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To know the gaps in ANM Training School's course in relation to the dynamic role of ANM in Public Health System of India

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Abstract: *The effective health services depend upon number of factors including the capabilities in terms of updated knowledge and skill of human resource pertaining to current needs of the system. Focusing on primary health care, Auxiliary Nurse and Midwives Training School/Centre (ANMTC) facilitates the Auxiliary Nurse and Midwives (ANM) production which ensures public health services. ANM is the technical frontline force of public health system of India, thus updated knowledge and technical skills is in demand to make the public health more efficient and effective. Since health demands is high and with limited availability of nurses especially in the rural area, it hampers her from rendering comprehensive and qualitative care that includes effective health promotion activities, maternal and child care; and thus diluted the very important midwifery component. ANMTC's conducts basic course for ANMs and follow a curriculum set by the Indian Nursing Council. Present situation of the ANMTC's are not satisfying the need of the primary health care. The quality in terms of delivery of education and implementation is degraded. The study expressed a comparison between the role of ANM set by Indian Public health Standard (IPHS) and the course contents of the ANMTC's. It has identified the gaps in the contents of the course conducted in the ANMTC with actual role played by ANM and expressed the suggestions required in the curriculum as per the need of present scenario of public health care.*

Keywords: *Auxiliary Nurse Midwives, Auxiliary Nurse and Midwives Training School/Centre, Course, India, Roles.*

I. Introduction

Since the country's independence in 1947, India has come a long way in its efforts to improve health services especially the public health system which include primary health centres (PHC) and sub-centres (SC) staffed by doctors and Auxiliary Nurse Midwives (ANMs) as well as male health workers to provide basic medical care. Since independence colossal health personnel's along with infrastructure were developed. Although no private competition was dynamic at that time but callus system was not able to improve much of health statistic. The services were available at the community level but the quality was degraded. Various important concerns like technical female worker, health infrastructure, and institutional delivery were among most important were analyzed especially for the pastoral areas of India. [9]

This paper will focus mainly on ANMs which is a foundation of public health system of India. ANMs are regarded as the first contact person between people and health institution, between needs and services and between consumer and provider. Since inception of the community health worker there has been changes in program priorities, the role and capacity of the ANM substantially.

Although India had well trained midwives during the British rule but due to various reasons this professionals lost the importance and thus maternal mortality was remain high in India. Mavalankar stated that "*The reasons of dilution in the midwifery profession included amended regulations, lack of social or political priorities, and change in health programme directions*". [7] The effective health services depend upon number of factors including the capabilities in terms of updated knowledge and skill of human resource pertaining to current needs of the system.

Government of India and state level had ensured the capacity development process of health personnel through training programmes. Since the public health demands were high and with limited availability of nurses especially in the rural area, the Auxiliary Nurse Midwives (ANMs) were introduced at the community level to cater to the growing Mother and Child Health needs. Focusing on primary health care, Auxiliary Nurse and Midwives Training Centres (ANMTCs) facilitates basic training course for ANM which ensures public health services at community level. ANM is the technical frontline force of public health system of India. ANM founds niches of Indian health care system and therefore updated knowledge and technical skills is in demand to make the public health more efficient and effective.

The training course for the ANMs is provided by the ANM Training Centres or ANM Training School in a capsule programme of 18 Months including theory as well as practical part. These training schools are recognised by Indian Nursing Council, an Autonomous Body under the Government of India, Ministry of Health & Family Welfare constituted by the Central Government under section 3(1) of the Indian Nursing

Council Act, 1947. The objective behind constituting the Indian Nursing Council was to establish a uniform standard of training for Nurses, Midwives and health visitor (INC).

The minimum standard requirements devised by Indian Nursing Council for a functioning of ANMTC includes minimum both in regard to what should be included in the curriculum and to the teaching, clinical and physical resources necessary for its implementation. This includes an appropriate infrastructure, affiliation to a health facility for the hands on experience for the students, proper teaching aids and equipments and adequate faculty which include Principal who head the training school followed by the experienced nursing tutor.

It has been extremely important to understand the role of ANM in Indian public health system and the quality of education which generates the technical health workers. Delivering health services under NRHM is a big task for the health worker where various health services are rendered by ANM. The relationship have not been explored earlier between the services provided by ANM at present and the updated skills training provided by the ANM schools. There is a need to understand dynamic role of ANMs in Indian Public Health System with respect to ANM Training Course. In addition to this an up-gradation of the Basic Training Course for the development of efficient trained health workers.

