# Health policy processes in Gujarat: A case study of the Policy for Independent Nurse Practitioners in Midwifery

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**W.P. No. 2012-08-01**
August 2012

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**AHMEDABAD-380 015**
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# Health policy processes in Gujarat: A case study of the Policy for Independent Nurse Practitioners in Midwifery

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## Abstract

Background: The policy processes of the policy on 'Nurse practitioners in midwifery' (NPM) are described. The policy aims to educate and create a new cadre of competent midwives in the government hospitals as an alternate human resource for maternal and newborn care for remote rural facilities.

Methods: Participant observation in every day setting, in depth interviews with actors involved in policy processes and a self administered questionnaire to one batch of 37 NPMs were used. The conceptual framework of policy processes developed by Andrew et al (2011) was used for analysis.

Findings: The NPM policy was delayed because of frequent change of secretaries and commissioners of health who led the policy process but did not share the vision of policy initiators, and there was less push and shared vision unlike the national programmes, being a state driven policy. The nature of the issue influenced the policy process; many were unconvinced about developing an autonomous cadre of midwives who can fill in for doctors. It was seen as competition by obstetricians. The policy processes were closed though many departments within the government and some actors outside the government were involved. There was less space for open dialogue amongst the various actors, all the discussion was through notes on the file. The main actor s to push the policy forward were less powerful within the government machinery.

Overall the NPM course has been successful in developing competence for normal childbirth; some more practice is needed for complications during labour. Since majority of the candidates for the course come from cities, the objective of human resource for remote rural facilities may only be partially fulfilled.

Conclusions: There is a need to develop a protocol for robust policy processes which are unaffected by changes in leadership, where there are opportunities for dialogue, to bring in and examine evidence, to improve policy processes.

**Key words**: Midwifery, India, Policy processes

# Contents


| Title | Page |
|---|---|
| 1. INTRODUCTION | 5 |
| 2. METHODS | 6 |
| 3. FINDINGS | 7 |
| SECTION-1: Policy processes | |
| 3.1 Stages of Policy processes | 7 |
| 3.2 Policy content | 12 |
| 3.3 Generating Priority | 13 |
| 3.4 The actors and their role | 15 |
| SECTION-2: Policy evaluation:The first batch of NPMs | |
| 3.5 Profile at entry and current posting | 21 |
| 3.6 Quality of training | 22 |
| 3.7 Competence and practice of skills | 25 |
| 3.8 Opportunities to utilize competence | 28 |
| 4. DISCUSSION AND RECOMMENDATIONS | 29 |
| 5. REFERENCES | 33 |
| 6. ANNEXURES | 35 |

| List of Abbreviations | |
|---|---|
| AD | Assistant Director |
| AMDD | Averting Maternal Deaths and Disabilities |
| CEmOC | Comprehensive emergency Obstetric Care |
| CHC | Community health centre |
| FIGO | Federation of International Gynecologists and Obstetricians |
| FOGSI | Federation of Obstetrics and Gynecological Societies of India |
| GAD | General Administrative Department |
| GNM | General Nursing and Midwifery |
| H &FW | Health and Family Welfare |
| ICM | International Confederation of Midwives |
| IIMA | Indian Institute of Management, Ahmedabad |
| INC | Indian Nursing Council |
| LR | Labor Room |
| MBBS | Bachelor of Medicine and Bachelor of Surgery |
| MCH | Maternal and child health |
| MIS | Management Information System |
| MoHW | Ministry of Health and Family Welfare |
| NPM | Nurse Practitioner in Midwifery |
| NRHM | National Rural Health Mission |
| ObGyn | Obstetrician and gynecologist |
| OPD | Out Patient Department |
| PHC | Primary health centre |
| PIP | Program Implementation Plan |
| PPH | Post Partum Hemorrhage |
| RCH | Reproductive and Child health |
| RM | Registered Midwife |
| RN | Registered Nurse |
| SBA | Skilled Birth Attendants |
| Sida | Swedish International Development Agency |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |

# Health policy processes in Gujarat: A case study of the policy for Independent Nurse Practitioners in Midwifery

## 1. INTRODUCTION

With nearly a quarter of the world's annual births, India has been categorized as having critical shortage of doctors, nurses and midwives (defined as countries which fail to attain the 80% coverage level) leading to lack of skilled birth attendance (WHO, 2006). According to census 2011, more than 70% of India's population lives in rural areas (GoI, 2011) while 75% of specialists and 85% of technology services are in the cities in the private sector (MoHFW, 2005). Only 10% clinicians are in the public health facilities. Human resources for basic and emergency childbirth services are unevenly distributed skewed towards urban areas.

The government of Gujarat has attempted to compensate for the shortage of human resources for maternal health through strategies such as; establishing public private partnerships through the Chiranjeevi Yojana a voucher scheme involving private obstetricians (Bhatt, et. al 2009), upgrading skills of medical officers with MBBS degree to perform C-sections and give anesthesia (Mavalankar et. al, 2009). Midwives are regarded as the primary service providers for childbirth (WHO, 2005), and there is evidence that historically midwives have contributed in reduction in maternal and newborn mortality (Loudon, 1992). Midwife led care has been found to be beneficial in many ways, is economical with no adverse effects (Hatem, et. al, 2009). Though staff nurses in India (nurse -midwives) have been providing childbirth services, they have not been considered a feasible alternative as human resources for childbirth services.

In India all nurses are by default a midwife too as midwifery is a small but mandatory section within the overall nursing curriculum. This is true for both the types of nursing programmes implemented in India; the 3.5 year diploma in general nursing and midwifery (GNM) and the 4 year Bachelor programme in nursing and midwifery offered at the university level. Graduate candidates of both these programmes get an automatic registration as Registered Nurse (RN) and Registered Midwife (RM). All RN and RM are posted as general nurses or staff nurses in hospitals and may be shifted from one department to another. The midwifery practice of staff nurses is not by choice but by chance and their scope of midwifery practice extends or restricts depending on circumstances (Sharma et al, 2012).

The International Confederation of Midwives (ICM) and WHO recommend at least 3 years of education for direct entry midwives, and 18 months for nurses training to be midwives (WHO, 2005). In addition the ICM has prepared a list of essential competencies for midwives into seven domains of care for the mother and the baby, from before the event of pregnancy to child care two months after birth (ICM, 2011).

By the standards of the duration of midwifery education and the long list of essential competencies, Indian staff nurses need further education to be a licensed midwife equivalent to the international standards. Gujarat has taken a step in creating a cadre of autonomous midwives for maternal and newborn health through a one year post graduate diploma since August 2009 called the "Nurse Practitioner in Midwifery (NPM)". This post graduate diploma in midwifery is a second such attempt in the country to create specialized midwives with advanced skills in maternal and newborn care. The West Bengal province had educated a few midwives sometime before the year 2005 but struggled to get them their due recognition as specialized professionals which happened only in 2010.

This paper is a documentation of the policy development and implementation process of the policy on NPM. This is important as NPM is not just about implementing a course but about creating/reviving a cadre of skilled, autonomous and accountable professionals for maternal and newborn care.

## 2. METHODS

The study used a mix of qualitative and quantitative data collection techniques to follow the policy processes. The participant observation technique in everyday setting was one of the methods. The authors were actors in the policy development process; being members of the multidisciplinary committee set up at the provincial level as an advisory body for the implementation of the policy. Detailed notes were taken by the first author of all informal interactions with the actors involved, and of the meetings held of the multidisciplinary committee. A timeline of important events during the preparation of the course and its implementation was maintained.

In addition in-depth interviews with the graduates of the first batch and with the course coordinators were carried out. The first batch of the 37 graduates were given a self administered questionnaire which consisted of information on their professional experience, their motivation for joining the course, their self assessment of the skills learnt during the course and their role in the current place of posting. The questionnaire was an adaptation of the tools available on the website of Averting Maternal Deaths and Disabilities (AMDD) given as annex-1a and b.

The field notes have been used to describe the chronology of events during policy development and implementation (Figure-1). Themes from both field notes and in depth interviews were constructed to understand policy processes using the conceptual framework described in the next section.

### Conceptual framework:

The conceptual framework developed as part of the project 'Health Policy in Vietnam, India and China (HEPVIC)' (Figure-1) (Green et. al, 2011) was used to document the policy processes of the NPM policy. As seen in figure-1, the framework for policy making contains four inter-related elements

- How policies are made (*processes*) with three stages: agenda setting, policy development and policy implementation (including evaluation)
- By whom policies are made (*actors*)
- What are the wider issues affecting health policies (*context*)
- What are the policy outputs, (*contents*)

The conceptual framework distinguishes two new elements to this*; the nature of the policy issue* which is related to the context, and *evidence*.

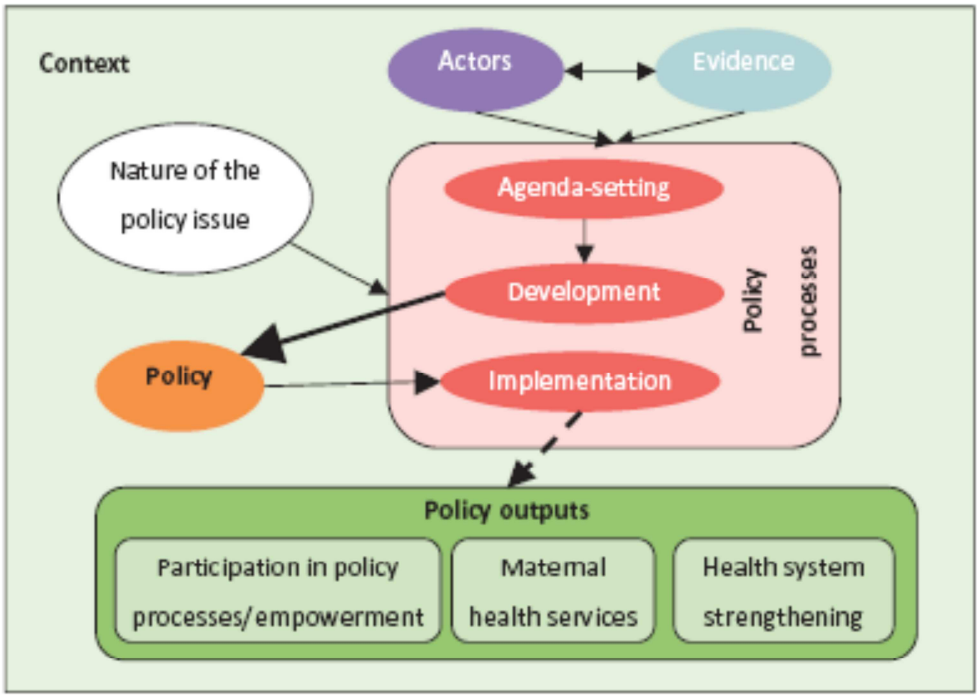



Figure-1: Conceptual framework for policy analysis

## 3. FINDINGS:

The results are presented in two sections. Section-1 is a brief description of the policy processes and section -2 presents the results from the survey of the first batch of graduates.

## Section-1 Policy processes

### 3.1 Stages of policy processes

The critical events and timeline of policy development and implementation from the year 2006 when the idea took birth to the present time are given as figure-2.

