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Perception of Security By Health Workforce At Workplace In Nepal

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ABSTRACT

Background: In Nepal, the relationship of health worker and patient or community people is now deteriorating and the security and safety of health worker is becoming emerging issues. The poor relationship between community people and health worker is hampering the health service especially in rural setting. This study was aimed at finding the security perception and situation of health workforce in Nepal.

Methods: A cross-sectional descriptive study was conducted using both quantitative and qualitative methods. Out of 404 sample health institutions, 747 health workforce from 375 health institutions were interviewed (<10% non-response rate) using the probability proportionate to size method as per World Health Organization (WHO) guidelines. .

Results: Nearly 168 (23%) of health workers felt some level of insecurity at their workplace. Mostly, doctors felt insecure at their workplace 24 (30%) and argued with service users , 26 (32.50%). Feeling of security was highest in central region 160 (83.30%). Nationwide, 121 (16%) of health workers faced some level of arguments with service users, which was highest in Tarai 64 (18.08%). Of the total harassment, both gender based and sexual harassment was higher among female health workers [20 (62.5%) and 13 (56.5%) respectively]. Only, 230 (30.7%) of health workers who suffered from workplace accidents got compensation and treatment.

Conclusions: Higher proportions of health workers feel insecurity at workplace whereas provision of compensation was minimal. There is a need of strict implementation of Security of the Health Workers and Health Organizations Act, 2066 (2009) for effective health service delivery.

Keywords: compensation; harassment; health workers; Nepal; security.

BACKGROUND

Security of health workforce has been identified as a way to bridge the gaps in achieving millennium development goals (MDGs).[1] Healthcare institutions need to be educated that they have much to gain from efforts to identify and reduce the current epidemic of violence in these settings.[2] In Nepal, the relationship of health worker and patient or community people is now deteriorating and the security and safety of health worker is becoming emerging issues. The poor relationship between community people and health worker is hampering the health service especially in rural setting. Security issues like violent incidents are severely underreported and when studied are usually limited to formal incident reports.[2] This study was aimed at finding the security perception and situation of health workforce in Nepal.

METHODS

A cross-sectional descriptive study, using mixed method (both qualitative and quantitative research methods) was conducted to obtain comprehensive information on

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the Human Resources for Health (HRH) situation of the country.

A multi-stage cluster sampling method was used to select a representative sampling frame for this study. Of the 75 districts in Nepal, 15 districts were selected, one from each of the three ecological belts (Mountain, Hill and Terai) and each of the five development regions (Far-Western, Mid-Western, Western, Central and Eastern) using a random sampling method.

The sampling frame consisted of 5,146 health institutions in the selected 15 districts, including government hospitals (regional, zonal or district), primary health centres, health posts, sub-health posts, ayurvedic centres, non-governmental and private health outlets. A total of 404 health institutions were then selected using the probability proportionate to size (PPS) method, based on the size of health institution by available HRH, as per WHO guidelines.[3] Out of the selected health institutions, data was collected from 375 health facilities. A total of 29 health facilities were not included in the study due to the unavailability of staff, resulting a response rate of 93%.

Structured questionnaire was administered to 747 health workers (doctors, specialists, nurses, midwives, public health workers, health assistants, auxiliary health workers, laboratory technicians, radiographers, and pharmacists) from the 375 selected health institutions in 15 districts, following the WHO guidelines.[3] Self-appraisal forms were also completed by 54 doctors, 218 nurses and 324 paramedical staff from within the sampling frame, with the exclusion of 20 respondents due to lack of complete information.

Similarly, based on availability, a total of 645 participants were selected for the qualitative study, which aimed to support quantitative research findings. A series of 74 FGDs were held, with at least one group of service providers, service users and Health Management Committees in each district. Purposive sampling was used to select 29 informants to take part in semi-structured KIIs.

Quantitative data was entered into a computer software system (EpiData 3.1) by trained data entry personnel. In order to validate the data, 10% was randomly crosschecked. After editing and cleaning, statistical package for social sciences (SPSS) v16.0 was used for analysis. Qualitative data was transcribed and translated into English, and was then analyzed according to different thematic areas based on the relevant research objectives. Then, the data was triangulated with quantitative and secondary findings.

