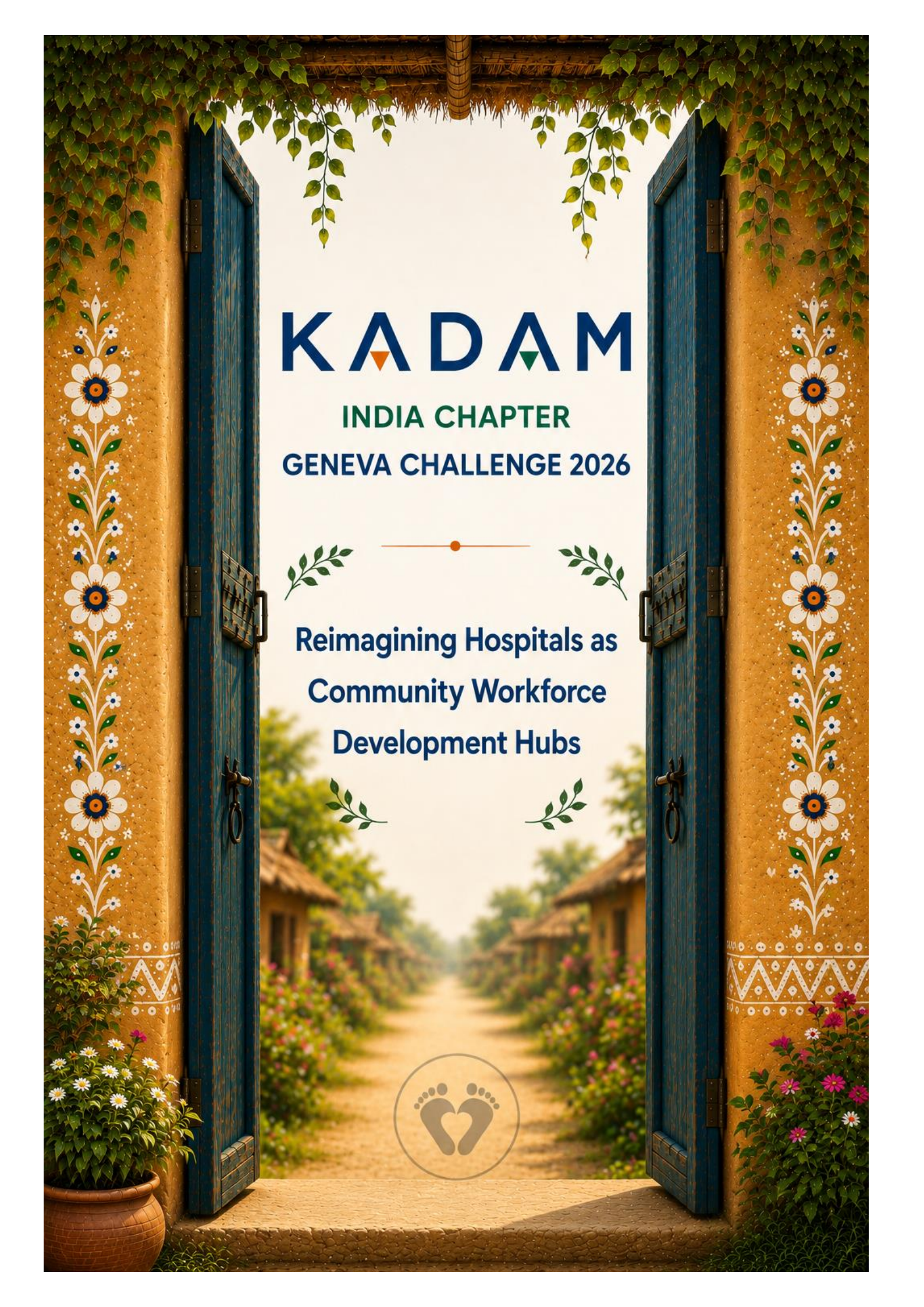




KADAM

INDIA CHAPTER
GENEVA CHALLENGE 2026

Reimagining Hospitals as
Community Workforce
Development Hubs





ABSTRACT

India stands at the intersection of two converging crises: a persistent healthcare workforce deficit and a rapidly evolving labour market. The country is estimated to face a shortage of 3.6–6.5 million allied health professionals to meet global workforce benchmarks, with the most acute deficits concentrated in rural and underprivileged regions. The accelerating adoption of artificial intelligence is redefining the nature of work, disrupting traditional employment pathways and intensifying concerns around workforce displacement, *particularly among low- and semi-skilled populations*. Together, these trends threaten to deepen both health inequities and economic exclusion, underscoring the urgent need for innovative models that simultaneously expand healthcare capacity and create future-ready employment opportunities.

KADAM (Knowledge-Driven AI-Assisted Detection and Monitoring Network) is fundamentally a workforce creation model that addresses two interconnected challenges: *the shortage of healthcare workers and the exclusion of millions of young people from meaningful employment opportunities*. By reimagining hospitals as workforce development hubs, KADAM recruits, trains, certifies, and deploys local youth as KADAM Health Associates (KHAs), creating a new cadre of digitally enabled frontline healthcare workers. Supported by IIHMR for certification, the model combines competency-based training, supervised clinical experience, and AI-enabled diagnostic technologies to equip KHAs with employable skills and clear career pathways. By substantially lowering the educational, financial, and geographic barriers traditionally associated with healthcare careers, KADAM democratizes entry into the healthcare workforce while expanding access to care in underserved communities. In doing so, it transforms healthcare delivery into a vehicle for job creation, economic inclusion, and health system strengthening, offering a scalable blueprint for the future of work in healthcare. KADAM's impact extends beyond healthcare delivery. **Communities benefit** from earlier diagnosis and continuity of care, **hospitals benefit** from a sustainable workforce and referral pipeline, and **healthcare systems** benefit from a scalable framework that connects digital health infrastructure with first-mile healthcare access, ensuring that individuals enter the healthcare system *before disease progresses to advanced stages*.



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CHAPTER 1: INTRODUCTION

Delivering healthcare in a Tier-2 city offers a unique perspective on the realities of health systems in low-resource settings. Despite major advances in medical science, digital health, and artificial intelligence, access to quality healthcare remains constrained by a persistent shortage of skilled allied health professionals. Hospitals in Tier-2 and Tier-3 cities struggle to recruit and retain personnel such as vision technicians, laboratory technicians, rehabilitation staff, and patient navigators, also limiting their ability to extend screening, referral, and follow-up services beyond hospital walls.

As hospitals operate with limited allied health capacity, clinicians become increasingly burdened with tasks that could be delegated, weakening first-mile healthcare access despite continued investments in healthcare infrastructure and digital health. The consequences are evident across rural communities. Patients frequently present with advanced stages of otherwise preventable or manageable diseases—not because effective treatments are unavailable, but because health systems lack the workforce needed to deliver early screening, health education, referral coordination, and continuity of care.

INDICATOR	FIGURE
WHO projected global health worker shortage by 2030	11 million
India's required allied health professionals	4.7 million needed; only 0.8–1.1 million available
Nurses per 1,000 population in India	1.96 nurses/1,000 vs WHO recommendation of 3/1,000
Registered nursing personnel in India	3 million

Table 1: Depicting Shortage of healthcare professionals¹

KADAM positions AI as a **workforce multiplier**, expanding the capacity of existing health systems rather than replacing healthcare professionals. AI-enabled screening, clinical decision support, digital documentation, remote specialist supervision, and LLM-based learning platforms enable Health Associates to deliver safe, protocol-driven care while continuously building their skills, even in remote settings. This allows clinicians to focus on higher-complexity care while extending quality healthcare into communities.

These realities formed the foundation of **KADAM—Knowledge-Driven AI-Assisted Detection and Monitoring Network**. KADAM reimagines hospitals as **workforce development hubs**, recruiting and training local youth as AI-enabled Health Associates who bridge hospitals and communities through screening, health education, referral coordination, and continuity of care. By integrating workforce creation with healthcare delivery, KADAM simultaneously addresses healthcare workforce shortages and youth employment.



In doing so, KADAM advances **SDG 3 (Good health & Wellbeing)** by strengthening first-mile healthcare access, **SDG 4 (Quality Education)** through competency-based certification, **SDG 5 (Gender Equality)** by expanding employment opportunities for women, **SDG 8 (Decent Work and Economic Growth)** through skilled workforce creation, and **SDG 10 (Reduced Inequalities)** by improving equitable access to healthcare in resource-constrained communities. As a scalable hospital-led model, KADAM offers a practical blueprint for strengthening health systems while preparing communities for the future of work across India and other low- and middle-income countries.

CHAPTER 2 — PROBLEM STATEMENT: The Health Workforce

2.1 A Widening Workforce Gap

According to Niti Aayog (2024) India's overall healthcare workforce density averages about 49.5 per 10,000 population². However, this national average conceals substantial disparities between urban and rural areas across states. Karan et al (2021) demonstrated that states such as Uttar Pradesh, Bihar, Jharkhand and Telangana report significant workforce shortages particularly in rural and underprivileged communities³. India needs approximately 1.8 million additional healthcare professionals to meet global workforce standards, with the greatest shortages in rural and underserved communities⁴.

According to the WHO regional office for South-East Asia, region has made significant progress, increasing the density of doctors, nurses and midwives by **69.3% between 2015 and 2024**. Yet these gains remain fragile. Bhutan lost 16.1% of its nurses in 2023, Sri Lanka lost 6.1% of its specialists, and Myanmar's nursing workforce declined by an estimated 73% between 2019 and 2022⁵. Numbers trained do not necessarily translate into numbers retained, nor do retained workers guarantee equitable deployment where need is greatest.

The defining challenge in global health is no longer a lack of technology, but a lack of people trained and deployed, to use where it is needed most. The World Health Organization projects a global shortfall of **11 million health workers by 2030**, despite a global workforce exceeding 70 million⁶. This aggregate figure conceals stark regional disparities: high-income countries continue to expand their workforce through international recruitment, while many low- and middle-income countries struggle with shortages, migration, and retention.



2.2 The Silent Epidemic: Rising Non-Communicable Disease Burden

India is referred to as the “Diabetes capital of the world” and faces a significant burden of diabetes mellitus, with an estimated 77 million cases in 2019, projected to rise to 134 million by 2045⁷. At the same time, the nature of healthcare demand has fundamentally changed. Many NCDs remain asymptomatic for years, resulting in delayed diagnosis and preventable complications. At the same time, India's ageing population is increasing the demand for long-term management of chronic conditions, placing additional pressure on already constrained health systems. As chronic diseases become more prevalent, the challenge facing India is not only a disease burden but also a workforce burden. Regions experiencing the fastest rise in NCDs are often those with the fewest community-based health workers, creating an urgent need for new models that connect communities to screening, referral, and long-term care. KADAM is designed to address this additional gap through a digitally enabled, community-rooted health workforce.

Large number of NCD related morbidity and premature mortality could be prevented through early detection and continuous management, those at greatest risk often face the poorest access to care⁸. Despite major investments in screening programmes, primary healthcare, and digital health infrastructure, persistent frontline workforce shortages continue to weaken last-mile service delivery.