#### 3.1.1 Agenda setting:

The Swedish International Development Agency (Sida) supported a project for strengthening midwifery for maternal health in India from 2006 to 2009, under which a consortium for maternal health and midwifery consisting of Indian and Swedish institutions working on

maternal health and midwifery issues was constituted. As part of the project exposure visits were organized for key government programme officers and policy makers to Sweden to learn about the education and scope of practice of Swedish midwives and quality of midwifery based maternal and newborn services in the country. Sweden is haled as an example for a strong midwifery profession which led to rapid reduction in maternal mortality in the country historically (Loudon 1992). Midwives in Sweden are autonomous professionals having midwifery as an additional qualification after nursing. They are formally recognized as the primary care providers for maternal and newborn health, while obstetricians handle only complicated childbirth.

From Gujarat a state programme officer, a gynecologist by profession and a nursing officer, a nurse-midwife by profession went to Sweden in 2006. This exposure visit was a trigger to initiate The NPM policy (figure-2). Impressed by how midwives served as linchpins to the entire maternity care system in Sweden, the short report of the trip to Sweden submitted to the commissioner argued for creating a distinct "Nurse practitioner in midwifery".

### 3.1.2 Policy development

This led to "*starting a file*" in the government system to develop a separate cadre of midwives distinct from general staff nurses in Gujarat. The file was initiated on September 2006. This was before the Indian Nursing Council (INC) introduced the course for NPMs. This file had to pass through for approval from several desks and most importantly through the department of General Administrative Department (GAD) and finance.

It took more than a year to fully develop the proposal as it had two major parts although in the file it was a continuation from one to another; One was design the education of the specialized midwives, the admission eligibility, identifying sites for education for both theory and clinical practice, setting up infrastructure, criteria and qualifications for recruiting faculty and so on.

Learning from the experience of West Bengal, the second section of the proposal was concerned with creating 100 special dedicated positions for the nurse practitioners in midwifery with better salaries, and a career path to sustain the interest of these professional midwives. The Assistant Director nursing wanted to get approval for both the implementation of the course and the more difficult part of getting special posts sanctioned. Unfortunately this did not happen; the course was started much before any posts could be sanctioned.

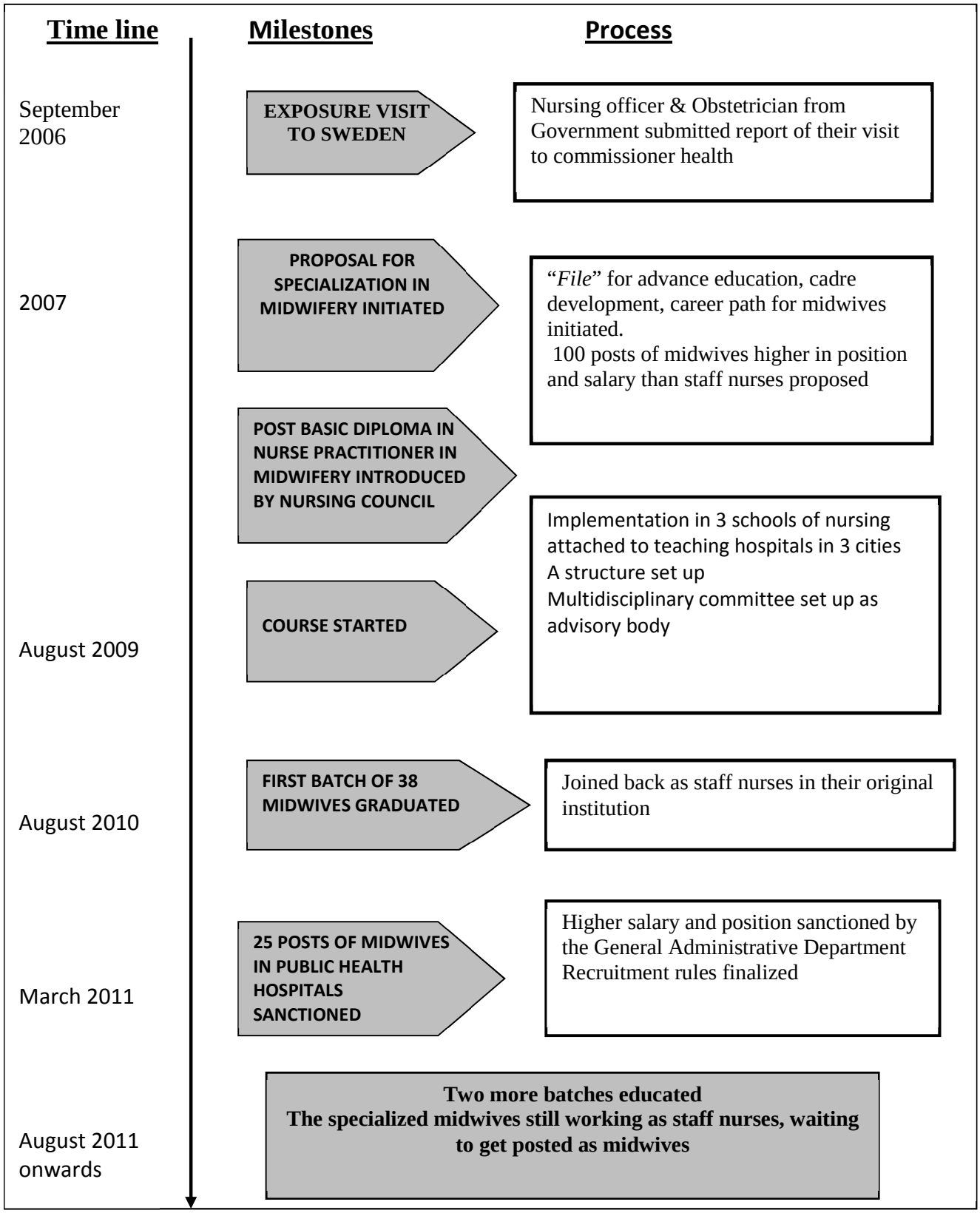
As seen in the figure-2, the approvals for only the course implementation took 2 years as the file went back and forth from the desk of the Assistant Director Nursing through the commissioner health to the secretariat. Each time a question was raised indicated as a noting on the file, it had to be answered by the AD nursing and sent back for further approval.

### 3.1.4 Implementation

#### a. Implementing the course

The course was initiated in three schools of nursing in August 2009. There were 20 seats each in schools aof nursing in Ahmedabad, Vadodara and Bhavnagar, almost three years after the idea for the policy was born. After the first batch of midwives graduated in 2010, three more centers were added in Rajkot, Jamnagar, and Surat. As Jamnagar had 30 seats, the province now has the capacity of130 seats for educating specialized midwives.

Figure-1: Policy development process and timeline for creating Independent Nurse Practitioner in Midwifery



In between this process of approvals the Indian Nursing Council also introduced a post basic diploma in midwifery in 2008, adding authenticity to the policy which helped in getting approval for the NPM course and also reduced the effort required in designing the course. The second important development was the setting up of a multidisciplinary committee with an advisory role in 2009, *"to guide the implementation of course as well as cadre and future plans"*. The committee consisted of senior heads looking after medical services and health, family welfare, and training, the senior state level nursing officers, the head of the Gynecology and obstetric department of the largest government tertiary care hospital, Principals of college of nursing, representatives from the Trained Nurses Association of India, the Society of midwives, the societies of gynecologists and obstetricians and the Indian Institute of Management. This committee has met four times since it was set up.

Since August 2009 till date three batches have graduated, 38 midwives in the first, 13 in the second and 28 in the third ongoing batch. Gujarat will by August 2012 have about 79 midwives educated in advanced midwifery skills. The advanced midwives of batch one and two have joined back as staff nurses at hospital of their last place of posting but majority have been shifted to the maternity sections. A circular has been issued to the heads of the hospital not to transfer these midwives to any other section.

**b. Implementation Structure**

The office of the health commissioner implements the course through the Assistant Director Nursing who reports to the Additional Director Medical Services. There is a course coordinator appointed for planning, monitoring and day to day administration. The multi-disciplinary committee plays an advisory role.

Each school of nursing selected for implementation has appointed a course coordinator under the principal of the school. There are three tutors appointed for classroom teaching. At the clinical site, there does not seem to be a set structure. The students work under the professors of ObGyn, Pediatrics and the matrons and sister-in-charge.

**c. Creating a cadre of midwives**

Though the proposal was to create 100 new posts, with great effort from the state officers of nursing and programme managers from the health commissioners' office, and through the involvement of the health ministers' office, the GAD sanctioned 25 new posts of midwives in the Community Health Centres (government hospital with 30 beds below the district), in March 2011. The staff nurses educated as NPMs will be given a position equivalent to Matron Class III, in the grade-1 with a pay scale of Rs. 9300-34300. They skip one position of Sister-in-charge in the promotional ladder and get a salary equal to the starting salary of a medical officer.

The government resolution for the new cadre of nurse practitioners in midwifery gives them the right to admit, refer and discharge the mother on their own discretion (Annex-2), they

have the right to run antenatal and postnatal clinics, prescribe basic laboratory tests, and medicine. The job description of NPMs describes their scope of practice (Annex-3).

Since the positions were at a higher level, the GAD rule required recruitment to fill the posts by merit made through a competitive examination. The recruitment rules were prepared and approved in April 2011. At present the file is with the GAD for approving the administrative details of the competitive examination.

**d. Steps still to be taken**

There are still important steps to be taken before the midwives can start autonomous practice. Once the details of the competitive examination are approved by GAD, the AD nursing will invite examiners, set an examination paper for a written examination; the merit list will be prepared from the examination results and sent back to GAD for approval. Only then will the 25 chosen midwives be posted to prove their mettle as midwives.

**3.2 Policy content**

The course is residential for one academic year with 42 weeks of integrated theory and practice and 4 weeks of internship in a CHC or a primary health centre (PHC- below the block with 6 beds). The 42 weeks have both theory and clinical practice in the teaching hospital as well as a district hospital. In the district hospital the student midwives get more opportunity to practice independently in a safe environment as the obstetrician is always on call. The nursing schools affiliated to hospitals which have enough caseloads (at least 500 births for every 10 student midwives) are certified by the Indian Nursing Council to run this course.

During clinical practice in the medical college hospital, the students were made to learn with the ObGyn resident doctors under the tutelage of a professor of Obstetrics and Gynecology and also a pediatrician. The student midwives attended theory classes with the resident doctors integrated with hands on experience held at the clinical site. As course requirement, the Indian Nursing Council recommends NPMs to perform at least 20 antenatal assessments, normal births and post natal assessments independently, and 10 episiotomies and suturing. Under complications they are required to perform artificial rupture of membranes, vacuum extraction, application of outlet forceps, breach delivery, vacuum extraction, manual removal of placenta and controlled cord traction. They perform prescription and administration of fluids intravenously, laboratory tests, Doppler assessment, and contraction stress test.

As a policy 60% of the seats are reserved for staff nurses who are permanent employees of the government, not more than 10% for male nurses interested in midwifery. If the remaining 40% seats open for other candidates are not occupied then they can also be give to government staff nurses. Staff nurses who are above 40 years, or working on contract, or are pregnant are not eligible for admission. For the 60% seats for government staff nurses, only those who apply with permission through their institution heads are accepted on deputation. The midwives who complete the course successfully have to sign a bond to work

as nurse practitioner in midwifery for at least five years in the government system that too two years in the rural areas or else pay a fine of Rs. 50,000. The total fee for the course is Rs. 26,000 for the independent candidates and Rs. 16000 for the staff nurses from the government.

