namely their patients, medical officers from local PHCs, and the village heads looking at legal status of RMPs, spectrum of diseases treated, operational style, fees charged, understanding people's perceptions, impact on the health of the patients especially the women, assess training undergone, and areas of weaknesses and strengths.

This study was conducted in remote and rural villages namely Mantralayam, Peddakaduppur, Kosigi, Alur and Adoni region in Kurnool district of Andhra Pradesh; Thiruvallur and Nagercoil district of Tamilnadu and Wynad district in Kerala. A total of 322 persons were interviewed which includes 59 RMPs, 81 village heads, 55 PHC doctors and 127 patients. The participants were assured that their response will be used only for research purpose and their identity will not be divulged and strict confidentiality of their responses will be maintained.

The responses were collated and analyzed.

Findings

Status of medical training of Rural medical practitioner

Status of medical training of Rural medical practitioner (multiple responses) is shown in **Table 1**.

More than seventy three percent of RMPs in Tamilnadu and 60% in Kerala have done a medical course to practice medicine whereas in AP it is only 20.8%.

53.3% of Tamilnadu RMPs have worked with General practitioners and 60% have pharmacy experience also. In Kerala 20% has experience under a qualified doctor and 36% in a pharmacy. In Andhra Pradesh 87.5% have worked with RMPs while 25% of them also have experience under qualified doctors.

Impression of village heads on the benefit of RMPs

In total 30 village heads from TN 40 from Kerala and 11 from AP were interviewed and their impression is presented in **Table 2.**

Easily accessible (100%), familiarity to villagers (100%), availability round the clock(95%), and affordable service (90%) are the important reasons given by village heads as the benefit of having RMPs in villages.

Table 1
Status of medical training of Rural medical practitioner (multiple responses)

Status	TN (N=15)	Kerala (N=20)	AP (N=24)	Total (N= 59)
Medical course in some hospitals/ colleges	11 (73.3)	12 (60)	5 (20.8)	28 (47.3)
Worked with general practitioner(qualified doctor)	8 (53.3)	4 (20)	6 (25)	18(30.5)
Worked in hospital pharmacy in some capacity	9 (60)	9 (36)	2 (8)	20(33.9)
Worked with some RMPS/ father	6 (40)	7 (28)	21 (87.5)	34(57.6)
(Numbers in parenthesis indicate percentage)				

Table 2
Impression of village heads on the benefit of RMPs (multiple responses)

Benefit	Tamilnadu (N=30)	Kerala (N=40)	Andhra (N=11)	Total (N=81)
Affordable service	30(100)	33(82.5)	10(90.9)	73(90)
Available round the clock	26(86.7)	40(100)	11(100)	77(95)
Gives satisfactory service	30(100)	27(67.5)	9(81.8)	66(81.5)
Easily accessible	30(100)	40(100)	11(100)	81(100)
Familiar to villagers	30(100)	40(100)	11(100)	81(100)
(Numbers in parenthesis indicate percentage)				

Impression of Primary Health centre doctors

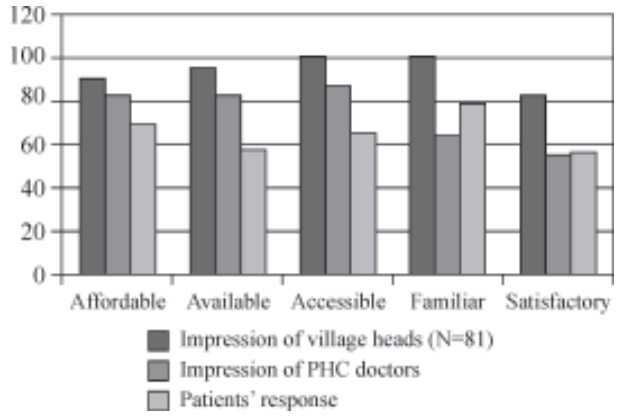
Fifteen PHC doctors from Tamilnadu, 20 each from Kerala and Andhra Pradesh were interviewed as to why patients go to RMPsfor treatment offered by RMPs. Findings are shown in **Table 3** and **4.**

Impressions of PHC doctors as to why RMPs are consulted by villagers are availability (90.9%), Accessible any time (85.5%) and affordable (81.8%).

Over seventy eight percent PHC doctors feel that RMPs use improper medication, make wrong diagnosis (65.5%)and give unnecessary injections/IV (36.4%).

From **Fig. 1**, it is seen that for patients, familiarity with RMPs is of highest value 78.7%%, then affordability 68.5% and accessibility 65.4%, whereas the village heads give equal importance to the RMPs' familiarity 100%, accessibilityand availability around the clock 95%, The PHC doctors give the highest value to RMPs' availability 85.5%

Fig. 1
Impressions about services offered by RMPS



Response of patients for choosing treatment from RMPs

In total 127 patients (45 from TN, 34 from Kerala and 48 from AP) were asked the reason for choosing RMPs for treatment. Their response is shown in **Table 5.**

Table 3
Impressions of PHC doctors as to why patients go to RMPs(multiple responses)

