



World Health  
Organization  
India

Enabling prescription by

# MID-LEVEL HEALTH WORKERS IN INDIA

POLICY BRIEF

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## Introduction

- This policy brief outlines policy options, policy recommendations and implementation suggestions to operationalize mid-level health workers' (MLHWs) prescription in India.
- Such an initiative is also an opportunity to strengthen workforce response in providing primary health care in pandemic situations such as COVID-19 and during other epidemics.
- A global systematic review of the literature and legal analysis related to MLHW prescription was carried out. Indian case studies of Chhattisgarh and Assam and international case studies of South Africa were also carried out to generate suggestions for implementing MLHW prescription in India. This brief is based on the data obtained through various study components.
- The structure of this brief is as follows: it describes the problem or policy challenge and moves on to presenting policy options on specific dimensions such as legal changes, pre-service education/training, and model of prescription. A list of policy recommendations is presented that emerges from the examination of the policy options.<sup>i</sup>
- This brief also presents implementation considerations to be kept in mind (related to medicine lists, in-service training and stakeholder consultation) followed by specific implementation suggestions.
- A WHO review defines a MLHW as follows: *"A mid-level health worker is not a medical doctor, but provides clinical care (may diagnose, manage and treat illness, disease, and impairments) or engages in preventive care and health promotion."* Mid-level health workers are also those whose training has been shorter than doctors (2 to 4 years) but who perform some of the same tasks as doctors.<sup>ii,iii</sup>
- A systematic review carried out by Global Health Workforce Alliance, WHO in 2013 on the role and performance of MLHWs in the delivery of essential services found that MLHWs play an important role in the delivery of maternal and child care, antiretroviral therapy, health promotion and prevention and care for non-communicable diseases (NCDs). Noting the limitations in the quality of evidence on available studies on the performance of MLHWs, the review concluded that the quality of care by MLHWs for essential services is comparable to the quality of care delivered by doctors.
- The National Medical Commission (NMC) Act 2019 in India has already introduced the model of Community Health Providers (CHPs). Section 32 of the NMC Act states that the NMC may provide limited licence to practice medicine at mid-level as a community health provider, to such persons connected with a modern scientific medical profession who qualify such criteria as may be specified by the regulation. The CHP may also prescribe specified medicine independently, only in primary and preventive healthcare. The regulations which would clarify the scope of practice have not yet been prepared/finalized.
- The enactment of the NMC Act, 2019 in India and the imperative of working out

the specific details needed to operationalize the CHP system create the need to study insights from a global context and domestic experiments in the domain of MLHW prescription. Such insights can give direction to the implementation of the system and the draft regulations being prepared.

## Problem description

- In India, on average, one government doctor serves more than 11,000 people, ten times more than the WHO mandated doctor: population ratio of 1:1000.
- The first point of contact in India between the community and a government doctor (medical officer) is at the level of the Primary Health Centre which on average serves a population of 30,000. There is, therefore, a need for a cadre of MLHWs to provide regular outpatient services closer to the population, at the level of the Sub-Centre, which serves a population of 3,000-5,000.
- The Government of India has announced that 1,50,000 Health and Wellness Centres would be created by 2022, by transforming the existing Sub-Centres and Primary Health Centres to deliver comprehensive primary healthcare. This creates the need for suitably trained workers to staff the MLHW (Community Health Officer or CHO) positions in these Health and Wellness Centres. These functionaries are expected to provide clinical care as specified in care pathways and standard treatment guidelines. Since they would provide clinical care in remote settings where doctors would be

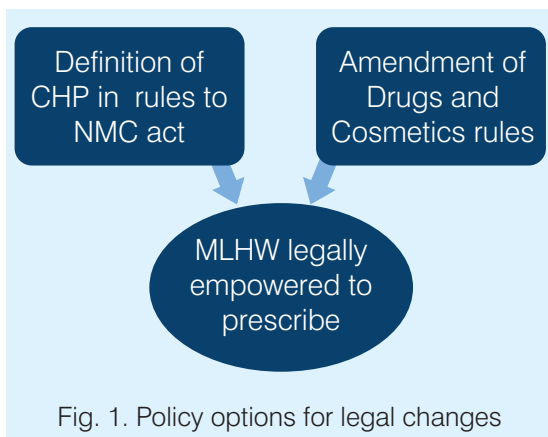
absent, there is a need to clarify the scope of practice and range of medicines that can be prescribed by them.<sup>iv</sup>

