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Review Article

Role of community health officers: opportunities and challenges

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ABSTRACT

Mid-level health care providers in India were introduced as community health officers under Ayushman Bharat in 2018. There were introduced with objective of providing comprehensive primary health care (CPHC) services through health and wellness centers (HWCs). It is the new cadre that leads the primary care team in providing services under essential care packages at HWCs. They are expected to perform different roles and functions as formulated under the guidelines by Government of India. The job title of community health officer gives the mid-level health care providers, provides opportunity in terms of autonomy, training, management of health and wellness center, leading the team etc., but they face several challenges while performing their tasks under CPHC. The aim of this review paper is to highlight the roles and functions of community health officers and opportunities and challenges they face while delivering services to people.

Keywords: Community health officers, Mid-level healthcare providers, Comprehensive primary health care

INTRODUCTION

The concept of mid-level healthcare provider (MLHP) was introduced a century ago, for increasing access to healthcare services and achieving optimum health among the community people. It is only in the last decade; it has gained momentum to meet the new challenges of health care system. Mid-level health provider (MLHP) is considered as the new emerging work force in the health sector across the globe to provide efficient and cost-effective primary healthcare.[1,2] Countries with weak health infrastructure and inadequate human resource in primary health have adopted this concept.[1-3] Countries have different job titles and scope of practice for MLPs, depending upon their health goals.

MID-LEVEL HEALTHCARE PROVIDER

According to World Health Organization (WHO), mid-level provider (MLP)/MLHP, is a trained, authorized, and regulated professional who work autonomously, after receiving pre-service training at a higher education institution for at least 2-3 years and whose scope of practice includes being able to diagnose, manage and treat illness, disease, and impairment, prescribe medicines as well as engage in preventive and promotive care.[3]

The available evidence indicate that MLHPs are executing several clinical functions that were conventionally handled by physicians. They are making up for the scarcity or absence of health professionals. Their roles have been progressively expanding in LMICs to overcome the challenges of health care system and achieve universal health coverage.[2-4] The MLHPs play significant role in bridging gaps between people and health facilities. They also play a pivotal role in improving quality of life of community people and empowers the healthcare settings.[1]

MID-LEVEL HEALTHCARE PROVIDERS IN INDIA

In India, MLHPs were first introduced as non-physician clinicians under the job title of rural medical assistant (RMA) in the state of Chhattisgarh, India. This state was a

pioneer to start a 3-year diploma course for non-physician primary care providers for public facilities in rural areas in the state. The RMA has been a significant reference point in carving non-physician healthcare providers, including the community health officers (CHO) cadre in India.[5,6] CHOs were brought in to play important part in providing expanded range of essential package of services under comprehensive primary health care (CPHC), one of the two components under Ayushman Bharat. They serve as coordination link to ensure continuum of care and are also envisioned to reduce out-of-pocket-expenditure (OOPE) incurred by families. CHO/MLHP approach has been institutionalized and given legal status under National Medical Commission Act, 2019, which gives limited prescription rights to CHOs.[1]

In India, CHOs are trained nurses with GNM diploma/B. Sc (N) degree or an Ayurveda practitioner who are certified by IGNOU or any other Public health/Medical Universities to lead the primary care team.[1] Evidence has shown that nurses as non-physician providers were able to treat patients as per protocols.[7-9] Many countries in the past have shifted to nurse-based MLHPs. India too adopted the same by including IGNOU modules for MLHP course in B. Sc Nursing and post basic nursing curriculum from the academic session of 2020-21 as mandated by Indian Nursing Council. This enabled instant filling of CHO posts in many states and shifting non-nurse MLHP to nurse-based cadre of CHO.[10]

ROLES AND FUNCTIONS OF CHO UNDER CPHC

Community health officers were launched to lead Ayushman Bharat Health and wellness centers and act as first point of care or source of information for the community people. They have following roles to play.[11]

Client oriented roles

Primary care provider

CHOs provide people centered, holistic health care services under 12 essential care packages to all the people, through HWCs.[5]

Case manager

CHOs manage various health conditions as per standard treatment guidelines and care pathways. They diagnose conditions and initiate the treatment where possible and also dispense medications as prescribed for patients by medical officer.[5,12]

Referral resource

CHOs make timely referrals for complication screening at CHC or refer to specialized services for further management after pre-referral stabilization and do follow ups of back referrals.[5,9,12]

Counselor

CHOs counsel individuals, families for primary and secondary prevention. They counsel for lifestyle modifications and reducing risk factors for various health conditions.[5,12,13]

Role model

CHOs are a role model of health promotion activities and responsive measures like eat right movement, and Fit India Campaign, and arranges wellness activities like yoga sessions on a weekly basis.[5,12,14,15]

