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## SHORT COMMUNICATION

# Empowerment of Community for Universal Health Coverage: Home Health Guides, the sustainable solution for the human resource gap

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## ABSTRACT

The shortfall in the health workforce laid the foundation to establish a supplementary cadre of healthcare workers at the grassroots level. This additional team would serve to strengthen the current healthcare infrastructure and facilitate effective communication and coordination between the community and the healthcare system. The importance of this cadre was recommended in various health committees and was revealed through previous ICMR research and followed in the ongoing Labike project which aims primarily to evaluate the Acceptability, Scalability, and Linkage within the Health System of ICMR Pre-Validated Labike/Technologies for Screening and Diagnosis in Rural and Urban Population.

We identified young volunteers both from rural and urban settings to participate in the study without incentives. The Certificate of home-based healthcare course was given to these volunteers in coordination with IGNOU and around fifty families were assigned to each candidate to monitor and record the healthcare needs of these families. Although the idea was extremely useful for the community and the healthcare delivery system. However, we faced many challenges at every level starting from the identification of the candidates, enrollment in the course, training etc.

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We have seen significant growth in the health workforce; however, the Rural Health Statistics 2021-22 report reveals that as of March 31, 2022, there exists an overall deficit (excluding the surplus in certain states) in the positions of Female Health Worker (HW) / Auxiliary Nurse Midwife (ANM). This shortfall amounts to 3.5% of the total demand, based on the established standard of one HW (F) / ANM per Sub Centre (SC) and Primary Health Centre (PHC) in rural regions. Similarly, there is a deficiency of allopathic doctors in PHCs in India, with a shortfall of 3.1% in relation to the whole national demand. According to the data, a significant proportion of specialists, specifically 79.5%, are not meeting the necessary criteria for the current Community Health Centres (CHCs). Likewise, an insufficiency of 35.5% is observed in the availability of Health Workers (Female)/ ANM in PHC in urban areas, relative to the overall need at the national level in India[1]. Nevertheless, the aforementioned data mostly pertains to the healthcare workers present within the healthcare facilities. In order to enhance public health and achieve the intended results, it is imperative for the community to establish a supplementary cadre of healthcare professionals. This additional team would serve to strengthen the current healthcare infrastructure and facilitate effective communication and coordination between the community and the healthcare system.

The importance of a trained healthcare workforce has been emphasized by various public health committees. In 1946, Bhore committee mentioned a list of trained manpower for the Primary Health Centres. Chaddha Committee in 1963, recommended the vigilant activities of trained health workers in proportion to one in 10000 population for National Malaria Eradication Program along with Family Planning. Mukherjee Committee advocated a designated healthcare staff for family planning only. Kartar Singh Committee in 1973 amalgamated the entire peripheral health workforce into a single multipurpose worker cadre.

The idea of establishing a proficient healthcare workforce to enhance community empowerment through the identification of proactive volunteers emerged as a result of previous research conducted by the Indian Council of Medical Research (ICMR). The research conducted by ICMR revealed that a limited number of community people possess the necessary skills to effectively connect the community with the established healthcare system, in addition to the healthcare professionals already there.

Few preceding studies conducted by the ICMR task force revealed that frontline health professionals, specifically ASHA and ANM, are engaged in monthly home visits to address various health issues affecting all members of a given family. This was perceived as a way to document their monthly report on health status. Nevertheless, it was recognized that the primary obstacle in maintaining community health data is the excessive workload faced by healthcare professionals and the absence of dedicated personnel for record-keeping purposes. Therefore, those studies concluded that the training of local health volunteers is a recommended course of action. It was also felt that training should not be confined to good record keeping but it should also cover the home-based health care. The recognition of the significance of formal certified training arose from the realization that individuals could neither engage in self-employment nor become recognized healthcare professionals without undergoing requisite training and obtaining certification.

