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Performance And Satisfaction Of Auxiliary Nurse Midwives At The Sub-Centre Level In Two Blocks Of Darjeeling District, West Bengal, India

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Abstract: Background: *Responsible, productive and competent health workforce is an essential pre-requisite for effective health outcomes and favourable health indicators. Existing on geographical and organizational periphery of the formal health care delivery system, Auxiliary Nurse Midwives (ANMs) operate from subcentres, catering 5000 population in plains and 3000 in hills. Darjeeling district has wide geographical variations, thus finding the difficulties faced by ANMs in the area are of utmost necessity, so that these issues are addressed and productive outcome of health workforce ensured.*

Objective*: To assess performance and satisfaction of ANMs working in the two studied blocks of Darjeeling district.*

Materials and Methods*: All the ANMs working in the two randomly selected blocks of Darjeeling district, one situated in hilly terrain and one in plains were studied for one year. A self –administered questionnaire incorporating the three major areas of assigned responsibility with identified core activities based on West Bengal State Government Orderwas used to assess their performance which was graded as Good, Poor and Average. Satisfaction of ANMs in different components was assessed using a Measure of Job Satisfaction Scale.*

Results: *A total of 41 ANMs were studied. Majority of ANMs performed all the activities and were graded as good performers. They were dissatisfied regarding their pay scale, workload and training received. However no significant difference was observed due to geographical variation among ANMs.*

Conclusion *– Though all identified core activities were carried out their performance grading varied. Most of the ANMs were dissatisfied. A larger study is recommended.*

Keywords*: ANMs, performance, satisfaction, geographical variation*

I. Introduction

The frontiers of health extend beyond the narrow limits of curative care encompassing the preventive and promotive aspects as well.[1]The multidimensional growth of a nation is solely dependent upon its healthy manpower. Unfortunately ailing unresponsive health system with existing social complexities is all pervasive in India. In health they are manifested as differences in morbidity and mortality as observed by our national level health indicators.[2, 3] However for effective health outcomes a responsible, productive and competent health workforce is an essential pre-requisite.Defined by WHO as "stock of all individuals engaged in promotion, protection or improvement of population health" ,it includes clinically trained health professionals, nonclinical health management and support workers.[4] Adequate resource allocation with appropriate skill mix and deployment at various levels of health care are essential as they positively determine a country's ability to meet its goals of organizing and delivering health services like immunization coverage, maternal and child health care, outreach of primary health care etc.[5] Thus an extensive network of three tier public health care delivery system evolving through various stages was established nationwide to ensure accessible, affordable and available health care services in India where geographical variations lead to inequitable distribution of health workforce.[4,6,7]

A new tier of **auxiliary workers** were introduced to work in unison with other health staff and get unanimously engaged in public health interventions, disease preventions, health promotion, research management and support services. "Auxiliary" has been defined as "a technical worker in a certain field with less than full professional training" (WHO 1961).[8] Female auxiliary workers newly introduced were termed as Auxiliary Nurse Midwives (ANMs).and were earlier known as Female Multipurpose Health Worker under Multipurpose Health Worker Scheme (MPHW Scheme) launched in 1974 by Kartar Singh Committeeto ensure essential primary health care services at every corner of the country.[8,9,10]ANMs receive a vocational training of 18 months and subsequently operate from subcentres which are the most peripheral formal health outposts.[11] Catering to 5000 population in plains and 3000 population in hilly, tribal and backward areas they are aided by MPHW (M), Village Health Guides, Trained dais, skilled birth attendantsand Accredited Social Health Activists. Theyareimmediately supervised by Health Supervisorswhoare in charge of at least four to six

subcentres.[9] Acting as interface between people and organization, needs and services, consumers and providers they serve as the first contact point of rural India with the formal health care delivery system of the country.[9]It is through the activities of the ANMs that people perceive the health policies and strategies and health planners at upper level gain insights into the health problems and needs of rural people. In West Bengal, 10356 subcentres were functional in 2011 with 9865 regular ANMs and 6088 second ANMs reflecting the acute shortage.[12] They are either regular permanent staffs working directly under state government as first ANMs or contractual staffs working under NRHM as second ANMs.[13] Standards being the main driving force for quality monitoring and improvement, Indian Public Health Standards (IPHS) was setup stating various essential and desirable services to be delivered at subcentres. Two ANMs are required for functioning of a subcentre.[14] They are entrusted with the responsibility of performing the identified core activities as stated by their state government order to the best of their abilities, notwithstanding all limitations.[15]

Existing on geographical and organizational periphery of the formal health care system and despite their frugal existence, ANMs are neither panacea of weak nor cheap option for underserved population but backbone of our extensive public health care delivery system.