### 3.3 Generating priority

#### 3.3.1 Developing right arguments and language

It was not possible to go through the '*file*' and analyze evidence used behind the various arguments put forth to justify developing a separate cadre of midwives. The insights shared in this section come from the in-depth interviews with actors involved, the participation in meetings by the authors, and the Government Resolutions shared with members of the multidisciplinary committee.

Gujarat has experimented with many innovations for improving maternal and child health. The Chiranjeevi scheme, a public private partnership initiative is an attempt to fill the gap for basic and comprehensive emergency obstetric care services for the poor (Bhatt et al, 2009). Under this scheme private obstetricians are enrolled and paid a fixed amount for childbirth services to women below poverty line. Gujarat has also experimented with task shifting in terms of training graduate physicians (medical officers) for performing C-sections and giving anesthesia (Mavalankar 2009).

Although nurses and auxiliary nurses are being given a short refresher training for skilled birth attendance, most of the alternative and innovative policies for human resource for maternal and child health have revolved around doctors. Internationally midwives are considered as the "primary and first level service providers" for maternal and newborn health (WHO 2005).

Developing advanced midwives and an independent cadre of midwives as even "an alternative" rather than primary first level providers did not occur naturally in Gujarat. This endeavor was/is fraught with challenges. The idea was and still is equally novel for the policy makers, and programme officers of the department of health, for the practicing obstetricians who at present lead the services for both normal and complicated childbirth. Accepting midwifery as a separate entity is novel for nurses themselves as they have considered midwifery within their professional umbrella since many decades. This is obvious by the fact that this course is termed as "Nurse practitioner in midwifery" making it as one of the specialization of nursing. The idea of a midwife taking over many of the tasks of an obstetrician or a physician met resistance from the obstetricians. Also extricating midwifery from the umbrella of nursing is not welcome by the nursing profession.

The NPM policy had to be worded in the right language and to be argued for several times. Arguments in this case were all in writing, as there were no presentations. Questions were asked in writing on the file back and forth. The report of the visit to Sweden was the beginning of the argument, a part of this policy file. In the report short term goals for

developing midwifery were listed such as; improving the access of services by creating an alternative cadre for maternal and child health as there was a shortage and skewed distribution of doctors in rural areas, improving the quality of services. Interestingly the report also included larger goals of professionalizing midwifery; of improving skills of midwives to offer wider range of services, of professional space and collaboration with obstetricians, of improving the image of nurses in the community and empowering women. The short term goals were explicit arguments used to justify the need for implementing the one year special course on midwifery. At the same time the arguments for professionalizing midwifery underpinned the proposals for cadre development, with better compensation and career avenues for the NPMs compared to staff nurses.

One of the nursing officers shared however that none of these arguments were good enough for the GAD. With repeated contact with the staff of the GAD, one of the staff guided the nursing officer to prepare justifications in monetary terms; arguments which would convince the financial benefit of creating a new cadre of midwives over the long run. For instance comparing the cost of training one obstetrician and one NPM with the possible output they will be able to give in remote rural areas was calculated and the cost of training one NPM was found to be much lesser.

### 3.3.2 Evidence used

As described earlier the evidence in the form of a trip report by two government officials to Sweden was the basis for initiating the policy. The final government resolution giving recognition to NPMs sent out by the Department of Health and Family Welfare however, largely drew parallels with ongoing national policies and innovative strategies already sanctioned by the GAD for maternal and child health in Gujarat.

The resolution endorsed the NPM cadre on the basis that they were registered nurses and registered midwives and in addition had undergone a one year special diploma in advanced midwifery skills. This course was approved by the Indian Nursing Council which is the top regulatory body for the nursing profession.

The special cadre of NPMs was projected as congruent with the ongoing National policy of Skilled Birth Attendants (SBA). The NPMs were projected as having skills included in the Government of India SBA guidelines. This added further credibility to the policy as the national SBA policy is based on International evidence (RCH PIP, 2005).

The resolution also drew parallels between the NPM policy and other ongoing human resource policies in Gujarat. The doctors trained in C-sections and anesthesia is seen as a solution to the unavailability of specialists in the remote rural areas. The justification of creating NPMs is also given as an alternative human resource for maternal and newborn health where obstetricians are hard to recruit.

It seems the existing knowledge from implementation of maternal and child health programmes was used as evidence for the policy. The shortage of human resource and the

perceived success of the CEmOC and anaesthesia training of MBBS doctors were enough justifications for creating NPMs. Though the evidence for the success of the CEmOC and anaesthesia training only comes from the Health Management Information System of the government. The actors involved in the policy used evidence which would help to get through the policy and appeal to the final decision makers.

### 3.4 The actors and their role

There were four levels of actors with different roles, involved in the process. Some actors were constant s and there were the "important others" (Table-1). The nursing cell in the health commissioner's office was the "fulcrum" at all stages of the policy process.

There were two levels of decision makers; the highest level, the ones who made the final decision was the minister's office, the Secretaries of health and the General Administrative Department. The second level of "intermediate decision makers" was the Commissioners of health and family welfare (H & FW) and the mission director of the National Rural Health Mission (NRHM). At the third level, the programme officers in the commissioners' office prepared the file (the policy proposal) in consultation with the commissioner who gave the first level approval and sent the file forward to the Secretariat and the minister for final approval. These actors were the "designers and planners" (table-1).

After the policy was approved, the teams at the schools of nursing "the executers" selected for implementation of the course, executed the one year NPM diploma. The "important others" as seen in table-1 were outside the government system; the national and state nursing councils who set a standard curriculum, regulated and certified the institutions as well as the graduates of the course. They gave authenticity to the policy. There was also the multidisciplinary committee and the IIMA who were sounding boards, advocators and propellers of the policy.

The role of each of these actors is weaved into the story of policy development described in the next section.

#### 3.4.1 Getting the file in

The most important task was to prepare a policy proposal or a file which was justifiable or convincing enough, and to "get it into the system". This was the policy development stage during 2006-07. The policy took birth in the minds of the MCH consultant and the Assistant Director Nursing-1 after they visited Sweden. The visit report prepared by the MCH consultant caught the attention of the Commissioner H & FW-1 who encouraged the AD nursing-1 and the consultant to prepare a detailed proposal for developing midwives with advanced competence. The visit report argued for advanced training as well as separate cadre of midwives.

The first AD nursing took over from here, and in consultation with the registrar of the Gujarat Nursing council and one of the Additional Directors developed a detailed proposal. Comfortable working relationships between the commissioner and the two programme

officers and also between the commissioner and the Secretary H & FW -1 made it easy to get the file in the system. Both these decision makers, the commissioner and the secretary were available for substantial time (2-3 years) during the initial stages of the policy which helped in active tracking, and pushing the file through the system, and providing satisfactory answers to the questions raised at each stage. This time was also enough to put in place the brass-tacks; proposal for cadre development, job descriptions of the NPMs, recruitment rules etc. Now the task remaining was to keep the file going and getting approvals.

### 3.4.2 Keep the file going

With time all the individuals in this team who were the driving force behind the policy, changed (annex-). New leaders brought in their own set of people transferring the old who were on deputation. The two new secretaries and commissioners took some time to understand the need for a special cadre of midwives with advanced skills when the state already had staff nurses attending normal childbirth. Therefore the follow up for approvals was delayed. The new AD nursing was not convinced herself about the need of advanced midwives. The "fulcrum" itself around which the policy was being developed lost its grip and weakened the process. There was also lack of experience and knowledge about the rules and regulations and how the file moves which led to incorrect unnecessary back and forth delaying the process.

The IIMA had worked closely with the nursing cell during the 3 years of the midwifery strengthening project; conducting research, coordinating exposure visits, conducting training programmes for nursing leaders. This relation with the nursing cell contributed to the policy processes. There was formal and informal exchange of information about the file location and predicting problems in order to prevent them. The IIMA wrote several letters to the new secretaries and commissioners congratulating Gujarat to be the first state in the country to develop advanced midwives and inquiring about the progress on the policy. The letters necessitated tracking the file in order to answer the questions raised in the letters. Through its letters the IIMA played the role of the "propeller" managing to bring the file back into priority in spite of frequent changes in leadership. The pressure was kept on by IIMA.

### 3.4.3 Preventing rejection of cadre

The GAD in somewhere around January 2011, called a meeting of the Secretary and the commissioner health with the nursing officers to discuss the proposed cadre development. None of these actors were the ones who had started the proposal but at that moment had to defend and argue for the need for specialized midwives.

Though the letter of the commissioner to IIMA stated that the GAD was positive, the programme officers who had attended the meeting shared concern with the IIMA team informally that judging from the response of the GAD during the meeting, they felt it will refuse to sanction the posts. They feared that they were not effective enough to convince the GAD of the merit in creating a cadre which the state would have to sustain with its own funds in the future.

Creating new positions is a difficult task at a time when the government was cutting administrative costs. Realizing this difficulty, the IIMA had involved the Minister of Health and his advisor. The advisor to the minister was known to the IIMA team which helped. He was convinced about the need for a special cadre of midwives. After several discussions with the nursing officers, he sent a note to the GAD through the health minister. It became difficult for the GAD to ignore the note of the minister and 25 posts out of 100 proposed were sanctioned in April 2011.

### 3.4.4 Ensuring clinical competence, getting around the obstetricians

The importance of adequate clinical skills was stressed during the first meeting of the multidisciplinary committee. The IIMA team carried out a quick evaluation of the three sites of implementation and provided feedback to the commissioner's office.

The course is being implemented in schools attached to the medical college hospitals where the education of obstetric students is given priority. Initially it was difficult to ensure adequate clinical practice of the midwifery students. As shared by one of the course coordinators, their students were not allowed to get hands on experience in the clinical sites.

Actors who were missing from the policy development process played a crucial role in ensuring quality of NPM education. The principals and course coordinators of the implementing schools had discussions and formal presentations with the heads of gynecology and obstetrics sharing the objectives of the course and seeking their cooperation. This was important as formal dialogue between the obstetricians and the schools of nursing is rare. At the same time the state nursing officers issued a circular from the commissioner to the heads of ObGyn to ensure the required clinical experience for midwife students.

Left out of the policy development process the MCH- consultant who had visited Sweden was back as a professor of ObGyn becoming active in policy implementation. With his help a system was set up first in the school at Ahmedabad, for clinical training and assessment of clinical skills of the NPM students. The students were allocated to the units of ObGyn with the students of obstetrics under the tutelage of a professor of ObGyn. This system was then implemented in the other two schools also.

