ijNr

Review Article

A Bird Eye View on Recent Developments of Community Health Providers in India

Jyoti M. Nirapure

Department of Nursing, Government College of Nursing, Gandhi Medical College, Bhopal, Madhya Pradesh, India

Abstract

In this research work discuss a recent development in the area of community health providers (CHP). In the last few years, India face many challenges in community health services sector. Recent India move on giant development in the area of CHPs. For any development and changes required a legal amendment, for development of community health national medical commission bill presented the midlevel medical practitioner under chapter V (autonomous board), clause no-32. In the research work also discuss the previous work presented in area of CHPs in India. In short discuss the role of community health officers in India for the improvement of health services. Although being the backbone of the COVID-19 campaign in India, community health workers' welfare but also employment conditions have not received enough attention. The nationwide lockdown, which was announced in March 2020, caused a migration of migratory workers from cities to home villages and towns, placing a heavy burden on public services and public health professionals. Regular immunizations, childcare services, and education suffered as a result of staff in these fields being redirected to cope with the containment of COVID-19 and especially those working in rural India. Field Epidemiology Training Program, strengthens the capacity of the public health workforce to detect, respond, and control disease outbreaks at the source. CDC India continues to support advanced, intermediate and frontline FETP programs, provide mentorship for outbreak investigations, surveillance evaluations, COVID-19 activities, and regular remote training. This research work also focuses on other major issues and problem of CHPs. Not only in COVID time duration but also after pandemics.

Keywords: Community health providers, community health services, legal amendment, mid-level practioner's, national health services, national medical commission

"Health is not mainly an issue of doctors, social services and hospitals. Health is an issue of Social Justice." - We have the goal of "Health for all by 2000 AD"

Introduction

Developing countries like India has double burden of disease and community level health-care services are very poor. To get over with health issues the country requires health-care professionals and health-care facilities for providing required health-care support. Global shortage of health-care professional is directly related to health status of the country. Thus, every country requires good set of healthcare facility and expertise at community level for universal health coverage (UHC). In India, the government is working toward easy access of health-care services for all.1,2 The community health officer is new step by Indian government which comes under mid-level health-care providers (MLHP). As per new NMC bill, they are called community health providers (CHP). An ideal health workforce is multilayered and multi-skilled, with complementary roles delivering competent, comprehensive, continuous, and compassionate care. Doctors and nurses are most identifiable, but a variety of allied health professionals and community health workers (CHWs) are also integral. India needs MLHPs in several forms - nurse practitioners, physician

Date of Submission: 21-07-2022
Date of Revision: 30-07-2022
Date of Acceptance: 03-08-2022

Access this article online
Website: http://innovationalpublishers.com/Journal/ijnr
ISSN No: 2454-4906
DOI: 10.31690/ijnr.2022.v08i03.002

Address for Correspondence:
Jyoti M Nirapure, Government College of Nursing, Gandhi Medical College, Bhopal, Madhya Pradesh, India. E-mail: jyoti.nirapure25@gmail.com

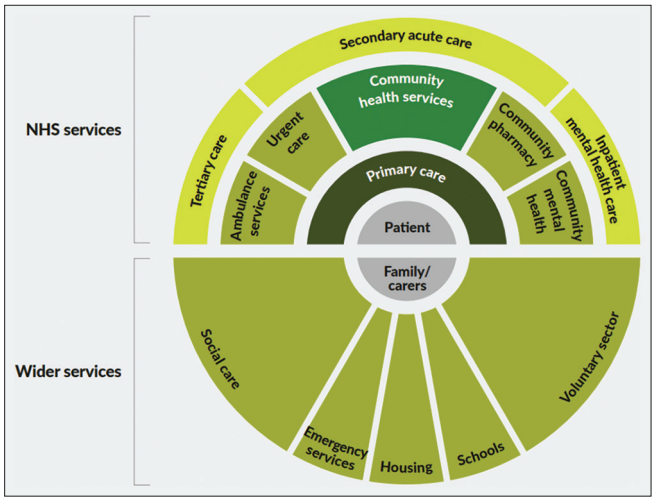

Figure 1: National health services community health services (CHS) fit within systems that support health and care

