NURSING POLICIES, REFORMS AND GOVERNANCE STRUCTURES

ANALYSIS ACROSS FIVE STATES IN INDIA

2017

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LIST OF ABBREVIATIONS

AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife
BSc	Bachelors of Science
CBHI	Central Bureau of Health Investigation
CNE	Continuous Nursing Education
CHWs	Community Health Workers
DHS	Directorate of Health Services
DME	Directorate of Medical Education
DHFW	Department of Health & Family Welfare
DPHNO	District Public Health Nursing Officer
SHRC	State Health Resource Center
IMNCI	Integrated Management of Neonatal and Childhood Illness
IUCD	Intra Uterine Contraceptive Device
IYCF	Infant and Young Child Feeding
RKSK	Rashtriya Kishore Swasthya Karyakram
RBSK	Rashtriya Bal Swasthya Karyakaram
ARSH	Adolescent Reproductive and Sexual Health
FBNC	Facility Based New-born Care
RTI/STI	Reproductive Tract Infection/ Sexually Transmitted Infection
GNM	General Nursing Midwifery
GOI	Government of India
HRMIS	Human-Resource Management Information System
IGIMS	Indira Gandhi Institute of Medical Sciences

IGNOU	Indira Gandhi National Open University
IMR	Infant Mortality Rate
INC	Indian Nursing Council
JPHN	Junior Public Health Nurse
KNMC	Kerala Nursing and Midwives Council
LHV	Lady Health Visitor
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MPW	Multi-Purpose Worker
MSc	Master's of Science
NHM	National Health Mission
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
NNC	National Nodal Centre
PBBSc	Post Basic Bachelors of Science
PSC	Public Service Commission
RMNCH+A	Reproductive Maternal New Born Child and Adolescent Health Programme
SC	Sub-Center
SDGs	Sustainable Development Goals
SHS	State Health Society
SIHFW	State Institute of Health and Family Welfare
SIMET	State Institute of Medical Education and Technology
SNC	State Nursing Council
TMIS	Training Management Information System
WBH&FW	West Bengal Health & Family Welfare Department
TNAI	Trained Nursing Association of India

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Executive Director
NHSRC, New Delhi

EXECUTIVE SUMMARY

Nurses and midwives constitutes the largest component of health work force and are often the first point of contact between the community and the health system[1,2,3]. The need to strengthen nursing and midwifery has been reiterated in many reports and can be traced historically in recommendations by Bhore committee (1946), Mudaliar committee (1962), High Level Expert Group on Universal Health Coverage report (2012) and National Health Policy (2017).

Studies and surveys across the globe suggest a severe shortage of nurses and midwives.[4,5] Based on data from the Ministry of Statistics and Programme Implementation, Government of India, it is estimated that India has 1.44 nurses and midwives per 1000 population and a ratio of 2.24 nurses and midwives per doctor, which is less than the international norms.[6,7] This shortage of health professional; particularly nurses and midwives has an adverse effect on the uptake of maternal and child healthcare especially in rural areas.

In addition, there is a wide variation in the density of nurses and midwives across states - Goa and Kerala have a higher density of health workers in contrast to Bihar and Uttar Pradesh[8,9].

The role and responsibilities of nurses and midwives has expanded rapidly in terms the range of service delivery components. However, the involvement of nurses and midwives in decision and policy making, establishment procedures, educational opportunities, remuneration, benefits and the nature and quality of training has not progressed at the same pace. This has an adverse impact on raising the profile of the nursing cadre and consequently on the quality of health care services provided by nursing professionals[10]. However, recently states have introduced and streamlined workforce management policies thereby bring reforms in nursing cadre.

National Health Systems Resource Centre (NHSRC) has conducted a study to review the recently introduced nursing policies, reforms and governance structure across five selected states in India. The study covered three broad areas: (1) leadership and regulation, (2) education and development and (3) deployment and utilization.

STUDY OBJECTIVES

The key objectives of this study have been listed below:

1. **Leadership and Regulations:** To review the regulatory framework including governance structure, policy reforms, and its implementation in the nursing sector
2. **Education and Development:** To assess the status of pre-service education and the capacity building of nursing personnel
3. **Deployment and Utilization:** To review the current institutional mechanisms and workforce management of nursing professionals.

In order to achieve the study objectives, a systematic method for data collection and analysis was developed. The study was conducted in five states namely, Bihar, Chhattisgarh, Kerala, Rajasthan and West Bengal; in two phases, adopting a qualitative method approach, including primary and secondary data collection. First phase involved secondary data collection and review of 103 manuscripts including the State Nursing Act, amendment rules, government orders, media articles, relevant websites etc. and in second phase primary data collection was done of 125 key informants shared their experience and perceptions.

STUDY FINDINGS

Leadership and Regulation

All five states have framed a State Nursing Regulation Act with different levels of implementation. Even though nurses and midwives are an integral part of health system, the degree of involvement of the nursing staff in decision-making and policy development varies across states. The different State Nursing Councils have some common issues; these include a limited authority to regulate, along with a weak nursing leadership among health regulatory bodies, chronic understaffing, inadequate working space, a lack of inspectors for conducting periodic inspections of training institutes and external interference in their regulatory functions. Some of the states have made significant progress in terms of strengthening their nursing cadre, these including the setting up of a dedicated governing body – a nursing wing under NHM, establishment of State Nodal Centres (SNC) for in-service training of nursing tutors, formulation of need-based training strategies, better opportunities for career progression, and integrated training for health workers. Some of these models are example of good practice that can be replicated in other states for strengthening their nursing cadres.

Education and Development

There is a difference in the structures of nursing pre-service education in terms of types of courses and the standard of education across states. This has a direct influence on the quality of services being provided at health facilities. There has been a significant increase in the number of nurse training institutes, but with the mushrooming of new private nursing institutions it has become increasingly challenging for the regulatory bodies to ensure standardized quality. The All India Institute of Medical Sciences (AIIMS) has established nursing colleges in Bihar, Chhattisgarh and Rajasthan to encourage high quality pre-service education for nursing. Most of the government nursing schools provide relatively better clinical exposure due to being attached with teaching hospitals, but have inadequate infrastructural resources in comparison to the private nursing institutions.

Some states have taken steps to improve nursing pre-service education based on state needs and introduction of new in-service training courses, which include technology enabled teaching methods and the creation of an autonomous body for e.g. in Kerala- State Institute of Medical Education and Technology (SIMET) for initial establishment of training institutes. In all selected five states, the process of inspection of the training institutes is unsystematic in terms of frequency and rigor. Moreover, there are no continuous learning opportunities in the nursing sector; these should be encouraged to provide refresher trainings and this should be included as a criterion for renewal of the service license for nursing personnel.

Deployment and Utilization

Delay in registration, lack of competency based recruitment, pay disparity, poor career progression opportunities, wide disparity between regular and contractual cadre and absence of professional development opportunities have led to a compromise in the quality of health services offered by nursing staff. To addresses these issues, some states have introduced reforms such as the establishment of health recruitment boards, skill-labs, need based trainings, on-site mentoring and online registration systems. However, there is a scope for further improvement in training needs assessments, post training deployment and adequate hand holding at health facilities. A comprehensive performance management system in states will enable staff to undergo continuous professional development and motivate them to perform better and empower supervisors to measure the performance of staff against clearly specified roles and responsibilities through a rational process.

DISCUSSION

This study has shown that improving the nursing sector in states requires emphasis on all the three major themes of the health workforce - a. Education and Development, b. Leadership - Regulation, and c. Deployment and Utilization. It is evident that these inter-linkages have direct and indirect implications on expected outcomes. The continuous need-based policy amendments and reforms in the nursing sector made by Kerala and West Bengal indicate the strong willingness of some states in improving nursing structures, empower the nursing cadre and provide opportunities for growth of nursing personnel. However, it is important to realize that if changes are made too frequently and rapidly, it can affect stability at the administrative and technical level compromising their effective functioning.

Vacancies should be filled on an urgent basis through competency-based recruitments introduced to ensure delivery of quality health services to the community. Participation of state level regulatory bodies must be encouraged, fair and transparency in establishment procedures will reassure the growth and advancement pathway for nurses and midwives. Cross learning among states regarding shared leadership among DHS and NHM, establishment of State Nodal Centers, building competencies based trainings, career advancement opportunities, and state need based reforms should be emulated.

RECOMMENDATIONS

I. Leadership and Regulation

1. State Nursing Councils could be more pro-active and dynamic in their approach towards regulating the quality of nursing institutes, both government and private.
2. Collaborative leadership among the governing and regulatory bodies, as observed in West Bengal and Kerala should be encouraged in streamlining objectives and functioning of the nursing profession.

3. States should increase involvement of nurses and midwives in decision-making which will help in ownership and expedite the implementation of policies.

II. Education and Development

1. Interstate variations in quality and standards of education and qualified nursing professionals should be evaluated and necessary corrective action taken. States need to cooperate with each other to verify candidates migrating to other states for education and deployment.
2. States can be innovative in proposing strategies and establishing structures to expand and strengthen the existing nursing institutes. Kerala has established a separate body, the State Institute of Medical Education and Technology (SIMET) with the sole purpose of establishing new nursing colleges with strict adherence to standard guidelines.
3. States should increasingly focus on skill building of the faculty of nursing institutes through appropriate training.

III. Deployment and Utilization

1. Standardized procedural guidelines, job descriptions and performance management systems should be developed to attract, motivate and retain staff within public health facilities in the rural and remote areas.
2. There is an urgent need to fill the substantial vacancies through competency-based recruitments and seniority-based promotions across the nursing cadre - including academic, clinical and public health nurses - to ensure the quality of in-service nursing staff.
3. Workforce management for nursing cadre should be strengthened to ensure fair and transparent procedures for recruitment, training, career progression, postings and transfers. This will further enhance the performance and retention of staff within the public health system.
4. There is scope for enhancing competencies and skills of nursing personnel to ensure that high quality comprehensive services are provided at all facility levels. The integrated training approach initiated by Rajasthan has ensured all-inclusive skill building in a single round of training.
5. Promoting opportunities for higher education for in-service nursing staff has contributed to improve the knowledge and capacities in states. However, complementary strategies such as study leaves and salary increments, sanctioning of positions must be in place to encourage such participation to enhance service delivery.
6. States should streamline the career progression opportunities, as observed in few states, have a positive influence on the availability of nursing staff at all levels.

CHAPTER 1

BACKGROUND

Nurses and midwives, the primary providers of health services and the largest component of health work force, is the first point of contact between the community and the health system[11,12]. They provide a range of nursing and midwifery services at different levels of health facilities[13] and has made a valuable contribution towards delivering effective health care services and improving the health of patients. In addition, they make a significant contribution to the global nursing workforce.

The contribution of nurses is vital to achieve the targets set by the NHM[14], the Millennium Development Goals (MDGs)[15] and recently the Sustainable Development Goals (SDGs) at the local, regional and national level. Along with the provision of clinical care, nurses play a vital role in the delivery of public health services.

Under NHM, the increasing focus on Reproductive Maternal New Born Child and Adolescent Health Programme (RMNCH+A) has led to a reemphasis on the role of nurses and midwives in the public health delivery system. However, the challenges like pre-service education quality, limited career progression, low salaries, poor working conditions, huge vacancies in the health system, training resource constrain, limited involvement in decision making, difficulties in implementing policies, compounded by the overshadowing dominant role of medical doctors pose serious challenges to nursing and midwifery services in India.[16,17] There are also issues with the overall governance mechanisms for nursing at national and state level; for example, postings and transfers are not done in a timely, regulated manner and many posts lie vacant. In addition, there is no mechanism for grievance redressal in most of states.[18,19]

While, there is much diversity across states in the status of nursing and midwifery services, the concern and challenge of strengthening the nursing profession is shared by all. To ensure progress in the health sector, the quality, quantity and relevance of nursing and midwifery services in India needs to be reviewed and strengthened. As new health needs emerge, nurses and midwives need to equip with additional skills progressively to successfully acquire new roles and responsibilities.

