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(A Multi Disciplinary Peer-Review Bi-Quarterly Social Science Research Journal)

Volume 6 Issue 3, July - September 2023

(An ISO 9001-2015 Certified)

Editor
Dr. D. Suresh

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PROBLEMS OF MULTI-PURPOSE FEMALE HEALTH WORKERS IN THE HEALTH SECTOR – A STUDY IN WARANGAL URBAN DISTRICT OF TELANGANA STATE

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Introduction

Health is perceived differently by people worldwide. The World Health Organization has defined health as "a state of complete physical, mental, social, and spiritual well-being, and not merely an absence of disease or infirmity." Therefore, good health is a synthesis of physical, mental, and social well-being (Simon, 1975: 3)."Health" holds a significant place in the constitutions of all states and United Nations agencies. Of the 30 articles of the Universal Declaration of Human Rights, several are particularly concerned with the right to health. Everyone has the right to a standard of living adequate for the health and well-being of themselves and their family, including food, clothing, housing, medical care, and necessary services. They also have the right to security in cases of unemployment, sickness, disability, widowhood, old age, or other circumstances beyond their control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Importance of Public Health Care

Optimal health is a fundamental requirement for human productivity and the progression of the 'development' journey. It plays a crucial role in fostering economic and technological advancement (Fritz Morotein Marx, 1964:3). A thriving community

serves as the bedrock upon which a financially sustainable society can flourish. The advancement of a society is profoundly influenced by the well-being of its individuals, encompassing both physical and mental health. It is unrealistic to anticipate meaningful contributions to development initiatives from individuals grappling with poor health. Consequently, health stands as humanity's most invaluable asset, as it forms the steadfast cornerstone of personal happiness (John and Vance, 1953: 3).Charaka, the esteemed Ayurvedic physician, once asserted: 'Health is paramount for the ethical, artistic, material, and spiritual evolution of humanity" (WHO, 1979: 14).

'Human development is influenced by a multitude of factors, both positively and negatively. These factors encompass various dimensions, including environmental (natural or man-made), physical, chemical, biological, and social aspects. They also extend to economic, cultural, educational, genetic, prenatal health, and nutritional elements. Consequently, the promotion of health cannot be achieved through isolated measures derived from any single health discipline. Instead, it requires a comprehensive approach that considers broader factors such as education, social structures, economics, and governance, all of which are integral to human development.

The relationship between socio-economic development and the advancement of health is of utmost significance. Every facet of the economy is intricately linked to the health component, which in turn exerts a significant influence on overall socio-economic development. As emphasized in a World Health Organization (WHO) publication on public health, 'The health component and other facets of the larger system are inherently interconnected. Health not only influences the rest of the socio-economic complex but is also subject to its influence, at times, adversely (Hanlon, 1964: 98).

Socio-economic development encompasses diverse components connected to productive activities. Health programs cannot be viewed in isolation within either the economic or social realms, as they exert an impact on both domains while also being reciprocally influenced by them.

A unified, integrated approach to public health is imperative, facilitating coordination among services aimed at enhancing nutrition, controlling communicable diseases, improving maternal and child health, and advancing family welfare. Hence, traditional linear planning and the implementation of discrete programs are inadequate to address the multifaceted requirements of human development, as underscored by T. Adeoye Lambo in his article 'Total Health' featured in the World Health publication (Tarasuk and Beaton, 1999: 488).

It is increasingly evident that a more holistic approach, considering the biological, social, and cultural dimensions of health, is required. Life is a dynamic process, not a static substance, within a living system characterized by the interconnectedness and continuous flow that spans the entire universe. To ensure that individuals and their families remain attuned to the evolving requirements within the changing environment,

the development of comprehensive interdisciplinary tools is imperative. These tools are essential for delivering a complete health solution that aligns with emerging needs (WHO, 1979: 23).

