During this phase, certain "Don'ts" become important. They are:

(a) Don't interpret the patient.
(b) Don't deny the patient's feelings.
(c) Don't make assumption.
(d) Don't use approval or disapproval.
(e) Don't threaten.
(f) Don't advise.
(g) Don't take-over responsibility of the patient.
(h) Don't demand. The patient gets better as a result of your help.

The goals of the working phase of the nurse–patient relationship on patient grow in self-understanding and self-responsiblity.

The last phase is the termination of the nurse-patient relationship. The nurse should prepare the patient for this and it may present some difficulties, depending on the individual patient. In any case, a relationship in a working phase that must terminate, should not come to an abrupt end without some explanation.

Limitations

As health services and their multiple categories of personnel become increasingly interdependent, the differentiation of functions and responsibilities among the groups involved become more difficult. And in the complex setting of medical care, there are certain limits in the role of the nurse that one mostly accepted.

A nurse cannot, by law, diagnose or prescribe. She cannot substitute through her own work, for what she considers to be incompetent on the part of physician.

Another problem in limitation that is often difficult is the short stay of patients and the limited time that a nurse may be in contact with a particular patient.

Nurses are often caught in situations in which although attempting to provide therapeutic interaction with patients, they receive little support from others in the working situation including nurses and doctors. Although this may constrict the scope of her effectiveness she is under obligation to continue her efforts. The quality of individual nursing care should not be sacrificed to the mediocrity of other personnel.

Another limitation placed on nurses is by the patient who rejects help or who denies any difficulty. Patients cannot be forced to help themselves and there is only acceptance to be offered to the rejecting patient. Hopefully, at some later day, repeated experiences of acceptance will help the patient to know himself better.

So, now, we can come to the conclusion that with the study of social sciences, which will help for a better understanding, the nurse can have a better working situation with the patient and this will help her to achieve her goals in treating the patient, in teaching the patient and above all this will create a peaceful and happy working field.

Further Reading:

1. *Fundamentals of Patient-Centered Nursing* by R.N. Mathney, chapter 7, page nos. 84 to 91.
2. *Behavioural Concepts and Nursing Intervention* by E. Cartson, chapter 18, page nos. 331 to 339.
3. *Scientific Foundation of Nursing* by T.N. Mark, chapter 1, pages 6 to 8.
4. *The Nursing Journal of India*, Aug. 1974, page Nos. 209 to 211.

IN THE REALM OF HEALTH EDUCATION

Miss A. CHACKO

In this paper presented at the International Conference on Health Education at Ottawa, Canada, on September 2, 1976, Miss A. Chacko, Principal, School of Nursing, Church of South India Hospital, Bangalore, describes the role of nurses in health education.

It gives me great pleasure to talk of our experiences at the Church of South India Hospital at Bangalore. I would like to present some of our new thoughts put into practice in Health Education.

A nurse's role in Health Education especially in a developing country is a difficult one. Her aim should be to impart Health Education that would result in : 1. Change of knowledge ; 2. A change in attitude; 3. A change in behaviour that would lead ; 4. To a change in habit and, ultimately ; 5. A change in custom.

If she can achieve this, she would have fulfilled her role fully.

Not in Isolation

Health Education cannot be viewed in isolation. It must be considered only in the context of an effective health delivery system if the nurse is to achieve; any success in her role as an educator. In India 80 percent of her people are in the rural situation while 20 percent are placed in the urban area. When we planned our health care system two decades back we established Primary Health Centres to cater to a large rural population of 100,000 people.

This type of health delivery system did not prove successful for two obvious reasons :

1. The resources in personnel and money were unevenly distributed resulting in 80 percent of the rural people obtaining 20 percent of these resources while 20 percent of the people in the urban situation shared 80 percent of the country's resources.

2. The second important factor was the distance prevailing in the rural situation which we call as the walking distance. It is quite clear that for every mile away from the Health Centre the attendance drops twice in number so that beyond 7 miles the people hardly ever use the facilities of the Health Centre.

Fifth Plan Target

In order to rectify these drawbacks in our health delivery system we have in the Fifth National plan reduced the serving population to 10,000. This reduced population is being served through sub-health centres. However, we, from the Church of South India Hospital, Bangalore, believe that the ideal population coverage should not be more than 5,000.

The functions of a nurse in these sub-centres are specified and include the following : 1. Preventive medicine ; 2. Family Planning ; 3. Nutrition ; 4. Minimal Health Care ; 5. Detection of early morbidity ; 6. Referral to higher appropriate centres.

Therefore, a nurse assuming her role as a health educator must be fully trained and that too specifically to assume an appropriate role in these six health programmes of the centre.

Another important factor that seems to come to the fore in our health delivery system is that health teaching must filter down from the top to the bottom of the skill pyramid. Unfortunately, the medical officers are so pre-occupied and busy with curative and administrative tasks that it is becoming more obvious especially in our country where the nurse by force of circumstances has had to assume a key role in planning and executing an effective health delivery to the rual masses in India. She has to diffuse her efforts through : 1. Individul teaching, 2. Literature, 3. Group teaching.

For, teaching is like a three pronged spear.

A Medical Out-Reach Programme

In order to practicalise this aspect the Church of South India Hospital, Bangalore, which is situated in the heart of the city has evolved an effective medical out-reach programme at two rural centres. 1. At Hoskote which is 20 miles away from Bangalore, and 2. Chennapatna which is 34 miles from Bangalore. I shall describe one of these out-reach centres and its work in detail.