II. Methodology

This study is descriptive in nature. Methods are used to identify and report published and unpublished reviews and articles systematically; our experiences and good practices in the conduct have been described in the study. Study has been divided into four sections that include: Dynamic Role of ANMs in Indian Public Health System, Present Scenario of Public Health in India and Role of ANMs, Development and Changes in ANM Training Course and Areas need to be focus on the Basic Training Course. The process of identifying and appraising all published reviews allows researchers to describe the quality of this evidence base, summarise and compare the review's conclusions and discuss the strength of these conclusions.

III. Dynamic Role of ANMs in Indian Public Health System

Christian mission related hospitals were developed during the late 19th century in northern part of India. They were called as 'Zanana' hospitals and run by nurses. In addition to this a training course on midwifery started in these hospitals. In 1934, ANM cadre was introduced and registered under Mid India Nursing Council which was an autonomous body at that time. They started working in specialised women hospital and also NGO hospitals. [2]

They used to conduct deliveries and visit a village with a population of 10,000 in addition to basic medical care and delivery care at the field level. The duration of the course of the midwifery training was different in different states of India. The duration documents from 6 months to one year for midwifery training. In certain training institutions in states there was a provision of domiciliary training. [17] There was a concern on scarcity of nurses were observed in Shetty Committee where it was suggested to change the language of the course or lower the qualification so that optimum number of the staff could be available in the centres. [10]

The Government of India programme to train indigenous dais (midwives) initiated in 1956 however it was given low priority by many of the states and rejected by others. Major problems identified as responsible for lack of success were failure of village level training in field, the midwifery kit was often not supplied and there was no continued incentive to midwives to have better work performance in Maternal and Child Health (MCH) services. [6]

To achieve family planning goals, fourth and fifth five year plan decided to integrate family planning with the MCH program as suggested by Mukerjee Committee in 1966. This was the time when the work of ANM was already scattered in many health development sectors. At last it was suggested to change the designation of ANM to "Multi Purpose Worker" who would provide range of services including family planning and MCH at the field level. [19] The immunization, family planning and infectious diseases prevention activities requires the field worker to travel to villages to cover the target population, which has reduced the time she spends at the health centres. Targets given for family planning and immunization led to improved accountability to these activities and neglect of emergency services such as delivery care.

Since International Conference on Population and Development (ICPD), Cairo 1994 and Beijing 1995 the workload of the ANM has been increased significantly. India being a signatory to the Cairo declaration adopted the charter and plan of action announced at the end of Cairo World Population Conference.

The Reproductive and Child Health (RCH) programme commenced in India in 1997. The major emphasis was on Reproductive Health of Women, Health care of children in the 0-4 ages, improvement of status of women – social, economic/work, promotion of female autonomy in decision making et cetera.

With the commencement of RCH programmes the women and children were again added in the focus area of the ANMs. These ANMs weren't able to perform midwifery properly as they lack experience of field practise level. In addition, they didn't have complete knowledge of the programmes and its components. The

feedback of the ANMs suggests that more emphasis should be given on the subject like midwifery and community health. [20]

IV. Present Scenario of public health in India and Role of ANMs

The National Rural Health Mission (NRHM) started on 12th April 2005 by the Government of India. The main aim of the mission is to provide, improve the availability of and access to effective health care to the rural population throughout the country. It has also recognised the importance of key health workers at the ground level ANM for establishing a contact with population for quality services. [15]

The NRHM has evolved the concept the two ANMs at a Sub-Centre, this additional ANM will play a major part in providing the quality services including the midwifery which was neglected in the past due to the excessive load on the ANM. [14]

A provision of Rs.10,000 as untied fund for Sub-Centre per annum has been planned under NRHM to strengthen the Sub-Centre. This fund is operated through a joint account of ANM and *Sarpanch* of the respective village to meets the local demands/needs of the health facility. This fund could be used in repairing or buying some medical equipment and also for the maintenance of the sub-centre building.