Non-communicable diseases (NCDs) accounted for 43.8 million deaths in 2021, representing 64.5% of all global deaths, with 82% of premature NCD deaths occurring in low- and middle-income countries. In the WHO South-East Asia Region, NCDs account for approximately 55% of all deaths, underscoring the region's ongoing epidemiological transition^{9,10}.

2.3 Rural and Small-City Workforce Attrition: The Talent Drain

Healthcare workforce shortages in India are driven not only by insufficient workforce production but also by persistent challenges in recruitment, retention, and geographic distribution. Small cities and rural districts face chronic difficulties attracting and retaining skilled doctors, nurses, and allied health professionals. Better salaries, stronger career pathways, advanced infrastructure, and improved living conditions continue to pull healthcare workers toward metropolitan centres and international markets, creating a sustained talent drain from underdeveloped regions.

Hospitals in Tier-2 and Tier-3 cities often struggle to recruit specialised personnel and frequently lose trained staff to larger urban centres, perpetuating cycles of vacancy and high turnover. Doctors and healthcare workers in smaller cities often operate with limited specialist support, fewer opportunities for professional development, and restricted access to advanced technologies.



Karan et al states a wide disparity in distribution of health workers in rural and urban setting; for a country like India where 70% of the population resides in rural area the percentage of health worker were only 36% and doctors and nurses separately were 34% and 33 % respectively¹¹.

This imbalance is concerning globally. As mentioned by Boye et al there is a wide disparity between doctor to population ratio which ranges from 1:3035 to 1:13606 in urban and rural areas of Ghana respectively^{12,13}.

2.4 AI Literacy and Adoption GAP

The Missing Link in India's Digital Health Transformation

The effectiveness of artificial intelligence in healthcare is largely dependent on the availability of high-quality digital health data. By analyzing comprehensive clinical information, AI technologies can improve disease prediction, facilitate timely diagnosis, and support evidence-based clinical decision-making. Consequently, the digitization of patient records and the development of interoperable electronic health information systems are essential for enabling scalable and reliable AI applications within health systems.

India has built one of the world's largest digital public health infrastructures through the Ayushman Bharat Digital Mission (ABDM). At its centre is the Ayushman Bharat Health Account (ABHA) — a unique digital health identity enabling interoperable, longitudinal health records across public and private providers. This represents an extraordinary technological achievement with the potential to improve continuity of care, strengthen population health planning, and support data-driven delivery¹⁴. Yet, it does not fully meet the expectations and main reason for this is lack of adoption of electronic health record adoption by smaller private clinics and hospitals due to high cost of implementation¹⁵.

Pradhan et al clearly elaborates on the challenges of AI adoption due to inconsistent digital infrastructure, fragmented health information systems, concerns about data privacy, and the absence of clear implementation frameworks. Equally important is the limited AI literacy among many healthcare professionals, particularly those working in primary care and resource-constrained settings. Many frontline workers have little formal training in interpreting AI-generated insights or incorporating them into routine clinical practice, reducing the potential benefits of these technologies. Addressing this capability gap through structured training and digital skill development will be essential to ensure that AI complements, rather than complicates, healthcare delivery in India¹⁶. The success of digital health depends on the people who use it — not merely the technology itself.

Various AI-enabled technologies, including medical image interpretation systems, clinical decision support systems, predictive analytics for disease surveillance and risk stratification, and virtual health assistants, are increasingly being integrated into healthcare. Collectively, these technologies have the potential to improve



diagnostic accuracy, expand access to specialist care, optimize healthcare resources, and enhance the efficiency and quality of health service delivery.^{17,18,19}

In major parts of India preventable blindness goes undetected, cancers are diagnosed late, diabetes remains poorly controlled, and high-risk pregnancies are recognised only after complications develop due to lack of first mile of healthcare — where communities are screened, counselled, referred, and followed up, as majority of rural India remains inadequately staffed or are filled by unqualified doctors often referred to as private non degree practitioner's²⁰. Creating a competent workforce who is digitally savvy can reduce the healthcare burden.

India's frontline workforce, ASHAs and Anganwadi Workers, has made remarkable contributions to maternal and child health. These programmes were designed for a different public health landscape. As responsibilities have expanded to include NCD screening and digital health data entry, training and digital competencies, the career structures have not kept pace. India has broadly achieved its target of one ASHA per 1,000 population — a significant achievement. ASHAs carry responsibility across 78 defined tasks, receive a central government honorarium of ₹2,000 per month and 23 days of induction training²¹. *As India's health priorities evolve, the opportunity lies in building the next generation of this workforce — equipping frontline workers with structured digital skills, AI literacy, formal certification, and defined career pathways.*

INDICATOR	VALUE
Digital competency pilot (ANMs)	70 ANMs trained
Digital competency baseline (ASHAs)	32 ASHAs assessed
ASHA digital literacy score	39.9% average
Weakest digital competency	32.5% (data collection)

Table 2. Baseline Digital Competency of Community Health Workers²²

The overall challenge extends beyond digital literacy. Community health programmes frequently operate as disease-specific or time-limited initiatives driven by short-term funding, leaving recruitment, training, certification, and fragmented career progression. Communities consequently experience inconsistent follow-up, weak referral pathways, and poor continuity of care.

Most critically, the human connection within digital healthcare remains irreplaceable. Artificial intelligence can analyse retinal images, predict disease risk, and automate documentation. It cannot build trust with a pregnant mother, motivate a diabetic patient to remain on treatment, or ensure a high-risk patient reaches care. These



remain fundamentally human responsibilities requiring empathy, cultural understanding, and sustained community engagement. AI is therefore not replacing the healthcare workforce — it is redefining it, creating demand for a new cadre of AI-enabled community professionals who combine digital literacy with clinical support, health education, and trusted community relationships.

Digital health is generating entirely **new hybrid occupations** integrating AI-assisted screening, patient navigation, referral coordination, and community engagement.

Bridging the Gap: Where AI Literacy and Implementation Fail India's Health Sector

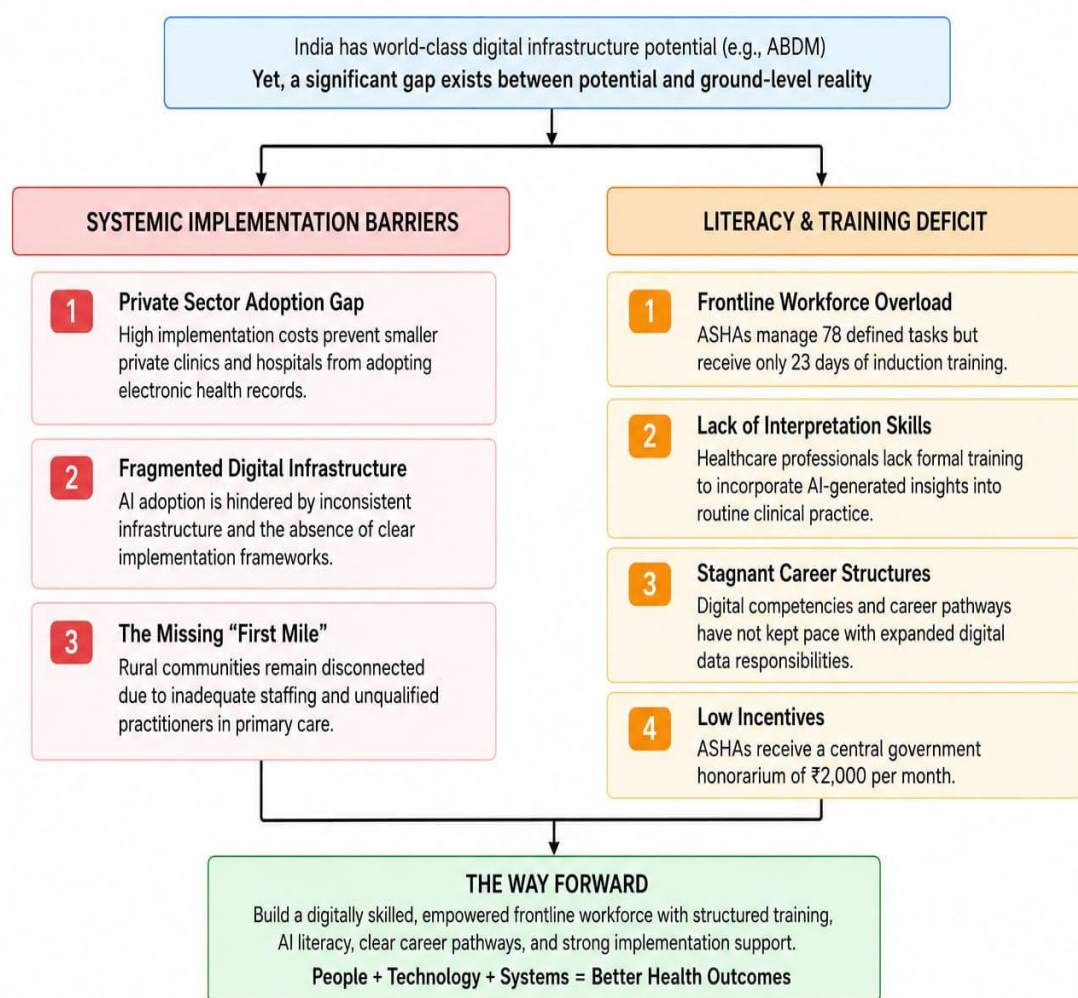


Fig 1: Depicting AI literacy and Implementation



CHAPTER 3 — CONCEPTUAL FRAMEWORK OF KADAM

3.1 Three Theoretical Pillars

Theoretical foundations

A Workforce Creation Theory Mehta et al., 2024 ²³ India's health workforce crisis stems from maldistribution, not just insufficient production. 33 studies confirm concentration of professionals in urban areas despite greatest need in rural communities. KADAM: Recruits and trains local youth — creating a community-rooted workforce that is accessible, equitable and sustainable.	B Community-Based Agency Pfeiffenberger et al., 2025 ²⁴ Community-based actors serve as critical connectors between patients and formal health systems — enabling earlier intervention, continuity of care, and more responsive service delivery. KADAM: Uses panchayat-led recruitment — embedding workforce development in local governance, accountable to the communities it serves.	C Competency-Based Development McCaughy & Somers, 2025 ²⁵ Workforce effectiveness depends on quality of training, supervision, and professional development. Task-shifting expands coverage without proportional increases in highly trained staff. KADAM: Built on hospital-linked supervision, IIHMR certification, and a digital referral architecture maintaining clinical accountability at every stage.
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Table 3. Theoretical Foundations



Evidence from global task shifting program

South Africa — nurse-initiated ART²⁶ Nurse-initiated antiretroviral therapy demonstrated that task-shifted cadres deliver specialist-level outcomes at scale when supported by standardised protocols and supervision.	Bangladesh — community midwifery diploma²⁷ Community midwifery training demonstrated a 16-fold return on investment — one of the strongest evidence cases for competency-based, locally trained health workforce models in LMICs.
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Table 4. Examples of Global Task shifting program

CONDITIONS FOR TASK-SHIFTING SUCCESS —

Adequate supervision Task-shifted cadres achieve comparable outcomes only when clinical supervision is structured and sustained	Standardised protocols Clear, validated protocols ensure consistent, safe delivery of clinical tasks by non-specialist workers	Functional referral systems A reliable pathway from community to hospital is essential for managing cases beyond the associate's scope
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Table 5. Task Shifting Surface²⁸

3.2 Research Question and Theory of change

This proposal contends that hospitals must be reimagined not only as providers of healthcare but as creators of healthcare talent. KADAM — the Knowledge-Driven AI-Assisted Detection and Monitoring Network — is a hospital-led workforce development model designed to address healthcare workforce shortages while simultaneously expanding first-mile healthcare access. Through structured recruitment, training, certification, and deployment, KADAM develops a new cadre of Health Associates drawn from local communities, equipped with AI-assisted screening tools, referral systems, and digital monitoring platforms.

