Short Article

Community engagement for healthcare delivery without incentive: sustainable or not for Universal Health Coverage?

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ABSTRACT

The growing digitalization of health records raises a need to connect every citizen with a digital health ecosystem under the Ayushman Bharat Digital Mission.

Considering this fact, an ICMR-funded project, the human resource in the form of Home Health Guides (HHGs) is envisaged to bridge the gap between the community and the health system as complementary to the existing health workforce. These are active volunteers in the communitywho are educated till matriculation andare willing to work in the field for at least two or three hours per day without any remunerations. Their assigned roles are to record and update the health-related information of the assigned families. They are also supposed to assesshealth emergencies, guide the community regarding their healthcare needs, and link them with the existing healthcare system.

As part of the project, we provided hand-holding support, IGNOU course fees, certificates, yoga training, Karmyog training, first aid kits, and stationary items for HHGs for almost two years. Even still, these volunteers were less motivated and avoid their responsibilities. Therefore, for scalability and sustainability of the HHG scheme, it is necessary to change the eligibility criterion and add other incentives crucial for their academic performances as well as daily life and careers.

KEYWORDS

Community engagement, Universal health coverage, doorstep healthcare, village health guides.

INTRODUCTION

Community engagement can be achieved by empowering individuals and families to taking owner ship of their health and that of community, culturally appropriate tailored services given to the community after engaging individuals from the community and strong relationship between health care providers and community members. Though attainment of Universal health coverage without sustainability and incentive is a biggest challenge.

At the Alma Ata International Health Conference in 1978, the World Health Organization (WHO) set the "Health for All" goal by the year 2000.This goal was reaffirmed as the declaration of Astana in 2018, which endorsed community empowerment to strengthen primary health care for universal health coverage. Access to a full range of quality health services they need, when and where they need them, without financial hardship is called Universal Health coverage(1).

In India, the National Health Policy 2017 also recommends provision of essential healthcare services to all its citizens with out suffering any financial hardships(2). Worldwide, healthcare sector stakeholders are trying many initiatives to achieve Universal Health Coverage. Such targeted steps are aligned directly with the Sustainable Development Goals (SDG) 3 related to good health and well-being, and SDG 17 related to partnership for the goals. Socially, SDG 5 and 10 related to gender equality and reducing inequality as well as economically SDG 8 and 16 related to decent work and establishing strong institutions can also be attained by such collaborative initiatives(3). Among these initiatives, decentralizing healthcare and bridging the gap between the health care system and the community has always been considered critical for healthcare services to cater to the needs of the community.

If we look into history, globally the concept of community-based healthcare services started with the 'Farmer scholars' in the 1930s. These were the forerunners of the Barefoot doctors of China. In the 1960s-70s, Community health worker programs emerged in many countries, especially in Latin America(4). The Indian government established the Rural Health Scheme in 1977 in response to the Shrivastav Committee's recommendations, with the intention of "Putting people's health in people's hands". This was done by identifying community members as village health guides (VHGs).

Although this program had promising origins in smaller demonstration projects, it failed to deliver the hope for impact at scale and therefore, it was abandoned. Despite the Government's efforts, many systemic factors were responsible for the failure of the Community health workers scheme, namely a lack of support from the forma health sector, overly hasty implementation of the scheme, and poor communication between the government and health centres about the role of the VHGs. The remuneration structure and the VHG selection process was at the root of the program's shortcomings(5).

Since 2005, with the inception of the National Rural Health Mission (NRHM), Accredited Social Health Activists (ASHAs) have been added as a bridging link between a pool of 250 families/ 1000 community members with the existing health care system.

Apart from healthcare service delivery, the growing digitalization of health records raises aneed of more health workers to connect every citizen with a digital health ecosystem under the Ayushman Bharat Digital Mission. It was also required to monitor smaller pools of communities of around 50 families and share their health data with the existing community health workers, who are bound to serve a larger population. This will not only lead to better monitoring and supervision of the community for their healthcare needs but also improve the quality and utilization of healthcare services.

Going forward, an ICMR-funded project has a component of community health volunteers as a Home Health Guide (HHG) to assist the existing community health workforce. This study is ongoing and being conducted in various districts of six different states of India. In Uttar Pradesh, Varanasi is the selected district and the study is being conducted in collaboration with the Department of Community Medicine, Institute of Medical Sciences, BHU. One of the study objectives is to assess the challenges related to the selection of home health guides, their activities in the field, and the community's perspective on the concept of home health guide.

As per the research proposal, the HHGs are active volunteers in the community who are educated till matriculation and are willing to work in the field for at least two to three hours per day. Their assigned roles are to record and update the health-related information of 50 households. They are also supposed to assess health emergencies, guide the community regarding their healthcare needs, and link them with the existing healthcare system.

The present study is an observational cross-sectional study conducted in selected rural and urban areas. The main objective was to identify volunteers with predefined criterion, who can work as HHG after completing IGNOU course and training of Yoga through ICMR validated government certified empanelled institutions and facilities, curriculum for life style diseases are included for skilling of HHGs in home settings.

