Title of research paper

An exploratory analysis of the factors affecting performance of additional MPHWs-F in undivided Andhra Pradesh

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Abstract

Introduction

Human resources are crucial assets in the public health domain. Emphasis on capacity-building & empowerment of public health personnel is essential to improve the public health system.

Purpose

This study undertook an exploratory analysis of factors that affect capacity-building & empowerment of additional or 2nd ANMs in Andhra Pradesh with the explicit purpose of formulating a performance management framework in order to enhance the role and responsibilities of 2nd ANMs in Andhra Pradesh.

Research methodology

The study adopted a quantitative research approach through a survey method in which interview schedules were utilised. Data analysis was done to identify and compare existence or absence of factors with the aid of the SPSS package. The target sample covered around 40% of available 2nd ANMs in three districts from three regions in the state of Andhra Pradesh. Medak district was selected from Telangana region while Anantapur district was identified from Rayalaseema region and East Godavari district was selected from Coastal Andhra region.

Results

The framework comprises tasks related to role and responsibilities; advocacy; knowledge and expertise; leadership and management skills; performance management skills; performance improvement mechanisms; information systems; and health services **r**esearch.

Conclusion

Planning and management strategies, based on utilisation of existing opportunities and techniques to cope with multi-tasking, were positive determinants of the 2nd ANMs capacity-building & empowerment. Management skill at subcentre level is a useful area for intervention to improve performance. Monitoring of individual performance and recognition of good work also facilitated better service coverage from the 2nd ANMs.

An exploratory analysis of the factors affecting performance of additional MPHWs-F in undivided Andhra Pradesh

Introduction

Public health nursing in India is delivered by the Multipurpose Health Worker – Female, also popularly known as MPHW-F. She is the first contact person between the village and the government, needs and services and consumer and provider. In fact, the quality of services rendered by her determines the public perception of health services provided by the government. It is through her that planners gain insights into health problems and needs of the rural people. Keeping in view her status as a grass-root level worker in the public health hierarchy, a heavy responsibility rests on her shoulder.

To provide accessible, affordable, accountable, equitable, effective and reliable healthcare, especially to poor and vulnerable sections of population in rural areas, the National Rural Health Mission (NRHM) was launched in the country. The Mission sought to deploy two female MPHWs at each sub-centre, since one has not been found adequate to meet the challenges associated with maternal and childcare in the village. The Government of India supports the Additional MPHW– F for appointment on contract basis. So there is a felt need to analyse the role being played by her.

This research paper titled “An exploratory analysis of the factors affecting performance of additional MPHWs-F in undivided Andhra Pradesh” is based on a study to analyse the roles and responsibilities and suggest novel methods to improve her expertise and performance. The new insights offer clues to improve the overall performance and contribute to the achievement of set goals under NRHM.

Rationale behind study

The Multi-Purpose Health Worker– Female (MPHW-F), formerly known as Auxiliary Nurse & Midwife (ANM), is at the bottom-end of the nursing hierarchy, who is engaged in primary healthcare. The General Nurse and Midwife (GNM) is at the low-end, while the Staff Nurse (SN) is at the mid-end of healthcare, with both being engaged in secondary healthcare. The speciality nurse occupies the high-end and the super-

speciality nurse is at the top-end of the healthcare spectrum with both being engaged in tertiary healthcare.

The sub-centre is the first contact point between the community and public health system and staffed by two female and one male MPHW. In the healthcare system, sub-centre is the most peripheral level of contact with the community covering an average of 3,000 population in rural areas. In undivided AP, there are 12,522 sub centres, effectively serving on an average a population of 4,424. The NRHM has mandated the appointment of the Additional MPHW-F in every sub-centre across all the 23 districts of the undivided state. She is paid a consolidated monthly salary. To provide quality services, the state government has divided the geographical area of each sub-centre into two parts and has allocated one part to regular and the other part to the Additional MPHW– F. She should be invariably resident of same village. An undertaking is also needed from the state that she would not be transferred before completing ten years at the same sub-centre.

As per the NRHM norms, she is not a substitute for the male counterpart but supportive to the regular MPHW-F. She should be appointed on the basis of local criteria and by local government against specific vacancy as part of the delegation of administrative and financial powers. The posting of an Aditional MPHW-F at the sub-centre could not completely address problems in the provision of basic health facilities at the village level. So there is a need to find out deficiencies and suggest solutions.

