ScieniQ Publishers

Journal of Nursing and Researchers

Review Article

PUBLIC HEALTH NURSING IN INDIA- A Review Journey of Midwifes to Community Health Officers for Comprehensive Primary Health Care in India

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Submitted: 28 Dec 2021
Accepted: 20 Jan 2022
Published: 26 Feb 2022

Abstract

Nurses have contributed a lot to the health care system in India since Bhore committee report in 1946. To achieve the Universal Health Coverage as committed under national Health Policy 2017, a strong nursing and midwifery workforce is one of the important components of the Indian robust health system. The scope of public health nursing is wide in India and their potentials are not fully utilized. Currently, public health nurses at PHC, Block and district levels plan, monitor, and mentor peripheral health staff to implement programmes on health promotion and disease prevention.

Sir Joseph Bhore (Health Survey and Development) committee first ever report of 1946 was accepted by independent India and a start was made in 1952 to setup primary health centres to provide integrated promotive, preventive, curative, and rehabilitative services to the rural population, as a component of wider Community Development Program. The same year a post-certificate Public Health Nursing programme was instituted at the college of Nursing, New Delhi and later transferred to All India Institute of Hygiene and Public Health, Calcutta. Community health nursing was integrated in the curriculum of GNM and BSc Nursing courses. Government OF India made lots of statement of good intentions in five-year plans after plans, but execution of the PHC system envisaged by Bhore committee eluded the country. India has over two million nurse-midwives and nearly 900 000 Auxiliary Nurse Midwives (ANMs). In its extraordinary leadership in midwifery, the Government of India has committed to an additional 85,000 midwives by 2023. Nurse -midwifes contribute for a large proportion of 70% of women workforce in Indian Health System. Governed by central and state nursing Acts that are outdated and disconnected, and numbers below global norms, nursing practice functions within caste - and gender-based prejudices in India. Nursing education is fragmented and siloed, and nursing practice is delinked from education. Inadequate nursing human resource is being experienced since April 2020 due to Covid 19 Pandemic.

This article is a strategic review that relooks at the acts and highlights pathways that can strengthen, sustain, or weaken nursing education and practice, and suggests how nursing education can be linked to practice for creating better public health nurse's cadre for the future.

Materials and Methods: Review of documents like Bhore committee report, NHPs 1982-83, 2002 and 2017, MNP guidelines of early 1970's, MPW scheme of 1973, some studies published, most importantly the personal experience of the author spread over from 1968 till today, working across the health system starting from PHC (9 years), sub-district health administration (6 years), district health set-up (4 years), Upgraded urban Leprosy Center attached to a Medical College, State MCH & Immunization officer and UNICEF (18 years) overseeing immunization program and Independent Public Health Consultant (last 16 years) for over last 52 years.

Keywords: National Health Policy 2017 (NHP), HWC, PHC, CHC, DH&FWO / CMHO, Auxiliary Nurse Midwife (ANM), multipurpose health worker- Female (MPW-f), LHV/ BPHN, staff nurse (GNM/SN), Graduate Nurse (GN), and Community Health Officer (CHO), District Public health nurse (DPHN/O)

Introduction

India has over two million nurse-midwives and nearly 900 000 Auxiliary Nurse Midwives (ANMs) as of 31 March 2020. In its extraordinary leadership in midwifery, the Government of India has committed to add an additional 85 000 midwives by 2023[1]. According to the Indian Nursing Council (Snapshots, 2016), 789,740 ANMs and 56,096 LHVs are registered in the different state nursing councils of the Country. About 2.00 lakh ANMs (Auxiliary nurse midwives) and thousands of female health supervisors and public health nurses are working in the public health sector alone [2].

Until seventh five-year plans Governments made a lot of radical statements, recommended progressive measures but did not take adequate action. The first ever National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002 and then in 2017. The NHPs 1&2 missed health system development and encouraged plucking low lying fruits [3]. Following NHP 2017Under the National Health Mission initiative of the Government of India, there is a strong commitment for providing newer roles for nurses in far flung areas where doctors are not available. The basic structure of sub-centres catering for a population of 5000 in the plain, and 3000 population in hilly, tribal areas are now renamed as "Health and Wellness centres (HWCs)" and are expected to provide comprehensive primary health care including running daily 6 hours of OPD for treating as many ailments as possible [2]. In addition to the earlier staffing of a male and female health worker implementing through Allopathy, Ayurveda, Homeopathy, Yoga and Siddhi systems' integrated approach the national health programmes, they are being strengthening by the addition of community Health Officer.

