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Supervisory support received by the Female Health Workers and their level of satisfaction with supervision in selected PHCs of Mangalore Taluk, Dakshina Kannada District, India

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Original Article

Supervisory support received by the Female Health Workers and their level of satisfaction with supervision in selected PHCs of Mangalore Taluk, Dakshina Kannada District, India

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Abstract

Introduction: A public health care worker is the most vital component of the public health care system. Today's health care worker is inflamed with smaller financial plans, greater responsibilities, time pressure and limited co-workers. Poor staff supervision, the absence of support and poor working domain have long been identified as bottle necks in the path of effective and efficient delivery of public health services in India due to the widespread crisis in the health workforce. The main objective of the study was to assess the supervisory support received by the Female Health Workers (FHW) and their satisfaction with supervision. **Methods:** A descriptive design was used and carried out in selected Primary Health Centres (PHCs) of Mangalore taluk, Dakshina Kannada district, India comprising conveniently sampled 53 Female Health Workers (FHW). **Results:** The findings show that 49% of the FHWs expressed their Lady Health Visitors (LHVs) were very supportive, 23% as supportive, 11% as just supportive, 13% as unsupportive and 4% as very unsupportive, while supervising the FHWs. The majority of the FHWs (33.9%) were extremely satisfied with supervision by the LHVs, 33.9% were very satisfied, 11.3% were moderately satisfied, 16.9% were slightly satisfied and 4% were not at all satisfied with supervision. There is a strong positive correlation (r=.865) between supervisory support received by the FHWs from the LHVs and their satisfaction with supervision. **Conclusion:** Increased supervisory support received by the FHWs, increases their satisfaction with supervision. The study emphasized the need of strengthening the health care workforce to render quality care service through supportive supervision.

Key words: Supervisory support, satisfaction with supervision, Female Health Workers, Primary Health Centre, FHW, LHV

Introduction

Health planning in India is an essential part of socio-economic planning. A serious strive to organize the health care delivery system in the country was initiated in the pre-independent era. The health planners have visualized the need to merge preventive and curative services at all levels and develop Primary Health Centres (PHCs) as an approach to meet the health needs of therural population (Thomas, 2013).

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Initially, one PHC for a population of 40,000 was established to meet the need of the rural population. Later on, PHC was divided into sub-centres (SCs) and each SC covered a population in the range of 3,000-5,000 depending on the topography and means of communication. The SC was staffed by a team of male and female health worker each (Thomas, 2013).The primary functions of male and female health workers are to assist, supervise and monitor the activities. One Health Assistant Female/LHV is expected to supervise the activities of five to six Female Health Workers (FHWs) and lend support to them in case of problems (Ganguly & Garg, 2013).

To provide qualitative health care, a set of standards were recommended for PHC to be called as Indian

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Public Health Standards (IPHS). These standards help to monitor and improve the functioning of the PHCs (IPHS, 2006). According to the IPHS guideline, in order to provide maternal and child health services, family planning services, disease surveillance, control of communicable diseases and non-communicable diseases, treatment for minor ailments and implementation of national health programmes, it was proposed to have two FHWs and one male health worker for a sub-centre. The second FHW is expected to supplement and augment the services provided by the first FHW and it is envisaged that they would complement each other (Thomas, 2013). FHWs working at PHCs and SCs provide comprehensive health and family welfare services to the people at their doorsteps. They work with uneducated, poor, unemployed, deep rooted with social customs and taboos. There is no end to their sufferings compounded with different social, health, official and transfer related problems. These problems of FHWs adversely affect their output. Thus, the health and family welfare services get affected (IPHS, 2006). Due to the shortage of health workers, LHVs end up performing functions of the health workers than assisting, supervising and monitoring them (Ganguly & Garg, 2013). Thus the quality of service rendered by the FHWs becomes poor due to lack of support, ineffective supervision and poor monitoring by the LHVs.

Health workers are the heart of the health systems. Yet, around the world and in India, the health workforce is in crisis. Inadequate staff supervision, lack of support and poor working environment have long been identified as bottle necks in the path of effective and efficient delivery of public health services in our country. There is a need for the supervisory cadre to be rationalized and held accountable, unnecessary post to be eliminated, roles and responsibilities to be redefined, capacities rebuilt and monitoring as well as evaluation systems instituted (Dobe, 2006), so that the health workers at different levels have a sense of satisfaction with their supervisors as well as their job.