The Hoskote out-reach medical work is in a rural area with a population of 45,00 people living in 106 villages separated from one another and having poor communication. The primary health centre is located in the Hoskote Town of 12,000 people and this centre is staffed with resident doctor and nurses for taking care of referrals from the sub-centres or what we call mini-centres.

There are eleven such mini-centres in this area and we are now working in three such centres and hope to expand into eight more centres when we have the adequate resources. One of these centres is situated in the village Dasarahalli which is the central village to a group of seven adjacent villages. The total population covered in these 7 villages is about 3,000. The people are mainly agriculturists, 20-25 percent educateable. The Church of South India Hospital has a mini-centre established right in the midst of these villages.

The plan of the mini-centre is quite simple in that the components are a small dispensary, with admission facilities for four patients, a community kitchen for service and for demonstration, staff quarters and a Community Centre for vocational training and family training programme. As a church related hospital, we have a small church which is the motivating force in our whole scheme. The team in service in the mini-centre is an integrated inter-disciplinary group consisting of the pastor who is the team-leader, the nurse, the agricultural extension worker and a social worker

The nurse's main role for the health of the rural community is :

The Main Role

1. Maternal and child health care and in this task the nurse concentrates on the antenatal, natal and post-natal care of her patients. In the village situation she must also reckon with the Dai who is the traditional birth attendant of the village. She must be careful to avoid appearing to be usurping the position of the Dai, but on the other hand she must use the Dai and teach her in the simple art of safe and scientific method of delivery of the baby and teach her also the care to be given to the new born. Once the Dai realizes that the nurse is not a competitor, but a teacher and a helper the Dai will prove to be one of the best multipurpose health workers to the rural community.

Children health care : This is done effectively through the "Under five Clinic" in the Health Centre.

2. She must be capable of giving basic curative care so that she begins to command the respect and the acceptance of the community.

3. In a village situation where she works with a tremendous amount of limitation she must be capable of recognising early morbidity and refer such cases to appropriate higher centres.

4. Her role in the Family Planning programme in the rural situation is different. 80 per cent of the people in the rural population are aware of the programme, but only 17 per cent accept methods of Family Planning. This disparity between knowledge and acceptance is almost an unsurmountable gap. Therefore, in a rural situation the nurse will not be successful in pushing the programme of Family Planning by any methods of teaching, coaxing or enticing with monetary or material rewards. She must first help the mother to see that the living have a fair chance of survival by immunization, nutrition, and health education programmes.

Her teaching is best done in an informal as well as a formal method. In her role as an informal teacher she will use actual situations to impart education. For example, nutrition talks are best done in an informal cooking session.

The home visits are the best times for Health Education as during this period while she is involved in a consultation, not only the mother but the other women folk of the family gather to listen to and imbibe health knowledge. Lastly, as a teacher during these informal sessions the nurse must be careful that she is not too technical, but helps to build her teaching on the mother's existing knowledge.

Formal methods of teaching are employed by our nurses in the mini-centres through family education programmes. Twenty mothers are recruited for each training session for a period lasting between 3-6 months when they are taught family budgeting, simple household skills and Health Education. The plan is a weekly programme which the nurse undertakes during the family education programme to inculcate the basic Health Education through demonstrations and discussion.

In all her methods of teaching her role as a communicator will be successful if she can:

1. Be brief-5 min. to 10 minutes is all that is needed;

2. Be simple-make one or two points clear, should-not confuse with too much information;

3 Be seen—Use visual aids and actual tools when possible;

4. Be heard–Speak loud to capture interest;

5. Be remembered—Use local events to illustrate—helps to remember.

The nurse is the team leader for health in the mini-centre in our comprehensive health programme. The strategy she will employ for finding her true role as a Health Educator is most remarkably brought out in the old Chinese poem :

Go to the people, Live among them;
Learn from them, Love them;
Start with what they know, Build on what they have;
But of the best leaders,
When their task is accomplished; Their work is done,
The people all remark;
"We have done it ourselves."

Lastly, in conclusion, I would like to leave this thought with you all. In our hospital which is a Church related hospital in which I am a member of a large team of workers and of associates, we have realized that we can only fulfil our mission if we realise soon that,

"If we offer only the gospel to the hungry of the world, without giving them bread to satisfy their hunger, we betray the gospel."

EDUCATION AND ADMINISTRATION : NEED FOR RESEARCH

B.K. NAYAR, C.R.S. RAO and S.S. GUPTA

The present paper by three scientists of the CSIR deals with some salient aspects of the current situation, and the need for research into problems connected with the education and employment of graduate nurses.

NURSING is a vital component of health services. Planning and development of high level nursing manpower has assumed great importance in the context of increasing stress on improved delivery of health care services in the country. Higher education, administration and research in the field of nursing require an adequate complement of specialists in various aspects of nursing.

Stock of Graduate Nurses

Nursing education at the degree level was started in India in 1948. The first outturn appears to have been in 1950. The outturn of graduate nurses in India from 1950 to 1974 is given in Table 1.

Table 1.
Outturn of graduate nurses in India, 1950 to 1974

Year	Outturn		
	Regular	Post Basic and Post-Certificate	Total
1950	14	—	14
1951	21	—	21
1952	30	—	30
1953	20		20
1954	29	—	29
1955	21	—	21
1956	32	—	32
1957	17	—	17
1958	24	—	24
1959	32	—	32
1960	25	—	25
1961	43	—	43
1962	49		49
1963	42		42
1964	58	—	58
1965	67	7	74
1966	70	10	80
1967	74	28	102
1968	110	22	132
1969	106	49	155
1970	101	63	164
1371	108	78	186
1972	123	84	207