The statistical tools used in this study were of WHO standards. Internal consistency reliability was ensured in quantitative data analysis by obtaining Cronbach's Alpha on key variables (>0.85). Pretesting of the questionnaire was done in three districts, and feedback from the pre-test was incorporated into the final questionnaire design to improve validity and reliability. Similarly, interviewers were also trained using WHO standard protocols. Triangulation of primary and secondary data ensured consistency of the research data.

Ethical approval for this study was obtained from the Nepal Health Research Council (NHRC). Researchers adhered to national NHRC standard operating procedures and ethical guidelines for health research. Prior to the interview, informed consent taken and participants were ensured about their confidentiality.

RESULTS

Security in working place

All together, 747 health workers had participated in the study. Among them 80 (10.71%) were doctors, 376 (50.33%) were paramedics (health assistants and auxiliary health workers), 56 (7.50%) were technicians (laboratory technicians or assistants and radiography technicians or assistants) and the rest 235 (31.46%) were nurses (staff nurses and auxiliary nurse midwives). The distribution of the health workers according to ecological belt indicated that 120 (16.06%) from mountains, 273 (36.55%) from the hills and the remaining 354 (47.39%) were from Terai.

This study revealed that 579 out of 747 (77.51%) of health workers felt secured in their workplace. The feeling of security was highest among the technicians 47 (83.90%) followed by nurses/ANMs 191 (81.30%), paramedics 285 (75.80%) and doctors 56 (70%) respectively. Further, region-wise distribution of feeling of security showed that highest number of health workers from central region 160 (83.30%) felt that they felt secured at their workplace while working. Similarly, the feeling of security was highest among the workers of health posts 101 (83.50%) while compared at institutional level (Figure 1).

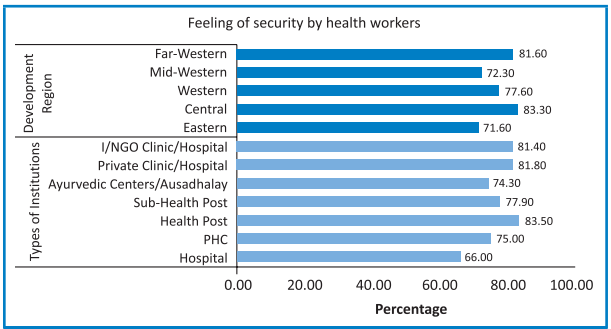

Figure 1. Health workers' feeling of security in the workplace.

Relationship between health workers and community

Health service provider-user relationship is one of the important factors for quality healthcare delivery. The study revealed that nationwide, 121 (16.2%) of health workers faced some level of arguments with service users, during the course of treatment. In Terai, such argument was higher 64 (18.08%) than national average whereas in the Hills and Mountain, arguments were below national average. Similarly, while analysing region-wise, the health workers of eastern development region (EDR) faced the highest number of arguments 40 (20.30%) followed by health workers from mid western development region (MWDR) i.e. 19 (18.80%) (Figure 2).

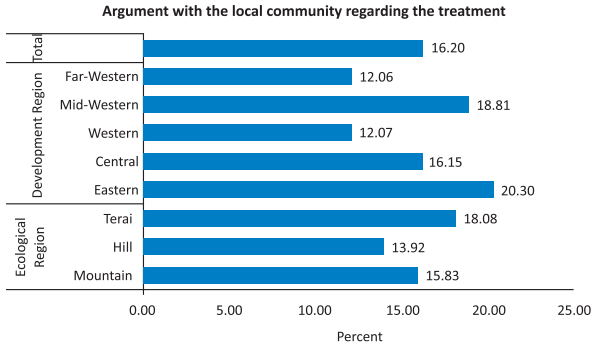

Figure 2. Arguments between Health Worker and local community regarding treatment.

Among different categories of health workers, doctors faced arguments most of the times 26 (32.50%) whereas paramedics were less involved 45 (11.97%) in arguments with service users. Similarly, more than 58 (27%) of urban healthcare workers faced some type of arguments with service users compared to rural 63 (11.80%). Institutional comparison showed that arguments with service users was found highest in the hospitals 62 (58.49%) followed by PHCCs 7 (13.46%) (Table 1).

