



A study on training needs of female health workers in tribal area of Telangana, India

Rapolu Ramakrishna Murthy *

ABSTRACT

IMR and MMR in tribal areas of Telangana are still worrisome. Often two main reasons attributed to this problem were; low number of institutional deliveries and deliveries in the absence of skilled health provider. This study intended to know how skilled are the skilled health providers and it attempted to measure the knowledge and skills of Female Health Workers in maternal care, labour/child birth and neonatal care including communication skills. The participants' perceived training needs were also considered as important and included in this study. Out of 700 notified scheduled villages, the participants were covered approximately in 1:2 ratio (n=350). Nearly 80% (mean=281.5) of the participants obtained scores below 50% and nearly 50% (mean=168.5) of the participants have scored below 30%. The scores of 40% of the participants reflected poor communication skills. Scores in all the areas found to be poor. Scores on skills in maternal care were better than skills in childbirth and scores on skills in child birth were better than neonatal care. On the scale of perceived training needs, skills in Labour/Child birth was given top priority by participants followed by Neonatal care, Communication skills and Maternal care respectively.

INTRODUCTION

Socio- economic inequalities in health and disease are ubiquitous.¹ Of all the health parameters, infant and child mortality clearly reflect the inequalities in a society. According to 'Child mortality key facts' released by the World Health Organization (2011) on Millennium Development Goals -4; 99 percent of infant deaths occur in developing countries.² In rural India, 86 percent of these deaths are due to infections, premature births, complications during delivery, perinatal asphyxia and birth injuries.³ Studies on Indian tribes have shown that a child born to a Scheduled Tribe family has 19 per cent higher risk of dying in the neonatal period and 45 per cent higher risk of dying in the post-neonatal period compared with other social classes.⁴ In the newly formed state, Telangana the illiteracy and inhuman living conditions are not uncommon among the tribal communities. Many studies have highlighted their

poverty and social exclusion.⁵ Like all other parameters, health indicators including child mortality also reflects their marginal condition.⁶ In these tribal areas, number of institutional deliveries are lower than the national average and percentage of pregnant women who had full antenatal care is much less than state average for rural areas i.e. 41%, according to DLHFS-4.⁷ The districts that constitute more tribal populations like Warangal and Adilabad has covered only 44% of immunization that is lower than the state average. According to a study, by Usha Shree et.al; among these tribals (in A. P.), it was observed that the IMR was ten times higher than that reported by the district authorities i.e., 22/1000.⁸ It was observed that 28% of infants died within first day, 68% within first week (including the first day) and 81% within first month. There has been strong criticism around the methods of Public Health

GJMEDPH 2015; Vol. 4, issue 4

*Corresponding Author:

Rapolu Ramakrishna Murthy
Independent Researcher at Centre for
Disabilities and Public health (CDPH) –
Transform, Hyderabad, India

Conflict of Interest—none

Funding—Supported by Transform,
Hyderabad, India



mechanism for failing to provide reproductive and child health services for these people. Lack of awareness on preventive health, their distance and inaccessibility to medical facilities, lack of proper road connectivity, unaffordable transportation make them health wise more vulnerable.⁹ The high IMR has been attributed mainly to low number of institutional deliveries and deliveries in the absence of Skilled Health Provider/Female Health Worker.¹⁰ The roads and distances are however the hurdles but how skilled are the Skilled Health Providers is also a question. Many researchers have emphasized on the need for re-training of Female Health Workers for identification and management of early warning signs during prenatal and neonatal conditions.¹¹⁻¹³

The Female Health Workers (FHWS) are the backbone of Public Health system. Their role is very significant particularly for the tribal communities as there is no other resort for them to depend on basic health needs. The services of FHWs are invaluable, despite their low number in proportion to population, the long distances they travel, difficulties they face to reach out during monsoons and the meager remunerations they get. The village sub-centre as a last primary health delivery point supposed to cater two or more villages (1: 5000 population) staffed with one Female Health Worker called as Auxiliary Nurse Midwife (ANM) supported by one or two Accredited Social Health Activists called ASHA workers drawn from community (1: 1000 population).¹⁴ National Rural Health Mission, has envisaged to provide minimum two ANMs (against one at present) at each Sub-Centre by 2010, as one ANM at a sub-centre has not been found adequate to attend to the complete needs of maternal and child care in any village.¹⁵ But this has not been realized yet.

