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RESILIENCE STRATEGIES ADOPTED BY HEALTH SECTOR ENTREPRENEURS OF KARNATAKA

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ABSTRACT

Knowing the stress that community health workers (CHWs) experience at work may help in developing interventions to entice and motivate healthcare workers to work in distant and underserved areas while also ensuring the quality of care. The purpose of this study was to ascertain the incidence, severity, and sources of occupational stress among CHWs as well as the coping mechanisms used by the CHWs.. From January to April 2019, 347 CHWs in 16 Primary Health Centers in the Mangalore Taluk, Karnataka, participated in this cross-sectional study. The Occupational Stress Index and the Short COPE scale were employed, respectively, to evaluate the stress level and coping mechanism [1, 2]. The Chi-square test and descriptive , statistics were applied. P = 0.05 was regarded as being significant. A 40.5% prevalence of work stress was discovered. Workplace stress was strongly correlated with stressors such limited engagement, helplessness, low position, and unprofitability. In order to cope with their stress, CHWs employed a variety of coping mechanisms, including self-distraction, active coping, denial, substance use, behavioural disengagement, venting, positive reframing, humour, and self-blame. To make CHWs "stress-free," stress intercession programmes could be implemented on a regular basis. Increased levels of stress could hinder employees' performance, thus managing this is essential. In a similar vein, encouraging healthy coping mechanisms like active coping is important for stress management.

Keywords: Multipurpose workers, Mangalore Taluk, qualified social health activists, auxiliary nurse midwives, community health workers, coping mechanisms, and occupational stress.

Introduction

The healthcare services are made more accessible to the general public by community health care. Their participation at the local level contributes to the "effective, democratic, and sustainable delivery" of healthcare in even the most rural locations. Importantly, in low- and middle-income nations, they have integrated seamlessly into healthcare systems and are seen as a tactical solution to the shortage of medical professionals. They offer a wide range of services, from basic health promotion and education to more complex and specialised treatment including maternal and child health, tuberculosis, and HIV/AIDS care, as well as the implementation of national programmes at the local level and the eradication of malaria. In order to achieve the Sustainable Development

Goals (SDGs) and achieve universal health coverage, primary health care was established with a primary focus on delivering a wide variety of services, including prevention, treatment, management, rehabilitation, and palliation. Strong primary health care requires highly qualified and driven healthcare professionals.[3, 4, 5] Stress was ingrained in our daily lives more than 50 years ago; the word is already common usage, and it co-existed as a perplexing as well as dynamic transaction between people and their environment. In general, stressors are actions or situations that have the potential to negatively impact wellbeing. Working hours, pay for performing the work, the organization's structure and culture where work is done, career advancement (problems with promotion and the risk of losing one's job), the job itself (obligation to others), and interpersonal relationships with superiors, partners, and subordinates are all potential causes of occupational stress. Particularly in various geographical regions of the nation, the overall perspective remained understudied [7, 8, 9]. In light of this, the current study was carried out to ascertain the prevalence, causes, severity, and coping mechanisms of occupational stress among community health workers (CHWs) in a region in Karnataka.

Materials and Methods

Study design and study setting

Over the course of four months, from January to April 2019, this cross-sectional study was carried out at a number of Mangalore Taluk, Karnataka, Primary Health Centers (PHCs).

Study population and sampling strategy

The study population consisted of CHWs, also known as accredited social health activists (ASHA), auxiliary nurse midwives (ANM), and multipurpose workers (MPWs) employed by PHCs. The study individuals were chosen using a two-stage selection approach. Out of a total of 31 PHCs, 16 PHCs (or 50%) were chosen in the first stage by lottery. In the second phase, the study included every CHW employed at the chosen PHCs [10, 11 ,12]. The District Health Office of Mangalore provided the complete list of healthcare professionals. Among 16 chosen PHCs in the Mangalore Taluk, there were 362 CHWs. Eventually, 347 CHWs were evaluated as a whole sample.

