CHAPTER I

INTRODUCTION

1.1 Historical background of auxiliary nurse midwife (ANM) training programme

In 1956 community health services were limited to areas outside the Kathmandu valley, specially in Rapti valley (Chitwan), where malaria was a big problem. His Majesty's Government in collaboration with USAID, started an integrated community health programme such as development of health services, agriculture, road (communication) and education in Rapti valley. There were teams of two USAID nurses, Miss Martha Grast, Public Health Nursing Adviser and Mrs Rafela; a Coello, Public Health Nurse Teacher, a public health doctor Dass, and four Nepali nurses, Mis J.Tamsang, Miss R.Ragain, Miss B.Rai and Mrs A.Subba, who were posted to start the community health programme as well as training programme. Result of the survey in Rapti Valley showed the importance of communicable diseases, malnutrition and high infant and maternal mortality rates. There were no hospital, very few health post and limited health workers.

Therefore a " women auxiliary health worker training programme was planned under the direction of health services with the help of USAID in 1958. This training programme was started at Hetauda and three batches of women auxiliary health workers(43) were trained. This training programme was shifted to Bharatpur hospital in 1963. It was a community based training programme. Matured women who knew how to read and write were recruited from all parts of Nepal and its title change to Assistant Nurse Midwife Programme. It was two year training programme with components of midwifery, community health and simple nursing care. Girls who passed class eight were recruited. But at present the criteria for ANM training programme (admission) are as follows:

- Female Nepali citizenship.
- Minimum academic requirement: eight class pass.
- Character certificate from last school attended.
- Minimum age requirement is 16 years and maximum 30 years.
- Preference will be given to the candidates from remote area, single, widowed and divorced.
- Preferably candidates should be trained at a centre nearest to their homes with the expectation that they will return working in their home areas.

- Pre selection test will be taken in order to screen the candidates and select those candidates that display similar capabilities and potentials for the ANM programme.

An interview by a committee will include nursing personnel experienced in ANM programme. The candidate must have a physical examination. The final decision for the selection is dependent on the outcome of physical examination.

The second ANM training programme was opened at Biratnagar in 1965 but was upgraded to certificate level nursing training in 1982. The third training programme was opened at Nepalgunj in 1967 but was upgraded to certificate level nursing in 1987. The fourth training programme was opened at Palpa Tansen in 1973 and still running well. The fifth training programme was opened at Chetrapati,Kathmandu as 'Crash' programme in 1974 and stopped in 1979.

The objective of the ANM programme is to train ANMs who will work in MCH/FP in rural health post, with limited resources viz:

1. To prepare women health worker (ANM) to function at health post level, to carry out various types of health services, including MCH/FP, mostly preventive

and promotive and to some extent curative care to individuals, families and communities. This will also include school health programme and training of traditional birth attendants.

2. To prepare the ANM to function in a supportive role to the professional nurse in limited and clearly defined areas of hospital nursing service.

1.2 Historical Background OF ANM

The number of ANM has increased rapidly in recent years and 60% are assigned to rural health posts. Official statistics indicate that Nepal had 16 ANM in 1965 and 404 in 1977. In 1980 over a thousand girls had received training at 5 ANM training programme (Jewan 1984). Most ANMS, although technically posted to health posts and paid as if functioning in the posts, never reached the remote areas to which they are assigned. In Nepal it is socially unacceptable for girls and women to travel and live alone, as ANMs are expected to do. The appropriate female role are limited primarily to those of wife and mother. Traditionally women do not work outside the family but contribute labour to the household and to domestic and agricultural projects. ANMs fill the gap in the hospital because there is no government fund for the services they are now

providing there. According to data of 1988, there were about 1430 ANMs already working and the total requirement was 2336 (Future1984-85).