An analysis of job responsibilities devised by the Indian Nursing Council, Ministry of Health and Family Welfare and Health Departments of various states shows that an ANM is likely to play varied task in Maternal Health, Child Health and Family Planning Services; Nutrition Education; Health Education; Collaborative Service for Improvement of Environmental Sanitation; Immunisation for Control of Communicable Diseases; Treatment of Minor Ailments and First Aid in Emergencies and Disasters.[5] Malik stated that "*the job responsibilities being performed by ANMs were in the areas of health education, medical termination of pregnancy (MTP), nutrition, immunisation, record keeping, minor ailments, MCH, communicable diseases, Family Planning and also team activities, vital events and dai training"*. This depicts the diverse role that ANMs are performing in their field areas. [13]

Furthermore, the ANM would also perform the functions in guiding and training the female Accredited Social Health Activist (ASHA), as envisaged in the Guidelines on ASHA, under NRHM to cater the needs of MCH services at the community level. [14]

NRHM has been focusing on rural health only however the situation is similar in urban areas as well for the degraded knowledge of women in maternal and child component. [2]

V. Development and Changes in ANM Training Course

During 1950s, ANM training was focused on midwifery and care of Mother and Child Health was their major role. During the same period, two standard courses were recommended by the Indian Nursing Council in nursing education. First, a 3 years programme with a minimum 6 months of midwifery practise. Second, a short term course of 2 years for auxiliary nurses and midwifes having 9 months of midwifery and 3 months of community practise. The latter course was in practise till the Kartar Singh Committee recommended Multipurpose Worker (Female) to provide services for National Malaria Eradication Programme. In order to make the existing ANMs competent to the new role a 6 months orientation programme was devised to function them in the role of MPW Female. [19]

To deal with the increasing demand of ANMs in the end of 1970s and beginning of 1980s for a health facility a new reduced course for ANM was introduced named as "Female Health Worker (FHW) training" of 18 months from the earlier course of 24 months.

As per the old 2 year syllabus of ANM course midwifery and community nursing were allotted a total 15 out of 24 months (Approx 60%). And out of these 8 months (Approx 33%) were devoted for the practical experience in midwifery and rotation in community nursing. [18]

Table 1: Time allocation to different areas/subjects in ANMs syllabus

S. No.	Course Content	Classroom Hours	Field Experience Hours	Total Hours
1.	Community Health	180	130	310
2.	Health Promotion	195	220	415
3.	Primary Health Care	320	440	760
4.	Child Health Nursing	180	200	380
5.	**Midwifery**	**360**	**560**	**920**
6.	Health Centre Management	75	60	135
	Total Duration	**1310**	**1610**	**2920**

(Source- Indian Nursing Council, Syllabus, Regulations and Courses of Studies for ANMs, 2004)

The shortened course of 18 months / 1.5 year was made on compromising some main element of the midwifery. The practical time was decreased while keeping the classroom teaching intact. It could be seen in the table above the focus on the midwifery is 27.5% in classroom teaching, 34.8% in field teachings and 31.50% in the total time of the new ANM course. In addition to this more subjects like Sociology, Microbiology, Communicable Diseases, Pharmacology were included in their curriculum. The period of 18 months was too short in absorbing different subjects. Furthermore, the shift in focus from midwifery to Family Planning, Immunization and other National Programmes worked a catalyst in deteriorating the midwifery skill as students didn't practise enough and lacked confidence in conducting deliveries on joining services. [18]

Table 2: Time allocation to different areas/subjects in ANMs new syllabus 2 Years (Council)

S. No.	Course Content	Classroom Hours	Field Experience Hours	Total Hours
1.	Community Health	170	110	280
2.	Health Promotion	195	200	395
3.	Primary Health Care	280	390	670
4.	Child Health Nursing	185	180	365
5.	**Midwifery**	**360**	**380**	**740**
6.	Health Centre Management	80	60	140
	Total Duration	**1270**	**1320**	**2590**
		Internship Period		
7.	**Midwifery**	**-**	**(Hospital 240 + Community 240)**	**480**
8.	Child Health	-	(Hospital 80 + Community 160)	240
9.	Community Health and Health Centre Management	-	Community 160	160
	Total Duration	-	**-**	**880**

(Source: Amendment for ANMs Syllabus and Regulation. 2012)

A recent amendment is observed in the ANM course where the duration of the course has been increased from 18 months to 2 full years of studies. This also includes a 6 months of compulsory internship which students have to undergo. Here the total duration on midwifery is reduced to 28.5% of the total time (excluding the internship period) as compared to the previous 18 months course. But more that 50% of the internship period is dedicated on the practice of midwifery skills. This could certainly be one of the steps to improve the status of ANMs in the public health setup in India which is expected to be implemented in the coming years.

