SOME PRIORITY CHALLENGES OF THE NURSING SECTOR IN INDIA

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This note identifies some key areas for priority action in the current favorable context for policy in the nursing sector in India. The present policy focus on increasing the numbers of nurses and nurse training centers is understandable given the country’s nurse-to-population ratio is very low. However, based on evidence from Uttar Pradesh and Tamil Nadu, the findings presented here suggest that such a focus on numbers alone are not the priority concerns of nursing.

AN OPPORTUNITY IN NURSING

The opportunity to improve the nursing situation in government health service delivery in India has never been better. After decades of neglect the Government of India has recognized the role of nursing as pivotal to the performance of the National Rural Health Mission (NRHM), and consequently a priority policy issue. It has started a new scheme, known as the Development of Nursing Services during the XIIth Plan period. The scheme has an expected outlay of Rs. 2900 crores. This additional financing will be used to substantially augment the numbers of nurses in the government system through expanding the numbers of nursing education and training institutes, including 24 centers of excellence, 145 ANM schools, 137 GNM schools, 6 nursing colleges, and 4 regional nursing institutes. These new institutions will be complemented by the strengthening of existing nursing councils and directorates administering nursing cadres in 17 states.

This planned significant increase in the numbers of nurses in the health system reflects the realization that the nurse to population ratio in India remains inadequate despite the expansion of nursing manpower in the last six decades, and especially in the last eight years through the multifold increase in private nurse training schools. While in India there is one nurse to 2500 people, in developed countries the number of people served by a single nurse range from 150 to 200. The nurse-doctor ratio in the country is particularly poor in comparison to other middle-income and developed countries: there are approximately 1.6 nurses and midwives per allopathic doctor, whereas for Brazil (3.1) and South Africa (5.1), this ratio is much higher (WHO Statistics, 2009). If only nurses are considered, there are approximately 0.5 nurses per doctor as compared to 3 and 5 in USA and UK, respectively.

Increasing the number of nurses is a worthy policy goal, but achieving it will require additional interventions to complement the planned expansion of educational capacity to form new nurses. The following are some key areas for priority action, based on national and state-level investigations of recent experiences with nursing development, drawing on the cases of Uttar Pradesh and Tamil Nadu.

THE NEED TO IMPROVE THE QUALITY OF ALREADY-EXISTING NURSE TRAINING SCHOOLS

The Government of Uttar Pradesh (UP) is focusing new attention on ways to produce more nurses. However, an immediate challenge the state faces in the nursing sector is the short supply of qualified and adequately trained nurse staff for teaching at the existing nursing schools providing General Nursing and Midwifery (GNM) diplomas. Such shortages place these institutions precariously close to being, if not already, deemed unsuitable for producing nurses. If the UP state government allocates funds to build new schools without addressing the faculty shortage, it could face the same situation. The cause of this problem affects the entire government-nursing cadre of the state.

At the root of the problem are the current service rules that were adopted in 1996 following the agitation of in-service nurses due to the lack of promotions. The resulting service rule change omitted any reference to educational

¹ Health workers in sufficient numbers, in the right places, and adequately trained, motivated and supported are the backbone of an effective, equitable, and efficient health care system. Success in creating and sustaining an effective health workforce in India to achieve national health goals will require sound policy and creative and committed implementation. More and better information on human resources for health in India is one element needed to achieve this. This note summarizes recent and ongoing work in support of India’s health work force goals. For the full report, see Raha, S. et al “HRH: A Political Economy and Institutional Analysis of the Indian Context” HRH Technical Report #2 at www.hrhindia.org
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qualifications required for postings and applies to teaching posts in nursing schools. Many of the trainers currently posted in nursing schools in UP fail the minimum eligibility criteria mandatory in the previous service rule to undertake such teaching. Instead they secure these posts as a result of promotions based entirely on 'seniority' criteria that apply to the nursing cadre as a whole. Moreover, teaching staff in all government nursing schools in UP no longer have the training that the Indian Nursing Council (INC) deems mandatory. Consequently, the INC has in the recent past withheld recognition from all nursing schools under the state government while the UP state authority continued to recognize these same schools.

THE GEOGRAPHIC MAL-DISTRIBUTION OF NURSE TRAINING CAPACITY
States with poor health indicators are the main focus of recent policies to increase the number of nursing schools. However, these states are particularly deficient in current nurse training capacity and also face more pervasive weaknesses in institutional and regulatory capacity. The four southern states (with relatively strong institutional contexts) have two-thirds of the nursing educational institutions in the country. This disproportion becomes even wider for higher level nursing education as in the case of M.Sc. nursing institutions, which typically provide faculty for B.Sc. colleges. Seventy percent of these higher level institutions are in the four southern states with the remaining 30 percent again unevenly distributed in the rest of the country.

