Nursing Practice in the Community

MRS. M. V. RANGNEKAR

Mrs. M. V. Rangnekar, Public Heatlh Nurse, Family Planning Training and Research Centre, Bombay, reports here on the work done by the Centre's trainees in the field practice area under her guidance. The Centre provides job oriented training to family planning workers for getting field experiences to develop field practice areas.

FAMILY Planning Training and Research Centre, Bombay is a central training institute where training is imparted to the family planning workers for different directions from various states in India. The training is in-service training for individuals already employed in the different jobs.

Training aims at enhancing the knowledge and skills of the trainees in health, family planning and public health activities and their implementation in the community groups. For this purpose 'Field Practice Areas' are allotted to the groups of trainees for different field activities. I, as a P. H. Nurse, guided this group to go through the following experiences.

Field Work

The present group consisted of eight trainees. They were assigned field at Municipal conservancy staff colony for a period of thirty working days. The field was selected on the following basis:

i) Nearest to the centre.
ii) Population above 500.

The group of trainees under the guidance of a P. H. Nurse were given the responsibility of collecting the information to diagnose the community ills and plan the programme. The steps taken were as follows:

I. Characteristics of field practice area

a) *Demographic characteristics of the area :* Here the group studied the population of the area, sexwise and agewise, by observations and by interviewing the prominent personnel in the community. The group also visited the municipal ward office census department to find out the demographic and topographic characteristics.

b) *Topographic characteristics*: The group studied the site of the area and the place of location, then they prepared two maps of the area: one map shows the actual route from the centre to the field practice area along with the conveyance facilities. The other map was prepared to show the exact location in detail along with the numbering of houses.

c) *Socio-economic status of the people*: The group found out the occupations of the community people, the level of education and their income per month and other sources of income in the family. Further, they studied the habits and beliefs of the people towards nutrition and other routine work.

d) *Communication channels:* The group studied the different channels of communication. The different sources that make the community people get together to solve their own problems. The occasions and religious festivals are noted when the people get together. The other organizations are Mandals and associations to approach the community people for educational activities.

e) *Resources of the community*: The group found out the number of medical practitioners to where people go for medical advice, the number of hospitals in the nearby area where the people go for medical aid. This would help the group member to guide the cases properly to the concerned department. Further, the group got acquainted with the municipal ward office to direct the community people to get help for solving environmental sanitation problem and drainage problem etc.

f) *Past experience of the community*: The group made attempt to find out whether the community had any positive/negative experience of any other agency working for health education itself in the community.

g) *Public health problems in the community:* The group had several meetings with the community people to make the community diagnosis and came to conclusions that people were against family planning, though there is need for family planning. The younger generation is under the influence of the older people. They could not come out openly to support family planning. The community is in need of welfare programmes for the health of their children such as immunizations against different preventable diseases.

h) *Leadership pattern*: For different social and cultural activities the community has different organizing committees. The members on the managing committee are the leaders. This way there are formal and informal leaders. Unless somebody takes lead, the community does not move for any group activity.

II. Implementation of the programme

To meet the demands of the community, as far as possible, following programmes are sequenced by involving the leaders:

a) A film show on "Main Bhi Ma Hun" was arranged where 500 people were assembled.

(b) Immunization was done. The subsequent doses

of polio and D.P.T. were followed after one month's interval.

c) Children's Day was celebrated on November 14 in honour of the departed leader of the Nation, Shri Jawaharlal Nehru. This day was celebrated with full enthusiasm. The community members collected the funds from Municipal Corporation, members of Legislative Assembly, F.P.T. & R. Centre (our centre) and the community itself. On that day the president of Chawl Committee, Municipal Welfare Officers, Municipal Corporation, were present there for the celebration. They appealed to the audience to follow in reality the advice of the departed leader that "Today's children are the leaders of tomorrow and hence the future architects of the Nation". This can be possible only if children are really accorded the opportunity by their parents which will be possible only through planned parenthood and further they advised the community to cooperate in the National F.P. programme.

(d) Health and F. P. survey was carried out with the following objectives:

i) To be able to find out,

a) The total population of the area;

b) The total number of eligible couples in different age groups;

c) The knowledge and attitude towards F. P. and the use of contraceptives;

d) The status of immunization against preventable diseases among children of pre-school age;

e) The economic and educational status of the community;

ii) To do a critical study of the health and F. P. problems in the colony.

After collecting the data through survey and group discussions with the community members the following health problems were identified:

i) Environmental sanitation needs improvement.

ii) There is lack of knowledge about the scientific methods of contraceptives amongst the majority of the people.

iii) People in general are ignorant about the maternal and child health programmes.

e) An orientation training programme in F.P. was conducted for three days from 9 p.m. to 10.30 p.m., where twenty five leaders and members took advantage. They showed interest and enthusiasm in the programme by asking several questions. Also, the group participated in discussions. The group desired to know more about the M. C. H. and Environmental sanitation. Accordingly, display of posters and charts on M. C. H. was done and talks were given in small groups. One talk on Environmental Sanitation was also given during the orientation training programme.

Further, the same area was followed for a period of two years to fulfil the objectives of survey findings. Each individual family was given care and guidance for better health.

STRUCTURAL CHANGES IN NURSING EDUCATION IN INDIA (II)

A PLAN OF ACTION

K.C. AGGARWAL

Now, the time has come when we should remedy our system of education and make it mass-based and rural-oriented. There should be a need-based programme to help in the reconstruction of the country. Nursing Service should promote the health of the masses so that they could contribute fully to the overall development process, argues K.C. AGGARWAL, M.N. (P.H.), in this second and concluding article in the series.

NURSING education in India has a long history. It was initiated by the British missionaries on the British pattern. It was also one of the tools for the colonial administrators to keep the intelligentsia of the country happy by providing all the necessary facilities so that they could fall in line with the British Empire in our country. Therefore, standards of practice, curricula and system of examinations, etc., were all on the British pattern.

When the country became free in 1947, naturally, the responsibility for the administration of education and service fell on the people who were educated on the British pattern and were divorced from their own people. Such people in higher positions tried to perpetuate the old vicious circle of nursing education in the country. These leaders were so loyal to their old British masters that any departure in the education system from their familiar system was not even thought of.

The result of such mental attitude is that even today after 29 years of independence, when sweeping changes have taken place in all sectors of life, our nursing education still continues on the Anglo-Saxon pattern which is completely divorced from the socio-economic realities prevailing in the country. Therefore, it is no surprise to note that professionals prepared in such a system find themselves unsuitable to work in their own country and get their cherished satisfaction working in the hospitals in the west.

Need-Based Programme

Now, the time has come when we should remedy our system of education and make it mass-based and rural-oriented. There should be a need-based programme to help in the reconstruction of the country. Nursing service should promote the health of the masses so that