Generally, the factors that shape an individual's health can be categorized into three overarching groups: hereditary, environmental, and personal. Likewise, the numerous aspects that significantly contribute to an individual's health status can be categorized into three primary domains: mental health, spiritual health, and physical health (Seal, 1963).

Urban Primary Health Care Service

Approximately 30% of India's population resides in urban areas. The health status of urban slum dwellers often faces challenges worse than those encountered in rural areas due to urban migration and significant population influx into towns and cities. Unfortunately, there has been a lack of well-planned and organized efforts to provide primary healthcare services within 2 to 3 kilometres of people's residences and to establish connections between primary, secondary, and tertiary care institutions within defined geographical regions.

The infrastructure for Public Health Care Systems (PHCS) in urban areas should comprise health and family welfare posts, each serving a population of 10,000 to 15,000, staffed by a Multipurpose Health Worker (Female)/Auxiliary Nurse Midwife (ANM) and one male multipurpose worker with a helper. Additionally, Urban Health and Family Welfare Centers should serve approximately 1-1.5 lakh population, equipped with two Medical Officers and necessary support staff. These centres should offer preventive, promotive, curative, and rehabilitative services, as well as essential maternal and child healthcare and contraceptive services (NUHM).

Recognizing the imperative to offer primary healthcare services to the expanding urban population, various stakeholders, including municipalities, State Governments, and the Central Government, have allocated funds to develop Public Health Care Systems (PHCS) in urban areas. However, unlike rural health services, there has been a lack of well-structured and organized efforts to establish primary, secondary, and tertiary care services in geographically dispersed urban regions. Consequently, there exists either a shortage of primary care facilities or significant underutilization of existing ones, leading to congestion at secondary and tertiary care centres.

To address this issue, there is a pressing need for the reorganization of urban PHCS. The goal is to deliver fundamental health and family welfare services within a 1-3-kilometre radius of residents' dwellings while establishing effective connections between primary, secondary, and tertiary care centres within the area. This approach aims to optimize the utilization of available healthcare facilities for referral services and was identified as one of the priority areas during the 9th Five-Year Plan.

The 10th Five-Year Plan (2002-2007) shed light on the challenges faced by the healthcare services infrastructure and underscored the necessity for increased investments in establishing robust primary-level care and referral services. While the plan emphasized the restructuring and development of health infrastructure, particularly at the decentralized primary level, it did not provide explicit details on the implementation strategies.

During this period, program-driven healthcare received significant attention, with vertical approaches and technical solutions often taking precedence over the comprehensive delivery of urban healthcare services. A review of the plan not only highlights the gap between stated intentions and actual outcomes but also sheds light on the framework within which healthcare policies were formulated.

During the 11th Five-Year Plan period, several key health priorities were identified:

1. Establishment of Hospital Development Committees in all government hospitals.
2. Improvement of infrastructure and facilities in district hospitals.
3. Provision of high-quality secondary healthcare services in every block across the country.
4. Creation of state-of-the-art medical education, research, and healthcare institutions in all medical disciplines.
5. Establishment of new institutions and the upgrading of existing tertiary care hospitals.
6. Mainstreaming of AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy) systems to complement allopathic healthcare efforts.

The National Urban Health Mission (NUHM) was introduced to address the health needs of the urban poor, particularly those living in slum areas. NUHM aimed to provide essential primary healthcare services by investing in well-trained healthcare professionals, appropriate technology through Public Private Partnerships (PPP), and health insurance for the urban poor.

Recognizing the gravity of the urban health challenges, the 11th Five-Year Plan prioritized urban health as a thrust area. NUHM focused on urban slums and the urban poor. At the state level, it established a State Urban Health Program Committee, a District Urban Health Committee at the district level, and a Health and Sanitation Planning Committee at the city level. At the ward slum level, a Slum Cluster Health and Water and Sanitation Committee were formed. The plan aimed to incorporate the experiences of civil society organizations (CSOs) working in urban slum clusters and foster collaboration between NGOs and government bodies while encouraging community-level monitoring of resources.

