Original Article

Experience of Behvarzes (Iranian primary healthcare providers) from giving primary health services in health houses

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ABSTRACT

Background: Primary healthcare (PHC) providers play a major role in provision of public health in rural areas in Iran. They are considered as the key elements of health development in rural population. There is limited research on clarification of their experiences from provision of health services in their working conditions. This study aimed to clarify the experience of PHC providers from working conditions in giving primary health services in health houses (district branches of rural health care centers). **Materials and Methods:** This is a content analysis qualitative study, conducted through personal and group interviews with 12 health workers working in health care centers in rural areas in Isfahan province, 2010. Sampling continued until data saturation. Data were analyzed through conventional content analysis and constant comparative method. **Results:** Data analysis led to extraction of 11 categories, and finally, four themes of "ignoring the rights," "causing tension in working climate," "pressure or overload of expectations beyond the power," and "occupational worn out" were yielded from the categories. These themes reveal the concepts and nature of PHC providers' experiences from giving health care at health houses as the first level of PHC centers. **Conclusion:** The results of the present study showed that the PHC providers work in a tense condition in health houses. Although they devote themselves to the health of society members, their own health is neglected. Policy makers and authorities should amend working conditions of PHC providers through modification of resources and making supportive and collaborative strategies to improve the quality of services and promote the health level of the service receivers.

Key words: Health services, Iran, primary health care, qualitative research, rural health care providers

INTRODUCTION

Declaration of Alma-Ata (1978) defines the concept of primary health care (PHC) with focus on four principles of social justice, social participation, interdisciplinary participation and appropriate technology.

Resuscitation of PHC and access to an approach toward declaration of Alma-Ata can be a determinant in empowerment of health systems and modification of health fundamentals such as human resources.[1] Following

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declaration of Alma-Ata and with emphasis on the key roles of PHC in achieving health for all and reduction of health discrimination, Iranian government took actions to expand a primary care network in rural areas that actually gives services through health care centers with defined various referral levels.[2,3] At the present time, over 94% of the rural areas in Iran are under coverage of PHC network so that primary and basic health care is given through PHC network and by Behvarzes.[4] Rural health care staffs are called Behvarz in Iran. This word is a combination of two Persian words of "Beh" (well-being) and "Varz" (skill). Behvarzes are local staffs who are familiar with rural health needs. They play a key role in Iranian rural health and are in charge of a vast range of activities due to their deep understanding about the social components of where they work.[5] Therefore, consideration of physical and mental health of PHC staff is one of the most important duties of the authorities and policy makers in Iran.[4] A study showed that 30 years after establishment of PHC system in Iran, duties of working Behvarzes is increasing. Their mean occupational stress score was 42.8%. About 17.6% of them developed moderate to severe occupational depression and 28.3% were suspected for mental disorders.[4] Research in other countries show that health services provision system faces numerous problems. One of the studies reported lack of homogeneity and coordination in individuals' professional understanding in domain of health concerning work, shortage of human resources and time as well as the problems, associated to referrals as the main problems of the participants in Brasilia.[6] Another study also reported inadequately correct and precise data about the health care human resources in PHC level, shortage of work force in PHC, discriminative distribution, low sprit, low job satisfaction, inter-sectional conflicts and disputes, discrimination in salary and reward and constant circulation of the staff as the health providers' problems in Nigeria.[7] A study on the experiences of the PHC centers staff in Tanzania, showed that one of the major problems was the complications, resulted from having several simultaneous jobs and shortage of the personnel, and there is a demand for managers' structural and supportive supervision and a better clearance in occupational development opportunities.[8] Several studies in Iran showed that Behvarzes face numerous problems and job dissatisfaction in rural networks such as work overload, obscurity and conflict in role, and inadequate salary and reward.[3,4,9-11] Managerial factors were nonsupportive management and supervision, lack of communication with the supervisor to express the problems, no chance for progression and job promotion.[4,5,10,12] Organizational factors included inadequate life facilities, type of employment, lack of having a house and transportation vehicle among Behvarzes, no provision of basic facilities and recreational affairs, inappropriate organization structure, size and population of the villages under coverage, and living in the same village of giving service.[10,13] Based on a literature review, it can be concluded that most of the existing studies on Behvarzes' problems investigated their occupational experiences quantitatively. In such studies, researchers already make a default on the nature and the factors, effective on subjects' occupational structures, and then, investigate and report their levels and severity by specific tools, but do not explore the nature of their experiences and understandings in the way they themselves express. However, in the present study, researcher, with 20 years of experience in education and cooperation in health fields in different levels of health services, adopted a qualitative approach based on Behvarzes' own current understanding and experiences concerning their daily work in health care centers, under coverage of rural treatment and health centers and investigated their working conditions. Other co-workers in this research project had also experiences in accomplishment and counseling of several qualitative studies ad teaching these methods in Iran and other countries. The present study aimed to clarify the experiences of Behvarzes from working conditions in giving primary health services in health houses.