Benefit	Tamilnadu(N=15)	Kerala (N=20)	Andhra (N=20)	Total (N=55)
Familiar to community	15(100)	6 (30)	14 (70)	35(63.6)
Affordable	14 (93.3)	20(100)	11 (55)	45(81.8)
Available round the clock	14 (93.3)	20(100)	16 (80)	50(81.8
Accessible any time	12 (80)	20(100)	15 (75)	15(85.5)
Satisfy patients' needs	8 (55.3)	12 (60)	10 (50)	10(54.5)
(Numbers in parenthesis indicate percentage)				

Table 4
Impressions of PHC doctors on quality of treatment offered by RMPs (multiple responses)

Response	Tamilnadu(N=15)	Kerala (N=20)	Andhra (N=20)	Total (N=55)
Wrong diagnosis	5 (33.3)	20 (100)	11 (55)	36(65.5)
Improper medication	14 (93.3)	18 (90)	11 (55)	43(78.2)
Unnecessary injection/IV	4 (26.6)	8 (40)	8 (40)	20(36.4)
Unhygienic delivery procedure	6 (40)	3 (15)	9 (45)	18(32.7)
Unnecessary procedure	1 (6.6)	8 (40)	7 (35)	16(29.1)
(Numbers in parenthesis indicate percentage)				

Table 5
Response of patients for choosing RMPs for treatment (multiple responses)

Reason	Tamilnadu N=45	Kerala N=34	Andhra Pradesh N= 48	Total N=127
Familiar	35 (77.7)	34 (100)	31 (64.6)	100(78.7)
Affordable	37 (82.2)	21 (61.8)	29 (60.4)	87(68.5)
Accessible	32 (71.1)	19 (55.9)	32 (66.6)	83(65.4)
Always available	28 (62.2)	16 (47.1)	28 (58.3)	72(56.7)
Satisfy patients' needs	20 (44.4)	21 (61.8)	30 (62.5)	71(55.9)

According to patients themselves, familiarity (78.7%), affordability (68.5%) and accessibility (65.4%) are important reasons whytheychoose RMPs for treatment.

Discussion

RMPs play a significant role in providing health care in rural India. Especially in villages, there is a widespread presence of practitioners who donot have a professional qualification in any recognized system of medicine, indigenous or allopathic but who practice a blend of different systems of medicine[4]. **Table 1** shows that 47.3%. RMPS has undergone a course in hospital and college. Village heads feel that villagers go to RMPs because they are easily accessible, familiar, available round the clock andprovide affordable service (**Table 2**). Impressions of PHC doctors are almost similar to that of the village heads (**Table 3**).

Improper medication , wrong diagnosis,unnecessary injection/IV drips and unsafe delivery procedures are the impression of PHC doctors regarding treatment offered by RMPs (**Table 4**).Familiarity, accessibility, and availability are important reasons cited by all as reasons for the community going to RMPs for treatment (**Table 5** and **Fig. 1**).

In an analysis of the kind of drugs consumed by the public, Mitra J *et al* reported that allopathic medicines were consumed for 99.3% of episodes and major source(53.8%) of medical care was from private practitioners[5]. One of the common problems with the government health services in rural areas was that doctors in PHCs and Auxiliary Nurse Midwives in the subcentres often do not live in their place of posting even if quarters are available. This adversely affects the utilization of the government healthcare services[6].

The government has to aggressively focus on improving the availability and quality of care provided by the government network or private players The availability of qualified doctors varies across the country. Wherever there is a dearth for doctors, RMPs need to be acknowledged and supported with training. AYUSH practitioners among them should be networked with the health system as well.

To make improvement in the delivery of health service,

a radical shift in strategy that gives greater opportunity to choose between public and private provider is needed. The government should invest in public facilities in regions which are difficult to reach. where private providers not likely to emerge in the near future. Private sector hospitals which were given land and facilities at concessional rate must be motivated, if required, forced through legislation to provide free treatment to people below poverty line up to at least 10 percent of outpatientsand 5 percent of inpatient capacity. Ghuman and Mehta made almost similar recommendation[6]. Government should correlate cash transfer for outpatient care in private hospitals and institute an insurance for the rest of the patients for in patient care. Competitive price must be fixed for services at public facilities.

Priority maybe given to the existing practitioners engaged in treating routine illnessesbyproviding training with the goal of eventual replacement of all RMPs by qualified nurse practitioners, who then can be utilized for the success of National rural health mission.

According to a syllabus for a 3 year course drawn byBoard of Governors of Medical Council in India, 25 students with education of standard 10+2 students from rural areas/districts will be selected from each district after an examination. Students will be trained in community colleges by practicing or retired doctors from a nearby district hospital. Their practice will be confined to that region and registration will be for one year only[7]. What will be the long term consequences of this course and future of the students completing the course is a matter of debate.

Non-specialist PHC doctors can be trained in emergency obstetric procedures, anesthesiology, psychiatry and pediatrics to cope with acute shortages of resources in these areas. Innovative public private partnerships can avoid duplication of services and resources, telemedicine links can better connect rural and remote areas with human resources in big cities, and powerful incentives can be used to attract talented young medical graduates to rural areas[8].

Health care in the hard to reach areas should be based on scientific knowledge but made easily accessible and available to the people at a cost that they can afford, and suitable strategies should be developed by the government towards this.

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