During the focused group discussion (FGD) with service providers' group, the health staff expressed that there were some cases with severe impact of those argument. In total there were seven deaths occurred as severe consequences of such argument. Though the security of health workers and health workers act, 2066 (2010) strictly prohibits such argument in the workplace, such severe events are still occurring.[4]

Harassment faced by health workers at workplace

The most common types of harassment found were gender harassment, sexual harassment and caste/ ethnicity harassment. All together, 23 health workers felt sexually harassed and 32 health workers felt gender based harassment. The gender based harassment as well as sexual harassment was higher among female health workers 20 (62.5%) and 13 (56.5%) respectively in comparison to males. Both types of harassment were higher in rural areas compared to that of urban (Figure 3).

Table 1. Argument with the local community regarding the treatment.

Characteristics	Yes		No		Not stated		Total (N)
	Number	%	Number	%	Number	%	
Designation wise							
Doctors	26	32.50	54	67.50	0	0.00	80
HA/CMA Paramedics	45	11.97	327	86.97	4	1.06	376
Technicians	14	25.00	42	75.00	0	0.00	56
Nurses/ANMs	36	15.32	197	83.83	2	0.85	235
Urban/rural							
VDC	63	11.80	468	87.64	3	0.56	534
Municipality	58	27.23	152	71.36	3	1.41	213
Type of health facility							
Hospital	62	58.49	44	41.51	0	0.00	106
PHCC	7	13.46	44	84.62	1	1.92	52
Health post	14	11.57	106	87.60	1	0.83	121
Sub-Health post	21	7.61	254	92.03	1	0.36	276
Ayurvedic Centers/ Ausadhalaya	0	0.00	35	100.00	0	0.00	35
Private Clinic/Hospital	5	9.09	49	89.09	1	1.82	55
I/NGO Clinic/Hospital	12	11.76	88	86.27	2	1.96	102
Total	121	16.20	620	83.00	6	0.80	747

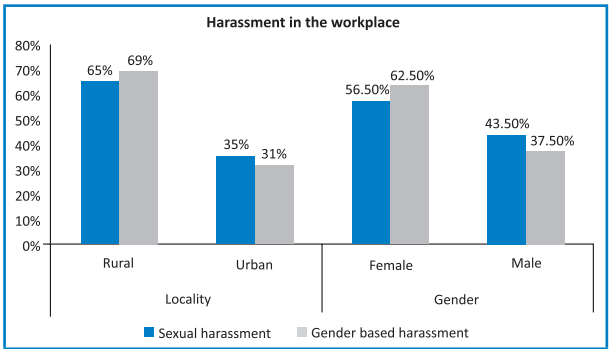

Figure 3. Harassment in the workplace.

Similarly, a total of 43 health workers felt caste/ethnicity harassment, out of which was 20 (46.5%) were from Terai belt. Among the health cadres who faced caste/ethnicity harassment, 17 (40%) were technicians (lab and radiography staff) followed by nurses/ANMs 13 (31.4%) (Table 2).

Table 2. Types of harassment felt by heath workers at workplace.

Chara-cteristics	Sexual harassment (N=23)	Gender based harassment (N=32)	Caste/ethnic harassment (N=43)
Ecological Region			
Mountain	13%	3%	36.40%
Hill	52%	62.50%	38.00%
Tarai	35%	34.50%	46.50%
Development region			
Eastern	22%	19%	34.60%
Central	22%	31%	40.00%
Western	4%	3%	25.00%
Mid-Western	22%	19%	30.00%
Far-Western	30%	28%	64.00%
Designation wise			
Doctors	13%	9%	21.40%
HA/CMA Paramedics	30%	35%	14.00%
Technicians	9%	6%	40%
Nurses/ANMs	48%	50%	31.40%

Compensation provided by working institution in workplace accidents

Only, 230 (30.7%) of health workers who suffered from workplace accidents got compensation and treatment. The study data showed that among the ecological belts provision of compensation and treatment was highest in Terai 107 (14.3%) in the event of an accident in the workplace. Despite the provision of the compensation to the health workers there were some cases where the health workers were also dismissed from the job 43 (5.8%). Findings also revealed that 93 (12.4%) of urban health workers received compensation and treatment facility (Table 3).

Table 3. Type of compensation provided to health worker in case of work place accident (N=747).