As evident from the figure: 1 below the proportion of nursing and midwifery personnel in the entire health work force is large; an estimated one in every five health care professionals is a nurse.

Figure 1: *Proportion of Nursing Staff among Total Human Resources for Health under NHM in 2014*[20]

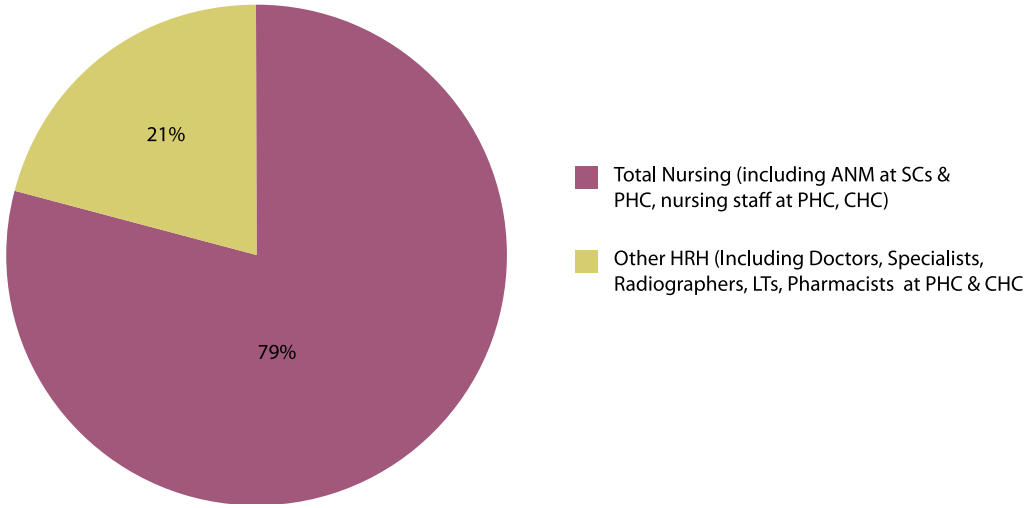
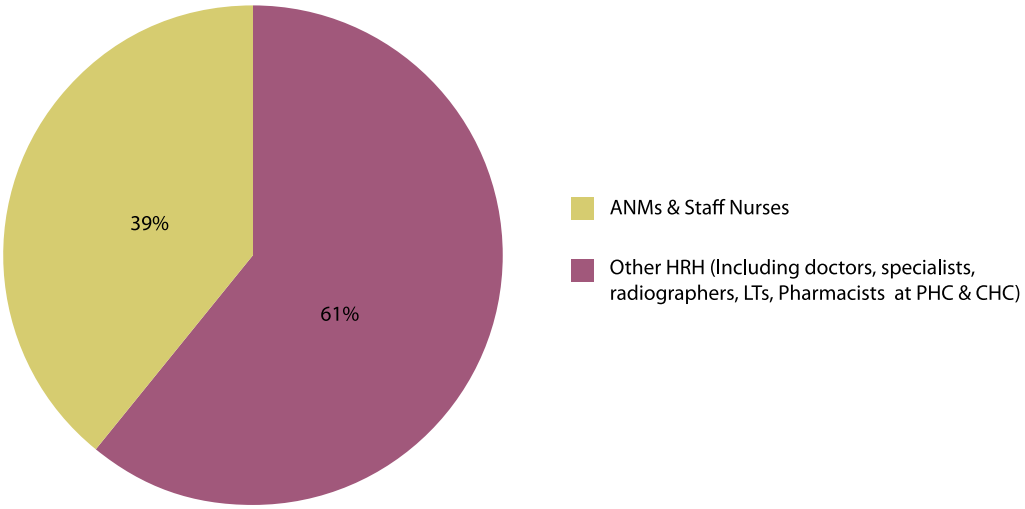


Figure 2: *Proportion of Contractual Staff Nurses & ANMs under NHM in 2014*



In an effort to address some of the concerns of the nursing profession mentioned above, the state governments have launched reform initiatives, amended existing policies and brought structural changes across different fronts of nursing - with a varying degree of success. In order to strategically address the issues related to nursing and midwifery it is crucial to review the existing policies, reforms and governance structures of nursing in states.

CHAPTER 2

STUDY DESIGN

2.1 RATIONALE FOR THE STUDY

Nurses and midwives are considered to be the backbone of primary health care service delivery in India. Nursing training programs approved by the Government of India include ANM, GNM, BSc (basic), BSc (Post basic), MSc, MPhil and PhD. For the purpose of this study all these nursing graduates will be consider as nursing professionals. As per the Rural Health Statistics, 2015 there are currently an estimated 2,90,596 nursing professionals in the Indian public health system.

The issues related to nursing have gained some attention from policy makers in recent times. The resultant initiatives are expected to have a positive impact on the nursing profession in India, even though limited studies have been conducted to review the overall situation of nursing personnel (including ANM, GNM, Staff nurses, LHVs and the nursing faculty in the health system).

Previous studies commissioned by NHSRC in five states including Chhattisgarh, Bihar and Rajasthan, identified gaps in nursing governance and regulatory mechanisms[21] such as the issues of limited nursing pre-service education opportunities specifically post-graduate courses. Many states in India are suffering from a number of issues, such as the quality of pre-service education and governance and work force management policies and practices. This current study is an effort to review and analyze the existing situation of nursing across five states in India.

2.2 RESEARCH QUESTION

What efforts have been made by states to strengthen education, leadership and regulations in the nursing sector - and review the challenges faced in this process?

2.3 OBJECTIVES

Based on the rationale, the key objectives for this study are:

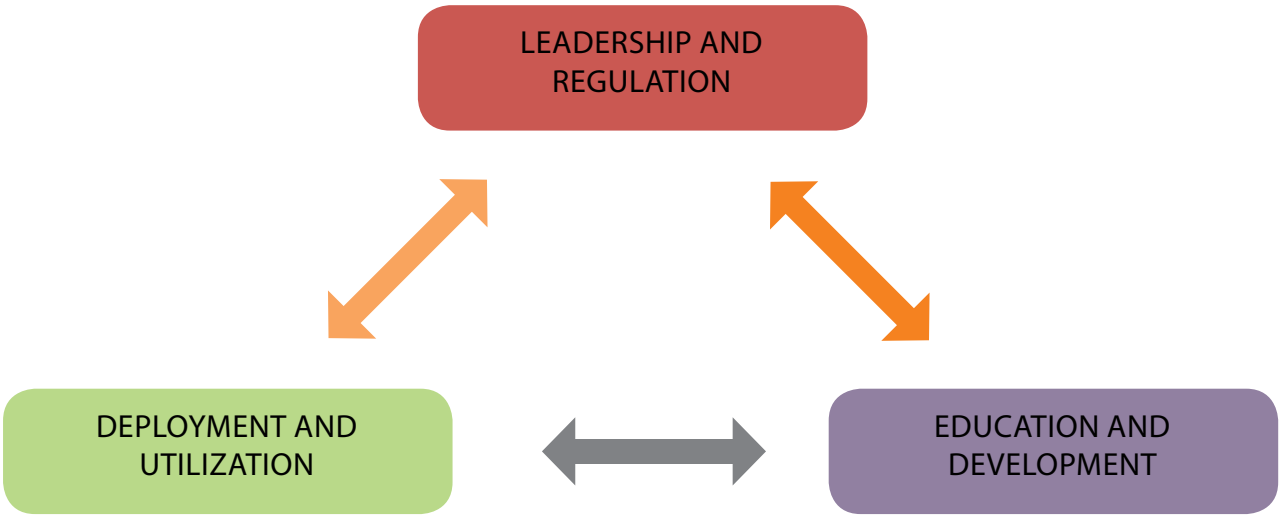
1. **Leadership and Regulations:** To review the regulatory framework including governance structure, policy reforms, and its implementation in the nursing sector
2. **Education and Development:** To assess the status of pre-service education and the capacity building of nursing personnel

3. **Deployment and Utilization:** To review the current institutional mechanisms and workforce management of nursing professionals.

2.4 CONCEPTUAL FRAMEWORK

A conceptual framework has been illustrated below to achieve the objectives of this study. The broad areas to be studied were identified according to a WHO recommended model. The three closely linked themes covered include: *Leadership &Regulation, Education &Development and Deployment & Utilization*. With a focus on the Indian context and a state specific approach, sub-areas were identified after a process of policy mapping from the Indian Nursing Council Act[22] (which regulates the operationalization of nursing policies in India).

***Figure 3:** Conceptual Framework for the Study [23]*

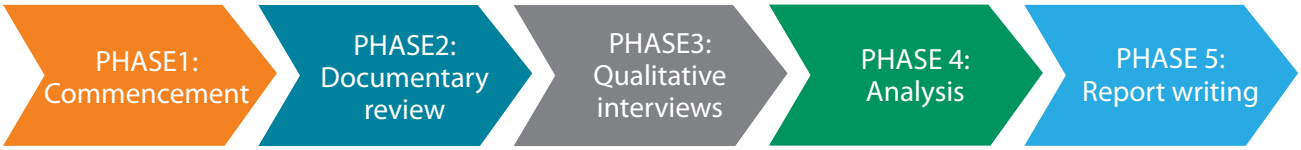


As illustrated in the figure above, there is a close correlation among the three thematic areas and variations in one area have implications on others. The relationship between these cross-sectional variants and their importance has been briefly described below:

1. Leadership and regulation is fundamental for ensuring strategic development in education and deployment. This incorporates various elements such as policy and planning, decision-making, professional education regulation, shared leadership and nursing reforms.
2. Education and Development is integral to the generation of skilled nursing personnel. The standards developed by policy makers and maintained by institutions for curriculum, pedagogy and assessments ensures the regulation and quality of education to generate skilled tutors and students.
3. Deployment and Utilization: Platform built on strong education and robust regulatory policies lays the foundation for an adequate resource pool of nurses and midwives. This is crucial for creating an effective nursing workforce to deliver services to the entire population.

2.5 METHODOLOGY

In order to achieve the study objectives, qualitative methods were used for data collection and analysis. The study was conducted through various processes including brainstorming discussions to establish the study objectives, selection of states and the study methodology. A preliminary literature review was also conducted during the early phase of the study.



There was a two tier sample selection process; first, at state level and second at the district level.

CRITERIA FOR STATE SELECTION: Based on the (i) Geographic Location, (ii) availability of baseline data and (iii) an understanding of good practices related to nursing, five states were selected to review and analyse nursing reforms in India.

This study was conducted in Bihar, Chhattisgarh, Kerala, Rajasthan and West Bengal. Bihar, Chhattisgarh and Rajasthan were selected based on the availability of baseline information from previous publications. Kerala was selected based on evidence that there is large generation of nursing personnel in this state[21, 24]. The presence of effective functioning of the Nursing Directorate under the Directorate of Health Services in West Bengal has been the criteria for its selection.

CRITERIA FOR DISTRICT SELECTION: Criteria were defined to conduct field visits in one district of each state: (i) any district other than the State capital in order to review the actual position of nursing in districts away from state headquarters, (ii) Any new specific initiative carried out by the state in the area of nursing in that district (iii) Presence of any nursing training institute, one each of private and government (iv) availability of faculty at all levels, and (v) Availability of staff from each level of nursing cadre at a health facility. The districts selected included Patna (Bihar), Mahasamund (Chhattisgarh), Kozhikode (Kerala), Ajmer (Rajasthan) and Hoogli (West Bengal). In Bihar, the state capital had to be selected, as an exception, to review an on-site mentoring initiative being carried out in Fatwa block (of Patna District) which would contribute to the study objectives.

Secondary Data

The second step involved a documentary review across all the study states. This included gathering information on policies, guidelines, relevant manuscripts including legal documents, government orders, circulars, letters, newspaper articles, important meeting minutes etc. The documents were analysed through policy landscaping. This helped in formation of a thematic framework for the study and identification of key actors/ organisations involved in functioning and development of nursing structures. The tasks assigned to each of these nursing cadre positions were reviewed to explore enabling and disabling factors for implementation.