NUHM aimed to achieve the following:

1. Allocation of resources to address health issues in urban areas, especially among the urban poor, with a focus on city-specific Urban Health Care Systems (UHCS).
2. Active involvement of the community in planning, implementing, and monitoring health activities.
3. Establishment of institutional mechanisms and management systems to address the health challenges posed by a rapidly growing urban population.
4. Development of partnerships with NGOs, charitable hospitals, and other stakeholders.
5. Implementation of a two-tier system of risk pooling, involving women's Mahila Arogya Samiti to address urgent financial needs for treatments and a Health Insurance Scheme to enable the urban poor to afford medical treatment.

NUHM aimed to cover all cities with a population exceeding 100,000, including slum dwellers and other marginalized urban populations such as rickshaw pullers, street vendors, railway and bus station workers, homeless individuals, street children, and construction site workers. Existing Urban Health Posts and Urban Family Welfare Centers were retained and classified as urban health centres based on their population coverage, with a focus on upgrading them as needed to meet the healthcare demands of urban areas (NHP, 2002)Top of Form

Public Health Facilities in India

According to the Rural Health Statistics for 2021-22, the distribution of healthcare facilities in India is as follows:

In rural areas:

1. 157,935 Sub-Centres (SCs)
2. 24,935 Primary Health Centres (PHCs)
3. 5,480 Community Health Centres (CHCs)

In urban areas:

1. 3,894 Sub-Centres (SCs)
2. 6,118 Primary Health Centres (PHCs)
3. 584 Community Health Centres (CHCs)

This data provides an overview of the healthcare infrastructure in both rural and urban areas of India, highlighting the number of Sub-Centres, Primary Health Centres, and Community Health Centres available to serve the population (Rural Health Statistics 2020-22: 13)

India's network of District Hospitals and Area Hospitals is a critical component of its healthcare infrastructure. These hospitals serve as the backbone of the healthcare system, ensuring that healthcare services are accessible to both urban and rural populations across the country. Here are some key points to highlight the importance of these hospitals:

1. Geographic Coverage: District Hospitals and Area Hospitals are strategically located to cover a wide geographical area. This ensures that people in both urban and rural settings have access to essential healthcare services, reducing disparities in healthcare access.
2. Referral System: District Hospitals often serve as referral centres for smaller healthcare facilities like Primary Health Centres (PHCs) and Community Health Centres (CHCs) within their respective districts. This hierarchical system allows for the efficient transfer of patients requiring more specialized care to higher-level facilities.
3. Range of Services: These hospitals typically offer a broad range of medical services, including outpatient care, inpatient care, surgical procedures, maternity services, and diagnostic services. This comprehensive approach to healthcare helps address a variety of health needs within the community.
4. Emergency Care: Many District Hospitals are equipped to provide emergency and trauma care, which is crucial for handling accidents and medical emergencies in their regions. Timely access to emergency care can be life-saving.
5. Capacity Building: District Hospitals and Area Hospitals often serve as training centres for healthcare professionals. Medical students, nurses, and other healthcare workers gain valuable experience and training in these facilities, contributing to the overall quality of healthcare in the region.
6. Disease Surveillance and Control: These hospitals play a role in disease surveillance and control efforts. They are often involved in managing outbreaks and implementing public health initiatives at the district and area levels.
7. Community Health Programs: They are instrumental in the implementation of various community health programs, including immunization drives, maternal and child health programs, and disease prevention campaigns.
8. Infrastructure Improvement: The government continually invests in improving the infrastructure and facilities of District Hospitals and Area Hospitals to enhance the quality of care provided and meet the growing healthcare demands of the population.

In summary, District Hospitals and Area Hospitals in India are a crucial part of the healthcare system, serving as hubs that connect primary healthcare facilities with more specialized care. This network is essential for ensuring equitable access to healthcare services and improving health outcomes across the country (Ibid: 108).