The training of paramedics was a key activity through nursing, ANM and Basic Health Workers and Health Assistant's training schools. After the Third Plan this emphasis got diluted. Investments in health services continuously declined and urban hospital-based services got priority over the rural 3-tier system proposed by Bhore Committee. To contain the emerging dissatisfaction in rural areas, the State introduced the Minimum Needs Programme in the Fifth Five Year Plan (1974) [3]. This period saw a glimpse of thoughtful action of introducing young female supervisory of lady health visitors. Through a 2-year course of Lady Health Visitors Training a semblance of bridging the big gap in supervisory tire of the primary health care was done. Unfortunately, the initiative did not last long taking cognisance of non-availability of trained manpower and doctors even in the primary health centre, a level above the erstwhile sub-centre, the Government of India has initiated a bridge course to update the knowledge and skills of working nurses (having a qualification of General Nurse Midwifery) or fresh nursing graduates in 2017. Titled as" Bridge Programme of Certificate in Community Health for Nurses (BPCCHN). The course is being funded by MOHFW, India and the desiring nurses are selected based on selection test, aptitude for working in rural area. The course is run for 6 months with skill development at the district hospital level. They are taught clinical skills, basic epidemiology of communicable, non- communicable diseases, identification, basic management of common health problems (all body systems) and provide referral in case of serious illnesses to higher health facility using Allopathy, Ayurveda, Homeopathy, Siddhi and Yoga systems approaches besides health promotion activities. Once the course is completed after passing a final examination, they are proposed to be placed in the health and wellness centres. During the course work, they are given stipend in addition to their salary Indian experience so far makes one feel that even graduates in all these systems with 4-4.5 years course and 1 year internship are not skilled enough to independently handle all illnesses. Only time can prove how far these Nurse-pimcary acre providers do justice to the expected work. Once they are posted in the health and wellness centres incentives in the form of higher pay scale are incorporated so that they stay in the rural areas. Their position is now being referred to as "Community Health Officer". The present initiative is supposed to provide a greater role to the nursing profession and boost the health care delivery in the rural and far-flung rural India.

The course has objectives of 1. Enhance knowledge and skill of learners in providing community health care services 2. Develop competencies in dealing with issues of public health.3. Provide comprehensive primary care based on protocols appropriate to subcentre level. 4. Perform preventive and promotive actions for improving community health. 5. Perform common laboratory investigations. 6. Provide treatment based on protocols as appropriate to subcentre level. [6,7,11].

History of Public Health in India

In 1978, at an international conference in Alma Ata, Kazakhstan, the World Health Organization (WHO) and the United Nations Children's Fund put forward a policy proposal entitled "Primary Health Care" (PHC). Adopted by all the World Health Organization member states, the proposal under the banner called "Health for all by the Year 2000," they had set out to turn their vision for improving health into practice. Primary health care was a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families, and communities. It addressed the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental, and social health and wellbeing. It provided whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. Primary health care could have ensured people receive comprehensive care - ranging from promotion and prevention to treatment, rehabilitation, and palliative care - as close as feasible to people's everyday environment.

Sir Joseph Bhore (Health Survey and Development) Committee constituted in 1943, submitted its first ever report on health and development in the country in 1946, that recommended organizational structure of the National Health Scheme was Primary unit: Each province had the autonomy to organize its primary units in the way it deemed most suitable for its population but there was to be no compromise on quality and accessibility. Hence, a highly dense province like Bengal may have had a primary unit for every 20,000 population but a Central Provinces (now Madhya Pradesh) which have a highly dispersed population may have a primary unit for every 10,000 or even less population unit. The deciding factor was easy access for that unit of population. Primary Health unit should have had a 75 bedded hospital served by six medical officers including medical, surgical, and obstetrical and gynaecological specialists. Six public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment should support this medical staff. At the hospital there should be a complement of 20 nurses, 3 hospital social workers, 8 ward attendants, 3 compounders and other non-medical workers. Two medical officers along with the public health nurses should engage in providing preventive health services and curative treatment at homes of patients. The sanitary inspectors and health assistants should aid the medical team in preventive and promotive work. Preferably at least 3 of the 6 doctors should be women. Of the 75 beds, 25 should cater to medical problems, 10 for surgical, 10 for obstetrical and gynaecological, 20 for infectious diseases, 6 for malaria and 4 for tuberculosis. This primary unit should have adequate ambulatory support to link it to the secondary unit when the need arises. About 30 primary units or less should be under a secondary unit. Secondary level care (secondary unit): The secondary unit was expected to be a 650-beded hospital (with bed distribution of Medical: 150Surgical: 200, Ob. & GY.: 100, Infectious diseases: 20, Malaria: 10, Tuberculosis: 120 and Paediatrics: 50) having all the major specialties with a staff of 140 doctors, 180 nurses and 178 other staff including 15 hospital social workers, 50 ward attendants and 25 compounders. The secondary unit besides being a first level referral hospital would supervise both the preventive and curative work of the primary units.