- Section 32 provision in the NMC Act, 2019 led to a strong reaction from the Indian Medical Association, which has described it as 'legalized quackery'. A nationwide strike of doctors took place after the legislation was passed. Obtaining the support of this major stakeholder is essential for the legally sustainable implementation of MLHW prescription in the country.
- At present, only medical practitioners can prescribe medicines. The sale of medicines based on a 'valid prescription issued by a medical practitioner' is governed under the Drugs and Cosmetic Act, 1940 and the corresponding rules (there is however no definition of "Prescription" in the Drugs and Cosmetics Act).
- In 2014, the Union Cabinet approved a three and a half year Bachelor of Science in Community Health (BSc) course. This was aimed at training mid-level health professionals with an aptitude in public health and ambulatory care to serve the rural population at Sub-Centres. However, the implementation of this course was ridden by certain obstacles and the course could not take off in India.

## Policy options

### A. Legal changes

- This section explores the policy options for legal changes required to implement MLHW prescription in India.



**Policy option 1:** Introduce a suitable definition of a Community Health Provider (CHP) and clause for recognition of Right to Practice in the Draft Rules of the NMC Act, 2019.

- In Section 32 of the NMC Act, 2019, it is stated that a CHP should already be connected to an existing modern scientific medical profession, and the CHP is allowed a limited license to practice which includes limited right to prescribe medicines. The following recommended definition of CHP should be included in the draft rules/regulations for the NMC Act– “Persons connected with modern scientific medical profession” includes a person who has completed the training under any degree programme recognized under the Schedules of this Regulation.
- Such a definition can enable introducing CHP courses at a Bachelor’s level, and quality control through a minimum degree qualification.
- Under the NMC Act, any new medical course requires approval from the National Medical Commission.

However, recognition of the degree is not sufficient to permit the graduates to practise medicine. The next legal step is recognition of the Right to Practise Medicine. The draft clause for the same is proposed below (for inclusion in the draft rules to the NMC Act).

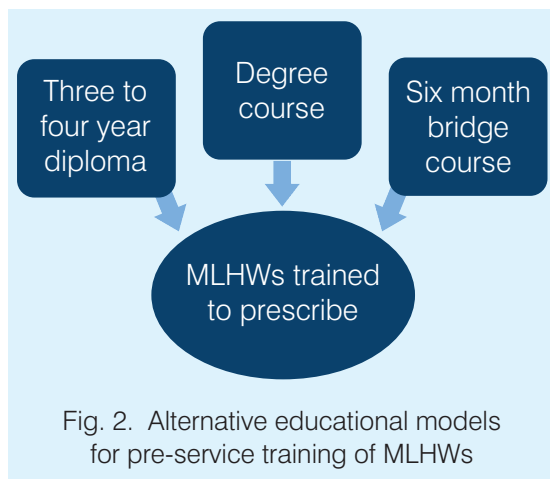
Any person who obtains a degree recognized in the Schedule of this Regulation shall be granted a license to practice primary and preventive medicine as a Community Health Provider and shall have his/her name and qualifications enrolled in the Community Health Provider National Register maintained by the Ethics and Medical Registration Board under Section 31 of the Act.

**Policy option 2:** Include the definition of prescription in Drugs and Cosmetics Rules, 1945.

- At present, medicines can be prescribed only by medical practitioners in India which includes dentists and veterinarians.
- The proposed definition of a prescription to be included in Section 2, Drugs and Cosmetics Rules, 1945 - “A prescription” is an authorization to dispense drugs issued by- (a) a registered medical practitioner, (b) a registered dentist, or (c) subject to Regulation for Community Health Providers issued by the National Medical Commission, a registered Community Health Provider for the medical treatment of an individual.

## B. Education and training (pre-service)

- This section explores alternative educational models that have been used in different developing country contexts to train MLHWs.