There being no appreciation or glamour quotient attached to the tireless toil of ANMs, widespread dissatisfaction often generates among the workers.[16] Thus along with accounting for their skill, knowledge and professional competence it is equally important to account for their satisfaction quotient at workplace as job satisfaction profoundly affects job outcomes.[17] Poor motivation and morale among frontline workers is a gating issue in quality improvement as studied in Karnataka.[18]

Remote hilly difficult terrains, hard to reach areas and rural areas are most often perceived to be neglected. Darjeeling district comprises of plains as well as rough hilly terrains. Thus in the aforesaid context, assessment of difficulties faced by ANMs in the area, their performance grading and assessing satisfaction of ANMs in different areas are of paramount importance as addressing of these issues will ensure effective outcome of health workforce. Thus a cross-sectional study was conducted in Darjeeling district, West Bengal to assess performance of ANMs in carrying out their responsibilities and determine their job satisfaction.

II. Materials And Methods

Darjeeling district has 12 blocks. A descriptive, cross-sectional study was conducted from May 2011 to April 2012 in two randomly selected blocks of Darjeeling district, West Bengal namely Sukna(situated on hilly difficult terrains, consisting of 24 subcentres) and Kharibari (situated in rural plains, consisting of 11 subcentres). All the ANMs working in the subcentres of these two blocks and their respective supervisors were included as study subjects. Thus a total of 41 ANMs and 11supervisors were studied.

Selected ANMs were briefed about the nature and purpose of the study and their informed consent was obtained as well as was assured about the anonymity and confidentiality of information. Ethical approval was also obtained from institutional ethics committee of NorthBengalMedicalCollege and necessary permission was sought from district health authorities before data collection. Study subjects were interviewed at their workplace (sub centres) using a pre-designed schedule for relevant data collection. Performance and satisfaction of the ANMs at the sub centre level were assessed as follows:

Assessment of performance: A self –administered questionnaire was developed incorporating the three major areas of assigned responsibility (viz. administrative, programme and public health) which in turn comprised few identified core activities based on the West Bengal State Government Order. [15]

ANMs self-rated their performance against each of the core activities on a scale of 1 to 10.Their immediate respective supervisors were also asked to rate the performance of the ANMs separately and independently. The average of these two ratings (of ANMs and supervisors) was taken as the final rating for that particular specified activity. The final rating for each activity was then graded as good (≥ 6), average (4-5.9) andpoor (<4). A similar performance grading system was also used by other researcher in West Bengal.[20] Mean score for each activity was also calculated.Mean rating for each core activity under the various specified responsibilities of the ANMs was taken and spider graph was drawn for their performance assessment. Reasons for low performance in core areas were also assessed by in depth interview of the study subjects.

Assessment of satisfaction: Satisfaction was assessed using Measure of Job Satisfaction (MJS) scale.[21] It is an instrument specially designed for assessing satisfaction in community nurse sector and comprises of 7 components with total 43 items. The components are personal satisfaction (6 items), satisfaction with workload (8 items), professional support received (8 items), training received (5 items), pay-scale (4 items), job prospects (6 items) and standards of care provided (6 items)**.**

Satisfaction was assessed using a 5 point Likert's scales very dissatisfied -1, dissatisfied-2, neither satisfied nor dissatisfied - 3, satisfied-4, very satisfied -5 for every item in a particular component. Thus depending on the number of items, each of the 7 components of the scale had a range of scores. The total score

foreach of the 7 different components was calculated by adding up the individual score of all items in a particular component. Accordingly the level of satisfaction was categorised and compared.

Collected data was analysed and presented using the principles of descriptive statistics and student's t test was applied to compare the mean score satisfaction between two studied blocks.