District Hospital & District Health & FW Office

Every district headquarter was to have had a 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, 50 hospital social workers and 723 other workers. The hospital should have 300 medical beds, 350

surgical beds, 300 Ob. & Gyn. beds, 540 tuberculosis beds, 250 paediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases. Many of these district hospitals would have had medical colleges attached to them.

Since 1970s, the ongoing global collapse of the welfare States made them forego their political promises. They opted for structural adjustments that called for withdrawal of State investments in welfare, and its centrality in provisioning of welfare services. The Indian State too succumbed to this pressure informally over 1980s and formally in 1992.

The training of paramedics was a key activity through nursing, LHV, ANM and Basic Health Workers and Health Assistant's training schools. After the Third Plan this emphasis got diluted. Investments in health services continuously declined and urban hospital-based services got priority over the rural 3-tier system proposed by Bhore Committee. To contain the emerging dissatisfaction in rural areas, the GOI introduced the Minimum Needs Programme in the Fifth Five Year Plan (1974), that recruited young women as LHV s providing pre-service training for 2 years along with in service training of 6 months for ANMs based on seniority to compliment the supervisory role. The effort was short lived for 5 years, as a result the supervisory tire continued to be the weakest link even today [2]. The recent addition of CHOs is in experimental stage and one wonders if it can meet the gap.

Public Health Nursing as it evolved in India [12]

1. Midwives Era (MWE)

India had well-trained European and indigenous midwives during the time of British rule. The strong midwifery profession lost its importance after independence for various reasons. The dilution in the midwifery profession, include amended regulations, lack of social or political priorities, and change in health programme directions from maternal health to Family planning and later family welfare [4]. Evidence from Sri Lanka and Malaysia in the 20th Century had showed that attendance at delivery by well-trained public health midwives with the back-up of emergency obstetric care (EmOC)services helped in the reduction of maternal mortality, even in resource-poor settings.

As early as 1797, a 'lying-in-hospital' for maternity was built in Madras city, where in 1854 the British Government sanctioned the opening of the first formal training school for midwives. Subsequently 8 more such schools were opened across the country. These midwifery schools had trained midwives from Britain and indigenous midwives as faculty who were trained by the European midwives. These midwives were skilled in their profession and were able to practice independently to provide childbirth care. During the 19thCentury, there were plenty of trained midwives, but no nurses were available to care for the sick and injured. To overcome this shortage of nurses, the then surgeon general of the Madras Presidency trained such midwives for six months in nursing. Only those who did not qualify as midwives were given a certificate in 'sick nursing' establishing a fact that midwifery required more skills than 'sick nursing.

2. Auxiliary Nurse Midwife (ANME) era

Acute shortage of nurses to manage injuries in the Second World War (1939–1945), the British Government had initiated a six-month course for intensive training in nursing and midwifery, which led to the formation of the Auxiliary Nursing and Midwifery Service in 1942. After the War, to continue in the government service, the newly created cadres of auxiliary nurses had to undergo one and half years of training in midwifery to get their certification as midwives thus making the total duration of training of 2 years. In earlier part of the 19th Century, many Christian-mission-related and Government women's hospitals called 'Zanana' hospitals for women were functional and some of them continue to provide services even today. They were in mofussil (suburban) towns and were largely run by nurses and midwives due to shortage of qualified doctors and the reluctance of women to be attended by male doctors [4]. The author can recall these arrangements in Gulbarga (now Kalburgi) in Karnataka since 1950, where not only the author but his sibling had the privilege of skilled birth attendance. In Independent India, the midwives were trained for a period of 2 years of which minimum 6 months were spent in labour room to acquire the requisite skill of conducting normal delivery, identifying obstructed labour and referral. Most of the fresh medical graduates in 1960's learnt their labour conducting skill working with the midwives.