VI. Areas need to be focus on the Basic Training Course

The duties and roles the ANM has to handle while working at a Sub-Centre or a Primary Health Centre is vast more than the taught during her training. According to the Indian Public Health Standard (IPHS) Guidelines for Sub-Centre (Revised 2012) the untouched areas during her 18 months training are follows:

(1) In Maternal Health, a modification is done under the Ante-Natal Care (ANC) which now includes 4 ANC visits (Administrator) and incorporated same in the SBA Guidelines 2010. But most of the ANM training schools or centers in the country are using the old SBA module/guideline published in 2005. In addition to this, Home Based Post-Natal Care (HBNC) has been recently launched in Indian public health system however ANMs are still unaware of this new concept since it is not been added in the course curriculum followed. Likewise the IMNCI modules/guidelines are yet to be get updated at the ANM training schools/centers. [21]

(2) Under Child Health, no use of Infant and Young Child Feeding (IYCF) national guidelines devised by the Ministry of Women and Child Development in the syllabus shows the downgraded knowledge of ANM in field of early breast feeding as compared to expected levels. It has been said that '*Efforts to eradicate malnutrition should include the broader goals of improving knowledge related to childhood nutrition and IYCF practices*' [8] but it is unfortunate when these guidelines are not included in the course curriculum of ANM who are frontline worker.

(3) In the Family Planning area ANMs must be taught about, on the spot treatment for the side effects on the women using a temporary or permanent method of family planning. There are some side effects associated with barrier methods. The most commonly used temporary method used by many women also has side effects. [1] The missing curative knowledge could one of the lacunae for the poor acceptance of family planning methods among the women.

(4) Apart from the main activities of ANMs i.e. MCH care services they are loaded with the work of various National Non-Communicable Diseases Programme. These programmes are yet to be included their syllabus namely; National Fluorosis Control Programme (NFCP), National Iodine Deficiency Disorders Control Programme (NIDDCP), National Programme for Prevention & Control of Deafness (NPPCD) and National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS). Without having the complete knowledge of the above said national programme they won't be able to contribute effectively and efficiently in those areas.

(5) Under the Nutrition, for distribution of Iron and Folic Acid tablets to the pregnant women, nursing mother and adolescent girls have to be done according to the national guidelines. But unfortunately the syllabus of ANM training haven't touched the national guidelines like Adolescent Sexual and Reproductive Health (ARSH) and Weekly Iron and Folic Supplement (WIFS) which are produced to put focus above said issues. Knowledge of Sexual reproductive health is carrying weight-age to rural adolescent group. It has been studied that in eastern India the knowledge of such subject is very poor among the rural adolescent group [3] Moreover the situation of unmarried men about the sex education is worse .has been a deprived sector in India especially for men. [4]

(6) ANM is expected to make cash book and handle the bank account for various schemes under NRHM. She is also expected to get the information from ASHAs regarding the progress made and consolidate the report at PHC level.

(7) No proper direction on Medical and Non-Medical books refers in ANM course.

(8) The Universal Immunization Programme (UIP) focuses on vaccinating even the last child for 6 deadliest disease of childhood, where in the components of tracking the dropouts, left outs or unvaccinated child is due to receive attention from various stakeholders are not visible in the course curriculum. ANMs must be trained in *Mother and Child Tracking* during their course for complete coverage of the UIP programme.

VII. Conclusion

This is an eloquent from the explained examples in the paper that many issues that are not a part of ANM course curriculum and are needed to be integrated to have efficient workers for Public Health. As observed in the section VI, the gaps that are presented in the ANM course (18 months) shows that there is a need of reframing the course with respect of IPHS standards. Synchronization among the theory, practical section of the course with her roles and responsibilities of job is an important act to have effective utilization of ANM. There are certain topics that can be addressed to have better understanding of health services by ANMs however the dynamicity of the public health system of India is intangible. The main gaps include updated information of Ministry of Health & Family Welfare guidelines and other National Health Programs that are not visible in ANM course curriculum. When the workers join service it is assumed that they would know most of the things through their basic training. It is expected with them to practice the skills they have learn during the course. There should have been more emphasis on practical and updated course curriculum for the health workers instead of given them waning standards of the education.

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