### Policy option 1: Three to Four Years Diploma Course

- Nigeria has a four-year direct entry diploma programme in community health, (trained nurses may opt for a three-year diploma). Uganda has a three-year Diploma in Clinical Medicine and Community Health with two years of internship. Kenya has a three-year Diploma in Clinical Medicine and Surgery with one year of internship.<sup>vi</sup> In Mozambique, Técnico de Medicina Geral (TMGs) was originally trained for thirty-six months but this was subsequently reduced to thirty months. TMGs did not score very well on assessments of physical examination and clinical case scenarios, having faced difficulty with rushed teaching and an inadequate internship.<sup>vii</sup>
- The model of a three or four-year diploma was also followed in the Indian states of Chhattisgarh and Assam

which implemented MLHW systems since the early 2000s. The MLHWs known as Rural Medical Assistants (RMAs) in Chhattisgarh were placed in Primary Health Centres (due to the absence of doctors or medical officers in these facilities) whereas the MLHWs known as Rural Health Practitioners (RHPs) in Assam were placed in the Sub-Centres.

- Assam's Diploma in Medicine and Rural Health Care (DHRHC) for training RHPs was a three and a half year course (including a six months internship) while Chhattisgarh's Practitioner in Modern and Holistic Medicine (PMHM) for training RMAs was a four-year course (including clinical postings and a one-year internship at Sub-Centres, Primary Health Centres, Community Health Centres and District Hospitals). Both these courses had a 'compressed MBBS'<sup>viii</sup> course design; the major difference in MBBS was the absence of topics such as forensic medicine and major surgery in the MLHW course.
- A study of the diploma-trained RHPs in Assam by the National Health Systems Resource Centre (NHSRC) during 2013-14 stated that the training was considered significant by the 91 RHPs covered, to serve in rural and remote settings. The same textbooks were used for MBBS and MLHW candidates and pharmacology training was the same for both courses. The cut-off marks (60% in Assam and 75% in Chhattisgarh) ensured that only students of certain merit were able to join the course.
- In Chhattisgarh, the doctors who trained the RMAs mentioned that



clinical exposure during training equipped the RMA students to identify essential conventional treatment, and evaluate when they should refer patients and when and when not to prescribe antibiotics.

- The in-service RMAs in Chhattisgarh underwent a thorough examination (including questions of the post-graduate medical entrance test level) for regular appointments in the health services. As a result, 741 RMAs were regularized, which was proof of their competence, acquired based on training and subsequent field experience.
- A study analysing the quality of prescriptions issued (for disorders such as diarrhoea, pneumonia, TB, malaria, preeclampsia and diabetes) by doctors, RMAs and other health personnel in primary health facilities in Chhattisgarh found that medical doctors and RMAs had similar average prescription competence scores. 61% of medical doctor and RMA prescriptions were appropriate for treating the concerned medical condition.<sup>xi</sup>

### **Policy option 2: Degree course**

- South Africa launched a three year Bachelor of Clinical Medical Practice (BCMP) in 2008 for training its MLHWs known as Clinical Associates. South Africa followed a well-planned approach in launching this course; in 2004, it had set up a National Task Team to establish a scope of practice, training curriculum, and exit outcomes for the then proposed clinical associates cadre. The standardized competency-

based curriculum of BCMP was designed to be problem-based learning to acquire hands-on clinical skills. Three South African Universities have produced 1, 070 qualified Clinical Associates by 2018 and all of them are employed in the public sector.<sup>x</sup>

- However, the passage of the NMC Act, 2019 presents the opportunity to give a legal footing to a degree course for training MLHWs on the lines of the BSc (CH) course that was already approved by the Union Cabinet in 2014.

### **Policy option 3: Bridge/Certificate course**

- Because of the urgency of responding to the rapidly increasing incidence of NCDs by strengthening comprehensive primary healthcare, the Government of India initiated a six-month bridge course for registered nurses (GNMs or BSc nursing graduates) and Ayurveda doctors or Bachelor of Ayurveda Medicine or BAMS graduates to be delivered by IGNOU (Indira Gandhi National Open University). This course was launched in May 2017.
- The persons trained under the bridge course (Certificate in Community Health) were to function as MLHWs known as Community Health Officers (CHOs). These CHOs were to be posted at Sub-Centres, which would then be converted into Health and Wellness Centres. The objective of the course is to equip trainees to provide comprehensive primary care skills based on protocols appropriate to Sub-Centre level along with managerial/administrative skills.
- Experts and medical doctors interacted

with during GRAAM's field study in Chhattisgarh expressed concerns about the readiness of Nursing/BAMS graduates trained under the six-month bridge course to take up the MLHW/CHO roles in the Health and Wellness Centres. One specific concern was related to the preparedness of candidates (quality concerns about nursing institutes and their graduates). Medical doctors and experts spoke to express concerns about the inadequate duration of a six-month course, the relative suitability of a three or four-year course and the difficulty in changing the orientation or mindset of GNM/BSc nursing and BAMS graduates within six months. A doctor opined that a medical provider should possess diagnosis knowledge, else, there could be more harm than help. Even in referrals for chronic NCDs like diabetes (where the CHO is expected to sort out refills of medication), clinical judgement is required, without which could lead to complications.

