CHAPTER VI

LIVING CONDITIONS OF THE NURSING COMMUNITY

(1) NEED FOR THE STUDY OF THE LIVING CONDITIONS

People join an organisation and function as its members because they perceive it as a means to help them reach their goals. At the same time, the organisation employs people and allows them to function as its members because it needs people to help reach organisational objectives. However, people are related to different organisations at one and the same time. An individual spends only a specific part of his day with an organisation which employs him and supplies him his bread. For the remaining part of his day, he may be a member of a family, he may be a student of an educational institution, he is a loyal citizen of the nation, he is a tax-payer of a corporation, he may be a member of some political or social association. The same individual performs so many different roles during a day. The organisation which employs him for money is not directly related with other organisations of which he is a member. It employs him for his particular ability or skill, but it is often observed that skill or ability does not exist separate from back-ground of the individual. The organisation has to employ not only his
skill or brain but a whole person. Work life cannot be separated from home life. They are so much inter-linked with each other that each affects the other to a very large extent. It is often experienced that generally a successful work life leads to a happy home life and an individual who has a happy home only can concentrate fully on his work and make an efficient employee. Therefore, the employer-organisation always has to take care of an employee's home life in addition to his work life. It has to provide him with ideal working conditions and it can never afford to neglect his living conditions.

Davis has supported the above viewpoint while describing the nature of people and the basic assumption of a "whole person" about them. "Although some organisations may occasionally wish they could employ only a person's skill or brain, all that can be employed is a whole person, rather than certain separate characteristics. Skill does not exist separate from background or knowledge. Home life is not totally separable from work life and emotional conditions are not separate from physical conditions. Each affects the other. When management practises organisational behaviour, it is trying to develop a better employee, but also it wants to develop a better person in terms of growth and jobs fulfilment. Research suggests that do shape people
somewhat as they perform them, so management needs to be concerned about its effect on the whole person. Employees belong to many organisations other than their employer and they play many roles outside the firm. If the 'whole' person can be improved, then benefits will accrue beyond the firm into the larger society in which each employee lives. That is why a detailed study of the working conditions of nurses in government hospitals is supplemented by the study of their living conditions also, in short, for the purpose of the present thesis.

The study of the living conditions is necessary for understanding the nurses' problems fully. It broadly consists of the study of families of the nurses, their housing and home life. Most of the working women who take to nursing, do not take it as a career. They are forced to this paid work in order to help their families. As seen in the chapter relating to working conditions of the nurses, most of the nurses in the sample were not motivated or attracted but pushed into outside employment because of the economic necessity to work and they frankly told that they would

always welcome the first opportunity to leave their jobs as soon as their family conditions improve. In the present chapter, it is intended to analyse the various family conditions which had necessitated these women to work outside. It is intended to make certain observations regarding family types, family heads, educational status of the family members, occupations of earning members, information about fertility and family planning in case of married women. The economic position of the families with reference to earner status, income of the family, income from other sources such as property or remittances from outside, indebtedness of the family etc. is also discussed. Further, it is proposed to study the nurses' housing conditions and to see how they try to make their home life comfortable by adjusting their household duties with their work as employees.

(2) FAMILIES OF THE NURSES:

a) Family Type and Size: Families of the nurses were classified in three distinct classes - 1) The nuclear family 2) The joint family 3) Non-existence of a family.

The nuclear family was usually the rule as is often found in the society in modern times. Modernisation, urbanisation and socio-economic changes have made the society approve of a nuclear household now-a-days. The nuclear
family consisted of the husband, the wife and their children. It is interesting to note that many nuclear families had a related or unrelated person staying with them. For example, mother, father, mother-in-law, sister-in-law, non-adult educand cousin or a paying-guest student. This pattern of family could be called an extended family which was included in the class of nuclear families for the purpose of the present survey. Working housewives preferred extended families, it was found. By this way, they could avoid the drawbacks of a traditional joint family but could have convenient organisation of labour within the family. Such related or unrelated persons staying with the family were often a great help to do the housework and look after the children. It was reported that domestic labour was becoming costlier every day, and in such circumstances, the voluntary household work and babysitting done by these persons was much useful. Rent from a paying guest was a supplementary source of income. In addition to the extended families, some other types of families were also regarded as nuclear families. For example, if widowed or divorced nurses acting as heads of the families were