MATERIALS AND METHODS

In the present study a qualitative and conventional content analysis method was adopted. Qualitative studies are appropriate for understanding of the phenomena in their context and declaration of the ties between concepts and behaviors, and formation and modification of theories.[14,15] Content analysis is a regular and repetitive qualitative analytic method that is adopted for regular description of behavior and acts as a reference for analysis of semi-structured interviews.[15] Research environment, fitted for qualitative research, was a real and natural environment and all interviews were held in health care centers by the first researcher. Participants with highest age range (22–52 years) and work experience (6–26 years), marital status (nine married and three single) and sex (nine females and three males) were selected from Behvarzes working in health houses under coverage of rural health centers through purposeful sampling.

Inclusion criterion was having at least 1 year of work experience of giving fulltime services in the health houses. Sampling continued until data saturation so that in the three last interviews, no new codes were obtained, and finally 14 participants attended the study. To collect data, after attaining permission from vice-chancellery for research and making coordination with vice-chancellery for health of Isfahan University of Medical Sciences, a letter of introduction was given to provincial health office. To form focus groups sessions and conduct personal interviews with Behvarzes, a letter of introduction was obtained from health office and was handed to managers of rural health care centers. The location and time of interviews were determined based on participants' decision in the centers or health care centers in not crowded hours at the end of working shift. All participants were informed about the goal of study and participated in research voluntarily. They were assured about confidentiality of their information including recording their voice and their right to leave the study whenever they liked. A written consent form was signed by them. Data collection was conducted from October 2008 to September 2010. This

study is derived from a PhD dissertation, whose proposal was approved in Ethics Committee of Isfahan University of Medical Sciences. There were 11 personal and one focus group interviews, conducted with 14 Behvarzes (11 personal interviews with Behvarzes and one focus group interview with 5 Behvarzes). After several personal interviews and researcher's understanding from the effect of group interview on free and out of occupational threat expression of the facts, the researcher held the session and focus group interview. Deep and unstructured interviews were held by grand tour questions. This type of interview fits qualitative research due to its flexibility and dept.[15,16] The length of focus group session was 179 min and personal interviews lasted for 24–75 min (average of 39 min). All interviews were digitally recorded and transcribed verbatim. First of all, participants described their personal and professional characteristics. To collect data, the interview started with a grand tour question stating the main research question (Behvarzes' experiences from their work conditions). For group interview, explorative and deep questions such as "what do others think about it?" were adopted to reach a better understanding from participants' narrations. In this qualitative study, content analysis.[17] was adopted to analyze the date and deductive method was used to make a briefing and categorize the elements or text parts and to label them as themes.[18] Researcher considered questions such as "who says?", "where is it happening?", "when did it happen?", "what is happening?" and "why?" to immerse in data, parallel to frequent review of data. In the second stage, for deductive analysis, organizing the data was achieved by open coding process, making sub-themes and themes and generalization. In the present study, each interview formed a study analysis unit. Interviews were divided into meaning units, and then, to compressed meaning units and were summarized. Summarized meaning units were generalized more and yielded 734 codes. During compression and coding of meaning units, the general text and context of the interview was considered. Various codes were compared based on their similarities and dissimilarities and were arranged in form of 42.

sub-themes and 11 themes and formed an apparent and clear content. Temporary categories were discussed and reviewed by the researchers. Process of discussion and revision resulted in consensus on codes combination. Finally, based on fundamental meaning, latent content in categories were extracted in form of four themes. Samples of content analysis have been presented in Table 1.