assistants and CHPs to fill the vast gaps of easy access and quality in health services. They are especially required for primary care. 3,4 Over 100 years mid-level health providers are working effectively in many countries with their pivotal role for achieving the optimum health. The rates of mortality and morbidity have also improved after task shifting as change agent at community level.5-7 community health officers (CHO) and frontline public health workers play a role to bridge the gap between community people and health-care facilities. The services provided by them improve the quality of life in community and also empowers the community health-care settings. They can also be the members of various societies and agencies for community health approach. The primary objective of healthcare is preventive approach to any epidemic and it can only be achieved when entire community is empowered. The empowerment of people from different community in globe is a need and due to shortage of health-care professionals there is workforce barrier to overcome. The CHO will identify the need of community and expand the healthcare facility with providing knowledge and support by organizing different programs. A paradigm shifts from vertical programmatic approach in public health by NHM brought new insight at community level. NHM exist with vision to provide effective healthcare in rural population. The CHO is pivotal in community setting which brought by NHM for improving the healthcare availability and accessibility to rural population in country [Figure 1].

Recent Developments of Chps in India

In 2018, under Ayushman Bharat, for delivering public health and primary health-care services, a new task force was presented as MLHP who would be a CHO. Further, in 2019, national medical commission bill presented the midlevel medical practitioner under chapter V (autonomous board), clause no-32. The person who connected with modern scientific medical profession and holds limited license to practice modern medicine at mid-level as CHPs as per this commission bill.

Details of this subsection of clause no-32 are as follows

1. Permission granted to practice medicine at mid-level as CHP to such person connected with modern scientific medical profession who qualify such criteria as may be specified by the said regulations and provided that the number of limited license to be granted under this sub-section shall not exceed one-third of the total number of licensed medical practitioners
2. The CHPs who are granted limited licenses under sub-section (i), may practice medicine to such extent, in such circumstances and for such period
3. The CHPs may prescribe specified medicine autonomously, only in primary and preventive healthcare, but in cases other than primary and preventive healthcare, he may prescribe medicine only under the supervision of medical practitioners.

Hence, The MLHP Or CHO Or Mid-level practioner's Or CHP are sounds the same and ultimately it means the majority of nurses will be in this role.

Need of Chps

Studies reported around 11.5% households in rural areas and about only 4% in urban areas, are not receiving any form of OPD care at sub-center, primary health center and CHC level. This indicates the low utilization of primary healthcare for minor ailments or it may be because of inefficient health-care services or unavailability of health-care providers. 10 To expand access to comprehensive primary healthcare (CPHC), government of India has launched Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PMJAY) in September, 2018. PMJAY is a centrally sponsored scheme. Under this scheme - health and wellness centers (HWCs), sub health centers, and primary health centers (PHCs) are being strengthened as HWCs. The services in HWCs will be provided through a MLHP/CHO placed at a HWCs and medical officer at PHC (rural/urban). The MLHP/CHO will undergo a certificate in community health through IGNOU or public university.11 CHO are healthcare workers with training less than that of a physician but greater than that of more ordinary nurses and other medical assistants. India is a second most populous nation in the world and also a developing country. As per the WHO, by 2024 the projected population would be 1,447,560,463.12 With this growing population, India is in a great demand of doctors and nurses.[1] At present India has a shortage of an estimated 600,000 doctors 14 despite of more than 529 government and private medical colleges having an annual intake of 70,978 students.15 According to Indian nursing council (INC), New Delhi, there were 1.79 million registered nurses/midwives in India (as of 2014). Recommended WHO ratio for nurse to population is about 1:500 and as per NHP 2016 data, on average, India's nurse-to population ratio is 1:475.14, including registered nurses and midwives and lady health visitors. But still there is shortage of around 13,000 nurses as per rural health statistics 2016 data, because Government of India has

a norm of one nurse per PHC and seven per CHC that leads to shortage of nurses in rural health system.[2]