One consequence of the absence of nursing educational institutions for higher level education in some states is the near collapse of the lower levels of nursing education. In Orissa, for example, the only college of nursing in the government sector, currently, has less than three qualified faculty though it provides undergraduate and postgraduate education (Prakasamamma, 2008). In UP, the lone Government College of Nursing offering a Post-Basic B.Sc. (N) degree does not have within the state a pool of suitably qualified nurses from which to draw its faculty. Also, since the current service rules in UP no longer require further education as relevant for career progression, very few government employed nurses are inclined towards further education.

THE NEED TO STRENGTHEN THE ROLE OF PUBLIC HEALTH NURSES AND RELATED TRAINING CAPACITIES
The National Rural Health Mission (NRHM) is calling for increasing staffing to 2 Auxiliary Nurse Midwives (ANMs) in every Sub-Centre (SC) and has allocated funds also for an increase in the overall number of SCs. Achieving this goal will require institutions with teaching staff for the production of ANMs. However, in past years, the capacities for training in public health nursing have deteriorated more than in educational institutions for clinical nursing. In some states such institutions have simply ceased to exist.

For example, in UP, upon meeting the target of filling the post of one ANM in every SC in the 1990s, government closed the ANM training schools and in turn terminated further production of ANMs. The decision was partly driven by budgetary constraints at the time. The resulting consequence and the immediate challenge currently faced, therefore, is to revive teaching institutions that once functioned and bring back trainers to these training centers.

It is, again, the poorer NRHM-focus EAG states that have suffered most from this effective de-institutionalization of public health nursing. Attention must be given to restart closed training centers, including educating new ANM trainers and providing incentives to them to work in government service. The case of UP is illustrative: an additional ANM in existing SCs combined with the staffing of planned SCs proposed by NRHM would require the induction of approximately 34,000 ANMs in the span of five years. There are currently 20,251 SCs in the state with each reportedly staffed by an ANM. The policy therefore aims to more than double the number of ANMs through training. However, all the 40 ANM Training Centres and 4 health schools, which were producing ANMs, Lady Health Visitors (LHVs), Public Health Nurses (PHNs) and PHN Tutors were closed down in 1992.

To meet the scale of the proposed ANM production government should consider recruiting ANM trainers who were forced to change profession with the closure of schools. Nevertheless, inducting former or new trainers into the system will require new regulations and incentives. This would normally have entailed amendments in the service rules, but in UP no service rules currently exist for the entire cadre of public health nursing. The State Government stipulates, for instance, through a 1990 ruling, that promotions can only be officially sanctioned if service rules are in place. The continued absence of service rules and delay in framing them leaves these ANM trainers with no career advancement or promotional avenues. The lack of an enabling institutional and incentive environment for ANM trainers to join government service, especially in the light of past record of abrupt closure of schools and extinction of jobs when targets are met, does not bode well for expanding the cadre of ANM, at least for UP.

POOR CAREER ADVANCEMENT OPPORTUNITIES FOR PUBLIC HEALTH NURSES
Promotional opportunities for nurses are a concern not only in the states with weaker health administrative structures. This issue should not be overlooked as government moves to increase the numbers of nurses. In some states promotions have been delayed due to the infrequency of Department Promotional Committees convened to decide on the promotion of eligible nurses. This is now further exacerbated by the lack of institutional capacity to provide the necessary additional training mandatory in the service rules for nurses to be deemed eligible for promotion.
In Tamil Nadu, a state with relatively better functioning government administrative structures, the problem of promotions of public health nurses remains. Village Health Nurses (VHNs) had not been adequately promoted to Sector Health Nurses (SHNs) and Community Health Nurses (CHNs), because there was a mandatory 22-month further training that a VHN was required to undergo in order to be considered for SHN/CHN posts. The training was not taking place for no fault of the nurses, but due to the lack of institutional structure to support such training and the absence of adequately qualified trainers. With a significant rise in the backlog of overdue promotions, the State Government decided to reduce the months of training required from 22 months to 6 months. In a subsequent decision two years later, the stipulation of further training even for 6 months was done away with entirely for consideration of promotion of the VHN. While the changes have eased the possibility of promotions, it has come at the cost of eliminating further training that had previously been deemed necessary to perform the added functions of a SHN/CHN.

