Original Article

Community response towards health care providers delivering health care services during COVID-19 pandemic: A strategy framework based on findings of a qualitative study in Odisha, India

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Abstract

Context: While there are studies on peoples' behaviour toward health professionals (doctors and nurses) during the Coronavirus diesease (COVID-19) pandemic in hospital settings, there is limited literature on Community Health Workers (CHWs). Our study attempted to explore the behaviour of community people towards CHWs during the pandemic and its underlying reasons. **Material and Method:** A qualitative study using In-depth interviews (IDI) and focus group discussions (FGD) was conducted among CHWs and community people from six districts of Odisha from February to April 2021. The researchers transcribed the audio recordings in the vernacular language of the Odisha province, i.e., Odia, and later translated them into English. A qualitative content analysis method was used to prepare the detailed report using Max Weber Qualitative Data Analysis (MAXQDA) software. **Result:** The study found two major categories-Reflection on community behaviour towards CHWs during the COVID-19 pandemic and reflection on availing health care services by community people during a pandemic. Many CHWs revealed that the community people acknowledged their work and dedication and extended all sorts of co-operation and support. However, few community people were non-cooperative and non-supportive. Community reluctance owing to perceptions that the CHWs might be infected, was the significant cause that they faced a lack of support from the community. Further, to create awareness of COVID-19 infection among community people, CHWs adopted different strategies such as door-to-door visits, wall painting, poster display, and awareness through mikes. **Conclusion:** The efforts made by the CHWs during health emergencies need to be recognized and appraised.

Keywords: Community behaviour, community health workers, COVID-19, healthcare service

Introduction

Healthcare professionals play a critical role in providing health services at different levels of the health system. The efficiency of a country's health system is determined by the quantity and quality of its available health workforce.[1] Considering the fact that they handle the patients physically to treat or make them healthy,

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sometimes they encounter difficulties in the form of mistreatment by the public, more so in case of any adverse treatment outcome. Incidences of such mistreatment towards healthcare providers have increased worldwide over the last 10–20 years,[2,3] especially towards the doctors and nurses working in clinical or hospital settings.

The work environment of health professionals also varies depending on their job-related roles and responsibilities. For instance, the doctors and nurses mostly perform their duties in hospital environments, whereas Community Health Workers (CHWs), such as Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwives (ANM), work closely with community people. While there is some sort of security provision available at health facilities, no such scope is available for CHWs. During the COVID-19 pandemic, community people were in fear of isolation,[4] and most were reluctant to be labelled as Coronavirus disease (COVID-19) patients despite being tested positive.[5] Evidence suggests that during the COVID-19 pandemic, most healthcare providers were stigmatized, isolated, and socially ostracised.[6-8]

Similar situations were also reported during past pandemics. For example, during the Ebola outbreak, in Sierra Leone, many community members believed the disease to be transferred by the health workers through their contact, blood transfusions, or injections and labelled them as 'carriers for infection'.[9,10] People were afraid of the healthcare personnel, and they denied them of using water, taxies, and lodgings in the villages.[11] Similarly, in Guinea and Liberia, CHWs had to experience fear, mistrust, and rejection by the community people.[12]

Some literature on peoples' behaviour toward health professionals during COVID-19 is available for hospital settings in India (doctors and nurses).[13,14] However, there is a dearth of studies on community behaviour and response towards CHWs while rendering healthcare services at the community level in the event of the COVID-19 pandemic. In Low and Middle-Income Countries (LMIC) like India, where scarcity of health workforce has been a major concern,[15] it is important to ensure better performance by CHWs through conducive community response so that the work burden of primary care providers and physicians can be reduced, which will result in better work performance and service provision. This study is highly significant to understand community people's behaviour toward healthcare professionals during any health emergency situations so that necessary action and preparedness can be adopted. The study attempted to explore the community behaviour and response and the reasons thereof, to help health program officials and decision-makers to develop appropriate strategies for better healthcare service delivery, especially during public health emergencies.

Method

Study design, setting and participants

A qualitative study using In-depth interviews (IDI) among 36 antenatal and postnatal mothers and 12 Focus Group Discussions (FGD) among CHWs, two FGDs from each district were carried out. The study participants such as ASHA, ANM, and antenatal and postnatal mothers were enrolled from the randomly selected study clusters (villages). A multistage sampling method was adopted in selecting the districts, blocks, and health facilities for study. From each study block, one cluster (village) was randomly selected to recruit the community participants, and from the health facility of the same cluster, CHWs were selected.