1.3 Historical Background of MCH/FP in Nepal

The Family Planning (FP) and Maternal and Child Health (MCH) Project started in 1968, and has functioned under the direction of the semi autonomous Nepal Family Planning and Maternal and Child Health Board in the Ministry of Health. The project is the official agency responsible for FP/MCH at the national level. The FP/MCH project spent its first several years integrating MCH and FP operation using the existing health institution in Kathmandu valley. During this period, the project also trained a number of paramedical personnel for service in districts outside the valley. According to the 4th, 5th plan, the goal of MCH/FP was to bring a balance of the various resources and population growth to improve the quality of human life. The 6th five year plan concentrated more specifically to bring equilibrium between resources and population growth and improve the health of mother and child. The 7th five year plan identified MCH service as a priority programme in the health sector.

1.4 Geographical Background of Nepal

The total area of the country is 147,181 square kilometers high consisting of flat subtropical plain in the terai, hill and the high snowy mountains of the Himalayas 23% of total land area are terai, 42% hills and about 35% snowy mountain. Up to 45% of total population lived in terai, 42% in hills and only 8% in snowy mountains. Hill area is the most heavily populated part of the country. The climate of Nepal is determined by its topography and the monsoons. The terai is subtropical, the hill region is temperate, the inner himalayans have an alpine type of climate, short summer and long winter, cold and temperature ranging from 0 degree to a maximum of 16 degree centigrade. The terai on the other hand, has 3 well marked seasons, i.e., summer from March to June, rainy season from July to October and winter from November to February. The cycle of season in the hill is similar but the climate is more moderate. Ropeways and sky lakes are important means of transportation, especially in the mountain and hill regions, waterways are used for transporting goods in short distances. Travel by air has recently become an important mode of transportation, otherwise people have to walk for 1 to 5 days according to their necessity and distance.

1.5 Relevant Competence of Job Description of ANM for ANC Service

The health posts which are the heart of Nepal's rural health programme are theoretically to have a health assistance, one to two assistance health workers, two assistance nurse midwife 2 to 6 village health workers and poen (helper). Each health post is expected to serve between 5 to 10,000 population depending on its location (country health profile 1988). District health office are situated in the district level and district health officer, who can be health personel or non health personel is incharge. The public health nurse is incharge of the MCH/FP clinic. ANMs is trained to work in MCH. ANMS directs the work of maternal and child health activities in a specific community and performs related administrative and clerical duties. Her duties require considerable independent judgement and initiative based on experience, knowledge of rural communities and standard practice of the nursing profession. ANMs work under, or are responsible to, health assistants, health inspectors, senior auxiliary health workers, public health nurses. Junior auxiliary health workers, village health workers, community health leaders and TBAs are subordinate to her. Job

		- Referral of cases at risk.
		- Hospitalization of emergencies.
		- Treatment of minor complications.
		- Vaccination of pregnant women.
2.promotion	1.2 Education	- The risk to mother and children.
		- Hygiene during pregnancy.
		- Nutritional balance.
		- Birth spacing.

The relevant competences for assessment of ANM in antenatal care are as follows:

Function	Activities	Tasks
1.Care	1.1 Antenatal	- Communication and interview skill.
		- History taking.
		- Physical examination.
		- Obstetrical examination.
		- Blood pressure measurement.
		- Urine test for sugar and albumin.
		- Vaccination of pregnant women.

2.Promotio 1.2 Education - The risk to mother and children.
- Hygiene during pregnancy.
- Nutritional balance.
- Birth spacing.

International Variation in Midwifery Training and Practice

The midwife has a central place in the provision of care in pregnancy and child birth. The main elements of maternity care are the combination of clinical assessment and monitoring and the provision of advice and support. These elements are the focus of the International Congress of Midwife (WHO 1966, Federation of Gynecology and Obstetrics, 1973 as quoted in Sarah Robinson 1989). They recognize midwife as qualified to provide care throughout pregnancy, labour, and the puerperium to recognize those signs of abnormality that require referral to medical staff and to provide, advice information and emotional support to women from the early stage of pregnancy to the end of the postnatal period. In practice, the range of midwives responsibilities and the degree of clinical judgement have considerable variation from one country to another and one period to another (Sarah Robinson). Hall and Meijia (1978)

summarized the variation of trainings and roles midwives need to fulfill. In many parts of the country of Northern Europe, midwives are trained as professional midwives. In Nepal midwives are trained as auxiliary nurse midwives. However the title does not fit according to Hall and Meiji because these midwife qualifications as previously mentioned are: 6 to 8 years of general education, 2 years training but without 1 to 2 years or 2 to 3 years integrated nursing.

