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Research Article

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Time Utilisation Pattern of Front Line Health Workers in India – A Case Study from Mangalore District

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Introduction

Sustainable development goal 3: Ensure healthy lives and promote well-being for all at all ages reports that most of populations are living healthier than before but there are many suffering from many disease and its prevalence and targets to achieve all them. Health workers are the core of the health care service system to deliver the care to the community. World Health Organization section of Nurse and Midwifery states that they comprised of more than 50% of the total health workforce, and there is a global shortage but the largest need based shortage in the Africa and South East Asia regions (https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery). WHO statistics consists of Auxiliary nurses midwife (ANM, two years of training), registered nurses and midwifes (it varies from 3 -4 years of education).

In Indian health care system ANM is the first contact point between the community and health care institutions. They are the front line Female Health Worker's (FHW). They deliver all the health program activities to the door steps of the community. They all are female and obliged to stay within the areas there served. Their duties and responsibilities were changed as per the need of the community and program. There was a shift from the hand on practice of their skills to data collectors or communicator. Under Janani Surakhsha program, institutional deliveries were promoted. So ANM referred the mothers to the primary health centre. This study explores time utilization pattern of ANM in the Dakshin Kannada district, Karnataka, India.

Research Methodology

Explorative survey was adopted to study female health workers' performed activities for a period of 1 month (30 days) are collected using the log book prepared by the investigator. The study is designed in two phases. Phase I: Discussions were carried out with ANM regarding the working pattern and problems faced by them while delivering the health services. Then baseline information were collected and log books were distributed with instructions. Phase II: Follow up of ANM was done through the phone calls and non participative observations were carried out to assess the time utilization of female health workers. At the end of one month (30 days) log books were collected back. Investigators did the non participative observation of the activities of the twelve ANM's. Each day first half day was spent on home visit so he accompanied each day with one ANM and noted the time spent on each activities.

Sampling technique

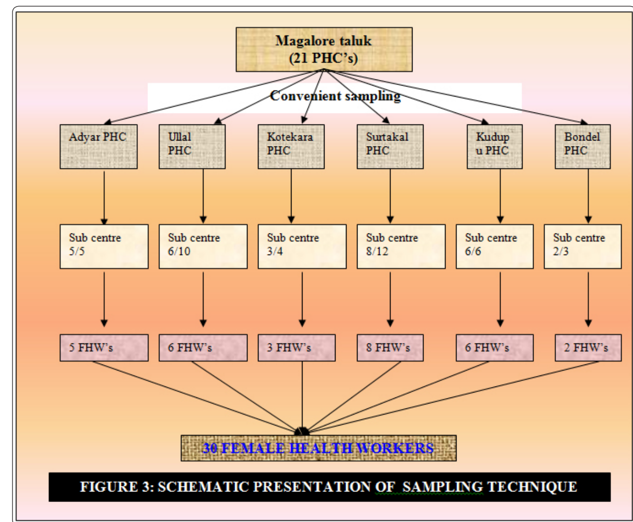

FIGURE 3: SCHEMATIC PRESENTATION OF SAMPLING TECHNIQUE

Setting of the study

This study was conducted in selected Primary Health Centre's (PHC) of Mangalore taluk, Dakshina Kannada district. The district has 63 PHCs and 430 sub centre. There are 444 posts of female health worker, out of which 6 are vacant. In Mangalore taluk alone there are 130 sub centres covering the geographical area of 15,005 square kilometres with a population of 8, 82,856 [31]. Following PHCs were chosen for the study: Adyar, Ullal, Kotekara, Kudupu, Surathkal and Bondel. There were a total of 40 sub centres in these PHCs.

Result

Majority of the ANM reported to be residing at the sub centre area (90%) and were not using their own vehicles during visits (93.34%), more than half (56.67%) of having the government accommodation facility, many of the FHW (40%) were having experience of 26-30 years and were covering 5001-7000 population (40%). All the health workers were planning their activities some days or week before. More than half of FHWs (56.6%) were adhering to the planned activity.