The research question guiding this proposal is: *How can hospitals become **workforce creation hubs that equip local youth with AI-assisted tools** to deliver first-mile healthcare access, strengthen referral systems, and improve continuity of care in underserved communities?*



KADAM seeks to:

- ❖ Transform hospitals into sustainable workforce development hubs;
- ❖ Expand KADAM Health Associate-led first-mile access by screening and referral;
- ❖ Create structured employment pathways for local youth;
- ❖ Leverage AI as a workforce multiplier; and
- ❖ Develop a scalable model transferable across India and comparable LMICs.

THEORY OF CHANGE: KADAM MODEL

Hospitals as Workforce Creation Hubs for First-Mile Healthcare

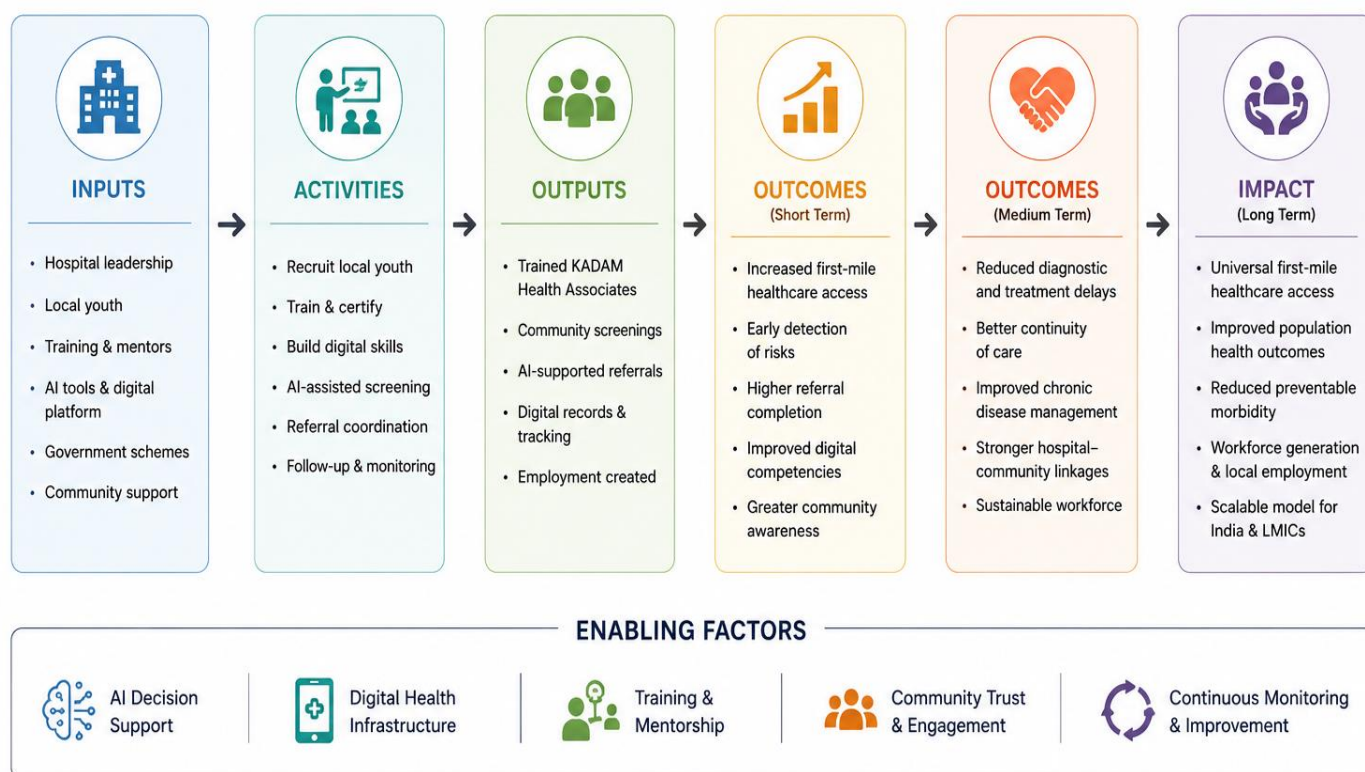


Fig 2: The Transformation Model



CHAPTER 4 — KADAM: Reimagining Hospitals as Workforce Development

4.1 Genesis of KADAM

Shamli a Tier-3 district in western Uttar Pradesh, India, functions as a healthcare hub serving approximately 150 surrounding villages (source Wikipedia) — characterised by a predominantly rural population, rising healthcare demand, and a chronic shortage of skilled health personnel. These conditions are not unique to Shamli; they are widely observed across Tier-2 and Tier-3 districts in India and comparable LMICs. Shamli is not where KADAM was tested — it is where **KADAM began**.

Seven years of healthcare service delivery in the district revealed a recurring structural constraint: not a shortage of willing people, but a persistent gap between formal academic qualifications and practical clinical competencies. *Facilities operated as de facto training institutions, absorbing 8–12 unpaid or low-paid students annually seeking applied clinical experience.* Simultaneously, a significant proportion of young people — particularly women — remained outside the formal workforce despite demonstrated motivation, constrained by social barriers, restricted mobility, and limited access to skill-development opportunities. A talent pool sat directly adjacent to an unmet institutional need. KADAM was built to connect the two.

The Patient Who Made KADAM Necessary: The idea for KADAM was shaped in a part by a patient who arrived at the Shamli eye hospital (an experience witnessed first-hand by one of the authors) — after nearly six months of persistent headaches and eye pain. By the time she reached the hospital, she had already lost vision in one eye; the remaining eye retained only central tubular vision due to advanced glaucoma. Throughout this period, she had repeatedly sought care from a local unqualified provider who neither recognised the seriousness of her condition nor referred her to a specialist.

Glaucoma causes irreversible vision loss when diagnosis is delayed — yet timely screening and referral could have preserved much of her sight. This case revealed a critical gap: not merely a shortage of specialists, but the absence of a trained first-contact workforce. A KADAM Health Associate — equipped with structured clinical education, AI-assisted screening tools, and clear referral protocols — could have recognised the warning signs, measured intraocular pressure, and ensured early referral to an ophthalmologist. The intervention could have prevented irreversible blindness.

This experience **reinforced our conviction** and became the founding principle of KADAM.



4.2 The KADAM Vision

KADAM—the **Knowledge-Driven AI-Assisted Detection and Monitoring Network**—reimagines hospitals not merely as providers of healthcare, but as **engines of workforce creation**. KADAM operationalises the 'grow your own' principle (O'Sullivan et al. 2021)²⁹ by recruiting local youth from within Shamli's own communities, training them through a hospital-anchored competency-based programme, and deploying them back into the villages they already know and are trusted by — producing a workforce that is not just skilled, but rooted, particularly women—as *AI-enabled Health Associates*, it simultaneously expands first-mile healthcare access, strengthens referral systems, and creates pathways to skilled employment.

The name *KADAM*, meaning "step" in Hindi, reflects the programme's core philosophy: every step toward healthcare access should also be a step toward employment, dignity, and community empowerment. Rather than confining healthcare delivery within hospital walls, KADAM extends care into communities through trusted local workers who understand the social, cultural, and linguistic realities of the populations they serve.

4.3 KADAMs Dual workforce strategy

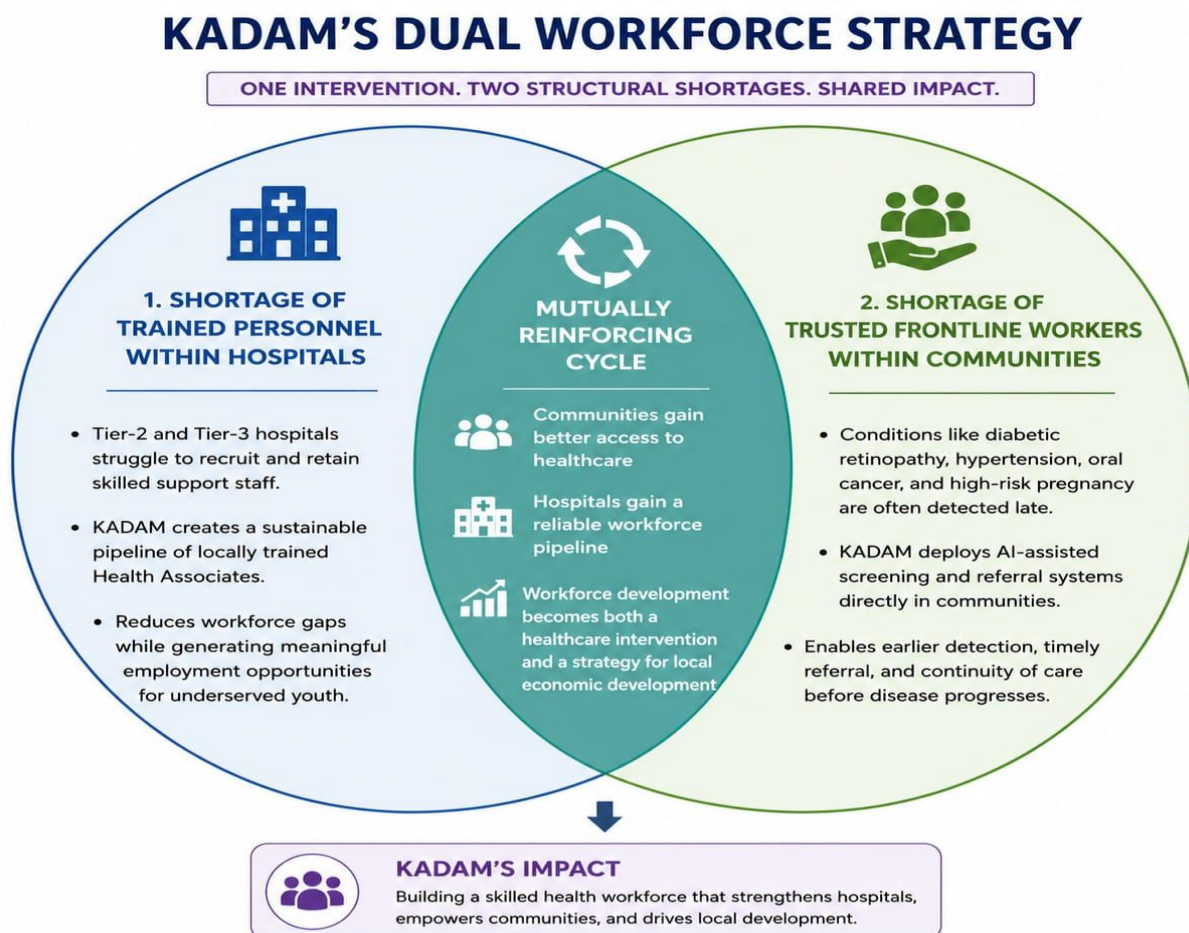


Fig 3: Venn Diagram depicting Dual Workforce strategy



4.4 Building the KADAM Health Associate Workforce

KADAM is designed for those who conventional systems are often overlooked—young people, particularly women, who's educational and employment opportunities have been constrained by financial hardship, caregiving responsibilities, or social norms.