- While the training course for RHPs in Assam included a six-month clinical internship and the course for RMAs in Chhattisgarh included a one-year clinical internship, the bridge course described above, only presents an eighteen-day clinical internship, which may be insufficient to strengthen clinical competencies.

Therefore, there is a strong case for a three or four-year training course compared to a six-month bridge course.

- Keeping in mind that the Government of India has planned to staff its Health and Wellness Centres with CHOs and make

1, 50,000 Health and Wellness Centres operational by December 2022, it may not be viable to immediately have a mandated three or four-year training for CHOs. Nevertheless, the Government of India should plan to introduce the three to a four-year course after achieving the target for the Health and Wellness Centres. Subsequently, the bridge course for training CHOs may be withdrawn in a phased way.

- While there is a strong case for keeping the clinical training aligned with certain elements of the MBBS course (especially the pharmacology component and clinical postings), the course should not be a mere replication of the MBBS course. Also, a degree course may possess more credibility and may address quality concerns better than a diploma course, which bolsters the case for a degree qualification. Furthermore, degree programmes provide more in-depth knowledge and will potentially equip CHOs at a higher level.
- After 2022, the degree qualification should be mandated for fresh recruitments of CHOs at Health and Wellness Centres. This also mandates for systematic engagement of the medical profession in planning the course and smoothing its future implementations.
- The six-month bridge course, if found necessary to be retained in future, should be accompanied by the following:
  - 1) Improved quality of nursing education so that the BSc nursing graduates who take the bridge course are proficient.

The entry requirements of the course should be made stringent (for example through a national entrance test of clinical competencies). The curriculum of the BSc nursing course should also be amended to incorporate a certain level of relevant clinical competencies including prescribing skills.

- 2) Institute extensive, frequent and systematic in-service or refresher training for trainees undergoing the bridge course who will then become CHOs.

### C. Model of prescription

- The law may require non-medical graduates such as MLHWs to either prescribe independently or under the supervision of doctors. The supervised prescription may be a solution acceptable to the medical profession and desirable due to the superior training of medical doctors. However, it may be difficult to implement in practice as a result of the frequent non-availability of doctors in health facilities located in rural or remote areas.

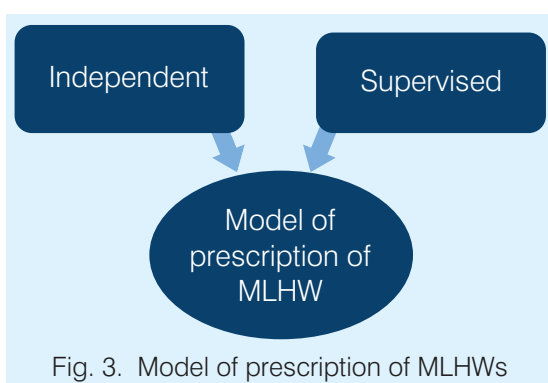


Fig. 3. Model of prescription of MLHWs

#### Policy option 1: Independent

- Section 32 of the NMC Act 2019, India grants independent rights of prescription to CHPs as far as primary and preventive care is concerned. In

secondary care, however, the CHPs are required to practice under supervision.

- In Chhattisgarh, RMAs can prescribe/practice independently for a defined list of medicines and procedures (Appendix I). In Assam, the initial legislation empowering MLHWs had defined the list of drugs and procedures for RHPs. However, a court challenge led to new legislation in 2015 which specified the role of RHPs as assisting doctors only.