The availability of healthcare personnel, particularly Multipurpose Health Workers (Female) and Auxiliary Nurse Midwives (Females), abbreviated as MPHW(F) and ANM(F) respectively, holds immense significance in facilitating healthcare access across both urban and rural regions in India. In rural areas, a workforce of 207,587 MPHW(F) and ANM(F) professionals is actively deployed across Sub-Centres (SCs) and Community Health Centres (CHCs). These dedicated health workers assume a pivotal role in the provision of essential healthcare services to the rural populace. Their responsibilities encompass a wide spectrum, including maternal and child healthcare, immunization programs, family planning services, and the dissemination of general health education within these underserved communities (Ibid: 79).Additionally, there are 21,501 such professionals diligently serving in Urban Primary Health Centers (UPHCs) (Ibid: 168).

Public Health Care Facilities in Telangana State

Telangana, the 29th state of India, was established on June 2, 2014. Covering an area of 1,14,840 square kilometres, it is home to a population of 3,52,86,757 individuals. The state is geographically divided into 33 districts and contributes approximately 2.90% of India's overall population. Projections indicate that the population is expected to increase to around 0.37 crores by the year 2021 (Population Projections, 2011-2036).

In Telangana state, most of the population, accounting for 61.12%, resides in rural areas, while the remaining 38.88% live in urban areas. Regarding healthcare administration, the Telangana Government has established a comprehensive network of healthcare facilities, including:

- 31 Area Hospitals
- 11 Ayush Dispensaries
- 99 Community Health Centers (CHCs)
- 4 Civil Dispensaries
- 6 District Hospitals (DHs)
- 8 Mother and Child Hospitals
- 20 Medical College/Specialty Hospitals
- 638 Primary Health Centers (PHCs)
- 249 Urban Primary Health Centers (UPHCs)
- 4797 Sub-Centres (SCs)

This extensive infrastructure plays a crucial role in providing healthcare services to the diverse population of the state *(https://chfw.telangana.gov.in)*

Within these hospitals, it is noteworthy that a significant portion of the healthcare staff consists of Multipurpose Health Workers (Female) and Auxiliary Nurse Midwives (Females), commonly referred to as MPHW(F)/ANMs. In rural areas, there are a total of 6,025 such professionals, while in urban areas, there are 735 of them, collectively contributing to the delivery of healthcare services across the state (Rural Health Statistics, 2022-22: 79 & 168).

Significance of the Study

Per government guidelines, the allocation of Multipurpose Health Workers (Female) and Auxiliary Nurse Midwives (Females), or MPHW(F)/ANMs, is typically at a ratio of one for every three thousand population in rural areas. However, due to varying circumstances, some MPHW(F)/ANMs find themselves responsible for serving populations ranging from 3,000 to 5,000 individuals in rural regions.

Conversely, in urban areas, Urban Primary Health Centers (UPHCs) serve as pivotal points for healthcare delivery under the National Urban Health Mission (NUHM). These UPHCs have adapted their services and service delivery mechanisms to address the unique health and livelihood challenges faced by the urban population. Urban areas, especially slums and slum-like settlements, often contend with issues like overcrowding, inadequate sanitation, water supply, poor garbage disposal mechanisms, and resurgences of urban infectious diseases.

The population coverage of a UPHC varies depending on the distribution of slum populations within a city. It can range from 50,000 in cities with sparse slum populations to 75,000 in areas with densely concentrated slums. Generally, a UPHC caters to a slum population of approximately 25,000 to 30,000 individuals.

To ensure accessibility for the urban working population, UPHCs operate during hours that are convenient for the community. While the recommended operating hours are from 12 noon to 8 pm, states have the flexibility to choose suitable timings if the UPHC provides a minimum of 8 hours of service. In cases of high caseloads, additional staff may be allocated to UPHCs.