III. Results

A total of 41 ANMs, 20 from Suknaand 21 from Khoribari were the final study subjects. There were no non – responders. Background characteristics of study subjects: Out of 41 ANMs, 29.3% belonged to 36-45 yr. age group, 85.4% were Hindus and 53.6% were SC/ST/OBCs. 75.6% of them were married and living with their spouse. In Suknaand Khoribari block,85% and 71.4% ANMs respectively had service duration of more than three years and 55% and 57.2% ANMs respectively resided more than 3 kms. away from their designated subcentres. Performance grading of ANMs of the two studied blocks in relation to the core activities in administrative, public health and program responsibilities are presented in Table 1 and 2 and by spider graph in Figure 1 and 2. The '0' in spider graph denotes nil performance and '10' maximum performance. In areas of administrative and public health responsibilities, 100%ANMs performed all identified core activities. However in program responsibilities, majority of activities were performed by all ANMs except 4th.ANC home visit and reporting of AFP, AEFI or measles outbreak. (Table 2, Fig. 2)

In relation to core activities of program responsibilities like routine immunization, family planning services and family welfare activities, most of the ANMs were graded as good performers (Table2). However it is seen that Khoribari performed better in areas like routine immunization, Vitamin A oil administration and family planning services though referral services and birth preparedness counselling was performed better in Sukna Block. (Fig.2) The major reasons for low performance stated were poor infrastructural support, maldistribution of health workforce, lack of technical support, poor pay scale, hard difficult terrains,poor compliance of community with ANMs and more reliability of community on quacks than government health care facilities. Table 3 shows satisfaction of ANMs on 7 components in relation to their job and service delivery. In Sukna and Khoribari block,majority of ANMs were dissatisfied with personal satisfaction, workload, pay scale and training received. However majority of ANMs in both the studied blocks were satisfied with professional support received and standards of care provided though they were neither satisfied nor dissatisfied with their job prospects. (Table 3). However the mean score of satisfaction in all 7 components among the ANMs of both plain and hilly terrains were found to be not significantly different. (Table 4).

However the study had few limitations. Opinion of the beneficiaries attending the sub centres could not be recorded. Third party assessment for job performance could not be done.

IV. Discussion

Performance (quality and efficiency) of a health system depends on knowledge, skill and motivation of people responsible for delivering the services.[22] Similar to the present study, a study found majority of MPHW (F)s to be aged between 26 to 35 years and belonging to SC/ST categoryand another study revealed that 42.9% ANMs commute an average of 10 kms.to her workplace regularly.[23,24]

100% ANMs in the present study were graded as good performers in carrying out family welfare activities. However, in contrast Mavalankar et al stated that too much focus of ANMs on preventive services like family planning and immunization had taken its toll on the comprehensive MCH services, increasing MMR to alarming proportions.[25]I t was studied that in tribal areas of Andhra Pradesh, ANMs lacked planning and only 40% had training on IUD insertions.[26]

Other studies similar to the present study concluded that ANMs didn't conduct home visits regularly and had poor communication skills.[26] In Rajasthan, 50% ANMs did not conduct deliveries and 70% births went unregistered.[27,28] Overburdening of ANM has been a consistent finding in many studies conducted on them due to high priority accorded to the records.[29]

Similar performance grading system was used by other researchers in W. Bengal and Andhra Pradesh. ANMs services in Andhra Pradesh were graded as excellent (performing subtasks in >75% cases), satisfactory (50-75% cases) and poor (50% subtasks not performed well). However in striking contrast none of the ANMs were found to be performing well.[30] Bose et al concluded that self-assessment was particularly valuable in developing-country healthcare settings,where individual service providers often work without a supervisor or colleague to guide their performance. It is also less costly and easier to implement.Self rating by health workers were motivated by more non-financial incentives like recognition, appreciation, job prospects and training.Self-assessments are usually carried along with evaluation by supervisor or peers as they validate, especially during monitoring or evaluation.[30]A case-control study on impact of self assessment on provider performance in Mali found self assessment to be an important tool for quality improvement and to have significant effect on compliance with standards. [31]

