SOCIAL FORCES AND FACTORS INFLUENCING NURSING EDUCATION IN INDIA

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With this article by Miss Ruth Harnar, we conclude the publication of a series of articles on the subject : Nursing Education in the Development of India. This article covers some very vital points on the socio-cultural influnces on nursing pattern and nursing education.—Ed.

Part I. Historical Factors : Religious, Cultural and Social Values

For India, the most important *historical* forces which have influenced the development of nursing, a predominantly feminine occupation, have been Hindu or Muslim beliefs and values which have

placed women in a subordinate and lowly position in the home and joint family where they had very little opportunity for independent action ;

prevented girls and women from receiving a formal education ;

prevented women from entering occupations outside the home ;

prevented change from the traditions of a hierarchical caste system, rigid rules of behaviour, slowing modernization needed for today's India ;

placed occupations, such as nursing, which involve contact with "polluting" substances and lower caste patients at a subordinate level in society ;

placed value on accepting one's fate with passivity, but also on the qualities of loving devotion, spiritual rather than logical thinking, and less clear differentiation between good and evil than is true of the Judaic or Muslim religions.

Successive waves of political invasions by various ethnic groups disseminated cultural advantages but also fixed the pattern of caste, the secluded and limited role of women and regional groups of people who had similar culture, language and ethnic patterns but accepted new rulers and their laws. Contact with Western civilization through trade, colonialism, education and Christian missions began to bring about widespread changes. Reform groups within Hinduism, due in large part to the Christian example of social work and teaching, as well as social welfare and education brought by the British rulers, began a process of change led by such men as Mahatma Gandhi, which is still occurring. For example, there is :

increasing concern for social justice and rights including health and education,

sentiment against discrimination against anyone due to caste, religion or sex,

an increasing feeling of responsibility for others' welfare rather than concern exclusively for one's own soul,

active participation of women in social welfare programs, and campaigns for legal rights.

Education, encouraged by the British and carried on by Christian missions and later by other private bodies, became concerned for neglect shown to girls. The school system greatly expanded, especially after Independence. Some important features of the Indian educational system have been :

a classical British pattern, neglecting until recently, the sciences and technical education subjects ;

lack of sufficient resources and prepared and experienced teachers, poor quality of textbooks, and inefficient management due to the sudden expansion and lack of sufficient finance ;

an anxiety producing examination system, using essay questions to a great degree, at the end of higher secondary school, which encouraged rote memory ;

teaching the students to pass examinations rather than encouraging logical thinking, or problem-solving skills such as the ability to make decisions on the basis of facts ;

social demand for higher education that has led to too rapid expansion, resulting in increasing numbers of educated unemployed.

Recent changes in policy, important for nursing education, have shifted toward more technical and vocational education ;

recommended expansion of primary and pre-primary schools, increase in adult and informal education, functional literacy and special educational programmes for women ;

planned to increase vocation preparation in the school system linked to preparation of manpower for development needs of the country.

If nursing education programmes are moved into the general education system as is being recommended by nursing leaders, they should not only benefit from the changing priorities in education but should have much to offer the schools in carrying out the new policies.

The status of nursing as an occupation in India has suffered from the stigma attached to it by a society which could not approve of women working outside the home with tasks considered unworthy of all but the lowest caste people. Raising educational qualification required of nursing candidates has made effective changes in the status of nurses and is responsi-

ble for increasing numbers of non-Christian girls entering nursing. The professional organizations have worked to bring about these changes in status by continual improvement in standards of nursing education and services.

Major health problems in India, caused in large part or aggravated by the socio-religious beliefs, customs, superstition, ignorance and poverty, are population expansion, malnutrition, infant and mother mortality, preventable and communicable diseases, and increasingly disease conditions of old age, mental illness and unsanitary living conditions not only in rural areas, but in slum areas of the cities. Public Health nursing, Family Planning, and Psychiatric Nursing have recently been integrated or added to the nursing curriculum requirements, verbally at least, but the practical result is in doubt. A large percentage of the student nurses never have experience in rural community nursing or in psychiatric nursing. Over 90 percent of the graduate nurses and even about 30 percent of the Auxiliary Nurse-Midwives are being absorbed in the nursing service of large city hospitals rather than the health center system which is more likely to reach the majority of the people in the rural areas with preventive as well as curative health care. A recent study shows that Delhi, the most highly urbanized State (less than 60 percent rural population) has a nurse-population ratio of 1 to 2856, while in contrast the States of Orissa, Bihar, Uttar Pradesh and Jammu-Kashmir, with over 80 percent rural population, have more than 23,000 population to one nurse. [See Figure 5, "Rural population in Indian States showing the number of the population to one General Nurse (GN) and Auxiliary-Nurse Midwife (ANM).]