Crucially, UPHCs are strategically located either within or no more than half a kilometre from slum or slum-like habitations to ensure easy access for the most vulnerable segments of the urban population. This proximity aims to enhance healthcare accessibility and address the specific needs of urban communities *(https://www.nuhmts.co.in/services.aspx)*.

Female Multipurpose Health Workers (MPHW(F))/Auxiliary Nurse Midwives (ANMs) indeed face a host of challenges and disparities when compared to their male counterparts within the healthcare sector. These disparities encompass areas such as salary, working hours, and promotions. It is crucial to acknowledge the multifaceted nature of the problems they encounter, both within their workplace and at home, and the burdens they bear due to the demanding nature of their duties.

In many instances, female MPHW(F)/ANMs find themselves subjected to discrimination in terms of remuneration, with their male colleagues receiving more favourable compensation packages. Additionally, they often work longer hours, far exceeding the standard 8-hour workday stipulated by Indian labour laws. Their strenuous work schedule extends to 12-hour shifts at the workplace, which includes interactions with the public, doctors, and male health workers. After their workday, they return home to attend to their domestic responsibilities, which typically involve caring for their husbands, in-laws, children, and other family members.

This unfortunate situation not only places a heavy physical and emotional burden on female MPHW(F)/ANMs but also exposes them to deliberate discrimination and, in some cases, various forms of violence. It's imperative to address these disparities and challenges comprehensively to ensure the well-being, rights, and dignity of these dedicated healthcare professionals. Initiatives to promote gender equality, fair compensation, and improved working conditions for female healthcare workers are essential steps in this direction.

Objectives of the Study

This study has the primary objective of assessing the roles and challenges faced by Multipurpose Health Workers (Female) and Auxiliary Nurse Midwives (Females), or MPHW(F)/ANMs, within the public health system of Warangal Urban District (now known as Hanmakonda District) in the state of Telangana. The key goals of this study are outlined as follows:

1. To review the public health care system.
2. To analyze the functions of MPHW (F)/ANMs.
3. To study the socio-economic status of MPHW (F)/ANMs.
4. To analyze the problems, they face at their workplace or in their personal life due to their job.
5. To find out the real cause of problems/hindrances, which MPHW (F)/ANMs must face due to their jobs and to suggest suitable remedies to overcome the problems.

Hypothesis

To complete this study following hypotheses have been tested.

1. The MPHW (F)/ANMs from the public health system are facing more problems than other government organizations.
2. The Working Women Act and provisions made by the Central and State Governments are sufficient and enough.
3. The socio-economic status of MPHW (F)/ANMs has been improved.

Research Methodology

To accomplish this study, the research methodology employed consists of the following components:

Data Collection: a) Primary Data b) Secondary Data

A) **Primary Data**: Primary data about the roles and challenges faced by MPHW(F)/ ANMs in the Public Health Centers (PHCs) of Warangal Urban District (currently Hanumakonda district) is obtained through interactions with 144 MPHW(F)/ANMs. This data is collected using a structured, close-ended questionnaire and interviews conducted with the healthcare professionals.

B) **Secondary Data:** Secondary data necessary for the study is gathered from a variety of sources. These sources include government reports, research studies, statistical data, reputable national and international journals, books available in libraries, research projects, and relevant websites. The secondary data enriches the study by providing additional context and information from existing sources.

Sample

For this study, samples have been drawn from the pool of MPHW (F)/ANM respondents who are working in all Urban Primary Health Centers (UPHCs) and Primary Health Centers (PHCs) in Warangal Urban District (now Hanumakonda District).

In total, 17 PHCs are operating in rural areas and 7 UPHCs in urban areas within the district. The combined number of MPHW (F)/ANMs across all these health centres is 144. As such, the sample population for this study encompasses the entire population of MPHW (F)/ANMs working in the district, ensuring comprehensive coverage for the research.