In India, historically there is no separate association of midwives in India. The term nurse-midwife is used to represent the nursing and midwifery staff of all cadres, including the staff nurses (GNMs), ANMs, LHVs and Nursing graduates. Nursing and midwifery have been regarded as low-value professions to provide support to doctors and not as autonomous clinical professions. Due to the socio-cultural barriers in the past and to some extent even in present times, upper middle class Indian women do not enter these professions because they consider the nursing and midwifery profession as menial job. Many nurses and midwives were from the lower socio-economic class and often from the lowest castes.

3. Multipurpose Health worker- female Era (MPWE)

Until the early 1970s, ANMs were providing comprehensive maternal health care, including birth care, in rural areas. In 1974, ANMs were designated as multipurpose workers (MPW-F) to provide care for multiple national programs along with MCH services [3]. With the conversion of ANM into MPW health workers, ANM's basic training was reduced from 24 months to 18 months with a reduction in the midwifery component. This further devaluated and deskilled the midwifery role and emphasized community nursing and primary health-care role. To orient the ANMs to function as MPW-Fs, short orientation training was carried out during the 5th and 6th Five Year plans.

National Health Mission- Onslaught on midwifery?

Instead of strengthening midwifery training, cadre and services, the Government of India, under National Rural Health Mission (NRHM) initiative, has developed a policy of promoting 'institutional childbirth' by providing cash incentives to mothers. This 'Janani Suraksha Yojana' (safe motherhood scheme), instead of strengthening midwifery India is supporting large-scale development of village-level volunteers called ASHA. They have also introduced a short training course for ANMs/MPW-F and staff nurses to orient them to skilled birth attendance, neglecting quality professional services for birth through the development of midwifery.

Despite promotion of institutional deliveries over the last one-decade, domiciliary deliveries are not uncommon particularly in remote rural and tribal population even in 2021.A midwifery- based model of care which includes professional care and humanised care may be better for developing countries like India, as we saw in recent Covid 19 pandemic many hospitals were in accessible. The development of midwifery- based maternal care would reduce maternal mortality and support a reduction in the over-medicalisation of birth, and the increasing caesarean section rate, which is happening in most urban India, especially in private sector. Midwives can also provide home based reproductive and post-natal and neonatal care services as they are desperately needed at low cost. For example, in Sweden, only complicated cases are referred to obstetrician.

From 1977-till date, with the introduction of Multipurpose Health Worker's (MPW) Scheme following Kartar Singh's Committee report in 1973, most of the categories of staff under various uni-purpose programmes were re-designated for multipurpose work. The auxiliary nurse midwife (ANM) gradually replaced the Dais (midwives) to serve in the village through the primary health centre and its sub-centres. In 1977, the Indian

Nursing Council revised the curriculum for ANM course, to prepare candidates with high school certificate as Health workers (Female) and Health workers (Male) under the MPW scheme. As on 31st March 2020 the overall shortfall in the posts of HW(F)/ANM is 2% of the total requirement, mainly due to shortfall in States like, Gujarat (1073), Himachal Pradesh (992), Rajasthan (657), Tripura (389) and Kerala (277). While the shortfall of sanction post of FHW dropped from 3.9% in 2019 to 2% in 2020, vacant positions increased from 8.9% in the same period [8].

Due to these changes, the priority of ANMs and the public health system shifted from birth care to all national health programmes. Whereas today's Female health workers are doing a good job of tasks of antenatal care (ANC), Immunization, disease surveillance, vector borne diseases, family planning motivation and minor ailments treatments on 2-3days a week, the same is not true when it comes to skilled birth attendance, postnatal care, home based new born care (HNBC), non-communicable diseases (hypertension, diabetes, cervical and other cancers) screening, running regular out patients for 6 hours as envisaged in NHP 2017.