The ICMR has initiated a project entitled "*Task Force Study for Evaluation of Community Level Acceptability, Scalability and Linkage within the Health System of ICMR Pre-Validated Labike/Technologies for Screening and Diagnosis in Rural and Urban Population- An Implementation Research*". The present undertaking is a continuous endeavour cantered around the concept of providing healthcare services at one's doorstep. The process of selecting Home Health Guides (HHGs) is a crucial element of this study.

During the process of designing above-mentioned project, insights and knowledge gained from previous investigations were integrated. Several issues were observed pertaining to the training, roles, and responsibilities of HHGs. For the training of HHGs, the Indira Gandhi National Open University (IGNOU) course was adopted based on

extensive research conducted on various available courses and curricula, taking into consideration the associated training costs and their commercial feasibility. It was also realized that the inclusion of a certified Yoga course and emergency cardiac care training, in addition to the IGNOU course, would enhance the comprehensiveness of the health guide for preventative home health care. This expanded curriculum holds significant potential for commercial demand and opportunities for self-employment. By adopting this approach, the HHGs might become a valuable resource for both the government and the community, while avoiding any associated budgetary burdens.

A proposal was put up suggesting that these HHGs can achieve self-sustainability by implementing a fee-based system for the on-demand home-based healthcare services they offer to 50 households within the community. However, it was proposed after the completion of the project because it might dilute the self-motivation factor towards social welfare and also dilute the purpose of assessing the sustainability of this idea without providing financial incentives for home-based healthcare. A total of 25 HHGs per site was proposed to be necessary, taking into consideration the presence of floating and migrating populations. The objective is to provide training of two batches per site, for health data management and doorstep preventative health care. The logistics required for one HHG catering to 50 families were determined in a prior study conducted by the ICMR. This estimation was based on the observation of the demand and need within the community. The study found that one part-time HHG was able to effectively address the needs of 250 individuals through monthly personal contact.

The matter of providing compensation to volunteers remains unaddressed in this proposal, as it was perceived that once the HHGs receive training, they will possess the necessary skills to become self-employed healthcare providers and will not add any financial burden on the healthcare system. The project allocates funds just for the training and provision of kits for preventive health services for each health guide.

According to the project proposal, it is recommended that monthly meetings be held on a predetermined date with local stakeholders. The purpose of these meetings is to disseminate local health data, engage in discussions, and implement locally suitable interventions.

This collaborative effort involves various stakeholders such as local practitioners, administration, grassroots workers, NGOs, and volunteers. In addition, updating a user-friendly health data website (as per ABDM /EHR norms) to make use of a simple data entry format is also mentioned as one of the important roles of HHGs.

The ongoing project is a multi-centric study, involving six states as active participants in its implementation. The aforementioned states encompass Jammu and Kashmir, Assam, Uttar Pradesh, Bihar, Madhya Pradesh, and Tamil Nadu. The district Varanasi has been selected as a sample site to capture the perspectives and encounters of the inhabitants residing in the state of Uttar Pradesh. Varanasi, situated in India, holds the distinction of being one of the most ancient towns in the country, renowned for its rich heritage of art and culture. This place attracts visitors from all parts of the globe due to its distinctive characteristics shaped by conventional thoughts and beliefs. This conventional approach is also observed in the health-seeking behavior of its population. For the purpose of our study, Sarai Dangari hamlet was chosen in Varanasi to represent the rural perspective, and the ward Bajardiha to represent the urban perspective. Both of the areas are part of the same development block in Varanasi. It has been noted in both rural and urban areas that a significant proportion of the residing population has a lack of education and awareness about health-related matters. The majority of the residents of Sarai Dungari primarily engage in dairy farming, whereas those residing in Bajardiha are predominantly involved in the saree weaving industry. Individuals in these areas often exhibit a preference for maintaining their conventional lifestyle and may not always be inclined to adapt to contemporary trends. For the assignment of HHG, individuals who have completed high school and possess an active outlook were mandated. Nevertheless, the process of

identifying active volunteers from the community for the purpose of health promotion and disease prevention proved to be a challenging endeavour.