Primary Data

The qualitative data collection was undertaken through in-depth interviews, informal discussions and experience sharing at state and district levels. One district was visited in each state to assess inter-linkages between state, district and block - and to identify the policy-practice gaps between the state and district level within the nursing cadre. The participants selected for primary data collection were based on identification of actors from a policy analysis and secondary data review. In-depth interviews and informal discussions were held with each participant to understand their experience of the system. Four broad categories of staff interviewed were:

- Key informants (policy makers and development partners)
- Stakeholders (management units at state and district level)

- Nursing personnel (nursing faculty, students and staff)
- Nursing Associations (State and District level)

An interview guide was prepared (Annexure: 1), a brief overview of the study was provided to each interviewee prior to their participation and verbal consent was taken. Discussions were influenced by their willingness to engage and their availability in office. Participants were offered the option of withdrawing their participation at any time without the need for any notice.

Secondary Document Review

Table 1: List of Primary and Secondary Documents

TYPE OF DOCUMENT	NUMBERS	ACTORS	REMARKS
Legislations (103)	15	State Nursing Act, related amendments and rules	Provided the base material to study the nursing framework
	88	Government orders/ Circulars/letters	Provided information on modifications and progress made by states
Legal and public documents (10)	10	Newspaper articles, court proceedings, court judgements, pamphlets, brochures	Provided clarity on public opinion and legal actions undertaken in the public interest
PRIMARY DATA COLLECTION			
In-depth interview/ informal in depth discussions	**115**	President and Registrar (State Nursing Councils). State nodal persons for Training, Human Resource and Nursing cell, SIHFW officials, District level nursing officials, LHV, ANMs, staff nurses, Principal and tutors of government and private nursing institutes, nursing Unions. Officials in the nursing Directorate,	These discussions focussed on their key responsibilities and job functions within the framework of the study. Also included general questions on other related areas.
In-formal discussions	**21**	SPM, CMHO, DPM, ex-experienced officials, nursing students at training colleges, SHRC nodal persons	These discussions were more generic and involved sharing of past experiences and their understanding of nursing structures and functions
State Nursing Council	1 in each state		To interact with the relevant officers at state level
State HR Division/ establishment cell	2 in each state		
State training division	2 in each state		
State nursing division	1 in each state		
Nursing training institutes (Govt. & Pvt.)	2 in each state		Interaction with the teaching faculty and students in nursing schools/ colleges
In-service training center	1 in each state		To discuss the provision of in-service training of nursing faculty and care providers
State Nodal Centre/ National Nodal Centre	1 in each state		

TYPE OF DOCUMENT	NUMBERS	ACTORS	REMARKS
District hospital/ Medical College	1 in each state		To interact with the nursing staff at health facilities and understand their roles
Health Sub-center	1 in each state		
Nursing Associations	1 in each state		
Development partners	1or 2 in each state		To gauge their involvement in nursing activities
Any other relevant body Contributing towards Nursing governance	1 in each state		Any state specific organisation contributing to the development of the nursing cadre

In the fourth phase, all the collected primary and secondary data was mapped into a thematic matrix– according to the conceptual framework adopted for the study. The sub-themes were generated based on observations from all states (to avoid exclusion of any collected data for a more comprehensive analysis). A comparative analysis was done regarding the strategies and progress across the five states as there has been a difference in relation to the number of institutions, human resources related to nursing and also the structure of governing bodies in these states . The study also tried to determine the level of implementation of nursing reforms and strategies for strengthening the nursing cadre. These factors identified good practices and provided recommendations to be adopted (or adapted) by states as per their specific needs.

2.6 LIMITATIONS OF THE STUDY

- A fear of disclosure restricted a significant number of key informants from cooperating fully and providing in-depth information.
- Even though appointments were fixed well in advance according to the convenience of participants, some of them could not honour their scheduled appointments; re-arranging meetings proved difficult.
- All the relevant information was often not available in the first visit to the state. An attempt was made to collect the missing information and obtain clarifications, if needed, during a second state visit and also from telephonic conversations. Despite this, there were still some data and information gaps.

CHAPTER 3

LEADERSHIP AND REGULATION

This chapter illustrates the existing structure of nursing governance and the regulatory mechanisms in these five states. Effective operationalization of policies depends on the nature of leadership and the prevailing governance mechanism within the system. This chapter presents findings about the process and dynamics of power, politics and decision-making in the nursing profession.

3.1 REGULATORY POLICIES

All five states have framed a State Nursing Regulation Act, which broadly encompasses the establishment of a Nurses and Midwives Council (for the registration of nurses, midwives, health visitors and auxiliary nurse-midwives in the state). Related state Acts acknowledge the establishment and constitution of the Council with their roles and responsibilities specifically defined. Some include further details such as the process of registration of qualified nurses, disciplinary directives for appointed nurses and training institutions for nurses. However, recognition of qualification, code of ethics, professional conduct (and misconduct) is determined according to guidelines mentioned in the Indian Nursing Council Act (1947) in all states.

Table 2: Legislative Framework in Five states

State	Year of publication	Remarks
Bihar	1935	No amendments for 78 years; rules for establishment procedures published in 2013
Chhattisgarh	2003	Adopted Madhya Pradesh Nursing Registration Council Act (1973)
Kerala	1953	Well-structured and elaborate Act, supported by rules and timely need based amendments
Rajasthan	1964	No amendments after publishing and lack of implementation
West Bengal	1951	Continuous amendments introduced for strengthening

3.2 PROFESSIONAL EDUCATION REGULATION

All States have established autonomous State Nursing Councils (SNC) according to guidelines laid down by the Indian Nursing Council (INC), which regulate uniform standards in pre-service education for nurses, midwives and health visitors in each state.

Table 3: Current Situations of State Nursing Councils across Five Study States

State	Situation	Remarks
Bihar	There is limited involvement of the nursing council in a regulatory role; it has been reported that even the Registrar is occupying this position in violation of the Bihar Nursing Act 1935	State Health Society has played a significant role in improving the nursing pre-service education in the state. Important contributions have been made by the Development Partners as well.
Chhattisgarh	Council is functional; however, the lack of adequately trained staff and limited logistical support restrain them from functioning at full capacity.	SHRC provides technical support to the SNC. In addition, NHM is planning to establish a separate division for strengthening nursing in the state
Kerala	Since 2008, Kerala Nurses and Midwives Council (KNMC) operates as a separate entity with its own President and Registrar selected from the nursing cadre; this enables more focused decision making for nurses registering in the state	
Rajasthan	Limited involvement of nursing officials in decision-making; the lack of a full time post for Registrar is emblematic of the low priority afforded to nursing in the state.	
West Bengal	A well-structured and organized Directorate of nursing has resulted in streamlining all the establishment processes. Close collaboration between SNC and the Directorate is present and provides an excellent example for other states to emulate	West Bengal provides an example of good practice for other states to replicate

These councils have some common issues, which include a limited authority for regulatory functions, inadequate infrastructural support (understaffing, lack of working space, lack of inspectors for conducting periodic assessments of training institutes) and external interferences in the regular functioning of councils. As already mentioned, a few of the council registrars are only invited to participate in periodic meetings and have a limited role in decision-making.

The diversity in background of the constitutional members of State Nursing Councils is shown in the table: 4 below. Kerala have included members from public health staff, the private sector and the Medical Council; this provides a more holistic approach to the issues faced by the nursing sector. However, the disproportionately high over representation of medical professionals carries a concern about misrepresenting the priorities of the nursing cadre and influencing their developmental priorities. There is a need to safeguard their interests and status within the health system as they are an independent and disparate health functionary within the health system with their own unique issues and priorities.

Table 4: Constitution of the State Nursing Councils in Five States

Work Areas	Bihar	Chhattisgarh	Kerala	Rajasthan	West Bengal
State Officials (DHS)	✓	✓	✓	✓	✓
Nursing Staff At Facility/ Teaching Hospitals	✓	✓	✓	✓	✓
Medical Practitioners	✓	✓			✓
Public Health Professionals			✓	✓	✓
Nursing Associations		✓	✓	✓	
Medical College Representatives	✓	✓		✓	✓
Nursing Faculty		✓		✓	✓

Work Areas	Bihar	Chhattisgarh	Kerala	Rajasthan	West Bengal
Representatives From Private Sector			✓		
MCI			✓		
Others	✓	✓			

3.3 NURSES IN DECISION-MAKING

The degree of involvement of nurses in the process of decision-making and policies associated with their working is inconsistent across states. To frame equitable and fair policies and reduce policy-practice gaps in the health system, nurses and midwives need to be an integral member of policy level and decision making committees. In contrast to this, they are merely the implementers of prescribed policies and guidelines, which clearly reflect the power dynamics within the health functionaries.

In West Bengal, qualified and experienced nurses work as senior decision-making positions in close coordination with senior medical administrative officials. In Kerala, nursing is a well-respected profession and senior positions have been created in nursing administration, yet it is disheartening to observe that there is limited scope for participation in important meetings and forums. On the other hand, nurses in Chhattisgarh and Bihar have minimal administrative roles and decision-making powers currently due to a lack of equal opportunities and a lack of robust policy frameworks to strengthen the profession. In Rajasthan similarly, the nursing profession is struggling to make its voice and presence felt.

The individuals occupying senior nursing positions also has a strong influence on the level of authority granted and exercised. There are a few states where pro-active individuals and institutions have taken ownership for strengthening the cadre. These individuals, along with a highly motivated team on some occasions, have been actively involved in utilizing the limited powers provided in order to achieve greater outcomes. They have been diligently working towards recommendations and guidelines suggested by state, national and international reports. However, external influences and vested interests from other health related bodies and organizations outside of nursing have negatively affected the strengthening of the cadre.

3.4 SHARED LEADERSHIP

Integration within health care is an approach characterized by a high degree of collaboration and communication among health professionals and health related organizations. There is a need to further develop and strengthen leadership and regulatory structures in states; State Nursing Councils working in close coordination with the state DHS and SHS should ensure an integrated work approach and thereby encourage a holistic development of the nursing profession.

Though the health Directorates in many states have limited space for nurses to function in leadership roles, yet there are exceptions. In Kerala and West Bengal, the close coordination and reasonable flow of information between the SHS and DHS has contributed to good governance structures in these states. This helps in developing effective strategies for workforce management practices for in-service employees, including nurses, within the public health system.

Furthermore, integration between the nursing and medical sections within the Directorate, which is evident in West Bengal, is a good example of teamwork, which helps in the upliftment of the nursing cadre. Other states should understand the importance of integration at all levels of the health service and work in collaboration to strengthen the nursing cadre.

3.5 INITIATIVES IN NURSING AND MIDWIFERY

Reforms related to nursing at the state level can be broadly classified into structural, educational, and regulatory. The influencing factors vary across states so as the political will and social context. Many of these reforms are elaborated in detail in later sections of this report. All the states have made efforts to strengthen the nursing cadre. A few examples of good practices as observed across states are as follows:

BIHAR: Based on the recommendations suggested by NHSRC in 2008, the Bihar Government has initiated the establishment of a separate governance structure for nursing within the Directorate. Furthermore, many structural reforms have been observed in Bihar such as the operational nursing wing under NHM, establishment of a State Nodal Centre for in-service training of nursing tutors, formulation of an innovative training strategy for nurses, introducing career progression opportunities for nurses, and a coordinated working approach between the SHS, development partners and other nursing stakeholders in supporting various nursing related activities.

CHHATTISGARH: Created a channel for progression of CHWs (known as *Mitanins* in the State) to ANMs and GNMs. This was initiated by the active advocacy of the SHRC, Chhattisgarh and was well received by the Mitanins. The state is undertaking a process to establish a nursing section under NHM to coordinate activities with the SNC and DHS.

RAJASTHAN: SIHFW has launched an 'Integrated Training for Health Workers' which includes the nursing staff. This training (for duration of 30 days) includes eight related comprehensive trainings (eg. *SBA, RTI/STI, CAC, NSSK, IYCF, RI, IMNCI and IUCD*) to prevent duplication of efforts and also reduce wastage of resources.

