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A Cross-Sectional Study to Identify the Barriers and Challenges Faced by Health Workers in a Rural Area of Haryana, India

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Abstract

Introduction: India, faces an acute shortage of health workforce, and this seems to be one of the prior reason of our country not being able to achieve the millennium development goals too. With only about 50% MPHW (M) being available, the MPHW (F) is heavily overworked, which affects outreach services in rural areas. *Objective*: Identify barriers in the working process of health workers in a rural area of Haryana. *Methods*: An entire PHC was taken up for the study to interview ASHA workers, AWW, MPHW (F), PRI about the various challenges they face in their day to day work process. Data collected was summed up and compiled to find out the various associations of the level of satisfaction with their work process. *Result:* It was found that none of the ASHAs were satisfied with the incentives drawn by them. About 60% felt their basic minimum should be fixed. depictions on group discussions denote that most of time (71%) group discussions were based on topics related to health followed by nutrition (50%), sanitation (42%) and family planning (46%). About 98% were a part of some or other sessions held. When questioned about whether they felt people tend to less utilize the health services provided to them, it was found that, about 90% felt so and just 10% did not feel so. *Discussion*: The study found a strong nexus between the healthcare delivery system's status and the community health worker's level of performance motivation. As demonstrated in similar settings, resource constraints such as limited transportation to escort mothers and stock-outs of commodities hindered the community's trust on them. The communication gap among different actors led to delay in receiving the stocks and non-clarity on the responsibilities among health workers.

Keywords: Health Worker; Barriers; Incentives; Work Satisfaction.

Introduction

"Reproductive health and rights are integral to sustainable development and poverty reduction. Investing in universal access to reproductive health is crucial investment in healthy societies and a more sustainable future".

Ban Ki-moon, Secretary-General, UN on World Population Day, 2012

Nearly three fourth of the population of the country live in villages. This rural population is spread over more than 10 lakh habitations of which 60% have a population of less than 1000 [1]. If the Mission of Health for All is to succeed, the reform process would have to touch every village and every health facility. Clearly it would be possible only when the community is sufficiently empowered to take leadership in health matters. The rural public health care system in many States and regions is in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. India is in the midst of an epidemiological and demographic transition–with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to an ageing of the population [1-2].

India, faces an acute shortage of health workforce, and this seems to be one of the prior reason of our

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country not being able to achieve the millennium development goals too. Since independence, we have struggled hard to keep our fight against the various forms of diseases which creep up from time to time and tend to cripple our economy [1,2]. The fact that we are a 121 million nation, but still have deficit in spheres of manpower in health area, seems absurd. Studies have shown that the lack of retention of manpower in this sector is mainly due the problems faced by them which are unattended, the difficult terrain in our country which poses problems in travelling and communication, the gradient system where no one takes the accountability, parallel problems like poverty etc which when compared become more important and the working environment which at times becomes suffocating [2]. With only about 50% MPHW (M) being available, the MPHW (F) is heavily overworked, which affects outreach services in rural areas [3]. Currently Anganwadi Workers (AWWs) under the Integrated Child Development Services (ICDS) are engaged in organizing supplementary nutrition and other supportive activities. The very nature of her job responsibilities (with emphasis on supplementary feeding and pre-school education) does not allow her to take up additional responsibility of health in a village [4]. Thus a new band of community based functionaries, named as Accredited Social Health Activist (ASHA) was proposed to fill this void. ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services [5,6].

Health workers are an important link between community and health facility who provide service & create awareness in the community on determinants of health such as nutrition, sanitation, healthy living, information on existing health services and utilization of health & family welfare services. They play important role in identifying health related problems at the earliest stage. Identification of problems in community at grass root level can help in improving the health status. The barriers they face would be an indicator of the level of service they provide since work environment plays a great deal on your outputs too. Hence it is important to assess the challenges they face in their process of work [6-9].

The set of roles and responsibilities allotted to them needs to be constantly monitored and refined from time to time based upon the priorities of the goals and objectives of the government of India. Although many studies on assessment of health workers related to their allotted activities had been done so far, yet the functioning of these community workers is a dynamic process with new responsibilities merging up and old ones less importantly attended to. Moreover, the study was specifically undertaken to find out the challenges faced by the health workers in one of the developed states of our country which claims to have good indicators as regards to health. What is more important is to provide a good working environment to those who are taking strides to do better. This besides reducing the negativity will also improve the work output.

Method

The present study was carried out in the sub-centers under PHC Chiri. There are three primary health centres under the CHC Chiri which serves as the rural field practice area of Department of Community Medicine, PGIMS, Rohtak in Haryana. The area includes 24 villages and caters to a population of 1,05,400. One PHC was chosen entirely and all the subcentres under it were considered for the purpose of my study. Thus the study was carried out in PHC Chiri having 5 subcentres under it and serving a population of 27000.

