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Original Research Article

LANDSCAPE OF SKILLED MANPOWER IN HEALTH: EXISTING GAPS OF TRAINING WITH FIELD EXPERIENCE

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ABSTRACT

Background: Through their grassroots connections between communities and government healthcare institutions, community health workers are integral to India's healthcare system. Despite the size and diversity of this workforce, there are still significant disparities between the training they get and the challenging circumstances they encounter on the job. Employees may not be adequately prepared for the many challenges of delivering community health care, including cultural variations, few resources, and shifting disease patterns, by training programs that usually follow the same curriculum The training and field experience disparities across four key groups—Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs), and Multipurpose Health Workers (MPHWs)—are examined in this narrative analysis. In order to identify systemic issues between standardized training programs and the complex reality of providing community health care, this study examines recent research and policy articles. The most significant findings indicate that the training is too brief, that there are insufficient opportunities for skill development, that the compensation structures are inadequate, and that there are insufficient channels for community input. The assessment makes research-based policy recommendations to increase the likelihood that India's community health workforce will achieve universal health coverage. Redesigning training, developing performance-based incentive programs, and enhancing supervisory frameworks are some of these modifications.

Keywords: Community health workers, Training gaps, Field experience, Health workforce, India, Universal health coverage.

INTRODUCTION

The effective utilization of skilled community health workers, who are the first members of a community to get in touch with the formal healthcare system, is essential to India's aim of universal health coverage (UHC). Beginning in 2005 and subsequently renamed the National Health Mission (NHM), the National Rural Health Mission (NRHM) established a comprehensive network of community health workers to address the healthcare requirements of India's varied population, particularly in underserved rural and tribal regions. In India, there are several varieties of community health workers, each with a unique set of responsibilities, educational requirements, and working environments. The foundation of grassroots health care is comprised of four primary groups: Multipurpose Health Workers (MPHWs), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs), and Accredited Social Health Activists (ASHAs). Together, these teams of medical experts assist more than 2 million individuals and more than 650,000 communities throughout the country.[1,2]

Despite the size and diversity of this workforce, there are still significant disparities between the training they get and the challenging circumstances they encounter on the job. Employees may not be

adequately prepared for the many challenges of delivering community health care, including cultural variations, few resources, and shifting disease patterns, by training programs that usually follow the same curriculum. Additionally, there is still a lack of effective communication between field experiences and training program modifications, which prevents skill gaps and poor health outcomes from improving. In order for the community health workforce to realize its full potential, it is critical to close training and field experience gaps as India attempts to enhance primary healthcare via the Ayushman Bharat initiative.[3,4]

This narrative assessment examines all available data on training-field experience gaps across India's community health worker cadres in order to identify systemic issues and provide evidence-based solutions to enhance policy and practice.

MATERIALS AND METHODS

The guidelines for health policy and systems research,[5] were followed for conducting this narrative review. We used a comprehensive search strategy to locate relevant literature from a range of sources, including government policy documents, WHO publications, PubMed, Google Scholar, and National Family Health Survey (NFHS) data.

Method of Search: Peer-reviewed research, government reports, policy papers, and grey literature published between 2005 and 2024 were all sought for. The following search terms were among the most crucial: "community health workers India," "training-practice mismatch," "ASHA training gaps," "ANM field experience," "health workforce challenges," and "community health worker effectiveness."

The training, fieldwork, and performance evaluations of ASHAs, ANMs, AWWs, and MPHWs in India were examined in studies and documents that met the inclusion criteria. Both qualitative and quantitative research articles were examined. The data was compiled thematically, with a focus on training initiatives, field issues, community feedback, and policy implications. The comparative research was centered on the four cadres and sought to identify patterns common to all cadres as well as challenges specific to each.

3. Cadre Profiles

Accredited Social Health Activists (ASHAs),[6-7]

ASHAs were the largest group of community health workers in India as of 2018. ASHAs were established by the NRHM in 2005–06 as community-based volunteers, serving around 2,500 individuals in urban areas and 1,000 people in rural regions. With continuous training sessions aimed at enhancing knowledge, abilities, and confidence, ASHA training is modular. The first training is broken up into several courses and lasts for 23 days. This covers the cost of transportation, supplies, and trainers. Although individuals with a 10th grade education are recommended, ASHAs must have completed at least the eighth grade. Gram panchayats and community members participate in a process to choose them from within the community. This ensures that they comprehend the locals' culture and are accepted by them. ASHA remuneration is mostly performance-based, with monthly wages varying from ₹2,000 to ₹7,000 dependent on state and individual success. ASHAs provide a wide range of services, including health education, promoting institutional births, assisting with vaccinations, treating minor ailments, and engaging people in community health initiatives. Since they were the first to concentrate on contact tracing and community education during illness outbreaks like the COVID-19 pandemic, their role has expanded significantly.