It is in the fitness of matters to conduct a continuous series of formative, concurrent and summative evaluation studies in various thematic areas and human resource development at both the national and state levels under the National Rural Health Mission (NRHM). This study undertakes a formative evaluation on the roles and responsibilities of the Additional MPHWs –F in undivided Andhra Pradesh.

Purpose of study

To analyse the roles and responsibilities of the Additional MPHW(Female) with emphasis on factors that are strongly associated with improved performance.

Methodology

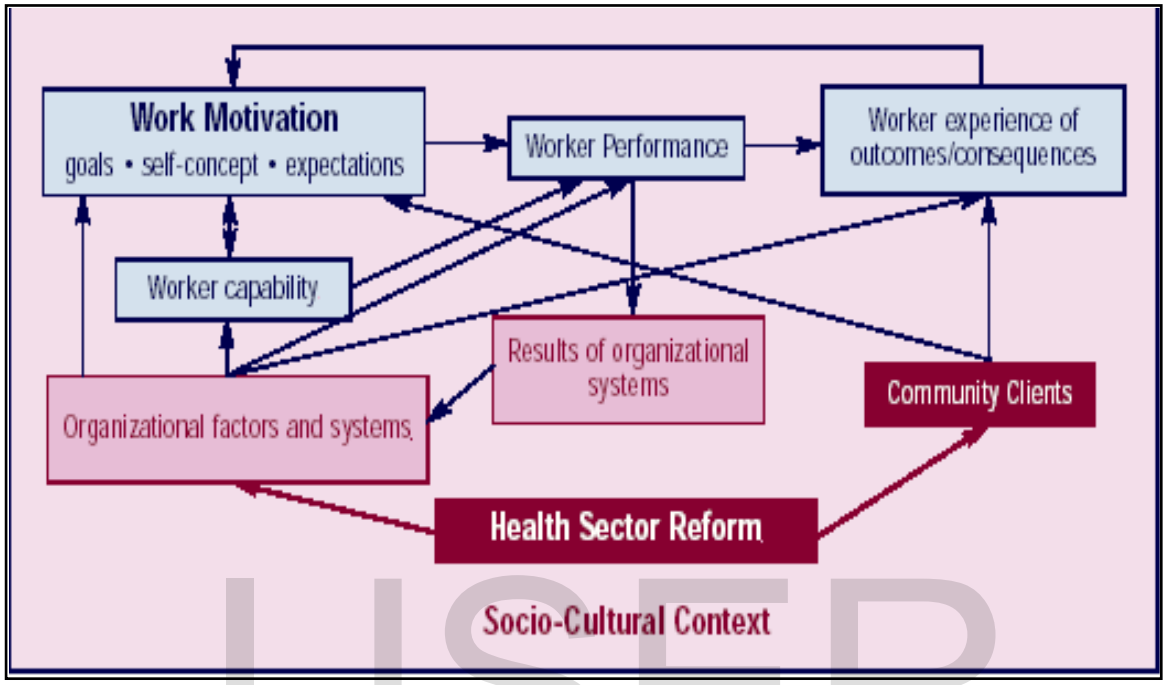
A multi-stage stratified random sampling method was adopted. In the first stage, undivided Andhra Pradesh is stratified into three geographical regions, namely Telangana, Costal Andhra and Rayalaseema. Medak, East Godavari and Anantapur districts were randomly selected from the three respective regions in the second stage. As on 20-04-2012, 10,381 Additional MPHWs(F) are working in undivided AP. In the third stage, 40% of working Additional MPHWs in each selected district were randomly selected based on the Cochlear's formula. The sample covered a total of 662 respondents representing three districts and 60 mandals.

Both qualitative and quantitative techniques were adopted. To collect quantitative data, a structed self-administered questionnaire comprising both open-ended and closed questions was used. The sectional content of questionnaire is focused on personal information, roles and responsibilities, knowledge base, human resource management issues and organisational processes. The questionnaire is based on the performance model of Bennett and Franco (1999). To collect qualitative data, a total of 30 in-depth interviews with Additional MPHWs were conducted @ 10 per district. This study could be perceptual and not factual as the Additional MPHWs– F have furnished an optimistic self-appraisal about their roles and responsibilities.