Materials and Methods

The conceptual framework of the study was based on the concepts of Supportive and Motivational Model. A descriptive study was planned to assess the supervisory support received by the FHWs and their level of satisfaction with supervision. In this study, supervisory support rating scale was used to assess the supervisory support received by the FHWs and the domains covered were interpersonal communication, technical skills, personality and management skills for supervision. Supervisory satisfaction rating scale was used to assess the level of satisfaction with supervision among FHWs and the domains covered were communication, problem solving/decision making, education and guidance and managerial skills.

The study was conducted in selected PHCs of Mangalore Taluk, Dakshina Kannada District. Fifty percent of the PHCs were chosen for the study: Adyar, Katipalla, Ullal, Bondel, Ganjimata, Kompadavu, Atturkemral, Beluvai, Kallamundkur, Suratkal and Nellikar. Fifty-three FHWs were supervised by LHV from these PHCs were selected for the study through convenient sampling. The tool was prepared after an extensive review of literature and discussion with all stake holders such as the experts, FHWs and their supervisors. Content validity of the tool was ascertained by 15 experts in the field of Community Health Nursing. Reliability of the supervisory support rating scale was established using test-retest method. Karl Parson's correlation coefficient formula was applied and the reliability was found to be .9. Reliability of the supervisory satisfaction rating scale was assessed using Cronbach's Alpha formula and the reliability was found to be .94. Demographic data was collected using a structured baseline proforma, supervisory support rating scale and supervisory satisfaction rating scale. A formal written permission was obtained from the DHO to conduct the study in selected PHCs of Mangalore Taluk, Dakshina Kannada District. The data obtained was analysed using both descriptive and inferential statistics with the help of Statistical Package for Social Sciences (SPSS) 16.0.

Results

Among the 53 FHWs, 14 (26%) were below 40 years of age and 26 (74%) were above 40 years of age. Twenty-six (49%) underwent Auxillary Nurse Midwife (ANM) training after SSLC, 26 (49%) underwent ANM training after Pre-university College (PUC) and 1 (2%) completed General Nursing and Midwifery (GNM). Forty two (79%) were Hindu and 11 (21%) were Christian. Forty-eight (90%) were married, 2(4%) were unmarried and 3 (6%) were widow. Twenty-two (42%)

had an income of less than Rs 18,000 per month and 31 (58%) had income more than Rs 18,000 per month. Two (4%) were employed on temporary basis and 51 (96%) were employed on permanent basis. Twenty two (42%) have less than 18 years of experience as FHW and 31 (58%) have more than 18 years of experience as FHW. All the 53 (100%) FHWs have a LHV in their PHC. Twelve (23%) covered a population of less than 4000 and 41 (77%) covered a population of more than 4000. About 34 (64%) covered less than seven sq. km and 19(36%) covered more than seven sq. km. Thirty (57%) covered one village, 16 (30%) covered two villages and 7 (13%) covered three villages. Five (9%) covered more than 600 households and 48 (91%) covered less than 600 households. Thirty (57%) received LHV visit less than four weeks ago and 23 (43%) received LHV visit more than four weeks ago. Thirty seven (70%) reported to receive regular supervisory visits by the LHVs and 16 (30%) reported that they did not receive regular supervisory visits by the LHVs. The majority of the FHWs 49 (92%) felt that supportive supervision is essential for improving their performance and 51 (96%) felt that supportive supervision improves job satisfaction. About 39 (74%) received most of the supervisory support from the LHVs and 14 (26%) received supervisory support from the Medical Officer.

Table 1:
Distribution of Female Health Workers Based on the Supervisory Support Received by them from Lady Health Visitors

N=53

Supervisory support received by FHWs	Score	Range in score (%)	Frequency	Percentage (%)
Very supportive	>135	>90	26	49
Supportive	112-134	75-89	12	23
Just supportive	90-111	60-74	6	11
Unsupportive	67-89	45-59	7	13
Very unsupportive	45-66	30-44	2	4

Distribution of FHWs based on the supervisory support received by them from Lady Health Visitors is described in Table 1. Twenty six (49%) of the LHVs were very supportive, 12 (23%) were supportive, 6 (11%) were just supportive, 7 (13%) were unsupportive and 2 (4%) were very unsupportive while supervising the Female Health Workers. The main domains covered were interpersonal communication, technical skills, personality and management skills for supervision.