Trustworthiness

To be sure that the data interpretation revealed the study phenomenon, participants' review was adopted and Behvarzes confirmed the primary codes although some codes were modified based on their indications. For data transferability, sampling was conducted with upmost variety in different centers. For data credibility (data coverage through categories) some samples of transcribed narrations were mentioned in the final report, and during the study, other researcher's colleagues and four participants reached a consensus about interpretations and results.[19] For data conformability and audit, analysis process and obtaining results were described in details so that the readers could have a clear understanding from the method of conducted analysis as well as its strengths and limitations. Researchers tried to represent rich and reliable finding, accompanied with appropriate narrations, to empower conformability.[20] Conformability was conducted by peer reviewing and external check.

Table 1: Examples of codes, sub-categories, categories and themes obtained from content analysis of narrations concerning behvarzes' working and organizational conditions

Codes	Sub-categories	Categories	Themes
Health system pressure on behvarzes to cover all mothers	High work responsibility	Undefined job range and description	Expectations overload (beyond power)
Behvarzes' accountability for high formula consumption			
Behvarzes' accusation in case of infants' death			
Behvarzes' complaint of high work overload, high number of plans, numerous duties and giving several and various services	Work overload		
Behvarzes' complaint of unfixed work location	Working in multiple health centers		
Giving services in different service location			
Behvarzes' disappointment with working in other health centers due to unfamiliarity with the village residences			
Behvarzes' complaint of spending time on unnecessary services	Negative feedback from existing services and useless tries		
Nothing resulted from services			
Behvarzes' complaint of increasing the number of services from 11 to 30-40 tasks	Numerous duties	Too variety of work	
Behvarzes' complaint of being involved in all plans			
High number of services			
Behvarzes' complaint of health care duties overlap	Duties contraction and conflicts		
Conflicts between in and out of health care center			
Behvarzes' complaint of yearly increase of projects and unfinished former projects	Frequent instability in duties		
Behvarzes' confusion with new projects			

RESULTS

In the first stage of content analysis, 734 codes, 42 sub-categories and 11 categories were obtained from personal and focus group. In the second stage, four themes including "ignoring the rights," "causing tension in working climate," "pressure or overload of expectations beyond the power," and "occupational worn out" were yielded from the categories, presented in Figure 1. In the following, the themes, as expressed by Behavrzes, are presented:

Ignoring the rights

This theme was extracted from three sub-themes of "inadequate salary and wages," "organizational ignorance about Behvarzes' promotion," and "existence of stereotyped and unpleasant strategies." Behvarzes were so dissatisfied with unbalanced and discriminative workload, attendance hours at work, and their low level of income. They complained of doing extra tasks in form of numerous inter-sectional plans with no extra payment. They were also upset with untrue promises of reward to do the plans and no payment in return of their given services in this field.

Behvarzes complained of not having any time to review their texts and references as well as the frequent ministry announcements and being forced to acquire necessary information to educate their clients and claimed that continuing educational classes in their sessions were inefficient and useless. Their skin-deep information and feeling of disability to answer families' questions also disappointed them. They complained of lack of their spiritual needs fulfillment and appropriate reward, limitation of recreational facilities and their problem of taking some days off and going on vocations. It was so that some participants claimed they would not receive any rewards under any circumstances. They were so upset with organizational stereotyped and unpleasant strategies due to nondynamic and inflexible regulations, and authorities' extra focus on physical attendance at work.

"Our working hours are too long but useless." "In fact, our afternoon time is somehow waste of time" (p1).