There are around 30.4 lakhs nursing personnel registered in the country as on December 31, 2018, as per INC.17 As per NHP, the total number of registered allopathic doctors was 1,041,395 and Ayush doctors was 773,668 as up to 2017.18 These statistical data speaks about existing number of doctors and nurses toward the number of population, when we deeply look into rural health-care services, sub-centers are not having doctors, and many of the PHCs are serious need of doctors. Figures 2 and 3 explains about current scenario of our rural health-care system, there are serious requirement of doctors but presently our country is not having enough number of doctors, to come across this deficiency the use of graduate nurses as community health officer after additional training would be more betterment then nothing. So community health officer will bridge the gap between population and sub-center, primary health center, and community health center. CHO's are permitted to serve the community independently to diagnose, manage, and treat minor ailments and impairments and also engage in preventive.

Roles and Responsibilities of Cho

CHO is evolving concept in health-care sector and their roles and responsibilities are purely population oriented in public health. They are expected to provide specific service delivery, leadership, supervision, management, and take pro-active role in all the activities at community level, organize various health program and activity in health promotion according the need. These roles of CHO help to bridge the gap between health-care facilities and population seeking health care.[3]

Health-Care Services

1. Maternal healthcare: Prenatal care such as antenatal checkup, screening for high risk, immunization and supplementation, child birth, postnatal care, and if require referral to higher center
2. Neonate and infant healthcare: Management of high-risk newborn, screening of congenital anomalies, IMNCI services, and immunization
3. Childhood and adolescent healthcare: Adolescent health counseling, identification of drug abuse, detection of any deficiency, nutritional supplement, and referral services
4. Reproductive healthcare: Family planning, prevention and management of STI, identification of gynecological problems, and referral services
5. Communicable diseases: Diagnosis and treatment of vector or water borne diseases, provision of DOTs and (disability prevention and medical rehabilitation) services for leprosy along with referral services
6. Illness and minor ailments: Identification and management of fever, respiratory infection, diarrhea, cholera, skin rashes, pain, typhoid, etc
7. Non-communicable diseases: Screening, prevention, control, and management along with follow-up and maintenance of treatment modalities