In this process five candidates from rural areas (two males and three females) and four from urban

areas (three males and one female) were identified as HHGs. Our challenges begin even from the start of process of identification and selection of volunteers as HHGs. Multiple meetings were conducted at various levels i.e. health workers, Key influentials, Gram Pradhan and community members to make them understand the objective of identification of HHGs. Both boys and girls high school were also visited in the area for the same purpose. Eligibility criterion, benefits, free training, kits and outcome was explained to them in detail.

At the beginning they were reluctant to participate without any monetary incentive, however after repeated visits and continuous motivation ten candidates agreed to work as HHG from the selected area. Almost half were student (both school going and drop out) and rest were involved in part time business. One of them withdrew even before starting the training and another had to move to the other city. Finally eight consented to take part in the scheduled training. List of HHGs were shared with the funding agency. After so much of motivation to become HHGs and facing challenges in whole process of enrolment, still two female candidates from the rural area submitted their withdrawal letters. They were contacted again to find out the reason and motivation.

Further, an academic counsellor from the institute was identified to facilitate the supervised training of HHGs. After enrolment, digital copies of study materials were distributed to all HHGs. However, many participants expressed discomfort with digital formats and requested printed reading materials. Which was later provided by the IGNOU at their postal addresses.

Online training sessions were scheduled for two weeks. Attendance was poor due to participants' ongoing academic & personal commitments. Despite repeated reminders and notices through WhatsApp group messages & telephonic calls most of the candidates failed to attend or respond to any of the correspondence. Following the online component of the IGNOU course a practical training schedule was prepared by the academic counsellor. The schedule spanned 20 days, totalling 160 hours, with 8-hour daily sessions. This was communicated to the participants in advance, and daily follow-ups were conducted telephonically. Finally, only one rural and two urban participants attended the practical sessions, with most others unable to join due to academic obligations & personal commitments. Only three candidates appeared for the term-end examination. Field-based training and orientation sessions were also conducted repeatedly in the community & work place.

Observing challenges to engage volunteers for HHG course further, a 7-day online workshop on Yoga, Personality Development, and Communication Skills under the Pradhan Mantri Kaushal Vikas Yojana (PMKVY) was organized by funding agency. Despite clear and repeated communication through WhatsApp and phone calls and travel reimbursement only few participants attended the session or responded to the outreach efforts.

I am XYZ, I have been identified as Home Health Guide (HHG) for my community. I am expected to update the health- related data of few assigned families every month and to provide health related care, suggestions and assistance to those families. Additionally, I have to connect these families to the existing health facilities. All these tasks are expected to be done without incentives.

I have been periodically trained by the project staff and also by theoretical and practical training under certificate course of home-based health care by recognized government agency.

Initially, such roles and responsibilities seemed very exciting and enriching as well. However, it turned out to be difficult task because I am currently pursuing a regular degree course and after coming from my college, I run my cyber café near my residence. Therefore, It became almost impossible to engage in such time consuming task without incentives

HHGs were expected to update health data of all family members of the 50 assigned households by collecting the carbon pages of health dairies every month and to provide health related care, suggestions and assistance to them. According to them it was a time-consuming task and reluctance from the family members added to the challenge of performing their duties in the community and it was difficult to adjust to their existing academic and professional commitment. Community members also needed probing and assistance from HHGs to keep their health data updated.

Though the earlier studies suggest that medication and post-discharge hospital errors can be minimized by effective communication between the community healthcare workers and the patients(6).In previous studies, it was also found that community health workers were able to improve the participant's knowledge and behaviour in Diabetes care(7), the detection of diseases like Malaria(8) and the treatment of mental health cases(9).

Given the importance of community engagement in improving the health status of that community, the need is to consider the issues in performing the roles of HHGs and make necessary changes based on the local and contextual factors. One of the studies recommends that there is a strong need of effective support from the health system, productive interactions between community health workers and health system staff and engagement of the community. However, it requires health sector leadership from national to local levels, support from local government, and partnerships with the community(10).

It is expected that building a trained workforce in the community can improve the quality and utilization of the healthcare system by complementing the existing manpower. As part of the project, hand-holding support, IGNOU course fees, certificates, yoga training, Karmyog training, first aid kits, and stationary items for HHGs for almost two years . Even still, these volunteers were less motivated and avoid their responsibilities. Therefore, for scalability and sustainability of the HHG scheme, it is necessary to modify the eligibility criterion and add other incentives crucial for their academic performances as well as daily life and careers.

Authors Contribution

SK, AK, NA & AB conceptualized the study & designed methodology. AP collected and curated the data. AP wrote the original draft. SK reviewed the final manuscript. NK provided overall mentorship & guidance. All the authors approved the final manuscript.

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Conflict of Interest

There are no conflicts of interest.

Declaration of Generative AI and AI Assisted Technologies in the Writing Process

The authors haven't used any generative AI/AI assisted technologies in the writing process.

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