RESULTS

Statistical analysis

With the help of SPSS (Statistical Program for Social Science) version 23, the data were coded, inputted, and analysed. Frequency and percentage were used to describe sociodemographic factors. The data's normality was evaluated using the Shapiro-Wilk test. Since the data were not regularly distributed, association tests like Chi-square and likelihood ratio were used. P = 0.05 was used to define statistical significance. Using the geometric mean approach, the mean prevalence for both moderate and severe stress was determined (low stress was considered as normal stress for any work, hence was not considered).

347 healthcare professionals took part in the study overall [13, 14, 15]. Among them, there were 25 MPWs, 238 ASHA, and 84 ANM. 335 (96.5%) of the participants, who had an average age of 39.86 + 8.05 years, were female. The majority (335 [96.5%]) of respondents were married, 275 [79.3%] had a family of five, and 276 [79.5%]

lived in their own home. Married participants had 308 (91.9%) children, which equals two. 200 (84%) of the 238 ASHA employees said they received performance-based incentives, the majority of whom (98 [49%]) earned less than Rs. 1000/month. In the PHCs where they were employed, every participant said they had a vacant position that they had to fill in addition to their regular duties. 25% of the ANM, or one-fourth, One-fourth (25%) of the ANM and 40% of MPW's attained graduation course prior to health professional training, while only 6.7% of ASHA workers had graduation degree and 12.4% had completed 10th standard.

The distribution of occupational stress among CHWs is seen in [Table 1]. It was discovered that among CHWs, the mean prevalence of occupational stress was 40.5%. With a range of 92–168, the mean score for occupational stress was discovered to be 133.63 13.78. The overall occupational stress score was 230. The findings revealed that the majority (70.6%) of CHWs had moderate levels of occupational stress, with severe and low levels of stress occurring in 23.3% and 6% of cases, respectively.

Characteristics	*n* (%)
Level of occupational stress	
Low	21 (6.1)
Moderate	245 (70.6)
Severe	81 (23.3)
Occupational stress	
Mean prevalence	141 (40.5)

Table 1: Prevalence and level of occupation stress (*n*=347)

The coping mechanisms used by CHWs are shown in [Table 2]. According to CHWs, they never employ substance abuse or comedy as stress-reduction techniques.

Table 2: Coping strategies adopted by community health workers (*n*=347)

Coping strategies	Never, *n* (%)	Rarely, *n* (%)	Occasionally, *n* (%)	Frequently, *n* (%)
Self-distraction	67 (19.3)	99 (28.5)	129 (37.2)	52 (15)
Active coping	20 (5.8)	58 (16.7)	138 (39.8)	131 (37.7)
Denial	79 (22.8)	120 (34.6)	114 (32.8)	34 (9.8)
Substance use	246 (70.9)	55 (15.9)	36 (10.4)	10 (2.8)
Use of emotional support	30 (8.6)	102 (29.4)	127 (36.6)	88 (25.4)
Use of instrumental support	17 (4.9)	82 (23.6)	137 (39.5)	111 (32)
Behavioural disengagement	33 (9.5)	118 (34)	128 (36.9)	68 (19.6)
Venting	92 (26.5)	129 (37.2)	93 (26.8)	33 (9.5)
Positive reframing	35 (10.1)	80 (23)	153 (44.1)	79 (22.8)
Planning	31 (8.9)	86 (24.8)	151 (43.5)	79 (22.8)
Humour	124 (35.7)	104 (30)	105 (30.3)	14 (4)
Acceptance	37 (10.7)	78 (22.5)	124 (35.7)	108 (31.1)
Religion	13 (13)	78 (22.4)	133 (38.3)	123 (35.3)
Self-blame	115 (33.1)	127 (36.6)	82 (23.7)	23 (6.6)

The relationship between occupational stress and several demographic characteristics is shown in [Table 3]. The number of years of experience (P 0.01), the number of incentives received each month (P 0.001), and the monthly wage (P 0.016) were all found to be substantially correlated with occupational stress. No correlation between occupational stress and other socio-demographic characteristics, such as age, gender, education, work title,

population covered, quantity of field trips, and monthly salary, was found, though. Significant correlations have been shown between occupational stress and a variety of stressors, including limited participation, powerlessness, low status, and unprofitability.