The consultant also helped in overcoming the resistance from the ObGyn students who felt professionally threatened thinking the midwives will "take away all the normal work from us". This professional resistance was observed from the member of the Federation of Obstetrics and Gynecological Societies of India (FOGSI) who was a member of the multidisciplinary committee. He objected to creating dedicated posts of midwives "to be posted where there is no gynecologist available". With the support of the Ex MCH consultant and the head of ObGyn, the midwives could manage to step in the professional jurisdiction of the obstetricians.

| Table-1: Description of actors, and their role in the policy processes for developing Nurse Practitioners in Midwifery | | | | |
|---|---|---|---|---|
| **Type of actor** | **Actor name** | **Stage of policy process** | **Role** | **Effectiveness** |
| **LEVEL-1 Final decision makers** | | | | |
| Politicians/ governors | **2006 onwards**<br><br>Minister of Health, Gujarat &<br>Advisor to the minister of health | Policy formulation | The Advisor to minister of health was directly approached by IIMA for cadre development<br><br>GAD could not ignore as minister got directly involved to get 25 posts sanctioned in end of 2010. | Prevented rejection of proposal for a separate midwifery cadre |
| Administrative heads | Secretary H & FW-1 (2 ½ yrs) | Policy formulation | 1. Setting up of multidisciplinary committee<br>2. Appointed coordinator for NPM at nursing cell<br>3. Approval for course & cadre, pushing decision at higher level | Got the file into the system |
| | Secretary H & FW-2 (7 months)<br><br>Secretary H & FW-3 (current since 2 ½ yrs) | Policy formulation | Facilitation<br><br>Facilitated the process of cadre development and approval of Recruitment rules | Follow up |
| ***Approvers, Financers*** | General Administrative Department | Policy formulation | 1. Approved cadre of Nurse Practitioners in midwifery<br>2. Approved finance for new cadre -25 posts of midwives<br>3. Approved recruitment rules | |
| **LEVEL-2 Intermediate decision makers** | | | | |
| Administrative heads in the commissioner's | Commissioner H & FW-1 (3 yrs) | Policy formulation and | Supported and gave initial approvals for NPM course and cadre development.<br>**1.** The *file* was initiated | Got the file into the system |

| Table-1: Description of actors, and their role in the policy processes for developing Nurse Practitioners in Midwifery | | | | |
|---|---|---|---|---|
| **Type of actor** | **Actor name** | **Stage of policy process** | **Role** | **Effectiveness** |
| office | | implementation | **2.** Course started in 3 schools | |
| | Commissioner H & FW-2 (1 yr) Commissioner H & FW-3 (8 months) | Cadre development | Follow up of approval for process of recruitment (filling the 25 posts) | Follow up |
| | Mission Director, NRHM (current 2 yrs) | Cadre development | Follow up and support to the policy | Follow up |
| **LEVEL-3 Designers & planners** | | | | |
| Programme officers/ managers in the commissioners' office | 2006<br><br>MCH consultant commissioners' office at state level | Policy initiation & Execution of course | Triggered the policy through a report after trip to Sweden<br><br>Arranged for | Giving birth to policy<br>Overcoming resistance from obstetricians |
| | 2006- Mid 2010<br><br>Assistant Director Nursing-1 | Policy initiation & Execution of course | Was partner in triggering the policy and took over formulation and refining the policy; admission rules, job descriptions, career paths etc for NPM<br><br>Coordinated the initiation of the course in 3 schools | Giving birth and carrying it forward with passion |
| | Mid 2010- Mid 2012<br><br>Assistant Director Nursing-2 | Approval for recruitment rules | Got the course started in 3 more schools<br><br>Follow up and facilitation of getting posts sanctioned | Follow up |
| | Additional Director Medical Services & FW | | Supporting the movement of the file | Follow up |
| **LEVEL-4 Executers** | | | 1. | |
| Teams within institutions | Course coordinators, teams at school of nursing & clinical sites | Implementation | 2. Implementing the one yr course<br>3. Ensuring quality of clinical education | Managed to step in professional jurisdiction of obstetricians |
| **THE IMPORTANT OTHERS** | | | 1. | |
| Autonomous bodies | Indian Nursing Council | Formulation | 2. Designing and approving the course curriculum and technical requirements<br>3. Certifying the schools for course implementation | Gave authenticity |

| Table-1: Description of actors, and their role in the policy processes for developing Nurse Practitioners in Midwifery | | | | |
|---|---|---|---|---|
| **Type of actor** | **Actor name** | **Stage of policy process** | **Role** | **Effectiveness** |
| ***Regulators/ examiners*** | Gujarat Nursing Council | Design & implementation of course | 1. Assisting AD nursing in setting admission criteria, job descriptions, examination criteria<br>2. Certifying schools for course implementation | Gave authenticity |
| Advisory body<br><br>***Sounding board*** | Multidisciplinary committee | All stages | 1. Providing technical advise<br>2. Pressing for quality of education, job descriptions, scope of practice of NPMs | Kept the pressure on |
| Individuals representing organization<br><br>***Propellers*** | Indian Institute of Management, Ahmedabad | All stages | 1. Supported trips to Sweden which triggered the policy<br>2. Active follow up/ advocacy for expediting policy by regular letters to secretaries, com-missioners, minister of health<br>3. Mid evaluation of course implementation and feedback to government<br>4. Documentation of the policy process | Advocated as neutral party<br><br>kept the pressure on |

## Section-2: Policy evaluation

### The first batch of NPMs

The first batch of 38 Nurse Practitioners in Midwifery were given a self administered questionnaire, covering their personal and professional profile before the course, their change in role if any after the course, their self assessment of the knowledge and skills gained during the course and their suggestions to improve the course. The data was analyzed using Micorsoft Excel. The section-2 describes the results from the same.

### 3.5 Profile at entry and current posting

As seen in table-2, majority of the first batch of NPMs were between 30-45 years, the median age being 39 years. All of them had a diploma in general nursing and midwifery with no other specialization, except one who was trained as a Public Health Nurse waiting for promotion. Twenty two out of 38 (68%) had more than 10 years of total work experience as staff nurses in clinical settings. Most of them were married with children.

**Table-2: Age distribution of the first batch of the NPMs**

| | 28-30 | 31-35 | 36-40 | 41-45 | 46-50 | Total |
|---|---|---|---|---|---|---|
| Ahmedabad | 1 | 3 | 5 | 4 | | 13 |
| Bhavnagar | | 3 | 4 | 3 | | 10 |
| Vadodara | 1 | 1 | 8 | 3 | 2 | 15 |
| **Total** | **2** | **7** | **17** | **10** | **2** | **38** |

As seen in table-3 Fourteen (37%) out of 38 candidates came from medical college hospitals which are essentially located in cities and are training sites for all medical as well as nursing students. Thirteen (36%) came from district hospitals which are located in towns. Only 9 participants (24%) came from CHCs and Sub-district hospitals which can be considered more rural.

**Table-3: Place of posting of the candidates before the course**

| | Ahmedabad | Vadodara | Bhavnagar | Total |
|---|---|---|---|---|
| Teaching Hospital | 5 | 8 | 1 | 14(37%) |
| District Hospital | 3 | 5 | 5 | 13 (34%) |
| Sub District Hospital | 1 | 2 | - | 3 (8%) |
| Community Health Centre | 3 | - | 3 | 6 (14%) |
| Self financed | 1 | 1 | - | 2 (5%) |
| Total | 13 | 16 | 9 | 38 |

Therefore more than 70% of the participants have been working and are settled in urban areas. This is significant as at the time of admission they have signed a bond to work in rural centres for at least two years which might be difficult for these candidates. At present, most of them have been posted back to the same hospitals after passing out.

Half of the participants (19) have been posted in the maternal and child health sections in their current posting (Table-4). They exclusively look after or assist in the services in the obstetric OPD, the labour room and post natal wards. Twelve (31.5%) participants have been given additional duties with maternal and child health, such as the general operation theatre, or the other indoor patient wards. Six (16%) of the participants have been given general duties as staff nurses just as before the training.

Table-4. Role assigned at current health facility

| **Role assigned at workplace** | **Frequency** |
|---|---|
| General nursing duties | 6 |
| MCH+Other duties (pediatric wards, general wards, OT) | 12 |
| Clinical Teaching | 1 |
| MCH (LR, postnatal wards, obstetric OPD) | 19 |
| **Total** | **38** |

### 3.6 Quality of training

#### 3.6.1 Clinical experience

The Indian Nursing Council has recommended performing 20 normal births with no specifications for complicated births as requirement for the NPMs. Gujarat made it mandatory for all the participants to perform at least 50 normal births with no specifications for complicated births. As seen in table-5, all except one participant were able to perform 50 or more than 50 normal births, 15 of them reported performing more than 90 and 8 more than 100 normal births during their training.

Table-5: Number of normal deliveries performed during training by training centre

| **Training centre** | **<50** | **50-70** | **71-90** | **91-100** | **100-150** | **Do not remember** | **Total** |
|---|---|---|---|---|---|---|---|
| Ahmedabad | | 7 | 4 | | 2 | | 13 |
| Bhavnagar | | 1 | 2 | 4 | 3 | | 10 |
| Vadodara | 1 | 6 | 1 | 3 | 3 | 1 | 15 |
| **Grand Total** | **1** | **14** | **7** | **7** | **8** | **1** | **38** |

As reported by the participants, differences can be seen between centres in the number of complicated deliveries performed. Out of 38 participants 16 reported performing more than 10 complicated births, 4 of them more than 20. Four out of 15 participants from the Vadodara training centre did not perform any complicated births, and 2 could perform less than 5. The Ahmedabad centre was inconsistent as 5 out of its 13 participants performed less than 5 complicated deliveries. The Bhavnagar training centre was able to ensure that all 10 participants could perform more than 5 complicated deliveries

### 3.6.2 Clinical supervisor during internship

The NPM students went for a two month internship to a community health centre or a Primary health centre as part of course requirement. During internship they were required to practice autonomously under supervision. It is not specified who should be the supervisor. Internship is supposed to be a continuation of their education. As seen in Table-6, fifty percent of the NPMs were supervised by a medical officer or an obstetrician, 15% by others which is not specified and about 24% were not supervised at all.

**Table-6: Supervision during internship**

| | **Staff nurse** | **Medical Officer** | **Staff Nurse & Medical Officer** | **Obstetrician** | **Others** | **Nobody** | **Total** |
|---|---|---|---|---|---|---|---|
| Ahmedabad | 0 | 3 | 0 | 3 | 2 | 5 | 13 |
| Bhavnagar | 0 | 3 | 0 | 2 | 3 | 2 | 10 |
| Vadodara | 2 | 5 | 2 | 3 | 1 | 2 | 15 |
| **Total** | **2** | **11** | **2** | **8** | **6** | **9** | **38** |

### 3.6.3. Perceptions about quality of education

The participants of the first batch were asked three questions about their opinions rated on a six point liekart scale about the quality of education they received in the NPM programme; general opinion about quality of education, whether it has changed the way they practice and its adequacy for the tasks they are required to perform (tables 7,8 and 9).

**Table-7: The education received in general has been of a high quality**

| **Training centre** | Agree | Strongly agree | Disagree | Strongly disagree | Neither agree nor disagree | No response | **Total** |
|---|---|---|---|---|---|---|---|
| **Ahmedabad** | 4 | 1 | 0 | 1 | 7 | 0 | 13 |
| **Bhavnagar** | 2 | 3 | 0 | 1 | 4 | 0 | 10 |
| **Vadodara** | 11 | 0 | 1 | 0 | 2 | 1 | 15 |
| **Total** | **17 (45%)** | **4(10.5%)** | **1(2.6%)** | **2 (5.2%)** | **13 (34%)** | **1 (2.6%)** | **38** |

The course was rated as high quality by more than half of the participants (21); 45% agreed and 10.5% strongly agreed that the course was of high quality (table-7), and one third (34%) were undecided. Three out of 38 participants thought the course was not of high quality. But as seen in table-8, majority 85% were of the opinion that the NPM education programme had changed or improved their midwifery practice

**Table-8:The education has improved or changed practice**

| Training centre | Agree | Strongly agree | Disagree | Strongly disagree | Neither agree nor disagree | **Total** |
|---|---|---|---|---|---|---|
| Ahmedabad | 4 | 7 | 0 | 2 | 0 | 13 |
| Bhavnagar | 3 | 6 | 1 | 0 | 0 | 10 |
| Vadodara | 8 | 4 | 1 | 0 | 2 | 15 |
| **Total** | **15 (40%)** | **17 (45%)** | **2 (5%)** | **2 (5%)** | **2 (5%)** | **38** |

More than half of the participants (53%) felt they needed more education as they were undecided about the adequacy of programme to cover everything they needed at their work situations as midwives (table-9). There were more participants from the Ahmedabad centre who were undecided. The participants from the Vadodara centre were the most satisfied with the adequacy of the programme to have covered the required competencies.