#### Policy option 2: Supervised

- In South Africa, clinical associates were envisaged not to replace medical doctors but instead work as a team along with them. South Africa continues to employ clinical associates in district hospitals as part of a team that assists doctors and nurse practitioners. The unavailability of medical doctors in the public sector had created serious service delivery issues, which have been partially addressed by introducing primary care nurses (nurse practitioners or NPs) with clear distinctions in scope of practice and prescribing authority between NPs and clinical associates.
- In practice, a supervised prescription is difficult to implement in the absence of doctors. A clear (though restricted) scope of independent practice for sufficiently trained MLHWs should be defined to enable them to freely perform their roles in treating minor illnesses, managing emergencies before referral, refilling/following up for chronic conditions, and carrying out non-complicated deliveries and simple procedures.

- In Chhattisgarh, MLHWs have demonstrated their competence in practising independently. Doctors who taught at the course also believe that the system would work as long as MLHWs are well aware of their limitations and when to refer.

## Policy recommendations

- The scope of the right to prescribe medicines by CHPs should emanate from the Regulations that would be formulated concerning Section 32 of the National Medical Commission Act, 2019.
- The recommended legal definition of the requirement for CHPs mentioned in Section 32 of the NMC Act 2019 should incorporate the following: “includes persons who have completed the training under any Degree Programmes recognized under Schedules of the Proposed Regulations.”
- There is a strong case for the four-year model of training MLHWs compared to the six months bridge course which is being used to train CHOs for Health and Wellness Centres, from the point of view to develop clinical competencies of MLHWs.
- Given the greater credibility associated with a degree course than a diploma course, it is recommended to train MLHWs through a degree course in the future.
- Assam and Chhattisgarh already have trained MLHW cadres (trained in three and a half year or four-year programmes) who have also

undergone extensive field experience of 12-15 years. It is recommended that these cadres be recognized as having completed the required qualifications. All future candidates should however be required to take up degree courses.

- However, the ‘abridged MBBS’ design for training MLHWs should also not be completely replicated. A standardized competency-based curriculum focused on problem-solving and building hands-on clinical skills is recommended.
- The training course for MLHWs should be better tailored to the responsibilities that they would handle as CHOs at Health and Wellness Centres so that they are well equipped to carry out their responsibilities. The pharmacology component, preparation for NCD screening and referral as well as the management of common communicable diseases should be addressed strongly in their training. Given the important role of CHOs in the referral chain, their diagnostic capabilities should be bolstered. There is also a need for strengthening the role of CHOs in the referral mechanism.

## Implementation considerations

### Education and Training: In-Service Training

- The shorter the training of MLHWs, the greater is the need to strengthen the in-service training of MLHWs. The additional benefit of in-service training would be to demystify treatment pathways and keep the skills of the MLHWs updated.

## A. Comprehensive and customized refresher training model

- Chhattisgarh had designed a ten-day refresher training on primary health care management for all its RMAs who were trained under the PMHM course. All 1, 200 RMAs received this one-off training on primary health care management at the reputed medical institute, CMC Vellore in batches between 2011 and 2016. At this course, the RMAs also obtained a better understanding on how to treat patients using first-generation and second-generation antibiotics.
- Apart from the CMC Vellore training, other refresher pieces of training were also conducted for RMAs. These included a four-day training to strengthen RMAs' skills to handle Health and Wellness Centres, a six-day training on paediatric care at AIIMS Raipur, and 15 days training on maternal health at the State Institute of Health and Family Welfare (SIHFW), Raipur. Various other training programmes at the district and state level under the National Health Programmes have also been conducted. These training programmes have not only helped in motivating the RMAs, but have also helped enhance their skills in a more structured and comprehensive way.
- There is a need for customized and in-depth refresher training of MLHWs, on the lines of the approach followed in Chhattisgarh and other innovative approaches, such as the use of distance learning platforms. Alongside, importance should be given to the

development of standard treatment guidelines or protocols for a variety of illnesses.

## B. Algorithms, protocols and guidelines and training to explain them

- Algorithms, protocols and guidelines for screening, treatment and drug titration are very important to simplify prescription for non-medical prescribers. However, the better uptake of protocols may be facilitated by well-designed training programmes used to explain them.

### The PALM PLUS Training Initiative for Nurses and MLHWs in Malawi

In Malawi, a training initiative known as PALM PLUS was conducted which had 8-12 training sessions over a three-to-four month period. The training included small group in-service and on-site sessions using case-based pedagogy, facilitated by a trusted peer. The training allowed healthcare workers to grasp the guidelines for proper diagnosis and management of HIV and certain other communicable disorders.