Data collection procedures

Data collection was done from February to April 2021, using a pre-designed pre-tested IDI guide. For all the interviews, informed verbal consent was obtained, and they were audio-recorded after the approval of the participants. Interviews were conducted by trained researchers in the local vernacular language (Odia).

Data analysis

The researcher transcribed the audio recordings in the vernacular language, and later translated them into English. A qualitative content analysis method was used to prepare the detailed report, and Max Weber Qualitative Data Analysis (MAXQDA) software was used for analysing the qualitative findings.

Ethical consideration

Ethical approval for this research was obtained from the institutional review board at Regional Medical Research Centre, Odisha, India. The study objectives were clearly explained to the participants, and verbal informed consent was obtained prior to the interviews.

Quality appraisal

The Consolidated Criteria for the Reporting of Qualitative Research (COREQ) Assessment Tool was used to assess the quality of selected articles.[16]

Result

Category 1: Nature/type of behaviour

Most of the participants revealed that the majority of the community people acknowledged their work and dedication and extended their co-operation and support. People showed their deep gratitude when CHWs were delivering health care services at the doorstep during the pandemic. Most community people understood how the CHWs, despite the risk of getting an infection, were dedicated to health care services during the COVID-19 pandemic.

"Some people said that no doctor ever comes to our house, but ASHA comes to our house to see how we are doing. They believe in us." (ASHA)

Some participants expressed the support they received from the community while managing the migratory people in the quarantine centres. When a migrant person came to the village

and was reluctant to stay in the quarantine centre, the whole community supported the ASHA in moving that person to the quarantine centre. In addition, when migrant returnees were coming to the villages, the community people were immediately contacting the CHWs and keeping them updated.

"A man came from outside Odisha and refused to go to the quarantine centre. So, the villagers informed me and also advised him to move to a quarantine centre. When everyone told the same, that person agreed to go" (ASHA)

When their own community recognized the micro-level efforts done by the CHWs, workers felt motivated. The community's support helped them perform their responsibilities better even when they were overburdened with a plethora of work. In this regard, a participant explained,

"When my own people recognized my efforts, I wanted to do more and more for them" (ASHA)

However, some participants also explained that a few community people were non-cooperative and non-supportive as well. In fact, they said that in such scenarios, they had to face problems in performing their responsibilities.

"Some people did not allow us to enter inside their home," said one of the participants.

"They would not let us go near their houses by saying that we are roaming outside all day and we go to the hospital too. But still we kept on doing our duties" (ANM)

Few participants explained that they had received hostile behaviour from the community people.

*"I have faced a lot of problems. One person came from **** to our village. We had a verbal fight among us because he refused to go to the quarantine centre." (ASHA)*

Community people's experiences while availing services

During the COVID-19 pandemic, CHWs were striving to ensure continuity of delivering routine healthcare services. Apart from the essential services they deliver, they also had to perform other pandemic-related activities. While asking this to community participants, they explained that they had received enormous support from the CHWs during the pandemic like health assessment of pregnant mothers and newborns, medications, and nutritional supplements were done at the doorstep by the CHWs.

"Yes, ASHA visited our home during the pandemic and asked about mine and my baby's health. She gave me one packet of grounded food, 12 eggs, and other things per month." (PNC mother)

However, a few antenatal mothers explained that they could not avail of routine antenatal check-ups during the pandemic because of cancellation or postponement of the community-level services. Furthermore, visiting a health facility was a challenging task for them during the lockdown.

"During the pandemic, for two weeks they did not conduct VHND sessions. Also, because of lockdown and COVID situation, I did not go to the hospital for my check-ups." (ANC mother)

Participants additionally explained that lack of information from the CHWs regarding the community level services (for example, Village Health and Nutrition Day (VHND) sessions) was also a major factor that prevented them from availing the Maternal and Child Health (MCH) services.

"I did not know when those sessions were held and where they were held. No one informed me about them. Also, she has never told me about Mamta Divas." (ANC mother)

On a positive note, respondents also revealed that immunisation services were not significantly disrupted during the pandemic. However, Village Health Nutrition Day (VHND) sessions were called off or postponed in some sites considering the increased incidences of COVID positive cases.