KERALA: Built as a separate organization, the State Institute of Medical Education and Technology (SIMET) reviews the establishment of self-financed nursing colleges apart from medical and paramedical colleges. SIMET ensures that there is compliance with stipulated national and state standards in the setting up and running of these institutions.

WEST BENGAL: Many important reforms such as a Nurse Practitioner's Model for training midwives for rural postings, trainee reserve (a in-service higher education opportunities for nursing staff who have completed a minimum number of service in health system) and GNM courses for male candidates have been introduced. West Bengal has made the most impressive progress in nursing governance among the states reviewed due to its long-standing and active governance structures and the close coordination between the DHS and State Nursing Council since the 1950s.

It is noteworthy and encouraging that most of these models can be built by re-organising existing resources in the state public health delivery system without significant financial inputs. States can adapt or adopt these examples of good practices as per their own local need and context.

CHAPTER 4

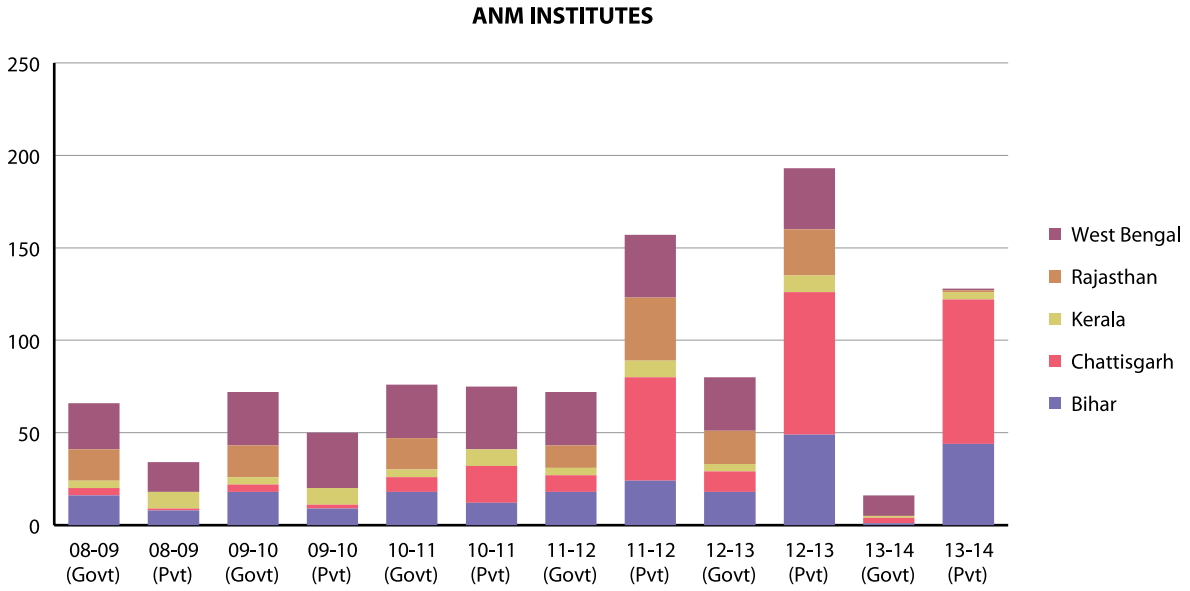
EDUCATION AND DEVELOPMENT

The social and cultural background plays an important role on these aspects. In Bihar, there is a belief that *'a girl who is not worthy enough in her life chooses nursing and midwifery as a career option'*. Therefore, this hampers reforms for social and gender equity for this profession. There is also a general perception that *'the preponderance of females in this profession means there is less power and authority to raise their concerns'*. However, there are exceptions – reviews and interrogations in Chhattisgarh suggest*' better gender equality'* and *'lesser social obstructions'* associated with the nursing profession. In Kerala, strong social reforms and movements over last couple of centuries have ensured that the nursing profession enjoys a high profile, is well respected and the state has contributed significantly to the nursing cadre - both nationally and globally.

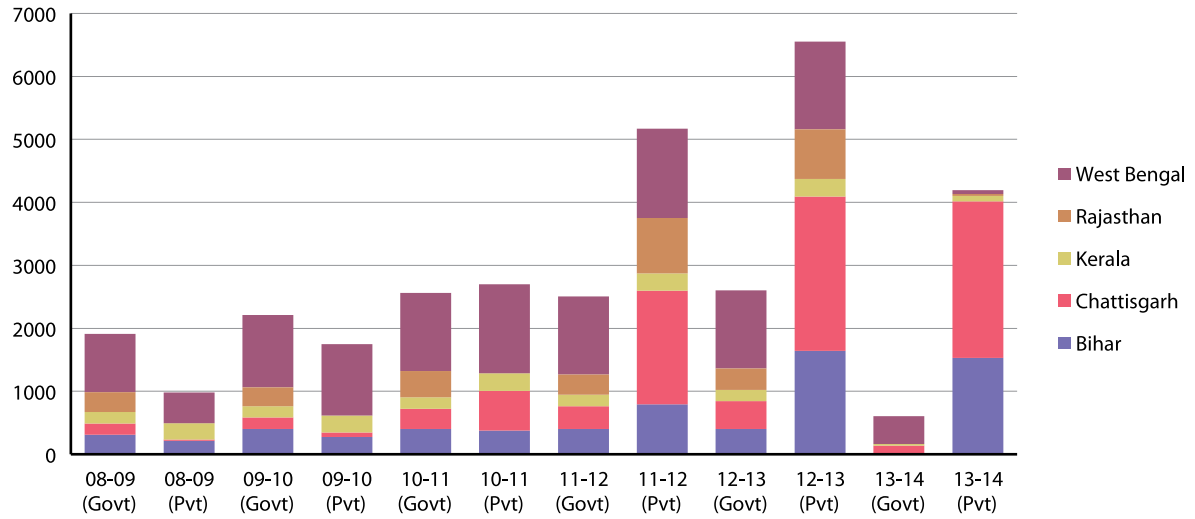
4.1 PRE-SERVICE EDUCATION

This section depicts the structural growth of nursing education from 2008 to 2014. This clearly shows that there has been an increase in the number of institutes, mostly private, and a corresponding increase in the annual generation of qualified health workers/nurses. This increased generation of nursing staff has a direct implication on the number of professionals available for registration and employment.

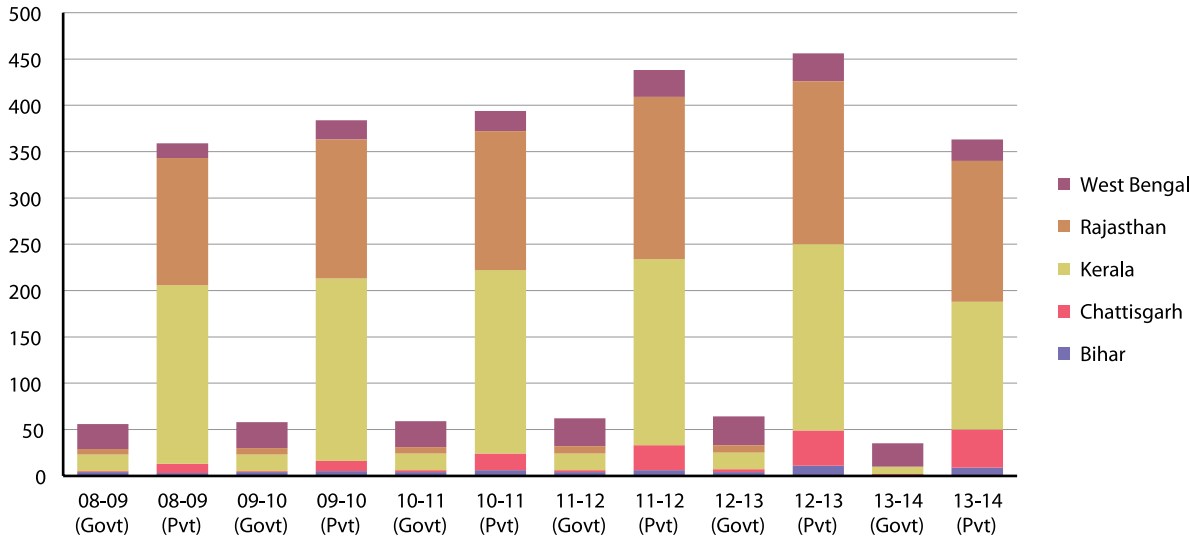
Figure 4 Nursing Pre-service Education Institutional Capacities across Five Study States[25]