Coverage

Particulars	Medak	Anantapur	East Godavari	Total
Number of serving Additional MPHWs (F)	376	489	802	1667
Number of Additional MPHWs (F)	150	192	320	662

interviewed				
No. of mandals	28	19	13	60

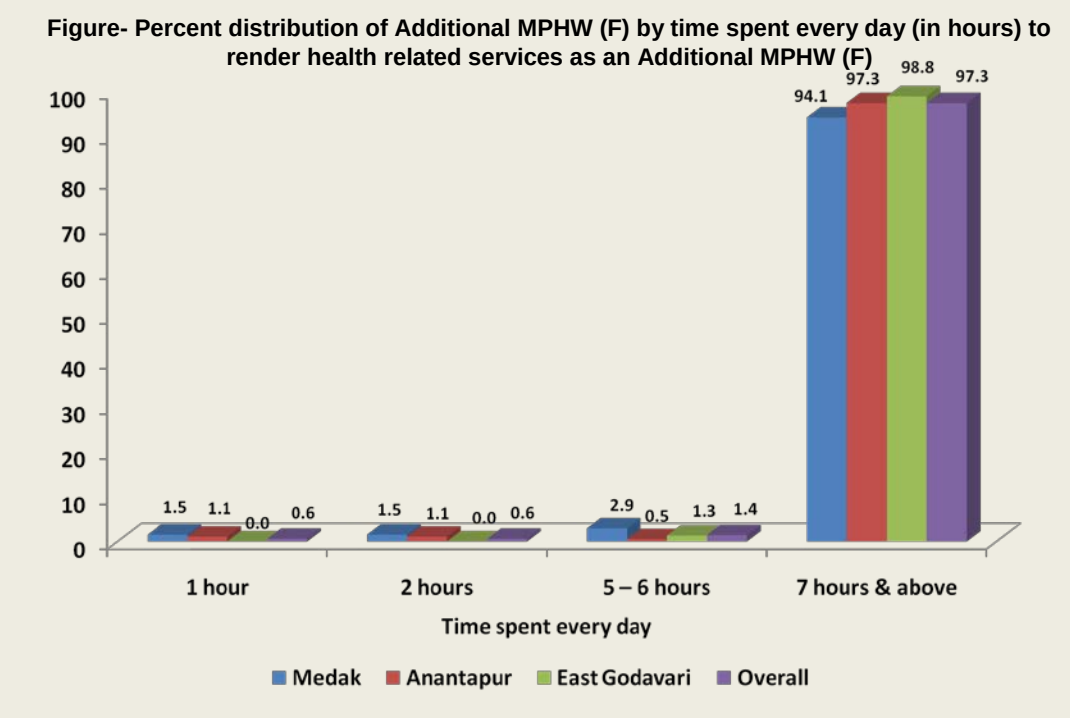


Results

Profile of respondents

A typical Additional MPHW is aged 30 years, has passed 10th class and the 18 months basic MPHW-F training course, has three years of experience and works for about seven hours per day. She is married, belongs to SC community, respresenting joint family and earns above Rs. 20,000 per month as family income.

She has cited rendering of health services as the main reason for joining as Additional MPHW. She had prior experience in healthcare before joining as an Additional MPHW. She has not undergone any induction training.



Job profile

As many as 55 activities were enumerated by the average Additional MPHW-F with regard to her job profile. However, the following responsibilities were analysed to assess her performance.