staying with their children along with some related person like mother or father, their families were included in the class of nuclear families. There were some unmarried nurses who were staying alone or with other room-mates in Poona in rented rooms for the purposes of employment while their parents and other relatives lived in some village in Maharashtra. These nurses were regarded as members of nuclear families. In our sample, eight nurses were found to be members of nuclear families. Only eight of the sampled nurses came from traditional joint families. The joint family consisted of patrilineally related males who had equal rights to property, sharing a common budget, residence and hearth. In other words, the joint family of a nurse included her father-in-law, mother-in-law, brothers-in-law and their wives and children in addition to the nurse herself, her husband and children. For the purpose of present survey, an unmarried nurse living with her parents' family which was a traditional joint family, was regarded as a member of a joint family. Such a nurse had her father, mother, sisters, brothers and their wives and children etc. as members of the family. In the sample, it was noticed that four nurses did not have a family at all. Three were divorced or separated nurses who had unfateful marital life and the remaining one was unmarried, in her late forties and she had
reported that she had no relatives at all. All these four
nurses having nobody to love or be loved, had decided to
spend their life in service of the society. They gave motherly
or sisterly love to the patients. The hospital itself was
like a home for them. They stayed in hostels or in rented
rooms as paying guests.

b) Head of the Family: There were 65 nurses who were
Generally, married, in the sample. The husband acted as the head of the
family. Out of these, two nurses came from a joint family
in real sense of the term, and the nurses' father-in-law was
regarded as the head of that family. 15 of the sampled
nurses were unmarried out of whom 6 were living with their
parents in joint families in which their fathers were heads
of the families. The remaining 8 unmarried nurses were
staying alone away from their parents because of service and
they themselves were acting as family-heads. One unmarried
nurse had no family at all and she herself consisted a family,
if any. There were eight widowed nurses and four divorced
nurses either living alone or with their children and
with some elderly relative like father or mother. These
acted as sole income earners of the family and they were
regarded as family heads. Three of the divorced nurses had
reported of having no family at all.
c) **Family members : Age group and educational status**

On an average, a married nurse in the sample was younger than her husband by five years.

As regards educational status of the family members, it was observed that out of the 65 married nurses, there were 43 nurses whose spouses had been educated up to matriculation or even less than that. 18 nurses' husbands had been graduates or were even post-graduate degree-holders or were holders of more than one degree. Four nurses' spouses had been graduates but, unfortunately unemployed, for three years, on an average. It was observed that the remaining adult members of the family were less educated than the nurse and her husband, having barest minimum school education. The children of the nurses were being educated at schools or colleges and all the nurses were conscious about their children being educated properly. Some of the nurses even told that even if they themselves were less educated, they would like to see their children as highly qualified persons. They said that they lacked an opportunity to educate themselves and suffered lot because of that, but they would not let that happen with their children.
d) Family members : Occupational status and income :

The spouses of 55 nurses had service as their occupation. 6 nurses' husbands were either in business or were having private practice as doctors, lawyers, consultants etc., that means they were self employed. The remaining four nurses' husbands were unemployed, as we have already seen. It is interesting to note that the self-employed spouses were mostly highly qualified with post-graduate degrees.

Those spouses of the nurses who had limited/upto matriculation had an average monthly income of Rs. 600/- . Those spouses of nurses who were highly qualified, earned substantial income per month which was found to be Rs. 1250/- on an average, the highest income per month among them was found to be around Rs. 3500/-. Those who were unemployed earned nothing. It was found that generally the nurses whose husbands earned Rs. 600/- per month on an average, accepted paid work out of economic necessity. The rising costs of living pushed them in employment. Those nurses whose husbands were in search of employment and those nurses who were unmarried, divorced, separated or widowed also looked upon their service primarily as a source of income to support themselves and their families. Of course, some of them told that they had accepted nursing profession for reasons other than economic necessity, like social work,
aptitude towards medical studies etc., as we have already seen. Generally those nurses whose husbands earned Rs. 1250/- per month on an average, were quite well-placed and needed no paid work to be done for supporting the family but they had voluntarily accepted employment as a means of self-development and independence.