Globally, women comprise approximately 67% of the health and social care workforce, yet in LMICs, women remain among the most economically marginalised — excluded from formal employment, denied access to education and career pathways, and underrepresented in leadership across²⁴. KADAM builds on this existing strength by creating structured pathways for women to become certified Health Associates and future community *leaders*, transforming an often-informal workforce into one characterised by *professional recognition, career progression, and economic mobility*.

Eligibility is deliberately low-barrier — Class 10 completion, basic digital literacy, local-language fluency, and genuine commitment to community service. Enrolment is primarily through referrals from Lions Club, Rotary Club, government and local schools, Vaish Kutumb associations, and Mahila Samooths — civil society organisations with established trust and reach within the communities."

Enrolment prioritises underserved local youth with demonstrated commitment to community service, empathy, leadership potential, and willingness to learn rather than academic attainment alone. By recruiting directly from the communities, they will ultimately serve, KADAM strengthens trust, cultural understanding, and long-term workforce retention.

A distinguishing feature of the model is its panchayat-led recruitment architecture. Sarpanches and gram panchayats serve as frontline recruitment partners, embedding workforce development within existing local governance systems rather than creating parallel institutional structures.

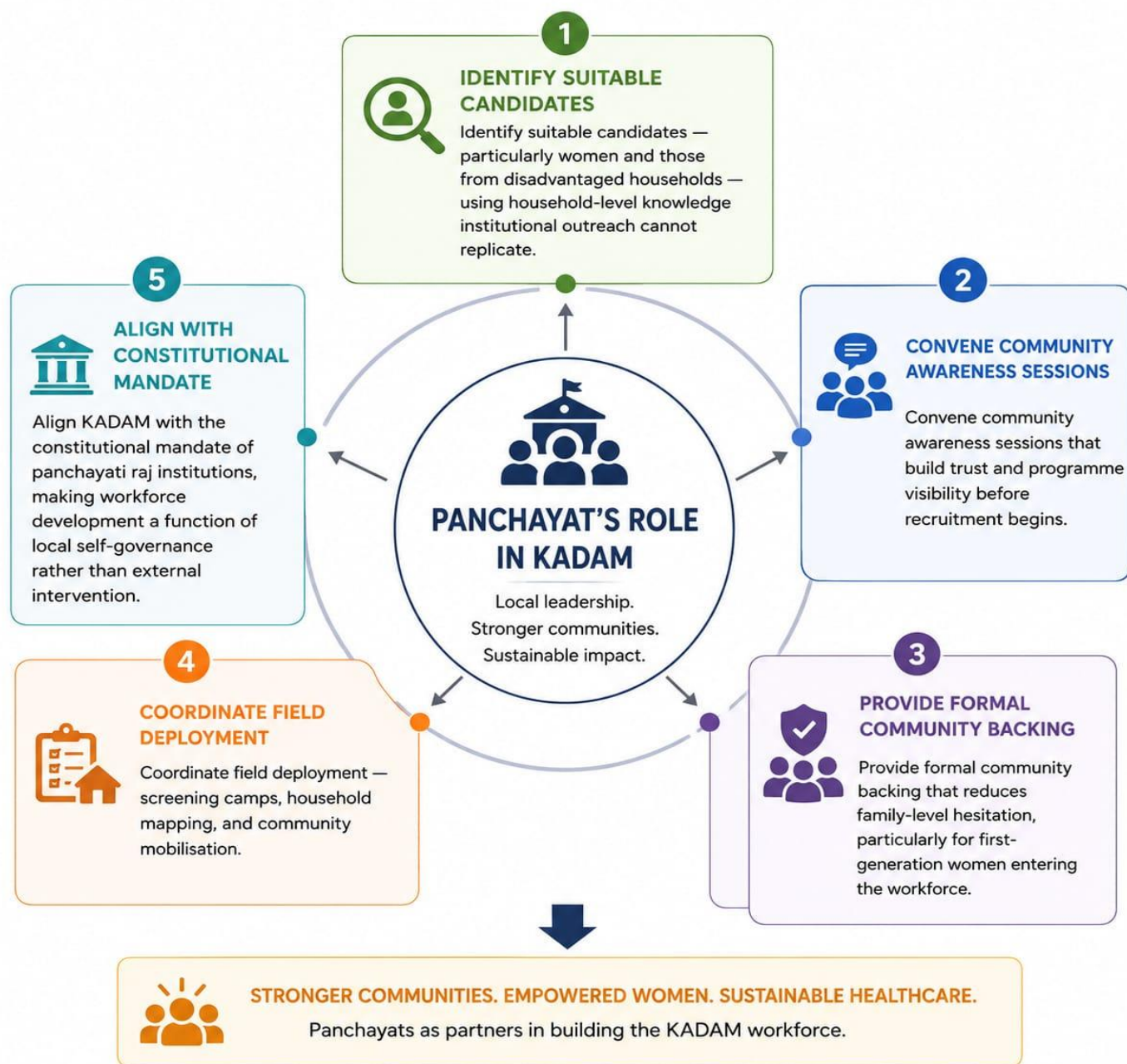


Fig 4: Depicting Panchayat's role in KADAM

4.5 Hospital-Led: Training and Certification Journey

Each partner hospital functions as a Workforce Development Hub, delivering a competency-based training programme designed by KADAM in collaboration with the hospital — aligned to local disease burden and specialty requirements — with certification and examination conducted through IIHMR, lending the programme nationally recognised academic credibility.

Training is integrated directly with service delivery. From the outset, Health Associates participate in screening programmes, patient navigation, referral coordination, and follow-up activities under clinical supervision,



creating immediate value for both hospitals and communities while developing practical competencies in real-world settings.



KADAM ASSOCIATE JOURNEY

ENROLLMENT TO CERTIFICATION



Fig 5: Certification Journey

4.6 The KADAM Data-to-Care Architecture

The **KADAM Data-to-Care Architecture** converts community health data into actionable insights through a secure digital ecosystem. AI-enabled mobile tools capture screening, risk assessment, referrals, and follow-up data during community outreach, which is securely stored on a centralized cloud platform. Real-time dashboards enable hospitals to monitor service delivery, workforce performance, and patient referrals, while analytics identify care gaps and guide timely interventions. This continuous feedback loop strengthens training, improves programme quality, and supports data-driven decision-making, ultimately creating a skilled workforce, improving health outcomes, and building stronger health systems.



THE KADAM Closed-Loop Data-to-Care Architecture

From Community Data. | To Actionable Care. | To Stronger Health Systems.

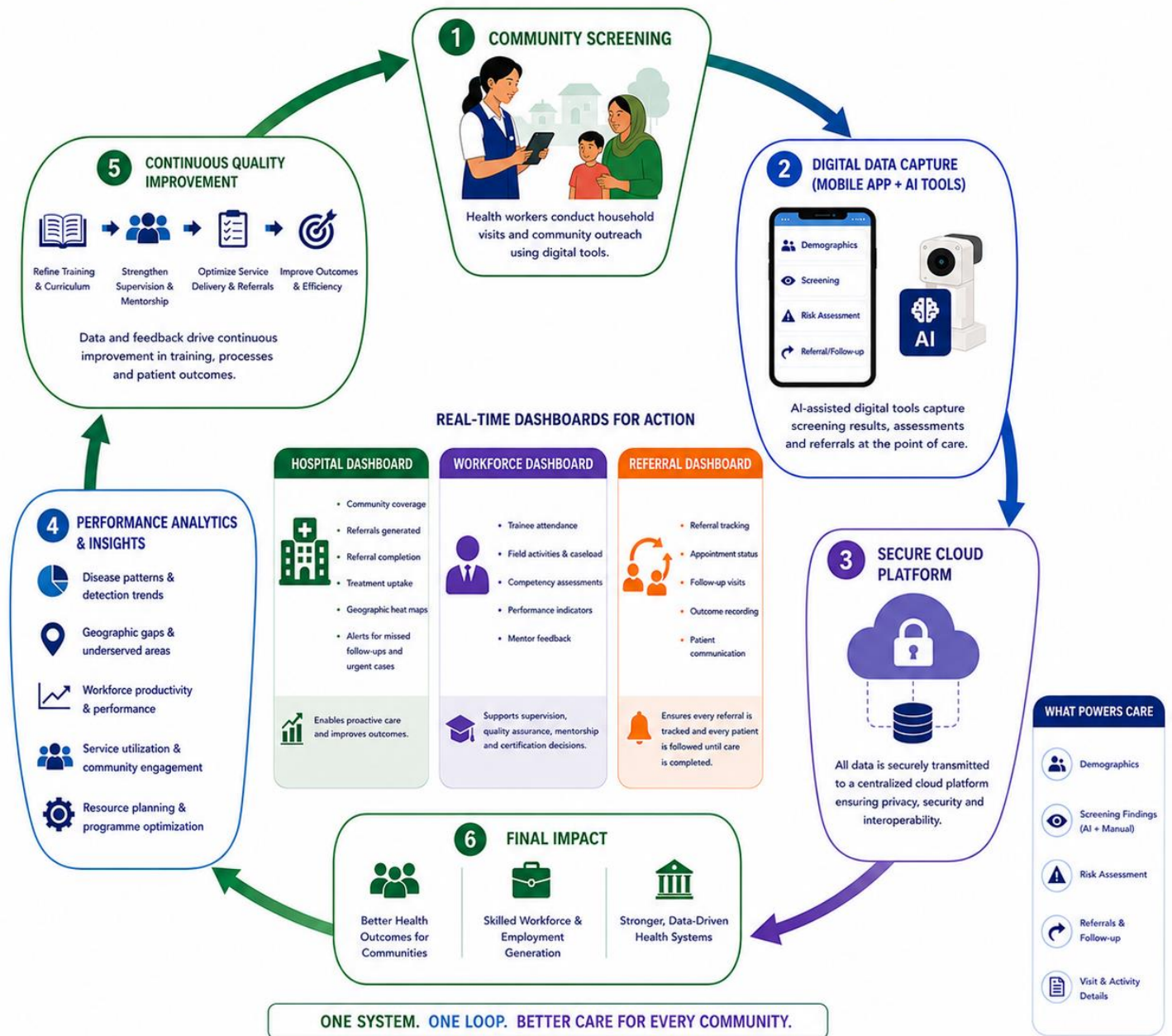


Fig 6: Data to care Architecture



CHAPTER 5— PILOT IMPLEMENTATION: The Drishti Model, Shamli,

Shamli Pilot represents the first real-world implementation of the KADAM framework at *Shamli Eye Hospital, Uttar Pradesh* and serves as the ***proof of concept*** for the Community Workforce Development Hub model. It demonstrates how an existing hospital can move beyond providing healthcare services to become a centre for workforce creation, community engagement and digitally enabled care delivery. Rather than establishing a parallel institution, KADAM integrates training, service delivery and employment generation into routine hospital operations.