"Every day positive cases were getting detected at that time, so for a few days the VHND sessions were cancelled. But immunisation service was not interrupted." (PNC mother)

Category 2: Ill response and reasons

According to the CHW participants, a few community people showed ill behaviour towards them while delivering health services. We tried to explore the possible reasons for such behaviour and response. Community reluctance owing to perceptions that the CHWs might be infected, was a significant reason for which the workers had to face a lack of support from the community. Also, while managing migrant returnees, they encountered mistreatment. The reasons for such mistreatment were due to CHWs asking them to do their COVID-19 testing, mobilizing them to the quarantine centres, and asking them to stay inside their homes.

"Some people also scolded us; we should not discuss that now." (ANM)

Such ill-treatment affected the morale of the CHWs and their work performance. Participants expressed that during the pandemic, they were exhausted and emotionally drained when they faced such mistreatments from the community people.

"A positive patient was drunk that day and scolded me like anything. I cried that day." (ASHA)

The CHWs delivered a series of COVID-19 related services such as testing for COVID-19 infection, creating awareness in the community, daily reporting of the COVID-19 cases, visiting the quarantine centres, contact tracing of COVID-19 positive cases, and community-level surveys to find out any symptomatic

COVID-19 cases.

However, several members of the community were apprehensive about getting COVID-19 testing and isolation at government-run quarantine centres. People often hesitated to move to quarantine centres, and in the presence of CHWs, they promised to stay inside their homes and obey COVID-19 guidelines. However, in the absence of CHWs, they socialized themselves with villagers. Despite the CHWs' effort in contact tracing of COVID-19 cases, contacts and migrant returnees were reluctant to visit the testing centres and often expressed anger on the CHWs.

"We planned to hold a mass testing camp for the community. But they did not allow us to do so. They did not want to level themselves as COVID-19 patient." (ANM)

Being a part of social groups in the society, the frontline workers lived their life in the same community and delivered health care services to the people of their community. One of the participants stated that in spite of such an ill response, they felt they had to work with the community, and they are their own people, so they need to adjust accordingly to the circumstances.

"When you are working in the field, it is quite obvious that you may listen to many things from various people. But what to do?" (ANM)

Reflections from community people/beneficiaries

The fear of contracting the infection, spreading it among their family members and society, and stigma pertaining to COVID-19 were the main reasons for such community reluctance. The instances of boycotting the COVID-19 positive cases were the root cause of why people did not want to undergo COVID-19 testing. CHWs also had the task of counselling the migrant returnees and getting their COVID-19 test done. One reason for the people's reluctance to undergo COVID-19 testing was their misinformation regarding COVID-19 infection and mistrust of the health care workers.

"If my neighbour came to know that I am tested COVID-19 positive, they would never come to my home. Also, the villagers will boycott us." (PNC mother)

Another significant reason for not availing the community-based maternal health services was the "fear". Many pregnant women experienced anxiety and distress during the pandemic and were worried about their delivery and the health of their new-born. So, they were reluctant to visit the community-level service delivery platforms.

"Mamta Divas was conducted, but I did not come. Because of the pandemic, I did not move out from my house." (ANC mother)

Category 3: Mitigation methods by CHWs

CHWs delivered the healthcare services at an optimum level by adopting various strategies such as checking and re-checking the register they maintained, communicating with the beneficiaries, and visiting their homes. Apart from that, the supervisors ensured their activities through regular monitoring and supervision.

"We check our register to confirm their EDD dates. If that date is nearby and they did not attend the meeting, we went to their house" (ANM)

Further, in order to create awareness of COVID-19 among community people, CHWs adopted various strategies such as door-to-door visits to counsel the people, wall painting, poster display, and awareness through mics make the community people aware of COVID-19. With support from the community leader, small meetings at the village level were organized to minimize the discrimination and stigma at the community level.

"Wall paint, awareness through mics, poster presentations, meetings etc., were done to make people aware. The survey was conducted every day. We provided our contact numbers to people. This awareness was effective." (ANM)

Proposed framework for better community involvement

A strategy framework was developed based on study findings and referring to other similar concepts[17,18] for better community involvement in health service delivery. Under the framework, five key components for improved community engagement have been considered, and the actionable strategies to be implemented through two levels a. Individual-level by CHWs and b. Health system level [Figure 1].