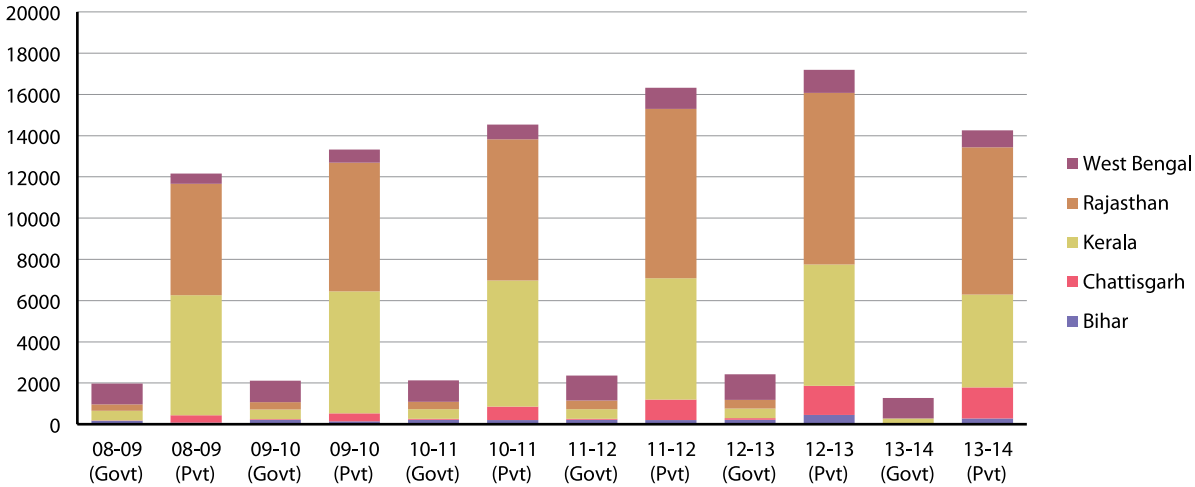
ANM ANNUAL SEAT CAPACITY



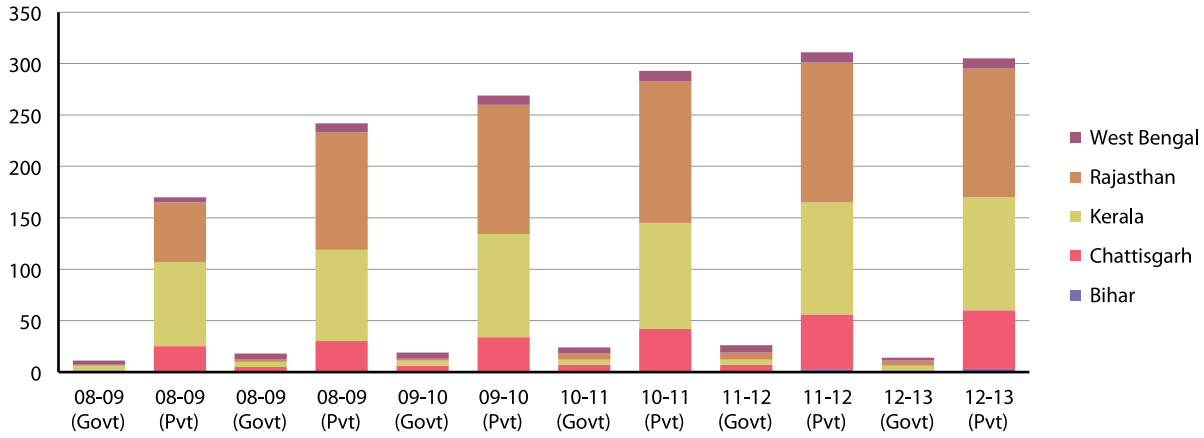
GNM INSTITUTES



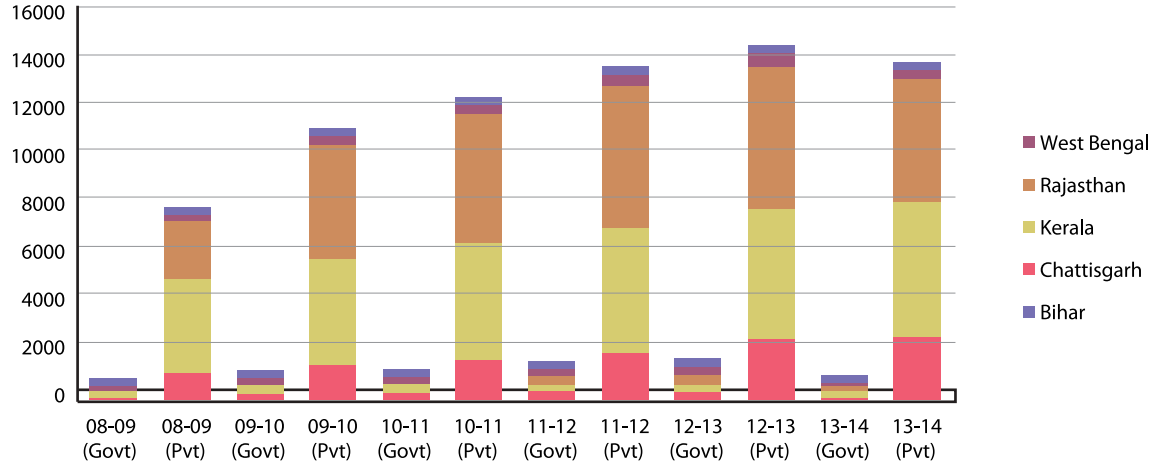
GNM ANNUAL SEAT CAPACITY



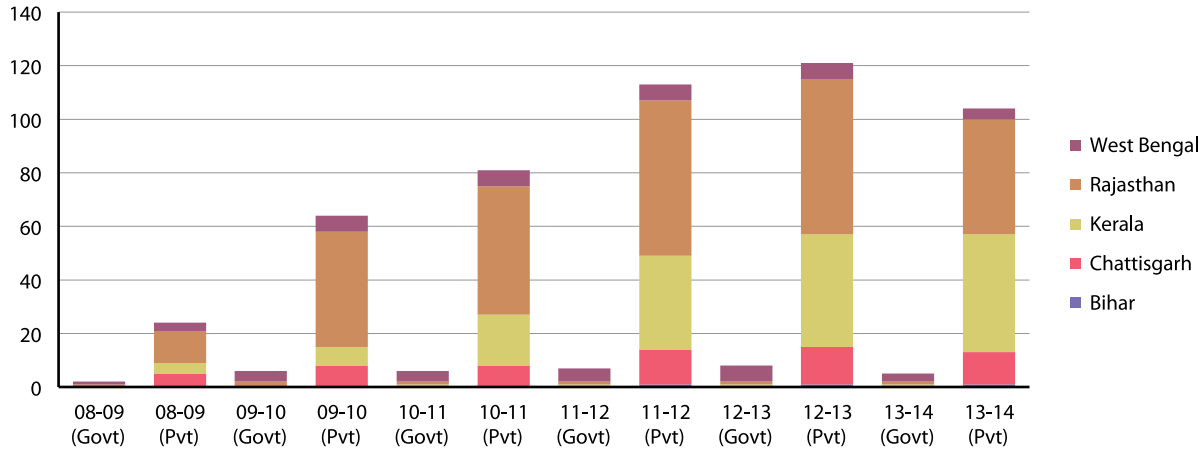
BSc NURSING INSTITUTES



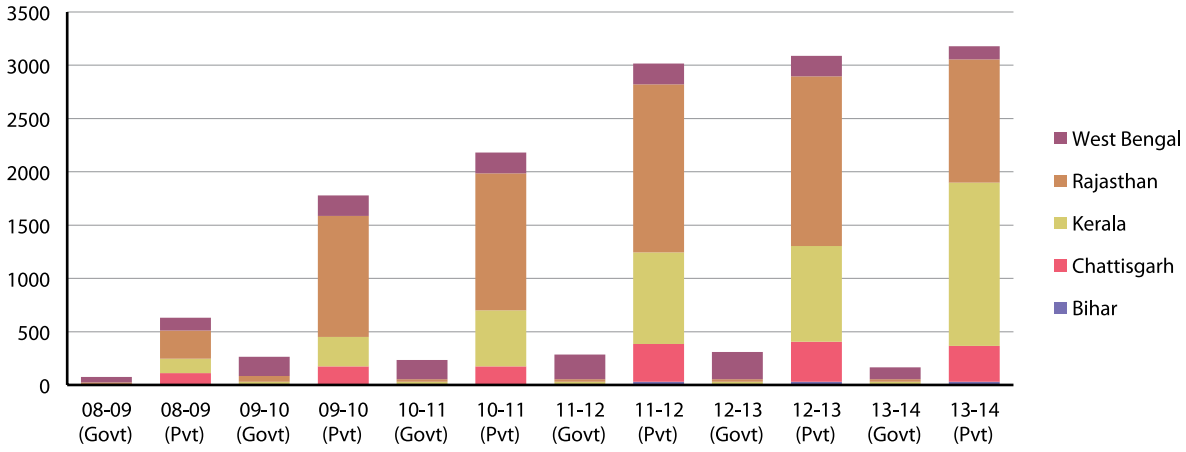
BSc NURSING ANNUAL SEAT CAPACITY



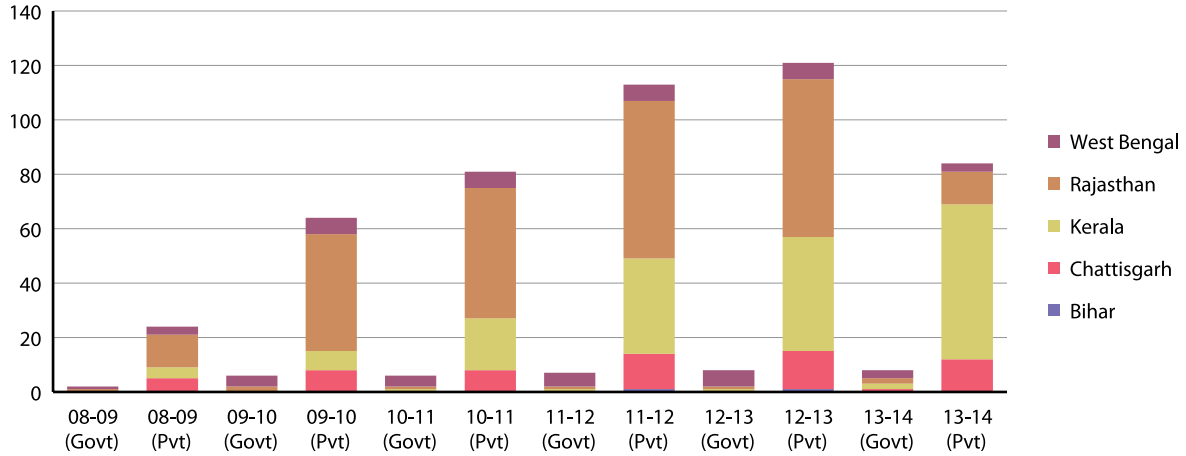
POST BASIC BSc INSTITUTES



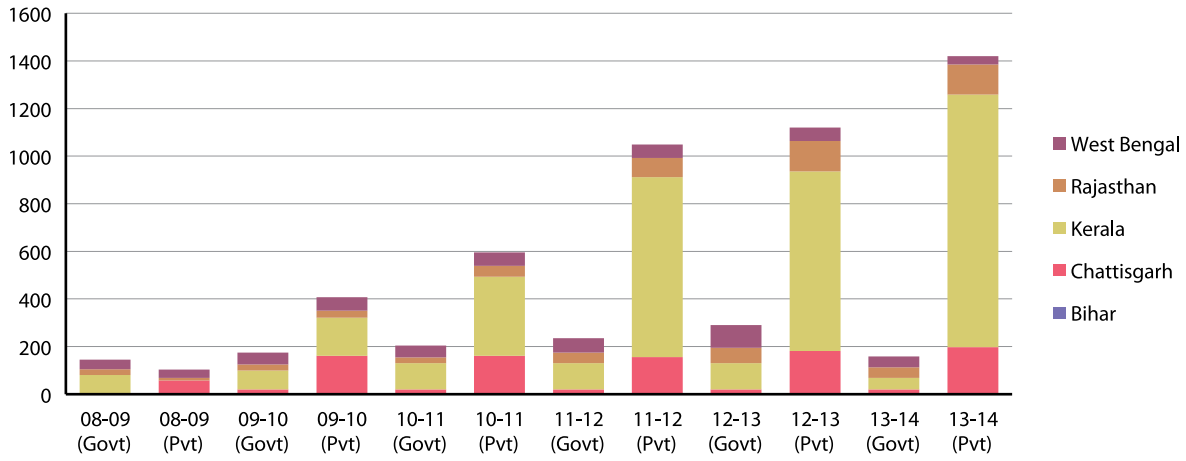
POST BASIC BSc ANNUAL SEAT CAPACITY



MSc NURSING INSTITUTES



MSc NURSING ANNUAL SEAT CAPACITY



The trend displayed in the graphs above indicate the increase in the number of nurse training institutes across five states, which is somewhat similar to the situation in other states as well. Despite this, there are still huge vacancies of nurses and midwives in the public health system in this country. This clearly indicates

that inspite an increase in the production of nursing personnel, the majority of them choose not to enter the public health system. The reasons are multiple and include irregular recruitment procedures, international migration and low salaries in the government sector as compared to the private sector. Moreover, increase in the number of private training institutes is disproportionately higher than government and graduates from the former typically prefer to work in the private sector.

Many key informants shared a concern that the apparent mushrooming of new private nursing institutions (as is evident from the figures above) pose a serious threat to the quality of nursing profession in long run. It has made it increasingly challenging for regulatory bodies to maintain quality standards who have their own limitations in terms of resources (time, funds and HR). It has been mentioned by key informants that even if these private institutions do not adhere to INC guidelines, they generally have little difficulty obtaining college affiliation, temporary or permanent.

In addition to this, the Government has made an attempt to address the shortage of nursing personnel and enhance their skill by establishing additional nurse training institutes. One of, the recently established AIIMS in Patna, Raipur and Jodhpur have also started to set a benchmark and raise standards in the field of nursing education in India. Faculty recruitments are correspondingly being made to impart nursing education of the highest standards in these states.

Box 1: Organizational Development in Kerala

GOOD PRACTICE: ORGANISATIONAL DEVELOPMENT IN KERALA

To expedite the process and ensure standardization, SIMET, an autonomous body is accredited for the promotion and initial establishment of medical and paramedical education and training institutes. After establishment and recognition, the funding for operating and running expenses is borne by the institutes themselves. An official from DHS has been given additional charge as the Project Officer for supervision and coordination. The State government nominates the other members of the Governing Body periodically. The funds for functioning of this body are through grants from the state and national government and contributions from other corporate bodies and agencies. This body has a mandate to support the establishment of nursing institutes as stated in guidelines by the INC and KNMC; this includes the maintenance of infrastructure, raising funds for immovable and movable property of institutes and to provide legal support and defensefor proceedings associated with the establishment of new training institutes.

4.1.1 Government vs Private Sector

An important difference between Government and private nurse training institutes is in terms of the degree of clinical exposure. Government-training institutes, despite having limited infrastructure, are mostly attached to a Government Medical college or hospital and this enables students to have sufficient hands-on opportunities for clinical exposure. In contrast, private institutes generally have adequate infrastructure and logistic support, yet struggle to provide adequate clinical exposure to students due to limited opportunities to review patients and practice clinical procedures in government medical college hospitals. This has serious implications on the skill and competency of nursing graduates from private institutions.