Lady Health Visitors (Senior Health Assistant- Female)

Plans after plans the investments in health services continuously declined and urban hospital-based services got priority over the rural 3-tier system proposed by Bhore Committee. To contain the emerging dissatisfaction in rural areas, the GOI introduced the Minimum Needs Programme in the Fifth Five Year Plan (1974), that recruited young women as LHV s providing pre-service training for 2 years along with in service training of 6 months for ANMs based on seniority to compliment the supervisory role. The effort was short lived for 5 years, as a result the supervisory tire continued to be the weakest link even today [2].

The main role of Health assistant female in Indian Public Health system is to Supervise and guide the health workers in the delivery of health care services to the community. Their job descriptions include supervising and on-job training of Female health workers, fostering a PHC team work, monitoring and replenishing supplies and equipment, guiding FHWs in maintenance of individual records and collating progress reports, organizing community level reproductive and child health services, immunization services, Family planning and Nutrition services , oversee comprehensive primary health care services, disease surveillance and skill upgradation of FHWs and training of community level functionaries and health promotion. They are expected to visit 4 subcentres at least once in a week on fixed days supervisory home visiting and provide on- job training to the health workers (female) in distribution of conventional contraceptives to the couples. The also respond to urgent calls from the health workers and trained dais and render necessary on-job support. They must organize and mobilize the Mahila mandalas teachers etc., in the motivation of eligible couples for adoption of birth spacing and small family norm. The provide information on the availability of services for MTPs and refer suitable cases to the approved institution and supervise the immunization of all pregnant women and children (0-5 years). They collate and compile the weekly reports of births and deaths, disease surveillance occurring in their area. They are expected to educate the community regarding the need of registration of vital events.

Most of the ANMs registered with Auxiliary Nurse and Midwifes registered of any State Nursing Council in India were trained for six months promotional training prescribed by Indian Nursing Council or a Diploma in General Nursing (GNM) from a recognised Board were recruited. Since majority of such experiences ANMs were 45 years plus and some of them had hardly passed matriculation their ability of supervisory role was limited. During the 5th five-year plan (1974-79) Fresh Class 12 passed candidates were directly recruited (50%) and provided in-service training for 2 years. These were some young ladies who were with better educational and intellectual capabilities, the supervisory work was getting due attention. Unfortunately, these courses were abruptly stopped, and the country continued the promotional ANMs cadre with 6 months training.

This group of public health nurses are challenged due to their age, commuting challenges, low basic educational background, inferiority complex as most of the FHWs better educated than them, poor training and retraining, family, and personal health problems their contribution in monitoring quality of services provided by the FHWs is limited. Consequently, the first level supervision is the weakest link in today's public health system. With CHOs induction job description and their role clarity vice versa CHOs is the need of the time

HEALTH ASSISTANT at PHCs in Rural Areas as on 31st March 2020 [9]

Required	Sanctioned	In Position	Vacant	Shortfall
49836	19685	12449	7411	35824

General Nurses and Midwives Era (GNME)

For the first time a staff nurse was recruited to a PHC under MNP program in 1974-75 for conducting institutional deliveries and assist the medical officer in examining female patients. Surprisingly, these posts were created in MNP PHC's majority of them were either new institutions without labour room or upgraded local dispensaries or health unit type dispensaries in the erstwhile Community development blocks. Again 1996 7 posts of GNMs in CHCs and 1 each in PHCs were created to support institutional deliveries and Reproductive health services. While CHC are benefitted by GNMs in majority of the PHC's GNMs are underutilized. Their Public health orientation is limited due the training curriculum.

NURSING STAFF (STAFF NURSE) at PHCs in Rural Areas [9]

Level	Required	Sanctioned	in Position	Vacant	Shortfall
PHC's	24918	34521	29973	7248	5772 (21%)
CHC's	36281	47163	41874	8393	3334 (17.8%)

Graduate Nurses and Community Health Officers (CHO)