Shamli Eye Hospital was selected because it has decades of experience in community eye care, outreach programs and referral management. It serves a predominantly rural population where access to specialist care is often delayed because of limited awareness, geographical barriers and shortage of trained frontline workers. These characteristics make Shamli an ideal setting to validate whether a hospital-led workforce model can strengthen access to care while creating meaningful employment for local youth.

Ophthalmology was selected as the pilot discipline because it builds upon more than 40 years of institutional experience. For over four decades, ***Shamli Eye Hospital*** has delivered comprehensive eye care through hospital-based services and community outreach, providing the expertise and infrastructure needed to develop a competency-based curriculum and implement the model within a real-world healthcare setting.

Clinical experience as retina specialists also shaped our decision. We have repeatedly encountered patients with irreversible vision loss from conditions that could have been prevented through earlier detection and timely referral. These experiences highlighted that reducing avoidable blindness requires not only specialist treatment but also *a trained frontline workforce capable* of identifying at-risk individuals within their communities.

Although ophthalmology serves as the proof of concept, the **KADAM framework is designed to be disease-agnostic.**



5.1 Stakeholder Responsibilities

STAKEHOLDER	RESPONSIBILITIES
Certification Partner (IIHMR)	Provides academic oversight, conducts assessments, and awards certification.
Partner Hospital (Shamli Eye Hospital)	Curriculum Design, Develops SOPs, recruits' trainees, delivers clinical training, mentors' participants, validates referrals, and provides specialist care at a <i>subsidised cost on referrals</i>
Trainer	Any one with following degrees: BAMS, BHMS, BDS, MBBS + 2 years of clinical experience
KADAM Health Associates	Conduct vision screening, patient counselling, AI-assisted screening, digital documentation, and referral coordination under supervision.
Technology Partners	Provide AI tools, portable diagnostics, teleophthalmology, electronic health records, and digital dashboards.

TECHNOLOGY PARTNERS	POTENTIAL ROLE IN KADAM MODEL
REMIDIO	Portable smart phone-based fundus camera with AI assistance for screening of diseases like retinopathy
3nethra neo(FORUS HEALTH)	Wide field digital imaging for pediatric diseases
GOOGLE HEALTH	AI algorithms for retinal image interpretation and clinical decision
GOOGLE GEMINI	Multilingual Ai assistant for frontline associate, health education, patient counselling
MICROSOFT AZURE	Clinical decision support, Hospital analytics, referral dashboards

Table 6. Technology Partners

5.2 Academic Partnership: IIHMR

Certification Partner, Academic Framework and Standardized Training

The **Indian Institute of Health Management Research (IIHMR)**³⁰ serves as the academic and certification partner for the KADAM Drishti Pilot through a formal Memorandum of Understanding (MoU) with Shamli



Eye Hospital. Under this collaboration, trainees are enrolled in the **Diploma in Community Health and Digital Healthcare Operations (DCHDHO)**, and upon successful completion of the academic, clinical, and community-based competency requirements, are awarded the DCHDHO diploma by IIHMR. In addition, learners receive four progressive competency certificates issued after the successful completion of each training level, following IIHMR's competency-based certification framework. While the certification model is based on IIHMR's established community health education programme³¹, the ophthalmology curriculum has been specifically developed and customized by Shamli Eye Hospital for the KADAM Drishti programme.

The KADAM Drishti ophthalmology module, designed by the clinical faculty of Shamli Eye Hospital, has been integrated into the IIHMR diploma framework while maintaining IIHMR's academic standards and assessment methodology. The curriculum equips trainees with competencies in community eye care, digital vision screening, early disease identification, referral coordination, patient counselling, tele-ophthalmology, and follow-up care through a structured four-level progression from **Vision Screener** to **Community Vision Health Leader**. The programme comprises twelve ophthalmology modules delivered over an 11-month training period (34 academic credits; 340 learning hours), combining classroom instruction, supervised clinical practice, digital learning, and community-based field training.

To ensure consistent training and service delivery, Shamli Eye Hospital has developed comprehensive **Standard Operating Protocols (SOPs)** aligned with each competency level of the KADAM Drishti curriculum and the learning outcomes of the DCHDHO programme. These SOPs standardize clinical procedures, digital workflows, competency assessments, documentation, quality assurance, infection control, equipment handling, referral pathways, and community outreach activities. Together, IIHMR's competency-based academic framework and Shamli Eye Hospital's standardized ophthalmology protocols create a scalable, quality-assured model for developing community-based eye care professionals capable of delivering safe, digitally enabled vision services in resource-limited settings.

5.3 Pilot Phase Financing

Pilot Phase

The pilot is designed to establish proof of concept at a single partner hospital with an initial cohort of 10 Health Associates serving a community of approximately 5,000 individuals



COST HEAD	AMOUNT (US DOLLARS)	NOTES
Application Development	1200\$-3500\$	One time cost
Application Maintenance	60\$/ month	Recurring monthly cost(<i>will increase with scale</i>)
Trainer fee	200\$/month	Recurring monthly cost
Screening Tools	2300\$-3500\$	One time cost, Borne by Partner hospital, recovered to the referral generation
Certification and Examination Fee	120\$	Paid to IIHMR per student
Programme fee per student	265\$	Enrolment fee, paid at the time of admission

Table 7. COST Break up

Student Category	Fee Arrangement
Can afford in full	265\$ paid upfront
Partial capacity	Self-payment + CSR subsidy for the remainder
Unable to afford	Full fee covered through CSR funding

Under India's Companies Act 2013^{32,33}, qualifying companies are mandated to allocate 2% of net profits to CSR activities. KADAM is structured to receive CSR funding as a certified workforce development and community health programme — ensuring accessibility without compromising financial sustainability.

The pilot is designed around a sustainable financing model in *which workforce development is integrated into routine hospital operations rather than functioning as an externally funded outreach programme. Initial investment supports curriculum development, digital infrastructure, diagnostic equipment and training delivery.* As Community Health Associates begin community deployment, they increase screening coverage, *strengthen referral pathways and improve utilisation of specialist services.*

5.4 Implementation Timeline

The Drishti–KADAM Pilot is implemented through three overlapping phases. Rather than following a linear sequence of classroom training, followed by practical experience at the community level. The training, service delivery and workforce development occur simultaneously, ensuring that participants contribute meaningfully to healthcare services while acquiring practical skills.



DRISHTI-KADAM PILOT: 18-MONTH IMPLEMENTATION ROADMAP (GANTT CHART)

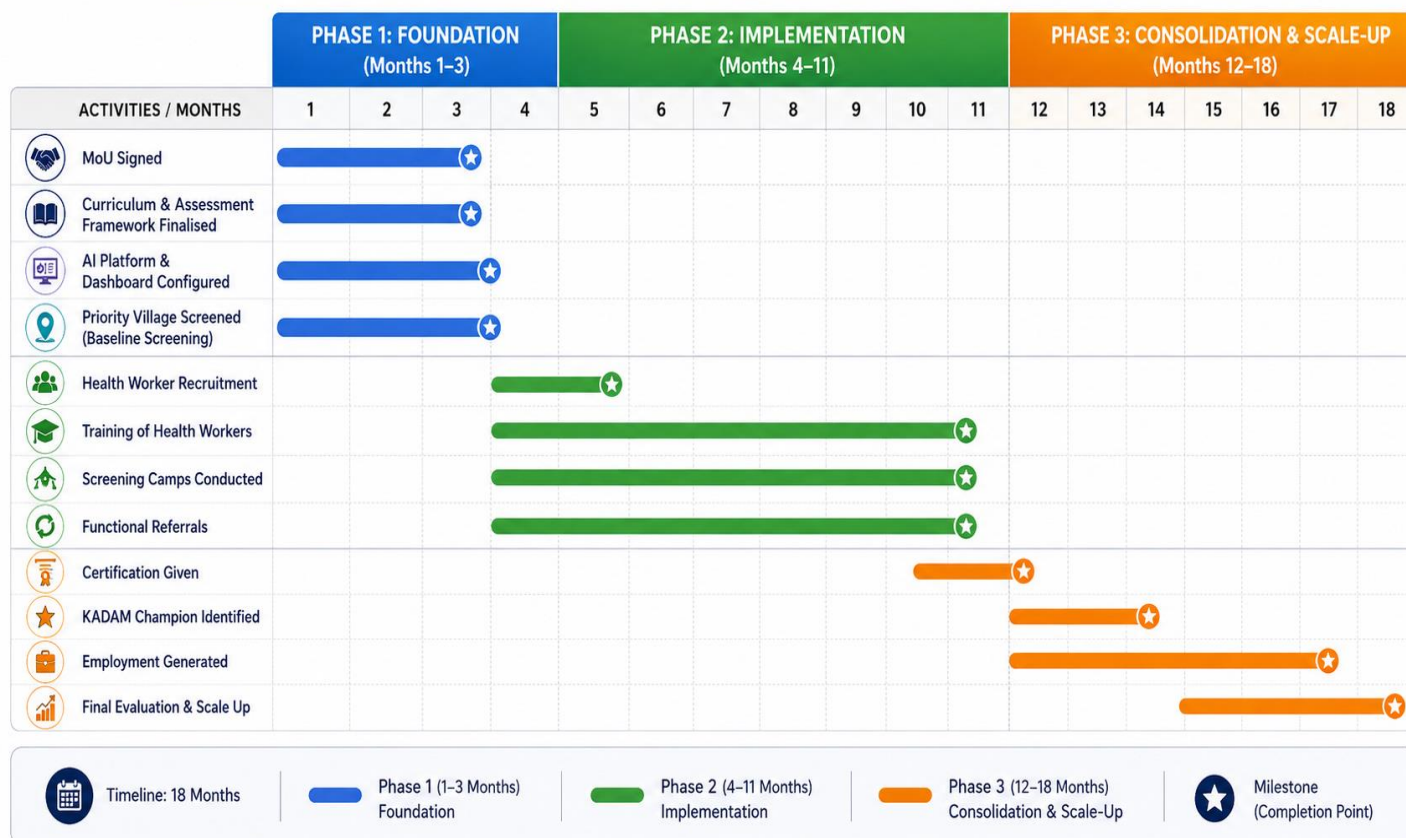


Fig 7: GANTT CHART

Three-Phase Implementation Strategy (18 Months)

Phase 1: Foundation and System Establishment (1–3rd month)

The first phase focuses on formalising partnerships, governance structures, and regulatory approvals while finalising the curriculum, certification, and assessment framework. Conducting baseline community mapping, configure AI platforms, and procuring portable diagnostic equipment to prepare for implementation.