In the United kingdom, midwives have legal right to practice as practitioner and can provide care throughout pregnancy, labour and puerperium on their own responsibility. In France and the Netherlands, midwives can practice independently. In Nepal according to the job description, ANM has to practise or give care under supervision of skill health personnel (PHN). But in practise, most of the time they have to perform without supervision. The study by Blondel et al (1985) revealed the difference of the role and responsibilities of midwives. In the Netherlands, midwives can give service to women without complication independently. But in countries like Switzerland, obstetricians supervise most women. In poor rural communities,

grannies, who are trained by midwives provide care to pregnant women, like TBAs in Nepal and India.

1.6 Rational for the Study

The goal of the WHO "Health for all by the year 2000" is a great challenge to all government health professional and communities in developing countries. In Nepal, the primary health care approach has been undertaken as a basic strategy to meet this goal. MCH is one of the essential components of the primary health care and it is one of the most basic need in developing country like Nepal. Millions of mother face the risk of death during pregnancy or childbirth. The health of children depends on the health of mothers and it should be remembered that protection of a mother's health require all her needs to be met. Behind every smiling child there should be a mother who is physically and mentally healthy and looks to the future with confidence and satisfaction. (Freda 1. Paltiel 1989).

Nepal have an infant mortality rate of 107/1000 live birth, and a maternal mortality rate of 8.5/1000 pregnancy according to the data of 1988. Nepal's 7th five year plan identified MCH service as a priority programme in the health sector. The basic

health need programmes for the goal by the year 2000 are to increase life expectancy at birth from 52 to 65, to reduce annual growth rate to 2% from 2.66 and total fertility rate to 2.5 from 5.8, to bring down infant mortality to 45/1000 from 108/1000 and maternal mortality rate to 4/1000 respectively. His Majesty Government determined to provide basic minimum health services through primary health care approach to the rural people from 1987/88 onward in the form of preventive, promotive and curative services, at the health post at ilakha level and district hospital. This would include the creation of awareness and motivation for healthy living through health and nutrition education, critical intervention like immunization, control of diarrhoeal diseases and acute respiratory infection, provision of safe drinking water and sanitation, adequate supply of essential drugs to all health institutions and family planning services to curtail the undesirable growth of population (Country Health Profile 1988).

The high mountainous terrain, divided by three river system isolates the rural population from the central government in the Kathmandu valley, hindering the communication and other infrastructures including health facilities. Many villages can be reached by

walking hilly trails for hours or days (Future 1984-1985). About 85% of the population live in rural areas. Mistaken or inadequate action by medical personnel was judged to be a contributing factor to between 11% to 47% of maternal death in the developing countries. In Nepal, 32% of women who died in the hospital arrived in very poor conditions and another 17% arrived unconscious (WHO 1985). The ultimate goal of health services of any country is to distribute their resources in such a way as to put essential health care within the reach of the entire population of the country. Due to the shortage of nurse or skilled health personnel, the government of Nepal tries to produce these lower level health workers to provide health services in every part of the country. These ANMs are the only health personnel available in remote rural areas for providing MCH services. whether these health personnel are performing according to their standard or not, need to be assessed. So if government assign these health personnel in these areas and if they are not performing according to standard job description, they will not be beneficial to the community and the country.

Therefore this study is intended to determine the level of competence and knowledge between the terai and the hill auxiliary nurse midwives who work in antenatal care. This study also tries to identify the factors associated with the competence in both groups. Whether these health personnel are performing according to standard job description or not need to be assessed.

There is a standard of performance in each ANMs Campus. On graduation, they have to reach the same standard level. After graduation, they are appointed in different areas, because of difference in job placement, geographical area, environment, communication and remoteness. Some of them have been detached from the same source of knowledge or education facilities or resources.