Present study found dissatisfaction among ANMs regarding workload, pay scale, personal satisfaction and training received. Asimilarstudy on 'Imbalance in health workforce' found nurses to be dissatisfied with pay scale, job avenues and promotion opportunities.39% registered nurses were dissatisfied with their current job and remuneration and 48% were dissatisfied with level of recognition received from employers. However unlike the present study, where mean scores on various components of satisfaction did not differ significantly among ANMs working in plains and hilly terrains another study found geographical mal-distribution of health workforce leading to widespread dissatisfaction among those working in difficult terrains.[32]

Lack of motivation, their rampant absenteeism from work, poor infrastructure, inadequate access to existent facilities and inappropriate capacity building efforts with unsatisfactory remuneration were found to be the causes of their dissatisfaction.[33]

V. Conclusion

ANMs are the key health field level functionaries entrusted with responsibility of delivering need based, client centred, and demand driven services at the doorstep of community.

From the findings of the study it may be concluded that identified core activities were performed by ANMs. However there was variation in their performance grading as all the activities were not performed uniformly. Dissatisfaction among ANMs exists in certain areas related to their jobs like pay-scale, workload, personal satisfaction and training received irrespective of the geographical location of their designated sub-centres in plains of hilly areas. Health planners and policy makers may ensure productive outcome of health workforce by addressing the areas of dissatisfaction with appropriate interventions.

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Figures:

Fig.1: Spider graph depicting the administrative core activities performed by ANMs in the two studied blocks of Darjeeling district.

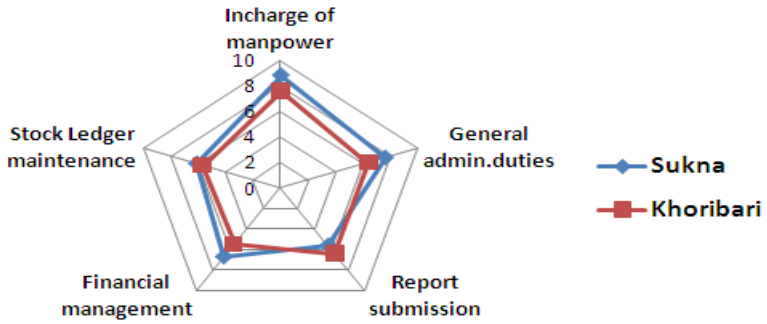
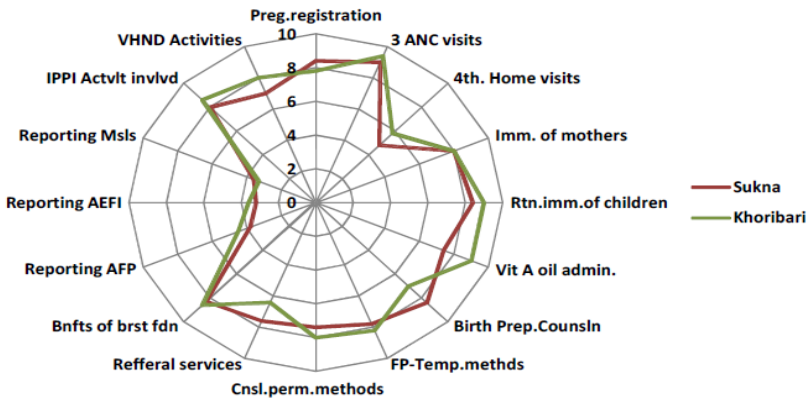


Figure 2: Spider graph depicting program core activities performed by ANMs in the two studied blocks of Darjeeling district



Tables:

Table 1: Distribution of ANMs according to performance grading in relation to administrative and public health responsibilities and core activities (n = 41)

Responsibilities / Activities	Sukna(n=20)			Khoribari (n= 21)		
	Good	Average	Poor	Good	Avg.	Poor
Administrative:						
Being in-charge of manpower	17 (85)	3(15)	-	15(71.4)	6(28.6)	-
General administrative duties	17(85)	1(05)	-	13(61.9)	5(23.8)	3(14.3)
Submitting reports to hierarchy	19(95)	1(05)	-	21(100)	-	-
Financial management	15(75)	2(10)	2(10)	12(57.1)	6(28.6)	3(14.3)
Maintaining stock ledger	16(80)	1(05)	3(15)	19(90.4)	1(4.7)	1(4.7)
Public Health :						
Carrying out hierarchy orders	20(100)	-	-	21(100)	-	-
Performing staff duty in her absence	19(95)	1(05)	-	19(90.4)	1(4.7)	1(4.7)