All PALM PLUS trainees who completed at least six educational outreach sessions were issued a certificate and awarded continuing professional development (CPD) credits with the Malawi College of Nursing or the Malawi Medical Council. The linkage of CPD credits reinforced the uptake of the educational outreach session. Although PALM PLUS guidelines are simple and self-explanatory, PALM PLUS included an instructional programme on how to use the guidelines, since “the impact of passive guideline dissemination on practice” is minimal.”<sup>xi</sup>

The Malawi case presented in the text box above highlights the importance of not only explaining guidelines through suitably designed training sessions but also on improving the uptake of such sessions through incentives such as CPD credits.

### Medicines that can be prescribed

- The rules for Section 32 of the NMC Act would need to specify the medicines that MLHWs can prescribe.
- In Assam, RHPs deployed in Sub-Centres can only select medicines from the Assam Essential Medicines List (EML) reserved for SC level. Interviewed RHPs felt that the medicine list was not sufficient, since even common medicines like antacids and cough syrups were not covered by this list which had only 31 medicines. They also felt that they were trained to prescribe a larger range of medicines.
- Chhattisgarh's 2019 EML has listed 43 medicines in the universal list which reaches up to the Sub-Centre level. 157 medicines have been listed in the Primary Health Centre list where the RMAs mostly practice.
- The need for enhancing patient awareness is evident from both the Assam and Chhattisgarh case studies since patients pressurize the MLHWs to prescribe medicines that are either not available in the EML or are beyond the competency of the MLHW.
- The Ayushman Bharat Operational Guidelines for Health and Wellness Centres (HWCs) defines a much larger list with 91 medicines that should be made available at the HWCs.<sup>xii</sup> These include the antibiotics Ciprofloxacin,

Gentamicin, Metronidazole and Amoxicillin. Gentamicin, Metronidazole and Amoxicillin are categorised as the access group of antibiotics in the WHO 21<sup>st</sup> Essential Medicines List in 2019. Ciprofloxacin, a fluoroquinolone is however categorised under the Watch Category due to its increased potential for resistance. Replacing Ciprofloxacin with one of the access group of antibiotics, Ampicillin, Benzylpenicillin, or Amoxicillin + Clavulanic Acid should be considered.

- While the list under the Ayushman Bharat Yojana is a good reference point, it does not include medicines required for other National Health Programmes such as National Vector Borne Disease Control Programme or Revised National Tuberculosis Control Programme (RNTCP). Clarifying the list in accordance with all national programmes is desirable.
- The medicine lists to be defined should also be aligned with local morbidity and mortality data, and based on Standard Treatment Guidelines for the MLHWs. Striking a balance between the imperatives of drug safety, attending to commonly seen health problems, the training of MLHPs and the availability of diagnostic facilities are important.

### Stakeholder consultation

- The sustainability of the implementation of MLHW prescription depends on the support of key stakeholders, which includes the medical profession.
- In both Assam and Chhattisgarh, the system was adopted without the systematic engagement of the medical

profession. The MLHW systems in both states faced prolonged legal battles from the Indian Medical Association as a consequence, and the training course had to be discontinued in both states.<sup>xiii</sup>

- In South Africa, the clinical associate system was consciously planned and fleshed out for four years before it was launched. buy-in from the medical profession for the clinical associate system was obtained partly by the involvement of doctors in preparing the curriculum. Committed and technical expert family physicians were carefully selected to support decision-makers in the government. These physicians participated in reviewing international evidence, making country visits, delineating the scope of practice for MLHWs at the district hospital level and developing the national curricular framework.
- The sudden introduction of transformational systems such as MLHW prescription is not conducive to gain support from stakeholders such as the medical profession. The key is to engage influential or reputed doctors in dialogue and planning over a longer period; such doctors in turn can help develop support to the idea among their networks.

### Implementation suggestions

- The comprehensive refresher training design in Chhattisgarh for RMAs is worth emulating from the points of view of capacity building and also the motivation of MLHWs, instead of relying only on piecemeal refresher training under the national programmes.