Research Tools

The collected data is subjected to a rigorous process of scrutiny, tabulation, and analysis to serve the objectives of the study. The following tools and techniques are employed for data analysis:

1. Simple Percentage: This method is utilized to calculate percentages to gauge the prevalence or distribution of specific responses or variables among the MPHW (F)/ANMs. It provides a straightforward way to express proportions and trends within the data.
2. Questionnaire: The data collected through the structured, close-ended questionnaire is analyzed to derive insights into the perceptions, opinions, and experiences of the MPHW (F)/ANMs. This allows for a quantitative assessment of their roles and challenges.

3. Tabulation: Data is organized and presented in tabular form, facilitating a systematic and visual representation of the collected information. This helps in summarizing and comparing various aspects of the study, making it easier to identify patterns and trends.

By employing these analytical tools and techniques, the study aims to draw meaningful conclusions and insights from the data collected, shedding light on the functions and challenges faced by MPHW (F)/ANMs in the public health system of Warangal Urban District (Hanumakonda District).

Scope and Limitation of the Study

The scope of this study is exclusively focused on Warangal Urban District, which is now known as Hanumakonda District. The geographical scope encompasses all 14 Mandals within the district, while the demographic scope pertains to a sample of 144 MPHW (F)/ANMs who have been selected for the study.

The data used for this study pertains to the preceding year, specifically the year 2021-22, which provides a recent snapshot of the functions and challenges faced by MPHW (F)/ANMs in this district.

However, it's important to acknowledge certain limitations associated with the study. One significant limitation is the necessity to visit various Urban Primary Health Centers (UPHCs), Primary Health Centers (PHCs), and Sub-Centres within Warangal Urban District (Hanumakonda District). This task may be logistically challenging and time-consuming.

Additionally, the responses of the MPHW (F)/ANM respondents might not always be accurate or complete. This could be due to factors such as time constraints or reluctance to disclose certain information during interviews. These limitations should be considered when interpreting the study's findings and drawing conclusions from the data.

Expected Outcomes From the Study

This study is dedicated to examining the roles and challenges encountered by Multipurpose Health Workers (Female) and Auxiliary Nurse Midwives (Females), or MPHW(F)/ANMs, operating within Public Health Centers (PHCs). The primary goal of this research is to offer valuable insights that can be utilized by the government, PHC administrators, and relevant offices to gain a deeper understanding of the responsibilities and difficulties faced by MPHW(F)/ANMs working within their respective Urban Primary Health Centers (UPHCs), PHCs, and Sub-Centres.

By shedding light on the functions and issues experienced by MPHW(F)/ANMs within their units, this study aims to foster a compassionate and supportive approach among government officials and PHC administrators. It is intended to serve as a tool

for identifying the specific challenges faced by MPHW(F)/ANMs, thus enabling the development and implementation of suitable remedies to address these challenges effectively. Ultimately, the study seeks to enhance the working conditions and well-being of these healthcare professionals, thereby contributing to improved healthcare delivery within the community.

Design of the Study

The research document is structured coherently and systematically, progressing through the following chapters:

1. The "Introduction" chapter provides an initial overview of the research, including its context, methodology, and objectives. It outlines the research's sources, hypothesis, survey methods, and questionnaire design while presenting a chapter scheme for an overview of the document's structure.
2. In the "Review of Literature" chapter, the study extensively reviews existing literature on the topic, drawing insights from various sources such as journals, books, government reports, and research publications, highlighting the significance of prior research.
3. The "Functions of Multipurpose Female Health Workers" chapter delves into the specific roles and responsibilities of MPHW(F)/ANMs working in Urban Primary Health Centers (UPHCs) and Primary Health Centers (PHCs).
4. "Socio-Economic Profile of the Sample Multipurpose Female Health Workers" offers a comprehensive exploration of the socio-economic characteristics of the sampled MPHW(F)/ANMs.
5. The "Problems of MPHW(F)/ANMs" chapter investigates the multifaceted challenges faced by these healthcare professionals in both their personal and professional lives, encompassing financial, family, workplace, and social issues, while also analyzing their historical and current economic conditions.
6. Finally, the "Conclusions, Findings, and Suggestions" chapter synthesizes the research's conclusions and key findings, culminating in substantial recommendations and suggestions derived from the study's outcomes. This structured approach ensures a logical and comprehensive examination of the research topic, guiding readers through the research process from introduction to actionable recommendations.