Discussion

The CHWs, while performing their multiple responsibilities, met tremendous challenges such as extensive working hours, limited personal protective equipment, fear of contracting the infection, lack of community support, and many more. Our study revealed that while the majority of the people availed the community-based routine maternal and child health services (i.e.,

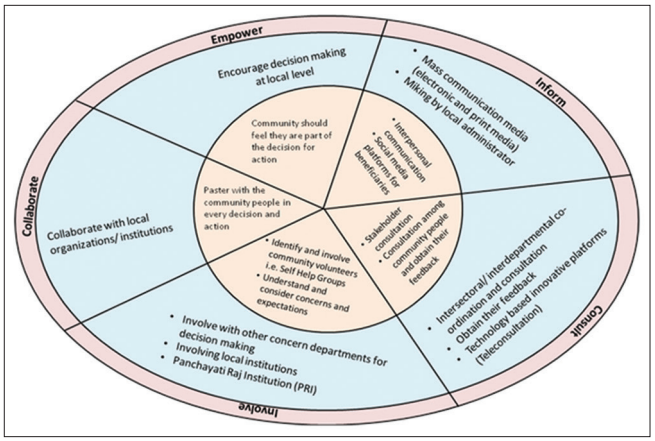

Figure 1: Strategies at the individual level by CHWs and health system level Inner circle: Strategies for Individual-level action Middle circle: Strategies for system-level action

immunisation, nutritional supplements, VHND sessions) and appreciated the work by CHWs during the COVID-19 pandemic, on the other side, some people were reluctant to avail of the COVID-19 related services such as testing, isolation at the quarantine centre. This hesitancy among the community people was grounded in fear of getting identified and stigmatized by their community.

The study revealed the implications of such challenges faced by the CHWs on health service delivery. While CHWs received appreciation from the community people that motivated them to perform better, the ill-treatment by a few people discouraged and demotivated them. A study conducted by[19] explained that the previous Ebola outbreak not only weakened the sense of trust among the healthcare providers, health facilities, communities, and households, but it also had a profound sense of isolation, loneliness, and stigmatisation. The findings of the study also resonate with other previous studies.[11,20]

In spite of all this, the CHWs normalised themselves and focussed on their job responsibilities. This signifies the accountability towards their service and the dedication to their work. The efforts put in by the CHWs during this COVID-19 emergency need to be strongly appreciated. A study conducted in Nepal revealed that the individual commitment to responsibilities prompted the health staff to return or to stay in their workplace during the earthquakes.[6]

There is a need for effective communication for community people along with their participation in health care services, including COVID-19 related services. This could be achieved through effective Social Behaviour Change Communication (SBCC) strategies involving community leaders. During the pandemic, in various places, such strategies were adopted, for instance, meetings, wall paintings, posters, awareness through mics, and interpersonal communication. This not only generated awareness but also wiped out the misinformation and built community trust for the health system and healthcare providers. Similar to our study findings, a study conducted by Armstrong suggested that community involvement in public health activities could possibly enhance countries' abilities to prevent, detect, and respond effectively to future infectious disease threats.[9] The significance of community participation was also suggested as an effective strategy in other studies.[21,22]

To overcome the challenges and provide uninterrupted services to community people, various strategies were adopted by the CHWs. Sensitising the community through small meetings at the village level, and spreading awareness to mitigate the misconceptions and misinformation among the community were effective in improving the community's behaviour and responsiveness. Similar to current study findings, Bhaumik *et al.*[6] highlighted that community and family support, and religion were the strategies adopted by CHWs in continuing to serve their community.

Training to CHWs, appraising their job roles and responsibilities and work instructions, and coordination with the local leaders while implementing newer guidelines during an emergency situation were effective methods for improving service delivery. Support in the form of incentives and rewards for appreciating the CHWs would motivate them to perform better, especially during a health emergency. There is a need for developing and implementing 'work environment safety and security guidelines' for the frontline workers.

We advocate for implementing the actionable strategies both at the individual level (CHWs) and health system level, developed based on study findings. Five key components: Inform, Consult, Involve, Collaborate and Empower, can be achieved by leveraging the available platforms and resources such as existing institutions/ departments in the community, communication platforms such as electronic, print, and social media, and information technology platforms for teleconsultation.

Strength and Limitation to this Research

The collection of data across diverse geographical locations and from different cadres of community health workers helped to understand the context better. Our findings are limited to rural communities and emergency situation (COVID-19). However, we strongly believe our findings would be similar for other settings too.

Conclusion

The efforts made by the CHWs during health emergencies need to be recognized and appraised. Both the community and health system should make efforts to ensure safety and security for the CHWs, more so in the event of a health emergency situation. Our proposed strategic framework will help the HCWs, program personnel, and policymakers to adopt and adhere to the suggested activities for better community involvement. Further research will help to understand the work environment of CHWs better and provide evidence about the adherence and effectiveness of such strategies aimed to overcome the embedded challenges.

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Conflicts of interest

There are no conflicts of interest.

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