Key Outputs

- Project governance established
- MOUs signed with implementation partners
- Certification curriculum and assessment framework finalised
- Baseline community assessment completed
- AI platform configured and equipment procured



Phase 2: Workforce Development and Integrated Service Delivery (4–11th month)

The second phase operationalises intensive workforce development and deployment. Community health workers recruited with special consideration for women from resource-constrained communities. Recruits undergo structured classroom and field-based training before establishing village-based KADAM screening camps. Portable AI-enabled diagnostic devices are deployed, enabling screening for eye diseases and selected primary healthcare conditions. As training credits and screening performance accumulate over this phase, one or more KADAM Champions are identified within the batch, taking on coordination of screening camp logistics and peer mentoring for the remainder of the pilot.

Screening data are transmitted through telemedicine platforms for specialist review, facilitating early diagnosis, referral, and treatment. Continuous mentoring, supportive supervision, and performance monitoring ensure quality service delivery while refining operational workflows based on implementation experience.

Parameter	Assumption / Estimate
Community screening camps	2 camps per week
Active implementation weeks	48 weeks/year
Total camps conducted	96 camps/year
Average individuals screened per camp	100 (range: 80–120)
Total individuals screened annually	9,600
Expected referral rate	15–20%
Estimated referrals generated annually	1,440–1,920 individuals

Table 7. Projected Annual Community Screening Capacity per Hospital

Note: Estimates are based on the operational assumptions of the Drishti–KADAM Pilot

Key Outputs

- Community Health Workers certified and deployed
- Village KADAM screening camps operational
- One or more **KADAM Champions*** are identified within the batch
- AI-assisted screening and teleconsultation services launched
- Functional referral pathways established
- Continuous monitoring and quality improvement systems operational



Phase 3: Employment Transition, Evaluation and Scale-up Planning (11–18th month) The final phase focuses on transforming trained community workers into a sustainable health workforce. The recruits are given competency certification and receive employment mentoring and placement support through healthcare institutions, NGOs, and public health programmes. Simultaneously, *project outcomes are evaluated using predefined indicators covering employment generation, workforce competency, healthcare access, screening coverage, referral completion, and community health outcomes*. Lessons learned are incorporated into a comprehensive scale-up strategy designed for district and state-level expansion, creating a replicable model that strengthens both healthcare delivery and future workforce development.

- Employment placement and certification completed
- Comprehensive impact evaluation conducted
- Health and workforce outcomes documented
- Sustainability and financing strategy developed
- District and state scale-up roadmap prepared

5.5 KADAM_Drishti KADAM Drishti is the first speciality implementation, applies to the Workforce Development Hub model to **community eye care**.

KADAM DRISHTI

Building Skilled Eye Care Professionals. Strengthening Communities. Creating Employment.



DURATION
11 MONTHS



MODULES
12



CREDITS
34



TOTAL HOURS
340 HOURS

LEVEL	ROLE	DURATION	KEY LEARNING AREAS (MODULES)	COMMUNITY CAMPS	CREDITS	HOURS (THEORY / PRACTICAL)
LEVEL 1 	Vision Screener Foundation in Eye Health & Screening	2 MONTHS	- Anatomy of the eye - Visual acuity testing - Basic optics & refractive errors - Introduction to digital tools	— No camps at this level	8 CREDITS	80 HOURS (50 Theory / 30 Practical)
LEVEL 2 	Ophthalmic Technician Clinical Support & Ophthalmic Procedures	3 MONTHS	- Tonometry & slit-lamp assist - Fundus imaging basics - Digital ophthalmic records - Patient safety & basic procedures	Vision Screening Camp Take part in door-to-door and school-based screening camps in assigned villages.	9 CREDITS	90 HOURS (40 Theory / 50 Practical)
LEVEL 3 	Clinical Optometry Assistant Advanced Testing & Clinical Assessment	3 MONTHS	- Retinoscopy & keratometry - Imaging basics (OCT, fundus) - Tele-ophthalmology - AI-assisted screening tools - Patient history communication	Eye Care Outreach Camp Assist in comprehensive eye check-up camps for adults & elderly in rural areas.	9 CREDITS	90 HOURS (35 Theory / 55 Practical)
LEVEL 4 	Community Vision Health Leader Community Engagement & Leadership	3 MONTHS	- Health communication & education - Motivational interviewing - Eye camp coordination - Community leadership & follow-up	Integrated Eye Health Camp Lead & coordinate community camps with screening, education & follow-up care support.	8 CREDITS	80 HOURS (40 Theory / 40 Practical)

COMPETENCY-BASED LEARNING
Classroom instruction, digital learning, supervised clinical training & community deployment
 OUTCOME
Job-Ready Eye Care Professionals
Strengthened Communities
Sustainable Employment
 ONE PROGRAM. FOUR SKILL LEVELS. ENDLESS IMPACT.



Empowering communities with skills. Enriching lives with vision." – KADAM DRISHTI

Fig 8: Certification Journey



5.6 KADAM CHAMPION: Community Health Leadership Model

While certification marks the formal completion of training, the KADAM model is designed to recognise sustained excellence beyond it. The highest-performing Associates within each batch are informally recognised as **KADAM Champions**, emerging from within the cohort itself based on sustained performance across the pilot. Depending on batch size and performance distribution, a batch may produce more than one Champion. Champions help coordinate the batch internally — supporting day-to-day scheduling and logistics for screening camps and helping guide fellow Associates through the remainder of their training under the trainer or supervisor. Candidacy is visible early through training credits and initial screening performance, with recognition confirmed as that performance holds over the course of the programme. Also, *champions are given preferential opportunities for absorption into the organisation upon successful completion of the programme.*

This mechanism strengthens workforce retention in two ways: it gives Health Associates a visible incentive to excel from early in their training.

The Drishti–KADAM Pilot demonstrates that even secondary care hospitals can evolve beyond centres of healthcare delivery to become engines of inclusive economic development. *KADAM framework positions **employment generation as the primary objective**, with improved health outcomes emerging as a sustainable and measurable consequence and bridging the gap with rural India.*



★ KADAM CHAMPION ★

COMMUNITY HEALTH LEADERSHIP MODEL

From Learning to Leadership • From Associate to Champion



Fig 7: KADAM Champion Journey



CHAPTER 6 — From One Hospital to a National Platform

6.1 Scaling: The next phase: KADAM MAA Framework

The KADAM framework scales through existing hospitals rather than new infrastructure. Participating hospitals function as Workforce Development Hubs, embedding training within routine clinical operations — supervision, mentoring, outpatient services, and community outreach already in place.

The long-term vision is to enable hospitals across rural India to function as Workforce Development Hubs that recruit, train, certify and deploy community-based Health Associates.

The model aligns incentives across all stakeholders. Hospitals earn an upfront training fee per trainee, building a pipeline of workers fluent in their protocols — reducing recruitment costs, onboarding time, and attrition. Academic partners provide certification; the KADAM Foundation supplies curriculum, digital tools, AI-enabled support, and programme governance. A unified digital platform integrates learning management, competency assessment. A KADAM dashboard, clinical decision support, referral tracking, EHR, and monitoring across all hubs, standardized SOPs and AI workflows ensure consistency while allowing local adaptation.

This hub-and-spoke approach reduces implementation costs, ensures quality through standardized certification and enables rapid replication across districts with different healthcare priorities.

Scale operates across two pathways. **Horizontal scaling** replicates the model across hospitals delivering the same specialty — for example, expanding KADAM Drishti across secondary eye hospitals with identical standards. **Vertical scaling** introduces new specialty tracks — KADAM MAA, KADAM Mukh (Oral Cancer)— using the same platform, governance, and workforce architecture.

KADAM MAA

Following validation of KADAM Drishti, the same workforce platform will be extended to maternal and child health through MAA. It reuses the same Hub architecture, certification philosophy, digital platform and governance mechanisms while adapting the clinical curriculum to maternal health.

Maternal Health Associates will support women throughout the continuum of care, including early pregnancy registration, antenatal follow-up, nutrition counselling, birth preparedness, identification of high-risk pregnancies, referral coordination, postnatal follow-up and newborn care education. Digital decision support,

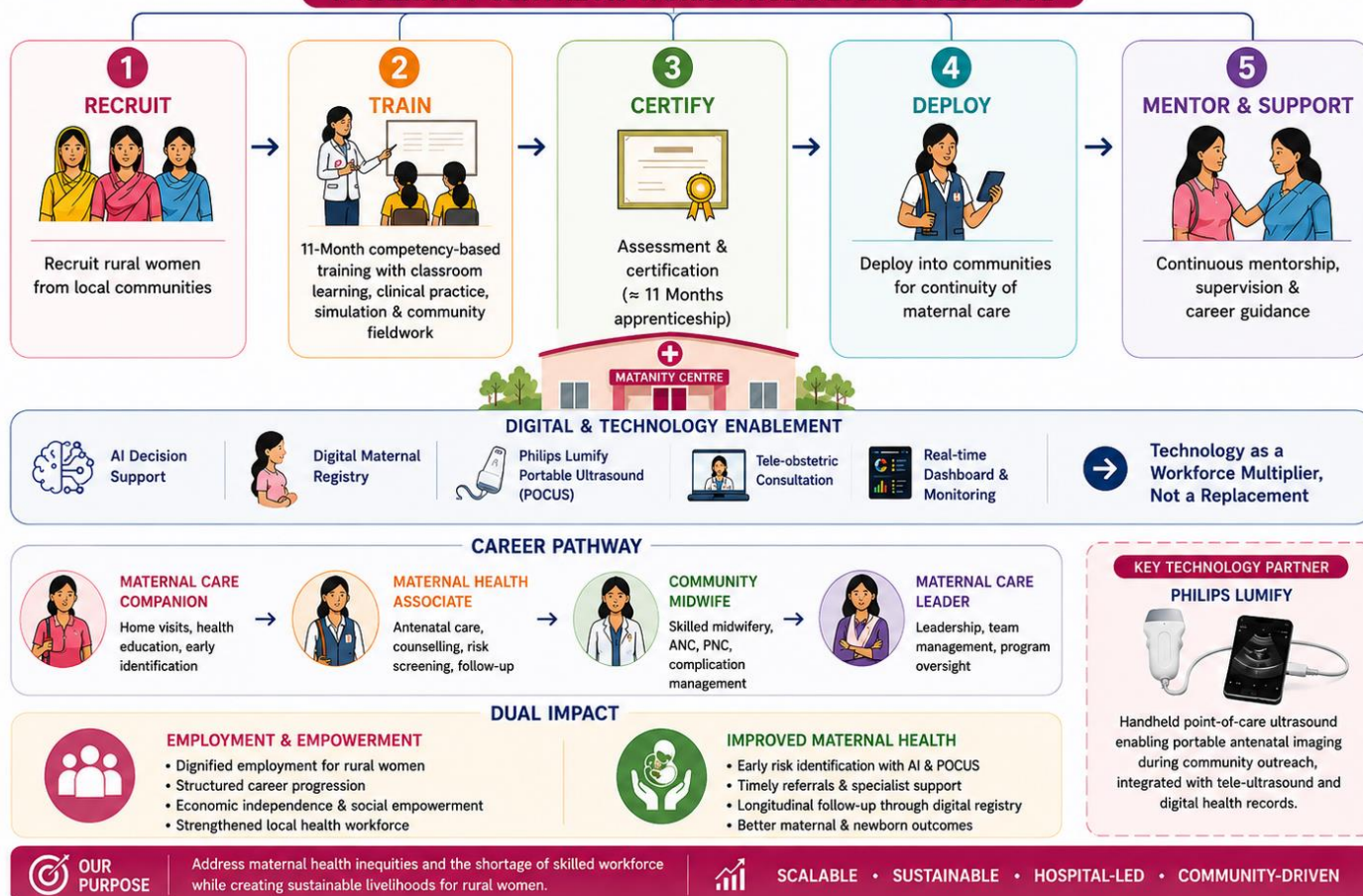


maternal registries and specialist supervision strengthen continuity of care between the community and health facilities.