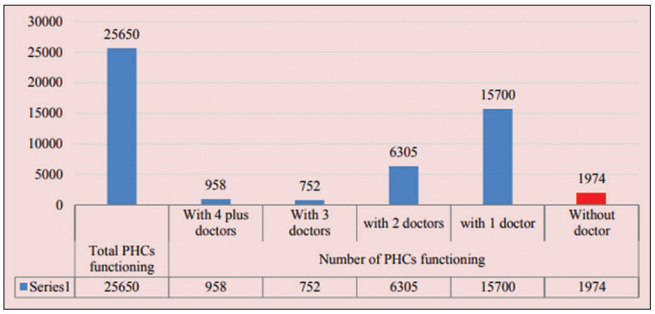

Figure 3: PHC with doctors and without doctor

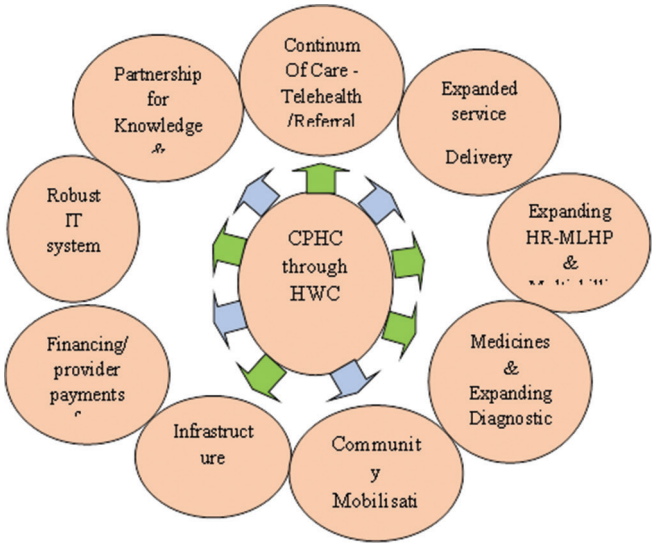

Figure 2: The key elements for roll out of CPHC through HWC

Figure 4: Skills and training for CHO

8. Eye and ENT: Screening along with primary care of ophthalmic and ENT problem and referral services of any emergency
9. Oral health: Regular checkup and screening of oral health. Geriatric and palliative care: Health camp organization routine checkup
10. Emergency services: Burn, injury, trauma along with first aid management. Mental healthcare: Screening and counseling along with referral services. Administrative and supervision services
11. Administrative services: Guidance to other co-health workers and maintain inventory, report submission
12. Care pathway: Provide specific care according to standard treatment guidelines
13. Case coordinator and manager: Provide communication to higher authority regarding specific case, coordinate in care, and management of care
14. Disaster and outbreak of disease: Local response to disease outbreak and early management of disaster
15. Fund management: Support the team for entitling the fund for various projects and program
16. Data management: Record population data with various health indicators and communicate it
17. Environmental role: Education to community, speak about safe water, sanitation, disposal of waste, pollution control, and identify environmental hazards and control. Other skills communication skills, interpersonal relationship skills, transcultural competence, assessment skills, training capability, professionalism, advocacy, education, and facilitation.

Training Program for CHO

1. Certificate program of community health: 6 months duration
2. Training program on new health policy: 5–7 days every year
3. Digitalize application training program: 3 days
4. Regular training from ECHO platform [Figure 4].

Literature Survey in CHs Provided

Desai *et al*. (2020). Since we have shortage of doctors and specialists, the shift in role to MLHP will relieve the overburdened doctors and specialists, at least in rural health setting. MLHP has the limited license only in primary and preventive healthcare to practice medicine at mid-level to such persons, who qualify such criteria as may be specified by regulations which will have an overwhelming representation of doctors. This initiative by government of India will help to provide easy and affordable health care services to the population which also plays an important role for UHC in India.[4]

Bhaumik *et al*., (2020). CHWs play an important role in the prevention and control of pandemics like COVID-19. This is relevant and feasible in countries that already have existing CHW programs. However, there is a need for role clarity, further training, and regulation to ensure preparedness of CHWs in pandemic-like situations. The use of CHWs in countries without pre-existing CHWs programs may be challenging considering the health systems reorientation needs and the lack of established community relationships. Applicability of available evidence on CHWs for pandemic response should be considered by such countries before embarking on ambitious CHW programs amid a public health crisis.[2]

Khetan *et al*. (2019). SEHAT demonstrates that an integrated intervention through CHWs can lead to improved control of hypertension in a developing country, with an inconclusive effect on controlling diabetes. Given the simplicity of the intervention and robust results, these findings have potential implications for all developing countries that face a similar burden of NCDs.[5]

Komaromy *et al*. (2018).CHWs provide valuable support to communities around the world, leading to improved population health. For example, polio eradication in India would not have been possible without vaccination and education efforts of CHWs. CHW visits to promote hand washing helped to reduce all childhood diarrhea and pneumonia cases in Pakistan by 50%. CHWs need ongoing training and mentoring to maximize favorable impact on health in their communities. The ECHO model offers an effective way to provide this. To take advantage of the great promise of the ECHO model worldwide and to tailor programs to each region, it will be important to understand the needs of local communities and of CHWs.[6]

Ballard and Montgomery (2017). Variations in recruitment, supervision, incentivization and equipment may improve CHW performance. Practitioners should, however, assess the relevance and feasibility of these strategies in their health setting before implementation and researchers should consider conducting component selection experiments on a greater range of interventions to improve performance. Nonetheless, mounting pressure to meet ambitious new international health goals and avoid repeating mistakes of the past underscore the timeliness and relevance of these findings.[7]

Tripathy *et al*., (2016). The managers and policy makers should recognize the importance of non-financial motivators such as interpersonal relations, family support, skill, and career development opportunities. Frequent supervision and continuous training are essential to maintain high levels of motivation. Policy-makers and program implementers can use the various sources of motivation as a guide to design incentive structures and not just consider organizational level as a source of motivation to ensure the sustainability of CHW programs.[8]