The development of various committees starting from Bhore Committee (1943) to High Power Committee (1987) alongside five-year plans did bring about a transition in the status of nursing and midwifery. The recommendations made were in relation to staffing in hospital nursing service, public health settings, and schools/colleges, working and living conditions, infrastructure and equipment, regulations, and intensification of training programmes to meet the staff shortage. These reports and National Health Policy (NHP, 2002) laid emphasis on improving the skill-level of nurses and on increasing the ratio of degree-holding nurses vis-à-vis diploma-holding nurses in the health system. Until recently Graduates nurses were appointed only in Hospital services. Community health nursing is integrated in the curriculum of GNM and BSc Nursing courses but their exposure to community health nursing is limited. The recent addition of CHOs is in experimental stage and one wonders if it can meet the gap.
The plan is to create 1,50,000 HWCs by financial year 2022, under the Ayushman Bharat scheme will generate employment of 1,20,000 community health officers who will be placed at health and wellness centres by 2022. National Health Mission (NHM) has declared a new pivotal role of community health officer (CHO) with its constructed roles and responsibilities for public health. According to NMC bill 2019, nurses are the first choice for CHO, and this will also pave the way for professional development. The Government of India has initiated a bridge course to update the knowledge and skills of working nurses (having a qualification of General Nurse Midwifery) or fresh nursing graduates only in 2017. Titled as" Bridge Programme of Certificate in Community Health for Nurses (BP-

aim of Universal Health Care by 2030 [6]. Most of the States are under the process of selection of candidates for Training. 1-2 batch have come out but no details of how many are on board and their experience contribution is not available.

Having interviewed, about 15 such (8 male and 5 female CHOs , I am of the opinion that given on job support of skill building through periodical visits of medical officer -weekly, and basic specialists like Pediatricians/ Obstetrician/ Physician/ eye/ ENT/ Mental health/ Oncologist at least once a month and supplies and logistic female nurse CHO can definitely be value add, but the same can't be said about male CHOs)

District Public Health Nurses (DPHNE)

The District Public Health Nurses (DPHNs) are class III employees, originally from Maternal and Child Health division of Department of health. They are primarily responsible for monitoring maternal and child health services in the district. Some of the sates have created a gazetted post of District Public Health Nursing Officers (DPHNOs) as class [12].

Gazetted officers' class II under the Family Planning wing

They were primarily The DPHNs based on their seniority were promoted and were responsible for supervising the family planning activities in the district. Over the years, both have come to have the same job profile.

Most of the District Public Health Nurse (DPHN) or DPH Nursing officers (DPHNOs) are promoted from the cadre of staff nurses or Lady health Visitors with a 10-month training to develop knowledge and skills upgradation in public health to qualify for PHN. They spend about 30-35% of their time in field supervision mostly visiting centres accessible by public transport as they do not have an allotted government vehicle, thus their supervisory role for nurses and midwives has lost its importance as either they do not submit any field report, or the district level program officers do not follow-up action from their visit reports. Nevertheless, they have an important role in solving problems of field workers as they are mediators between the district program officers and peripheral facilities. The latest Rural Health statistics (2020) of government does not even show this cadre in their Human resources. A time motion study in one of the progressive states Gujarat in 2010 indicated that 50% of the posts were vacant (11/24). All 13 interviewed were over the age of 40 years. In terms of the work done, as seen in the graph is unproductive like attending to personal work, idle conversation, sitting idle and breaks.

The study pointed out that Five (38% of all) out of 7 DPHNs/DPHNOs of the age group 41 to 50 reported good health, while 5 out of 6 (83%) DPHNs/DPHNOs in the age group of 51 reported having illness like high blood pressure, diabetes, joint pains, and cataract. That amounts to only 6/13 were physically capable of taking travel and field supervisory duties.

While 11 of them were Registered Nurse and Registered midwife (RN & RM) after a 3-year Diploma in General Nursing and Midwifery (GNM), starting their career as staff nurses in the Community Health Centres (CHCs), Two of them had Auxiliary Nurse midwife (ANM) training followed by GNM. One among them had worked at the field level for 24 years- 11 years as ANM & 13 years as Health Visitor. Except these two DPHNs the others did not have public health experience although 6 had more than 10 years of experience as a staff nurse. Majority of the DPHN and DPHNs lack the appropriate public health experience required for monitoring the work of the LHVs/FHS and the FHWs.

Only 15% of the interviewed were highly satisfied, 77% are somewhat satisfied and 8% are not satisfied with their job. The reasons expressed were, not having much experience for supervising field level work. Majority (69%) DPHNs/DPHNOs were highly dissatisfied with the facilities provided to them especially official vehicles for travel [4].