ANMs (Auxiliary Nurse Midwives),[8-9]

Currently, there are over 208,000 ANMs working in India, making them a significant group of qualified medical professionals. They are sometimes the first qualified medical personnel that villagers see. ANM training, which lasts 18 months and culminates in a diploma, is more rigorous than that of other community health worker cadres. Basic emergency protocols, maternity care, immunization, curative therapy, and family planning are all included in the program. Training costs range from ₹10,000 to ₹50,000 year, depending on the kind of institution (private, state-specific, or government). The educational criteria for becoming an ANM is higher than that of other cadres; must have finished 10+2 course with at least 50% of the possible points. The purpose of this criteria is to ensure that maternity and child health care providers possess the fundamental knowledge necessary to perform the technical skills required for their positions. Depending on where they work, their level of expertise, and their employer, ANM salaries range from ₹15,000 to ₹25,000 a month. ANMs often get a fixed wage, unlike ASHAs, which increases their economic stability but may also demotivate them from putting up their best effort. ANMs provide basic medical care, family planning advice, vaccinations, and maternity and child health services. They oversee ASHAs in certain circumstances and play a key role in encouraging institutional delivery and skilled birth attendance in rural regions.

AWWs (Anganwadi Workers),[10]

The Anganwadi system was established in 1975 by the Integrated Child Development Services (ICDS). With around 1.2 million AWWs operating in communities throughout India, it is one of the largest early childhood development initiatives in the world. Health education, child development, and nutrition are the main topics of AWW training. Every five years, each Anganwadi Center must pay ₹3,000 for the first training. After that, it costs ₹1,000 year for the next four years. Given the variety of responsibilities that AWWs have, the training period is very brief. A minimum of a 10th grade education is required to be an AWW. Preschool instruction, nutritional counseling, and health promotion are only a few of the AWWs' many responsibilities that form

the basis of the educational requirements. The monthly compensation for AWWs is ₹3,500 for mini-centers and ₹4,500 for big centers. This wage structure has generated a lot of debate, with workers demanding equal perks and recognition as government employees. AWWs provide community action, health education, nutrition education, and childcare. They have many distinct duties to fulfill since they work in several fields, such as early childhood education and health.

MPHWs, or multipurpose health workers,[9]

Since its first introduction in 1974, the National Rural Health Mission has introduced additional MPHWs. They are employed by Sub-Health Centers (SHCs), which typically provide services to 3,000 people in hilly, tribal, or difficult-to-reach areas and 5,000 people in plains. You must finish a two-year diploma curriculum covering anatomy, physiology, and emergency care in order to become an MPH. The government provides funding to upgrade MPHW training facilities, which first cost ₹46.45 lakh and thereafter ₹12.55 lakh annually. You must have finished your 10+2 education with a foundation in biology or science in order to become an MPHW. This need for education demonstrates the specialized nature of their work and the significance of possessing a fundamental grasp of science. MPHWs assist with many public health initiatives, including those related to child health, leprosy, TB, and malaria. At the sub-center level, they provide basic healthcare, communication and counseling, disease detection and control, and logistical support.

4. Analysis of Training-Field Gaps

Curriculum and Reality Inconsistencies,[11-13]

The complex, situation-specific issues that workers encounter in the field are usually not covered in the traditional training programs for all four groups. The same modules are often used in training programs regardless of the cultural background, geographic location, or kind of illness being treated. This indicates that employees are ill-prepared for the health issues they may encounter in their local communities. For instance, workers in urban slums or the plains have distinct health issues than those in tribal communities, although training programs seldom ever contain modules tailored to those regions. For instance, ASHAs working in regions with high rates of malaria should have more knowledge about vector management, while ASHAs working in regions with high rates of drought should gain more knowledge about treating malnutrition and water-related illnesses. Even though community health workers operate in a variety of cultural contexts, training programs frequently place insufficient emphasis on cultural competency. This disparity is particularly evident in maternal health services, where traditional beliefs and practices significantly influence how people seek care. Employees who have mostly received training in infectious illness management are struggling to manage the rising prevalence of diabetes, hypertension, and mental health issues in their communities.