**Table-9: The education was adequate for tasks to be performed**

| | **Agree** | **strongly agree** | **Disagree** | **Strongly disagree** | **Neither agree nor disagree** | **Total** |
|---|---|---|---|---|---|---|
| **Ahmedabad** | 3 | 1 | 0 | 0 | 9 | 13 |
| **Bhavnagar** | 4 | 2 | 0 | 0 | 4 | 10 |
| **Vadodara** | 7 | 0 | 1 | 0 | 7 | 15 |
| **Total** | **14 (37%)** | **3 (8%)** | **1(2.6%)** | **0** | **20 (53%)** | **38** |

The participants were asked to give feedback and suggestions for improving the course implementation. Ten participants thought the tutors for the course should be more competent in midwifery, and suggested that the tutors should participate more during the clinical experience of students. Some suggested that the tutors should attend all practical sessions so that their skills in midwifery improve. Twelve participants suggested that all the practical education should be by doctors.

Many thought that the duration of the training should be more than a year. They were of the opinion that the theory in the course curriculum should be reduced giving more time to hands on experience.

Twenty one of the participants mentioned the need for a separate identity as midwives, with a clear job description and scope of practice, and better compensation compared to staff nurses.

### 3.7 Competence and practice of skills

All except one participant expressed that the NPM education had improved their overall confidence in performing normal childbirth and handling first level complications. They were asked to assess themselves on key skills of normal childbirth and first level complications (tables-10, 11).

**Table-10: Self assessment by participants skills, confidence and practice for managing normal childbirth**

| Skill | Whether learnt in NPM | | Whether confident | | Whether practice | |
|---|---|---|---|---|---|---|
| | Number | % | Number | (%) | Number | (%) |
| 1. Assess progress of labour | 38 | 100 | 38 | 100 | 30 | 79 |
| 2. Use partograph to monitor labour | **34** | **89** | **31** | **82** | **10** | **26** |
| 3. Manage normal labour & childbirth | 38 | 100 | 35 | 92 | 30 | 79 |
| 4. Perform active management of 3rd stage of labour | 38 | 100 | 36 | 95 | 31 | 82 |
| 5. Routine newborn care | 37 | 97 | 37 | 97 | 37 | 97 |

For each skill the participants were asked to respond to whether they learnt the skill during NPM programme, whether they are practicing the skill in their current workplace and whether they felt confident in practicing the skill.

As seen in table -10, eight participants reported that they did not manage normal childbirth in their work settings as many were given other routine nursing duties.

| Table-11: Self assessment by participants of skills, confidence and practice for managing first level complications | | | | | | |
|---|---|---|---|---|---|---|
| **Skill** | **Whether learnt in NPM** | | **Whether confident** | | **Whether practice** | |
| | Number | % | Number | % | Number | % |
| 1. Make and repair episiotomy | 35 | 92 | 31 | 82 | 27 | 71 |
| 2. Newborn resuscitation | 36 | 95 | 35 | 92 | 24 | 63 |
| 3. Recognize antepartum hemorraghe | 37 | 97 | 31 | 82 | 18 | 47 |
| 4. Recognize post partum hemorraghe | 38 | 100 | 31 | 82 | 22 | 58 |
| 5. Administer parenteral uterotonics for PPH | 35 | 92 | 31 | 82 | 27 | 71 |
| 6. Administer magnesium sulfate -eclampsia/pre-eclampsia | 37 | 97 | 18 | 47 | 17 | 45 |
| 7. Manage HIV-positive woman in pregnancy | 37 | 97 | 30 | 79 | 20 | 53 |
| 8. Recognize antepartum sepsis | 35 | 92 | 27 | 71 | 17 | 45 |
| 9. Recognize post partum sepsis | 35 | 92 | 27 | 71 | 17 | 45 |
| 10. Administer parenteral antibiotics | 34 | 89 | 30 | 79 | 25 | 66 |
| 11. Manual removal of placenta | 30 | 79 | 24 | 63 | 19 | 50 |
| 12. Repair cervical/vaginal tears | 31 | 82 | 26 | 68 | 14 | 37 |
| 13. Curettage of retained products | 27 | 71 | 14 | 37 | 10 | 26 |
| 14. Vacuum delivery | 22 | 58 | 11 | 29 | 5 | 13 |
| 15. Forcep delivery | 23 | 61 | 7 | 18 | 4 | 11 |
| 16. Manage malaria in pregnancy | 25 | 66 | 19 | 50 | 10 | 26 |
| 17. Vacuum aspiration of retained products | 14 | 37 | 8 | 21 | 5 | 13 |

More than 90% of the NPMs were confident in most of the skills required for normal labour. Though majority of the participants reported learning using the partograph to monitor the progress of labour, out of 38, only 10 (26%) reported using the partograph. Almost all learnt the active management of 3rd stage of labour, and 31 reported performing the same.

The competence to manage first level complications is arguably the basic difference between the staff nurses who also perform normal childbirth and the NPMs. This one year course is supposed to develop this competence. As seen in table-11, the participants assessed themselves on 17 skills for first level complications. The cells highlighted as green are skills reported by 80-100% of the participants, the yellow cells are for skills reported by 60-79% of the participants and skills reported by less than 60% are highlighted as red. The cells marked in red and yellow show substantial gap in learning the skills, gaining confidence or practicing the skill in the work situation.

The NPM programme did not adequately cover 6 skills out of the 17 listed in the table. The skills in vacuum delivery and vacuum aspiration of retained products were not learnt by almost 40% of the participants (cells marked in red). Similarly between 40-20% did not learn skills of manual removal of placenta, curettage of retained products, and managing malaria during pregnancy.

Though the programme seemed to have covered most of the skills, the participants could gain confidence in only the first five listed skills; Make and repair episiotomy, Newborn resuscitation, Recognize antepartum and post partum hemorrhage, and administer parenteral uterotonics for PPH. Less than 60% participants reported being confident in administering magnesium sulphate for eclampsia and pre-eclampsia, performing forcep and vacuum delivery, vacuum aspiration of retained products and managing malaria during pregnancy.

Most of the cells in the columns of “practice” are red or yellow indicating that very few participants practiced even the skills they had gained confidence in.

| Table-12: Scope of practice of the NPMs in their current place of posting | | | | | | |
|---|---|---|---|---|---|---|
| | **Do not perform** | **Direct orders** | **Own decision** | **SOP** | **No response** | **Total** |
| Administer parenteral (intravenous or injection) uterotonics for PPH | 1 | 29 | 7 | 1 | 0 | 38 |
| Perform active management of 3rd stage of labour | 6 | 14 | 16 | 2 | 0 | 38 |
| Administer intravenous fluids | 0 | 31 | 7 | 0 | 0 | 38 |
| Administer magnesium sulfate for the management of eclampsia/pre-eclampsia | 4 | 29 | 3 | 1 | 1 | 38 |
| Perform manual removal of placenta | 18 | 8 | 9 | 2 | 1 | 38 |
| Administer blood transfusion | 16 | 21 | 1 | 0 | 0 | 38 |
| Perform Vacuum delivery | 26 | 7 | 2 | 1 | 2 | 38 |
| Perform curettage for retained products | 24 | 9 | 3 | 0 | 2 | 38 |
| Perform forcep delivery | 27 | 9 | 1 | 0 | 1 | 38 |

Though in table-11, the participants have reported practicing only episiotomies, and giving intravenous injections and drugs for PPH, and infection, they seem to be performing many skills as direct orders of the doctor (Table-12).

Managing 3$^{rd}$ stage of labour has been reported as an own independent decision by 16 (42%). Direct orders were most often given for administering IV injections and fluids, magnesium sulphate, and blood transfusion. Performing manual removal of placenta, and blood transfusion are skills often performed under direct orders. Performing vacuum delivery, forcep delivery and curettage for retained products is clearly out of the scope of practice of the NPMs who are still working as staff nurses. These procedures have been included in the curriculum of NPMs by the INC and also in the Job Descriptions for NPMs developed by the Government of Gujarat.

### 3.8 Opportunities to utilize competence

The participants have gone back as staff nurses to their health facilities in spite of learning new skills. Therefore the support of the heads of the health facilities and other supervisors becomes important.

Though majority (34) of the participants felt their supervisors appreciate their new skills, and they have got recognition (table-13), a lesser number (23) thought their supervisors were supportive of their practice, 5 felt the supervisors were unsupportive and 10 were

undecided. The obstetrician and matron of a district hospital where two of the NPMs are posted were appreciative of their services. The obstetrician said the NPMs deal with normal and complicated childbirth cases competently. He is now free to attend to other gynecological problems and complicated childbirth.

The NPMs discussed the difficulties they face with their peers, the other staff nurses posted in labour rooms. Since the NPMs are still general staff nurses by designation in spite of higher competence their burden increases as, possibly because of professional rivalry many times the other staff nurses do not cooperate. Since the NPMs get more recognition from doctors, the other staff nurses leave everything on them. They manage the labour room as well as attend cases.

The table-13 further shows that all except one participant felt their services as midwives was accepted by the mothers. It did not take long for the people to know and start utilizing the services of the midwives during their one month internship. One of the NPMs held meetings with the grassroots volunteers and health workers and the staff of the emergency ambulance service 108 to give across a message to women in need about the services of a new midwife in the government hospital. The number of births in that hospital increased substantially in just a few weeks.

**Table-13: Support for supervisors in the current work setting and acceptance by mothers**

| | Agree | Strongly agree | Disagree | Strongly Disagree | Neither agree nor disagree | Total |
|---|---|---|---|---|---|---|
| **Supportive supervisors** | 14 | 9 | 3 | 2 | 10 | **38** |
| **Supervisors appreciate new skills** | 18 | 16 | 2 | 0 | 2 | **38** |
| **Acceptance of mothers** | 14 | 22 | 0 | 1 | 1 | **38** |

Eleven of the participants did not mention any infrastructure and supply related constraints in their workplace but the rest constraints in supplies of gloves, linen, and medicines. They also mentioned difficulties because of less equipment such as the baby warmers, forceps, cord clamps etc.

## 4. DISCUSSION AND RECOMMENDATIONS

### 4.1 NPM as compared to International midwifery

The NPM programme is a good initiative taken by the government of Gujarat for developing midwifery led maternal and newborn care services. For autonomous practice these NPMs will be given the authority to admit, refer and discharge on their own responsibility. Since the NPMs are nurses with 6 months of midwifery education and some experience, this one year programme is comparable to the international recommendations of WHO and the

International Confederation of Midwives (ICM); 18 months of midwifery education for nurses and 3 years for direct entry midwives (WHO, 2005).

The NPMs are Skilled Birth Attendants according to the definition of SBAs (WHO, FIGO, ICM, 2004); to be able to take responsibility of normal childbirth and recognize and deal with first level complications before referral.