- Restrictive medicine lists may hamper the role of MLHWs in treatment processes. The Ayushman Bharat's medicine list for Health and Wellness Centres is a good reference for the preparation of medicine lists for MLHWs (with some changes such as dropping of 'Watch' categories of antibiotics and addition of drugs from the National Programmes), provided that the required laboratory and refrigeration facilities are in place.
- Pharmacovigilance and rational use of antibiotics should be well addressed in the training of CHOs. Training MLHWs on the concept and utilising the Access, Watch and Reserve classification (AWaRe) categorisation of antibiotics is recommended.
- There is a need for MLHWs to be well trained in protocols for management and referral of NCDs as well as communicable diseases like malaria. Such protocols (for example those based on the National Vector Borne Disease Control Programme) should be disseminated amongst the MLHWs and the application of the protocols should be lucidly explained through appropriate training programmes.
- There is a need for evidence-based advocacy and extensive stakeholder consultation with representatives of the medical profession over a long period to dismiss their misconceptions and fears concerning the MLHW system. There should be an outreach to all professional associations of doctors. The South Africa case affirms the significance of involving doctors in the planning of the MLHW systems and curriculum.

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  - Appendix I: Scope of Practice of RMAs in Chhattisgarh
  - Prescription: Drugs that can be prescribed by an RMA (as per Govt Order dated 19.06.08)
    - Antacids, H2 Receptor Blockers, proton pump inhibitors, Antihistaminic
    - Antibiotics - Cotrimoxazole, Trimethoprim, Norfloxacin, quinolones, Tetracycline, Gentamycin, Cephalosporin, Erythromycin, Nitrofurantoin, Metronidazole, Tinidazole, Ampicillin
    - DID Antitubercular - INH, rifampicin, ethambutol, pyrazinamide, Anthelmintics- mebendazole, albendazole
    - Anitimalarials - chloroquine, quinine, primaquine, sulfadoxine-pyrimethamide
  - Antileprosy - dapsone, rifampicin, colfazimine
  - Anti-amoebic - metronidazole, tinidazole, dooloxanide furoate
  - Anitiscabies - benzyl-benzoate, gamma benzene hexachloride
  - Topical antifungal
  - Antiviral
  - Anticholinergic Dicyclomine
  - Antiemetics
  - Antipyretics and analgesics
  - Laxatives
  - Oral rehydration solutions
  - Hematinics and vitamins
  - Bronchodilators - Salbutamol, theophylline, aminophylline
  - Expectorants
  - Oral contraceptives
  - Gentian violet 1% solution
  - Miconazole 1% cream
  - Vitamin A liquid
  - Vitamin B Complex
  - Folic Acid Tab
  - Xylocaine local
  - Methylergometrine tablets
  - Methylergometrine injections (for PPH)
- Certain emergency drugs can be given before referral, Referral of all sick patients after initial management
  - ***Surgery: Operative procedures permitted to be carried out by a Rural Medical Assistant (as per Govt Order dated 19.06.08):***



- Repair of small wounds by stitching, drainage of an abscess, burn dressing, and applications of splints in fracture cases, application of tourniquet in case of a severe bleeding wound in a limb injury
- Conduction of delivery, basic management of complications of pregnancy and childbirth, suturing of 1st-degree Perineal tears
- **Other tasks: Other procedures/tasks (Govt. order dated 19.06.08)**
- Follow up of all National Health Programmes in Coordination with Block Medical Officer
- Linkage with communities to increase service delivery
- Regular meeting with peripheral health staff
- Procedures not to be performed (Govt order dated 19.06.08)
  - Medicolegal cases
  - Post-mortem
- **Other elements of the scope of work:**
  - Provide primary level treatment for

5-7 days: only if the improvement is visible in the condition of the patient or else they should refer the patient to a nearby CHC for further treatment

- Follow up treatment of diseases initiated by medical Officers of CHC and PHC

## Contributors and acknowledgements

This policy brief is the outcome of a multi-pronged and comprehensive study that GRAAM has carried out in partnership with WHO, to generate evidence for policy makers to consider introducing regulated MLHW and Nurse prescription.

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## End Notes

<sup>i</sup>The recommended policy solution for each thematic component in this brief is either one of the policy options presented or a combination of elements from multiple policy options presented.

<sup>ii</sup>World Health Organization. (2018). Mid-level health workers: a review of the evidence.

<sup>iii</sup>In this brief, we consider graduate nurses/Registered nurses as being outside the purview of the category of MLHWs, unless where trained nurses themselves undergo to become clinicians performing functions similar to doctors (for e.g. nurses who take up the bridge course to become CHOs at Health and Wellness Centres). Nurse practitioners who undergo more prolonged training are also excluded from this definition.