Major Findings

The study provides detailed information about the employment and work conditions of MPHWs in both rural and urban areas. The study insights into the demographics and socio-economic characteristics of a group of respondents. Here is a brief analysis of the key findings:

Profile of the Sample MPHW(F)

1. The largest age group among the respondents is 31 to 50 years old, comprising 65% of the total.
2. Most respondents belong to Backward castes (29%), followed by Scheduled Castes (26%) and Scheduled Tribes (21%). Other Backward Classes (BC) make up 18%, and Minorities constitute 6% of the total.
3. 58% of respondents have completed education up to the Intermediate Vocational (MPHW) level. 28% hold Undergraduate degrees, and 14% have Postgraduate qualifications.
4. 90%of respondents are married.
5. Most spouses fall in the age group of 31 to 60 years (89%).
6. 61% of spouses have completed education up to the Intermediate level.
7. 61% of spouses are self-employed.
8. 88% of respondents have male children, while 83 % have female children.
9. Most children (42%) fall in the age group of 18 to 23 years.
10. 25% of children have education up to the upper primary school level. 19% have completed primary education, and 15% have achieved SSC.
11. 87% of children are unmarried.
12. Most children (87%) are currently engaged in their education.
13. 92% of respondents have children as dependents.
14. 8% have elderly individuals relying on them.
15. 69% of respondents own their houses, while 31 % live in rental properties.
16. 80% of respondents reside in Pucca houses.
17. A majority (56%) of respondents do not possess any land.
18. 60% of family members are dealing with various health issues.
19. The largest proportion of families (40%) fall in the annual income range of Rs. 3-4 Lakhs.
20. 69% of respondent families do not have any savings.
21. Only 15% of the sample MPHW(F) families have indebtedness.Top of Form

Role and Responsibilities of MPHW(F)

1. Out of the total MPHW(F), 62% are working in PHCs and 39% working in UPHCs.
2. Most of the MPHW(F), 39% have a service duration spanning from 6 to 20 years.

3. About 83% of MPHW(F) are working as Second MPHW(F) who are recruited on a contractual basis. This MPHW(F) does not have any leave, loan, health cards, medical allowance, local conveyance allowances, risk allowance, transfers, promotions, pension, or life security.
4. It is found that every MPHW(F) have received periodic refreshing training programs regarding newly launched programs and updating training programs that are already running.
5. Nearly 83% of MPHW(F) covers two or more two villages in rural areas and wards in urban areas.
6. About 68% of MPHW(F) cover up to 5000 population and 24% are 10001 – 20000 in their administrative jurisdiction.
7. It is found that overall MPHW(F) are engaging with all health and its associated programs which are implemented by the Central and State governments.
8. It is observed that overall MPHW(F) are maintaining the 42 records/registers online and offline which are health care programs implemented by them.
9. It is found that an average of 51% of the MPHW(F) are receiving support from their superiors, and subordinates in discharging their duties, while 49% were not.
10. It is noticed that the MPHW(F) do not have the freedom to innovative work methods within their profession.
11. It is indicated that 69% of the MPHW(F) staff do not pay any attention to solving the problems faced by the respondents raised by the local people.
12. It is observed that the overall MPHW(F) are working more than 12 hours per day.
13. It is noticed that the MPHW(F) are having a grievance redressal system in their mother department, but it is not implemented properly.
14. It is observed that the MPHW(F) have rewards for their best performance.
15. It is noticed that none of the MPHW(F) has a stationary allowance, sub-centre rent, or mobile/table allowance for charging.
16. It is found that only 7% of the MPHW(F) have pension facilities.
17. It is noticed that 93% of MPHW(F) are recruited on a contractual basis or regularized as regular after 2007.