At lower levels of public health nursing in many other states, the possibility of career advancement has never existed. The ANMs in most states now no longer need further training to function as the supervising Lady Health Visitor (LHV). There is, however, generally little opportunity for further advancement since the posts of Public Health Nurse (PHN) and District Public Health Nurse Officer (DPHNO) are vacant, if not abandoned. Moreover, there is currently an absence of institutions to allow a bridge-course for an experienced ANM/LHV to graduate to a GNM. The absence of such institutions do not permit the use of a pool of existing experienced nurses, and their aspirations, to fill the shortages of GNM-trained nurses existing in the system.

DEVELOPMENT OF NEW ROLES FOR NURSES IN RURAL HEALTH CARE?

It is increasingly recognized that meeting the needs of the rural population for basic health care will have to rely more proportionally on nurses and paramedical workers, than on physicians. But today’s nursing education doesn’t prepare nurses well for independent clinical practice or in public health management to run a facility. This moment of launching expansion of nursing education capacity may also be a good opportunity to create new types of nurses with skills more suited to the challenges of managing and delivering rural health care.

CLARITY ON ROLE OF ANM

This moment of renewed focus on nursing may also provide the opportunity to critically assess the job descriptions of existing nursing personnel, especially the ANM. Increasing the numbers of ANMs must not necessarily be focused on as the sole, or the foremost, immediate challenge the nursing sector in the country faces. It is pertinent to note that, over time, there has been a de-skilling of ANMs in clinical training to multi-purpose workers and that the current role is still not clear. Simply increasing the numbers, without clarity on feasible functions for the ANM, would be unwise.

INSTITUTIONAL REFORM IN THE STATE NURSING SECTOR

The only High Power Committee of the Government’ that reviewed in detail the principal challenges existing in the nursing sector reported (1989) the need to reform, not simply strengthen, the directorates of nursing in the States. The Committee recommended that a single directorate of nursing be created with separate functional institutional structures for clinical nursing, public health nursing and nursing education within it. Apart from the intention to bring better governance and accountability to key functions of strategic planning and management of the separate nursing cadres, the institutional reform also aimed to enable greater voice to nurses in the policy-making process by removing the nursing directorates from the largely exclusive control by doctors. The gradual disappearance of the post of the DPHNO in the districts of most states (including Tamil Nadu) is a signal of the lack of institutional support to the role of supervision of the public health nursing cadre.

CONCLUSION: POLICY IMPLICATIONS AND RECOMMENDATIONS FOR ACTION

There have been in 2009 reviews of the nursing workforce that the Academy of Nursing Studies at Hyderabad has undertaken in collaboration with the National Health Systems Resource Centre (NHSRC). Four excellent reports on Chhattisgarh, Rajasthan, Bihar and Orissa have already been prepared. In drawing on this additional body of work and the findings of field research in Uttar Pradesh and Tamil Nadu that this policy note directly draws upon, we recommend the following actions:

1. Every state needs to ensure that all teaching posts in nurse training schools must be occupied by nurses who have received the minimum training or education mandated by the INC for adequate teaching. In the case of a shortage of qualified nurses in government service, other innovative methods may be considered: (a) drawing on qualified nurses in government service, other innovative methods may be considered: (b) recruiting nurses from states with a greater supply of qualified nurses; or (c) establishing a scheme to further train existing nurses of the state in training schools located in other states.

2. Beyond a focus on increasing ANM numbers, the current institutional weakness of public health nursing in several states needs urgent attention. This requires placing priority in: (a) establishing service rules for all posts in the public health nursing cadre (where still absent); and (b) providing adequate planning and funding to re-establish schools for ANM trainers (and not focus solely on augmenting the number of ANMs).
3. In every state an empowered high-level review is needed of the career promotional opportunities and the current institutional bottlenecks (such as infrequency of required Committee meetings) that result in inefficient and ineffective implementation of existing rules.

4. To address the inadequate numbers of trained staff nurses in the health system and the poor career opportunities for existing ANMs, each state should consider the feasibility of creating institutions that provide a bridge-course for an experienced ANM/LHV to graduate to a GNM.

5. Given the current opportunity for advancement of the nursing sector, there should be a serious evaluation of the role and function of nurses the current system produces. This assessment should include a feasibility study on how best to re-mould further training of nurses to serve the health system with a special focus on creating a more skilled nurse practitioner that can head facilities at lower levels of primary care, where doctors are less likely to be present.

6. The manageable duties of the ANM, based on the training she has received, need to be better defined especially in light of several different and multiple demands derived from the various vertical programs.

7. The weak supervisory structure for nursing staff, both in clinical and public health cadres, may be partially explained by the weakness or absence of institutions and posts at higher levels such as a Directorate. The organizational structure proposed by the 1989 High Power Committee needs to be addressed by every state and adjusted, where required, to bring institutional reform by creation of Nursing Directorates in each state.

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