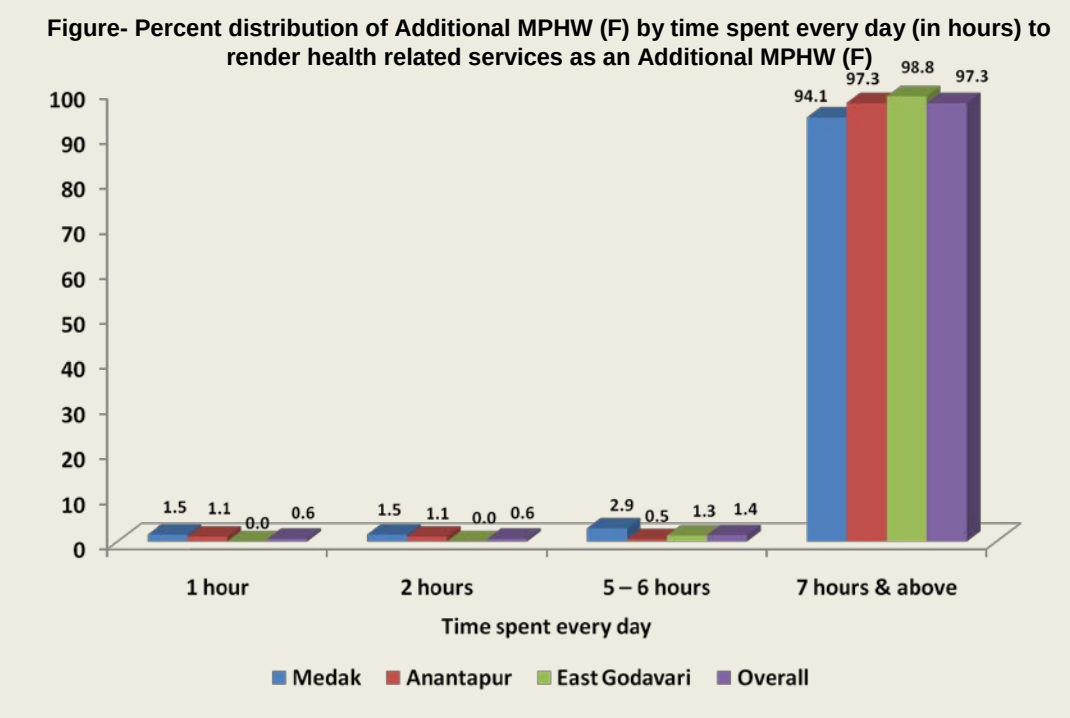
- Availability at official headquarters as well as her round-the-clock accessibility.
- Record-keeping of births and deaths; prenatal care including simple diagnostic tests like urine test, VDRL test and high blood pressure check-up; and procurement-cum-supply of contraceptives, IUD insertions, vaccines, drugs and other consumables.
- Number of referrals of high risk cases of pregnant women to her superiors and or to higher level healthcare centres.
- The nature of guidance she gets from the female health supervisor.
- The reporting relationship between PHC Medical Officer and Additional MPHW-F.
- Counselling and motivational styles adopted by her to facilitate institutional deliveries and support of trained birth attendents in home deliveries.
- Health education methods implemented by her to promote maternal and child care with focus on key messages related to breast-feeding, family health, family planning, nutrition, immunisation and personal and environmental hygiene.

- Average number of monthly ANC and PNC visits.
- Role in conduct of MCH clinic.
- Level of distribution of conventional contraceptives.
- Engagement in family planning follow-up services.
- Inter-sectoral convergence initiatives in coordination with anganwadi workers and gram sewaks.
- Involvement in immunisation for pregnant women, infants and children.
- Preparation of local health action plans.
- Level of participation in monthly staff meetings at PHCs.
- Curative treatment skills with regard to minor ailments and first aid.
- Report-writing skills.
- Adeptness at identifying women in need of Medical Termination of Pregnancy (MTP).
- Disease surveillance activities including monitoring and evaluation.
- Escort services to visiting public health officials.

In short, the Additional MPHWs-F are entrusted with preventive, promotive, diagnostic, curative and supportive grassroots healthcare which makes a critical difference to the village public health scenario of her jurisdiction. So it is all the more essential to assess her day-to-day performance.

Maternal care

As many as 88% of the respondents visit almost all houses in their allocated areas. She visits every house once in 15 days. Almost all are able to determine TT status and vaccinate according to national guidelines in all the districts. It is found that 95% of them are regularly checking warming/danger signs like vaginal bleeding, high temperature and severe abdominal pain during ANC. An average of four deliveries were performed every month with the participation of MPHWs at SC or PHC.



The average number of high risk pregnancies referred monthly by Additional MPHWs comes to two cases. It is noted that 89% of them reported that their doctors/staff nurses use a partograph during labour to chart progress. Almost 98% of them assist mothers with breast feeding or assess mother's knowledge of their ability to breastfeed. They discuss throughly about personal hygiene (98.8%), nutrition (98.5%), family support (85.6%), family planning (97.0%) and benefits of exclusive breast feeding (97.7%) with the mothers. Over one-thirds replied that skilled birth attendants (SBA) of their areas come to the clinic either frequently or occasionally. More than two-thirds reported that obstetic emergencies like excessive bleeding were handled effectively during deliveries in which they participated.

Child care

Nearly half confirmed that one immunisation session at the sub centre was conducted in a four-week period. Similarly, 45% confirmed that one outreach immunisation session was conducted by the sub centre in a four-week period. Almost 98% of Additional MPHWs affirmed that they do assessment and monitoring of weight among low birth weight and pre-term babies. Almost all confirmed that they made home visits to assess breast feeding problems. Though 92% looked for pneumonia signs and symptoms in

newborn, the corresponding figures were less at 81% with reference to sepsis and much lesser at 54% with regard to hypothermia. Almost all counsel the mothers and family members about newborn care. Almost all advise the mothers on diarrhoea, malaria and measles to an extent of around four-fifths.