Those nurses who were unmarried and who lived with their parents were mostly the main income earners in the family. (There were only two exceptions to this.) The father of the nurse or her brother was mostly a retired govt. servant, a factory worker, the owner of a very small private business like a tailoring house/a grocery shop or he was a small farmer with a very limited income in the range of Rs. 100/- to Rs. 350/- per month. Those nurses who were from a joint family also were the only income earners other than their husbands. All the other members of the family contributed negligible amounts to the total family income. Other female members of the family were unemployed in all cases. The salaries of divorced or widowed nurses were the only source of income for their families. Same was the case with the unmarried nurse who had no family at all.

e) General economic position of a nurse's family:

Even though the proportion of nurses accepting employment out of economic necessity was quite large, their
families peculiarly had two incomes. Nursing profession is dominated by women. When women were employed, men had to be employed. So even if each of them earned a limited income, the total income of the family could not be dismissed as negligible. It was observed that the average income per month of a nurse's family in the sample was Rs. 1255/-. On an average there were 5 persons in each family. So the income available per head per month was Rs. 25/- on an average. This amount was quite sufficient to maintain a satisfactory standard of living for the family. It is quite clear that with only one income earned by a nurse's husband, it would not have been possible to have this much average monthly income per head.

While studying the general economic position of a nurse's family, many more points had to be taken into account in addition to points discussed above. Twenty of the sampled nurses declared that some of their family members were staying out of Poona. Mostly these family members were in-laws of the nurse or her own parents. All these 20 nurses said that they remitted fixed amounts to the family members outside Poona as they had a responsibility of supporting them. The range of remittances was Rs. 25/- to Rs. 300/-. The members staying out of Poona never sent any money to these nurses. Sometimes, a nurse's husband was the member staying out of
Poona for service purposes but in that case also amounts were not received but were regularly sent to him.

When inquired about the income from property, if any, 89 of the sampled nurses told that they had no such income. A few of them said that their family traditionally owned some land or a house, but the small income received from the property was taken by their relatives who looked after the maintenance of that property. Not only this, but sometimes the nurses had to pay for the repairs or maintenance of the property, instead of receiving any income. Only 3 of the sampled nurses reported that they had a small income from property which was in the form of goods like a few bags of grain or fruit and vegetables from their land or a rent of their house, which was less than Rs. 50/- per month.

As regards indebtedness of nurses' families, we had some difficulty in gathering the necessary information. As most of the middle class people made it a prestige point not to have an indebtedness, the nurses, naturally, seemed reluctant to supply information in this respect. 76 of the sampled nurses did not respond to the inquiry about the indebtedness of their family. The remaining 16 sampled nurses admitted that they had borrowed money from others, but only 9 of these supplied all the necessary information about their indebtedness. Generally, the loan was taken
from a finance corporation or a bank or a co-operative credit society for purchasing an ownership flat. It was noticed that the interest rates at which banks supplied the loan was substantially higher than the interest rates of a finance corporation or co-operative societies. There were a few cases when loan was raised from relatives like sisters or brothers or from influential and reputed friends for dealing with some temporary financial difficulty or for discharging a domestic responsibility. Such a private loan was found to be without any charge of an interest and without any terms and conditions of repayment. On the whole, it was noticed that nurses avoided indebtedness and they avoided to disclose it to us, if there was any.

Out of the 65 married nurses, 62 nurses had children. Out of these, 18 nurses had only one issue. 24 nurses had two children. 16 nurses had three children and there were only four nurses who had four children. Not a single nurse had more than four children. It could not be possible to get any information as regards abortions etc. from most of the respondents. Having close association with medical profession every day, all the married nurses, were family planning conscious. 48 of the married nurses, who were in a reproductive age, reported that they practised family planning.
In addition, there were 8 nurses who had taken resort to surgical sterilisation. Those married nurses who could not have children for physical reasons had taken up employment to pass time and to do some social work.

