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INCREASING USE OF SKILLED ATTENDANCE AT BIRTH IN DUMKA, INDIA

Introduction

In 2005, the Government of India (GoI) developed guidelines[1] that expanded the skills sets of auxiliary nurse midwives (ANMs) to provide skilled attendance at birth. In 2006, the ACCESS Program[2] worked with Centre for Development and Population Activities (CEDPA) and GoI to implement a program to operationalize these guidelines and test a model for maternal and newborn care (MNC) that would improve access to skilled birth attendance during pregnancy, delivery and the postnatal period.

With USAID support, ACCESS and CEDPA designed an operations research project in selected blocks of Dumka district of Jharkhand. One of the project's key objectives was to demonstrate increased use of ANMs as skilled birth attendants (SBAs) at the facility and community level in Dumka district of Jharkhand.

A woman in Dumka District of Jharkhand brings her baby for a health check to one of the newly trained ANMs

Photo credit: Stephanie Suhowatsky

A rapid assessment undertaken in June 2006 found that:

- ANM practice did not cover childbirth and newborn care. Traditional birth attendants (TBA/Dai) conducted most home deliveries and communities viewed the ANM as a person to provide immunization, not to conduct deliveries.
- ANMs were deskilled in MNC and unable to conduct deliveries.
- Two ANM schools exist in Dumka: Mohulpahari Christian Hospital (MCH) and the district Auxiliary Nurse Midwife Training Centre (ANMTC). The district ANMTC was dilapidated and under renovation in 2006.
- Provision of EmONC[3] was a concern for quality clinical training, particularly at Sadar Hospital, Dumka (SHD). MCH was better staffed and had better care. SHD lacked specialist staff and services (e.g. vacuum delivery).

ACTIVITIES

1. **Assess current practices of ANMs, training centers and clinical training sites (hospitals)**
   - Clinical training capacity was assessed at the ANMTCs. Included in this assessment was an EmONC assessment at the two hospitals (MCH and SHD).
   - Clinical standards for EmONC were adapted for the local context. They were used along with a modified Standards-Based Management and Recognition model as a performance improvement approach to measure quality and monitor progress.

[1] Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs, Lady Health Visitors, and Staff Nurses. Ministry of Health and Family Welfare, Government of India (GoI). 2005.

[2] ACCESS is a 5-year global program, sponsored by the U.S. Agency for International Development (USAID) that aims to improve the health and survival of mothers and their newborns. Jhpiego implements the program in partnership with Save the Children, Constella Futures, the Academy for Educational Development, the American College of Nurse-Midwives and IMA World Health.

[3] Basic EmONC services include the following: parenteral antibiotics; parenteral uterotonics; parenteral anticonvulsants; manual removal of placenta; manual removal of retained products/MVA; assisted delivery by vacuum, and newborn resuscitation. Comprehensive EmONC services should include all of the above plus surgical capability (caesarean section), anaesthesia and blood transfusion.

- Baseline findings identified many gaps especially in SHD.

2. Strengthen quality of clinical care at hospitals to ensure appropriate learning environment

- To ensure a high-quality clinical environment for learning/teaching where MNC practices were up-to-date, evidence-based and consistent with the expanded ANM guidelines, a series of technical updates were conducted on infection prevention and MNC.
- One of the main challenges was procurement of provisions and supplies
- By 2008, both sites worked to make improvements with regular support from project staff.

3. Develop clinical training materials

- Competency-based training materials were adapted from international resources to the Indian context and per the scope of practice agreed for ANMs.
- In addition to teaching the expanded skills set in the GoI guidelines, this training course fully refreshed the ANMs in basic MNC.
- After a review of the proposed three-week training schedule (prepared by GoI), it was decided the three week duration would not be sufficient to ensure competency in the full range of skills. A 12-week schedule was developed, as it was considered the minimum time necessary to prepare ANMs to be competent in the core competencies.
- The full set of training materials is a learning resource package (LRP) of 16 modules with teacher/trainer handbooks, participant notebooks, a clinical experience logbook, and PowerPoint presentations. All are available in English and Hindi.

4. **Strengthen ANMTCs to offer high-quality maternal and newborn health training**

- A teaching skills workshop was conducted for tutors combined with the technical update and clinical skills standardization. Facilitators used participatory teaching methods including: question and answer; group work; brainstorming; role-playing; skill demonstration and practice; and clinical practice.
- To support competency-based training, skills labs were established at both ANMTCs. These contained models and supplies for skill practice and simulation.
- Classrooms were equipped with visual or other teaching aids. Further rehabilitation of the Dumka ANMTC has ensured living accommodation for ongoing courses.

All my life, I have used only lecture method for teaching. Now I have learned and use methods of teaching such as case studies, role plays, interactive presentations, exercises, skill demonstrations. This creates interest in learning for the students.— Ms.Uma Pramanik working as an ANM Tutor, Dumka

ANM tutors such as Sister Uma and Sister Mohanti (pictured left) now use anatomic models and skills learning guides during training.

Photo Credit: Sanjay Paul

5. Support ANMTC staff as they train ANMs

- The training of the ANMs was closely monitored and supported by the ANM Training Coordinator.
- During the course, trainers with the training coordinator monitored the ANMs' progress towards competency in skills using clinical logbooks. The ANMs completed seven weeks of clinical practice on day and night shifts, including at least one week in the community.
- It was evident during clinical practice that ANMs were very deskilled and required increased supervision and time to practice to become competent and confident.