Since the objective of the study needed us to look for the barriers and challenges faced by the health workers in their work process, we used a semi-structured questionnaire to interview all the health workers at their respective centres. For others like the PRI representatives, we visited their place of work in order to interview them. Five subcentres had 6 villages, 28 ASHA workers, 6 multipurpose health workers (female), 23 anganwadi workers, 5 panchayati raj representatives. So on calculating the total number of people who had to be interviewed, it came out to be 62 people. It was a population based cross-sectional study blending both qualitative and quantitative data and was done in Oct 2013- March 2014.

On the day of visit, the investigator met the health workers in order to explain them the purpose of the study and obtain their consent. All the study subjects were fully informed about the purpose of the study. Informed consent was obtained before the assessment. Anybody unwilling to participate was excluded from the study. A pretested semi-structured schedule was used for interviewing them & for collecting the requisite information. Data collection was done at a time convenient to them. The number of questions that could address the objectives of the study was gathered from different sources. One subcentre was taken up at a time. On the day of first

visit to a particular subcentre, the MPHW (F), Anganwadi workers and the panchayati raj representatives were the ones to be interviewed. The schedule for them included their demographic details, rapport with the other health workers working in the same area, any complain or difficulties in the working process and their opinion on improving their performance.

Collected data were entered in the MS Excel spreadsheet, coded appropriately and later cleaned for any possible errors in a SPSS (Statistical Package for Social Studies) for windows version 20.0. Analysis was carried out using SPSS (Statistical Package for Social Studies) for Windows version.20.0 and online Graph Pad software (Prism 5 for Windows) version 5.01. Categorical data was presented as percentage (%). Pearson's chi square test was used to evaluate differences between groups for categorized variables. All tests were performed at a 5% level significance, and thus the value less than 0.05 (p value < 0.05) was taken as significant association.

Since the ASHA worker is the worker at the grass-root level and is an honorarium incentivised worker, we decided to take her as the prime and make all comparisons of other health workers as regards to her profile.

Result

Opinion regarding the incentives found 75% of ASHA workers agreeing on the fact that they got incentives less than what was calculated. Rest 25% either did not feel so or had not received the due incentives till then. From among these 25%, just 29% felt incentives were deposited as calculated by them, whereas, the other 71% of workers had not yet received their incentives since their date of joining. Opinion regarding the knowledge of ASHA workers about cuts made in their incentives found that 75% did not know who made the cuts, whereas, the rest 25% either were alright with their incentives or had not yet received it since joining and so were not in a position to comment.

None of the ASHAs were satisfied with the incentives drawn by them. About 60% felt their basic minimum should be fixed and made monthly and another 40% felt the pay should be increased.

In the table above, depictions on group discussions denote that most of time (71%) group discussions were based on topics related to health followed by nutrition (50%), sanitation (42%) and family planning (46%). About 98% were a part of some or other sessions held.

When questioned about whether they felt people tend to less utilize the health services provided to them, it was found that, about 90% felt so and just 10% did not feel so.

The table above depicts the various reasons as stated by health workers on whether they felt people tend to less utilize the services which is provided to them by the government. From among the 90% workers who felt so, 36% said it was because of long waiting hours and wastage of time. About 20 and 25% felt that quality of services was poor and there was no one accountable respectively. Twelve percent felt that when people have certain past bad experiences, they tend not to utilize the services from next time onwards and nearly 8% also felt that it was due to rush that services were less availed.

Table 1: Difficulties in the incentivisation of health worker

Variable	Options	Frequency	Percentage
Does your incentives come less than calculated	Yes	21	75.0
	No	2	7.14
	NA	5	17.86
	Total	28	100
Do you know who makes a cut in your incentives	Yes	0	0
	No	21	75
	NA	7	25
	Total	28	100
Are you satisfied with your incentives	Yes	0	0
	No	28	100

Table 2: Suggestions on incentives

Suggestions	Frequency	Percentage
Fix basic minimum	11	39.3
Make it monthly	6	21.4
Increase the pay	11	39.3

Table 3: Group discussion held by health workers in the last 3 months

Topics	Frequency*	Percentage
Health	20	71.4
Nutrition	14	50
Sanitation	12	42.8
Family Planning	13	46.4

*Multiple responses

Table 4: Utilisation of health services by people

Question	Response	Frequency	Percentage
Do you feel people tend to less utilise the health services provided to them	Yes	55	89.2
	No	7	10.8
	Total	62	100

Table 5: Reasons for non utilisation of services provided to people

Sr. No	Reason for non-utilisation of health services	Frequency	Percentage
1	Rush	4	8
2	No one accountable	15	24
3	Past bad experience	8	12
4	Waste of time	22	36
5	Poor quality	13	20
6	Total	62	100

Table 6: Satisfaction and difficulty in the working process of health worker.