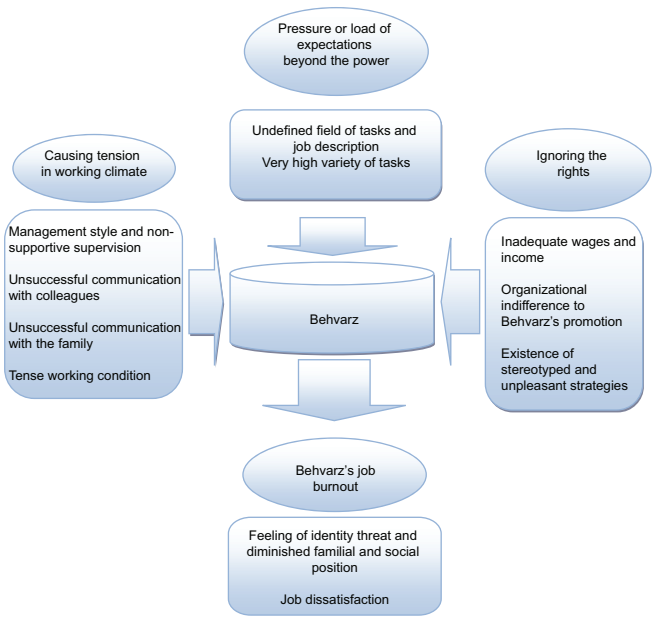

Figure 1: Experiences of Behvarzes as the front-line watch of family health concerning primary health care

Causing tension in working climate

The second theme, causing tension in working climate, was often a negative feeling, experienced by Behvarzes. This feeling was the theme for sub-themes of "nonsupportive supervision and management style," "unsuccessful communication with colleagues," "unsuccessful communication with the families," and "working conditions causing tension," which reflect Behvarzes' unpleasant feeling and experience from their working conditions. Behvarzes complained of the incorrect evaluation process in form of being forced to be accountable in front of several authorities and the concurrent inspection of the inspectors.

"Two or three supervisors come here, with no coordination etc., Behvarzes are like a soccer ball …" (p8).

Behvarzes complained of the way the inspectors feedback them in front of the clients, which leads to the clients' distrust. They also were upset about sick referral system and lack of receiving a feedback from upper levels, especially specialists as well as their own lack of information about the patients they refer to upper levels. One of the major problems of the Behvarzes was that the mothers, under the coverage of the specialist, were not interested in receiving care from the health care center. On the other hand, some parts of the education, the mothers had received, had been rejected by the specialists. Therefore, the families did not mind Behvarzes' education due to the existing controversy. Behvarzes complained of the controversy and the difference between the specialists' recommendations and their received instructions, making a negative reputation for them, and being addressed as illiterate and low-educated by the specialists, and consequently, families' confusion, imposing them a high mental pressure.

"These specialists ruin everything … in case of a baby with diarrhea, parents go to visit a specialist, for example they say, the specialist ordered us not to breastfeed the baby!" (p12).

Absence of executive coordination in the system, in form of lack of coordination in the deadline of completing and sending the official forms and the time of sending them to the main office as well as the mess made in Behavrzes' function, caused by midwifes and physicians in health care center, were obvious. Lack of mothers' referral for perinatal care and incompletion of the perinatal form despite frequent follow-ups were among other Behvarzes' major problems. They complained of the mothers' distrust toward them and being counted as a low-educated person and lack of families' compliance with their medication orders.

Lack of obtaining skills and mastery due to numerous duties, assigned to the Behvarzes was among their problems.

They believed that variety of duties acted as a barrier in their attaining knowledge, skill and professionalism. Lack of coordination between the health system expectations and Behvarzes' ability with regard to their low education led to their dissatisfaction and high tension. Inadequate and inappropriate physical atmosphere (no balance between the physical space and numerous services) was in form of inappropriate physical work environment and space for holding educational classes. Behvarzes were worried about clients' health due to lack of inadequate care facilities. Long working hours and inappropriate conditions for Behvarzes' rest between two working shifts led to their complaint. They complained of having no facilities for their rest and nutrition between two working shifts. They were upset with bureaucracy in the system and their role as an evaluation tool.

"… When they come from the main office and check the logbooks, they don't care who did what!" (p6).