Disparity between the distribution of nursing personnel, including both general nurses and ANMs also exists. Again it is very evident that the same States—Orissa, Bihar, Uttar Pradesh and Jammu and Kashmir—have been neglected. The same situation exists in the number of nurses completing training programmes each year—the most rural states having the least number of schools and graduates.

Part II : Political and Economic Forces

The various historical forces and conditions culminated in the new state and government of free India in 1947, with a constitution based on the principles of social justice and the welfare of the people. The Health Ministry was set up to carry out the role of the government in the provision of health care services to ensure the right of good health to all. But only in the most recent of the Five Year Plans sufficient attention has been given to the human and social aspects of the economy. Rather than spending most of the effort on large scale industries, communication and irrigation projects which were stressed in the early

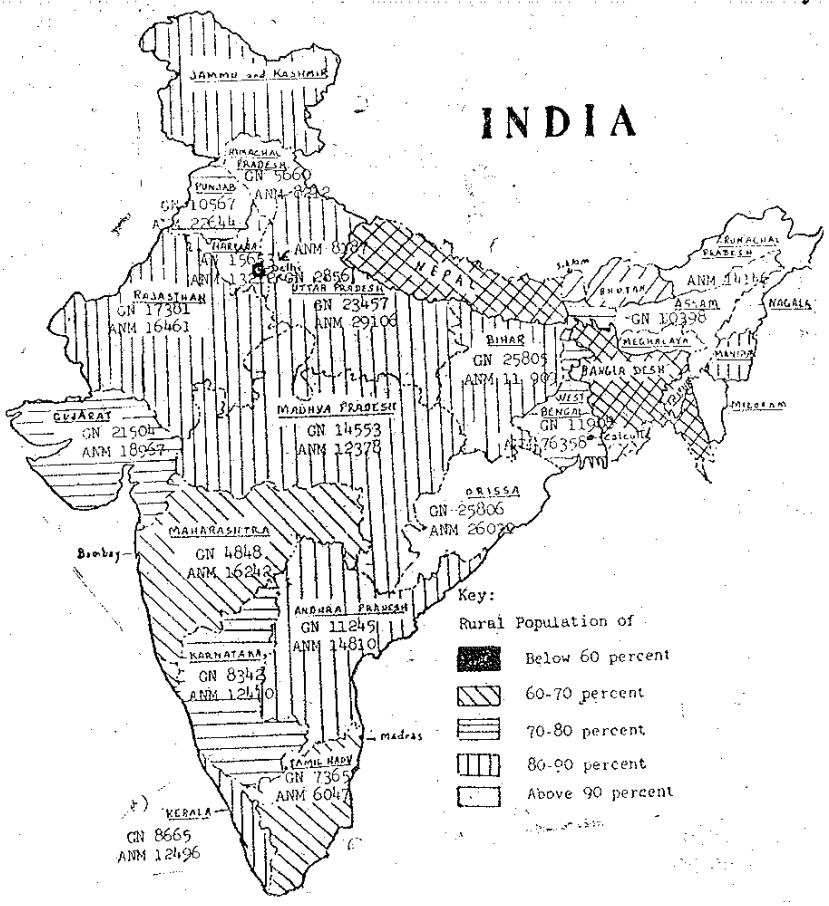

Fig. 5. Rural population in Indian states showing the number of the population to one General Nurse (GN) and Auxiliary Nurse-Midwife (ANM).

Source : CAHP, "Report of a Nursing Survey in India", pp. v, xi.

plans in order to rapidly increase the Gross National Product of the country, emphasis has shifted to integrated planning and programmes, as it has been realized that without allround attention to problems of the people, the needed changes in the social milieu cannot occur.