Table 2:
Distribution of FHWs Based on Satisfaction with Supervision by the LHVs

N= 53

Satisfaction with supervision among FHWs	Score	Range in score (%)	Frequency	%
Extremely satisfied	>112	>90	18	33.9
Very satisfied	94-111	75-89	18	33.9
Moderately satisfied	75-93	60-74	6	11.3
Slightly satisfied	57-74	45-59	9	16.9
Not at all satisfied	<56	<45	2	4

Table 2 describes that 18 (33.9%) of the FHWs were extremely satisfied with supervision by the LHVs, 18 (33.9%) were very satisfied, 6 (11.3%) were moderately satisfied, 9 (16.9%) were slightly satisfied and 2 (4%) were not at all satisfied with supervision.

The data in Table 3 denotes that computed value ($r_{(52)}$ =0.865), which indicates that there is a strong positive correlation between supervisory support received by the FHWs from the LHVs and their satisfaction with supervision. Hence, it can be inferred that as supervisory

Table 3:
Correlation between Supervisory Support Received by the FHWs from the LHVs and Their Satisfaction with Supervision

N=53

Variable	Score obtained Max	Score obtained Min	Max possible Score	Mean	SD	Median	Mean %	r value	p value
Supervisory support	150	40	150	122.8	28.1	133	81.9	.865	.0001
Satisfaction with supervision	125	28	125	98.3	24.6	103	78.64		

support received by the FHWs increases, their level of satisfaction with supervision also increases.

Discussion

The study intends to assess the supervisory support received by the FHWs and their level of satisfaction with supervision in selected PHCs of Mangalore Taluk, Dakshina Kannada District. The findings of the present study revealed that 26 (49%) of the LHVs were very supportive, 12 (23%) were supportive, 6 (11%) were just supportive, 7 (13%) were unsupportive and 2 (4%) were very unsupportive while supervising the FHWs. These findings are consistent with a study conducted in two districts of Rajasthan with one of the objectives to describe the system of grass-root supervision which showed that 33% Accredited social health activists (ASHAs) suggestive for supervisory support(Abel, Alma, Brown, Sahni, & Serotta, 2008). Similarly, a five-year project conducted in Pakistan showed that there was infrequent and poor quality of supervision due to shortage of supervisors, lack of supervisory support, confusion over roles and responsibilities (Assessment of District Health Supervisory System, 2006).

A descriptive cross-sectional study on job satisfaction and its influencing factors among public health workers in the public sector showed that overall satisfaction was only 41%. About 45% were somewhat satisfied and 14% of professionals highly dissatisfied with their jobs, in which one of the factor being improper supervision (Kumar, Ahmed, Shaikh, Hafeez, & Hafeez, 2013). A cross-sectional survey of Malaysian nurses showed that there was moderate satisfaction among the nurses with their supervisors (Masroor, & Fakir, 2017). In the present study, it was found that 18 (33.9%) of the FHWs were extremely satisfied with supervision made by the LHVs, 18 (33.9%) were very satisfied, 6 (11.3%) were moderately satisfied, 9 (16.9%) were slightly satisfied and 2 (4%) were not at all satisfied with supervision.

The present study showed high positive correlation (r=.865) between supervisory support received by the FHWs from the LHVs and their satisfaction with supervision. Perceived supervisor support has strong, positive correlation with job satisfaction. Study revealed that supervisor support significantly predicted employee job satisfaction (Kopp, 2013). A cross-sectional study in Philippines identified a correlation between frequency of supervision and improvement in the performance scores of health workers and they concluded that supervision can improve the delivery of services by health care workers (Loevinsohn, Guerrero, & Gregorio, 1995).

Conclusion

In conclusion, the findings of the study reveal that supervisory support received by the FHW is directly proportional to the level of satisfaction with supervision. The modern idea of supervision is to guide and help the subordinates in their task by training, demonstration, checking, individual counselling and guidance. But, there are certain subordinates who consider supervision as inspecting and finding fault with them. Supervision is essentially an educational process where the LHVs take up the responsibility of helping the FHWs to develop themselves, thereby being more competent and satisfied with their job. LHV education should prepare those regarding supervisory responsibilities and need of supporting their subordinates during supervision.

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