Pressure of work with expectations beyond the power

The third theme showing the unpleasant feeling is pressure of work with expectations beyond the power with sub-themes of "undefined job description" and "too various tasks," which made Behvarzes very upset. Behvarzes were under pressure of various, constant and several expectation of different health sectors and were confused with receiving load of work and numerous inter- and intra-sectional plans, regardless their ability with no modification and balancing other tasks. They were upset with the frequent changes of various forms and refilling them resulting in their disappointment as they believed it would diminish their quality of care.

"They never decrease the load of work … every year, they have new plans, new forms and new logbooks." (p2)

"You know, when we are overloaded with work, quality falls and work is not well-done" (p3).

Occupational burnout

The fourth theme was Behvarzes' occupational burnout with sub-themes of feel of threat and diminished familial and social position and occupational dissatisfaction. Behvarzes were upset with the negative effect of work on their family and transferring their occupational fatigue and problems to their family unit and the negative effect of nervous pressure, resulted from work in form of bad temper due to work overload and hunger, especially after increase of working hours. They also felt that the services were counted useless and the families contempt them. They believed they were not respected like before by people. Low self-image in the service providers was in form of feel of contempt and valueless, helplessness and having no right of objection. They complained of authorities' ignorance and not paying attention to their needs.

"When I go to school, they do not care, they do not mind us, Behvarzes are ruined here" (p9).

"Nobody cares our own health" (p1).

"They never consult with us about anything."

High worry about the health status of the population under Behvarzes' coverage and feel of burnout, low motivation were manifested in form of feel of haplessness and indifference and loss of eagerness to do their tasks in their remarks. They mostly said that they did their tasks with low motivation and as they had to do due to external control. A brief of results have been presented in Table 1.

DISCUSSION

The results showed that Behvarzes' understanding and perception in health care center from the working conditions was very unpleasant. Their unpleasant understandings were expressed by ignoring the rights," "causing tension in working climate," "pressure or overload of expectations beyond the power," and "occupational worn out." These finding, are in line with the challenges of the staff working in PHC in Nigeria, indicated low number of work force in PHC, unfair distribution of resources, low spirit, low occupational satisfaction, inter-sectional conflicts and disputes, inequality in salary and reward, and constant staff transfer.[20] In the present study, some of the worst Behvarzes' experiences were the violation of their rights in form of receiving inadequate salary, organizational indifference to their spiritual and monetary promotion, and existence of stereotyped and unpleasant strategies in organizations. They complained of imbalanced work-salary ratio and not receiving any reward for administration of extra plans.

This finding was in line with Javanparast *et al.* in which lack of rewards and educational opportunities and occupational promotion mechanisms were mentioned as the barriers in efficient Behvarzes' function.[12] Tourangeau *et al.* reported the level of income, yearly leave, paid vocation and the opportunity in development of the staff's knowledge, skill and experience as their most important motivation to remain in the system as a health care provider.[21]

Causing tension in work climate was a negative feeling resulted from management style and nonsupportive supervision, unsuccessful communication with the colleagues and tense working conditions. Javanparast *et al.* also reported Behvarzes' high occupational stress and mental problems.[5] The participants in the present study mentioned the experience of management style and nonsupportive supervision as the causes for their dissatisfaction. A study in Canada showed the effect of managers' quality of communication and support on nurses' desire to remain at service. Nurses expected the managers to be fair, and to respect, support and have efficient communication with them.[21] Research showed that despite official supervision mechanisms, the quality of supervision

was reported poor and supervising teams lacked technical and emotional needed support for Behavarzes. A study showed that most of the Behvarzes indicated instead of their strength points, their weak points are more magnified.[5] In addition, making appropriate interaction with health care authorities leads to a reduction in Behvarzes' and other health staff's burnout.[4]

