

Quality of Health Assistants in Primary Health Centres in Rural Maharashtra, India

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Abstract

Introduction: Health assistants are important functionaries of the primary health care system in India. Their role is supervision of field-based services among other things. A quality assurance mechanism for these health assistants is lacking. The present study was undertaken with the objectives of developing a tool to assess the quality of health assistants in primary health centres (PHCs) and to assess their quality using this tool.

Methodology: Health assistants from three PHCs in the Wardha district of India were observed for a year using a tool developed from primary health care management Aavancement program modules. Data was collected by direct observation, interview, and review of records for quality of activities.

Results: Staff strength of health assistants was 87.5%. None of the health assistants were clear about their job descriptions. A supervisory schedule for providing supportive supervision to auxiliary nurse midwives (ANMs) was absent; most field activities pertaining to maternal and child health received poor focus. Monthly meetings lacked a clear agenda, and comments on quality improvement of services provided by the ANMs were missing.

Conclusion: Continuous training with sensitization on quality issues is required to improve the unsatisfactory quality.

Keywords: quality, primary health care, health assistant, supervision, India

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Introduction

The primary health care system in India focuses on effective patient care and various health promotional activities with the participation of community as well as scrupulous monitoring and supervision at each level. The key staff responsible for carrying out these activities are the health workers and medical officers. There is also a cadre of health assistants (HA) whose primary functions are to assist, supervise, and monitor the activities of the health workers under their supervision in the field.¹ One health assistant is expected to supervise the activities of 5 to 6 auxiliary nurse midwives (ANMs) and lend support to them in case of problems. They are selected for the position of HA (male) after they have completed a certain number of years serving the primary health care system as health worker (male), or as an ANM for being promoted to the position of HA (female). [Health assistants may be either male or female. Their subordinates are health workers (males) and ANMs (all of whom are females).] Thus, health assistants are expected to understand the intricacies of service delivery at the field level and also understand and solve the common problems arising therefrom. Their monitoring visits include random checking of service delivery points and also of households for estimating coverage and quality of services provided by the ANMs. They conduct monthly meetings with the ANMs to discuss the progress in their allocated areas and also provide training to them on needed issues. At the end of every month, they submit the progress report to the medical officer in charge of the primary health centre.² The health assistants are also expected to attend multiple training sessions periodically on different health aspects and newer technologies in the field.

However, at present, the role of health assistant is confusing because most do not clearly understand their job descriptions³ and the burden of work shared with other health workers under them. This is because there is also a shortage of health workers, whose work is done by the HAs. As a consequence, HAs end up as merely supplementing the work of the health workers. There is lack of clarity among HAs regarding the expectations of their position. There is also a lack of method to measure their competency, since no uniform standards for quality assessment of HAs are available.

Hence, the present study was designed with the objectives of developing a tool to assess the quality of health assistants in primary health centres and assessing their quality using this tool.

Methodology

The present observational study was conducted in three primary health centres namely, Anji, Gaul, and Talegaon in Wardha district of Maharashtra province in India that are attached to the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram. The study was carried out from June through December 2006. Ethical clearance for conducting the study was given by the institutional ethical committee of MGIMS. First, a tool for assessing the quality of health assistants was developed from the Primary Health Care—Management Advancement Program (PHC-MAP) toolkit, which includes 9 units called modules that focus on essential information that is needed in the traditional management cycle of planning, doing, and evaluating.⁴ These modules can be used by different cadres of health functionaries to gather information that fits their needs. Each module explains how to collect, process, and interpret PHC-specific information that can be used to improve planning and monitoring. The modules include user guides, sample data collecting and data processing instruments, optional computer programs, and facilitator's guides for holding training workshops. For developing a tool for health assistants, modules 3, 6, and 7 were utilized.⁵⁻⁷ These modules were pretested, and after appropriate modifications, they were adapted into one tool for use in the rural areas of Wardha district.

This tool comprised parameters such as the number of health assistants in positions, clarity of job descriptions of health assistants, quality of field activities, quality of supervision of health assistants, and so on. Data were collected by the investigator by interviewing the health assistants and making direct observations of activities of health assistants, as well as reviewing of the records maintained by them. Seven health assistants were contacted based on an informed schedule after obtaining informed consent from each of them. The primary health centre medical officers, who act as supervisors of the health assistants, were also informed about the purpose of the study, and the supervisors also provided consent to include their staff in the study. Individual activities of each of the 7 health assistants were observed for data collection. The observations were made at various points; at least 20% of the observations were selected by a simple random sampling method and included monthly meetings with ANMs (three in

each PHC), maternal and child health (MCH) clinics in villages (21 MCH clinics in subcentre villages; a subcentre village is a village with 5000 population which is catered to by a health subcentre), field visits with the ANMs (3 visits randomly chosen with each HA), and training sessions (3 sessions randomly chosen at each PHC). Thus, a total of 21 meetings with ANMs, 21 MCH clinics, 21 field visits, and 21 training sessions were observed (Fig. 1). The collected data were entered into a Microsoft Excel spreadsheet and analyzed. Descriptive statistics are reported below. Feedback was given to the medical officers of the respective PHCs for identifying training needs of the HAs.