Box 1. A Representative Organogram of Public Health Nursing in a State Commissioner / Director H&FW Add. Director (FW) Family Welfare/ Dir. RCH/ Director NHM

Deputy Director (Health)	Deputy Director (Medical Services)
Assistant Director (Nursing)	Assistant Director (Nursing)
State Public Health Nursing Supervisor Class I Regional level Public Health Nurse (PHN Class III) District Public Health Nursing Office (DPHNO) Class II District Public Health Nurse (DPHN) class III Block Health Visitor (BHV) Female Health Supervisor (FHS) / Lady Health Visitor (LHV) Female Health Worker (FHW)	Nursing Superintendent Hospital Specialist Nurses Graduate General Nurses General duty Nurses

The scene in all other states of the country is similar, may be worse in the north Indian states of UP, MP, Rajasthan, Bihar. Odisha, Chhattisgarh, Jharkhand, Assam This emphasis the need for direct recruitment at least the Block PHC level as public health Nurses and get promoted in the hierarchy after 10 years, with periodical training in Public Health Nursing.

The meaning of primary health care (PHC) has evolved over time. It originated as primary medical care where patients met health workers and got requisite care for common complaints that could be dealt with easily. This early definition had 2 elements i) level of services and ii) the activities themselves. Among the levels of services, it denoted an almost "grass-roots" level of health services. At Alma Ata in 1978 the concept was extended to include the socioeconomic and political factors affecting poverty and inequality which affected health. In earlier years PHC focused mainly on rural areas in developing countries, but not the urban poor in these countries. Thus, many stakeholders saw the PHC system as a second class, rural health system. UHC is based on a) The WHO constitution of 1948 declaring health a fundamental human right, b) The Health for All agenda set by the Alma Ata declaration in 1978 that advocated better health and protection for the poorest. UHC cuts across all the health-related Sustainable Development Goals (SDGs) set in 2016 and brings hope of better health and protection for the world's poorest. It advocates to include all people, including the poorest and most vulnerable, cover full range of essential health services, including prevention, treatment, hospital care and pain control and costs shared among entire population through prepayment and risk-pooling, rather than shouldered by the sick and access must be based on need and unrelated to ability to pay.

Key Targets of the NHP 2017 [3], include

- Increase health expenditure of Government from the existing 1.15% to 2.5% of the GDP by 2025.
- Increase Life Expectancy at birth from 67.5 to 70 by 2025.
- Reduction of Total Fertility Rate (TFR) to 2.1 from 2.3 birth per woman in FY 2016 by 2025
- Reduce Under Five Mortality to 23 by 2025 and Maternal Mortality Ratio (MMR) from currents level's 130 (2019) to 100 by 2020. Under Five Mortality in India was 29 (per 1000 live births in 2015 as per UNICEF estimates and MMR was 130/100,000Lbs in 2014-16 as per SRS special report.
- Reduction of 40% in prevalence of stunting of Under- Five Children by 2025.
- Reduce Infant Mortality Rate (IMR) to 28 by 2019. In 2016 the IMR

was 34 per 1000 live births.

- Reduce neo-natal mortality to 16 and birth rate to "single digit" by 2025. Neo-Natal Mortality (NMR) was 28 per 1000 live births in India in 2013 and CBR was 20.4 in 2016
- To reduce the prevalence of blindness to 0.25/ 1000 by 2025 from current levels of 0.5% in 2015
- Achieve & maintain elimination status of Kala-Azar & Filariasis by 2017 & Leprosy by 2018
- To reduce premature mortality from cardiovascular diseases, diabetes or chronic respiratory diseases and cancer by 25% by 2025.
- To achieve and maintain a cure rate of more than 85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
- Increase utilization of public health facilities by 50% from current levels by 2025.
- More than 90% of the new-born are fully immunized by one year of age by 2025. Defining the supervisory role of the CHOs (clinical and SBA skill development and erstwhile Sr Health Assistants (M&F) LHV and Sr. HI (Public health services oversight and health promotion and Data collation support & supervision) is the need of the time
- Ensure skilled attendance at birth above 90% by 2025.
- Relative reduction in prevalence of current tobacco uses by 15% by 2020 and 30% by 2025.
- Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).
- Reduction of occupational injury by 50% from 334/lac agricultural workers by 2020.
- Increase the share of State on health to more than 8% of their budget by 2020.
- Decrease in the health expenditure of the households from the current level by 25%, by 2025.