Variables	Option	Frequency	Percentage
Are you satisfied with your career option.	Yes	51	82.14
	No	11	17.8
Do you find any difficulty while working	Yes	47	75
	No	15	25

Table 7: Association of level of satisfaction of ASHA workers with help received by others

Sr. No	Variables Are you helped by the following in your work		Are you satisfied with your career option as an ASHA			Significance
			No	Yes	Total	
1	MPHW(F)	Yes	3	23	26	
			60.0%	100.0%	92.9%	F = 9.91
		No	2	0	2	Df = 1
			40.0%	0.0%	7.1%	p = 0.002*
		Total	5	23	28	
			100.0%	100.0%	100.0%	
2	AWW	Yes	1	22	23	
			20.0%	95.7%	82.1%	F = 16. 03
		No	4	1	5	Df = 1
			80.0%	4.3%	17.9%	p = 0.001*
		Total	5	23	28	
			100.0%	100.0%	100.0%	
3	PRI representative	Yes	1	5	6	
			20.0%	21.7%	21.4%	F = 0.007
		No	4	18	22	Df =1
			80.0%	78.3%	78.6%	p = 0.9
		Total	5	23	28	
			100.0%	100.0%	100.0%	

p< 0.05 significant, F = Fischer exact test, Df = Degree of freedom

It was found that nearly 82% of the health workers were quite satisfied with their career option while the rest 18% not. Difficulty in the process of working was encountered by 75%, whereas, the rest of them

didn't feel so.

The table above shows the association of level of satisfaction among ASHA workers with the help received by MPHW(F), AWW and PRI representative. It was found that from among those ASHA workers who were satisfied with their career option as ASHA, cent percent said that they were helped by their MPHW(F) in their activities, whereas, from among those ASHAs who were not satisfied, 60% were aided by MPHW(F) and the rest 40% were not. Similarly, 96% of satisfied ASHAs felt that they were aided by their AWWs in their activities but just 20% of dis-satisfied ASHAs felt aided and the rest 80% not. Both the relations with MPHW(F) and AWW were found to be statistically significant (p< 0.05) denoting that, the more the ASHAs coordinated their activities with other health workers, the better was their level of satisfaction regarding their career options as an ASHA. However, the association with PRI representative was non significant and so can be said not to have a bearing on the level of satisfaction of ASHA workers.

Table 8: Association of difficulty in work with help received by other health workers

Sr. No	Variables Are you helped by the following in your work		Do you find any difficulty while working as an ASHA			Significance
			Yes	No	Total	
1	MPHW(F)	No	2	0	2	
			9.5%	0.0%	7.1%	F = 0.72
		Yes	19	7	26	Df = 1
			90.5%	100.0%	92.9%	P = 0.39
		Total	21	7	28	
			100%	100%	100%	
2	AWW	No	4	1	5	
			19.0%	14.3%	17.9%	F = 0.08
		Yes	17	6	23	Df = 1
			81.0%	85.7%	82.1%	P = 0.78
		Total	21	7	28	
			100%	100%	100%	
3	PRI representative	No	19	3	22	
			90.5%	42.9%	78.6%	C = 7.07
		Yes	2	4	6	Df =1
			9.5%	57.1%	21.4%	P = 0.008*
		Total	21	7	28	
			100%	100%	100%	

*p< 0.05 significant, F = Fischer exact test, Df = Degree of freedom, C = Chi square

The association of difficulty in the working process of the ASHA worker with the help received by MPHW(F), AWW and PRI representative has been depicted in the table above. From among those ASHA workers who felt they faced difficulty in their day to day work process, about 90% and 80% said that they were aided by the MPHW(F) and AWW respectively in their activities.

However, the association was non significant statistically. But those ASHA workers who had coordinated well with their PRI representatives found to have less difficulty in their work process. From among those ASHAs who faced no difficulty, 57% said that they had well coordination with the PRI representative and the rest 43% had not. This relation bore significance with p< 0.05.