Figures in parenthesis indicate percentage

Table 2: Distribution of ANMs according to performance grading in relation to various program responsibilities and core activities (n = 41)

Major areas/Core Activities	Sukna (n=20)			Khoribari (n=21)		
Family Welfare Activities	Good	Avg.	Poor	Good	Avg.	Poor
Carrying out three ANC visit	19(95)	1(05)	-	20(95.2)	1(4.7)	-
Carrying out 4th ANC home visit	5(25)	3(15)	2(10)	9(32.8)	2(9.5)	1(4.7)
Routine immunization	18(90)	2(10)	-	21(100)	-	-
Birth preparedness counseling	20(100)	-	-	19(90.4)	2(9.5)	-
Providing temporary methods of family planning.	18(90)	2(10)	-	21(100)	-	-
Referral services	20(100)	-	-	16(76.2)	5(23.8)	-
Reporting of AFP	7(35)	5(25)	2(10)	8(38.1)	4(19.1)	3(14.3)
Reporting of AEFI	5(25)	3(15)	2(10)	9(32.8)	2(9.5)	1(4.7)
Reporting of Measles outbreak	5(25)	5(25)	4(20)	8(38.1)	4(19.1)	3(14.3)
Involvement with VHND	19(95)	1(5)	-	21(100)	-	-
JSY Implementation						
Registration	19(95)	1(5)	-	19(90.4)	2(9.5)	-
Cash disbursement & maintenance	17(85)	2(10)	1(05)	18(85.7)	2(9.5)	1(4.7)
Relevant report submission	19(95)	1(5)	-	21(100)	-	-

Figures in parenthesis indicate percentage

Table 3: Satisfaction of ANMs in relation to the various components in the two studied blocks of Darjeeling district.

Components of satisfaction	Sukna (n=20)			Khoribari(n=21)			Total(n=41)		
	D	NDNS	S	D	NDNS	S.	D	NDNS	S
Personal satisfaction	11(55)	3 (15)	6(30)	12(57.2)	4 (19.1)	05(23.8)	23(56.1)	7(17.1)	11(26.8)
Workload	13(65)	4(20)	3(15)	13(61.9)	3(14.3)	05(23.8)	26(63.4)	7(17.1)	08(19.5)
Professional support	5 (25)	3(15)	12(60)	5(23.8)	5(23.8)	11(52.4)	10(24.4)	8(19.5)	23(56.1)
Training received	11(55)	6(30)	3(15)	14(66.6)	5(23.8)	02(9.5)	25(60.9)	11(26.8)	05(12.2)
Pay scale	15(75)	3(15)	2(10)	15(71.4)	4(19.2)	02(9.5)	30(73.2)	7(17.1)	04(09.7)
Job prospects	3(15)	10(50)	7(35)	03(14.3)	11(52.3)	07(33.3)	06(14.6)	21(51.2)	14(34.1)
Standards of care provided	3(15)	2(10)	15(75)	04(19.1)	4(19.1)	13(61.9)	07(17.07)	06(14.6)	28(68.3)

- **Figures in parenthesis indicate percentage**
- Note : The 5 point Likert's scale has been presented in 3 categories as D = Dissatisfied (Very Dissatisfied and Dissatisfied); NDNS = Neither satisfied nor dissatisfied and S = Satisfied

Table 4: Mean satisfaction score in relation to several components among the ANMs of the two studied blocks of Darjeeling district.

Components of Satisfaction	Possible range of score	Sukna (n=20) Mean score	Khoribari (n=21) Mean Score	Statistical tests
Personal satisfaction	06 - 30	10.6	11.5	t = 0.62, p = 0.53
Workload	08 - 40	13.5	14.3	t = 0.76 , p = 0.93
Professional support	08 - 40	25	25.6	t = 0.83 , p = 0.46
Training received	05 - 25	09	8.9	t = 0.93 , p = 0.34
Pay scale	04 - 20	7.1	7.8	t = 0.62 , p = 0.54
Job prospects	06 - 30	15.5	15.7	t = 0.89, p = 0.61
Standards of care provided	06 - 30	20.5	20.6	t = 0.94, p = 0.36