Box 2: Virtual Classrooms in Bihar

GOOD PRACTICE: VIRTUAL CLASSROOMS IN BIHAR

In order to strengthen the quality of pre-service education, virtual classrooms have been established at Skill Labs in Bihar with support from the development partners. Training centers with a lack of adequate teaching capacity or with limited access to patients are provided support through these virtual classes. This also helps in addressing the issue of shortage of teaching staff in nursing training institutes. Currently this facility only facilitate to Government run nurse training institutes.

Box 3: Recognition of New Courses in West Bengal

GOOD PRACTICE: RECOGNITION OF NEW COURSES IN WEST BENGAL

WB has taken steps to introduce the following two new need-based nursing courses:

1. The council has recognized a new Diploma course for Male GNMs in December 2014. Earlier, male candidates were not eligible for GNM and other nursing related courses leading to a shortfall of nurses. Their need has been specially felt in Operation theatres and Orthopedic departments.
2. A pilot project for Nurse Practitioners in Midwifery Course was started in 2002, based on guidelines from GoI and the INC. The main objective of training was to strengthen skilled midwifery services for mothers and newborns in remote and under-servedareas. A total of 15 candidates had completed the course in two batches till 2014. There had been a delay in the approval of these posts by the Finance Department, as the functionaries had demanded higher pay scales. They are responsible for providing autonomous care for family planning, pregnancy, childbirth and post-natal care for mothers and newborns.

4.2 INSTITUTIONAL ACCREDITATION AND REGULATIONS

In states, the process of inspection of training institutes is not systematic with regards to frequency, rigor and timeliness. A few training institutes do have the potential to apply for permanent affiliation but there is lack of awareness regarding this. The increase in the number of inspectors and staff in regulatory bodies is not proportional to the increase in training institutes. External interventions and influences also affect the routine process of inspection. This affects the process of quality assurance in these institutes. There is a strategic lack of inter-linkages between training institutes and regulatory bodies leading to non-compliance of regulatory norms and regulations.

4.3 COMPETENCY BASED EDUCATION

A review of the extent of competency assessment at various stages of education is discussed in this section.

4.3.1 Candidate Selection

For pre-service education, the selection of candidates for admission to training institutes in all states is merit based. The INC has passed a resolution providing relaxation to students from a non-science stream (in class 12) and those from vocational courses - granting them eligibility for admission to ANM/ GNM courses. Concerns have been raised regarding the competence of these students when compared to students from a science stream - as the evaluation process and study content varies significantly between these streams. There could be a formal basic assessment to ensure knowledge and aptitude of all students joining a course is similar. This will ensure uniform standards in pedagogical structures. However, INC has issued guidelines

for entrance into PBBSc and MSc courses with specific past educational qualifications and adequate years in service.

4.3.2 Curriculum Design

There is a standard curriculum shared by the INC curriculum for all states. The last modification in course content for the ANM course was done in 2012 and for the BSc course in 2010. This fact suggests that a good mechanism is in place to review and update the curriculum based on the emerging needs of the health system e.g. the introduction of computer literacy and updates in the bio-medical waste rules in accordance with revised GoI guidelines.

A requirement of 100% attendance for practical and internship ensures that sufficient importance is on hands-on training and is a pre-requisite before the certificate/ degree is awarded. As already mentioned, many of the private colleges do not have an affiliated hospital/Medical College in their close proximity as mentioned in the guidelines, thus limiting the clinical exposure necessary for training and compromising adequate development of their professional career.

4.3.3 Assessment

In most states, nursing institute examinations are conducted by State Nursing Councils. The Council provides scrutiny, printing and dispatching of question papers. Examiners are also selected by the Council and placed at examination centers to ensure fair conduct of examinations. Answer sheets are sent to examiners identified by the Council in most of the States. INC also provides guidelines for examination procedures and these have to be strictly adhered to.

4.4 LEARNING TO PRACTICE

There is direct co-relation between the quality of nurses qualifying from nursing training schools and colleges and the quality of services provided at health facilities. Therefore, synchronization between the education and service sector is critical for the benefit of students and the community. Policies to encourage higher education should be supplemented with supportive strategies in the service sector. This will also reduce the burden on in-service and refresher trainings.

4.5 FLEXIBILITY

With varying burden of disease varies across states, the need of health services required from the community varies. It would be beneficial if job responsibilities of health service providers could be contextualized depending on the nature of services demanded from community (e.g. sickle cell anemia is more prevalent in some states). This necessitates flexibility and adaptability in the curriculum. However, the INC is rigid regarding the curriculum and does not provide flexibility to states to supplement or adapt the curriculum according to state specific needs. The states should be provided the opportunity to add further study topics after appropriate permission from INC.

4.6 SUPPORTIVE MECHANISMS

In Rajasthan, there is a feeling of discrimination among nurses with respect to some other categories of health service providers. This is evident from certain workforce management policies e.g. A Medical Officers are allowed to go on a study leave with pay whereas nurses receive reduced pay during study leave and are not eligible for increment after obtaining higher education. This results in a financial loss to nurses leading to a lack of interest in higher education and low morale.

Box 4: Higher Education for in-service Nurses in West Bengal

GOOD PRACTICES: HIGHER EDUCATION FOR IN-SERVICE NURSES IN WEST BENGAL

Opportunities for higher education for in-service candidates are facilitated through the mechanism of'trainee reserve' in the Nursing Directorate. A maximum of three percent of the cadre in Grade (I) and (II) nursing can undergo training each year. Candidates can directly apply for courses and appear in the entrance examinations and simultaneously apply to DHS for sponsorship certificates. A minimum number of years of service for each grade and maximum age limit of 53 years has been laid down as basic criteria for eligibility to the trainee reserve. Successful candidates have to sign a post-training bond agreeing to serve in government facilities or pay a fine for waiver of the bond - depending on the course duration undertaken. Personnel who discontinue or drop out of any course have to forgo any further privilege of being placed as a trainee reserve and the period spent on the incomplete course is adjusted against admissible leaves. Hence, this clause discourages the candidates from dropping out from these courses.Any other education or training event (other than sponsored by the Government) shall be eligible for admissible leaves.

This initiative in West Bengal has motivated candidates to pursue higher education and enhance their skills and performance. Post-training, most of the candidates are eligible for promotion and salary increments. However, there is no hike in salary or any other incentive for candidates who undertake MSc programs within the health system. This has resulted in a lack of willingness to pursue this course leading to a subsequent scarcity of specialist nurses in WB.

4.7 CONTINUING NURSING EDUCATION (CNE)

A continuing education system is essential to improve and appraise the skills, attitude, knowledge and behavior of the nursing cadre. However, there is no systematic lifelong learning culture in the nursing sector. CNE also provides a base and benchmark for renewal of service licenses for nurses and midwives.

In Kerala, Continued Nursing Education (CNE) programs have been organized to enhance the skills of nurse and midwives, which will eventually lead to improvements in service delivery.

Box 5: Continuing Nursing Educations in Kerala

Good Practice: CONTINUED NURSING EDUCATION (CNE) IN KERALA

Programs have been supported by the Trained Nursing Association of India (TNAI) - which has a separate branch in Ernakulum district. As mandated by their Training policy 2004, every employee is expected to undergo training every five years but due to lack of infrastructure and facilities, it has been difficult to achieve this. However, efforts have been made to improve implementation.

The state is in the process of developing software, which will help in tracking credit hours of registered nurses. These credit hours will be assigned to nurses using their registration number on the basis of hours of workshops and in-house trainings attended. Private nursing and medical colleges also organize workshops and short-term in-house trainings. A registration fee is charged fromparticipants and is utilized for conducting the workshops. KNMC decides the allocation of credit hours for all theseworkshops on a request received from the organizers. At the end of 5 years of service, everynurse is required to complete 150 credit hours of education.

CHAPTER 5

DEPLOYMENT AND UTILISATION

This chapter focuses on the workforce management policies and practices related to the employment cycle of nurses in the states. It also reviews policy-practice gaps and various factors that influence availability, capacity building, performance and job satisfaction of nurses within the health system.

5.1 REGISTRATION

Different states have varying policies and processes for registering nurses qualifying from their state. In terms of the available workforce, factors like migration to other states and a preference to work in the private sector explains the mismatch between the annual production, registration numbers and availability of nurses within the public health system across states.

However, Kerala, Chhattisgarh and West Bengal, have made an attempt to address this issue by developing an online system for registrations of qualified nurses and midwives and get real time data. The frequency of data utilization for planning and decision-making from the online portal will ensure its quality.

5.2 RECRUITMENT

The process of recruitment of nursing staff (in both academic vs. service delivery, regular vs. contractual) varies across states. For regular staff recruitment, most of the states have well-established service recruitment rules, which are implemented by the State Government and executed through the Public Service Commission (PSC), Department of Health & Family Welfare (DHFW) or committees constituted from nominated members. In some states, written entrance examinations are conducted whereas in others, only knowledge-based interviews are carried out.

The NHM is supporting contractual appointments to augment service delivery in public health system. Most SHS are recruiting at frequent intervals as per their respective state needs.

The NHM also recommends competency-based recruitment of contractual staff. However, states have been slow in developing strategies based on these guidelines and their subsequent implementation.

West Bengal has initiated training of ANMs (to be posted as second ANMs) on a contractual basis. The major criteria for selection for these trainings are local area selection, and postings are preferably made to their home districts. This results in better retention of ANMs in the local area and the good rapport of these ANMs

with the community helps in ease and effective service delivery. Other eligibility criteria include age, marital status etc. and these can influence local area selection.

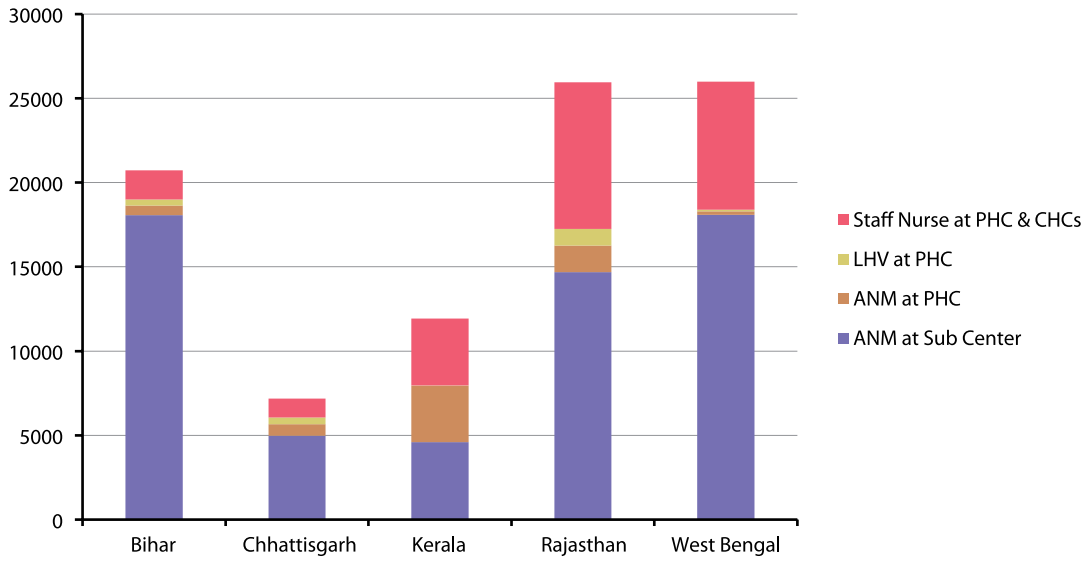
Box 6: Health Recruitment Board in west Bengal

Till 2012, WB PSC (West Bengal Public Service Commission) conducted recruitments; there was a considerable time gap between the need for staff by the department and the supply of selected candidates for filling up vacant posts. To expedite this process a statutory body 'West Bengal Health Recruitment Board'was established to facilitate the direct recruitment of all categories of posts under the WBH&FW. The composition of the board includes members from the state government, serving or retired, headed by a Chairman (equivalent to the rank of Special Secretary). However, there is a shortage of staff within the Board currently to carry out their nominated functions.