ANM provides services like immunization, ANC, PNC and basic management of sick children and primary health care to the local population.^{16,17} She is responsible for early registration of pregnant women and proper care during pregnancy and tracking children until age three and maintaining village wise records, care of under nourished children: ANM will conduct health check-up of severely underweight, screen children for severe acute malnutrition and

provide appropriate treatment and take necessary next line of action. As far as Maternal and Neonatal Care, the ANM's role is very crucial and therefore their level of knowledge and skills matter most in the health care of tribal communities and present study focused on the assessment of Female Health Workers' level of knowledge and skills and identification of training needs.

OBJECTIVES

- 1) To assess the knowledge and skills of Female Health Workers in antenatal care, labour/childbirth and neonatal care.
- 2) To identify the actual and perceived training needs of Female Health Workers.

METHODOLOGY

This cross sectional study was done using a structured questionnaire prepared in local vernacular (Telugu), one part to test the knowledge and practices of the ANMs in maternal care, labour/child birth and neonatal care including communication skills and use of IEC material; and the other part, to scale their perceived training needs by giving them the choice to assign a number on a nominal scale based on their priority. According to the Ministry of Tribal Welfare, Government of India, there are nearly 700 scheduled villages in Telangana spreading across mainly in four districts viz. Warangal, Adilabad, Mahabunbagar and Khammam with approximately equal number of sub-centres staffed with ANMs. The purposive sampling was used covering tribal villages in Warangal and Khammam districts (one in two randomly; N=350) as the all other features including the methods and standards of the primary healthcare staffing across the state are the same. Oral consent was taken from all the participants explaining the objectives of the study and choice was left to them whether to be anonymous. The questionnaire was administered in the presence of a guide to clarify the doubts related to the questions used in.

RESULTS

The first part of the questionnaire was intended to check the knowledge and practices of FHWS on Maternal care, Labour/Child birth, Neonatal care, and Communication skills and Use of IEC Material and the second part to know their perceived training needs.



The number of participants were classified against to class intervals of scores (>30%, 30%-50%, 51%-70%, and >70 %).

Table 1 Knowledge and practice of FHWs

Scores (C I)	>70%	51%-70%	30%-50%	<30%
Maternal Care	2	57	121	170
Labour/Child birth	9	62	113	166
Neonatal Care	8	51	105	186
Communication skills & Use of IEC Material	7	78	113	152

Overall score pattern indicates that approximately 80% (mean=281.5) of the participants obtained below 50% and nearly 50% (mean=168.5) of the participants have scored below 30%. When scores are compared skills in maternal care, reflected better than labour and neonatal care. Average of participants who

scored between 51% and 70% is only 62 (17%). Over 40% of the participants have scored very low on communication skills and use of IEC Material. The mean of participants scored over 70% is only 6. 5.