(3) HOUSING AND HOME LIFE

a) Added responsibilities of a working housewife in a city

Among the middle classes, the lot of women who have to cope with both house work and employment outside the home is not much easier. It is still less easier to the women who take to nursing because of the peculiar and inconvenient features of the profession. A working woman in a city like Poona gets certain aids of an urban life, which make house-work easier. For instance, she may not have to fetch water and fuel from a distance, but she is expected to give greater care and attention to the children and their studies, to keep home in a better and more attractive manner, provide more varied menus and play hostess to guests and friends of the family more frequently than her counterparts in rural areas. For working women, there has been considerable role expansion since they are called upon to assume many new roles, in addition to their traditional ones. The efficiency that is required of them in full time employment with its consequent professional responsibilities, as well as in
running a modern home with its extra familial dimensions, create considerable psychological stress which make their life very difficult. Only few such women have the income as well as understanding and sympathy from the family which can ensure some rest and leisure for their self-improvement, or enable them to adjust the patterns of social interactions demanded by their jobs with the demands of the home.

"The change in attitudes to women working outside the home or participating in public life has been slow and uneven, because they are related to deep-rooted prejudices about a woman's inherent aptitudes and capacities, her proper sphere of work and man-woman relationships. A woman is primarily associated with the home, is expected to look after domestic chores and her typical roles are those of a housewife and mother. In the cultural understanding of the people, home-making like child bearing and child-rearing, is identified with feminity. Whether women work in the fields, factories or mines, at construction sites or in white collar jobs, all of them are expected to be home-

makers in the same manner as women who confine themselves exclusively to home-making activity. Their role in the outside world has not yet been accepted in the same manner as men's.

"Thus the teaching profession or medicine is considered respectable for women because it does not conflict with traditional norms of feminity. Nursing, on the other hand, though not in conflict with feminine roles, involves contact with impure objects, male patients and doctors, and odd hours of work and has still not attained the same degree of acceptability among the middle classes, except in a few regions and communities." The Bible emphasizes certain qualities of a woman such as her capacity to work, caring for her family, kindness and charity for the needy outside the home and wisdom. Christianity does not emphasize marriage as a woman's sole destiny. She has an independent moral entity and responsibility. Because of this tradition, Christian women were the first to enter the field of education and employment as nurses. Even if this is the case, we have to admit that though the taboos on women are less in

65) Ibid - 31
Christianity, the basic concept of their inferiority to man is beyond dispute. Further, the trend in the labour market shows that there is no more a majority of Christian women in nursing profession and the local girls of other religions are enthusiastically coming forward to take their place and it is a known fact that other religions are less permissive to women than the Christianity. In the middle class, from which most of the nurses come, the roles and spheres of activities of men and women are sharply demarked. Their economic condition is not bad. Women are spared of much of the drudgery of house-work as they can afford to pay for a domestic help but they are primarily expected to run the home and bring up the children. The precise activities may depend upon the locality, educational level, economic level and extent of modernisation, but the real differentiation remains.

On this background, it would be interesting to know more about the nurses' housing and home-life.

b) Living area and number of rooms in the houses of nurses:

In the survey, it was found that the average area of a nurse's home was 240 square feet and the home consisted of two rooms on an average. The rent paid per month was in the range of Rs. 10 to Rs. 225/- . About 26 nurses were staying in family quarters provided by the government and they did not have to pay rent but got their house rent
allowance cut from their salaries. A nurse's home housed an average five persons. So the number of persons on an average was more than two. Poona Survey of 1937 defined overcrowding as existing when there were more than two persons per each living room. Applying this test, it was found that the homes of the nurses in our sample were over-crowded, but this finding may seem to be somewhat superficial because the rooms may be different sizes. So we had to apply another test for determining whether the nurses' homes were over-crowded. The Bombay Textile Labour Inquiry Committee (1937-40) held 180 square feet of living area for a family of four persons as the minimum in Bombay. This Committee further observed that the standard of the floor area might be put a little higher in less over crowded cities. Adopting this view, it could be considered that more than 2 persons per 100 square feet indicated over-crowding in Poona. When this criterion was applied to the sample-data, again it was found that generally there were more than two persons per 100 square feet


in a nurse's home. So it could be definitely concluded that nurses in the sample lived in over-crowded houses. 40 of the sampled nurses told that there was no open space around their home where they could move around or where their children could play.