Advocate

CHOs advocate for safe environment including safe water, proper sanitation, disposal of waste, pollution control in the area covered by them.[12]

Delivery oriented roles

Coordinator

CHOs coordinate with primary care team members for developing local action plan. They ensure continuum of care by coordinating with PHC/CHC. For addressing local health issues, they coordinate with other health stakeholders like PRI, ULBs, MAS and SHGs. CHO coordinates and facilitates tele-consultation.[5,12,14]

Team leader

CHOs ensure delivery of health services at household levels and empanelment of households through ANMs and ASHAs. The role includes procurement of medicines, conducting regular meetings with the team and reviewing community based assessment checklist (CBAC) forms for effective service delivery.[12]

Liaison

CHOs liaison with the government, community, and local self-help groups for activities under various programs. CHOs liaison with primary care team for early detection of cases in the community.[12] This helps in improving care coordination among health care professionals.

Collaborator

CHOs collaborate with physician at PHC/CHC, schools, health agencies, members of the community for the effective delivery of services.[5,12]

Supervisor

CHOs provide supportive supervision and guides ANM and ASHA in planning and organizing health care activities. They carry out supervisory home visits,

undertakes administrative functions and maintains reports and records of the service delivery. [5,12]

Population oriented roles

Case finder

CHOs screen population for several communicable and non-communicable diseases. CHOs conduct disease surveillance and participate in control activities initiated by the PHC.[5,12]

Leader

CHOs influence community people by taking health promotive measures through different campaigns in the community. They collect population related data and plan and organize services for all people covered under HWC.[5,12]

Change agent

CHOs initiate change for managing NCDs that causes premature deaths in young adults. They facilitate change in health behavior through strategies adopted under care packages.[5,12]

Community developer

CHOs engage in social mobilization of the community for health promotion. They plan and organizes meetings and activities with patient support groups (PSG), Ayushman ambassadors in schools, VHSNCs for addressing identified local health issues.[5,12]

According to the induction module for CHOs by Government of India, the functions of CHO may be classified as given in Table 1.[12]

OPPORTUNITIES FOR COMMUNITY HEALTH OFFICERS IN DELIVERING CPHC

Autonomous

CHOs take autonomous decisions regarding managing and treating various communicable and non-communicable diseases as per standard treatment guidelines (STG). As CHO they also take independent decisions for the utilization of untied fund for effective functioning of health and wellness centers (HWCs).[1,3,12]

Training

CHOs get an opportunity of pre-service training, for diagnosing various disease conditions, screen for NCDs including common cancers, i.e. cervical, breast and oral. The training helps them in managing conditions independently. They also act as the gate-keepers for the secondary and tertiary care services. IT training helps them in recording and updating data of their catchment area in time.[5,16,17]

Table 1: Functions of CHOs under Ayushman Bharat.

Clinical functions	Public health functions	Managerial functions
Early detection, screening and first level management, referral, follow up care, counselling, teleconsultation	Collection of Population based data, planning and organizing services at HWCs, community level action for health promotion and prevention, disease surveillance	Recording and reporting, administrative functions at HWCs, supportive supervision

Continuous mentorship

CHOs are supported by the in-service training programs organized through ECHO platforms and technical teams at District level.[1,5] Mentorship and continuous support helps CHOs, in effective case management and solving problems arising at the HWCs.

During COVID-19, NISHTHA training supported CHOs in managing COVID cases in their community, as they were better equipped to educate their community regarding the disease.[18]

Link in continuum of care

CHOs serve as a key stake holder in enabling the continuum of care by ensuring two-way referral process and follow up of client as prescribed by the secondary/tertiary facility. Through empanelment, CHOs also help the clients in getting services under PMJAY, further bringing down the out-of-pocket-expenditure for the client.[12] It was found that quality patients were referred to the doctors at Taluk and District Hospitals i.e. those needing secondary care, by the CHOs.[14]

Facilitate consultation

CHOs facilitate teleconsultation which aims to reduce the travel expenses of the client for consulting the experts at secondary and tertiary level.[5,12,16] CHOs can fix appointments with consultants, use tele-consultation to improve availability of higher-level care and maintaining the care continuum.[14] CHOs has facilitated 8 crore teleconsultations using e-Sanjeevani, world's largest government owned telemedicine platform.[19]

Empanelment of population

CHOs register the individuals and maintain the family folders, to ensure effective services to target population under specific essential care packages in CPHC. Empanelment also helps beneficiaries in availing the

benefits of the schemes under various national programmes of health and social importance. This has potential in reducing the burden of patients at already congested higher facilities.[5,12,20]

Leading the team

CHOs lead the primary care team to deliver services under CPHC. CHOs supervise the services provided by ASHA and MPWs in community and household level for effective delivery of CPHC services.[20] CHOs also supervise the activities of VHSNCs which are instrumental in arranging health promotion and prevention activities in the community.