	Compensation and treatment facility	Pension or Incentive	Manage paid leave	Fire from the job
Total%age	30.7	22.2	29.2	5.8
Ecological Belts				
Mountain	5.4	3.2	4.8	1.3
Hill	11.1	9.4	9.9	1.7
Tarai	14.3	9.6	14.5	2.7
Development Regions				
EDR	8.3	5.5	8.3	0.9
CDR	6.2	5.5	6.3	1.9
WDR	5.2	3.2	2.3	0.7
MWDR	3.6	4.1	4.3	1.3
FWDR	7.5	3.9	8	0.9
Service Categories of HRH				
Doctors	3.5	2.1	2.9	0.5
HA/AHW paramedicals	14.6	14.1	15	2.3
Technicians	3.5	0.5	2.5	0.8
Nurses/ANMs	9.2	5.5	8.7	2.1
Types of Institutions				
Hospital	5.1	3.6	5.1	1.3
PHC	2.5	2.7	3.1	0.4
Health Post	3.6	4	4.3	0.4
Sub-Health Post	8.6	9.8	10	1.1
Ayurvedic Centers/ Ausadhalaya	1.2	1.2	1.1	0.7
Private Clinic/ Hospital	2.1	0.1	2.3	0.7
I/NGO Clinic/ Hospital	7.6	0.8	3.3	1.2

The FGDs among the service providers' and facilitators' groups showed that cooperatives in Palpa had started the 'health security fund' programme for improvements in the security of health workers in the district. Similarly, the media, I/NGOs and different clubs have supported in raising health awareness messages and providing free advertisements in the region. A KII with the representative of a NGO told of their provision of additional health workers to the health institutions. However, often this support can go unrecognized, as was the case in a discussion during a FGD among service providers in Palpa district, who expressed that they do not play a functional role in support to health care services.

Table 4. Health workers of the institution awarded for their good work by the local community.

Characteristics		Number of health workers awarded for good work	Percentage
Ecological Regions	Mountain Region	6	11
	Hill Region	28	50
	Tarai Region	22	39
Types of Locality	Rural	38	68
	Urban	18	32

DISCUSSION

This study highlighted the issue of security feelings of the health workers where nearly 168 (23%) of them felt some level of insecurity at their workplace. Among different cadres of health professionals, 24 (30%) of doctors felt insecure at their workplace. Similarly, doctors also faced higher number of arguments with the service users. Nearly, one third of doctors 26 (32.50%) faced some kind of argument while treating them. This figure is twice bigger than that of nurses 36 (15.32%). Sometimes, this type of argument resulted to death. Contrastingly, a study in 1998 showed that nursing personnel and physicians were at considerable risk for workplace violence in the course of their careers.[5] Similarly, study carried out by Wells and Bowers revealed the fact that nurses as a whole do face a high level of risk compared with all workers and this excess risk holds for general nurses. They found 9.5% of general nurses working in general hospitals assaulted (with or without injury) in any 1 year.[6] The doctors are the first point of contact with the patients and the high expectation of patients from them, might have contributed to such feelings and argument. However, limited researches have conducted in these areas.

All together, 23 health workers felt sexually harassed and 32 health workers felt gender based harassment. The gender analysis of harassment faced by health workers revealed that females were more prone to gender based and sexual harassment. Similarly, a total of 43 health workers felt caste/ ethnicity harassment, out of which was 20 (46.5%) were from Terai belt. Among the health cadres who faced caste/ethnicity harassment, 22 (40%) were technicians (lab and radiography staff) followed by nurses/ANMs 74 (31.4%). Studies have shown that workers who had experienced non-physical violence were 7.17 times more likely to experience physical violence than those who had not.[7] The study data also showed provision of compensation and treatment was found highest in Terai 107 (14.3%) in the event of an accident in the workplace with some events of firing from job 43 (5.8%). These findings emphasize the need for effective community feedback or complaint mechanisms and punishment systems. These are not in place in health institutions, but are essential for improvements in workforce performance as they can be used not only to provide information on misconduct, but can also provide positive feedback from the community and can strengthen motivation among health workers.

CONCLUSIONS

The security of health workers at workplace is a major issue that it is linked not only with prolonged stay but also has impact on quality health service delivery. Feelings of insecurity and service user-provider argument have raised serious concern about the implementation of security laws and policy related to health workers safety at workplace. So, the study strongly recommends for the strict implementation of prevailing laws and acts related to security of health workers.

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