Results

A total of 7 HAs in 3 PHCs were interviewed and observed. Twenty subcentres were covered under these 3 PHCs. The total number of posts of HAs sanctioned by the Government in 3 PHCs was 8, of which 7 were filled and 1 was vacant. Of these 7, 57% were male HAs, and 43% were female HAs, also known as lady health visitors (LHVs). All the PHCs had at least 1 male HA and 1 female HA. Assessment of quality was made for 2 important functions, namely, field activities and supervision. It was found that none of the As was clear about their job description. They had a work plan in accordance with the targets of national programs (reproductive and child health, in particular!). None had received any skill

development training during the previous year. All the HAs expressed a desire to undergo such training.

Quality of field activities of health assistants

Supervisory schedule

Most (71.5%) of the HAs had a schedule for supervisory visits, and they met with the ANM at least once a month. Any change in the supervisory visit schedule was communicated to the ANMs by about half (57.1%) of the HAs. However, these visits only focused on percentage achievement of the targets. (Under the reproductive and child health program in India, the health workers decide on certain targets for service delivery, such as for family planning, which, if met, are appropriately incentivized. Monitoring of these targets is an important parameter to determine if the program is performing satisfactorily or not.)

Field activities

Most of the field activities such as making house visits, conducting MCH and family planning clinics, and organizing women's groups for the family welfare program (now the reproductive and child health program) received inadequate attention, as shown in Table 1. HAs made household visits only 42.86% of the time, and, during none of their visits, were any technical skills demonstrated to the ANMs. On only 28.57% of occasions, the HAs were found to organize and utilize women's groups in the rural areas for family planning activities. The focus areas of monitoring were antenatal care (100%), immu-

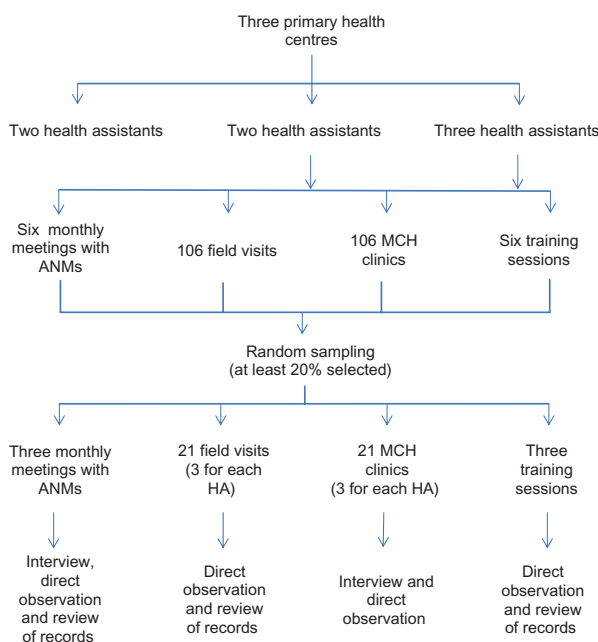


Figure 1. Flow diagram of the method of selection of service delivery points.

Table 1. Field activities of health assistants.

Field activities	Number (N = 21)
House visits	9 (42.86)
Technical skills demonstrated to ANMs during visit	0 (0)
Conducted MCH and FP clinics	9 (42.86)
Organized and utilized women's groups in family welfare program	6 (28.57)
Focus areas	
ANC	21 (100)
Delivery	0 (0)
Immunization	21 (100)
New born care	0 (0)
ORT	6 (28.57)
ARI	15 (71.53)
PNC	6 (28.57)
RTI/STD	3 (14.29)

Note: Figures in parentheses indicate percentages.



nization of children under 5 years of age (100%), and treatment of acute respiratory infections (71.5%). Other areas such as newborn care, postnatal care, treatment of reproductive tract infections, and treatment of diarrhea using oral rehydration therapy received attention on 0%, 28.57%, 14.29% and 28.57% of occasions, respectively.

Records and reports

None of the HAs maintained any supervisory records, nor did they record the corrective actions taken for problems reported to them by the ANMs. The generated reports were nevertheless submitted to the PHC medical officer in due time.