CHOs play an important role in formulating the PSGs for ensuring treatment compliance among patients with chronic ailments. Leadership provides opportunity to the CHOs to be involved with all the activities provided through the HWCs.[5,12,14]

Promotion of preventive and health promotive activities

CHOs organize health promotion activities on at least 30 days in a year on days like AIDS day, heart day etc. They involve ASHA, MPWs, PSGs, VHSNCs in mobilizing people for these activities. CHOs get opportunities to coordinate with Health ambassadors and messengers for promoting healthy behaviour among school students through school health program. CHOs take convergence initiatives to address the outbreaks of communicable diseases, with panchayats in their catchment area.[14] Most HWCs have started with the Yoga services provided by the CHO, who got trained for providing these services. CHOs were significant in providing preventive services during COVID-19 pandemic.[5,14]

Use of IT system

CHOs use IT applications in empanelment and registration of beneficiaries, computation of performance indicators, updating records, effective service delivery, managing logistics, and capacity building of the primary care team. The IT system helps in faster availability of data and storing large amount of information by the CHOs. It helps in smooth implementation of services under CPHC. It also gives opportunity to evaluate the performance of CHOs and primary care team for calculating their incentives which further motivates the CHOs and primary care team in providing quality services to the community.[5,12,14]

Diagnostics and dispensing medications

CHOs conduct diagnostic tests to diagnose conditions like anemia, pregnancy, malaria, dengue, and TB, which provide the opportunity in planning for the interventions to manage the case as per the STGs. CHOs are authorised to prescribe medications in consultation with MO-PHC. Their functions give them opportunity to manage cases effectively.[5,14]

Screening for NCDs

One of the major responsibilities of the CHOs is to screen the population for non-communicable diseases like HTN, DM, etc, and initiating treatment based on appropriate STGs or on basis of treatment plan prescribed by medical officer/specialists. This responsibility give opportunity to the CHOs to screen for common cancer like: breast, cervical and oral at HWC level and do the timely referrals for the confirmed cases. [5,12]

Instituting quality standards

CHOs provide quality services by following the STG provided for the treatment of various ailments under the care packages. They are also instrumental in participating in the maintenance of the quality standards at the HWCs through the initiative like Kayakalp, MusQan, and Mera Aspatal. Patient centered and respectful patient care by the CHOs are one of the pillars of maintenance of quality standards in delivering CPHC.[5,21]

CHALLENGES FACED BY COMMUNITY HEALTH OFFICERS IN DELIVERING CPHC

Manpower and material

Shortage of manpower, and critical shortages of equipments and medicines are major challenges for CHOs in delivering the quality services provided under CPHC. Critical shortages of medicines, forces people to buy even basic medicines from private stores, jeopardizing the objective of minimizing the out-of-pocket expenditure.[13,14,23,24] It requires sustained funding and supply chain management to ensure continued availability of the medicines for delivering CPHC.[20]

Work setting and work conditions

As per the guidelines, the HWCs require infrastructure to accommodate room for teleconsultation, drug dispensing and diagnostics and a dedicated area for health and wellness activities like Yoga. The existing sub-centres with only single room and some running in vacant spaces of Seva Kendras or religious places were made operational.[17] These centres lack space for conducting activities under CPHC.[14] Painting and branding of HWCs will not serve the actual objectives of CPHC, rather creating facilities and sufficient infrastructure for CHOs will be only way possible to provide effective services under CPHC.[21,22]

Workload

The activities of the CHOs span from community level to the referral linkages. The key challenge is to provide the quality services for all individuals in the community.[5,12,16] Multiplicity of tasks and recording each task on different digital platforms and on paper in timely manner, reduces the quality performance of the CHOs. The major effect is

seen on supervisory community visits by CHOs. Allocation of additional duties to CHOs interferes in their regular duties at HWCs.[14,17,25]

Poor recognition and support

The newly launched cadre of CHO have no counterpart in terms of job-title in the world leading to lack of support and advocacy.[26] The poor recognition and lack of constant support by the team members also lowers the motivation levels of CHOs, affecting their performance.[25] Lack of training of team members for NCD screening at community level, has a direct impact on CHOs performance.[22] Moreover, MPWs have been in-service for many years and have become used to working in a certain way. This has led to the faulty communication between the CHOs and team members, which resulted in hostility and non-cooperation.[20]

Supervision and training

Continuous support and handholding is a key challenge in maintenance of quality services under CPHC. It has been 6 years since the launch of CHOs, but still the gaps are seen in their competencies to facilitate teleconsultation services.[22] Deficiency in regular training programs is a barrier in optimal performance of the CHOs to provide CPHC.[25,27]