c) **Facilities regarding water taps, latrines and bath-rooms in the houses of nurses**:

As regards facilities regarding water taps, latrines and bath rooms, it was found that 36 of the sampled nurses had the facilities of independent water taps, latrine and bath-room at their homes. Still more 36 nurses had only independent water taps and bath rooms at their homes but had to use common latrines. The remaining 20 nurses reported that they had none of these facilities at their homes and had to use them in common with other families. In case of these nurses who shared the facilities with other families, the number of the other families was nine on an average. The maximum number of other families sharing these facilities was found to be 22. 61% of the sampled nurses had to face the inconvenience of sharing a latrine with other families and most of them complained that the common latrine was located far away at a very inconvenient place.
As the study proceeded to see whether the nurses were able to make their home life comfortable with the use of the purchasing power they earned through their employment, it was found that sixty sampled nurses had employed one or more domestic servants to do household work for them. By that they found it easier to adjust their household duties with their work as employees. The servants were employed for cleaning utensils, washing clothes, cleaning grain and getting it milled, cooking, looking after the children and other sundry duties. These servants were paid wages in the range of Rs.15/- to Rs.70/-, depending upon the nature and volume of work assigned to them. They were not staying with the families of the nurses employing them. Only eight nurses reported that their domestic servants had their food with them. Out of the sixty families in our sample that employed domestic servants, 52 families could employ only one maid servant and that too for cleaning the utensils and washing clothes only. They could not afford to employ servants for work like cooking or baby-sitting which was costly. It was quite natural as nearly all of these nurses had accepted employment for economic needs and they could not spend their salaries for personal comfort or convenience. 32 of these nurses reported that they had no domestic
servant to help them in household work. One of the reasons for this was the high cost of domestic labour. Some nurses said that the servants, who were arrogant and not punctual, caused more inconvenience than any help, so it was better not to employ any servant. Still some of these nurses told that they liked to do household work with their own hands and they had complete co-operation from their spouses and children. They said that even though traditionally a woman was supposed to do household work, their husbands were very understanding, giving equal status to them, and helped them in cooking etc. But these were only rare cases. In general, it was found that irregular water supply, method of cooking, totally unprocessed nature of food which was bought, absence of mechanical aids like mixer, washing machine etc. did considerable addition of time and arduousness to the housework and the time and effort involved in housework was disproportionately large in spite of employment of domestic servants. As seen in chapter 4, most of these nurses who were housewives and mothers, responsible for providing comfortable homes for their families, spent all the time available other than duty hours at the hospital, in domestic work. They could hardly find any time for rest and leisure. On the other hand, male nurses' contribution in household work was negligible. "Clearly the factor operating in these cases is the convention that
household work (however gruelling it may be) is women's work, and that a man found to be engaging in it would be considered strange or ridiculous. In general, it would not even occur to a man to offer, or a woman to ask a man to help with the housework. And because it is accepted as something like a law of nature rather than a socially determined fact, the callousness involved in expecting women to drudge all day is not perceived as such, but is seen as unavoidable and necessary. It is clear that the nurses who could not or had not employed domestic servants and who put in many hours of work at home in addition to their duty hours at the hospital were suffering from overwork which had an adverse effect on their health and well-being and capacity to work. It is likely that this situation would be intensified when there was a fall in real wages because there would be an attempt to compensate for the reduction in use-values of purchases by performing more work at home. This was why the demand by the nurses to have frequent revision of pay scales of nurses according to price index seemed reasonable.