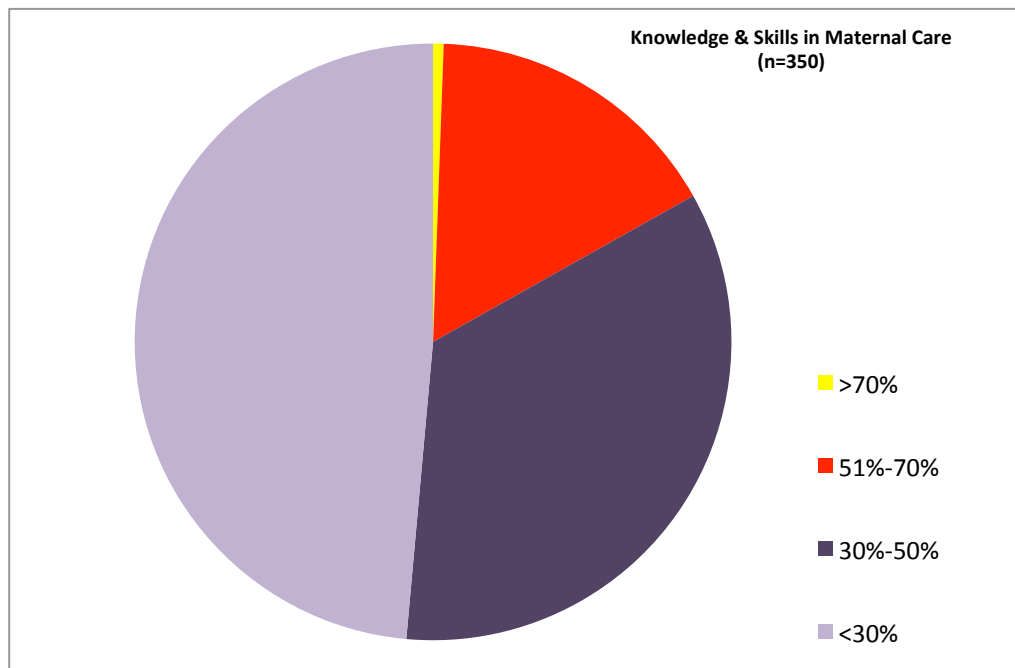


Fig 1: Knowledge and skills in maternal care (n=350)

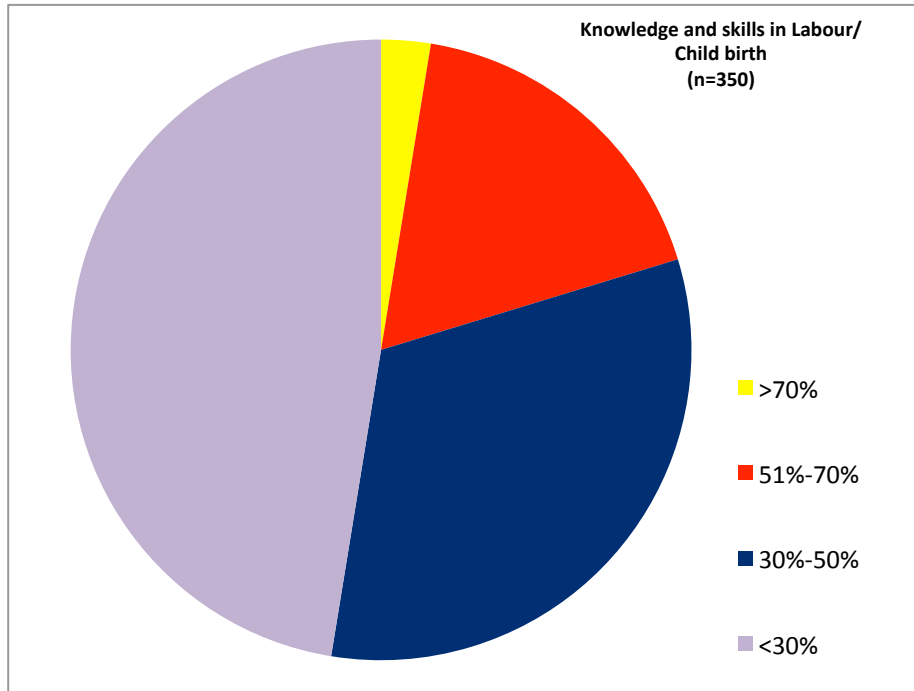


Fig 2: Knowledge and skills in labour/child birth (n=350)