The most pertinent of these plans and programmes for health care is the National Programme for minimum needs. It is intended that neglected areas be selected and "growth centers" be developed through integrated projects including primary schools, agricultural development, electrification, all weather roads, supporting small industries and home industries, development of home sites and environmental sanitation and ensuring "minimum uniform availability of public health facilities", including preventive medicine, family planning, nutrition, and early detection and treatment of disabilities as well as referral facilities for more serious cases.

Full implementation of the health schemes in relation to this programme projected for the Fifth Plan period up to 1979 would require more than twice as many effective stock of nurses as exist at present, not to mention additional Public Health Nurses or Health Visitors and Auxiliary Nurse-Midwives who would be utilized as multipurpose workers and Health Supervisors in the rural areas. Even if the educational facilities are continued at the present rate and not cut back, the shortfall in requirements for nursing personnel would be 53,000 nurses, 27,000 Public Health Nurses, and 84,000 ANMs.

Whether or not the various medical care programmes included in the plan, such as rural hospitals, mobile hospitals, improvement in district and central hospitals, rehabilitation programmes, and national health programmes for control of various communicable diseases, are implemented successfully is dependent on many factors. They will have to be carried out on the State level, and the policies decided upon or the priority given to health schemes or the National Programme for minimum needs, are dependent on political realities, on who makes decisions, administration and management skills of those in government, in the planning bodies, and those assigned to individual projects. The problems of regionalism, growing as a political force in recent years, may influence or prevent the appointment of those most capable of carrying out the new schemes, or of organizing the planning process, if they are outsiders from other state, or if it is not politically expedient for those in power to bring them in.

Social legislation is not enough to bring about social justice change without full use of knowledge in social psychology, communication methods and education on a mass scale. Even under the most auspicious circumstances possible on the political and social front, economic realities prevent the accomplishment of national purposes. Everyone wants social justice and the eradication of poverty for themselves and there are few political leaders who would fail to grant these to their people if it were in their power. But particularly in developing countries the matter of economic priorities is a fact which must be faced by every government. It must be frustrating to those who have the knowledge and technology needed to solve problems such as food production, control of population, growth and prevention of disease, and the management capabilities to see that these are distributed equitably to the population, to find that their particular field is not at the top of the list of priority decisions.

In addition to these problems there is the deepening economic crisis existing in India which can hardly be imagined by those who live in developed nations. Industry, agriculture and food production have been profoundly affected by circumstances which the government of India could not control. The Oil and Energy crisis and drought in 1974 have lessened production and the capability of distribution of products, and particularly food, within the country, increasing costs to a degree which has resulted in runaway inflation and increasing poverty, and forced the curtailment of many programmes, including the projected Fifth Five Year Plan schemes involving health services and health education.

One thing is clear, that all of the societal determinants discussed form a network of influences which cannot be ignored in planning for the future. Nursing and nursing education are a part of the answer, but they are also influenced by each of the historical, political and economic factors which must be considered if the profession is to make the contribution for which it is responsible.

The concern and service of every nurse at every level of nursing is needed by the country. It is certain that historical factors, social change and political forces have been helping the nurse to achieve a higher status in society, and that in present day India, fighting for the rights and privileges of the members of the profession without an equal and even greater concern for the rights and needs of the people as a whole, will cause the loss of position and force those who seek the help of the nurses to bypass them for others less selfishly oriented.

Now is the time to shift priorities toward helping to solve the urgent social and health problems of overpopulation and neglect of rural communities. Much can be done within the present curriculum required by the Indian Nursing Council, but curriculum development and change is also necessary. Planning is required to make the "clinical experience" hours during the training programme more relevant to the requirements of the country, including well planned and executed experience in community health instead of so many hours in the service of the attached hospitals. Nurses should involve themselves in planning, in community welfare activities, and in working with all those in the development teams needed to bring about improvement in communities, both urban and rural. Only by full involvement in the development plans of the country, with the use of nursing knowledge, the required commitment, and the personal and group behaviour necessary to make nursing a full partner in the development of the country, will the nursing profession earn the status it should have.

(Concluded)