KADAM MAA FRAMEWORK

Reimagining Maternal Care Through Community Workforce Ecosystems

MATERNITY CENTRE AS WORKFORCE DEVELOPMENT HUB



6.2 Transferability to Low- and Middle-Income Countries

Most LMICs share the same structural challenges: frontline worker shortages, rising chronic disease burden, limited specialist availability, and high youth unemployment — particularly among women. In sub-Saharan Africa, South and Southeast Asia, and parts of Latin America, health systems are simultaneously managing the unfinished agenda of infectious disease while absorbing a rapidly growing burden of chronic and non-communicable diseases — among them hypertension, cardiovascular disease, cancer, chronic respiratory conditions, and mental health disorders — conditions that demand sustained, skilled frontline capacity that most systems simply do not have^{8,34,35}.

KADAM directly addresses each of these fault lines. By embedding trained community health workers within hospital systems rather than deploying them in isolation, the model ensures clinical supervision, quality assurance, and career progression — gaps that have historically undermined standalone community health



programmes. The hospital-led financing structure generates an immediate revenue stream for participating facilities while simultaneously building a locally trained, locally retained workforce — reducing dependence on expensive specialist recruitment and mitigating the brain drain that strips rural and peri-urban health systems of their most skilled workers.

However, transferability is not without limits. A critical entry barrier to exact replication is the variation in healthcare regulation across countries. Several diagnostic procedures and clinical tasks performed by KADAM-trained community health workers in India operate within India's specific regulatory and scope-of-practice framework. The same procedures may require formal regulatory approval in other national contexts. Healthcare governance is inherently country-specific — what constitutes permissible practice for a trained community worker in one jurisdiction may be legally restricted in another.

This means that while the KADAM architecture — its training model, digital platform, and workforce development logic — is transferable, the *clinical and governance components require a country-level regulatory review before deployment*. Diagnostic protocols, AI-assisted decision support tools, and task-shifting arrangements must each be assessed against national health law, professional licensing requirements, and ethical standards applicable in the target country.

Transferability is therefore best understood as **principled adaptation rather than direct replication** — the model travels, but its clinical layer must be re-validated in each new context.

CHAPTER 7 - Monitoring, Evaluation, and Learning

Chapter 7

Monitoring, Evaluation and Learning (MEL)

A robust MEL framework measures performance, effectiveness, and equity outcomes using quantitative, qualitative, and domain-specific indicators across workforce, clinical, and institutional dimensions



Type	Domains	All indicators (combined)
Shareholder	Workforce Development	Recruitment, training completion, certification, placement rate, training competency (credit-based: Term Certificates),
	Community Impact	Households screened, coverage vs. target, referred patients treated at discounted rates
	Third -party partnership	Partner retention, programme expansion, leadership development, scale readiness, partner engagement (review)
Clinical	Clinical Outcomes	Diagnosis rate, referral completion.
	Digital Health	Digital records rate, AI screening use, data quality (periodic audit)
Financial	Financial Sustainability	Cost efficiency, cost recovery, reduction in out-of-pocket expenditure,

Table 8. KADAM Key Performance Indicator (KPI) Framework

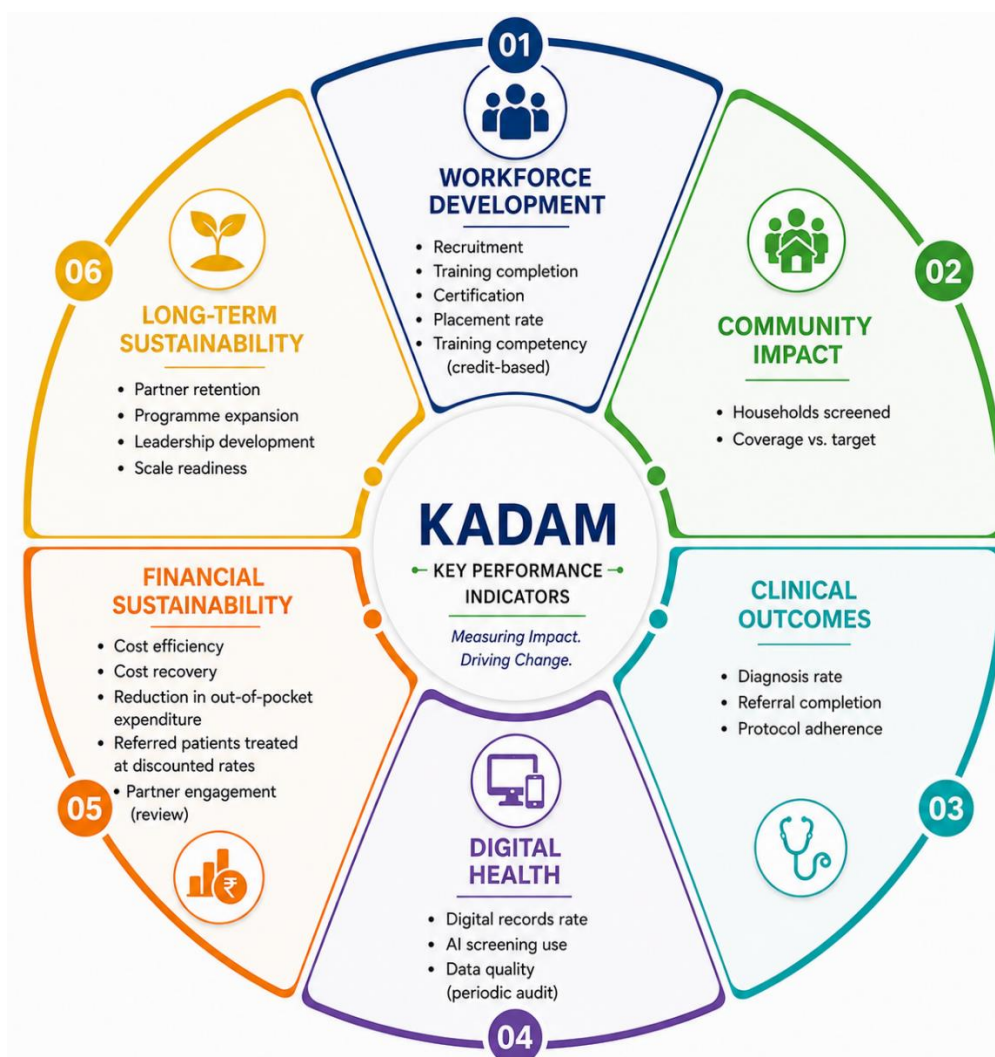


Fig 8: KADAM KPI Framework



The **KADAM Dashboard** provides real-time monitoring of programme performance through a centralized digital platform using traffic-light KPI indicators (Green, Amber, Red). An integrated EMR tracks patient outcomes, referrals, and follow-up, enabling data-driven decision-making. Together, they support continuous quality improvement, accountability, and programme oversight.

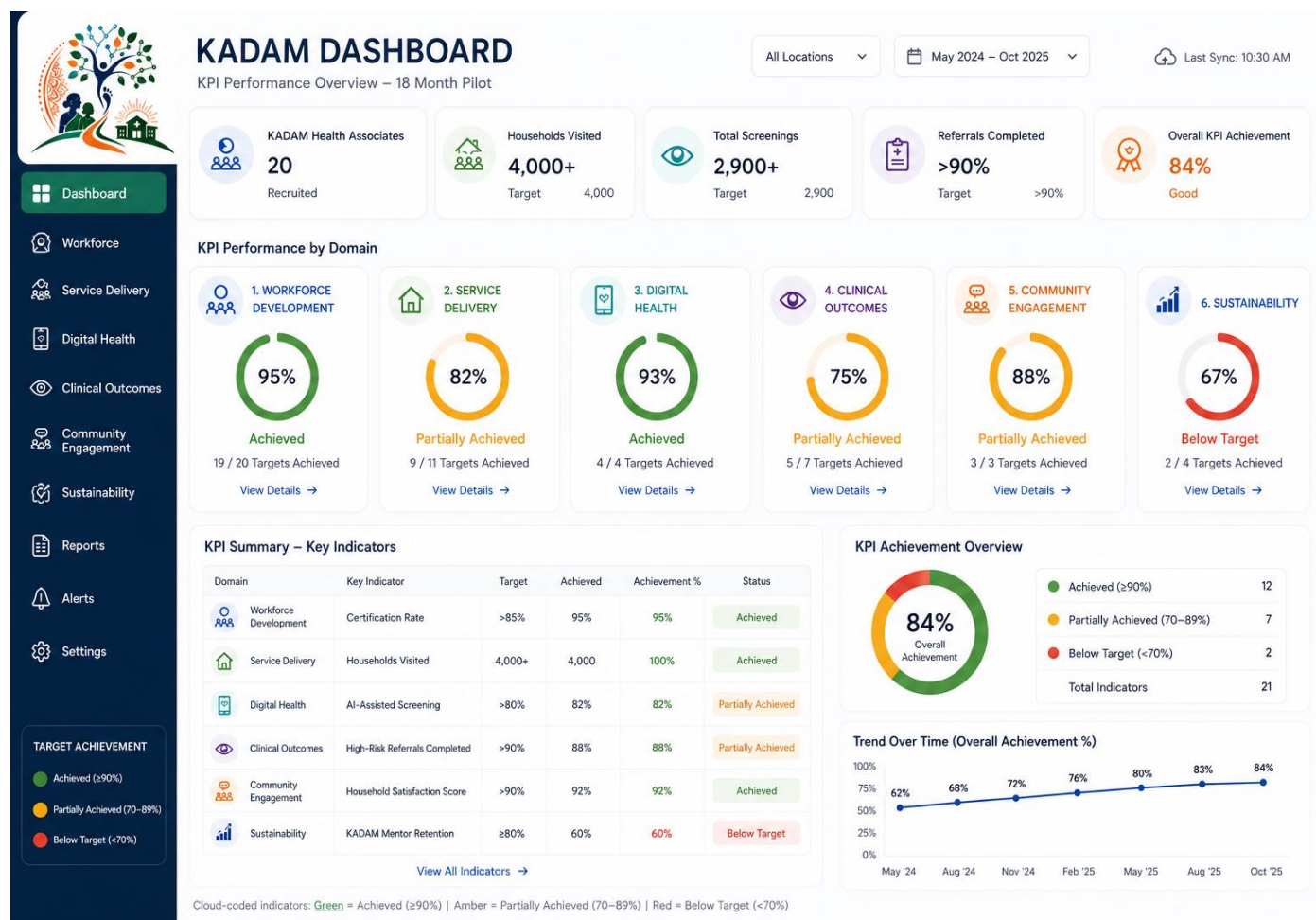


Fig 9: KADAM Dashboard: A Closed-loop Monitoring System

CHAPTER 8 — DEVELOPMENT IMPACT: Health, Work and Women's

8.1 Workforce Creation: Building AI Assisted Workforce

Despite a 69.3% increase in doctor, nurse and midwife density across South-East Asia between 2015 and 2024, **the bridge between primary communities and secondary care remains broken**. Aggregate numbers have grown — but the workforce capable of crossing that bridge, identifying risk early, coordinating referrals, and ensuring continuity of care, does not yet exist at scale⁵.