Family welfare

All of them discuss with the client on family planning services. Almost all of them confirmed that they explained the benefits, risks, side effects and other consequences of chosen contraceptive methods. As much as 94% encourage males to particilpate in family welfare programme. All provide follow-up services to the female family planning acceptors. Almost all provide spot treatment for minor complaints or side effects to the female acceptors of family planning. All the Additional MPHWs motivate couples in the village to adopt family planning measures and provide option to choose.

Disease control program

As many as 97% discuss about prevention of malaria during pregnancy through the use of bed nets and integrated preventive treatment. About 100% encourage the pregnant women and her partners to come for HIV counselling and testing. Around 99% discuss regarding local or traditional practice that might be harmful to the mothers or newborn. As much as 97% provide information about any health problems and the appropriate treatment. They also educate mothers regarding home management of diarrhoea with ORS. Demonstration of ORS preparation at home is done by almost all. An average of five diarrhoea cases, one malaria case and six respiratory infection cases are reported on a monthly basis by them.

Media usage

Regarding utilisation of IEC tools and activities by the public to prevent and control malaria, over two-fifths of Additional MPHWs reported low use of radio, while more than half reported moderate use of TV. Cinema was moderately used by the public as reported by over two-fifths of Additional MPHWs, while over half reported moderate use of the newspapers.

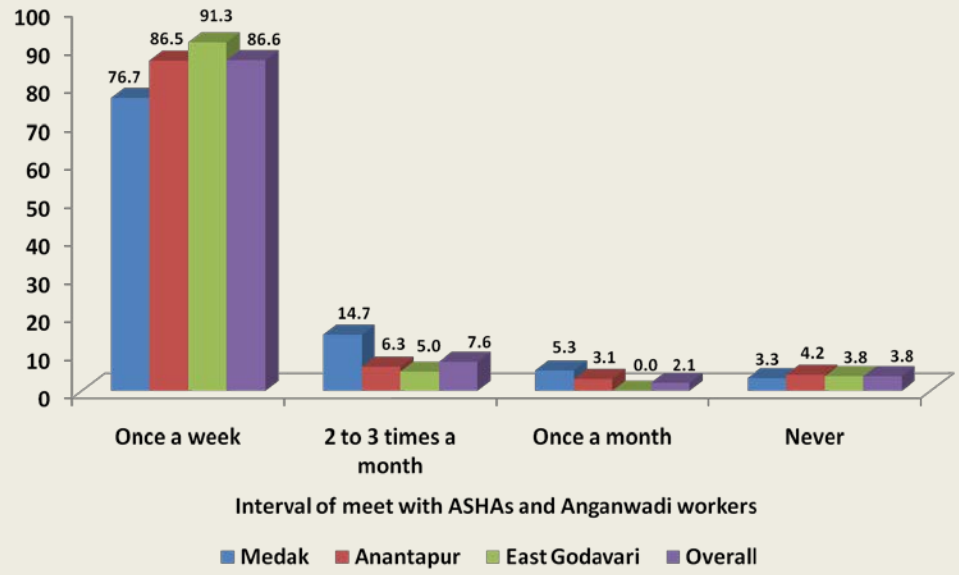
Health education

More than four-fifths discussed with both pregnant women and young mothers between two immunisation sessions or check-up of two ante-natal cases at the sub centres on the topics of general hygiene, facilities for healthcare, minor ailments of the people present there, next date of immunisation session and next date of ANC check-up. More than 90% conducted some major activities as preparation towards holding an outreach session. A very high 94% MPHWs regularly supplied educational material on different topics including safe motherhood, infant care, STIs, HIV and immunisation for the clients. A good 84% pasted health education materials on the wall in good condition and saw to it that clients saw them. All discussed on needs and benefits of full immunisation with the clients. All of them emphasised the need for at least three antenatal visists. Almost all even provided information about the expected date of delivery and a high 91% informed clients about the type of reproductive health services available at sub centres/PHCs.