Another Behvarzes' unpleasant experience concerning causing tension in work climate was unsuccessful communication with their colleagues in form of an atmosphere of distrust between colleagues, conflicts and specialists' lack of cooperation and lack of teamwork. Tourangeau *et al*. indicated the nature and quality of nurses' communication with their colleagues as the most important cause for their remaining at work while negative and suffering communicative factors acted as the most powerful cause for their drop out.[21] The experience of tension between Behvarzes and the families, families' distrust against Behvarzes, lack of families' compliance with Behvarzes' recommendations all make Behvarzes badly disappointed. Javanparast *et al*. showed that Behvarzes believed that one of the most important facilitating elements in successful administration of Behvarz project in rural areas was constant trustful communication with the society and social recognition.[5] Behvarzes complained of tense working conditions in form of imbalanced workload-number of staff ratio, inappropriate physical space and service equipments, lack of coordination, a bureaucratic evaluation system, lack of recreational facilities at work, and existence of high occupational stress and tension. A study on challenges in PHC in Brasilia, reported lack of human resources and time as well as the problems associated to referral system as the main participants' problems.[6]

These findings are in line with a research in Canada in which physical and psychological responses to work such as stressful and tense working conditions due to high workload and high number of patients as well as giving nonprofessional services were indicated.[21] In addition, these findings are consistent with an Iranian study that showed that only 17% of the PHC service providers had high job satisfaction while 41% had poor satisfaction.[10] The unpleasant experience of the pressure of expectations beyond the power and too many various tasks disturbed the Behvarzes severely.

Other studies reported that the most important male Behvarzes' problems were inadequate income, shortage of life facilities, accommodation problem and having no vehicle for transportation. Among female Behvarzes, the problems were work overload, unhealthy working environment and problem of transportation[13] and about 40% of health providers experienced moderate to severe stress in some dimensions such as their numerous and obscure roles. Type of employment, the distance to the nearest town and the number and combination of health houses had a high impact on health workers' stress and severely affected their quality of work.[22] Feel of fatigue, inefficiency and incapability at work and reduction of affection toward the clients, expressed by the participants, can reveal "occupational burnout" that refers to a syndrome with feeling of fatigue, and negative emotions and attitudes toward people, and one's professional role as well as emotional fatigue. It also includes emotional fatigue such as feel of severe emotional pressure and fatigue, no affection and cruelty toward others and negative evaluation from their success at work, mostly observed in the occupations with direct interaction with people.[23-25] A study on prevalence and determinants of burnout syndrome among PHC physicians in Qatar, showed that occupational burnout was more prevalent among the female young physicians working in PHC in Qatar.[26] Behvarzes' other experiences such as their deprivation from their rights, causing tension at work and pressure of expectations beyond their power indicate incidence of job dissatisfaction and occupational burnout in them that is manifested as fatigue, lack of motivation at work, desire to leave work and early retirement. In study of Malakouti *et al*., although the scores of emotional fatigue and depersonalization were low, 43% of Behvarzes reported their inefficiency and low personal success.[4] Among the limitations of the present study, low number of participants and lack of generalizability of the results to all Behvarzes, similar to the limitations of all other qualitative studies, can be mentioned.

CONCLUSION

The most important result of the present study was lowered and unstable social position of Behvarzes in form of distrust among colleagues, specialists, and more importantly, among all families. In addition, they felt that they were unable to be updated with everyday changes and to accomplish new health care system plans as they believed that they were practically and scientifically inefficient. Behvarzes' inefficient services, feel of incapability and lack of personal success at work, their lowered social position and working conditions problems affecting their families led to their feel of hopelessness and occupational burnout. Findings showed that the changes made in health system and various expectations from Behvarzes are more than their power. These feelings, especially occupation burnout not only threaten their own and their families' health but also endanger the rural families due to its inevitable effects on quality of the given services to these families. Therefore, Behvarzes need to receive emotional support and feel as an important element in the society and health system. Their participation in planning to develop the quality of care and receiving counseling from the health care authorities can bring about and increase feelings of positive self-control and self-efficacy among them. Reduction of the number and combination of services in rural health system, increasing the number of personnel, especially for more populated villages, consideration of motivations (such as financial rewards) for those working fulltime, provision of transportation costs and improvement of living conditions can enhance Behvarzes' job satisfaction. On the other hand, it seems that it is the time to employ those with higher education and ability (such as family or public health nurses) to help Behvarzes to fill the existing gap in health care system in Iran.

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Conflicts of interest

There are no conflicts of interest.

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