Challenge	KADAM Response
Shortage of hospital support staff	Workforce generated within and for the hospital system
Difficulty recruiting in Tier-2/3 cities	Local pipeline linked directly to partner hospitals
Weak referral completion	Community-based follow-up supported by digital tracking
Growing demand for digital health	Training in ABDM, telehealth, and AI-assisted tools
High staff attrition	Structured certification, career progression, KADAM Champion pathway
Limited rural healthcare careers	Accessible entry pathway into the formal health sector

Table 9. How KADAM Addresses Key Health System Challenges

Career Pathway Direct pipelines — the complete picture:

1. Tier-2 and Tier-3 hospitals and nursing homes

Small private hospitals and nursing homes in districts like Shamli, Muzaffarnagar, Saharanpur run on skeleton allied health staff. They cannot recruit from cities. They cannot afford trained specialists. A KADAM graduate — certified, supervised, hospital-experienced — walks in as the most qualified local candidate they have ever seen. No recruitment agency. No relocation. No training cost. KADAM Drishti and KADAM MAA are specialty-aligned workforce pipelines — one producing vision care associates for eye hospitals and ophthalmology departments, the other producing maternal health associates for maternity hospitals and obstetric units. For Both training and employer can be the same or different hospital.

Together these two competencies solve a structural problem for Tier-2 and Tier-3 hospitals simultaneously. Nursing homes and private hospitals in districts like Shamli, Muzaffarnagar, Kairana, Kandha, Bagpat, Baraut, cannot recruit sonographers or ophthalmic technicians from cities — due to high the salary differential. *No relocation cost. No recruitment agency. No training investment beyond what KADAM has already provided.*

2. Community health hub brands

Emerging community health franchise brands — Portea, MedCords, iKure, Swasth India — are building village-level health hubs across UP and Bihar. They need locally embedded, trained, trusted health workers who can run a hub independently. A KADAM Champion with 2–3 years of experience is their ideal franchisee or hub manager.

This is workforce creation and workforce retention in a single act. *The Health Associate gains a career that pays and progresses without leaving home.* The hospital gains a skilled technician it could not otherwise recruit. KADAM creates employment by training and certifying local youth as skilled community health workers who are absorbed into existing hospitals and healthcare providers. Instead of building new satellite centres, it



strengthens the capacity of partner hospitals to extend community outreach through a trained local workforce. This creates meaningful employment opportunities close to home, particularly for women and rural youth. By enabling healthcare providers to recruit locally trained professionals, KADAM reduces dependence on urban recruitment. The result is stronger rural health systems while helping curb the migration of healthcare talent to metropolitan cities.

8.2 Women's Economic Participation and Empowerment

Women represent approximately 70% of the global health and social care workforce — yet across LMICs³⁶, this majority remains disproportionately informal, and unrecognised. Financial pressures, caregiving responsibilities, social norms, and early marriage compound this exclusion, keeping women outside the formal economy not by choice but by circumstance.

KADAM addresses this as a central objective, not a side effect. Flexible, locally based, certified employment — accessible without leaving the community — converts women's existing commitment to care into a recognised professional identity. Competency-based certification and the KADAM Champion pathway provide credentials, professional networks, and routes into leadership roles previously out of reach.

KADAM does not bring opportunity to women — it builds it where they already are.

Expected Impact

- Increased formal workforce participation and household income
- Economic independence and social mobility
- Women-led community health promotion and local leadership
- Greater female representation in healthcare decision-making



8.3 SDG Alignment





CHAPTER 9— Risks, Mitigation, Quality and Governance

9.1 Operational Risks and Mitigation

ASHA worker friction. KADAM Health Associates operates in overlapping functional territory with ASHA workers — KADAM risks being perceived as competing with a nationally embedded workforce that has significant institutional and political backing. KADAM explicitly positions Associates as complementary to ASHA workers, operating in AI-assisted screening and clinical support domains beyond the original ASHA scope, KADAM's digital health and AI literacy modules may also be offered as optional continuing professional development (CPD) to complement their existing roles.

Informal provider resistance. In districts like Shamli, informal providers — including unregistered practitioners and local health intermediaries embedded in community trust networks — may perceive trained, certified Health Associates as a competitive threat to their patient base. This resistance can manifest as active discouragement of community participation or undermining of referral pathways. KADAM's panchayat-led model and civil society enrolment channels will build community trust independently of informal provider networks

Hospital equipment delays and referral pipeline dependency. The scalability model requires partner hospitals to invest in screening equipment before the referral pipeline is established. In practice, hospitals may defer equipment purchase for up to six months — waiting until *referral volumes demonstrate commercial viability* before committing capital. The model depends on access to AI-enabled diagnostic equipment. KADAM addresses this through upfront hospital payments and growing referral returns.

Recruitment Barriers for Women

Recruiting first-generation women into field-based healthcare roles faces resistance from families, communities, and social norms — including safety concerns, family permission requirements, and professional perception barriers. The panchayat model and Champions serve as the primary mitigation through visible role modelling and sustained community engagement.

Technology adoption

Digital tools are only as effective as the people using them. KADAM addresses this through phased, mentor-supported implementation, modules designed for low-bandwidth environments, and continuous technical



assistance. *The governing principle is human-centred design — technology serves the Health Associate; the Health Associate serves the community.*

9.2- Ethics, Quality and Governance

Ethical AI, AI in KADAM screens, flags, and prioritises — every diagnostic and treatment decision remains with a qualified clinician. Transparency, explainability, and the right of clinician override are conditions of deployment, not aspirations.

Quality Assurance, KADAM ensures quality through standards-based certification, competency-driven skill assessments, and structured clinical supervision — ensuring every trained worker meets defined practice standards before deployment.

Data governance. Every patient record is protected by four pillars: encrypted storage, role-based access controls, comprehensive audit trails, and privacy-by-design principles embedded from the point of data collection. The programme KADAM's digital infrastructure comprises three components: a custom-built Hospital Command Centre Dashboard for real-time referral tracking and clinical oversight; Moodle LMS for Associate training delivery and certification management; and Microsoft Entra ID for secure identity and access governance.

CHAPTER 10— Policy Shift: From Workforce Recruitment to Workforce

Policy Shift: From Workforce Recruitment to Workforce Creation

KADAM reframes a foundational assumption in health workforce policy. Rather than competing for a limited pool of trained personnel — the dominant and persistently failing approach in Tier-2 and Tier-3 settings — participating hospitals actively generate new healthcare workers from within their own communities. This shift from recruitment to creation has significant implications for ***Human Resources for Health planning (HRH), UHC financing, and youth employment policy***³⁷.

The policy shift KADAM proposes is not radical. KADAM is a working proof of concept — tested in one of India's most underserved districts — that the shift from recruitment to creation is not merely desirable but achievable



CHAPTER 11— CONCLUSION: Building the Workforce the Future Demands

The world's most sophisticated health technologies mean little if there is no one at the community level to deploy them. The gap that matters most in global health is not the gap between what medicine knows and what it cannot yet do — it is the gap between what medicine knows and who can reach the people who need it. That gap is a workforce gap. And workforce gaps, at their root, are failures of investment, design, and political will.

KADAM is a response to that failure. By transforming hospitals into workforce-development hubs, recruiting from the communities being served, training with AI-assisted tools, certifying through academic partnership, and tracking every patient from village screening to hospital treatment and beyond, *KADAM builds the connective tissue* that health systems in low- and middle-income countries most urgently need — not another vertical programme, but a horizontal platform capable of carrying multiple NCDs, multiple cadres, and multiple specialties within a single operational architecture.

AI connects the pieces — linking training, community outreach, diagnostics, referral, and follow-up into a unified digital ecosystem. But KADAM's deepest conviction is that the future of healthcare is not primarily a technology problem. It is a people problem. *Digital infrastructure without human infrastructure is incomplete, unequal, and ultimately unsustainable.* The communities most in need of health innovation are also those least likely to receive it unless there are trusted, trained, locally rooted people to carry it to them.

KADAM builds both. In doing so, it creates something that development programmes rarely achieve: a model that simultaneously generates decent work, closes the education-to-employment gap, empowers women, extends care to the unreached, formalises an informal workforce, and strengthens the health system from its most neglected layer upward.

The challenges to the future of work — automation, informality, youth unemployment, gender exclusion, the skills gap — are not abstract. In Shamli, they have names and faces. KADAM is what an answer to those challenges looks like when it is built from the ground up, with communities rather than for them, and sustained by the one resource no algorithm can replicate: people who belong to the place they serve.

That is not a pilot. That is a blueprint.



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The authors used AI tools to support the design of infographics and to refine the manuscript's language and readability.

No Conflict of Interest



Annexure A: Illustrative Term Certificate — To Be Customised for the KADAM Drishti Programme.



Institute of Health
Management Research, Bangalore
Accredited with 'A' Grade by NAAC



Healthcare
Sector
Skill Council

Institute of Health Management Research, Bangalore
In Association with
Healthcare Sector Skill Council (HSSC)

TERM 1 GRADE CERTIFICATE
Community Health Facilitator

Full Name: _____
Registration No.: _____
Sponsor Organization: _____

MODULE-WISE PERFORMANCE RECORD

Module Code	Training Module	Percentage Obtained (%)	Grade
DCH-001	Basics of Anatomy, Physiology, and Hygiene (20-10-3)		
DCH-002	Overview of Diseases (NCDs and Infectious) (20-10-2)		
DCH-003	Digital Health Tools Introduction (10-10-2)		
Overall Percentage / Overall Grade			

Trainer

Program Director

GRADING SCALE REFERENCE

O: Outstanding (90-100%); A+: Excellent (80-89%); A: Very Good (70-79%); B: Good (60-69%); C: Pass (40-59%); F: Fail(Below 40%)



Annexure B: Illustrative Diploma Certificate Awarded to KADAM Health Associates upon Programme Completion





Annexure C: Photographs of Hospital-Based Training in Progress





Annexure D: KADAM Programme Enrolment Flyer (English Version)



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