Challenges in Providing Services by the MPHW(F)

1. It is noticed that the overall MPHW(F) faced challenges in providing service in terms of work-life balance, safety concerns, limited access to education,

lack of representation, cultural and religious barriers, inadequate facilities & resources, social stigma, mental health struggle and lack of support system.

2. Only 12.5% of MPHW(F) are facing gender discrimination.
3. The overall MPHW(F) are suffering from various health problems in providing the services in terms of physical, infections, mental health, violence, harassment, lack of access to health care, nutrition, training and resources, social support, stigmatization, and reproductive health issues.
4. About 69% of the MPHW(F) face transportation problems in terms of safety concerns, limited access to vehicles, cultural and social barriers, lack of infrastructure, financial barriers, childcare responsibilities, and harassment & discrimination.

Family Problems of the MPHW(F)

1. It is noticed that the overall MPHW(F) are facing family problems in terms of gender roles & expectations, lack of family support, inheritance & property rights, social pressure & expectations, domestic violence, financial pressure, lack of flexibility, Stigma & Discrimination, children & elderly care, childcare issues, and work-life balance.
2. About 90% of the MPHW(F) are engaged in job-related work both at their workplace and at home. This phenomenon creates some problems for respondents in terms of heavy workload, time constraints, and disturbances in personal life.

Suggestions

To improve public healthcare administration and address the challenges faced by MPHW(F)s, a comprehensive approach is recommended. Based on the information you provided about the MPHW(F) and the challenges they face, here are some suitable suggestions to address these problems:

1. Age-specific Training Programs: Given that most respondents are in the 31 to 50 age group, tailor training and support programs to cater to the needs and preferences of this age group. This could include flexible training schedules and online learning options.
2. Caste-based Support: Recognize the diversity in caste backgrounds among the respondents and implement affirmative action measures to promote inclusion and equal opportunities for all, regardless of caste.
3. Educational Support: Offer education and skill-building opportunities for those with lower educational qualifications to help them advance in their careers. Encourage higher education for those who are interested.
4. Family Support: Provide resources and programs that support family well-being, as most respondents are married with children. This might include childcare services, family counselling, and financial planning assistance.

5. Health Programs: Address the health issues faced by family members by providing access to healthcare services and promoting health awareness programs.
6. Income Generation: Support income generation and financial stability for families, particularly for those with lower incomes. This could include vocational training, microfinance, or entrepreneurial support.
7. Housing Improvement: Assist families in improving housing conditions, especially for those living in rental properties or suboptimal housing situations.
8. Land Ownership: Explore ways to help families acquire land, as land ownership can be an important source of stability and income.
9. Work-Life Balance: Promote work-life balance for MPHW(F) by implementing reasonable working hours and ensuring that they are not overburdened with job-related work at home.
10. Supportive Work Environment: Improve the work environment by addressing grievances, providing support for innovative work methods, and offering rewards for good performance.
11. Gender Equality: Continue efforts to reduce gender discrimination and promote gender equality within the profession.
12. Transportation Solutions: Address transportation challenges by providing safe and affordable transportation options, especially in rural areas.
13. Family Issues: Implement programs that support family dynamics and alleviate stressors related to gender roles, family support, and domestic violence.
14. Healthcare for MPHW(F): Provide healthcare services and resources for MPHW(F) to address their own health issues, including physical and mental health concerns.
15. Support Systems: Establish support systems, including grievance redressal mechanisms and mentoring, to help MPHW(F) navigate their challenges.
16. Career Advancement: Create pathways for career advancement, including opportunities for promotions, training, and benefits like pensions.

These suggestions are meant to address a wide range of challenges faced by the MPHW(F) based on the information provided. Implementing these measures may require collaboration between government agencies, healthcare institutions, and community organizations to provide holistic support to MPHW(F) and their families.

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