The knowledge and skills listed in the NPM curriculum (INC, 2008) cover majority of the knowledge and skills covered in the list of essential competencies given by the ICM (ICM, 2005). Performing medical abortions, and some knowledge areas of epidemiology and public health, other social sciences is partially missing from the NPM programme. What is also missing is the discourse on the unique features of midwifery led care as put forth by the ICM and as understood in many countries where midwifery led maternal and newborn care is institutionalized. The features of "women centered" care, "empowerment of women" are missing from the NPM programme.

**4.2 NPMs in the context of Gujarat**

The winning argument for getting the policy of NPM through was that they were positioned as an alternative for the unavailability of obstetricians in remote rural health facilities. However since the admission to the NPM programme was through advertisement, 73% of the participants of the first batch are from urban areas, big cities or towns in Gujarat. Majority are senior with more than 10 years of experience, married with children in schools. Just like it is difficult for doctors to live in rural areas, it might be difficult for these women to shift base even temporarily from cities to rural areas.

Some NPMs of the first batch said they are prepared to complete their two year bond period to serve in rural areas but request the government to give them posting in a Community Health Centre near the city they live in currently. There are several CHCs without obstetricians located in relatively urban settings which would benefit from the services of NPMs. When the recruitment of the NPMs begins it should be negotiable so that both the NPMs and the government can benefit. The NPMs need to be psychologically relaxed from their family front to be able to show results of their midwifery practice on quality of maternal and newborn services.

Under the INC Act, it is unclear whether a midwife is an independent practitioner like doctors. The NPMs are Independent practitioners and will have the authority to admit, refer and discharge mothers on their own decision; they still cannot declare a death. So it is unclear whether they have full statutory right to practice outside the government system. They still feel taking responsibility is risky.

The Government also needs to differentiate the roles of the NPMs and the other staff nurses posted in the labour rooms. It should be clear that if the NPMs are incharge of childbirth services in the CHC, the staff nurses posted in the labour room should formally

recognize them as their reporting officers. Since the NPM will not be able to manage childbirth single handedly clear communication and reporting systems have to be developed for better team work.

The government should develop a system of support through close monitoring for NPMs. Since this is a unique initiative for developing alternate human resources who are also skilled birth attendants it is like a demonstration pilot project. There is a need for detailed documentation MIS to show results.

**4.3 Competence and autonomy**

Overall the first batch perceives that the NPM programme is of good quality; it has made them confident as midwives, and improved their midwifery practice. Except for the skill of monitoring the progress of labour using a partograph, more than 90% of them are confident and are practicing basic skills required for performing normal childbirth. There are still about 18 to 20% who donot perform childbirth as they are given general nursing duties.

However the same is not true for basic skills in dealing with first level complications. The NPM programme does not provide skills in vacuum delivery, and vacuum aspiration of retained products to more than half of the first batch of NPMs. About 30-40% reported the training was weak in learning manual removal of placenta, curettage of retained products, forcep delivery and managing malaria in pregnancy. Only about one fourth reported practicing these skills in their current workplace. More than half also feel they are not confident in administering magnesium sulphate for eclampsia and pre-eclampsia, while 30-40% feel they need to gain more confidence in recognizing sepsis, repairing vaginal tears, and administering parental antibiotics.

Since by job description and designation they are general staff nurses, most of the procedures for first level complications are by direct order of the doctor, it is not a part of standard operating procedure or the midwives cannot take autonomous decision. Moreover procedures such as management of 3$^{rd}$ stage of labour which is a part of normal childbirth, still requires direct orders of the doctor as reported by majority of the respondents.

Therefore the NPM programme needs to emphasize more hands on practice for dealing with first level complications before demanding autonomy of practice. Both these should go hand in hand as some skills remain uncovered in the programme and on the other hand there is a strong possibility of loss of skill as the NPMs do not have the autonomy of practice. Ensuring the competence of NPMs in the full range of services of performing normal birth and dealing with first level complications is extremely important since the 25 posts sanctioned are for CHCs where obstetricians are not available.

With autonomy the NPMs will have to take responsibility of the life of the mother and the baby. Therefore it would be more appropriate that before giving them posting for

autonomous practice they practice for initial 3-6 months in a safe environment where an obstetrician is on call. The government will also have to ensure efficient referral support for all 25 NPMs when they start their autonomous practice.

The feedback of the first batch clearly emphasizes the need to appoint midwifery faculty who are competent in clinical skills. The tutors of NPMs should also have their clinical practice as the professors of Obstetric and gynecology do. The NPMs are demanding more clinical hours under the tutelage of professors of obstetrics, but also want the presence and guidance of their tutors during hands on practice.

**4.4 Understanding policy processes**

Policy making in the case of nurse practitioner in midwifery was getting the file in the system, tracking and pushing it and keeping it alive. It is a complex process involving many departments at several levels from the huge government bureaucracy. There was very less face to face dialogue or representations and presentations which slowed the policy development process. It was difficult to convince people only using the written word.

Several actors at the positions important for decision making changed within the government from 2006 when the policy was initiated to the present time. The policy changed into hands of three Secretaries and four commissioners of health. There was also a change in the nursing leadership the progenitor and thereafter nurturer of the policy, the most important actor to work through all the bottlenecks. With frequent change in leadership the momentum and fervor for maternal health, and more so for the need to develop midwives with advanced skills, wavered. Each time the leadership changed, new individuals needed to be convinced for making efforts for follow-up. The policy champions were not consistent.

Since the policy process was depended on a few “policy champions” driven by individuals with the government state machinery, the change in individuals, their personality, working styles, attitudes had knowledge all influenced the process. There was lack of knowledge of rules and regulations within the government system especially of those just joining. There was no document describing the limits of decision making at each level of bureaucracy to be able to maneuver the ‘file’ without much trial and error, neither was there an orientation about it.

The professional images of the actors created mindsets which affected the policy processes. The fulcrum of the policy was the nursing cell which is one of the weak sections in the commissioner’s office (Bagga et al 2010) who by virtue of the policy issue had to take leadership. It is not a part of the culture to consult the nursing cell on policy matters, even though the matter may be related to the huge body of staff nurses. This set behavior pattern was hard to break. Though there was a passion to get it through in the beginning there was hesitance and tentativeness when the leadership changed.

Informal working relationships between the actors within the government and with the outside actors, were used and sometimes were more influential. Apart from the formal file whatever worked was used by the actors. Anecdotal evidence brought in by actors who were trusted by the decision makers in the form of trip reports was found enough to go ahead with the new NPM policy. This evidence was put against the knowledge about lack of human resource for maternal health in the remote rural areas which provided justification for the policy.

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**ANNEX-1a**

## Centre for management of health services
## Indian Institute of management, Ahmedabad

### FOLLOWUP OF THE INDEPENDENT NURSE PRACTITIONERS[1]

### TOOL-2: REPORT ON TRAINING OF NPM

Please tick the name of your centre where you received NPM training:

Ahmedabad ☐ Vadodara ☐ Bhavanagar ☐

| | | *Have you ever received formal training in this skill? - during pre-service or in-service courses.* *Please circle **Y** for Yes and **N** for No* | | *Have you performed the following skills in the last three months?* *Please Circle **Y** for Yes and **N** for No* | | | ***Do you feel confident performing this skill?*** *(tick the box)* | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **Y** | **N** | **Y** | **If Y how many** | **N** | **Yes** | **Some what** | **No** |
| ***Labour and Delivery*** | | | | | | | | | |
| 1 | Assess the foetal position | **Y** | **N** | **Y** | | **N** | | | |
| 2 | Assess progress of labour | **Y** | **N** | **Y** | | **N** | | | |
| 3 | Use a partograph to monitor labour | **Y** | **N** | **Y** | | **N** | | | |
| 4 | Manage normal labour and delivery | **Y** | **N** | **Y** | | **N** | | | |

[1] ADAPTED FROM THE AMDD- HEALTH SYSTEMS STRENTHENING SURVEY TOOL

| | | *Have you ever received formal training in this skill? - during pre-service or in-service courses.*<br><br>*Please circle **Y** for Yes and **N** for No* | | *Have you performed the following skills in the last three months?*<br><br>*Please Circle **Y** for Yes and **N** for No* | | | ***Do you feel confident performing this skill?*** *(tick the box)* | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **Y** | **N** | **Y** | **If Y how many** | **N** | **Yes** | **Some what** | **No** |
| 5 | Administer intravenous fluids | **Y** | **N** | **Y** | | **N** | | | |
| 6 | Perform active management of third stage labour: i.e. Administer uterotonic and uterine massage and controlled cord traction | **Y** | **N** | **Y** | | **N** | | | |
| ***Procedures for Newborn Care*** | | | | | | | | | |
| 7 | Perform routine newborn care | **Y** | **N** | **Y** | | **N** | | | |
| 8 | Perform newborn resuscitation with bag and mask | **Y** | **N** | **Y** | | **N** | | | |
| ***Bleeding in Pregnancy*** | | | | | | | | | |
| 9 | Recognize antepartum hemorrhage | **Y** | **N** | **Y** | | **N** | | | |
| 10 | Recognize postpartum hemorrhage | **Y** | **N** | **Y** | | **N** | | | |
| 11 | Perform vacuum aspiration for retained products (with electric suction/ vacuum) | **Y** | **N** | **Y** | | **N** | | | |
| 12 | Perform vacuum aspiration for retained products (with manual suction/vacuum) | **Y** | | **Y** | | **N** | | | |
| 13 | Perform curettage for retained products | **Y** | | **Y** | | **N** | | | |
| 14 | Administer parenteral (intravenous or injection) uterotonics for post-partum hemorrhage | **Y** | **N** | **Y** | | **N** | | | |
| 15 | Repair vaginal or cervical tears | **Y** | **N** | **Y** | | **N** | | | |

| | | *Have you ever received formal training in this skill? - during pre-service or in-service courses.*<br><br>*Please circle **Y** for Yes and **N** for No* | | *Have you performed the following skills in the last three months?*<br><br>*Please Circle **Y** for Yes and **N** for No* | | | ***Do you feel confident performing this skill?*** *(tick the box)* | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **Y** | **N** | **Y** | **If Y how many** | **N** | **Yes** | **Some what** | **No** |
| 16 | Administer blood transfusion | **Y** | **N** | **Y** | | **N** | | | |
| ***High Blood Pressure Problems*** | | | | | | | | | |
| 17 | Recognize preeclampsia | **Y** | **N** | **Y** | | **N** | | | |
| 18 | Recognize eclampsia | **Y** | **N** | **Y** | | **N** | | | |
| 19 | Administer magnesium sulfate for the management of eclampsia/ pre-eclampsia | **Y** | **N** | **Y** | | **N** | | | |
| 20 | Administer other anticonvulsants for the management of eclampsia/ preeclampsia | **Y** | **N** | **Y** | | **N** | | | |
| ***Infection in Pregnancy, Labour and After Delivery*** | | | | | | | | | |
| 21 | Recognize antepartum sepsis (amnionitis) | **Y** | **N** | **Y** | | **N** | | | |
| 22 | Recognize postpartum sepsis (endometritis) | **Y** | **N** | **Y** | | **N** | | | |
| 23 | Administer parenteral (intravenous or injection) antibiotics | **Y** | **N** | **Y** | | **N** | | | |
| ***Complicated Delivery*** | | | | | | | | | |
| 24 | Perform a forceps delivery | **Y** | **N** | **Y** | | **N** | | | |
| 25 | Perform a vacuum delivery | **Y** | **N** | **Y** | | **N** | | | |