Intersectoral convergence

It was found that 87% set an interval of once a week to meet ASHAs and AWWs. Around 77% conducted about seven monthly meets in a year. Around 65% of Additional MPHWs reported that seven and above monthly meets were held by the Gram Panchayat health committee between January and August 2012. Only 40% reported that the panchayat head or the deputy head attended to their needs seven and above times. It was noted that 65% obtained the active help of panchayat functionaries to motivate or catch up with those who skipped meetings.

Figure- Percent distribution of Additional MPHW (F) by responses of Additional MPHW (F) on the interval between each meet with ASHAs and Anganwadi Workers



Supportive supervision

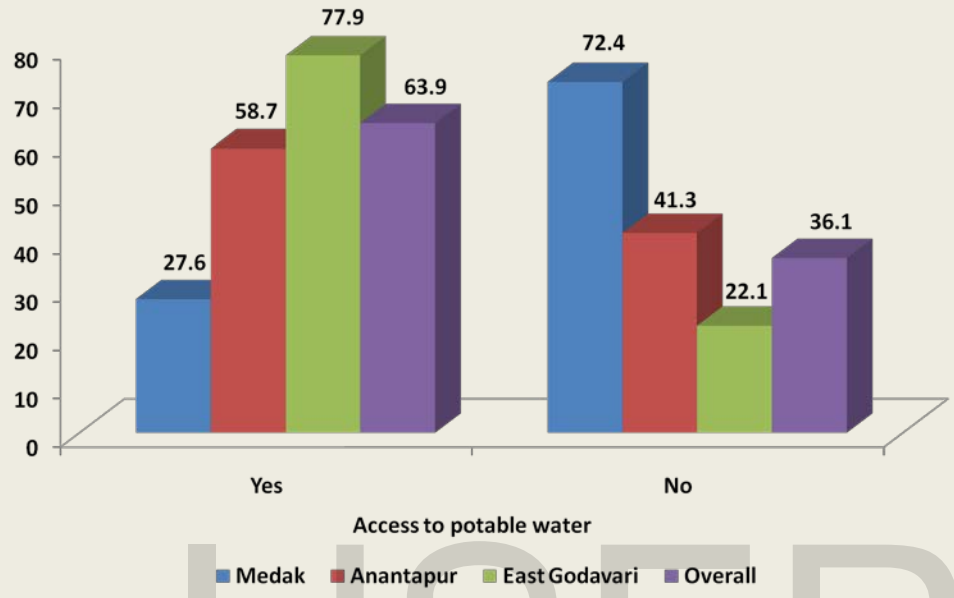
Almost all reported that their health supervisor corrects or monitors field performance and activities. Almost all confirmed that the health supervisor checks the reports prepared by them. Also, almost all reported that the health supervisor does help the healh assistants to solve problems in work or clarify any point. More than half said that the supervisor visits the field or clinic on an average of more than once a week. Almost all agreed that the supervisors appreciated their good work in front of others while monitoring their performance. Also, almost all of them agreed that the supervisors inspire them to do the best. A high 86% felt that constructive feedback on performance appraisal results is provided on regular basis.

Infrastructure and facilties

It is found that 70% reported the availability of enclosed space that can be used for case examination in sub centre and 4/5^{ths} felt that the things can be securely kept in the sub centre room. More than half reported the availability of toilet facility to the female clients. Coming to the sub centre, access to potable water is confirmed by 64%. More than 4/5^{ths} reported the availability of washing facility at the sub centre. Almost all affirmed

that vaccine supplies to immunise clients are adequate. All MPHWs felt that vaccines are administered at SC and outreach places as per cold chain standards.