Schneider and Lehmann (2016). CHWs have reemerged as significant cadres in low- and middle-income countries and are now seen as an integral part of achieving the goal of UHC. In international guidance and support, the emphasis is increasingly shifting from a focus on the outcomes of CHW-based interventions to the systems requirements for

implementing and sustaining CHW programs at scale. A major challenge is that CHW programs interface with both the formal health system (requiring integration) and community systems (requiring embedding) in context-specific and complex ways. Collectively, these elements and relationships can be seen as constituting a unique sub-system of the overall health system, referred to by some as the community health system. The community health system is key to the performance of CHW programs, and we argue for a more holistic focus on this system in policy and practice. We further propose a definition and spell out the main actors and attributes of the community health system and conclude that in international debates on UHC, much can be gained from recognizing the community health system as a definable sphere in its own right.[9]

Saprii *et al*. (2015) The ASHA program in India is an ambitious CHW scheme that offers an opportunity for the state government and policy makers and practitioners to improve health. There is need for better understanding of the opportunities and challenges faced by ASHAs in diverse Indian contexts, and this study has highlighted the challenges and realities of this work in rural, conflict-affected Manipur. In the context of rural Manipur, ASHAs were valued for their contribution and promoting opportunities to support maternal health education and ability to provide basic biomedical care, although their role as social activists was considered less substantial. Availability of monetary incentives, fair and commensurate to effort, is an important element for the continued participation of ASHAs. A well-equipped and functional health system can facilitate ASHAs' ability to perform their roles effectively and at the same time raise their credibility and trust in the community. There is a need to explore how ASHAs may better negotiate their gendered and professional roles in a patriarchal society, such as the socio-cultural context in Manipur and be appropriately supported to drive forward their activist role.[10]

Theobald *et al*., (2015, December). UHC is gaining momentum and is likely to form a core part of the post millennium development goal agenda and be linked to social determinants of health, including gender; Close to CHPs are arguably key players in meeting the goal of UHC through extending and delivering health services to poor and marginalized groups; Close to s are embedded in communities and may therefore be strategically placed to understand intra household gender and power dynamics and how social determinants shape health and well-being. However, the opportunities to develop critical awareness and to translate this knowledge into health system and multi-sectorial action are poorly understood; enabling close to CHPs to realize their potential requires health systems support and human resource management at multiple levels.[11]

Gautham *et al*., (2015). There are few tried and tested mobile technology applications to enhance and standardize the quality of healthcare by frontline rural health providers in low-resource settings. We developed a media-rich, mobile phone–based clinical guidance system for management of fevers, diarrheas, and respiratory problems by rural health providers. Using a randomized control design, we field tested this application with 16 rural health providers and 128 patients at two rural/tribal sites in Tamil Nadu, Southern India. Protocol compliance for both groups, phone usability, acceptability, and patient feedback for the experimental group were evaluated. Linear mixed-model analyses showed statistically significant improvements in protocol compliance in the experimental group. Usability and acceptability among patients and rural health providers were very high. Our results indicate that mobile phone–based, media-rich procedural guidance applications have significant potential for achieving consistently standardized quality of care by diverse frontline rural health providers, with patient acceptance.[3]

Mishra (2014).Mainstream public health writings on delivery of integrated services tend to focus on the health services *per se* and modalities of their integration, assuming that effective supply chain management, infrastructure and human resources would achieve integration. These writings approach health service delivery itself as a technical and mechanistic process. Based on ethnographic evidence, this article shows how building social relations of trust and teamwork are critical to health workers' efforts in delivering integrated services. The role of trust in health-care has traditionally been examined in relation to doctor–patient relationships. However, recent anthropological literature has sought to bring social relations of trust to the center stage in the study of health systems and policies. Drawing on empirical evidence from a number of contexts, these studies have demonstrated that trust matters to health systems. Health workers in our study reinforced this conviction. These CHWs espouse an integrated approach to care by fostering relations of mutual trust, teamwork, cooperation, addressing community health and other needs, promoting a continuum of care from curative to preventive care and valuing the role of regular and effective communication with villagers and also amongst health workers themselves. These values are indeed the cornerstone of a primary health care ideology that promotes democracy, equity and participation (Nichter, 1986). These values are enshrined, at least rhetorically, in India's NRHM.[12]

