Role of Auxiliary Nurse Midwives in National Rural Health Mission

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In India, public health nursing in the villages today is still limited to services rendered by Multipurpose Health Worker (Female) (MPHW(F)) or Auxiliary Nurse Midwife (ANM). ANMs are regarded as the first contact person between people and organisation, between needs and services and between consumer and provider. It is through their activities that people perceive health policies and strategies. It is through them that planners at the upper level gain insights into health problems and needs of the rural people. Considering their status as grass-root level workers in the health organisational hierarchy, a heavy responsibility rests on them. Their services are considered essential to provide safe and effective care and as a vital resource to achieve the health-related targets. The present concern in the country is to provide accessible, affordable, accountable, equitable, effective and reliable health care, especially to poor and vulnerable sections of population in rural areas. It is, therefore, interesting to analyse the role being played by ANMs in providing health care services to people in the changing context of National Rural Health Mission (NRHM).

Background
The role of ANMs has been changing with the times. In the ‘50s and ‘60s, training courses for ANMs focused on midwifery and Maternal and Child Health (MCH) as 9 out of 24 months, were earmarked for these subjects. India’s Second Five-Year Plan described the role of auxiliary health workers as those activities that supplemented the contributions made by doctors and other highly trained personnel for promoting preventive and curative health activities (GOI, 1986). Mukherjee Committee (1966) recommended a system of targets and incentives and identified ANMs and other village level workers as agents for the popularisation of the programme.

In 1973, the Government of India (GOI) integrated the various functions of the health services thereby changing the role of ANMs (Kartar Singh Committee, 1973).

In 1975, Srivastava Committee called for an expansion of the training to prepare them for multipurpose health work. ANMs were now required to provide child health services and primary curative care to villagers. In turn, the Indian Nursing Council (INC) approved an expanded syllabus in 1977. With this came the decision to reduce the training period from 24 months to 18 months.

The National Education Policy (1966) included the ANM programme under the stream of Vocational Education. The INC again reviewed the curriculum for the +2 level and submitted its recommendations to the Ministry of Health and Family Welfare. However, only a few states have adopted this course at the higher secondary level as a vocational course.

Role of ANMs in National Rural Health Mission
National Rural Health Mission, launched on 12 April 2005, to enhance comprehensive primary health care services especially for the poor and vulnerable sections of the society, continues to realise the ANMs as key workers at the interface of health services and the community.

The Mission seeks to provide minimum two ANMs (against one at present) at each Sub-Centre, as one ANM at a sub-centre has not been found adequate to attend to the complete needs of maternal and child care in any village. The Government of India would support the second ANM for appointment on contract basis and apart from fulfilling the other criteria she must be a resident of village falling under the jurisdiction of the Sub-Centre. The intention is to improve accountability at the local level. The second ANM would not be transferred before completion of 10 years at the same Sub-Centre and would not be a substitute for Male Health Worker (MHW). An untied fund of Rs.10,000/- per Sub-Centre per annum is being provided by opening a joint account of the ANM and Sarpanch, to meet the emergency type expenditures and to ensure that...
lack of drugs and other consumables is not an issue.

Although NRHM is not even two years old, there are significant achievements in certain areas with the active support of State Governments. For example, by engagement of contractual ANMs wherever required, and by provision of Rs. 10,000 annual untied grant, nearly all 1,46,026 Sub-Health Centres have been made functional. Sub-Centres have judiciously used the untied funds as per need, from buying blood pressure equipment, weighing machine, to repairing the examination table, cleaning the Sub-Centre, etc. Early evidence suggests that deliveries have started taking place in a few Sub-Centres because of the untied grants. Against additional contractual ANM to be positioned in 30 percent of Sub-Centres, a second ANM has already been in place in 7847 Sub-Centres.

A review of job descriptions prescribed nationally by the Indian Nursing Council, Department of Family Planning, Government of India and Health Departments of various states reveals that an ANM is expected to participate 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. Malik (2001) in her study of Delhi observed 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 indicates that the ANMs have been performing multifarious activities.

The Government of India has been funding the salary of ANM and LHV to the States. The salary of Male Health Worker is borne by the States but nearly 50 percent of the existing Sub-Centres do not have an MHW. This has also some bearing on the workload of the ANMs in position.

In addition to these duties, the ANM would perform the following functions in guiding and training the female Accredited Social Health Activist (ASHA), as envisaged in the Guidelines on ASHA, under NRHM:

- Holding weekly / fortnightly meeting with ASHA to discuss the activities undertaken during the week/fortnight.
- Acting as a resource person, along with Anganwadi Worker (AWW), for the training of ASHA.
- Informing ASHA about date and time of the outreach session and also guiding her to bring the prospective beneficiaries to the outreach session.
- Participating and guiding in organising Health Days at Anganwadi Centre.
- Taking help of ASHA in updating eligible couples register of the village concerned.
- Utilising ASHA in motivating the pregnant women for coming to Sub-Centre for initial check-ups.
- ASHA helps ANMs in bringing married couples to Sub-Centres for adopting family planning.
- Guiding ASHA in motivating pregnant women for taking full course of iron folate acid (IFA) tablets and TT injections, etc.
- Orienting ASHA on the dose schedule and side effects of oral pills.
- Educating ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- Informing ASHA about date, time and place for initial and periodic training schedule. ANM would also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

NRHM is expected to get information from ASHAs regarding the progress made and consolidate the report at PCH level. ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat. She will receive performance-based compensation for promoting universal immunisation, referral and escort services for RCH, and other health care delivery programmes. Against all ASHAs to be selected and 3 lakh of them to be given drug kits by 2008, 2.55 lakh ASHAs have already been trained (out of 3.65 lakh selected) to commence community level health initiatives.

**Conclusion**

NRHM provides that the ANMs will have the support of 4-5 ASHA and the AWWs in
discharging her duties and the role envisaged in the mission. It is therefore expected that they will be able to devote more time to render clinical services to the population and contribute to achieving the goals of the mission to provide universal access to equitable, affordable and quality health care which is accountable, and at the same time, responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilisation, gender and demographic balance.

Note
An auxiliary is a "technical worker in a particular field with less than full professional qualification (WHO Technical Report Series, 1961).

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