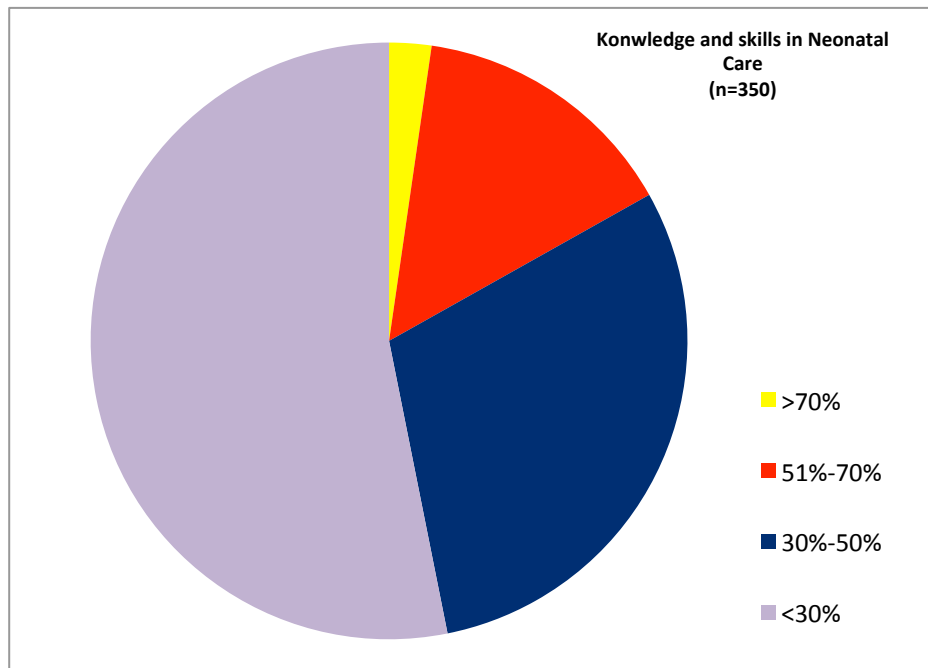


Fig 3: Knowledge and skills in neonatal care (n=350)

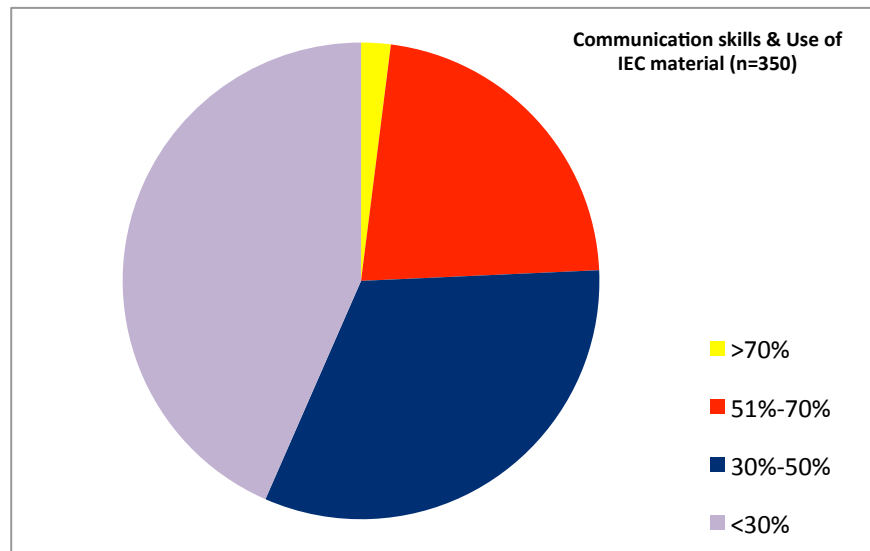


Fig 4: Knowledge and skills in communication skills and use of IEC materials (n=350)

Majority of participants chose 'labour/child birth' as first priority training need, followed by neonatal care, communication skills and maternal care respectively.

Table 2 Perceived training needs

Perceived Training needs				
Area of skills	Maternal care	Labour/Child birth	Neonatal care	Communication and counselling skills
No. of Participants	49	127	112	62

DISCUSSION

The aggregate results of the study show that the knowledge and practices of half of the FHWs are extremely poor; 30% of them scored average and less than 20%, scored above average.

Approximately 2% of the participants' scores reflect superior skills. This not only reveals the huge gap in the levels of knowledge and skills of FHWs but also the scope to develop their potentials. The level of knowledge and practices of FHWs is evidently of one of the probable causes of high IMR.