Box-2 A Representative Organogram of Public Health Nursing at District & sub-district For Comprehensive Primary Health Care (CPHC) (Universal Health Coverage)

LEVL	STATE PH NURSING SUPERVISOR	ASSISTANT DIRECTOR- NURSING
District	DISTRICT HEALTH & FAMILY OFFICER	Chief Medical Officer or DISTRICT SURGEONS (DISTRICT HOSPITAL)
	District PHN (2)	NURSING SUPERINTENDENT Staff nurses (GNMS/ Graduate N)
TALUKA	THO (NO PHN)	CHC/TQ/Sub-divisional Hospitals Matron / Staff Nurses
PHC	LHVs -1 & 1-3 SN	

Box -3: Staffing at Community Health Centres

S. No	Existing	IPHS proposed
1 Medical Officer#	4	7
2 Nurse Mid-Wife (staff Nurse)	7	9
3 Dresser	1	1
4 Pharmacist/Compounder	1	1
5 Laboratory Technician	1	1
6 Radiographer	1	1
7. Ophthalmic Assistant	1	1
8. Dental Assistant	1	1
15 Stat Asst. / Data Entry Operator	1	1
7 Ward Boys	2	2
8 Dhobi	1	-
9 Sweepers	3	3

Conclusion

India had well-established midwifery professionals before independence. The merger of nursing and midwifery and due to the attention to target-oriented preventive programs the profession declined.

Birthing's by doctors for all normal births is neither required nor possible, in both public and private institutions, due to the shortage of doctors in the country and their unwillingness.

India needs to reform its maternal health services using a midwifery- based model of maternal care. The development of high- quality, professionally trained midwives can form the backbone of birth services in the country. Midwives must work in teams with medical officers and obstetricians to provide basic emergency obstetric care and neonatal services.

Lack of qualified general doctors has pushed the country to create community health officers (CHOs) positions to serve at health and Welfare Centres. Therefore, Nursing graduation syllabus should provide for training in all primary, secondary including early diagnosis and case management of common ailments, and tertiary care of community level rehabilitation. The Nursing Council has not been able to maintain or nurture the development of Public Health nursing in India.

Way Forwards

National public health standards and accreditation bodies should insist on staffing of maternity units with fully qualified midwives rather than nurse-midwives to improve the quality of care.

The fact is that in most of the remote health & Welfare centres there would be on an average of 10 deliveries per month and in some of them home deliveries are still prevailing.

Based on the review of various frameworks for maternal health, a simple framework is suggested which focuses on midwifery and links village- lev

CCHN). The desiring nurses are selected based on selection test, aptitude for working in rural area. The course is run for 6 months with skill development at the district hospital level. They are taught clinical skills, basic epidemiology of communicable, non- communicable diseases, identification, basic management of common health problems (all body systems) and provide referral in case of serious illnesses to higher health facility besides health promotion activities. Once the course is completed after passing a final examination, they are proposed to be placed in the health and wellness centres. This initiative is supposed to provide a greater role to el care to district- level referral and emergency obstetric care for India.

As suggested in the framework, it recommended that the existing ANMs should be retrained intensively in midwifery for three to six months to become public health midwives, as in Sri Lanka.

Skilled midwives can provide antenatal care, assist in normal births, and provide obstetric first aid to complicated cases at village level, and refer to a health centre after first aid if required.

At the PHCs Nursing graduate midwife trained for one year under the newly developed nurse practitioner midwifery practitioner's course. At this level, medical officers will provide basic EmOC services to back - up midwives.

More complicated cases needing comprehensive obstetric care be referred to district level, where a team of professional midwives and obstetricians will provide comprehensive EmOC services.

In many rural and remote parts of India, it is not possible to have the mother referred to a higher level due to lack of transport, willingness of the relatives and lack of money. In such situations, the rural professional midwife can be the only source of definitive emergency care and be life-saving too.

A separate regulatory body for Public Health nurses will help to establish Public Health Nursing as an independent profession and foster it development. Developing a cadre of Public Health Nurses with skills of midwifery and IMNCI backed up by referral and EmOC is the most effective option for India to achieve the goal of reducing maternal and neonatal mortality and achieve SDG 3.

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Cite this article: Suresh Kishanrao (2022). PUBLIC HEALTH NURSING IN INDIA- A Review Journey of Midwifes to Community Health Officers for Comprehensive Primary Health Care in India. Journal of Nursing and Researchers. 3: 93-99.