As regards child upbringing, the questionnaire contained a few questions demanding information about the deliveries. The nurses were asked the date, place of delivery, information about child-deaths and their reasons, abortions, use of medical facilities where they were available etc. The information about the number of children these nurses had, has been given elsewhere in this chapter; but it seemed rather strange that many sampled nurses had not supplied information as regards their deliveries. In this regard, it would not be possible to neglect a shocking comment made by a responsible officer of one of the government hospitals in Poona while discussing the life and labour of nurses. According to him, it would not be possible to get true answers from nurses to questions about deliveries, abortions etc. because of the changing values of morality in the younger generation. Out of 65 married nurses in the sample, 62 nurses had children. All of them said that they had been working when their children were less than five years old. A child needs the love and care of the mother especially in such a tender age. Therefore, it is clear that these nurses had an additional work of taking proper care of their children at home in those years, along with their normal duty at the hospital and at home. 36 sampled nurses had either employed a servant to look after the
children or they had resorted to paid child-care in creches managed by private institutions. The remaining 26 nurses told that elderly women in the family like mother or mother-in-law of the nurse or other relatives or in some cases the neighbours looked after the children while their mother went to work in the hospital. More than fifty per cent of the sampled nurses who had children confessed that their children and family suffered a lot because of their employment. They felt guilty as they thought they had neglected their children. Those who had resorted to paid child-care were more worried. Those who entrusted their children to the care of elderly women in the family or other relatives did not feel that their children were much neglected. Still the fact that they had to be away from the children even if their children were ill and had to do the nursing of others' children as a part of their duty, was most painful for them. Long duty hours, break duty, night duty, absence of family quarters in the hospital compound, absence of transport facilities, absence of a creche at the hospital etc. were the reasons which were responsible for the neglect of the children, they felt. Many nurses told that when they came home from duty, they were too tired to have a meaningful dialogue with the children because of overwork at the hospital. They could not come up to the expectations of their children like other mothers.
Of course, in the absence of continuous protection and care of the mother, the children possibly became more independent, smart, sensible and practical.

A woman is primarily associated with the home. Therefore, the work life of a nurse could not be studied without studying her home life. A nuclear household, limited number of family members, limited number of children, two incomes, satisfactory diet and budget etc. were the factors contributing to a happy family life for a nurse. She was increasingly getting equal status and support from her husband and other family members. People in her family had started appreciating her work. Because of two incomes for a family, she could employ domestic servants to help her in household work and baby-sitting. Unlike her counterparts in rural surroundings, a nurse in Poona got aids of an urban life. Because of two incomes, she could buy mechanical equipments to make her domestic work easier, but these features were not common to families of all nurses. Rising costs of living superceded two incomes of her family. She lived in a house which was over-crowded, which had no sufficient facilities like water taps, latrines and bathrooms. There was no open space around the house where her children could play. Domestic servants were not easily available and their service was costly. She had a sense of guilt as regards child-care.
Long and inconvenient duty hours, night-duty, break duty, over-work at home and at hospital, absence of family quarters near the place of work, non-availability of transport facilities and a non-cooperative attitude of family members (in some cases) were the root-causes of her worries. They made her home life difficult and there was no doubt that many times her discontent had a reflection on her work at the hospital. Therefore, if the government wants an ideal and efficient employee of her, it must remove all root-causes of discontent and take following immediate moves to make her family life and home life happy:

1) Revision of wage-structure.
2) Rationalisation of hours of work taking into consideration the suggestions particularly as regards duty hours, timings, night duty, break duty, holidays and leave etc. as given in Chapter 4.
3) As suggested in Mohite Committee Report, provision of family quarters to at least 10% of the nursing personnel and residential accommodation in hostels to at least 50% of the nursing personnel at the site of work. A nurse should have a good home with excellent facilities like independent bathrooms, latrines, water-taps and an open space around, in the hospital compound. This will help attain easy availability of nurses for duty in case of emergency, easy administration of shift duties at odd hours, complete personal safety, punctuality of attendance.
4) Allotment of suitable land preferably near the place of their work at a concessional rate to build houses by forming nurses' co-operative housing societies.
5) House building loans on easy terms should be made available from the banks, Housing Board, LIC or from the nurses provident funds.

6) Co-operative efforts should be encouraged for the nurses to have their own co-operative stores for their domestic and household needs.

7) An adequate amount towards messing allowance should be merged with the pay of nurses and a cafetaria providing wholesome food, milk etc. round the clock should be opened in all the hospitals.

8) Adequate transport facilities should be provided.

9) Equal status and support and help in household work should be offered to a nurse by her family members.

10) At present, only the Sassoon General Hospital has the facility of a creche for the nurses. Creches should be opened in all the other hospitals on a similar basis.

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