Characteristics	Total	Occupational Stress			P
		Low (%)	Moderate (%)	High (%)	
Years of experience					
<5	170	53 (31.2)	105 (61.8)	12 (7.0)	
5-10	125	20 (16.0)	98 (78.4)	7 (5.6)	0.01*
>10	52	8 (15.4)	42 (80.8)	2 (3.8)	
Incentives per month (*n*=200)					
<1000	98	24 (24.5)	74 (75.5)	0 (0)	
1000-2000	60	16 (26.7)	35 (58.3)	9 (15.0)	0.001*
>2000	42	8 (19.0)	32 (76.2)	2 (4.8)	
Monthly salary (*n*=299)					
<5000	190	47 (24.8)	128 (67.4)	15 (7.8)	
5000-10,000	33	3 (9.1)	30 (90.9)	0 (0)	0.016*
10,000-15,000	12	0 (0)	10 (83.3)	2 (16.7)	
15,000-20,000	13	4 (30.8)	8 (61.5)	1 (7.7)	
>20000	51	12 (23.6)	37 (72.5)	2 (3.9)	
Occupational stressors					
Role overload	347	26 (7.5)	166 (47.8)	155 (44.7)	0.178
Role ambiguity	347	161 (46.4)	112 (32.3)	74 (21.3)	0.159
Role conflict	347	72 (20.8)	208 (59.9)	67 (19.3)	0.276
Unreasonable group and pp	347	60 (17.3)	178 (51.3)	109 (31.4)	0.213
Responsibility for persons	347	79 (22.8)	202 (58.2)	66 (19)	0.400
Under participation	347	91 (26.2)	135 (38.9)	121 (34.9)	0.042*
Powerlessness	347	187 (53.9)	137 (39.5)	23 (6.6)	0.011*
Poor peer relations	347	147 (42.4)	171 (49.2)	29 (8.4)	0.746
Intrinsic impoverishment	347	124 (35.7)	178 (51.3)	45 (13)	0.064
Low status	347	208 (59.9)	130 (37.5)	9 (2.6)	0.021*
Strenuous working conditions	347	58 (16.7)	123 (35.5)	166 (47.8)	0.234
Unprofitability	347	34 (9.8)	108 (31.1)	205 (59.1)	0.001*

Occupational Stress Index score=46-122 (low), Score=123-155 (moderate), Score=156-230 (high), *P<0.05. PP: Political pressure

DISCUSSION

A 40.5% prevalence of occupational stress was discovered among CHWs. In the current study, the majority of CHWs exhibited moderate levels of occupational stress (70.6%), followed by low levels (23.3%) and high levels (6.1%). Workplace stress was scored on average at 133.63 13.77. According to a study done in Neelamangala, the majority of front-line healthcare providers experience moderate stress (52.1%), mild stress (37.1%), and severe stress (10.7%). Although the degree of stress was similar between the two research' conclusions, their statistical methods were different.

In the current study, it was discovered that CHWs used a variety of coping mechanisms to control their work stress. Active coping, venting, positive reframing, and comedy were all positively associated with reducing work stress. Furthermore substantially associated with occupational stress among CHWs were avoidant coping mechanisms as self-distraction, denial, substance use, behavioural disengagement, and self-blame.

The current study's strength was that a universal sample was drawn for the study from the chosen PHCs and a pretested standard questionnaire was employed to quantify occupational stress. Due to the cross-sectional design of the study, it was difficult to determine the exact nature of the causality through which occupational stressors predict occupational stress. Furthermore, because the questionnaire was self-administered, recall bias may have been more prevalent, and there was no way to confirm or validate that the replies provided by the healthcare professionals were accurate, genuine, and right.

CONCLUSION

Among Mangalore taluk CHWs, occupational stress was present 40.5% of the time. The study made it clear that the main causes of professional stress were predictions like limited engagement, powerlessness, low status, and unprofitability. For CHWs to perform better, improved compensation, appreciation, and a structured career path could be guaranteed. Therefore, a more thorough analysis is required to determine how the use of coping mechanisms influences work-related stress.

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