5.3 SHORTAGE OF NURSING PERSONNEL

As mentioned above, different states have different procedures for recruitment of staff at various levels. The vacant posts can be filled either by direct recruitment, promotion or by a combination of two. However, shortage of nurses exists in public health facilities. There have been various reasons for this. The fact that a large number of government departments are dependent on the PSC (Public Service Commission) for filling vacancies often leads to delays in initiating the process of recruitments based on anticipated vacancies. Moreover, the process of promotion is also not standardized. There is also a lag in vacancy identification. The following figures, based on RHS data, show the proportion of vacancies against the sanctioned posts for different nursing personnel in these five states.

***Figure 5:** Situation of In-service Nursing Professionals across Five Study States*[26]



5.4 CAPACITY BUILDING

Advances in health care necessitate the need to update knowledge and learn new skills. Therefore, in-service training plays an important role in addressing this issue. There is long way to go for states in terms of decentralized training planning and effective policy implementation by ensuring rational post training deployment.

5.4.1 Multi Skilling

Some in-service training guidelines have been provided at the national level and states have also taken initiatives to develop need-based training strategies for nursing staff. Certain targets for providing trainings are prepared for districts and states - and corresponding achievements are subsequently assessed. The majority of trainings focus on reproductive and child health activities such as SBA, routine immunization, IMNCI, IUCD, IYCF, RKSK, RBSK, ARSH, FBNC, RTI/STI and refresher trainings for ANC/PNC.

Box 7: Innovative Approaches for Multi skilling of In-service Candidates in Rajasthan and Kerala

INTEGRATED TRAINING IN RAJASTHAN

Integrated training courses for health workers are being conducted for duration of 30 days for 16 participants per batch. This comprehensive training program includes training on SBA, RTI/STI, CAC, NSSK, IYCF, RI, IMNCI and IUCD and includes theoretical as well as hands on experience for relevant sessions. This concept of integration of trainings was initiated by SIHFW in 2013 to ensure that every health worker is competent with all expected skills within the broad domain of maternal and child care. The drawback with this approach can be that learning a number of new skills in a short duration can lead to information overload.

PROGRAMME BASED TRAINING IN KERALA

The state provides induction training to JPHNs and has also modified training to include school health programs. This has led to the formation of health clubs in schools helping to strengthen school health programs. They work in close coordination with teachers, parents and provide appropriate counseling sessions.

5.4.2 Training Selection Methods

The criteria for candidate selection for training are unsystematic in most states. Some candidates show willingness to attend those trainings that are conducted in capital cities of the state providing them the opportunity to avail personal benefits. In other instances, candidates are sometimes selected without consent or interest; at times they are not even aware of the training subjects. This leads to lack of interest and poor performance in these trainings. Therefore, the criteria and rationale for attending trainings should be clearly notified and verified by block/ district officials recommending the candidate. Human Resource Management Information Systems (HRMIS) are helpful in maintaining records of training needs and requirements as required.

5.4.3 Training Assessment

Pre- and post-test knowledge and skills are reviewed in training and capacity building exercises in some states, e.g. Rajasthan. But, this is not yet standard across the majority of trainings on offer in states.

5.4.4 Post-training Utilization

It has been observed that a lack of systematic rational post-training deployment policy has affected effective utilization of training received. For example, if candidates selected from a facility providing delivery facilities to undergo SBA training, it is the health system's responsibility to ensure posting of these trained staff back to these delivery points. However, this is often not the case and is often influenced by other external influences, including political considerations.

Box 8: Training Management Information System in Kerala

GOOD PRACTICE: TRAINING MANAGEMENT INFORMATION SYSTEM IN KERALA

The State Institute of Health and Family Welfare (SIHFW) in Kerala (with technical support from the National Institute of Health and Family Welfare (NIHFW)) have developed a Training Management Information System (TMIS) to keep track of trained personnel, their deployment and the emerging training needs in the state. This includes information on the type of trainings conducted and also a list of trained participants who can be utilized effectively post-training. This helps ensure rational deployment of trained resources. Consideration should be given to merging this with HRMIS to enable the availability of comprehensive information of an employee at once place.

Along with the rational deployment of trained nursing personnel, the confidence to utilize these new or refreshed skills requires on-site supportive supervision. No state, except Bihar, has made provisions for this sort of hand-holding. This impedes the utilization of newly acquired skills and with time – a lack of confidence in using them. The lack of adequate and appropriate resources in facilities has also been cited as a reason for limited opportunities for putting training into practice. This reduces the effectiveness of post-training utilization.

Box 9: On-site Mentoring in Bihar

GOOD PRACTICE: ON-SITE MENTORING IN BIHAR

It has been observed that in spite of in-service training and capacity building conducted by states, nurses and midwives find it difficult to effectively implement the skills acquired in training in real life working conditions. To overcome this, innovative approaches have been designed to fulfill this gap in skill utilization to ensure that high quality knowledge and practices in public health get translated in to improved outcomes. The nurses and midwives have appreciated the benefits of onsite mentoring and have expressed willingness in attending on site sessions as they provide confidence to practice learned skills in their own facility. Benefits of this approach include learning in familiar settings, a conducive and enabling environment for clearing doubts, a pedagogical structure of parallel sessions of theory and practicum and the potential for modifications in the training content according to the needs of trainees.

5.4.5 Training The Tutors

To enhance the quality of pre-service education states have initiated in-service trainings for teaching faculty at the state and national level. Currently there are Nodal Centers – one at national and two at state level for conducting these trainings across all states. The following section provides information on two of these pioneering institutes (one national and one state); other states may wish to emulate this.

National Nodal Centre (Kolkata)

Based on guidelines from GoI, five states have been suggested for the establishment of National Nodal Centers (NNC) for training the faculty of nursing schools, Kolkata has been the first to achieve affiliation in 2011. Till January 2015, NNC was managed and funded by development partner, Jhepigo. In-service training for the faculty of government nursing institutes has been initiated for high priority states in the

first instance. There is a selection criteria for candidates based on their area of expertise (midwifery, child health and community medicine primarily). The list of selected candidates is sent by states after approval from INC. There is pre-training and post-training evaluation to assess skill enhancement. The NNC is well equipped despite the space constrains within the nursing college premises and the availability of limited trained staff.

State Nodal Centre (Bihar)

The Indira Gandhi Institute of Medical Sciences (IGIMS) in Bihar is an autonomous institute established in 1996. The nursing institute under IGIMS started with GNM courses, and introduced a B.Sc. nursing course in 2011. The institute has 40 seats for B.Sc. nursing and 20 for the GNM course. It also provides in-service training to the teaching staff of the state and regional level nursing institutes. In January 2014, the institute was declared a state nodal centre -based on recommendations from GoI and the INC. In Bihar, the work of the SNC started with the support of the state Government and was driven by the SHS and organizations like *Jhpiego*. There are virtual class rooms (audio-visual aided) to impart practical training to the students of other nursing institutes and this has been enthusiastically received. Broadband internet facilities have been made available in all nursing institutes of the state and they are connected to these virtual class rooms to encourage new ways of teaching and learning.

5.5 WORK FORCE MANAGEMENT

In order to utilize the skills and knowledge of the recruited nursing personnel, an effective system for management of human resources is essential. The following steps have been taken at national and state level to attract, retain and maintain performance of nursing personnel.

5.5.1 Performance Management

A comprehensive performance management system enables staff for continuous professional development and motivates them to perform better. For, this clear understanding of job descriptions, contract management and remuneration by the clinical and management staff is necessary. Bihar, Kerala and West Bengal have developed descriptive job responsibilities for the nursing staff in health facilities as well as teaching institutes. This also enables the supervisor to measure the performance of staff against the expected roles and responsibilities in a consistent and systematic manner. A '*Guidebook for enhancing performance of MPW (F)*' is a prototype developed at the national level, contains guidelines on the mechanism for performance assessment and similar guidelines can be prepared for other personnel.

5.5.2 Supervisory Mechanism

The setting up of supervisory structures at relevant levels enables appropriate hand holding of nursing staff in facilities. The large number of vacancies (against sanctioned posts and/or IPHS norms), irregular recruitments and delayed promotions has led to a limited availability and uneven distribution of nursing supervisors in the health system. For instance, the supervisor for an ANM should ideally be an LHV. However, with no further generation of LHVs currently (except in Kerala), this supervisory function has increased the workload on the limited number of LHVs available within the public health system. This has led to deterioration in the quality of monitoring of ANMs and their performance consequently. There have been similar observations for other posts within the nursing cadre.

Table 5: Average Number of ANM per LHV and Average Rural Population Coverage By ANM

S. No	State/ UT	Number of ANM PER LHV	Average rural population [Census 2011] covered by ANM
1	Bihar	52	4957
2	Chhattisgarh	14	3461
3	Kerala	612	3085
4	Rajasthan	16	3168
5	West Bengal	206	3398

(Source: RHS 2014)

5.5.3 Working Conditions

Working conditions in the public health system should be conducive to retain and enhance performance of the work force. These vary significantly across states and depend on the governance structure and regulatory mechanisms in place. The relative profile and social standing of the cadre in comparison with other functionaries in the health system e.g. doctors has an implication on extent of support nurses receive at health facilities.

In medical institutes with attached nurse training institutes, where nurses train and work closely with other medical professionals under a common administrative structure, nurses have limited financial and decision-making powers in contrast to medical professionals. This often creates unnecessary delays in routine administrative functions - hampering the working spirit of the cadre. Most of the states have also not developed well-defined work charters, job descriptions and a competitive remuneration for nursing positions and this leads to decreased morale and dissatisfaction.

5.5.4 Grievance Redressal Mechanism

In spite of recommendations from the Supreme Court to frame a committee to address grievances related to work and working conditions, none of the states reviewed have established a mechanism for grievance redressal or a specific cell to deal with complaints.

5.6 CAREER PROGRESSION

States are creating career pathways for better opportunities for health staff including nurses. States have framed career advancement policies and instituted committees for nurses and midwives to examine this issue. However there is still inadequate implementation on the ground. As also highlighted in the previous study commissioned by NHSRC and ANSWERS in 2008, the processes related to career advancement are highly disorganized and irregular; awareness about promotional avenues is also limited. The long-term implication of delayed promotions has resulted in an increased number of vacancies for positions entirely dependent on promotion as a method for recruitment e.g. LHV, which is therefore seen as a dying cadre.

5.7 POSTINGS AND TRANSFERS

Postings and transfers is a complex and often politically sensitive area in workforce management of the public health system. This is influenced by the reluctance of staff members being posted in remote and rural areas due to the difficulties faced and lack of public amenities in these places. In most states, generic policies have been developed for staff working in all sectors of the government system. However, West Bengal and Kerala have developed and introduced policies, which are specific for health personnel; this is a welcome

intervention given that the needs and requirements of health professionals can be different from workers in other sectors.

5.8 SALARY AND BENEFITS

The salary structure for regular and contractual nursing staff employed in the public health service varies across states. Different states have different rules and regulations resulting in a differential salary structure within and across states. In addition, there is inequity in the pay structure in the public sector in comparison with the private sector. In most of the states, with the exception of Kerala, salaries in private hospitals is much higher and the working environment more conducive. This is an important factor influencing the retention of nurses in public facilities.

CHAPTER 6

DISCUSSION

This study aimed to review existing status of the nursing and midwifery profession under these three broad themes- 1. Leadership and regulation 2.Education and development and 3.Deployment and utilization in five purposively selected states. Literature, documentary review and discussions with key informants suggested that there area variety of measures being undertaken to strengthen the nursing cadre across these states and these have been implemented with varying degrees of success. Designing and implementing a single strategy is not sufficient to address the issues related to human resources for nursing personnel; indeed a comprehensive approach is necessary to develop a raft of relevant policies that will improve the professional working environment for nurses and provide them the social recognition and status they should be entitled to.