Bhatia (2014). There is a growing acknowledgment of the rights of the CHWs within the ASHA and Anganwadi programs, but like CHWs worldwide they are largely deprived of standard service conditions. The roots of this widespread practice lie in the expectation that the lowest rung of the health services should work in the spirit of community service. This deprives CHWs of their rights as workers. Where these CHWs are women, caring for the health of their own community is often seen as an extension of their nurturing role within their families. This is a gender issue that is easily overlooked. Such values do not fit into the current realities of the CHWs' lives. There is a need to redefine the basic characteristics of CHWs and to delineate their designations, tasks and timings, in order to protect their rights in large–scale programs. When the CHWs are in national programs, they facilitate the government's

health programs. Therefore, they are legally entitled to standard service conditions, and the modes of governance need to be changed to facilitate their incorporation as fully-fledged members of the public health team.[13]

Ekstrand *et al*., (2013). The high rates of stigma and discrimination among healthcare providers in these urban Indian healthcare settings appear to be driven primarily by negative feelings towards PLHIV, lack of experience as well as misconceptions and fear of casual transmission. Stigma reduction interventions are thus urgently needed to target transmission misconceptions and to increase interactions with PLHIV. Such programs need to be designed and implemented in collaboration with PLHIV networks and use a rights-based and gender-sensitive approach. To be both effective and sustainable, interventions should ideally make use of professional role models and be integrated into existing training structures in hospital clinics and the curricula in nursing and medical schools.[1]

Jarhyan *et al*., (2012).Unqualified PRHPs do provide substantial outpatient healthcare services in rural Ballabgarh, India. This study revealed their inadequate biomedical waste disposal practices and the need for monitoring and training them in this and safe injection techniques. It is strongly recommended that they be utilized in important public health programs such as disease surveillance.[14]

Armstrong *et al*., (2011) The mental health training facilitator's manual demonstrated potential to be an effective way to improve some aspects of mental health literacy among CHW, including the recognition of mental disorders in vignettes and the perceived helpfulness of inappropriate pharmacological interventions. The Armstrong *et al*. International Journal of Mental Health training had a limited positive impact on attitudes toward people with mental disorders. Strategies for improving the training could include facilitating contact with consumers of mental health services, including stories of recovery, and providing information on the effectiveness of interventions for mental disorders.[15]

Limitation of Community Health Services

The following limitations were beyond the control of the researcher:

- Empirical research is limited pertaining to the understanding of Somali culture
- Health-care professionals' understanding of Somali culture is not well documented
- The American Medical Association does not support mandatory cultural competence training for physicians
- Ideally, the researcher would have surveyed all health-care professionals employed by the rural primary care clinic
- Data were self-reported from participants, and may not be 100% accurate
- The Integrated Behavior Model cannot assess all attitudes and beliefs. This study isolated logical beliefs and those that were likely to have the greatest impact upon providing culturally competent care to Somalis
- Direct measures were not obtained through elicitation interviews.

Delimitations the Following Delimitations Were Used to Limit the Scope of the Study

1. Health-care providers included physicians, nurse practitioners, and physician assistants who were in non-administrative roles providing direct patient care
2. The survey was administered to health-care providers at a rural primary clinic in Minnesota
3. The survey used to gather data was available for 2 weeks from April 18, 2012 to May 2, 2012
4. Survey questions were based on the indirect measures of the Integrated Behavioral Model
5. 80 health-care providers at the participating primary care clinic were identified as possible participants
6. The survey was sent by e-mail and completed online using Zoomerang TM data collection systems.