Discussion

The various factors which can either motivate or demotivate the work process have been compared with the satisfaction level of the health workers. Opinion regarding the incentives found 3/4th of ASHA workers agreeing on the fact that they had received less incentives than what was calculated. Rest 1/4th either did not feel so or had not received the due incentives till then. Santhya et al reported 75% of ASHAs who received their money without delay and were dis-satisfied with their incentive package and Jain et al reported 83% to have earned 1500 per month as incentive which were near similar to our study findings [10-11]. Nandan et al also depicted similar dis-satisfaction among the workers

related to incentives [12]. Singh et al in his study reported that all the ASHAs in his study area were made cash payment and just 56% had a bank account which was in contrast to our study, where cent percent had an account, denoting that processes related to these has been scaled up in the last few years, wherein the system of having a bank account was made a preferred option for everyone to be incentivized. Most of the ASHAs had earned about 2000 in the last three months duration. Almost 50% of them felt that the incentives needed to be fixed, which was in coherence with our study findings [13].

The timely release of incentives has been considered as key link to ASHA's job satisfaction and performance [4,14]. The inclination towards incentivized job makes ASHA unavailable in her village on many occasions. The need to rush to the PHC to facilitate beneficiaries seriously compromises her scope to initiate any other duty on her own or adapt to situational requirements for jobs that do not fetch her incentive [15].

If ASHAs are not rewarded at all, or are rewarded less than the prescribed amount for certain activities, this greatly impedes their willingness to perform activities that fall under their responsibilities [16].

The study found a strong nexus between the healthcare delivery system's status and the community health worker's level of performance motivation. As demonstrated in similar settings, resource constraints such as limited transportation to escort mothers and stock-outs of commodities hindered the community's trust on them [17]. The communication gap among different actors led to delay in receiving the stocks and non-clarity on the responsibilities among CHWs. This weak supportive system to CHWs concerns many other countries also as it might lead to the exclusion of the poorest of the poor from appropriate health services.

From among 90% of health workers who felt that people tend to less utilize the services which was provided to them by the government, 36% said it was because of long waiting hours and wastage of time. About 20% and 25% felt that quality of services was poor and there was no one accountable for it. Twelve percent felt that when people had certain past bad experiences, they tend not to utilize the services next time onwards and nearly 8% also felt that it was due to rush that services were less availed. Near similar constraints to service utilization was also depicted in the study conducted in Uttarakhand by Shukla and Bhatnagar [18].

All the health functionaries; MPHW (F), AWW and PRI felt that ASHAs were necessary in their area. Our study results found that nearly 82% of the health workers were satisfied with their career option as an ASHA. Difficulty in the process of working was encountered by 75% of ASHA workers.

Association of level of satisfaction among ASHA workers with the help received by MPHW(F), AWW and PRI representative revealed that from among those ASHA workers who were satisfied with their career option as ASHA, cent percent said that they were helped by their MPHW(F) in their activities, whereas, from among those ASHAs who were not satisfied only 60% were aided by the MPHW(F). Similarly, 96% of satisfied ASHAs felt that they were aided by their AWWs in their activities. Both the relations with MPHW(F) and AWW were found to be statistically significant ($p < 0.05$) denoting that, the more the ASHAs coordinated their activities with other health workers, the better was their level of satisfaction regarding their career options as an ASHA. However, findings on the association with PRI representative was non significant and so can be said not to have a bearing on the level of satisfaction of ASHA workers.

Similarly, association of difficulty in the working process of the ASHA worker with the help received by MPHW(F), AWW and PRI representative revealed that from among those ASHA workers who felt they faced difficulty in their day to day work process, about 90% and 80% said that they were aided by the MPHW(F) and AWW respectively in their activities. However, the association was non significant statistically. But those ASHA workers who had coordinated well with their PRI representatives (57%) found to have less difficulty in their work process. It bore significance with $p < 0.05$. Nandan et al and Shasank K J et al also found out health workers to be satisfied with the services they rendered, but cited lack of coordination from their peer groups and less incentives as a cause of their demotivation [12,19,20].

NRHM evaluation studies in the 7 BEMARU states including Assam reported that 50%, 95% and 94% of ASHAs coordinated well with their gram panchayats, MPHW (F) and the AWW respectively which also affected their level of motivation in performing tasks. In the study by Srivastava SR and Srivastava PS in Maharashtra, it was found that 100% and 94% aided their MPHW(F) and AWWs respectively [21].

Few of the challenges faced by the health workers were lack of support from other staff, unclear reimbursement policies which delayed payments, lack of recognition and identity, problem in carrying the expectant lady to hospital at the mid of night, drunk drivers created nuisances in the ambulances and lack of clarity with overlap of job allocation which fetched them incentives.

Conclusion

Studies prove that health workers are over burdened with work. So the factor which becomes more important is managing the same thing with the same resources. In that case, improving the working environment, and inspiring them to work better, listening to their woes and finding out possible solutions become imperative.

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