Activities Performed by ANM

The ANM's reported to perform maternal care activities (Antenatal mother registration, antenatal mother revisit immunization,

conducting delivery, assists in delivery, post natal mother registration, post natal mother revisit, neonatal care, beneficiary programme), child care (Child home care visit, anganwadi visit, school visit, immunization), family planning activities (promotion, eligible couple visit, IUD administration and follow up, condom and oral pills distribution, referring to PHC, taking clients health camp, and their follow up), health programme (implementing all the vertical and horizontal programmes), care of minor ailments/ infections and referral, conducting health days, nutrition days, clinic at sub centre, environmental health care activities, vital statistics, participating in survey, meeting (Monthly ICDS and PHC meeting, Raksha samiti meeting, Village sanitary committee meeting), Record maintenance (mainly 13 registers and additionally NRHM and other records add totally more than 25) activities. There were many studies to support the above findings [10, 11, 14]. All the reported activities were observed by the investigator except chlorination of well, conducting delivery, IUD insertion, assisting in delivery, conducting health days and nutrition days, village health sanitary committee meetings.

Table : Activities performed by ANM

Sl No	Category of the activity	Number of ANMs Performed (reported) N=30	Number of ANMs Observed N=12
01	**Maternal care**		
	Antenatal care	30	12
	- Registration		
	- Revisit		
	- Immunization	-*	-*
	Intra natal care	1	-*
	- Conducting delivery		
	- Assists in delivery		
	Post natal care	30	12
	- Registration		
	- Neonatal care		
	- Revisit		
	Beneficiary programme	30	12
	-Janani suraksha Yojana		
	- Tayi Madilu		
2	**Child care** - Child care visit - Anganwadi visit - School visit - Immunization	30	12
3	**Family planning activities**	30	12
	-Family planning promotion		12
	-Eligible couple visit		-*
	-IUD insertion,		12
	-IUD follow up		
	-Condom and oral pills distribution		12
	-Referring to PHC		
	-Taking clients health to camp, and follow up		-*
4	**Health programme** -Implementing all the vertical and horizontal programmes	30	12
5	**Others**		
	-Minor ailments	30	12
	/ infectious disease care and referral	30	-*
	- Conducting health days, nutrition days	30	-*
	- Clinic at sub centre	30	
	- Environmental health	15	01
	• Water sample collection	05	-*
	• Well chlorination	30	12
	-Vital statistic		
	-Meeting	30	-*
	•Monthly ICDS and PHC meeting	17	-*
	•Raksha samiti meeting	13	-*
	•Village sanitary committee meeting	-*	-*
	- Dai training	-*	-*
	- Assisting ASHA		
6	**Record maintenance**	30	-*

-*: activities not reported/not observed.

Days spent by ANM in 30 days (as reported)

An average number of days spent on different activity per ANM per 30 days were: field visit days 11.1 days (37%), 8.94 holidays (29.78%), 4.84 days for fixed activities (16.06), meetings 1.53 days (5.11), report preparation were 1.26 days (4.22%) and days spent on other activities were 2.35 (7.83%).

Activity analysis

On an average, activity performed by each ANM per visit day were 3.18 maternal activity, 5.54 child care activities, 8.87 family planning activities, 3.02 health programme activities and 3.89 other activities.

Table 4: Distribution of days spent by 30 ANM for 30 days (as reported) N = 30

Sl No	Activity	Total Days spent/activity /30ANM's	Range of days	Mean (days spent/ activity/ANM/30 days)	Percentage of days spent/ ANM/30 days
1	Visit	333	06-17	11.1	37%
2	Holidays	268	05-13	8.94	29.78%
3	Fixed activity	144.5	00-08	4.82	16.06%
4	Meetings	46	00-03	1.53	5.11%
5	Reports	38	00-3.5	1.26	4.22%
6	Others	70.5	00-08	2.35	7.83%
	Total	900			100%

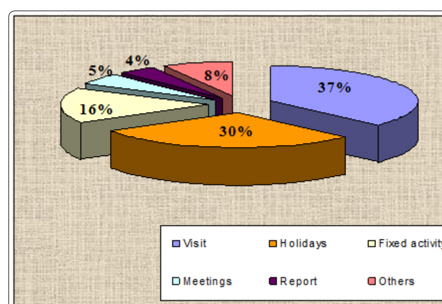

Figure: Distribution of percentage of days spent by ANM/activity/30 days (reported)

Time utilization pattern of female health workers

The study findings show that female health workers spent 137.15 minutes (2 hours 29 minutes) of time on home visit and 93.45 minutes (1 hour 56 minutes) in travelling per day. To sum up 66% of the time was spent in reproductive child health (RCH), 18% of the time was spent in health programme and 16% of the time was spent on other activities.

Conclusions

Front line health workers are a liaison between the community and health care institute. They are spending most of the time on documentation and reproductive activities than to provide a comprehensive health care. This shift of skilled workers to data collectors demoralised them in person but it is a waste of skill hands which can save the life of the community. Their skill need to updated with regular skill and knowledge based program.

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