Their priority of training need also reflects serious knowledge and skill gaps in the areas of intra-natal and neonatal care. However their knowledge and skills in maternal care also show the similar status. Communication skills are far more important for them because their major work is to listen, ask, tell and counsel the pregnant women and their family

members on various issues related to safe motherhood. Their communication skills play very important role in creating awareness among the communities and making right health decisions by families. Low level of communication skills among the FHWs will be a serious impediment for the successful implementation of community health programmes. Improving their skills can also augment the implementation of schemes like Sukhibava and Janani Suraksha Yojana that already have positive impact. Some of the responses of the participants on the communication skills also mirrored the need for the better attitudes and personality that can foster professionalism among them. So much of efforts, financial resources, and intellectual inputs are needed for the preparation of IEC material, all that will be a mere waste, when material is not used effectively.



Researcher recommends effective in-service training programmes and capacity building for FHWs as an imperative followed by vigorous training on personality and communication skills, so that their learning during the technical sessions will be optimised and also can yield better results on the ground. Improved monitoring and supervision are necessary besides providing them improved facilities

REFERENCES

1. David Leon, Gill Walt. Poverty, inequality and health in the international perspective: a divided World: Oxford University Press. New York. 2011, p 10.
2. Child mortality Key facts. New Newborn death and illness. (Updated September 2011). Millennium Development Goal (MDG) 4. World Health Organization.
3. C. Dandapani, Infant Mortality in India. Facets of Rural Health in India, Serials Publications. New Delhi. 2014. p 142.
4. National Institute of Medical Statistics (NIMS), Indian Council of Medical Research (ICMR) and United Nations Children's Fund (UNICEF). Infant and child mortality in India: levels, trends and determinants. New Delhi: NIMS (ICMR) and UNICEF India Country Office; 2012
5. Maitreyi B D, Soumya K M, Poverty and Social Exclusion in India: Adivasis-Issue Brief. The World Bank -2011.
6. Alok Ranjan C. Mortality Transition in India, Population, Health and Human Resources in India's Development. Academic Foundation. Institute of Economic Growth. 2011. 167-192.
7. State Fact Sheet –Andhra Pradesh (2012-13), District Level Household and Facility Survey-4, NHFS, Ministry of Health and Family Welfare, Government of India.2014. 2-5
8. Usha shree G, Giridhara R B, Hira P, Murthy GVS. A study of infant deaths in tribal area of Andhra Pradesh, India. Global Journal of Medicine and Public Health. 2013; 2 (4), 1-15.
9. Govindasamy P, Ramesh B M, Maternal Education and the Utilization of Maternal and Child Health and working conditions. It is also very important to consider the assessment of skills of AHSA workers, who mostly work with communities, support the ANMs, responsible in RCH and Universal Immunization Programme, and whose role is very important in the successful implementation of National Rural Health Mission at grass root level.
10. Countdown to 2015; Monitoring Maternal, New born and Child Health Survival- Understanding key progress indicators, WHO, 2011. 6-9.
11. Improving Health Services for Tribal Population in India. World Bank. 2012.
12. Rupa Prasad, Rajib Dasgupta, Missing Midwifery: Relevance for contemporary challenges in Maternal Health. IJCM. 2013. 38 (1), 9-14
13. Upasani RN, Saroj V, A study on knowledge, attitude and practices of MPHWS on selected components of safe motherhood programme in the state of Maharashtra
14. Statistical Profile of Scheduled Tribes in India, Statistics Division, Ministry of Tribal Affairs, Government of India. , 2010; 187-189.
15. National Rural Health Mission- Framework for implementation. Ministr of Health and Family Welfare. Government of India, 2006- 2012
16. Role Delineation for Frontline Workers- A framework for Convergence of Health & ICDS. Child Development Bureau Ministry of Women and Child Development Government of India. 2013.
17. Indian Public Health Standards (IPHS) Guidelines for Sub-Centres -Revised 2012. Directorate General of Health Services Ministry of Health & Family Welfare Government of India. 2012