Supervision quality of health assistants

Table 2 shows that less than half (42.9%) of the HAs helped the ANMs to plan their work during monthly meetings. All of the HAs reviewed the condition of the facility and the records but seldom commented on improving the service quality of the ANM. Only 42.9% of HAs were found to guide the ANM to establish depot holders for contraceptives (Depot holders are volunteers from amongst the community who are easily approachable by all segments of the community, and they store contraceptives for public distribution). Staff meetings were regularly conducted by most of the HAs, but the village governance did not lend any support through the supervisory mechanism. Above half (57%) of the HAs had a good rapport with the ANMs and supplied the needed materials to them in due time.

Discussion

Quality of the HAs in the present study was found to be unsatisfactory. This is mostly attributed to

Table 2. Supervisory qualities of health assistants.

Supportive supervision to ANM	Number (N = 7)
HA helped ANM to plan work	3 (42.86)
Commented on improving service quality/counseling	0 (0)
Conducted staff meetings regularly	6 (85.71)
Support to village health committee through supervisory system	0 (0)
Rapport with the ANM	Number (N = 21)
Asked if ANM had any problem	6 (28.57)
Praised/criticized ANM's performance	3 (14.29)
Procured and supplied needed materials to ANM in due time	12 (57.14)

Note: Figures in parentheses indicate percentages.

vacancies and lack of training. Multiple studies have reported staff shortages among health assistants.⁸⁻¹⁰ Staff shortages result in shirking responsibility and lack of accountability, which results in poor quality of work. The field activities were focused on antenatal care and family planning, to which incentives are linked; other areas were mostly neglected. One of the reasons for this neglect could be the content of the training, which failed to focus on other areas such as malnourishment, diarrhea, and acute respiratory infections among children. A study of 116 health assistants in adjoining provinces of Andhra Pradesh, Gujrat, Karnataka, and Haryana in India revealed that most of the HAs did not plan their supervisory visits, which is similar to our findings. Most of the HAs were not aware of the supervision components such as health education, records verification, issue of drugs, and so on. Sixty percent of male and 75% of female health assistants did not ensure full immunization of the beneficiaries,¹¹ whereas we found immunization services to be strong in our area. Published reports also suggest that most of the HAs are promoted without completing the basic requirements training; neither are they subjected to in-service training.^{3,12} During 2003, fewer than 15% HAs over the entire state of Maharashtra received training.³ This training is not focused on the HA's role, nor does it cover aspects like monitoring and supervisory mechanisms and enhancing of the quality of care.³ It becomes imperative to stress a clear description of the role of HAs in the primary health care system. The medical officers are also unable to guide the HAs because of the lack of such training. We found that the HAs were also paying inadequate attention to delivery and newborn care, which was mainly because of the poor infrastructural and equipment support present at the subcentres for these services. In addition to the above factors, we also felt that lack of motivation may also be an important contributory factor to poor quality of services. To uphold the high degree of interest and motivation, new skills should be taught to HAs and refresher training for other essential and desired skills should also be conducted on a regular basis. Though the small sample size of our study was a limitation, it was sufficient to highlight the state of the quality of service delivery by health assistants in our area and to draw the attention of the government to formulate policies and implement them to improve the quality



of service as well as to put a quality assurance mechanism in place.²

Conclusion

Sensitization about the roles and duties of the health assistants and imparting training for effective monitoring and supervision, along with incentives for additional work, in addition to filling vacant positions may be useful for improving the service quality of health assistants in India. Discussions on quality improvement in the periodic performance review meetings should be initiated so as to prime the health functionaries to the issues of enhancing and maintaining quality in primary health care delivery. Continuous professional development coupled with a quality assurance plan for health assistants is imperative to improve quality and utilization of services as well as client satisfaction.

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Author Contributions

Conceived and designed the experiments: EG. Analyzed the data: EG. Wrote the first draft of the manuscript: EG. Contributed to the writing of the manuscript: BSG. Agree with manuscript results and conclusions: EG, BSG. Jointly developed the structure and arguments for the paper: EG, BSG. Made critical revisions and approved final version: BSG. All authors reviewed and approved of the final manuscript.

Competing Interests

Author(s) disclose no potential conflicts of interest.

Disclosures and Ethics

As a requirement of publication author(s) have provided to the publisher signed confirmation of compliance with legal and ethical obligations including but not limited to the following: authorship and contributorship, conflicts of interest, privacy and confidentiality and (where applicable) protection of human and animal research subjects. The authors have read and confirmed their agreement with the ICMJE authorship and conflict of interest criteria. The authors

have also confirmed that this article is unique and not under consideration or published in any other publication, and that they have permission from rights holders to reproduce any copyrighted material. Any disclosures are made in this section. The external blind peer reviewers report no conflicts of interest.

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