Financing

Lack of funds and untimely payment to the CHOs and other primary team members has a direct impact on the motivation and performance of CHOs in delivering services under CPHC.[28] Moreover, many HWCs are not getting untied funds required for maintenance of services.[17] The complexity in calculation of performance parameters also serves as a barrier in effective functioning. The PBI calculation for female CHOs who availed maternity leave is a concern and reason for their demotivation.[13]

Local community acceptance

Instances where local community denies services from specific gender and demand the services only by doctors lowers the morale and efficacy of CHOs.[29] The communities still prefer the prescription to be made by the doctors. Many panchayat leaders in Maharashtra demanded the services only from doctor (Ayurveda/Allopath) but not by nurses. States like Bihar, Jharkhand recruited CHOs from other states due lack of local candidates which has caused low acceptance among the community people.[14]

Regulation

Variability in the eligibility for CHO post in states, makes it difficult to regulate the cadre by one common regulatory agency. The cadre has most nurses as CHOs functioning at HWCs and are thus regulated by Indian Nursing Council (INC) but having a different regulatory body which could voice their problems as mid-level providers is missing. States like Chhattisgarh and Assam already had a pre-existing cadre of mid-level health providers which are now serving under the same umbrella cadre.[13,14]

Overlapping of job responsibilities

There is lot of overlapping between the roles of MPWs and CHOs apart from organizing OPD services, managing cases as per STGs and prescribing medicines. Majority of the tasks can be shared with MPWs. This leads to role confusion and lack of clarity of the role expected as CHO for delivering CPHC. It leads to lower job satisfaction levels among the CHOs and there are also difficulties in cooperation between different personnel at the HWCs.[17,20,28,30,31]

Validation and acceptance by other health team members

Non-material factors like validation by the supervisors, acceptance in the community are critical factors influencing the retention of the community health officers. Conflict with the supervisors or the primary care teams regarding management of cases can also influence the quality services provided by the CHOs.[25,29] Many CHOs have verbalized facing disrespect from the senior officials which leads them to quit the job.[25]

Transportation

The procurement is made easy through e-Aushadhi, but transportation is required to get medicines from block to HWCs. Moreover, emergency services/referrals also get affected due to lack of transportation. Though some states give transportation expenses for procuring the equipment and medicines from block, but the amount is meagre, which slowdowns the supply of medicines, leading to less effective services by the CHOs.[32,33]

Internet connectivity

Internet connectivity is required for an operational IT system at HWCs. Majority of the HWCs are in rural areas, with lack of internet facility.[17] The teleconsultation services, updation of records and empanelment of the population gets affected due to poor internet connectivity. Moreover, it also affects the capacity building of CHOs provided through ECHO platforms.[5,14,17]

Bio-medical waste management

Biomedical waste management is also a concern as the guidelines suggest the burying of the waste.[5] Many HWCs lack colour coded bags and also disposal of sharps is done only at the PHC level, which requires transportation, as there is no calibration of biomedical equipment.[13] CHOs prevent themselves from the tasks which involves

generation of such waste or they dispose it by burning the waste, adding to environmental pollution.[17]

Conflict and discouragement

The clash in the case management and referral among CHOs and MOs lead to demotivation among the CHOs. The RMA introduced in Chhattisgarh had to faced similar discouragement on the part of prescribing medications which is contradicted by the medical fraternity.[6,34] Many people referred by CHOs to PHC, prefer going to private doctors in nearby areas as they find behaviour of the health staff including the doctors very rude at the PHCs.[13]

STRATEGIES TO OVERCOME CHALLENGES

Filing up all the vacant seats as per the IPHS 2022 guidelines given for HWC-SC.[33]

Expansion of the existing infrastructure, to provide sufficient space for providing services.

Budget allocation for infrastructure expansion for the existing structures.

Training programs and training partners to be increased to train all the primary care team members for all the care packages. More focus should be on increasing the skill competencies of the team members through hands on training.[22]

There should be awareness regarding calculation of the PBI among the Block and District program managers to provide adequate and timely payment to the health care team.[33]

Addressing the gaps in a fixed timeline manner.

Measures to increase internet connectivity in HWCs for smooth functioning and effective delivery.[14]

CONCLUSION

CHO cadre has been introduced to deliver comprehensive services under the flagship program Ayushman Bharat as one of the major components of HWC. CHOs play important roles in providing CPHC to the population under their HWCs. However, there are many challenges faced by the CHOs in delivering the services. There is a need to identify gaps and assess the challenges faced by community health officers, to strengthen the initiative to provide effective care delivery to the community under their care. Health professionals and administration must work on providing support, mentorship, handholding and supportive supervision to the new cadre. Apart from continuous training inputs, they also require updation in treatment protocols under various national health programs, continuous supply of medicines and equipment and a strong IT system to deliver CPHC effectively.

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