The study commenced with a series of meetings including community leaders, Accredited Social Health Activists (ASHAs), ANMs, and healthcare workers. One of the purposes of these sessions was to encourage the active involvement of young individuals in the study as HHGs. They distributed information about the program and the role of HHGs throughout their social networks. Some male individuals were found from the designated locations, who were affiliated with a self-help organization and expressed their willingness to participate as volunteers in the research project. In addition, the specialists associated with the ICMR were there to provide support and inspiration to the participants, with the aim of fostering their active involvement in the study. The details of their respective duties and responsibilities were explained throughout each convened meeting. Additionally, it was clarified that they will receive complimentary training from IGNOU.

During the process of candidate selection, it was observed that despite the implementation of several educational efforts by the government, individuals residing even in urban areas continue to face challenges in accessing fundamental education. Furthermore, it was observed that the offer of complimentary training sessions and home-based health care kits did not demonstrate sufficient effectiveness in motivating persons to participate in the study. The assignment was received with hesitance mostly as a result of the lack of any kind of remuneration or incentives. Conversely, female candidates in rural areas require additional motivation to actively engage in community work. Social considerations also played a role, as individuals from certain communities exhibited reluctance to participate in data-gathering efforts conducted by individuals from another community. Even families experiencing problems exhibited a reluctance to engage in communication with one another because of both personal and social factors.

Through the implementation of various meetings and effective counselling sessions, a total of four individuals residing in rural areas and an additional four individuals residing in urban areas were identified as HHGs. The contact details of the identified candidates shared with the ICMR and IGNOU. In order to get admission to the IGNOU course, prospective students were required to complete an online application form. In order to complete the form, individuals were obligated to remit the admission money via an online payment method. The task of disbursing admission fees was perceived as challenging due to the extensive paperwork and administrative procedures involved. Consequently, a decision was made to provide the individuals with a physical application form, accompanied by a request to complete the form and include their high school certificate. The completed forms were submitted to the IGNOU Regional Centre in Varanasi, and the total fees for all candidates were remitted to IGNOU via Enterprises Resource Planning (ERP). Subsequently, the individuals were registered by online means on the official website of IGNOU, provided by the regional centre at Banaras Hindu University. The commitment level of the students can be further perceived by the fact that after such extensive exercise of enrolment in the course, two out of four candidates from our rural settings withdrew their candidature even after free enrolment in the course.

Similar to this project, Government of India launched a national Community Health Worker scheme- Village Health Guides (VHGs) in 1977 to provide preventive, promotive, and basic curative care to rural populations. Although this program had promising origins in smaller demonstration projects, it failed to deliver the hoped-for impact at scale and was abandoned.

Several systemic factors emerge as main contributors to the failure of the VHG Scheme, namely, a lack of support from the formal health sector, an overly hasty implementation of the scheme, and poor communication between the government and health centers about the role of the VHGs. The remuneration structure and the VHG selection process were at the root of the program's shortcomings at the implementation level[2, 3].

The project has tried to incorporate the lessons from the previous studies. This article aims to provide a concise overview of the importance of considering financial, social, and regional considerations while implementing community empowerment initiatives through volunteer upskilling projects, with the ultimate goal of ensuring their long-term sustainability. The primary obstacle in identifying health volunteers was determined to be the absence of incentives or adequate compensation for their assignments. Despite the initial proposal to issue certificates to all trainees as a means of encouraging their involvement in the study as volunteers, this approach was ultimately deemed inadequate. However, by incorporating the provision of financial incentives for the services of HHGs. Further evaluation would be the assessment of the process of switching them as a complimentary cadre in the existing health workforce from trained project staff. Such initiative may fill the deficit of health workers and may prove a significant step towards universal health coverage. This is an ongoing implementation research study and the challenges/ observations from the research will be documented as and when required.

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