Advantages and Benefit of Community Health Services

CHS help to connect community members to available services and resources. They provide benefits to individuals, communities, providers, and payers. Since CHS are often members of the communities they serve, and rural communities typically have strong community connections, CHS have an opportunity to:

1. Develop trusting, one-on-one relationships with patients
2. Act as a liaison between the healthcare system, patients, and families/caregivers
3. Gain support from other organizations serving the community
4. Strengthen care coordination by connecting patients with available healthcare and social support services
5. Extend the reach of healthcare providers and services, which is particularly helpful in areas with shortages of providers
6. Deliver services that are appropriate based on the patient's language and culture
7. Give back to their communities.

Conclusion

India's health scenario currently presents a contrasting picture. While health tourism and private healthcare are being promoted, a large section of Indian population still reels under the risk of curable diseases that do not receive adequate attention of policymakers. India National Rural Health Mission is undeniably an intervention that has put public health-care upfront. Although the government has been making efforts to increase health-care spending through initiatives like the National Rural Health Mission, much still remains to be done. The priority will be to develop effective and sustainable health systems that can meet the dual demands posed by the growth

in non-communicable diseases and peoples' needs for better quality and higher levels of health care.

Conflict of Interest

These is no conflict of interest.

Funding

None.

Acknowledgment

I would like to thank Mr. Pranay Yadav, MANIT, Bhopal. Research staff in HEFA, Funding agency, Government of India.

References

1. Ekstrand ML, Ramakrishna J, Bharat S, Heylen E. Prevalence and drivers of HIV stigma among health providers in urban India: Implications for interventions. J Int AIDS Soc 2013;16(3 Suppl 2):18717.
2. Bhaumik S, Moola S, Tyagi J, Nambiar D, Kakoti M. Community health workers for pandemic response: A rapid evidence synthesis. BMJ Glob Health 2020;5:e002769.
3. Gautham M, Iyengar MS, Johnson CW. Mobile phone-based clinical guidance for rural health providers in India. Health Inform J 2015;21:253-66.
4. Desai S, Bishnoi RK, Punjot P. Community health officer: The concept of mid-level health care providers. Int J Community Med Public Health 2020;7:1610-7.
5. Khetan A, Zullo M, Rani A, Gupta R, Purushothaman R, Bajaj NS, *et al*. Effect of a community health worker-based approach to integrated cardiovascular risk factor control in India: A cluster randomized controlled trial. Glob Heart 2019;14:355-65.
6. Komaromy M, Ceballos V, Zurawski A, Bodenheimer T, Thom TH, Arora S. Extension for Community Healthcare Outcomes (ECHO): A new model for community health worker training and support. J Public Health Policy 2018;39:203-16.
7. Ballard M, Montgomery P. Systematic review of interventions for improving the performance of community health workers in low-income and middle-income countries. BMJ Open 2017;7:e014216.
8. Tripathy JP, Goel S, Kumar AM. Measuring and understanding motivation among community health workers in rural health facilities in India-a mixed method study. BMC Health Serv Res 2016;16:366.
9. Schneider H, Lehmann U. From community health workers to community health systems: Time to widen the horizon? Health Syst Reform 2016;2:112-8.
10. Saprii L, Richards E, Kokho P, Theobald S. Community health workers in rural India: Analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles. Hum Resour Health 2015;13:95.
11. Theobald S, MacPherson E, McCollum R, Tolhurst R. Close to community health providers post 2015: Realising their role in responsive health systems and addressing gendered social determinants of health. BMC Proc 2015;9:S8.
12. Mishra A. 'Trust and teamwork matter': Community health workers' experiences in integrated service delivery in India. Glob Public Health 2014;9:960-74.
13. Bhatia K. Community health worker programs in India: A rights-based review. Perspect Public Health 2014;134:276-82.
14. Jarhyan P, Singh B, Rai SK, Nongkynrih B. Private rural health providers in Haryana, India: Profile and practices. Rural Remote Health 2012;12:1953.
15. Armstrong G, Kermode M, Raja S, Suja S, Chandra P, Jorm AF. A mental health training program for community health workers in India: Impact on knowledge and attitudes. Int J Ment Health Syst 2011;5:17.

How to cite this article: Nirapure JM. A Bird Eye View on Recent Developments of Community Health Providers in India. Int J Nur Res. 2022;8(3):81-87.