6. Support and monitor ANMs post-training

- The ANMs required a lot of support following training to ensure effective transfer of learning. This was provided by the training coordinator in coordination with the district Lady Health Visitor supervisors who had received preparation for their role.
- Systems issues hindered ANM performance. Documentation and reporting were weak. There were many logistical and systems issues—such as a lack of functional health sub-centers–that impacted the ANMs performance. The ANMs were eager to provide their new skills and, with support from the district, many of these barriers were overcome.

OVERALL ACCOMPLISHMENTS, 2006–2008

- To date, 58 ANMs have been trained to competency in all the required skills.
- Both ANMTCs have increased capacity to conduct competency-based ANM training on MNC. With continued support and resources, this capacity can be sustained.
- Some best practices have become standardized and institutionalized in SHD: Active management third stage of labor (AMTSL)[4]; Newborn resuscitation—staff state they can now "save babies' lives" and; management of eclampsia with magnesium sulphate
- ANMTC tutors are more enthusiastic and motivated given the support they have received and they have fully embraced competency-based training approaches.
- Trained ANMs have demonstrated that they can perform deliveries and the new skills they were taught (AMTSL, partograph, newborn resuscitation)

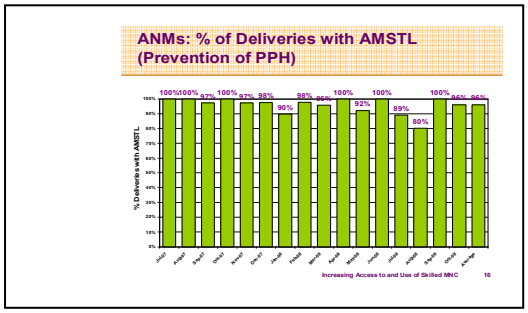

Figure1. % of deliveries with AMTSL

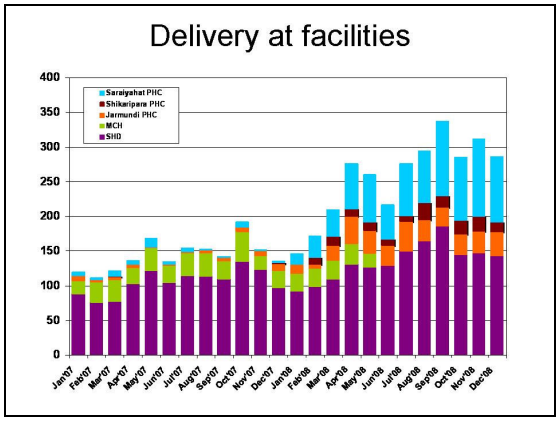

Figure 2. During the project period, there were consistent trends in the three blocks of Dumka showing that women were seeking skilled care and often from facilities. Trained ANMs increasingly conducted deliveries at facilities.

[4] Both Oxytocin and Misoprostol are used as uterotonics in AMTSL in facilities; ANMs are mandated to use Misoprostol at community level .

- Awareness and action on MNC increased through community mobilization
  - Mobilized 223 communities by Chetna Vikas (local NGO).
  - Trained more than 2,600 community members, including 434 safe motherhood volunteers, 231 safe motherhood advocates, and over 1,300 *mahila mandal*[5] leaders
  - By October 2008, the majority of the 223 mobilized villages had taken action to increase access to skilled care:
  - ⇒ 100% have a functional emergency transport system for birth preparedness and complication readiness during pregnancy and childbirth
  - ⇒ 70% are actively using the services provided by the ANM in their area

CHALLENGES, OPPORTUNITIES AND LESSONS LEARNED

Challenges

- Many challenges and gaps remain in the health system in Dumka which will seriously undermine the quality of clinical training, as well as quality of care. The hospital must also be able manage all components of EmONC.
- Throughout the healthcare system, documentation and reporting is minimal. Use of the partograph remains a challenge within the hospitals and among ANMs post-training.
- Government systems need to be strengthened. Procurement of supplies, training funds release, and overall supervision were recurrent issues throughout the project.

Opportunities

- A full set of Hindi training materials exists after field testing. These materials support competency-based training and the Indian Nursing Council has commenced the integration of these materials into the pre-service ANM programs.
- The two strongest and most motivated trainers are both service providers. This provides a model for future ANMTC capacity building. Faculty/tutors are often not clinically active and can be supported by a team approach, working with providers at the clinical practice site.
- ANM tutors/faculty and service providers were enthusiastic to participate in professional development. This motivation can be capitalized upon and sustained with systems support.
- Other nursing staffs are interested in updating their skills and there is some momentum for improving the quality of care. For example, all staff can now perform newborn resuscitation.

Lessons Learned

- Training site development needs to start well in advance of the training
- Twelve weeks was the minimum duration of the training in Dumka for many reasons: the ANMs were more deskilled than expected; skill development leading to competency using learning guides and checklists was new for the participants and teachers; and there were many new skills to address in addition to strengthening existing skills.

[5] Mahila Mandal – women's empowerment groups