Lack of Skill Development,[14-17]

A lot of community health workers claim they aren't prepared for the technical duties they must perform. Despite receiving 18 months of training, ANMs often lack confidence while doing emergency obstetric operations. Conversely, ASHAs struggle to correctly diagnose illnesses and decide which ones to refer. Communication and counseling skills are often overlooked in training programs, despite the fact that they are critical to the effectiveness of community health workers. Employees are often unprepared for difficult conversations, such as discussing family planning alternatives or interacting with patients who don't adhere to their treatment plans. Community health professionals must utilize mobile applications and other digital tools as health systems become increasingly digital, but training programs sometimes take a while to adopt new technologies. When staff members had to rapidly learn how to utilize digital reporting and communication systems during COVID-19, this disparity became quite evident.

Deficits in Mentoring and Supervision,[18,19]

When workers go from training to working independently, there isn't always adequate supervision and mentoring. Many new hires report feeling overburdened and ill-prepared for the challenging issues they encounter on the job. Many supervisors lack sufficient training on how to mentor and assist individuals in improving their performance, and the quality of supervision varies greatly across regions and levels. Variable standards for performance and skill development result from this variability. There aren't many methods to improve training programs using field experiences and challenges. This defect hinders the system's ability to adjust to new data and maintains training-field gaps.

Infrastructure and resource constraints,[20,21]

The quality of teaching is lowered in many training institutions because they lack the necessary facilities, tools, and educational resources. Infrastructure issues plague rural training centers, making it difficult to acquire practical skills. Sometimes the training materials are outdated or inappropriate for the location. Because training resources are sometimes unavailable in local languages, linguistic barriers make this issue even worse. Because they don't get enough supervised practical experience during training, workers are often unprepared for real-world issues. This disparity is particularly detrimental to technical abilities that need real-world practice.

5. Field realities and community feedback

Perceptions and Acceptance in the Community,[22-24]

According to community feedback, acceptance varies greatly by cadre and region, and individuals have differing views about how effectively health personnel do their duties. Neighborhood residents often commend ASHAs for serving as intergroup bridges since they are approachable and

knowledgeable about the region. Concerns exist, meanwhile, about the reliability of service availability and quality. Particularly when it comes to complex health issues, some communities have doubts about the technical proficiency of community health workers. Because they have seen individuals who were not adequately trained or who performed work that was above their degree of expertise, people are often distrustful.

The culture is often better understood by those who work in their home communities, but training programs don't always capitalize on this. Although formal training may make them less inclined to use culturally sensitive techniques, communities nonetheless esteem professionals who are knowledgeable about local customs and beliefs.

Issues with service delivery,[25-26]

Community health workers, particularly ASHAs and AWWs, claim to be overwhelmed with work and unsure of their responsibilities. Employees may find themselves in situations where they lack the tools, materials, or prescription drugs necessary to do their work effectively. Stress and a decline in service quality might result from this. Their responsibilities have also expanded beyond their training. These limitations harm effectiveness and trust by making things more difficult for communities and employees. Keeping up with therapy is difficult due to inadequate training in referral processes and a lack of connections with higher-level institutions. Employees find it challenging to ensure that suggested cases get the appropriate follow-up.

Employee Job Satisfaction and Retention,[27-29]

diverse groups have very diverse levels of job satisfaction, and one of the primary determinants is whether or not they believe their compensation is reasonable. ASHAs are concerned about their income uncertainty and the lack of social security benefits. Long-term motivation and retention are negatively impacted by a lack of opportunities for professional progress. Many employees believe that there are little opportunities for promotion and that their occupations are dead ends. Because ASHAs are volunteers, it may be challenging for them to understand their identity and how they fit within the health system and communities. They are less successful and less likely to endure over time as a result of this ambiguity.

6. Implications for Policy and Suggestions

Restructuring Training Systems,[30–32]

Replace time-based training with skill-based training to ensure that employees are proficient before entering the workforce. This strategy should include routine certification and testing. Provide training materials that address local health concerns, cultural variances, and resource scarcity, and that are suitable for every setting and purpose. These modules should be developed with input from local communities and seasoned field workers. Establish regular continuing education initiatives to keep staff members informed about emerging medical issues and treatments. Both formal training sessions and opportunities for peers to learn from one another should be offered under this framework.

Systems for performance management and incentives,[33]

Provide performance evaluation tools that include more than simply activity counts. Measures of community satisfaction and quality indicators should also be included. These metrics need to cover the whole spectrum of how employees contribute to maintaining community health. Establish compensation structures that provide employees a sufficient income, ensure that they can depend on it, and offer them with rewards for doing effectively. This might include a fixed minimum salary plus incentives based on your performance. Provide opportunities for specialization and leadership roles, as well as defined pathways for professional development within the community health worker system.