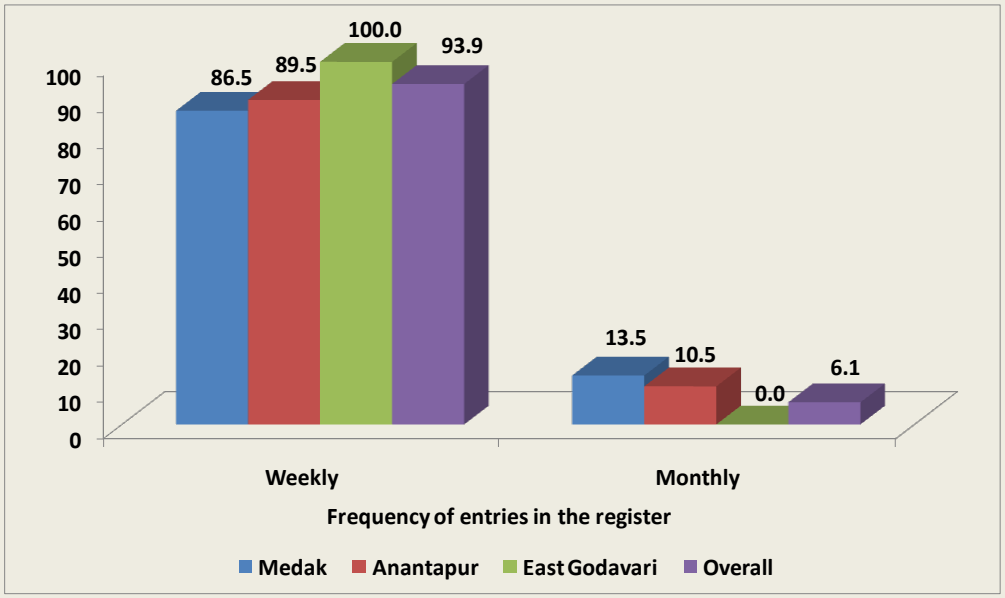
Figure 84 - Percent distribution of Additional MPHWs-F by responses of Additional MPHWs-F on the access to potable water



Documentation

Around 4/5^{ths} reported that ANC registers are updated at an interval of less than one week. A high 84% confirmed the supply of MCH card. Almost all also confirmed the supply of free service registers which are updated on a weekly basis. Almost all agreed that births and deaths are recorded and updated in the prescribed formats in the field service registers and the eligible couple register.

Figure- Percent distribution of Additional MPHW (F)s by responses of Additional MPHW (F)s on how frequently entries are made in the register



In-depth Interviews (IDIs)

The focus of IDIs with 30 Additional MPHWs was to develop a performance innovation framework for them. As part of this, a set of strategies were proposed by them to enhance their daily performance as follows:

- Job orientation training for three to five days.
- Strict enforcement of her availability at headquarters
- A performance-based appraisal system including nursing performance indicators.
- Standardisation of a monthly sub centre assessment report.
- Review of her job chart.
- Focus on specific health programs.
- Training program on supportive supervision and constructive feedback for her supervisors.
- Refresher training on clinical subjects to the Additional MPHWs.
- Provision of essential infrastructural facilities and civic amenities.
- Regular supply of pre-tested IEC resources to every sub centre.
- Review of data compilation formats.
- Motivational incentives.

- An arrangement of privacy for case examination in the sub centre.
- An adequate floor space in the sub centre building on the basis of NRHM norms.
- More participation from the local leaders, especially the gram sarpanch, in inter-sectoral review meets to acceleate the work done by Additional MPHWs.

Conclusion

The Additional MPHWs are by-and-large burdened with too many major and minor roles and responsiblities. During informal discussions, many disclosed that they are not aware of their official job chart as indicated by some of their responses in the study. They suffer from job insecurity and are unable to proritise their tasks. There are hardly any training and development opportunities for them, be it in the form of induction training or professional development training. Most of them lack job autonomy due to interference in work from the regular MPHWs and male MPHSs. But the most heartening aspect of their daily work is that their multi-functional exposure is of a high order. They are able to test and practice their clinical, para-clinical and non-clinical knowledge and skills in the sub-centre and the community. Most of them are looked upto with respect as public health service providers by grassroots functionaries in converging departments. A larger and deeper study is required to measure their key perfomance indicators (KPI) on the basis of their key result areas (KRA) which will facilitate a holistic assessment of their day-to-day performance. They also require constant critical feedback, mentoring, and coaching from their immediate supervisors to be able to work on their major performance shortcomings.

The Additional MPHWs need much more encouragement, support and guidance from the top level to her immediate superiors in order to occupy the centrestage of the village public health. Her negative impactors need to be reviewed and systematically removed at the policy and implementation stages. They definitely hold high potential to complement the regular MPHWs and serve as the rural public health sentinels.

References

1. The World Health Report-2006, W.H.O., Geneva

2. D. Varatharajan et al, Assessing the performance of primary health centres under decentralized government in Kerala, India; Health policy and Planning, 2004; 19(1) : 41-51

3. Prasad B.M. and V.R. Muraleedharan, Community Health Workers: a review of concepts, practice and policy concerns; August-2007

4. A.F. Ferguson & Co., Draft Report, Organizational/ Institutional Review of the Department of Health and Family Welfare, Government of West Bengal : Organization Development and Human Resource, May 2006