CHAPTER XII

PERSPECTIVE OF NURSING PROFESSION: A DISCUSSION

Because of the nature of the study, the implications have been discussed along with the presentation of the conceptual basis, the methodology and of the findings. Here, only some of the key issues that signify qualitative dimensions of the quantitative development of nursing manpower, given in the preceding chapters, are discussed. This discussion is quite relevant for placing the various activities relating to the formulation of any developmental strategy for nursing manpower in perspective.

One very significant feature of the study relates to its methodology. It has already been pointed out that there are enormous gaps in the availability of some of the data that are critical for the study. Most of these data are simply not available. Whatever is available, their location and retrieval presented a major difficulty. Over and above, there were serious problems of their reliability and comprehensiveness. Using such a data base for assessing the availability and requirements of nursing manpower in the country called for use of a number of techniques of manpower study to test the validity of the data and to come to certain conclusions, when the validity is reasonably established. To cite a few instances in this context - the determination of inter-state migration rates, identification of the magnitude of discrepancy in registration data of, INC
to be used as proxy for the total availability and identification of the proportion of 'practicals' in nursing profession.

As regards the data base available for the study, it need not be emphasised that even the most crucial figures with regard to the number of nurses currently engaged in the profession are not available from any source. Obtaining details regarding their distribution by levels of education/training, over states/location and by deployment pattern, were far more difficult problems. The present study has attempted to develop these information by adequately utilising the data available from the Census and other sources with appropriate adjustments. For the purpose, the estimates of stock worked out by accumulation of outturns over past years with due allowance for attrition on account of mortality and emigration have been treated as the 'control' figures for the entire exercise. The stock figures so built up represent the total stock of qualified nursing personnel, which automatically take note of the limitations of INC and Census data viz., the multiple registration, inclusion of those emigrated and died on the register and inclusion of practicals, etc. Similarly the distribution of nurses by states as brought out by the Census, provided a base for working out the inter-state migration rates during the period of two census counts. The exercise had to be undertaken by taking the pooled availability of nurses, ANMs and LHV's together as the data available from Census were in
two groups viz., nurses and ANMs/LHVs together. Although the aggregative availability of these two groups was fairly close to the estimated stock of these categories put together, but wide variation was noted with regard to their inter-se distribution. The individual group-wise comparison thus also brought out an element of under reporting of ANMs/LHVs and an over reporting of nurses in the census data. These deficiencies were also suitably adjusted in the exercise.

Thus the present study has provided a sound quantitative data base for planning nursing manpower development strategy. But as has been pointed out earlier, health manpower planning in India can be meaningful only when there is a scientific approach to the planning of health service development. Except in the case of formulation of India's National Tuberculosis Programme (NTP), there is virtually no instance where careful health systems research has preceded the development of health services. Under such circumstances, it is quite unrealistic to develop a very scientific and systematic approach to the development of nursing manpower in India. But all the same, it is interesting to observe how, despite major limitations in the methodology adopted for health service development, manpower development has kept pace with the health service development in India.

Banerji² has drawn attention to this aspect by describing how the colossal manpower needs for the programmes such as National Malaria Eradication Programme, Family Planning Programme, Community Health Volunteer Scheme and Universal Programme of Immunisation have been met within very short duration of time.

The success of the health manpower efforts in India can be seen from the changes that have taken place since Independence. According to the Bhore Committee (1946), there were, in 1941-42, 29,070 licentiates, 17,654 graduate doctors, 7750 nurses, (including health visitors) and 5000 trained midwives. These numbers have, in 1991, increased to 310,673 MBBS doctors, 184,779 general nurses, 168,895 auxiliary nurse-midwives, 245,17 LHV/HA(F) and 17,230 nurses above certificate level, including post certificate diploma holders, graduates, and post graduates³. This shows 6.5 times increase in the number of doctors and more than thirty times increase in the number of nursing personnel. This increase, even from a skeletal quantitative form, shows the enormous effort that have been made in developing manpower to keep pace with the developments that have taken place in the health service in the course of past five decades.


3. The number of nursing personnel in 1991 are quoted from the present study and the number of doctors from IAMR Working Paper No 5/88 entitled "Estimates of Stock of Different Categories of Educated Manpower up to 2001",
The problems faced in developing nursing manpower were particularly formidable. Quantitatively, there were problems of uneven distribution, brain-drain, inter-state migration, 'practical' nurses, and so forth. Over and above, there have been major qualitative problems both in terms of growth and development of nursing profession in India as well as in the attitude of the different segments of the population towards the profession. Historically, the nursing profession in India is closely associated with development of activities of Christian missionaries. Nursing the sick is considered to be a pious activity among those who followed the Christian faith, while taking up nursing was not particularly attractive proposition among women from Hindu and Muslim communities all through the nineteenth century. This, incidentally, left the field free for Christian missionaries to train a substantial number of girls from lower castes, who had embraced the religion. Because of this, the missionaries have played a key role in early phases of development of nursing profession in India.

It may also be noted that the standards for nursing were set up by the South and North India Boards of Mission Hospitals, which later formed the basis of Indian Nursing Council. Furthermore, the pattern of migration of nurses from areas with high Christian population, which can be observed even today, shows the lasting influence of this trend in the history of nursing in India. Equally notable feature, which is of considerable social and cultural sig-
nificance, has been the very rapid erosion of the earlier inhibition against the profession, particularly, among Hindu girls since the middle of the current century. This social and cultural change has been a key factor in the rapid growth of the number of nurses that has been observed since Independence. These historical and social data concerning nursing profession give a deeper perspective to the quantitative data presented and discussed in the earlier chapters.

Another significant feature of the qualitative changes in the nursing profession pertains to the overall question of the making of a 'nurse' in the context of the health service system of India. This is a remarkable case of restructuring the image of a profession to meet the newer requirements. A very significant part of the restructuring took place with the conceptualisation of an 'auxiliary-nurse-midwife', who now forms the sheet anchor of the health and family planning services of the country. This is a glaring example of demystification of public health practice. The entire framework for production of this category is built on this principle of demystification.

Concurrently, it was also realised that academic background and the role of 'traditional' registered nurse, which has a base in the conceptualisation of the early missionaries, do not live up to the academic and technological demands made from the nursing profession by the rapid advancements in medical sciences. This was the motive force for starting the degree course in nursing which later led to
the programmes at 'Masters' and 'Doctorate' levels.

The analysis made in the earlier chapters, therefore, ought to be visualised in the context of these very significant qualitative changes, which have been triggered by the very forces which have led to the growth and development of the overall health services of the country.

Under the emerging scenario of health service system where primary health care forms the key to achieve the goal of Health for All, the nursing profession faces the challenge of responding to the needs of the community. Because of the complex nature of the community health culture, the health manpower specialists have to be the members of an interdisciplinary team for health service development. Nurses form an important and crucial category of this team. They are required to be more responsive to the community's needs.

The nursing profession, while being an important component of health manpower, and that of health service system, is bound to be influenced by the various social, cultural, economic and political forces that are operating, behind the development of health service system. Even then, in view of the challenge of providing a community oriented health care package which is affordable and acceptable by the community and makes the community self-reliant, the nursing profession has to grow not only in adequate numbers but also in terms of the quality of personnel with adequate community orientation in their training, attitudes and actions.