<sup>iv</sup>The Operational Guidelines for Health and Wellness Centres (issued in 2018 by the Govt of India) clearly define that for chronic diseases, CHOs at Health and Wellness Centres would need to provide medicines under standing orders of Medical Doctors. However such clarity is not provided with respect to providing medicines for other/non-chronic illnesses. Also, CHOs are allowed by the operational guidelines to provide medicines under the very limited medicine list contained in Item 23, Schedule K of the Drugs and Cosmetics Act (which puts CHOs on the same footing as the much lesser trained community health volunteers and multipurpose health workers ). Furthermore, the scope of practice of CHOs also needs to be re-examined and redefined in the context of Section 32 of the NMC Act, which was passed after the Operational Guidelines for Health and Wellness Centres were issued.

<sup>v</sup>The Union Cabinet of India had approved the introduction of a course namely, Bachelor of Science (Community Health) of BSc (CH). Though the proposal for B. Sc. (CH) had been prepared in consultation with (the then) Medical Council of India, Indian Medical Association had opposed the proposal for the course. Though the Parliamentary Standing Committee on Health and Family Welfare had also recommended not to introduce B.Sc. (CH) course, the Ministry of Health and Family Welfare did not accept the recommendation, and sought the approval of the Cabinet; the Union Cabinet subsequently approved the proposal, after which the press notification for the course was issued in February 2014. In its press release, the Government of India declared that the course is not mandatory and will be introduced only in States that wish to adopt it.

Meanwhile the Delhi High Court was looking into the matter of the non-implementation of a course for

training Primary Health Practitioners. In 2015, before the Delhi High Court, the Additional Solicitor General of India stated that the graduates of the BSc (CH) course would be an integral part of the health care system and would support the health workforce at appropriate levels. However, he admitted that there was no Central Act which provides for the rights, duties and privileges of such proposed graduates. In its decision on 2nd September 2015, the Delhi High Court ruled that once the Central Government has undertaken to introduce the B.Sc. (Community Health) course, it must give the course a firm legal footing and introduce it in institutions and universities run by the Central Government and also provide help to the State Governments to introduce the same. It must be noted that the obstacle of there being no central act or legal footing was subsequently remedied through the NMC Act, 2019. The regulations for the NMC act need to be defined in a way that would legitimize a degree course for training the MLHW cadres.

<sup>vi</sup>Couper, I et al.. (2018). Curriculum and training needs of mid-level health workers in Africa: a situational review from Kenya, Nigeria, South Africa and Uganda. BMC health services research, 18(1), 553.

<sup>vii</sup>Feldacker, C. et al. (2014). Mid-level healthcare personnel training: an evaluation of the revised, nationally-standardized, pre-service curriculum for clinical officers in Mozambique. PloS one, 9(7), e102588.

<sup>viii</sup>MBBS (Bachelor of Medicine and Bachelor of Surgery) is India's undergraduate course which creates qualified medical doctors.

<sup>ix</sup>Rao, K.D. et al. (2013) Which doctor for primary health care? Quality of care and non-physician clinicians in India. Social Science and Medicine, 84.

<sup>x</sup>Ngcobo S. (2019), Clinical associates in South Africa. 109 (10): 706. Retrieved From:

[https://www.researchgate.net/publication/336215991\\_Clinical\\_associates\\_in\\_South\\_Africa/link/5d949ef992851c33e94fe58a/download](https://www.researchgate.net/publication/336215991_Clinical_associates_in_South_Africa/link/5d949ef992851c33e94fe58a/download)

<sup>xi</sup>Sodhi, S., et al. (2014). Supporting middle-cadre health care workers in Malawi: lessons learned during implementation of the PALM PLUS package. BMC health services research, 14(1), S8.

<sup>xii</sup>NHSRC. (2018). Ayushman Bharat Comprehensive Primary Health Care through Health and Wellness Centres - Operational Guidelines.

<sup>xiii</sup>A recent judgement of the High Court of Chhattisgarh (in Feb 2020) has recognized the four year PMHM course for training MLHWs as legally valid. The judgement comes after a 20 year legal battle.



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The policy brief outlines policy options, recommendations and implementation suggestions to operationalise mid-level health workers' (MLHWs) prescription in India. Such an initiative is also an opportunity to strengthen workforce response in providing primary health care in pandemic situations such as COVID-19 and during other epidemics.