| | | *Have you ever received formal training in this skill? - during pre-service or in-service courses.*<br><br>*Please circle **Y** for Yes and **N** for No* | | *Have you performed the following skills in the last three months?*<br><br>*Please Circle **Y** for Yes and **N** for No* | | | ***Do you feel confident performing this skill?*** *(tick the box)* | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **Y** | **N** | **Y** | **If Y how many** | **N** | **Yes** | **Some what** | **No** |
| 26 | Make and repair an episiotomy | **Y** | **N** | **Y** | | **N** | | | |
| 27 | Perform a craniotomy | **Y** | **N** | **Y** | | **N** | | | |
| 28 | Perform manual removal of placenta | **Y** | **N** | **Y** | | **N** | | | |
| ***Other Conditions Affecting Labour and Delivery*** | | | | | | | | | |
| 29 | Manage malaria in pregnancy | **Y** | **N** | **Y** | | **N** | | | |
| 30 | Manage an HIV-positive pregnant woman during labour and delivery | **Y** | **N** | **Y** | | **N** | | | |
| 31 | Provide PMTCT regimen to mother and newborn | **Y** | **N** | **Y** | | **N** | | | |

| | | |
|---|---|---|
| 32 | During your training as independent nurse practitioner in midwifery, how many normal deliveries did you perform? | _____ normal deliveries |
| 33 | During your training, how many complicated deliveries did you perform (approximately)? | _____complicated deliveries<br><br>*Write NR, if you do not remember the number* |

| | | |
|---|---|---|
| 34 | For your internship, what type of facility were you posted/assigned to? | 2. District Hospital<br>3.Community health centre<br>4. Primary health centre<br>4. Other _____ |
| 35 | Was there an experienced obstetrician/midwife at this facility who provided supervision and training in deliveries to you? | 1. Yes<br>0. No |
| 36 | If yes, what clinical qualifications did this person have? | 1. Obstetrician<br>2. Registered nurse and midwife<br>3. General Doctor<br>4. Clinical Officer<br>5. Other Specialty: (please write) _____ |

***For the following procedures you may have performed in the last three months, did you perform the procedure?***

***A. Based on independent decision/diagnosis, without direction from another health worker or according to Standard Operating Procedures* or**
***B. Under direct orders from another health worker* or**
***C. Acting according to Standard Operating Procedures* or**
***D. Did not perform the procedure***

***Tick the appropriate answer; please give only one response for each procedure***

| No. | Procedure | Independent Decision | Direct Orders | Standard Operating Procedures | Did not perform |
|---|---|---|---|---|---|
| 37 | Administer intravenous fluids | | | | |
| 38 | Perform active management of third stage labour: i.e. Administer uterotonic *and* uterine massage *and* controlled cord traction | | | | |
| 39 | Perform vacuum aspiration for retained products | | | | |
| 40 | Perform curettage for retained products | | | | |
| 41 | Administer parenteral (intravenous or injection) uterotonics for post-partum hemorrhage | | | | |
| 42 | Administer blood transfusion | | | | |

| No. | Procedure | Independent Decision | Direct Orders | Standard Operating Procedures | Did not perform |
|---|---|---|---|---|---|
| 43 | Administer magnesium sulfate for the management of eclampsia/pre-eclampsia | | | | |
| 44 | Administer other anticonvulsants for the management of eclampsia/preeclampsia | | | | |
| 45 | Administer parenteral (intravenous or injection) antibiotics | | | | |
| 46 | Perform forceps delivery | | | | |
| 47 | Perform vacuum delivery | | | | |
| 48 | Perform manual removal of placenta | | | | |
| 49 | Provide PMTCT regimen to mother and newborn | | | | |

*Please indicate the extent to which you agree or disagree with the following statements.*

*Please answer every question by ticking ☑ the appropriate box, leave no questions blank.*

| NO. | Question | Strongly Disagree ▼ | Disagree ▼ | Neither Agree Nor Disagree ▼ | Agree ▼ | Strongly Agree ▼ |
|---|---|---|---|---|---|---|
| 50 | I am adequately trained for all the tasks I perform. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 51 | Most of the training I have received has improved or changed how I practice. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 52 | I am sometimes asked to perform tasks for which I have not been adequately trained. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 53 | The training I have received in general has been of a high quality. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 54 | The training I have received in general has prepared me for independent practice in midwifery. | ☐ | ☐ | ☐ | ☐ | ☐ |

***Please give three suggestions to improve the NPM training further.***

***1.***

***2.***

***3.***

# Annex 1b
# Centre for management of health services
# Indian Institute of management, Ahmedabad

## FOLLOWUP OF THE INDEPENDENT NURSE PRACTITIONER MIDWIVES[1]
## Tool-1: Experience after NPM training

DATE:

**Please be assured that this information will be confidential and will only be used to improve the future of the Independent nurse practitioner midwife's role in maternal and child health.**

***SECTION A***

***This section asks general questions about you and your background and your employment. Please circle the number corresponding to your response to each question or, where indicated, fill in the blanks***

| No. | Question | Response |
|---|---|---|
| A1 | What is your job title? | _____ |
| A2 | What is your current medical or paramedical qualification?<br>*Circle one* | 1. Registered nurse midwife with GNM<br>2. Registered nurse midwife with BSc.<br>3. Other specialization other than NPM (*Please specify*) _____ |
| A3 | What is your age? | _____ years |
| A4 | How long have you worked in the health facility that you work in today? | _____ years _____ months |
| A5 | What is your total work experience? | _____ years _____ months |
| A6 | What date did you join back service after NPM course? | Year_____Month_____ Day_____ |
| A7 | What is your assigned work area since you joined after the course? | 1. Only labour room<br>2. Obstetric OPD<br>3. Postnatal wards<br>4. All three<br>5. Any other please specify ---------- |
| A8 | | |

[1] ADAPTED FROM THE AMDD- HEALTH SYSTEMS STRENTHENING SURVEY TOOL

***SECTION B: FACILITY INFORMATION***

| | B1 Number of deliveries in 2010 | | |
|---|---|---|---|
| | **Normal** | **Complicated** | **C-section** |
| January | | | |
| February | | | |
| March | | | |
| April | | | |
| May | | | |
| June | | | |
| July | | | |
| August | | | |
| September | | | |
| October | | | |
| November | | | |
| December | | | |

| **B2 Status of human resource available (In case of teaching hospital please fill in data only related to the labour room)** | | | |
|---|---|---|---|
| | No. in position | Positions vacant | Comment if any |
| Gynaecologists | | | |
| Anaesthetist | | | |
| Medical officers | | | |
| Staff nurses | | | |
| Ayahs | | | |
| Sweepers | | | |

**SECTION C**

*Please indicate the extent to which you agree or disagree with the following statements.*

*Please answer every question by ticking ☑ the appropriate box, leave no questions blank.*

| NO. | Question | Strongly Disagree ▼ | Disagree ▼ | Neither Agree Nor Disagree ▼ | Agree ▼ | Strongly Agree ▼ |
|---|---|---|---|---|---|---|
| C1 | I am able to use most of the skills learnt during the NPM course in my present posting | ☐ | ☐ | ☐ | ☐ | ☐ |
| C2 | I have the confident to take care of normal deliveries and handle first level complications after the course | ☐ | ☐ | ☐ | ☐ | ☐ |
| C3 | My present supervisors understand and give me opportunity to practice what I have learnt in the NPM course | ☐ | ☐ | ☐ | ☐ | ☐ |
| C4 | My additional skills and knowledge are recognized and appreciated by my supervisors in the present facility | ☐ | ☐ | ☐ | ☐ | ☐ |
| C5 | I have been able to get acceptance from the mothers and the community for my role as a midwife | ☐ | ☐ | ☐ | ☐ | ☐ |

***For the following questions, write your answers in the space provided.***

| No. | Question | Response |
|---|---|---|
| C92 | Thinking about equipment needed to manage deliveries and treat obstetric or newborn complications, list up to three equipment items that are missing, inadequately supplied or non-functional in this facility. | 1.<br>2.<br>3. |
| C93 | Thinking about the supplies (not including medications) needed to manage deliveries and treat obstetric or newborn complications, list up to three supply or consumable items that are not available or frequently out of stock in this facility. | 1.<br>2.<br>3. |
| C94 | Thinking about the drugs or medications needed to manage deliveries and treat obstetric or newborn complications, list up to three drugs that are not available or frequently out of stock at this facility. | 1.<br>2.<br>3. |
| C95 | Are there any other aspects of your work environment that make it difficult for you to do your job? Please describe. | |
| C96 | Have any recent changes been made that make it easier for you to do your job? Please describe. | |

***Please respond to the following questions. Your responses will be kept confidential.***

| |
|---|
| D1 What are three main factors that motivate you to stay in your current position?<br><br>1.<br><br>2.<br><br>3. |
| D2 What are the three factors which make your job difficult in your current position?<br><br>1.<br><br>2.<br><br>3. |
| D3. What are your three key suggestions for the independent nurse practitioner in midwives to be able to perform their job effectively?<br><br>1.<br><br>2.<br><br>3. |

**Please use the space below for any additional comments you wish to make.**

_____

_____

_____

_____

નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કેડર,ગુજરાત રાજય,
ઇન્ડીયન નર્સીંગ કાઉન્સીલના મીડવાઇફરીના અભ્યાસકમ
મુજબના પ્રોસીજર્સ તથા એસ.બી.એ.ગાઇડલાઇન ભારતસરકાર
મુજબ કામગીરી કરવા અધિકૃત કરવા બાબત.

ગુજરાત સરકાર
આરોગ્ય અને પરિવાર કલ્યાણ વિભાગ ઠરાવ
ક્રમાંક/.નસગ-૧૦૨૦૦૯/૬૪૨ / ઇ,
૭/૮ સરદાર પટેલ ભવન સચિવાલય,
ગાંધીનગર તા. 06 JUL 2010

વંચાણે લીધા:-

(૧) આરોગ્ય અને પરિવાર કલ્યાણ વિભાગના ઠરાવ ક્રમાંક:નસગ/૧૦૨૦૦૮/એસએફએસ/૨૬/ઇ,તા.૧૬/૯/૦૮

(૨) કમિશ્નરશ્રી આરોગ્યનો પત્ર ક્રમાંક:નર્સીંગ/પો.બે.મી./મલ્ટીડીસીપ્લીનરી કમિટી/ બ-૬/૧૦, તા.૨૫/૩/૧૦ ટીઆરજી

(૩) આરોગ્ય અને પરિવાર કલ્યાણ વિભાગ ઠરાવ નં.ટીઆરજી-૧૦૨૦૦૬/૧૪૨/જીએચ/તા.૩૧/૭/૦૬

પ્રસ્તાવના:-

રાજયમાં માતૃબાળ કલ્યાણ સેવાઓનો વ્યાપ વધારી માતા અને બાળકને ગુણવત્તા સભર સેવાઓ પહોચાડવા માટે તથા માતા મૃત્યુ દર તેમજ બાળ મૃત્યુદર ઘટાડવાના ભાગ રૂપે સંદર્ભ-૧ માં દર્શાવેલ ઠરાવથી રાજયમાં નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કોર્ષ શરૂ કરવામાં આવેલ છે તેમજ નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કેડર મંજુર કરવા માટે રાજય સરકાર પ્રયત્નશીલ છે.

નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કેડર કે, જેઓએ બેઝીક બી.એસ.સી. (નર્સીંગ) અથવા જનરલ નર્સીંગ એન્ડ મીડવાઇફરી કોર્ષ બાદ એક વર્ષની નર્સ પ્રેકટીશનર ઇન મીડવાઇફરીની સઘન તાલીમ મેળવી મેટરનલ ચાઇલ્ડ હેલ્થ સેવાઓમાં ઇન્ડીયન નર્સીંગ કાઉન્સીલ અને સ્કીલ્ડ બર્થ અટેન્ડન્સની ગાઇડ લાઇનમાં દર્શાવેલ પ્રોસીજર કરવા માટે નિપુણતા મેળવેલ હોય છે. જેથી તેણી માતા અને બાળક માટેના જીવન રક્ષક પ્રોસીજરો કરી શકે છે. જયાં સ્ત્રીરોગ નિષ્ણાંત ઉપલબ્ધ ન હોય તેવા કેન્દ્રો ખાતે પણ પોતે સ્વતંત્ર રીતે તાલીમ દરમ્યાન મેળવેલ નિપુણતા મુજબના પ્રોસીજરો ધ્વારા માતૃ બાળ કલ્યાણ સેવાઓ આપી શકે છે. સારવાર દરમ્યાન માતાને દાખલ કરી શકશે તથા વધુ સારવાર અર્થે નિષ્ણાત પાસે રીફર કરી શકશે. તેમજ રજા આપી શકશે.

ઉપરોકત સંદર્ભ-૩ ના ઠરાવ મુજબ એમ.બી.બી.એસ ડોકટરોને CEm.OC સ્કીલ તેમજ એનેસ્થેસીયા સ્કીલ માટે નિયત કરેલ સમયની તાલીમ મેળવ્યા બાદ ગાયનેકોલોજીસ્ટની ગેરહાજરીમાં CEm.OC (કોમ્પ્રીહેન્સીવ ઇમરજન્સી ઓબસ્ટ્રેકટીક કેર) આપવા માટે અધિકૃત કરવામાં આવેલ છે. તે જ રીતે નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કેડરને પણ મેટરનલ ચાઇલ્ડ હેલ્થ કેર માટેના પ્રોસીજર્સ કરવા માટે અધિકૃત કરવામાં આવે તો રાજયની માતૃબાળ કલ્યાણ સેવાઓ વધુ સુદ્રઢ અને સંગીન બની શકે છે. આ બાબતોને ધ્યાનમાં રાખી નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કેડરને નીચેની બાબતો માટે અધિકૃત કરવાનુ ઠરાવવામાં આવે છે.

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ઠરાવઃ-

જે, નર્સીસે ઇન્ડીયન નર્સીંગ કાઉન્સીલ નવી દિલ્હી ધ્વારા નિયત કરેલ અભ્યાસકમ તેમજ માન્ય કરેલ સંસ્થામાંથી નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કોર્ષ (એક વર્ષ) પાસ કરેલ હોય તેઓને નીચે મુજબની જીવન રક્ષક પ્રોસીજરો કરવા માટે અધિકૃત કરવામાં આવે છે.

(૧) જીલ્લા હોસ્પિટલ તેમજ સી.એચ.સી ખાતે ફરજ ઉપરનાં ડોકટરનાં પરામર્શ માં રહીને નર્સ પ્રેકટીશનર ઇન મીડવાઇફ, પ્રસુતિને લગતા કેસો ને દાખલ કરી શકશે સારવાર આપી શકશે સારા થયે રજા આપી શકશે. અથવા જરૂર જણાયે વધુ સારવાર અર્થે નિષ્ણાત પાસે રીફર કરી શકશે.

(૨) માતા અને બાળકને સારવાર આપવા માટે આઇ.એન.સી. સીલેબસ તેમજ સ્કીલ્ડ બર્થ અટેન્ડન્સની ગાઇડ લાઇન મુજબના પ્રોસીજર્સ કરી શકશે તથા નર્સપ્રેકટીશનર ઇન મીડવાઇફરીના જોબ ડીસ્કીપસન માં દર્શાવ્યા મુજબની કામગીરી કરી શકશે તેમજ ભારતસરકારશ્રીની આઇ.એમ.એન.સી. આઇ. તથા ઇ.એન.બી.સી.ની ગાઇડ લાઇન મુજબ નવજાત શિશુ, બાળકોને ઉપરોકત ગાઇડ લાઇનને આધિન અનુસાંગીક સારવાર તેમજ દવાઓ આપી શકશે. તથા પ્રીસ્કીપસન લખી શકશે. એન્ટીનેટલ કલીનીક અને વેલબેબી કલીનીક ચલાવી શકશે.

(૩) જે તે કેન્દ્ર ખાતે માતૃબાળ કલ્યાણ સેવાઓ અંતર્ગત સરકારશ્રી તરફથી પુરી પાડવામાં આવતી સવલતોનુ સંચાલન કરી શકશે તથા લાભાર્થીના હીત માટે મળવાપાત્ર સવલતો વાપરવા બાબતનો નિર્ણય લઇ શકશે.

(૪) એન્ટીનેટલ માતાની તપાસ, લેબોરેટરી તપાસ,પ્રસુતિ દરમ્યાનની અને પ્રસુતિ પછીની સેવાઓ તથા નવજાત શિશુ, બાળકને સેવાઓ આપી શકશે.

ગુજરાત રાજયના રાજયપાલશ્રીના હુકમથી અને તેમના નામે

ઉપ સચિવ
આરોગ્ય અને પરિવાર કલ્યાણ વિભાગ,
સચિવાલય ગાંધીનગર

બિડાણઃ- પરિશિષ્ટ (અ)
નર્સ પ્રેકટીશનર ઇન મીડવાઇફરી કેડરનો જોબચાર્ટ

પ્રતિ,
(૧) માન. મંત્રીશ્રી, આરોગ્ય ના અંગત સચિવશ્રી,
(૨) માન.રા.ક.મંત્રીશ્રી, આરોગ્યના અંગત સચિવશ્રી,
(૩) અગ્ર સચિવશ્રી,આરોગ્ય અને પરિવાર કલ્યાણ વિભાગના અંગત સચિવશ્રી,સચિવાલય,ગાંધીનગર.
(૪) કમિશ્નરશ્રી,આરોગ્ય તબીબી સેવાઓ, અને તબીબી શિક્ષણ,ગાંધીનગર.
(૫) અધિક નિયામકશ્રી, તબીબી સેવાઓ,ગાંધીનગર.
(૬) અધિક નિયામકશ્રી, જાહેર આરોગ્ય,ગાંધીનગર.
(૭) અધિક નિયામકશ્રી, તબીબી શિક્ષણ અને સંશોધન,ગાંધીનગર
(૮) અધિક નિયામકશ્રી, પરિવાર કલ્યાણ, ગાંધીનગર
(૯) નિયામકશ્રી, રાજય આરોગ્ય અને પરિવાર કલ્યાણ સંસ્થાન સોલા, અમદાવાદ
(૧૦)રજિસ્ટ્રારશ્રી, ગુજરાત નર્સીંગ કાઉન્સીલ, અમદાવાદ
(૧૧)રજિસ્ટ્રારશ્રી, ઇન્ડીયન નર્સીંગ કાઉન્સીલ, ન્યુ. દિલ્હી
(૧૨)એકાઉન્ટન્ટ જનરલશ્રી, અમદાવાદ/ રાજકોટ
(૧૩) વિભાગની સર્વે શાખાઓ/ સંકલન શાખા
(૧૪)ટી.સી.એસ.વેબસાઇટ પર મુકવા સારૂ.
(૧૫)સિલેકટ ફાઇલ.

# JOB DESCRIPTION OF NURSE PRACTITIONER IN MIDWIFERY

## Responsibilities & practice

The Nurse practitioner in midwifery will.

1. be responsible for promotion of health of women throughout their life cycle, with special focus on women during their childbearing and assume responsibility and accountability for their practice.
2. be responsible for providing autonomous care to women prior to pregnancy during pregnancy, after childbirth and care of newborn and assume responsibility and accountability for their practice.
3. practice within the existing peripheral health system consisting of birth attendants, auxiliary nurse midwives, nurses, doctors and specialists and will be posted at P.H.C.,C.H.C., Taluka and District Hospital as well as at medical college attached Hospitals.

## Job Description of nurse practitioner in midwifery

- She will work independently at P.H.C., C.H.C., Taluka and District Hospital as well as at medical college attached Hospitals.
- At P.H.C., C.H.C. and Taluka Hospitals she will be responsible to chief Matron (nurse practitioner in midwifery), at district and medical college attached hospitals. She will be responsible to Matron Cl - II (nurse practitioner in midwifery),

The job that the nurse practitioner in midwifery is expected to perform are.

1. Promote health of women before pregnancy through education and counseling for healthy family life including planning for pregnancies.
2. Promote health of women during pregnancy through.

   - Quality, technically advanced antenatal care to women with normal pregnancy.
   - Early detection of risk situations and management that commensurate with their level of competence
   - Management of minor disorders or pregnancy
   - Referrals as required

eng-r-r- 33 -

3. Assist women to have safe deliveries by providing:

- Continued monitoring and assistance during labour
- Recognition of problems and management that commensurate with their level of competence
- Referral as required
- Immediate care of newborn
- Recognition of problem and management that commensurate with their level if competence
- Referrals as required

Provide continued assistance to women and their babies during the postnatal period by providing

- care to mothers and their babies
- recognition of problem and management that commensurate with their level of competence
- referrals as required

Help women to plan their family by providing family planning services.

Promote women's health during non-childbearing period by early detection of gynecological problem with special focus on reproductive tract infections and cancers and providing appropriate care.

***Tasks***

1 Counseling of women before pregnancy for family planning (FP) counselling during pregnancy for practices and after pregnancy for breast - feeding and adoption of FP, HIV, Parental education and Genitic C
2 Prescription of drugs as per standard standing order.
3. Physical exam.
   - Checking BP
   - Auscultation of maternal and foetal heart
   - Fundal height; lie, presentation and position.

eng-r-r- 34 -

283

- Pelvice examination: non - pregnant early pregnancy, late pregnancy, during labour and post partum
- Abdominal examination of non - pregnancy abdomen to detect masses or any other abnormality.

4. Laboratory tests :
   - pregnancy test
   - Urine examination for acetone and pus cells
   - Vaginal smear for trichomonas and monilia
   - Prescribe HIV test, ABORh and V.D.R.L test
5. I.V. therapy: resuscitative
6. Use and interpretation of partograph
7. Use of manual vacuum aspiration for evacuation of uterus for post abortion care.
8. Performing episiotomy and its repair
9. Repair of minor perineal tears.
10. Use of local anaesthesia while repairing episiotomy and minor perineal tears
11. Use of Vacuum extraction to expedite delivery when indicated
12. Use of outlet forceps to expedite delivery when indicated
13. Breech delivery
14. Manual removal of placenta
15. Assessment of gestational age.
16. Neonatal resuscitation
17. Taking pap smear and preserving the specimen
18. Breast examination

## Regulation of Practice

1. Regulate the practise of the nurse practitioner in midwifery
2. License the nurse practitioner in midwifery to practise independently. Benchmarks for practise will be the practice standards in this manual
3. Authorize and be responsible for preparing approving and implementing the curriculum

Thus the code of ethics and practice standards are key documents for the licensing and regulation of the nurse practitioner in midwifery.

eng-r-r- 35 -