The correlation between three major themes (viz. leadership and regulation, education and development, deployment and utilization) has been documented through this study. Reforms and changes in one area have an impact on the other two due to the inter-connected and inter-dependent nature of these thematic areas. This needs to be borne in mind while introducing new policies or revising existing policies to ensure synergy and stainability of changes introduced in to the existing set up and structures.

SNCs are primarily responsible for regulating the quality of pre-service education. Any negligence of duty in this regard has the potential to adversely affect the quality of HR employed within the public system. Lack of active coordination among regulatory bodies at the central and state level further complicates this issue. Their joint cooperation and involvement is necessary to uphold the quality of training imparted to nursing trainees.

Competency based education – with a focus on developing hands-on skills - along with continuous nursing education plays a vital role in ensuring familiarity with new and innovative nursing techniques and procedures. With constant introduction of new technologies and healthcare methods, capacity building of working professionals is critical to maintain quality of care.

We need to reconsider our approach to address the chronic issue of shortage of nurses and midwives in the public health system. This includes the equitable and rational deployment of nurses graduating from nursing institutes. In addition, the issue of quality of nurses produced from these training institutes is critical. This has implications for the quality of training imparted both in government institutions and even more so in private establishments. Therefore, it will be crucial to focus attention on regulating and maintaining standards for pre-service education. Simply opening new and additional training institutes will fail to address

the issue without a focused approach on the quality of teaching and other core issues affecting the shortage of nurses and midwives in the public health system. Policies should aim to improve workforce management practices by ensuring equal opportunities to develop and contribute to the health system.

The lack of an integrated approach between major stakeholders such as DHS and NHM has been observed in most states and this has stymied the process of a seamless development of the health system. There has also been duplication of efforts with the development of parallel policies to achieve similar outcomes. Joint supervision and workforce management should be introduced to avoid duplication between the regular and contractual cadre.

While there are opportunities, there are also threats that can hamper the progress of the nursing profession. The mushrooming of private training institutes of questionable quality, under performing regulatory bodies, dominance of medical doctors, poor working conditions for nurses etc. will have a detrimental effect on raising the nursing profile.

This study illustrates that despite some of the challenges for nursing and midwifery mentioned above, efforts have been made by states for improving the working conditions and opportunities for this cadre. This includes instances of exemplary teamwork, innovative use of technology and pro-active leadership. There are other areas and opportunities for facilitating the progress of this cadre. States would be well advised to learn and scale up some of these good practices for improving the quality and morale of the nursing and midwifery profession.

CHAPTER 7

RECOMMENDATIONS

Information from the findings of this study, evidence from the literature and experiences from individual states has been used to draw up a list of recommendations for states to consider. Important thematic areas are used to categorize the recommendations

	Bihar	Chhattisgarh	Rajasthan	Kerala	West Bengal
Legislative framework	The Nursing Act needs to be updated and revised. It should be made comprehensive by clarifying the mandate of nursing legislative bodies	Effective implementation of the Act is required		Well developed Act; may act as a good practice model for other states	The state has a well developed practice of updating the Act regularly through relevant Amendments
Professional Regulation (Primarily for State Nursing Councils)	Immediate resolution of legal issues against the nursing council should be expedited to improve functionality	Proactive leadership and adequate resources/ staff should be made available to function according to the mandate laid down	Emphasis should be on instituting full time leadership and ownership - with freedom from political interference	Working well according to their mandate	Working well according to established systems
Shared leadership (At relevant levels)	DHS should work in close coordination with the state NHM to strengthen nursing governance in the State	The current silo working amongst stakeholders requires proper integration between DHS, NHM, Council and other stakeholders from state to district level	It is necessary to improve close working among DHS, State Health Society and Council	Establish effective working relationships between different bodies involved with nursing	Can be used as a good practice guideline for other states

Institutional Capacity Development (For pre-service education)	Limited clinical exposure in private colleges - requires intervention through strict implementation of relevant policies and guidelines; need to maintain quality standards of new private institutes; re-establishment of LHV training centers is required			Need to create more sanctioned posts in the state to absorb the annual production of nurses	
Institutional Accreditation & Monitoring	Need for regular and timely inspections by nominated inspectors		System should be more transparent with decreased external interference in the process	Concept of SIMET is a good example and benchmark (for standardization of institutes) for other states	Robust and timely inspection mechanism
Supportive Supervision	Strengthen established structures initially set up by SHS and development partners	States should consider restructuring the supportive supervision structure – it is currently inadequate to address existing need			
Continuing Nursing Education	Utilize existing resources to facilitate CNE such as skill labs, SNC and NNC as appropriate.			Trainee reserve is a good example; however expansion of National and State Nodal Centre for CNEs should be encouraged	Ensure strict implementation of the 5 year refresher training plans
Recruitment	Establishment of a Health Recruitment Board should be considered for quick, fair and transparent recruitment of nurses	Facilitate recruitment of all vacant nursing posts in DHS or NHM and consider establishment of a Recruitment Board	Immediate recruitment processes under NHM should be re-initiated	Adequate sanctioned posts should be created to absorb nurses qualifying from recently recognized courses in the state	
Capacity Building	Innovative training strategies such as 'on-site mentoring' and 'needs based competency enhancement' should be scaled up	Preparation of decentralized training plans should be considered	Integrated in- service training can be extended to develop similar training for other nursing professionals e.g. tutors	The use of TMIS is a positive finding and other states should be encouraged to adopt/ adapt this practice	The system of trainee reserves should continue to be encouraged
Workforce Management (Postings& transfers, salary and benefits)	Establishment procedures should be streamlined and proper implementation of existing policies should be done	States should encourage participation of nurses and midwives in policy formation and related decision making	Leave with pay for nurses should be allowed for clearly defined circumstances (like for other health professionals)	Involvement of nurses and midwives in the framing and implementation of workforce management practices and policies should be encouraged and strengthened	
Career Progression	States need to clear and address the large backlog of pending promotions to boost staff morale and avoid stagnation in the cadre			Regular and timely promotions need to be ensured.	

ANNEXURE

Nursing Governance study: Interview Guide

- Introduce self and engage respondent
- Provide information on the study and objectives
- Take informed consent for interview

Type of key informants at State and District level

- **At State-**
  1. Concerned Directorates (admin, training, recruitment transfer & posting etc.),
  2. State Level Nursing Consultant (if any)
- **At District-**
  1. CMHO/DPM,
  2. Nursing Admin/ Matron (Clinical Supervisory Staff),
  3. DPHN/LHV (Public Health Supervisory Staff)

Date of the Interview..... *Place of Interview*.....

Starting time of interview..... *Closing time of interview*:.....

Details of the Interviewee:

Name:	Contact No:
Designation:	Name of the organization:

Table 6: Broad Themes of the Interview

Leadership and regulation	Recognition of qualification
	Withdrawal of recognition (if any)
	Admission procedure
	Inspection of institution
	Quality of education
	Training material
	Enrolment in state nursing council
	Enrolment for higher qualification
	Disciplinary actions-termination/professional misconduct
Education and Development	Types of nursing courses
	Curriculum of courses
	New nursing schools established since 2009
	Number of trained faculty (clinical and administrative) and their shortage
	Annual intake of students in existing colleges
	Training institute for in-service candidates
	Examination and certification body (State and union govt)
Deployment and utilization	Nurse recruitment since 2009
	Total Number of Facilities
	Change in nurse availability-vacancy of cadres
	Types of nursing staff are there in the state
	Steps to improve nurse availability (financial and non-financial incentives, promotional avenues)
	Introduction of new cadre- DPHNO, PHN
	Mechanism for transfer and placement of nursing staff
	New functional SCs
	Union activities

Refer the detail section of the document

a. Policies and Current Status of Nursing Workforce

i. Total Number of Facilities – DH/SDH/Other Public Hospitals/CHC/PHC/SC

ii. Total Number of Nursing Staff sanctioned positions, vacancies at various levels in the state. (regular and contractual)

iii. Who are all concerned with the nursing education, recruitment, training and deployment in the State? How do these institutions function (collect organogram)? What are the policy and legal frameworks for governing these institutions?

iv. Is there any vision, mission document available for nursing services in the State? Has the Nursing situation analysed and need assessments been done properly? Is there an estimate of it with details of different categories within? Have they been updated periodically, based on the changing healthcare needs scenario?

v. How many types of nursing staff are there in the state? Any new initiatives for improving availability of nursing staff in public facilities? Any changes being made in the nursing staff norms, positions (viz DPHN, PHN) since 2005.

vi. Policies, guidelines, rules, circulars, official documents and manuals related to nursing education, training, skill building, deployment, transfer, posting, promotion and performance assessment and administration issued from state or district or nursing council?

vii. Is there any mechanism for training and placement of nursing staff in leadership positions? How many administrative positions are filled by nursing professionals at state and district level under public health system? How many of these administrative positions are vacant due to lack of suitable qualified candidate? Are contractual appointments allowed at these levels.

b. Workforce Management

i. When was last position for the various nursing staff being created across cadres? Is it updated time to time? Who creates positions and what is the process of creation of positions in the state? (regular and contractual)

ii. What is the process of selection and placement of nursing staff in public health system? Please explain the process, concerned authority and approximate time period from announcement of vacancy to the placement of staff in the facility. Is the process of recruitment decentralised in the state. How often recruitments are organised in the state at various levels? Is there any mechanism for campus recruitment- walk-in interview etc?

iii. What is the policy and process of transfer and postings of nursing staff in the state? Is there an institutional process in place for transfer and posting? What is the minimum working period in a position, Is transfer linked with promotion. What are the promotion and carrier progression opportunities available for nursing staff in the state? Are they allowed to specialise in any particular area?

iv. What is the remuneration for both contractual and regular staff at all levels. Is there any change in the remuneration of the nursing staff in recent years? What is the process of performance assessment of the nursing staff? Is the performance assessment is linked with the incentives? What is the minimum contract period for contractual staff and how contracts are being managed? What are the additional benefits they receive- monetary/ non-monetary (e.g. educational opportunities, priority postings etc)? Is there any mechanism for regularisation of contractual staff? Does the performance assessment takes in the account – number of training, skill utilisation and workload of each employee? Is there any training on leadership conducted for the nursing staff?

v. What is the supervisory support mechanism available for both regular and contractual nursing staff? What is the mechanism for grievance redressal and feedback? Is there any mechanism to revive LHV/public health nursing cadre?

vi. Is there any mechanism/plan for selection of candidates for particular training? Are these plans based on actual assessment of ground situations? Is there any mechanism for assessment of skills of nursing staff? How many institutes are there for the training of nursing staff and are available at what level? What all trainings are being done for nursing staff (regular and contractual)? What is the mechanism for induction training, on-job training and skill based training for both contractual staff and regular nursing staff? How there they deployed post training (data)? What is the mechanism to assess skill utilisation?

c. Tool for Nursing Education Administrators:

1. Registrar of Nursing Council
2. Principal of Nursing Institute (Public)
3. Principal of Nursing Institute (Private)

I. Total Number of Nursing Institutions in the state- ANM Schools, GNM Schools, BSc, MSc Nursing, Post Basic etc in both public and private sector. How many nursing institutes opened in the state each year from 2005?

II. What is the intake of students in each of these institutions? What is the admission/ selection procedure? What proportion of seats available for specialization? Which is the certification and examination body in the state for nursing education? How the examinations/ assessments are conducted?

III. How many faculty members are available in these institutions and what is the gap in terms of faculty and staff? What is the procedure for the faculty training and CNE? Are these functioning in own buildings or rented buildings? Is there facility for students' hostel available or not? What is the gap in terms of teaching and training?

IV. What pedagogy and training material is followed – is it in sync with nursing councils?

V. What is the mechanism of quality check by nursing council and other institutions? What is the support that these institutions receive from NHM/State government? What are challenges? Does state have nursing council chapter-what role it plays and support it provides.

VI. What is the mechanism of registration/de-registration/ withdrawal in these councils?

d. Interview with Few Nurses

Using workforce management questions and additional questions related to their job satisfactions, quality of working conditions, support mechanism if any and reasons for attrition if any?

e. Interview with Few Nursing Students

About quality of education, living conditions, job opportunities, issues and challenges etc.

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