Support and Supervision Systems,[34]

To make monitoring simpler and more efficient, develop integrated supervision solutions that function across various projects and staff levels. Teaching supervisors how to provide supportive supervision may be one way to achieve this. Create official peer learning networks so that seasoned employees may share best practices and mentor new recruits. These networks might provide ongoing professional support as well as formal supervision. For continuous assistance, make use of technology platforms including real-time guidance systems, digital learning resources, and telemedicine consultations.

Organizing and combining systems,[35,36]

Enhance the collaboration between different kinds of health professionals so that they may do their duties more effectively and address service shortages. Clear responsibilities and referral protocols are part of this. To ensure that information and referrals go smoothly, community health workers should strengthen their ties to the broader health system. To address the reality that community health issues impact many facets of life, establish collaborations with non-health sectors, particularly social welfare and education.

7. Talk about

According to the report, there are systemic discrepancies between training curricula and the actual experiences of all four categories of community health workers in India. These disparities manifest themselves in a variety of ways, including the curriculum's applicability, the standard of supervision, and the system's assistance. The impacts extend beyond an individual's work performance; they also impact community health and the advancement of universal health care.[88]

Systemic Character of Difficulties,[34,37,38]

In addition to being technical issues, the training gaps indicate that India's health system is beset by more significant issues that impact the whole system. Programs for community health workers have expanded rapidly, but sometimes without giving

enough attention to adaptive management and quality assurance. There are now trade-offs between quantity and quality since program expansion is given priority above quality enhancement in the allocation of resources. Budgets for training may not be sufficient to adequately prepare individuals for successful community health work, despite their size in absolute terms. This is because providing training involves several organizations and governmental levels, making it challenging to maintain consistency and high standards. The standards and methods used by various training providers may vary, which might reduce the consistency of worker readiness.

A Comparative Analysis of Cadres,[39-41]

The four categories' disparate training-field gaps demonstrate their varying roles and institutions of employment. Despite having greater training and a formal profession, ANMs have better technical skills, but they may not know how to become more active in the community. ASHAs, on the other hand, struggle with the technical aspects of care while having strong ties to the community. It's unclear whether training duration and effectiveness in the field are related. ANMs get 18 months of training, which provides them with a wealth of technical information, but it may not be sufficient to address real-world issues. Even if the training isn't as thorough, upgrades and modifications may occur more often due to ASHA's shorter training period. Their training needs and performance in the field are significantly impacted by the differences in job position across the various cadres. Although voluntary status could increase acceptance in the society, it also makes it more difficult to hold individuals responsible and monitor their performance over time.

Opportunities for Innovation and Adaptation,[42-46]

The issues discovered also provide fresh opportunities to enhance support and training systems. Peer learning networks, digital platforms, and community-based mentoring are all effective means of addressing training shortages. Decision-making, real-time support, and opportunities for continuous education may all be aided by mobile health (mHealth) technologies. But in order for integration to succeed, we must address issues with infrastructure and digital literacy. Training may become more relevant and responsible if communities are involved in its design and performance evaluation. This approach must strike a balance between community desires and what is both technically solid and supported by data.

The Global Context and the Lessons,[47-50]

The training issues for community health workers in India are comparable to those in other low- and middle-income nations. Global evidence indicates that community health worker initiatives need continuous investment in system integration, oversight, and high-quality training. Promising initiatives in nations such as Ethiopia, Brazil, and Thailand demonstrate the significance of thorough training, equitable compensation, and robust integration with the health system. We learn from these experiences how to improve community health worker initiatives in India. India's vastness, however, makes it challenging to establish systems for rigorous training and supervision. New approaches to maintaining high quality while attaining scale will be crucial for long-lasting gains. The most crucial suggestions include implementing competency-based training programs, developing context-specific training modules, bolstering mentoring and supervision systems, establishing equitable and sufficient compensation structures, creating career development pathways, and enhancing integration between cadres and the rest of the health system.

CONCLUSION

For India's community health workers, this narrative evaluation has shown significant disparities between training programs and the real world. These disparities manifest themselves in a variety of ways, including the curriculum's applicability, the standard of supervision, and the system's assistance. According to the report, addressing these issues requires more than simply altering training curricula; it also calls for enhancements in oversight, rewards, and overall integration. Due to their varying functions, training intensities, and institutional settings, the four groups under investigation—ASHAs, ANMs, AWWs, and MPHWs—each exhibit unique training-field gaps. It is widely acknowledged that India need more competency-based, contextual training approaches as well as closer ties between educational institutions and the outside world. Recognizing these workers as competent professionals who need proper training, continuous assistance, and equitable compensation is essential to the success of India's community health worker initiatives. In addition to being a technical challenge, closing the gap between training and the workplace holds the possibility of strengthening India's healthcare system and guaranteeing that everyone has equitable access to medical treatment.

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